DOCS 4 Patient Care FOUNDATION

The Physician's Prescription for Health Care Reform

The Docs 4 Patient Care Foundation is an organization of physicians committed to the establishment of an American health care economy which preserves the sanctity of the physician-patient relationship, promotes quality care, supports affordable access to care for all Americans and protects patient's personal health care decisions.

The economic and professional dysfunction of America's health care economy has developed as a result of policy decisions made over the last eight decades. These decisions are often driven by political ideology and expediency over rational economic and ethical principles. A thorough analysis of the present state of American health care, including the history of these developments, leads us to recommend the steps outlined in this Prescription for reform.

- All Americans must have access to an insurance market devoid of tax discrimination.
- Health insurance must once again become "true insurance", a hedge against a catastrophic loss, instead of an expensive pre-paid health maintenance plan.
- Individuals and families need to own their health insurance policies which need not be connected to or dependent upon employment.
- A true national competitive market for health insurance is necessary, where insurance is available without artificial boundaries and may be purchased in a variety of ways.
- Medicare, Medicaid and SCHIP must be gradually transitioned to fiscally responsible programs which would support individuals in need and give them the same consumer choices available to Americans who purchase their own health insurance.
- Reform of the current wasteful and dysfunctional medical malpractice system must be addressed.
- Health information technology, currently dictated by the federal government in a top-down centrally controlled manner, needs to be freed from government control and allowed to flourish in a true market as has been the case for all advanced electronic technology.
- States need to be empowered to act as laboratories for innovation in the design and implementation of new healthcare delivery models, including those outside of the traditional third party payment systems.
- Physicians must be freed from the weight of burdensome and ineffective regulation promulgated by governments and other regulatory bodies.
- Barriers to physician-led innovation must be removed at both the state and federal level.

While the need for American health care reform has existed for many years, we believe that the most recent sweeping legislation, The Affordable Care Act (ACA, aka Obamacare) of 2010, as well as the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) are flawed. These laws and the regulations resulting from them are unnecessarily complex and have added to the public confusion concerning health care financing rather than constructively addressing the primary problems. Good intentions based upon faulty assumptions have failed to address the underlying causes of America's health care economic dysfunction. The most recent legislative attempts to address these issues have compounded longstanding problems, when they could have provided necessary remedies. While the health care debate continues, we need to learn from past mistakes as we craft bold solutions to energize a flourishing new 21st century health care economy.

Lack of transparency, market distortion, limits on patient choice, and pressure to alter medical ethics have led to escalating prices, reduced patient access, decreased patient and physician autonomy, and limitation of treatment options. These tragic consequences were predictable and unnecessary.

Successful reform, based upon a rational and factual analysis of the issues, needs to be a non-partisan effort. Sincere reform efforts will require legislative solutions which directly address the core issues addressed by the following principles.

The Docs 4 Patient Care Foundation offers the following detailed outline as we move from a top-down, centrally planned and controlled health care economy to one which allows patients greater freedom of choice and physicians expanded opportunities for innovation through the removal of regulatory and legislative barriers to new models of care.

1: Individuals and corporations should receive equal tax consideration under the law for health care expenses.

During WWII, wages were fixed by The Standardization Act of 1942. Businesses were allowed to offer health insurance with pre-tax dollars as a benefit to attract employees. This was subsequently codified by the IRS and allowed to be collectively bargained in union contract negotiations by the National Labor Relations Board.

This is the origin of employer-sponsored health insurance which has had many negative effects. Individuals are disconnected from the true cost of health insurance, and policies became rich collections of health maintenance benefits, driving up premiums and moving health insurance away from the definition and functionality of true insurance. Employment and health insurance became linked, limiting portability when an individual changes jobs or loses employment.

2: A national market for individuals and families to purchase and compare health insurance policies must be developed:

Since the late 1800s, regulation of the health insurance industry has primarily been the responsibly of the states. The McCarran-Ferguson Act of 1945 allowed health insurance companies narrow exemptions from antitrust law, resulting in states retaining primary regulatory authority over the health insurance market. The net effect has been the creation of 50 separate markets, with narrow offerings and intense political influence, resulting in legislative mandates that require the inclusion of benefits in order for an insurance policy to be sold in a particular state. Premiums increase as individuals and employers are forced to pay for benefits that many simply do not want or need.

The federal and state insurance exchanges resulting from the passage of the ACA were never necessary. They are not a true market for health insurance. Private independent insurance agents and insurance offerings via the internet would thrive in a true open marketplace where competition would improve services and expand choices for patients and families.

The role of state and federal governments is to enforce contracts and protect American consumers from fraud. These are essential and appropriate responsibilities of government.

3: The Health Savings Account connected to an affordable High Deductible Health Plan could become the basic structural model for most Americans:

As the employer-sponsored insurance market developed and insurance policies included richer benefits extending to all types of routine care, Americans gradually became disconnected from the economics of medical treatment. When unseen third parties are paying and the employer is purchasing the coverage, the experience of most patients is that medical care is "free". Physicians are equally unaware of the cost of the tests and treatments they prescribe. This is particularly disruptive for routine and outpatient care, most of which is predictable and potentially quite affordable.

The growth of Direct Primary Care (DPC) and other outpatient cash services has clearly demonstrated that routine high quality medical care can be inexpensive. These models prove that patients can easily and successfully shop and pay for these services in a competitive market. A Direct Primary Care contract coupled with an appropriate High Deductible Health Insurance plan has the ability to provide the best medical services while bringing costs under control. The ability of patients to utilize Health Savings Accounts freely within this model expands access to care. Innovative health care policy options will thrive in a market where the current limitations imposed by the ACA are removed. These market-based, consumer-friendly alternatives enhance access to preventive services at very affordable prices.

States need to be free to serve as laboratories for innovation and exploration of new healthcare delivery systems. Federal and state regulation should encourage physician entrepreneurship in this arena.

In a Direct Primary Care model, medical practice overhead can be reduced by as much as 40%. Elimination of first-dollar coverage by third party payers allows both patients and physicians the freedom to form a mutually beneficial relationship and the flexibility to use new and exciting communication tools to enhance their interactions. Doctors spend their time and energy on patient care and communication, while patients receive the attention and quality they expect. Transparent pricing for healthcare services would rapidly become the norm, replacing current economic opacity. Competition would drive costs lower and patients would have the freedom to choose their physician, rather than being forced into a network they may not want or like.

4: Market Reform requires price transparency:

When the purchaser of a service (patient) and the provider of a service (physician) are both unaware of the economics (pricing), there is no market and no cost control. Meaningful cost-benefit analysis is simply impossible. This economic opacity emerged from the market distortions (employer sponsored health insurance and lack of competition) described in the above paragraphs.

The ACA has failed to "bend the cost curve" down. Instead of relying on patient choice and the resulting price signals and market forces, the law relied on top down government mandates, rationing and regulation. The massive failure inherent in this approach is evident in the government's two primary healthcare systems, Medicare and Medicaid. The inability to control costs was predicted prior to their enactment in 1965. However both then, in the case of Medicare and Medicaid, and today with the ACA, ideology was favored over economic reality. This resulted in an estimated 40 trillion dollars of unfunded future liability in the Medicare program alone. Demand will always outstrip supply when supply appears to be free and the true economics remain hidden.

The cost will only "bend down" when both the purchaser(patient) and the providers (doctors, hospitals, etc.) of health care services can see prices, make their own cost-benefit evaluations and have the choice and responsibility to spend their own dollars.

5: Medical Liability Reform:

The current medical liability system is not working for patients and physicians. It is adversarial, expensive and inefficient. The system drives a wedge between patients and physicians and forces the practice of defensive medicine. This drives the cost of American healthcare up over $200 billion per year in federal and state programs alone. Furthermore, many legitimate medical injuries are not compensated. That leaves many patients, especially the poor, minorities and the elderly, without the compensation they desperately deserve.

The Affordable Care Act not only ignored liability reform, but actually penalized states that had existing tort reform measures in place. We believe that medical liability reform is a key element of any health care reform proposal.

6: Medicare and Medicaid need to be gradually transitioned to sustainable models while protecting promises made:

Medicare and Medicaid, passed during the Johnson Administration in 1965, were fiscally irresponsible from their inception and remain so today. Medicare alone was projected to cost $10 billion by 1990; however the actual cost by 1990 was $110 billion, underestimated by a factor of over ten. Every attempt by the federal government to control spending in these massive programs has failed. The ACA expanded Medicaid without addressing a major fundamental financing flaw. States have an incentive to spend more Medicaid dollars to get additional matching funds from the Federal Government. The critical economic flaw in Medicare was that instead of assisting low income seniors, the law that was passed essentially provides nearly unlimited benefits to all seniors, even those who do not require help.

The Docs 4 Patient Care Foundation supports the gradual transition of Medicare to a premium support program in which eligible seniors would purchase insurance in the same national market as individuals under the age of 65, with sliding scale federal support for low income individuals. Promises made to current seniors and those approaching retirement should be kept, but America simply cannot afford to continue Medicare on this unsustainable economic path.

Medicaid should also be gradually transitioned to a fiscally sustainable model by allocating funds to low income individuals, assisting their purchase of private health insurance. Subsidies to establish health savings accounts for routine and outpatient services, which could include a Direct Primary Care medical "home", could provide additional assistance while still preserving

personal choice and control.

The financing of graduate medical education (GME) is currently linked to Medicare which has distorted and crippled this system. New and innovative financial support for GME must be developed to allow our excellent educational facilities to thrive unencumbered by the federal bureaucracy.

7: The pre-existing condition issue must be addressed:

Expanding individual ownership of health insurance policies creates portability with the potential to eliminate most of the problems related to pre-existing conditions. Economically responsible reform must address the issue of those who developed pre-existing medical conditions under the current system.

Many innovative models for these difficult situations combining new forms of insurance with taxpayer assistance are possible. The development of state/private partnerships from which high risk patients would obtain premium assistance to purchase private health insurance is one alternative.

The ACA mandates that all insurance companies must cover every patient with minimal regard to health status or previous medical conditions. New innovations in the health insurance industry such as large Health Savings Accounts and health status insurance, combined with Direct Primary Care, should be explored. This will incentivize individuals to live healthier lifestyles and access preventative services. Insurance companies should be freed from onerous actuarial restrictions and encouraged to develop market based incentives to attract consumers as customers. As barriers to innovation are removed better market based alternatives will develop.

8: Medical Information Technology:

No effective and sustainable reform plan would be complete without discussing the disastrous implementation of government mandated electronic health record systems (EHR). Federal requirements have forced the adoption of systems which do not lower costs, do not prevent medical errors and do not result in increased physician efficiency or the ability to communicate more effectively. These goals can be met. Digital information technology is being embraced enthusiastically by many Americans who are free to work outside of our over-regulated third party payment systems. The private sector has always led the way in producing the best, the most efficient and the most cost effective ways of developing new technology. Unencumbered by federal regulation, this will happen in medical informatics. When it does, doctors and hospitals will embrace it, and patients will be the beneficiaries.

9: Physician Certification, Re-Certification, Maintenance of Certification and Maintenance of Licensure:

Becoming a competent physician takes a tremendous amount of time and preparation. As physicians, we are dedicated to providing high quality care to our patients. We support rigorous education and post graduate training, initial certification, and individualized lifelong learning through continuing education.

We do not support the onerous development of recertification requirements, maintenance of certification activities, or maintenance of licensure laws. These activities have not been shown

to improve physician performance or quality, but do increase time away from patient care and place additional financial burdens on physicians. They should not be a basis to determine hospital credentialing or inclusion in insurance plans.

10: Barriers to physician led innovation must be removed at both the state and federal level:

Artificial restrictions on physician led innovation and entrepreneurship need to be removed at the state and federal level. This includes Certificate of Need laws which require state approval and an expensive application processes if a physician or group of physicians wish to open a new business, such as an imaging center or ambulatory surgical center. Federal restrictions on physician owned hospitals must be eliminated which would allow new and more efficient models of care to flourish. Stark laws, limiting physician's referrals, need to be reformed or repealed to allow freedom in building innovative networks to improve patient access and care.

In Conclusion:

The Docs 4 Patient Care Foundation supports the removal of federal and state regulatory and legislative barriers to market-based consumer directed health care reforms. This will require education of our patients, our medical colleagues and legislators as we move into a dynamic and exciting new century for American health care. America has an opportunity to enact health care reform that works for all citizens as well as for the professionals who devote their lives to providing Americans with the very best health care possible.

Update 2016-07