# National Continuing Care Residents Association, Working in Unity for America's Elderly

## Basic Concepts for Better Healthcare for America



***Introductory Summary.***

*We are consumers working together. We believe that America can engineer the provision of healthcare to provide high quality while matching the most cost competitive of our peer nations. To accomplish these aims, we favor a universal healthcare system that includes all, without exception, who are present within the United States. Universality, though, is balanced by competition at the point of enrollment and new liberties to allow enrolling providers to innovate, improving care, increasing accessibility, and containing cost.*

***Polities.***

*One political pole favors full coverage for all with little concern for cost. The opposite political pole favors unfettered individual choice and initiative with few constraints on profit potential. Cost control is given short shrift. Entrepreneurial disruption in the competitive system can achieve economies or improve outcomes or both. Enforceable minimum standards, though, are needed to prevent greed from overtaking obligations toward others.*

*In the meantime, costs have soared beyond all reasons and government efforts to rein in costs and to introduce value based reimbursements have had mixed success. We need a middle course between these polarities and we seek it here by emphasizing universal coverage, which overrides the preexisting and adult children questions, and balancing that by challenge the free enterprise system to come up with cost competitive approaches to healthcare delivery. The core idea is to unleash entrepreneurial creativity in addition to the current government approach to centralized planning as the means to contain cost.*

***Universal.*** *Universality requires a Federal Medicare-For-All default option. But America thrives through entrepreneurial competitiveness, so we support a Medicare-Advantage-style private enterprise alternative to allow Americans to choose better coverage at lower cost than what others, including the Federal program, offer.*

*Medicare-for-all should subsume all current Federal healthcare programs. There should be no confusion about whether Congress has better benefits, whether veterans are deprived of needed care, or whether Medicaid[1] provides more extensive benefits to the indigent than Medicare does for the rest. Clearly evident fairness and individual equity can gain popular support for any program guided by government action.*

***Competitive.*** *American enterprise and government have not given Americans healthcare costs in line with those elsewhere. The high cost of healthcare in America is a competitive disadvantage for America's businesses. Giving consumers choice at the point of enrollment can create incentives for healthcare providers, including CMS[2] for the government option, to engineer cost/quality tradeoffs to give Americans better quality care, readily accessible, and at a competitive cost.*

***Incentives.*** *For Medicare Advantage providers, the cost/quality benefit will be achieved through private initiatives with the incentives that enterprise can provide. For the government default option, it can be achieved through the continuation of the kinds of experimentation now underway in the Centers for Medicare and Medicaid Innovation Center.[3] We accelerate that impetus for innovation through a program of Presumptive Waivers to allow trusted providers latitude to set aside counterproductive regulatory constraints when to do so can improve quality and reduce cost.*

***Essence.*** *This is not a conduit insurance program like most health coverage offered through insurance companies. This is a social insurance program for which payments would be collected through the Social Security administrative apparatus with automatic enrollment in Medicare but*



[1] See table of Medicaid benefits at https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html.
[2] Centers for Medicare and Medicaid, https://www.cms.gov.
[3] https://innovation.cms.gov.

*with individual participants having the option to select alternative private providers to receive the mandated payments and to provide their coverage.*

*Thus, the system would work just as Medicare does now. People are required to pay into the Medicare Hospital Insurance program in the form of a payroll tax. To qualify for full benefits, they also have to pay premiums for physician and related services with those premiums deducted from their Social Security income. Under Medicare Part C, though, Medicare participants are allowed to opt for Private Medicare Advantage coverage in lieu of the default Hospital and Physician programs. Participants in Medicare-for-all will similarly be able to opt for private alternatives when the private enterprises are able to better meet their needs than does the government default option.*

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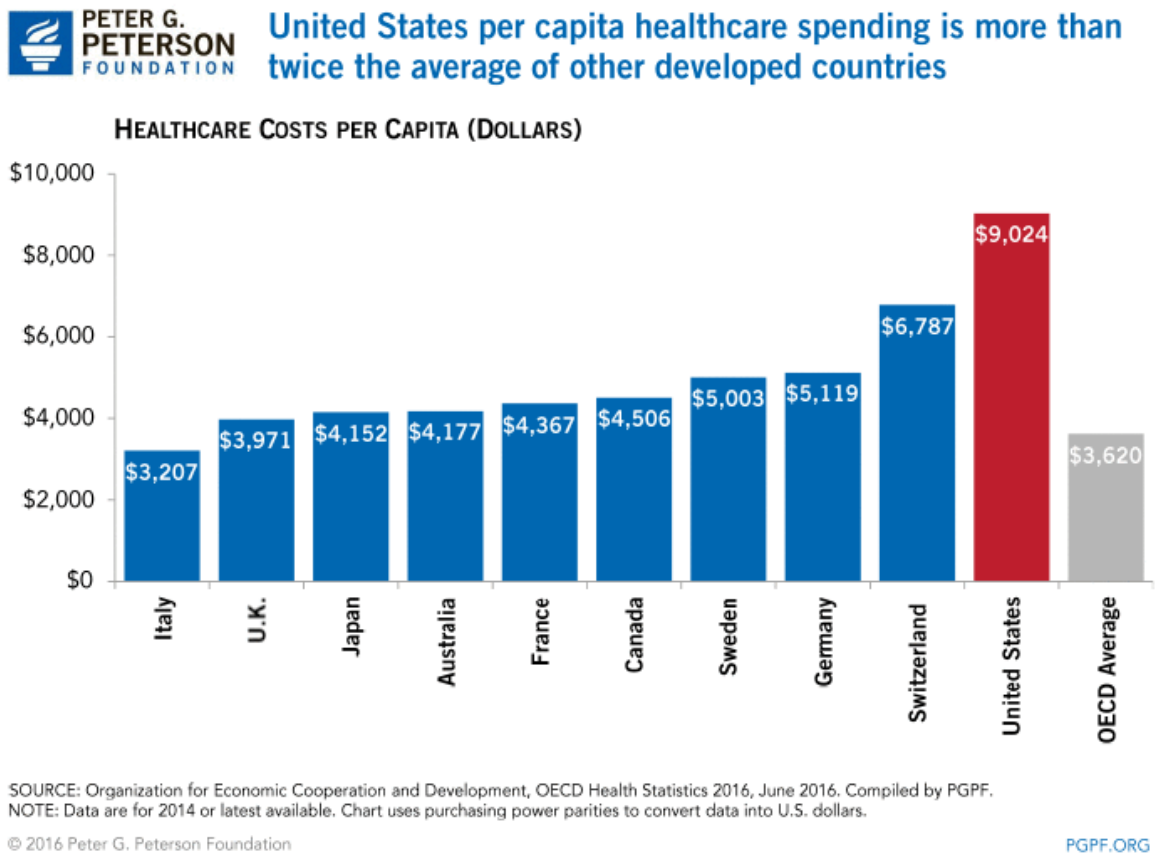
**Conceptual Framework.** We have a healthcare challenge in America. Our current structure is not working. It has given us by far the highest cost system in the world, and we have not generated economic value to offset that cost. Americans are not relatively healthier, nor do they have dramatically longer longevity than do residents of other advanced nations.[4] Still, our cost for healthcare is dramatically higher.

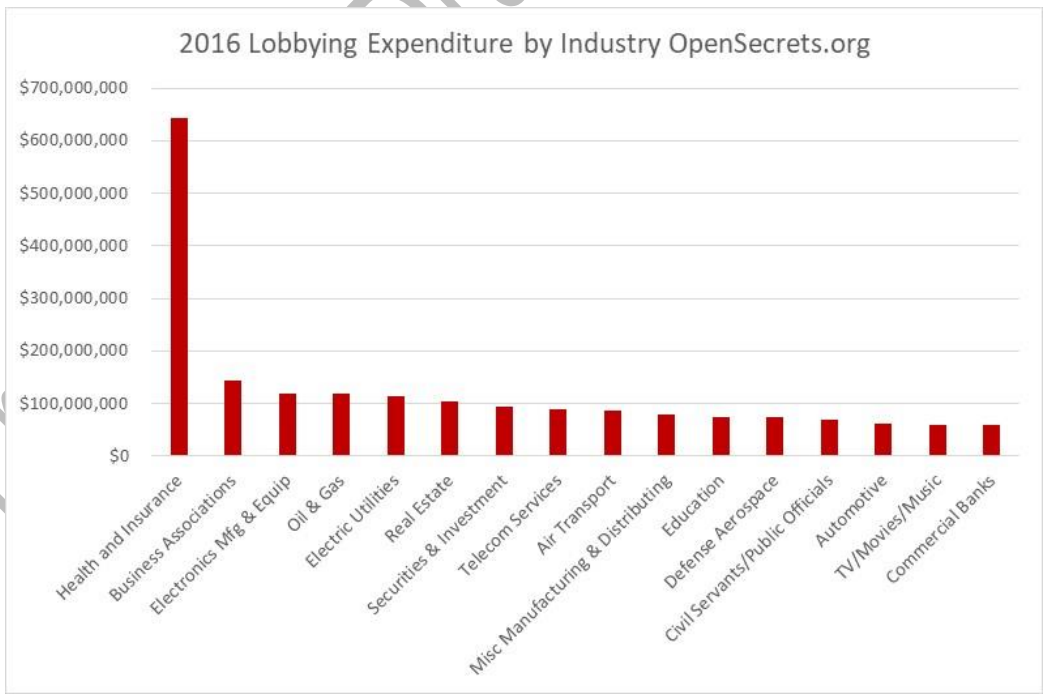



Healthcare has become political in America. Yet, it's an industry, like food or housing or defense, on which all Americans rely for sound practices and quality. Why is healthcare seen as problematic while food availability is generally acceptable? That is just one of the questions that we will explore in this paper as we look for insights concerning America's healthcare system.

[4] http://www.oecd.org/berlin/47570143.pdf

Healthcare policy in the United States has been characterized by debates, none of which seem to be converging toward national consensus. There is debate between advocates for single payer vs. private initiative. There is debate between those who believe that healthcare should be self-supporting and those who believe that the commonweal should share the cost. There is debate between those who believe that more providers are needed and those who believe we can do more with less. There is debate between those who believe that pricing should be regulated and those who believe that market constraints can work. Perhaps, most significantly, healthcare special interest groups have become a major source of campaign financing for Congressional and Presidential politicians.

The need of aspirants for national office for campaign funding to finance television ad buys has distorted the democratic process needed to ensure that popular sovereignty puts the needs of the People first, consistent with our constitutional commitment to the General Welfare. Lobbying expenses by healthcare special interests reflect the American healthcare cost imbalance. According to the OpenSecrets.org data, Federal lobbying expenditures in 2016 divided as shown in the graph below.



There is much political fuel for debate, but America needs merits-based solutions grounded in science and financial integrity. Something as essential as good health should reflect more than compromise of political polarities. In this paper, we develop a uniquely American approach that accords with traditional American values of competitive free enterprise. Value in healthcare means high quality services, readily accessible, at competitive cost.

**Principles.**

A sound healthcare system will be principled, universal, government guided, and conducive to free enterprise innovation and competition. We believe that is attainable with bi-partisan, bi-cameral consensus legislation by allowing fair competition, mandatory coverage, a default solution, and a focus on those receiving services over the special interests of those providing them.

**Universal Coverage**. Healthcare is our nation's first line of defense against disease and its first response to injury. Defense against contagion requires that everyone be included so that potential pandemics can be contained before they afflict the larger population. We live in an era of good health but it has not always been so. In 1348, a bacterium killed between 30% and 60% of the European population. We rely now on antibiotics but their effectiveness is diminished as antibiotic-resistant bacteria evolve. Healthcare is our first line of defense against these threats.

**Healthcare is Individual**. Wage controls in World War II brought employers into the provision of healthcare as an attraction for workers in a tight labor market. While employers should have an enlightened interest in the welfare of their employees, it is as individuals that we experience the challenges of maintaining good health. With today's employer run programs, some employees feel that the privacy of their health concerns may be invaded resulting in harmful employer actions. Employer's shouldn't have to choose between their religious convictions (as in the Hobby Lobby case[5]) and the nation's evolving values. Healthcare needs follow the individual from cradle to grave. Employers can subsidize their employees financially and can encourage good health, but healthcare choices are best when they are made by individuals.



[5] http://hobbylobbycase.com.

**Free Enterprise.** Innovation can come from either government or enterprise, but transformations generally result from entrepreneurs like Benjamin Franklin (Postal System), Andrew Carnegie (Steel for Railroads); Steve Jobs (Portable Connectivity); Jeff Bezos (Virtual Retailing); and many more. American healthcare, bloated and sub-optimized, is ripe for entrepreneurial redirection. That requires implementing competition at the enrollment level and then freeing the programs accepting enrollees to optimize care, improve convenience, and improve customer value

**Practical Priorities.**

Applying these principles to structure a Federally sanctioned system requires the setting of societal priorities. We rank these in order as: (1) universal coverage; (2) benefit adequacy; (3) safety and reliability of services; (4) constructive innovation; (5) value improvement; (6) fair cost distribution; and (7) achievement of global healthcare competitiveness relative to other nations.

**Universality.** To achieve universality, all people will automatically be included in the healthcare system just as they are now in the Social Security System. We already have universal access in the mandate that hospital Emergency Departments participating in Medicare provide medical screening to all people regardless of legal status or ability to pay. Foreign tourists could pay a fee for inclusion in the system for the duration of their stay. As a precedent, all people in the nation, regardless of status, benefit now from the national defense. Universal healthcare would extend a similar blanket protection to defense against disease or disability.

**Benefit Adequacy.** There are now three Federal Programs which provide primary healthcare benefits for Americans, Medicare, Medicaid, and the Affordable Care Act… five, when we include the Federal Employees Health Benefits Program and the Veterans Health Administration (including the Tricare Program). Currently, nearly 23% of the population are enrolled in Medicaid, and more than 17% of the population are covered by Medicare, with some overlap between the two. The same healthcare vision that requires universal coverage requires the resulting coverage to be adequate for medically necessary protections and treatments.

Adequate benefits for all can best be accomplished by extending Medicare – a popular and relatively noncontroversial system – to all ages, to all socioeconomic classifications, and to all entitlement groups. Benefit adequacy can be assured by modifying Medicare to include, provision by provision, the greatest of the benefit coverages under the five current Federal health programs.

Adequacy assumes standards for medical necessity. Vanity procedures fall outside of the mandated system. Also, there needs to be consideration of individual responsibility for conditions resulting from health impairing behaviors. It's inequitable for the vast majority of motorists whose cars include the latest safety advances to have to subsidize the care of motorcycle riders who have chosen a far less safe form of conveyance.

**Private Options.** As with the Postal Service, which is also a universal program, private ingenuity, initiative, and competitive spirit can be fostered by allowing people to opt out of the default Medicare-For-All program. Postal clients are free to use United Parcel Service, Federal Express and similar alternatives. Medicare-For-All clients of all ages and categories can have the option to choose a Private Medicare Advantage plan, as nearly a third of current Medicare eligibles choose to do. Medicare Advantage program benefits should be at least a great as the Medicare-For-All benefits.

**Presumptive Waivers**. The Affordable Care Act introduced the Centers for Medicare and Medicaid (CMS) Innovation Center to encourage creativity in healthcare delivery and cost containment. CMS Innovation allows deviations in the interest of better quality at lower cost. That same encouragement of innovation and experimentation can be extended across the healthcare spectrum and accelerated to allow rapid, entrepreneurial advance.

Today, the initiative for innovation is centrally controlled by CMS; proposals for change must be approved before implementation. This slows the pace of business as entrepreneurial initiatives await approval. With presumptive waivers, innovators can implement change immediately subject to subsequent regulatory review. An innovating organization, for example, say, Kaiser or the Mayo Clinic, can implement a new program using, perhaps, lower paid service providers for

services that would otherwise require a physician. They would not need advance approval to move forward. It would be presumed that they have the waiver needed to act immediately.

Although approval of the waiver is presumed, the innovative organization will simultaneously file a justifying study in a prescribed format. The filed study would document the expected benefits including monitoring to track outcomes versus expectations. CMS would then have a limited period, perhaps 90 days, to disapprove the program on valid grounds. As with most business actions, the organization benefiting from the presumed waiver bears liability for misjudgments.

**Who Should Pay For It?**

As previously noted, healthcare is individual and the involvement of employers is an anachronism held over from World War II when employers were able to offer fringe benefits to attract scarce employees in a time of wage controls. If the United States moves to a system including all, then there will no longer be a dependence of recipients on employment as a gateway to healthcare protection. There is nothing to prevent employers from continuing to reimburse employees' healthcare costs, but the selection of providers will move to the individuals and parents who are affected. Payments can be handled through the administrative apparatus of the Social Security System.

Tax policy is beyond the scope of this paper. Today, employers deduct healthcare expenditures as business expenses under IRC 162 subject to certain rules while individuals only get comparable deductibility if they meet threshold criteria. Working people are not taxed on compensation received in the form of employer healthcare premiums paid on their behalf. People who are between jobs, however, have to pay for their own health coverage without a comparable tax benefit. That seems inequitable and punitive of people in a time of need.

**How to Pay For It.**

**Individual Equity.** As a starting point, before figuring in subsidies, enrollment payments can reflect what fair pricing would be if all people could afford to pay the cost of enrollment consistent with their statistical benefit expectation. This follows the principle of Individual Equity

that payments be proportionate to the expectation of benefits. Few people, though, can afford to pay this starting-point payment scale. Until healthcare costs are brought to reasonable levels, widespread payment subsidies are needed.

Age is a challenge since the cost of healthcare increases exponentially with advancing age. CMS data show that healthcare costs for those age 85 and over are 7.25 times those for people 19 to 44. As with level premium life insurance, it would be better for people to prefund their elder-care. As a practical matter, though, while regulated insurance companies have proven trustworthy for safeguarding level premium reserves, that has not been true of government.

**Affordability.** Beyond helping people to prefund age-related healthcare costs, affordability is a challenge. Most Americans can't afford to spend $1 out of $6 for healthcare, but that is what current cost levels require. Healthcare in America is now more than 17% of Gross Domestic Product and that means that it is consuming $1 out of $6 of our national productivity.

Since we believe that benefit adequacy and good health take precedence over cost control, we need a system of subsidies until healthcare costs are brought in line. These affordability subsidies are in addition to hardship subsidies for those who are impoverished by disability and other incapacities. It's appropriate that government general revenues make up the excess of today's healthcare costs over that of other nations, since it is government ineffectiveness that has allowed the current situation to develop.

**Competitiveness.** Thus, the starting point for a universal system is one that charges participants according to their means while, at the same time, providing incentives for providers to manage cost just as other industry sectors, other than defense, are subject to cost management. Paradoxically, it appears that quality of care and outcomes may not be adversely impacted if cost is controlled.[6]

Any system of subsidies must be grounded in individual equity, or those who are unjustly disadvantaged will never accept it. Some people, due to infirmity or disability, can pay nothing,

[6] Virtual Mentor. February 2014, Volume 16, Number 2: 124-130 http://journalofethics.ama-assn.org/2014/02/pfor1-1402.html.

while others can pay the full cost for coverage. The system needs to provide acceptable gradations of subsidization between these extremes with the subsidies reducing as costs begin to come under control. To address the major cost challenge, patterns of subsidies need to reward those enrolling providers who deliver better outcomes at lower costs.

**Economic Impact.**

America's overspending on healthcare has handicapped American competitiveness. Companies have sought to offset that disadvantage through innovation; scientific management; lean, networked flat organizations; relocating operations overseas; and focusing sales on the American consumer marketplace.

In its March 2017 review MedPac (Congress's Medicare Payment Advisory Commission) concluded in part: "The high and growing level of health care spending as a share of the economy means that – absent substantial changes in spending or the economy – an ever-increasing amount of the country's economic activity and gain will be dedicated to purchasing health care."

A more candid commentator might have said: "The United States spends so much on health care that it can no longer be fully competitive among the major national economies of the world, and moreover all efforts to bring such spending under control have so far failed. Health care costs continue to rise." That is unacceptable if America is to prosper.

We must bring American healthcare costs in line with our peers.

**Inescapable Realities.**

**Unpredictability.** Health challenges can confront Americans unexpectedly at any time in their lives from before birth until death. That's an inescapable reality. We can never know when we will need medical attention. America already provides universal protection against such crises since anyone can go to a hospital emergency room and be treated.

**Lifestyle.** Unpredictable emergencies are not the whole story. It's best to look after your health even when you're not caught up in a crisis. We know the basics of a healthy lifestyle:

good food, weight control, reasonable exercise, avoidance of dangerous activities, and moderation in everything. There is an element of personal responsibility for the behavioral choices that we make and that ought not to be overlooked.

There can also be silent, hidden conditions that can be treated if discovered early: hypertension, malignancy, diabetes, glaucoma, atherosclerosis, and a multitude of carrier conditions, including cerebrospinal meningitis, scarlet fever, diphtheria, poliomyelitis, and cholera, and others. The conclusion: it's best to have periodic medical screening throughout life. Universal access improves on today's emergency access.

**Meaningless Competition.** Another inescapable reality is that point of service competition is meaningless. When a person is afflicted and bewildered by symptoms, the patient is in no position to question the wisdom of the physician. If the physician orders a test, a procedure, or a referral, the patient wants to be made well, and cannot be expected to challenge the physician's authority, expertise, or decisions.

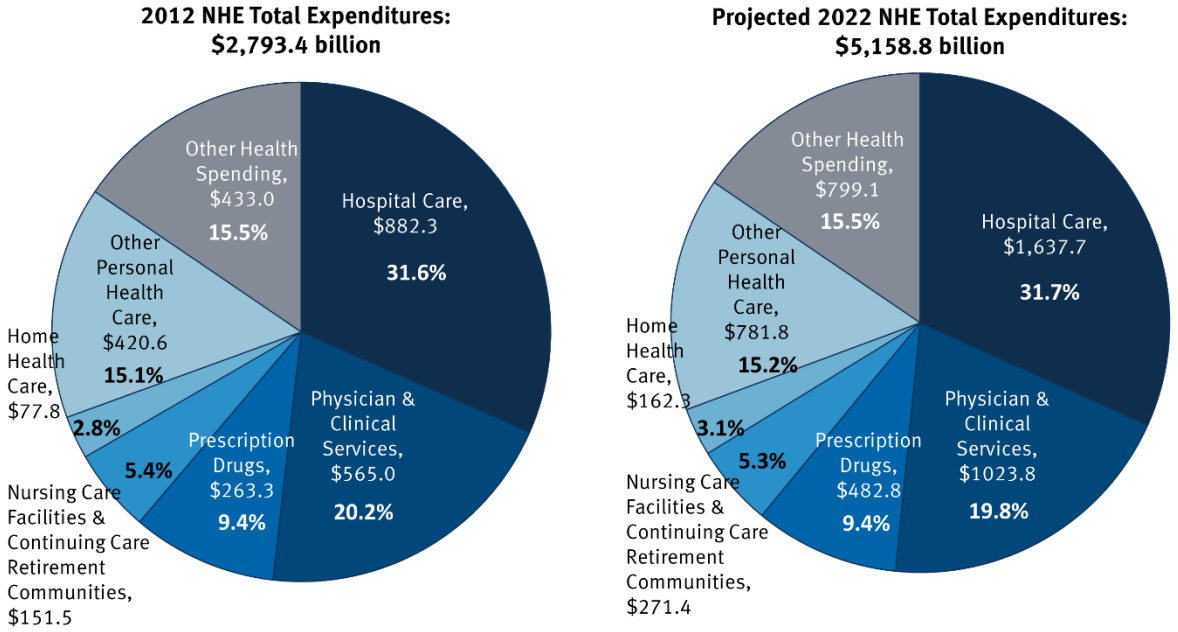
While some argue that patients should be more assertive, or that they should involve a patient advocate, such expectations as a matter of universal applicability are unrealistic. The primary time when a person is in a position to make a choice is when they are deciding in which healthcare system to enroll and to contract with for care. "System" here is used to refer to a payment system, such as Medicare, or to a care delivery organization, such as Kaiser Permanente.

**Cost of No Coverage.** When people, particularly young people, opt out of advance enrollment in a program for their health needs, they are most likely to turn to hospital emergency rooms when disease strikes or they are injured. This means that they turn to the most expensive, highest acuity provider without the screening benefits of a gatekeeper structure. This results in high costs with poorer outcomes. Delay in seeking treatment is not positive for good health.

**Cost Reality.** The cost of healthcare… either in the form of services or in the form of diminished health or death… is an inescapable reality whether those who incur the cost pay for coverage or

not. Bringing people within the system ensures better management to ameliorate these costs and to improve the health and vitality of the populace.

## Distribution of National Health Expenditures, by Type of Service (in Billions), 2012 and 2023




NOTE: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.
SOURCE: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (For 2012 data, see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2012; file nhe2012.zip. For 2023 data, see Projected; NHE Historical and projections, 1965-2023, file nhe65-23.zip).

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### What Is To Be Done?

**Medicare-for-all.** Our proposal is simple. We propose that Medicare be extended to all and that it incorporate the best of all other Federal programs. We further propose that paying for the new Medicare be based on the principle of Individual Equity with subsidies for those who can't afford the full cost of what American healthcare now costs.

**Fair Competition.** The Federal default option should compete with private enrolling providers, or with state or local initiated programs. If providers are able to deliver better care at lower cost than the Federal option, these competitive alternatives should be allowed to rebate redun-

dant payments as a competitive lure for enrollees. Moreover, the Federal option should be required to meet all regulatory standards applicable to private alternatives including financial requirements. It is inequitable to require one generation to subsidize another.

**Provide for the General Welfare.**

Our focus on the common good requires special interests – hospitals, physicians, insurers, pharmaceutical companies, nurses, unions, corporations -- to adapt to changed circumstances. The changes needed to make America competitive will be painful for some. The temptation is for them to continue the lobbying that fuels Congress and perpetuates special interests. Still, we believe that those who benefit from American freedoms, should be willing, as professionals, to place national needs before private interests.

**Who We Are.**

NaCCRA[7] collaborates with all Americans to address the needs of aging Americans. More than any other group, older people are reliant on a vibrant, advanced healthcare system. Our aim has been simple: to focus on the common good and to avoid political extremes that inhibit consensus.

NaCCRA is a membership organization representing individuals living on continuing care retirement campuses and those who support the continuum of care concept to alleviate the challenges of aging. NaCCRA is open for all who care about a trustworthy supportive aging process for America's elderly.



[7] Pronounced KNACK-rah, NaCCRA is the National Continuing Care Residents Association

## Related Papers

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