Illinois State Medical Society

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HEALTH CARE REFORM PRINCIPLES

The following health care reform principles were developed to serve as criteria for evaluating health care reform proposals and as the foundation for developing an ISMS reform plan. ISMS supports legislation consistent with these principles. Ultimately any health care reform proposal should strengthen the physician patient relationship and this is the final criteria by which all reform proposals must be judged. Record numbers of uninsured, rising health care costs, erosion of the safety net, reliance on third party payment, and increased cost pressure on physician practices characterizes the current health care market. The problems are complex but the current system can be used as a foundation for change as long as physicians and their patients are able to determine the best treatment on an individualized basis.

1. Health care delivery and finance system reform should use the current public-private system as a basis and focus on incremental evolutionary change.

This principle recognizes that while the current health care system is not without shortcomings, it should be used as the basis for change and any type of government-run proposal should be rejected. Single-payer, federally-run or state-run proposals would require radical restructuring of the health care financing system and would control costs by rationing services and limiting choice. Such systems may promise universal coverage, but coverage does not equate to access to care when the end result is centralized health care rationing.

2. All patients should have access to a health benefit plan that would include catastrophic coverage as well as preventive services, appropriate screening, primary care, immunizations, and prescription drug coverage.

This principle explicitly recognizes that it is most likely too costly to provide universal access to unlimited medical care and that, at a minimum, a plan that covers catastrophic coverage as well as primary care would serve as an acceptable level of coverage. This principle implies that it is up to the individual to determine what coverage best suits one's individual needs and, therefore, the coverage parameters such as first dollar coverage, deductibles, and the preferred setting for services, etc., could vary according to individual needs and preferences. Deductibles, copayments, and coinsurance should be structured to create incentives for patients and physicians to make consumer-directed, value-based decisions. Cost sharing in public programs should be means tested to ensure access to care.

3. Health insurance reform is needed to allow public and private plans to develop innovative coverage plans, including the development of health savings accounts and other high deductible plans to encourage patients, physicians, and other health care providers to pursue high value care.

Insurance policies should be structured in a manner that makes consumers more cost conscious. Currently many patients pay little or nothing for the health care services they receive and do not know – let alone care – about the costs of their treatment or the various settings in which such care can be rendered and the various pros and cons. Policies should be structured to include transparent payment schedules and a combination of deductible, coinsurance, and copayments in order to make patients conscious of the costs of the health care services they are seeking. Additionally, high deductible plans that limit patient choice of physicians and impose other restrictions are not reflective of true consumer directed health care that allows patients and their physicians to determine the best course of care.

Innovative insurance policies that reduce reliance on third party payment for services may hold promise for reducing utilization of discretionary spending. The current system of first dollar coverage distorts the market in that it encourages consumption since patients feel they are spending someone else's money. In fact, the costs are only being passed back to the insured though insurance middlemen. To control costs, payers attempt to implement utilization controls. A better approach would be to allow the decision makers (physicians and patients) to be more accountable. Patient demand should be tempered by cost sharing for most services through deductibles and copayments based on a percentage of the cost of all services received. Provider charges and volume of services would be moderated by the knowledge that the patient will be motivated to avoid unnecessary care and to seek the most valuable care. If this can be done at the level of the individual patient, with minimal intervention by third party payers, the highest satisfaction at the lowest cost would result.

4. All health care expenditures should receive equal treatment for purposes of tax deduction and tax credits.

The current tax system allows deduction for the full cost of employer provided insurance premiums while limiting the tax deductibility of out-of-pocket costs. Full deductibility of out-of-pocket expenses would make the shifting of costs more affordable for patients. To provide equity, all health care expenditures for premiums and out-of-pocket expenses should receive favored tax treatment. Additionally, individuals who do not receive employment-based health insurance should receive the same tax benefits as employees who buy insurance though their employer. Employees who purchase health insurance through their employer are able to exclude from their taxable income the amount spent on health insurance. This is effectively a government subsidy for purchasing health insurance. Most individuals who purchase insurance in the individual market do not have the same subsidy and are taxed on all of their income.

5. Professional liability reform – including caps on noneconomic damages – should continue to be pursued and defended as a way to reduce direct and indirect costs (defensive medicine) and to address the adverse effect the current medical liability system has on the physician-patient relationship and access to health care.

Professional liability costs are a significant portion of national health expenditures. Defensive medicine – while difficult to measure – is an even more significant factor. Professional liability reform will lead to a reduction in the practice of defensive medicine and will ultimately lead to moderation in liability premiums. One proven reform initiative is caps on noneconomic damages. In addition, other innovative reform strategies should be investigated such as judicial reform, including arbitration and medical courts. As patients make informed choices and value-based decisions accompanied by an unanticipated outcome, patient accountability around choice becomes an important element of reform as well.

6. Use of information technology in health care delivery should be encouraged to improve quality and safety of care, enhance efficiency, and control costs.

The development of new information system enhancements, such as electronic health records, may lead to improved transparency of costs and quality of care. Such systems should help patients make more informed decisions regarding the cost and benefits of medical care. In addition simplification of hospital bills and explanation of benefits statements from payers should be a priority.

Physician adoption of electronic health records will be central to the transformation of health care administration and quality improvement efforts, but currently physicians bear all of the costs for such systems and receive only a portion of the benefits. Others who benefit from physician adoption of health information technology, primarily public and private payers, should share in the costs of physician health information technology (HIT) adoption. Physicians should recognize that one potential drawback to EHR adoption is the potential loss of productivity during the transition phase but ultimately, EHRs should be able to demonstrate tangible benefits on the patient-physician relationship, or at least not interfere with this relationship. Expanding access to HIT should lead to improvement in health care quality, patient safety, physician and other providers' satisfaction and efficiency, while at the same time maintaining a warm and caring patient physician relationship and patient confidentiality.

7. Health care education and literacy must be an important part of any medical care financing and delivery system reform.

The medical care system provides preventive treatment, diagnoses medical problems, and treats those problems. However, most medical problems arise from factors outside the medical care financing and delivery system. Many medical problems arise from lifestyle, environmental, and similar factors. Individuals make choices regarding health, including, but not limited to, diet, exercise, smoking, sexual and other high risk behavior, drug use, alcohol consumption, and use of seat belts. Health care education and reform are important to improving the health status of citizens and to preventing medical problems and their associated costs. Extensive public health education programs should be considered – beginning at an early age – in elementary school. Health education should be expanded in the schools, should be required for individuals with conditions that can be adversely or beneficially impacted by changes in lifestyle or

environmental factors, and general public information campaigns on particular issues should be expanded. Programs should especially aim at the benefits of use of a primary care physician and should encourage preventive care. By providing a medical home, physicians are in an important position to perform these educational activities with their patients; however, payers should provide financial support for comprehensive health education and literacy activities performed by physicians, recognizing the continued importance of some element of first dollar coverage by the patient. Patients, physicians, other providers, hospitals, medical suppliers, and payers should become more cost conscious and the resulting savings should accrue to the benefit of patients. There is a need to ensure that providers and consumers are fully educated regarding the costs associated with various health care alternatives. In addition, individuals should be encouraged to establish an ongoing physician-patient relationship.

8. Health care reform proposals should include provisions for physicians to set and negotiate their own fees in order to adequately compensate physicians and other health care providers for the promotion of personal and public health.

This principle strengthens the medical profession so that access to care is maintained and medicine continues to be seen as a desirable profession for our best and brightest future students. Physicians and other health care providers are the foundation of the health care delivery system, though physician compensation is only a small component of overall health care spending. Therefore, health care reform proposals need to take into account the effect that reform policies have on physician providers because of the key role physicians assume in the overall reform of the system by helping patients make informed choices. As payers continue to strengthen their position in the market and public payers reduce physician payment rates while the costs of operating a medical practice continue to rise, physicians are placed under greater cost constraints, often mitigated by becoming employees of hospital systems that seek to control their practice decisions and encourage high cost solutions that drive up the overall cost of care. Declining reimbursements and increased costs simply cause the safety net to continue to erode without such solutions as disproportionate share payments, supplemental grants, etc. Physicians should be compensated for all services. Compensation, not charity, or "encumbered relationships" should be the foundation for a health care delivery system in search of accessible, cost effective, care. Having a strong medical economy will help to ensure that future generations will choose medicine as a career.

9. Evidence-based protocols should support, not replace the patient-physician relationship.

Medicine is delivered to individuals and while evidence-based protocols attempt to increase standardization of care, they should not adversely affect the physician-patient relationship that allows the physician to treat the individual. Evidence-based protocols cannot take into account every scenario and comorbidity that physicians face, and, therefore, they run a risk of adversely affecting patients who are unique because of medical, environmental, and economic circumstances. Physicians must not lose the ability to adjust their plan of care when needed and not be forced to follow guidelines they deem inappropriate. Strict adherence to protocols jeopardizes the essence of medical care, which is the caring of one individual for another.

10. ISMS objects to third party insurance carriers interfering with the practice of medicine and the patient-physician relationship.

Increasingly physicians are confronted by payer efforts to interfere in the practice of medicine. This interference takes many forms and includes such activities as:

- Non voluntary pay-for-performance programs designed to incentivize physicians to practice in adherence to payer designated objectives and protocols;
- Implying to patients that physicians' charges above insurance benefit allowances are excessive;
- Suggesting to physicians that insurance company reimbursement amounts be accepted as payment in full;
- Suggesting that physicians perform alternative surgical procedures;
- Utilization review of hospital patients in the private sector which bypasses local physician review mechanisms;
- Limiting patients' free choice of physicians through unfair business practices.