REFORMING HEALTHCARE IN THE 21ST CENTURY

A Federal Reserve Model

Abstract

Separating payment from clinical decision-making means Americans can have both “single payer” and private clinicians and provider organizations to reduce administrative and transaction costs while maintaining physician independence and consumer choice.

Sandra Raup, R.D., J.D., M.P.H.

sraup@datuit.com

Executive Summary and Proposal – "Federal Reserve for Health Care"

Earlier this year, a review of health-related polls published in New England Journal of Medicine demonstrated that healthcare issues will be a major election issue and why.[1] The problems aren't new, with incremental changes over decades making little impact on the quality and cost of services available to Americans.

Although the U.S. has gone through various iterations of healthcare reform, most of the efforts has involved changing payment models, with increasing levels of complexity. As a result, clinicians have had to manage two aspects of care – clinical and administrative/billing – wasting valuable clinician time and creating more levels of management that increase overall costs.

In this next election cycle, solutions are again proposed, but will they result in improvements in cost and/or quality? If the past is any indication, not so much. Restructuring the way we analyze our reimbursement approach – the only component that government can realistically impact – could allow clinicians on the ground to have the flexibility to deliver the kind of care that their patients want. Clinicians want to return to their fiduciary relationship with their patients. Getting government out of the way would allow that to happen, benefiting them and their patients while eliminating layers of expensive and wasteful bureaucracy.

- **Structure**. The federal government would use a single federal agency to pay for healthcare services for all Americans. It would operate as the "Central Health Board" (CHB) of the "Federal Health Reserve" (FHR) that oversees the "Regional Health Reserves" (RHRs). The CHR would make sure the RHRs follow the same access/benefit rules, and the FHR would distribute funds to RHRs based on population, cost of living, etc. The RHRs would distribute funds to hospitals, primary care, specialists and support services based on their assessment of need.
- **Benefits**. This approach would enable flexibility to cover basic needs as well as innovative approaches. By minimizing transaction costs, more money would be available for new ways of delivering and paying for care. In addition, methods of measuring quality and outcomes would be more flexible, leading to better data and analyses to speed improvement in care for patients and quality of life for clinicians.
- **Political hurdles**. For decades, healthcare policy has been politically polarized. Some want a "socialized" program vs. others who want a "free market" solution. What's obvious, however, is few people pay for their own care. Looking at a way to reduce overall costs may break through the political gridlock to allow a solution that's acceptable to all. As in other countries, healthcare can be privately delivered and publicly funded, with clinical decisions staying with patients and their providers. In addition, RHRs can effectively monitor the quality of provider organizations and adjust their funding to improve the health of their populations. The history of how the Federal Reserve came into existence serves as a model for achieving this kind of political reconciliation.

[1] Robert J. Blendon, et al. The Upcoming U.S. Health Care Cost Debate – The Public's View. N Engl J Med 280(26):2487-92 (2019). "About three fourths (76%) of the public believes that Americans are paying too much for its quality. A majority also believes that health insurance premiums are increasing primarily either to boost profits for insurance companies (47%) or to accommodate high prices for care (16%), not because care is better (21%) or coverage is broader (13%) (West Health – Gallup, 2019). Accessed at https://www.nejm.org/doi/full/10.1056/NEJMp1905710.

Background

Legislation to create the Federal Reserve was passed despite politicians' and stakeholders' opposition. State and local banks were afraid of big New York banks gaining more influence, and big New York banks did not want to cede their influence to smaller state and local banks. The problem, however, became too big to ignore when a serious event, the Panic of 1907, left bankers and politicians with the belief that some sort of central bank was necessary. Although it started with a single paper, it took a bipartisan group to create a system that was acceptable to both small state and local and big New York banks, as well as Americans skeptical of government (especially central) control. The framers of the Federal Reserve legislation determined that the key to a workable solution was to remove decision-making from political influence as much as possible (while still being accountable to Congress) and involvement of a broader voice with regional Reserve Banks (to represent regional concerns) and business representation that broadened its mission.

Over the past century, the Federal Reserve has evolved to meet the challenges it faces. It avoids the "top down" dictates of political will, something that administrative agencies cannot avoid, to craft timely solutions, also something that administrative agencies cannot do. A century later, a similar system could provide the same kind of stability and flexibility for the complex healthcare problems we face today.[2]

How We Got Here: A Brief History of Reform in America

In previous centuries, healthcare was paid for by individuals and charitable organizations when individuals could not afford to pay for their own care. As medical and health care became more complex, efforts to modernize and improve the delivery and payment methods happened in the U.S. and elsewhere. In the 19th and 20th centuries, other countries went from charity-provided care to "social" care, paid for either by government or trade unions/employers. The U.S., however, continued to rely on multiple private sources until the 1960's, when Congress created Medicaid and Medicare to fund care for the poor and the elderly.[3] With its strong belief in free enterprise and states' rights, the U.S. chose to tinker with state and federal regulations that force healthcare provider organizations to efficiently manage their services paid for via private and government health insurance. Each new regulation and piece of legislation added another layer of complexity that continues today, adding needless expense and opportunities to game the system and commit fraud. Starting in the 1940's, the federal government started encouraging employers to provide health insurance as part of their benefits. The federal government also began supporting acute care hospital construction[4] and established the first healthcare department, the Department of Health, Education and Welfare (HEW).[5] In the 1960's, Medicare and Medicaid were launched, and the Employee Retirement Income Security Act (ERISA) followed in the 1970's.[6] The Emergency Medical Treatment & Labor Act (EMTALA) was enacted in the

[2] Roger Lowenstein. America's Bank: The Epic Struggle to Create the Federal Reserve. (Penguin Press, New York, NY, 2014). This book contains a detailed history of the Federal Reserve's origins.

[3] The Social Security Act Amendments of 1965, also known as The Medicare and Medicaid Act. Accessed at https://healthlaw.org/announcement/medicare-and-medicaid-act-1965-2/

[4] The Hill-Burton Act was passed to help communities build hospitals and nursing homes with the provision that they would help provide charity care to those in their geographical areas. https://www.hrsa.gov/get-health-care/affordable/hill-burton/index.html

[5] The Department of Health Education and Welfare was established in 1953. Further information at https://healthlaw.org/announcement/medicare-and-medicaid-act-1965-2/

[6] More information available at https://www.dol.gov/general/topic/retirement/erisa.

1980's.[7] A big mashup of public and private healthcare services funding began, and even though in later decades efforts to rationalize the system began, it never really got better.

In order to slow the growth of healthcare expenditures, Congress formulated a new prospective payment system for hospital care in the Social Security Amendments of 1983. The result was the Diagnosis Related Group (DRG) system[8] that added a layer of management to make sure episodes of care were appropriately reimbursed by Medicare. As a result of changes in payment, the business and care models also started to change. The previous model of paying for individual physician visits, medications dispensed by pharmacies and hospital care with itemized charges began to change to a more bundled approach. Payers – government and private payers – started contracting with medical providers to limit what looked like explosive growth as more complex and expensive tests and therapies became available. Employers, who had traditionally given health benefits to their employees, began to find ways to limit their healthcare expenditures as well. The federal government responded to their concerns with two major pieces of legislation – Employee Retirement Income Security Act (ERISA) of 1974[9] and the Health Maintenance Organization (HMO) Act of 1973[10] that allowed employers more flexibility in designing and paying for their employees' health plans.

Concerns about healthcare costs led to an effort in the 1990's to create a national health plan that would fund health care for all Americans, but special interests mounted a campaign to stop it before it received a vote.[11] Politicians took that to mean that Americans didn't want a universal health plan. Many realized, however, that the problems weren't going away, and there would need to be ongoing, but perhaps incremental, reforms. Efforts to contain growing costs included managed care, where the payer and provider were combined in the same organizations with incentives to manage costs given to front line clinicians. After horror stories brought by patients who did not receive appropriate or timely care, that approach lost favor with the public.[12] The next approach to control costs was high deductible health plans (HDHPs), which made patients pay for a substantial portion of their own care in order to discourage over-utilization. This approach also came into disfavor as many individuals found they were unable to afford the care they needed, despite having health insurance. Healthcare costs continued to rise despite these efforts.[13]

---

[7] More information available at https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA.

[8] "A diagnosis-related group (DRG) is a patient classification system that standardizes prospective payment to hospitals and encourages cost containment initiatives." More information at https://hmsa.com/portal/provider/zav_pel.fh.DIA.650.htm

[9] ERISA Requirements for Employee Benefit Plan Administration. Office & HR, Walter Kluwer. Accessed at https://www.bizfilings.com/toolkit/research-topics/office-hr/erisa-requirements-for-employee-benefit-plan-administration.

[10] Notes and Brief Reports. Social Security Bulletin (March 1974). Accessed at https://www.ssa.gov/policy/docs/ssb/v37n3/v37n3p35.pdf.

[11] Hillarycare, the Health Security Act of 1993. Hillarycare: What It Was and Why It Failed. The Balance (October 4, 2019) https://www.thebalance.com/hillarycare-comparison-to-obamacare-4101814

[12] An example of how managed care was seen was shown in Pegram v. Herdrich, an ERISA case decided by the U.S. Supreme Court in 2000. https://www.law.cornell.edu/supct/html/98-1949.ZS.html

[13] Erin Golden. Dayton says Affordable Care Act has become unaffordable, needs reforms. StarTribune (October 12, 2016). Accessed at http://www.startribune.com/dayton-says-affordable-care-act-has-become-unaffordable-needs-reforms/396864871/.

After Democrats came to dominate Congress and the Presidency in 2008, the most comprehensive solutions yet seen were signed into law. The HITECH provisions of the ARRA of 2009 (a stimulus bill that funded electronic health records), [14] and PPACA of 2010 (healthcare payment and regulatory reform)[15] set in motion major changes to how acute and ambulatory care were delivered and reimbursed. PPACA placed new requirements on insurers, employers and individuals and enabled significant expansion of Medicaid benefits to more individuals for states that elected to do so. Individuals were to have access to private insurance via their own state or a federal insurance exchange that worked like a marketplace for insurers to offer policies that met PPACA requirements. Not as many states as anticipated created their own exchanges, and the federal exchange did not function as promised.[16] Acute and ambulatory provider organizations were incentivized via HITECH to follow directives for HIT adoption and quality metrics reporting. All these changes were expected to result in lower cost and better quality, as well as better access to care for those who did not otherwise have it. Unfortunately, predictions didn't pan out as expected, as the "health insurance exchanges" (state and federal) allowing individuals to purchase insurance experienced technical glitches, making them difficult to use, fewer insurance options were available than expected, and those available had higher premiums than expected. Not all states chose to expand Medicaid benefits, leaving low income individuals and families in some states without affordable options. In addition, high deductible health plans became much more prevalent, with patients' out of pocket costs reaching unaffordable levels. Even though insurers are required to cover pre-existing conditions, new issues arose – most recently, surprise medical bills and skyrocketing costs of medications.

Finding Out What Americans Want

At the start of the 21st century, politicians asked what their constituents wanted in a healthcare system. They had attempted big changes in the 1990's but had run into problems with public acceptance of the proposed legislation. Policy experts debated why that happened – were the proposals not what people wanted, or were people influenced by industry messages?[17] States and federal agencies engaged in substantial efforts to get a more nuanced view of what people saw as problems and what they thought would solve those problems. Two of those efforts are discussed below.

Minnesota Decides. In 2000, town hall forums and small-group discussions took place in various rural and urban settings around Minnesota. The goal was to address three questions: What kind of health care do Minnesotans want? How much are they willing to pay? How should the system be financed?[18]

- **Fairness**. Participants overwhelmingly valued fairness and believed that any system must meet that standard. They differed, however, in how individuals defined fairness. Some saw unfairness in the

[14] Howard Burde. The HITECH ACT: An Overview. Virtual Mentor 13(3):172-5 (2011). https://journalofethics.ama-assn.org/article/hitech-act-overview/2011-03

[15] Access to the full text available at https://www.healthcare.gov/where-can-i-read-the-affordable-care-act/.

[16] Vanessa C. Forsberg. Overview of Health Insurance Exchanges. Congressional Research Service (June 20, 2018). A more complete explanation is available in this report. Accessed at https://fas.org/sgp/crs/misc/R44065.pdf.

[17] Raymond L. Goldstein, et al. Harry and Louise and Health Care Reform: Romancing Public Opinion. J Health Polit Policy 26(6):1325-52 (2001). Accessed at https://read.dukeupress.edu/jhppl/article-abstract/26/6/1325/28223/Harry-and-Louise-and-Health-Care-Reform-Romancing?redirectedFrom=fulltext

[18] Minnesota Decides: Creating a Community BluePrint for Health Reform. Fall 2001 Report. BlueCross BlueShield BluePlus of Minnesota (2001).

differences between different benefit plans, such as a high level of benefit at no cost for government programs yet "sky-high" premiums for catastrophic coverage for individual policies. Others saw unfairness in the connection between health insurance coverage and employment, where different employers paid different amounts for the same coverage. Still others thought it was unfair to make care decisions based solely on cost. Some thought that it would be fair if a "certain standard of care" was maintained for everyone yet others could purchase "nicer care."

- **Cost.** Participants identified excessive costs as a problem. There was a sense that there was too much complexity in the system, and that reducing paperwork and bureaucracy would result in savings. They also believed that all who participated in the system – providers and consumers – "must feel responsible and be held accountable" for cost control to be realized.
- **Market driven**. Participants differed in their preferred approaches to reach their shared goals of fairness, quality management and cost control. Most preferred a "market-driven system" built on "what is working well today." They believed that more competition would drive down prices and provide greater choice. The minority thought a single-payer, state-run system would be better able to provide high quality, affordable care to everyone. They also believed that reduced administrative costs would create substantial savings.
- **Choice**. Most participants wanted more choice than was available as employers usually offered one plan with limited doctors and hospital choices. They felt that they had a right to use as many services as they wanted, even if they also believed they had a responsibility to use only necessary services.
- **Government oversight.** Although most participants did not want government providing or directing care, they wanted the government involved in improving the system and protecting consumers' interests. The participants did not express agreement on the degree to which government should be involved, as a substantial number believing that the government was already too involved and a similar number believing that more involvement is necessary.
- **Public health.** In general, most participants believed that individuals needed to bear responsibility for their lifestyle choices. They agreed, however, that more emphasis needed to be placed on public health and prevention measures, and communities should be involved in this effort.

Minnesota Decides Part 2. In 2003, two groups – one urban and one rural – were brought together to discuss how to proceed with health care reform. The groups included consumers, advocates, employers, policy makers, health plans and providers with a goal of reaching consensus on specific recommendations for reform.[19] In the end, four themes emerged:

1. **Change the system, including how health care is delivered.** Cost is impossible to control with the current fragmented system. A functional health information technology (HIT) system is needed, and also cost-effectiveness information should be available for drugs and procedures.
2. **Make it possible for people to be better health consumers.** The current system makes it nearly impossible for consumers to know the quality or cost of services because there is a lack of useful information.
3. **Encourage the practice of evidence-based medicine.** Providers should not have incentives to provide unnecessary treatment.
4. **Promote prevention.** Prevention, not curing illnesses, should be the focus.

[19] Creating Minnesota Solutions to the Challenge of Rising Health Costs: Report of the 2003 Health Care Cost Dialogues. National Institute of Health Policy and BlueCross BlueShield of Minnesota (2003).

Citizens' Health Care Working Group. The federal government also started exploring ways to improve the provision of healthcare and reduce overall costs in the early 21st century. It began when the Medicare Prescription Drug Improvement and Modernization Act of 2003 created a forum for discussing health care with American citizens to "engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage." The Working Group used public meetings, individual conversations, literature reviews and polling results to summarize the collective preferences of Americans. The most important principles identified were:[20]

- "**Health and health care are fundamental to the well-being and security of the American people.**
- **Health care is a shared social responsibility**. This is defined as, on the one hand, the nation's or community's responsibility for the health and security of its people and, on the other hand, the individual's responsibility to be a good steward of health care resources.
- **All Americans should have access to a set of core health care services across the continuum of care that includes wellness and preventive services**. This defined set of benefits should be guaranteed for all, across the lifespan, in a simple and seamless manner. These benefits should be portable and independent of health status, working status, age, income or other categorical factors that might otherwise affect health-insurance status.
- **Health care spending needs to be considered in the context of other societal needs and responsibilities**. Because resources for health care spending are not unlimited, the efficient use of public and private resources is critical." (Emphasis added.)

The Problems Are Not Solved

The results of both studies can be broken down into four problem areas: fairness, cost control, choice and prevention/wellness. In the 15 years since these studies were done, the problems have not been solved. Here's where we are today:

- **Fairness**. Economic issues make the system unfair – some can't afford essential care or coverage, and some pay more than others for the same products or services. Although technically more people have access to insurance, many have experienced financial hardship as their share of the cost burden has become unaffordable. Total costs have increased, and new billing practices have made consumers susceptible to unexpected costs. These include "surprise bills" and higher than expected costs of medications they need to use regularly, such as insulin.
- **Cost control**. PPACA and HITECH legislation included several experiments aimed at reducing costs. Unfortunately, most have not been proven effective, and some (notably, ACOs and value based care) continue to be in the experimental stage as "too early to tell". Provider organizations have consolidated, with the result that their prices have increased as they approach monopoly power. On the other hand, insurers have continued to develop new and better ways to obtain more money

[20]Citizens' Health Care Working Group, Health Care That Works For All Americans: Recommendations of the Citizens' Health Care Working Group. Available at https://govinfo.library.unt.edu/chc/.

from government and private payers. Pharmacy Benefit Managers (PBMs)[21] add another layer of bureaucracy that brings in even more money from employers and consumers, the ultimate payers.

- **Choice**. As the early 21st century efforts progressed, consumers saw that their choice of clinician had diminished. Recently, that choice has further eroded as many of the lower cost insurers and employer health plans have adopted narrower networks, giving patients fewer choices. In addition, in some cases consumers may end up with out of network clinicians involved in their care, leading to shocking out of network "surprise bills" that have caused serious financial hardship for some patients and families.
- **Prevention and wellness**. Research in the 1980's and 1990's suggested that major healthcare expenditures could be avoided if prevention and wellness were encouraged. PPACA added incentives for preventive care to insurers (mandating preventive services at no cost), Medicare (a no cost "Welcome to Medicare" visit that addressed prevention and wellness) and employers (greater allowance for tax free wellness services for employees). Since that initial research, however, there has been little evidence generated that preventive services or wellness programs reduce costs.[22]

A Possible Solution

A "Federal Reserve for Health Care" Approach: Separate financing of healthcare from clinical decision-making. Although payers have had decades to show that they can improve quality and reduce costs, they have been unsuccessful in either goal. Payers have used a variety of methods to identify individuals with greater risk, but this has led to more gaming of the diagnostic coding system by clinicians to increase their reimbursement. It has also led to more screening for more problems, distracting patients and clinicians from addressing problems that patients really want addressed. In the end, these efforts have increased costs and increased physician frustration without impacting the health of individuals or populations.

Because payers have been unable to improve quality or reduce costs, this proposal is to consolidate payers into one Federal Health Reserve (FHR)/Central Health Board (CHB) that distributes funds to Regional Health Reserves (RHRs) that distribute payment to clinical service provider organizations to meet the needs of individuals in their communities. This will eliminate the need for insurance companies to be involved in essential services payment, although supplemental insurance would be allowed for those who want it. Centralizing the payment system will (1) determine how to simplify the financing of care; and (2) allow both patients and clinicians to understand how care is reimbursed. The FHR/CHB would (1) distribute funds to RHRs based on population needs; (2) define the benefits to be funded and the payment mechanisms to be used by the RHRs; (3) give direction for measuring quality of care and outcomes; (4) make policy decisions regarding provider relationships and support system funding; and (5) issue reports to Congress regarding mandated goals of the system. In addition to physicians and health economists, the FHR/CHB and RHRs would also include representatives from ancillary professions, patient representatives and related interest groups.

The RHRs will distribute the funds to the various qualifying provider organizations following the CHB's policies, depending on their ability to serve their patient populations. Ideally, specific populations' needs

[21] Pharmacy Benefit Managers and Their Role in Drug Spending. The Commonwealth Fund (April 22, 2019). Accessed at https://www.commonwealthfund.org/publications/explainer/2019/apr/pharmacy-benefit-managers-and-their-role-drug-spending.

[22] Does preventive care save money? Nope – but it's a bargain, Aaron Carroll argues. Advisory Board (January 31, 2018). Accessed at https://www.advisory.com/daily-briefing/2018/01/31/preventive-carroll.

will be addressed by ambulatory primary care and specialty care organizations (including sole proprietor organizations) while coordinating with the larger healthcare ecosystem, including hospitals, pharmacies and rehabilitation centers. Hospitals and rehabilitation centers will be given annual global budgets, and pharmacies will dispense drugs according to a reimbursement schedule that allows payment for pharmacists' services. In this way regions of the country will be able to address their own healthcare issues without "top down" directives from the FHR/CHB.[23] A fair method of risk adjusting will provide per member per month (PMPM) fees to primary care providers, with RHRs determining methods to measure quality of care.

With this plan, state and local governments will continue to be responsible for long term care and public health. Their current responsibilities, including low income healthcare and employee health benefits, will be substantially reduced so they can concentrate on these more limited responsibilities. This can be accomplished by partnering with organizations in their communities to deliver care to those with long term care needs. The following table describes the components:

Service	Funding	Oversight
Primary Care	Patients will choose a primary care provider, and the RHRs will distribute a risk-adjusted monthly payment for each of their patients.	National licensing of physicians and other clinical professions (nurses, pharmacists, therapists, dietitians, etc.). National licensing of clinics and ancillary providers paid for as part of primary care services.
Specialty Care	Independent clinics or associated with hospital system. RHRs will determine how much specialty care is needed and distribute funds to various programs. If part of a hospital system, will funded separately.	National licensing of physicians and specialty practices. Organizations that deliver specialized care, such as migraine centers, joint replacements, ambulatory surgery centers, etc., licensed nationally but reimbursed by RHRs. Supplemental insurance may give access beyond what is funded by RHRs.
Prescription Medications	National drug contracting via FHR/ CHB with pricing uniform across the country. Independent pharmacies reimbursed to include pharmacist dispensing fee.	Drug plan approvals, availability and pricing determined nationally. The FDA will continue to vet medications for safety and efficacy.
Hospitals	RHRs distribute annual budgets to hospitals. Hospitals can supplement income by charging for parking, visitor food, gift shop and charitable fund raising.	National licensing of all hospitals via federal organization.
Rehabilitation	RHRs distribute annual budgets based on demonstrated need.	National licensing* of all rehabilitation centers via federal organization.

[23] For example, if a community experienced a lead poisoning outbreak from contaminated water, they could quickly shift funds to address care for affected individuals, even while public health and local government addressed the lead contamination issue.

Urgent Care/ Retail Clinics	Private pay via out of pocket or insurance as part of employee benefit package.	National licensing* of all urgent care and retail clinics via federal organization, with scope of practice defined for each.
Long Term Care (Nursing Homes, Assisted Living, Home Care)	Care for those who cannot afford LTC will be provided by states. States can also provide care directly if they choose.	National licensing* of all nursing homes, assisted living facilities, home care agencies via federal organization. Quality metrics monitored and reported nationally.
Public Health	State and local governments will be responsible for paying for public health programs.	Public health agencies and their scope of practice defined by state governments.

*States will inspect facilities to verify federal standards are implemented.

Other Proposals

Democratic presidential candidates have made proposals to solve the healthcare problems. Some support "single payer" solutions that others criticize as "government controlled" and too expensive. Others think the best approach is to build on past reforms, including PPACA, by subsidizing more policies and/or controlling prices. One organization, The Third Way, has developed an incremental reform proposal that some candidates support.[24]

Employer proposals. Dave Chase, founder of Health Rosetta,[25] has been attempting in the past several years to reduce cost and improve care paid by employer-provided health plans. He has written extensively about excessive costs due to insurance companies, provider organizations and drug manufacturers. He recommends employers directly contract with provider organizations, preferably using Direct Primary Care for primary care and eliminating insurers when possible. He has helped employers, unions and government agencies reduce their overall healthcare spend considerably, and shares stories of their success to encourage others to do the same.

Employers have also worked together to reduce costs and improve quality for employees' healthcare.[26] Their efforts have focused on cost and quality transparency and have made more information about the quality of a hospital or clinic available to consumers.

Physician proposals. Ideas for better management of healthcare services financing come from clinicians as well. The **Expanding Medical and Behavioral Resources with Access to Care for Everyone (EMBRACE)** plan was first introduced in 2007 but has been recently re-introduced as an approach to manage costs.[27] EMBRACE's primary mechanisms for improving the system and reducing costs include (1) a tiered benefit plans that can be supplemented by private insurance; (2) a central health information technology (HIT) platform to access any patient's record and submit bills to payers; (3) regional chapters to allow for regional differences in care needs; and (4) a National Medical Board to oversee medical care

[24] David Kendall et al. Cost Caps and Coverage for All: How to Make Health Care Universally Affordable. The Third Way (February 19, 2019). Accessed at https://www.thirdway.org/report/cost-caps-and-coverage-for-all-how-to-make-health-care-universally-affordable.

[25] Health Rosetta information available at https://healthrosetta.org/.

[26] The Leapfrog Group. https://www.leapfroggroup.org/employers-purchasers

[27] Healthcare Professionals for Healthcare Reform. Embracing a Unified Universal Healthcare System: The Expanding Medical and Behavioral Resources with Access to Care for Everyone (EMBRACE) Healthcare Plan. White Paper available at https://www.theembraceplan.com/home.html.

and hear from special interest groups. In another proposal, Mike Magee, M.D., proposes building on PPACA with incremental changes and emphasizes a central planning model. He sets a goal of healthcare spending at 14% of GDP – a substantial reduction from what it is today. He includes specific recommendations for lowering drug costs, such as reference pricing of pharmaceuticals (patterned after what is done in other countries) and eliminating PBMs, but not private insurers. He recently published a book, **Code Blue**, that gives his analysis of the problems with the Medical Industrial Complex as well as his suggestions for revising the system.[28] Other physicians and medical groups have weighed in on the problems we face and how to solve them.

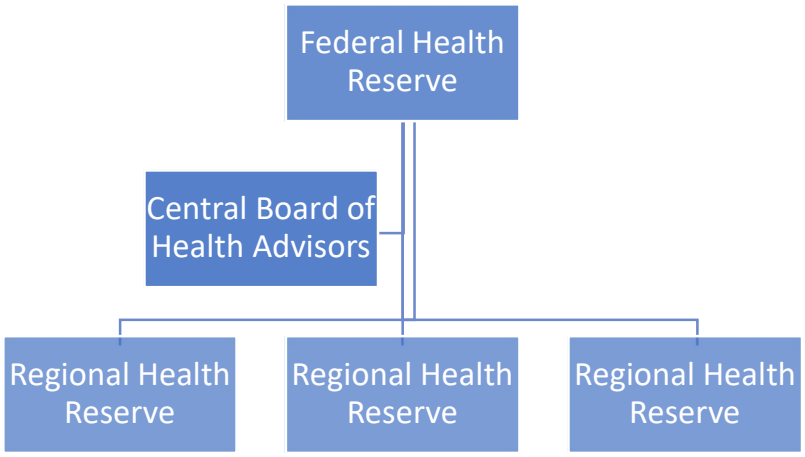
Advantages to the Federal Reserve Approach

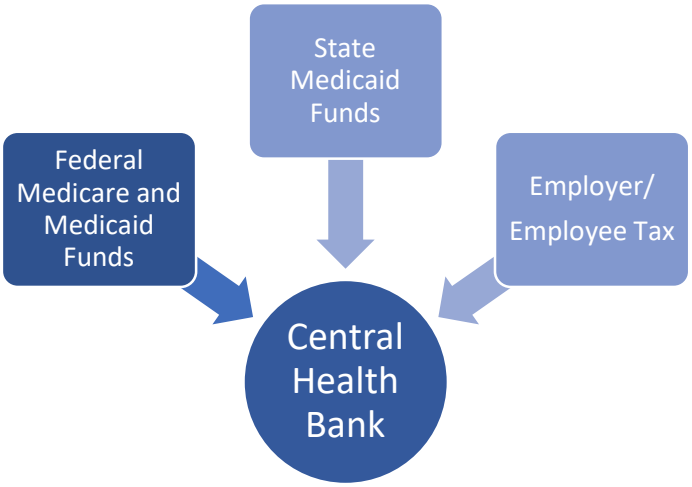
- **Administrative costs would be lower**. Without payer-provider adversarial relationships, transactions are made simpler. Costs associated with insurance companies and PBMs would be eliminated because their functions would be assumed by national and regional agencies. Supplemental health insurance and health plans would be available but would not be necessary to receive adequate, basic care.
- **Quality measurement would be more efficient and more effective**. With centralized payment, quality measures are easier to measure and report. Safety can be more effectively monitored by regional and state agencies while complying with federal mandates.
- **There would be more opportunity for innovation**. With more flexible reimbursement schemes, short-term and long-term innovative projects can be funded and tested for effectiveness and cost. Instead of today's system where almost all care decisions are driven by what's paid for and how it's paid for, clinicians can develop new ways of providing more convenient and effective care, utilizing the least expensive approach without worrying about the effect on how much reimbursement will be provided.
- **Politicians would not be able to use healthcare as an election issue**. Because distribution of money for care would be determined by the FHR/CHB and RHRs, voting for one person or party over another would have little impact on one's ability to access care. On the other hand, members of the CHB would be appointed by the President and approved by the Senate with staggered terms to minimize political influence. Provider organizations can be held more accountable with less administrative burden by simplifying the oversight and payment processes. In addition, consumers can access the oversight and payment processes so they, too, can understand how resources are utilized.

Conclusion

This paper is intended to start a conversation about finding a different approach to organizing and funding healthcare services that can truly reduce costs and improve care outcomes. Major goals should also include improving efficiency of all who interact with the healthcare system while reducing costs and making sure that consumers understand how these interactions work. By looking at what American citizens want and the practical issues facing today's healthcare clinicians and systems, perhaps we can reach a solution that delivers the cost and quality outcomes that Americans are seeking.

[28] Mike Magee. Code Blue: Inside America's Medical Industrial Complex. Atlantic Monthly Press (2019). https://www.google.com/books/edition/Code_Blue/KkSEDwAAQBAJ?hl=en&gbpv=0.





Regional Health Reserves will fund:

Primary Care	• Adult Care • Pediatric Care • Geriatric Care
Specialty Care	• Medical Specialty Care • Surgical Care • Ancillary Care
Acute Care	• Hospital Care • Rehabilitation Care