The HPfHR 3-Tier System

The basic level (Tier 1) of the new healthcare system would cover the entire population- “from cradle to grave” and would include, based on evidenced based data, all medical, surgical and psychiatric issues considered life saving, life sustaining and/or preventative. Examples would include outpatient services for conditions such as hypertension, diabetes, coronary disease, cancer, severe and persistent mental disorders, preventive medicine and pregnancy care. It will also cover most non-elective inpatient care and some elective inpatient admissions for therapies shown to be life saving, life sustaining and/or preventative. Tier 2 would cover all medical, surgical and psychiatric conditions considered to help with quality of life. These would include general medical conditions such as low back pain, knee replacement or other orthopedic interventions, and milder emotional conditions that do not impair functioning (e.g. adjustment reactions). Tier 3 would apply to all medical and surgical issues considered as luxury or cosmetic. These would include items such as “face lifts”, Lasik eye surgery and Botox injections.

Oversight

The Tier system would be overseen by a panel of physicians and other healthcare professionals, public health experts and economists specialized in health care, known as “The Board”. This Board’s mission will be to promote the health of the United States in a socially responsible and economically sound way.

Similar to a recently proposed “Federal Health Board”, the Board would be a quasi-governmental organization resembling the Federal Reserve, which should make it less beholden to political pressures. It will have oversight of CMS (Centers for Medicare & Medicaid Services), the FDA (Food and Drug Administration) and the NIH (National Institutes of Health). Using the already established DRG (Diagnostic Related Group), APC (Ambulatory Payment Classification) and ICD-9-CM (International Classification of Diseases, Ninth Revision, Clinical Modification) codes, the Board would decide which diagnoses and which services are covered by Tier 1, 2 or 3. For each coverage item, the Board would consider the medical importance (using evidence-based data including practice guidelines developed by expert medical panels, Cochrane Database reviews and other sources), the public health and economic impact. The Board would also be able to direct the FDA and NIH to commission Tier specific research to help it make better Tier determinations (see below).

Although it’s decisions about Tier allocation will be final, the Board will have hearings similar to those of the Federal Reserve for general appeals (not for individual cases).

Health Information Technology

To address the excessive overhead involved in claim submission by providers and institutions due to myriad payer-specific forms, a universal reimbursement
form (URF) would be created by the Board and would include all necessary data required to route payment requests for services rendered to the appropriate tier provider. Ideally, this would be implemented electronically using a web based tool distributed to hospitals and physician offices either through private vendors or a government/private industry coalition.

The Board will also be responsible for overseeing the development of a uniform standard for Health Information Technology (HIT) including electronic medical records (EMRs) and test reporting. This uniform standard will guarantee that as HIT is developed through private and public initiatives, there will be complete compatibility.

**Funding**

**Tier 1:** Funds for Tier 1 would be provided through a government subsidized account similar to Medicare. The method of raising this revenue can be similar to the present funding of Medicare (e.g. FICA), other payroll taxes (indexed to salary), a tax on businesses based on the number of employees (and their wages) or a combination of these. Medicaid will be eliminated, and therefore will not require funding. Since the number of items covered by Tier 1 in this new system would be substantially less than what Medicare and Medicaid cover now, there would be funds to redistribute and achieve universal Tier 1 coverage. We believe that this will be a “revenue neutral” redistribution. Theoretically funding also could be achieved through a commercial entity as long as it is regulated to follow the profit margins/overhead now achieved by Medicare.

**Tier 2:** Private insurance carriers would administer Tier 2 services. The private insurance carriers would be allowed to offer a limited number of plans that would be developed by the Board (similar to the Medigap Plans A to L now stipulated by CMS). Although each insurance carrier does not have to offer all the plans, the plans that are offered must cover all the services stipulated by the Board. This in turn assures that consumers (either employers or individuals) can compare the price of the plans and can be confident of their coverage.

These plans can be broad (covering most Tier 2 services) or can be customized for specific groups: a geriatric plan that covers extended care facilities but not fertility care, or a heavy laborer plan that includes chiropractic therapy. The price of this private coverage can either be regulated (variant 1), funded with tax incentives or health savings accounts (variant 2) or left to the “free market” (variant 3).

**Tier 3:** Tier 3 would not be covered under this system (as is true in the current system) and all bills would go to the patient.

**Billing**

All billing for services (whether in the hospital or office) would be submitted to one “Clearing House” using the URF previously described. Based on the
patient’s diagnoses and the services rendered, the Clearing House, through it’s computer based program, would pay the provider directly for Tier 1 items. Those judged to be Tier 2 items would trigger a search for private insurance coverage and if found would be charged to the private carrier. Those without insurance would be billed directly to the patient.

If the service is determined to be Tier 3, the patient is billed.

**Therapeutics and Pharmaceuticals**

The Board will be better able to accomplish its overall mission (to improve the health of the country and reduce costs) if it has oversight of the NIH and FDA. This will allow the Board to direct research focused on pharmaceutical and therapeutic issues that it needs to achieve its mission. This may be done with a combination of public/private funding depending on Tier. For Drug development, one possibility is to have public funds go to develop Tier 1 therapies (and then Tier 1 owns the drug) while private funds will finance Tier 2 drugs (with the pharmaceutical company owning part or all the rights to the drug when approved).

Drugs will have similar Tier assignments as medical coverage: **Tier 1** will be formulations and therapies that have been shown to treat or prevent life threatening illnesses. **Tier 2** drugs will apply to those that increase the quality of life and **Tier 3** will be for “luxury” items. Tier 1 medications will be owned by the Board and distributed either for free or at an affordable rate (can be linked to income). Tier 2 drugs will be owned by the pharmaceutical companies, but these firms will not be allowed to advertise prescription drugs to the public. Like Tier 2 medical coverage, these medications will either be covered by one of the Tier 2 insurance plans or will be paid “out-of-pocket”. Tier 3 will all be out-of-pocket and can be advertised.
Practical examples:
(Please note that Tier levels will be determined by the Board; the diagnoses used in these examples are hypothetical and based on what we envisage may be Tier assignments in the new system)

1) The patient’s experience:

   a. John Doe has a heart attack and goes to the hospital. He is admitted, receives treatment and discharged. There are no bills.

   b. Jane Doe has unstable angina diagnosed by her doctor during an office exam. She is admitted and has an angioplasty procedure. There are no bills.

   c. Jane Q Public has chronic stable angina. She is on medication, but is still limited by her chest pain. Because she has atherosclerotic coronary disease (considered a risk factor for heart attacks and death) her office visits to her primary care doctor and cardiologist are covered by tier 1. If she and her healthcare provider elect to have an angioplasty procedure (considered tier 2 care because angioplasty for chronic stable angina has only been shown to improve symptoms and not prolong life) she will either have to pay for it out-of-pocket or if she has tier 2 coverage, the insurance carrier will pay for it.

   d. John Q. Public has hypertension. He can choose any doctor he would like to see and Tier1 would cover all visits.

2) The healthcare provider’s experience:

   a. Dr. X sees a patient in his private office for diabetes and hypertension. He performs a complete physical exam and counsels the patient on diet and other lifestyle changes. Dr. X completes his medical chart on the URF driven computer program. His bill is automatically generated and sent to Central Billing with the diagnosis (or diagnoses) and level of service determined from the chart entry. If a test is ordered or a specialist referral is made, this will be automatically vetted and feedback given to Dr. X immediately (even while the patient is in the office).

   b. Dr. Y sees a patient in the hospital and recommends hip replacement surgery. She submits her consultation note and immediately receives confirmation of payment for the consult and who will pay for the surgery (that is, to which Tier the service belongs). This can then be discussed with the patient. There is never a denial of services or of testing by the Central Board; only who would have to pay the bill.
c. Dr. Z reads a chest x-ray on a patient with pneumonia. As soon as the report is entered into the URF driven computer program, the bill is generated.

3) The hospital’s experience:

a. All acute in-patient admissions will be covered by Tier 1 services (subject to verification from the admission history and physical). These services will be reimbursed by Central Billing as is presently done by Medicare and Medicaid (based on DRG, complications and acuity).

b. Elective admissions can be either Tier 1 (e.g. elective admission for bowel resection for colon cancer) or Tier 2. The tier level can be determined ahead of time and if Tier 2 is determined, the patient will have the option of paying for the procedure or, if the patient has insurance, it will be paid automatically by the carrier.

4) The insurance provider’s experience:

a. All plans are predetermined. No need to negotiate and design special packages for employers or healthcare providers. Insurance carriers can work on providing low cost packages to employers and other groups.

b. No need for large overhead for pre-approval, appeals etc. These services will be vetted through Central Billing.

c. No mandatory coverage. The carriers can choose not to cover patients, or to charge more if they desire.

5) The employer’s experience:

a. No need to offer insurance. All workers are now covered for basic healthcare.

b. If Tier 2 insurance is offered, it can be viewed as a “perk” and will be significantly less expensive than present policies.

6) The employee’s experience

a. Everyone is covered for Tier 1.

b. Portability from job to job and state to state.

c. Able to freely choose among physicians and hospitals.

d. The employee can choose among Tier 2 packages in addition to Tier 1.
Advantages of the HPfHR plan:

Assures universal coverage for essential health care
- Reduces mortality and morbidity
- Encourages preventive care

More efficient
- Saves costs
- Allows hospitals to reallocate funds to inpatient services
- Allows for more clinical time for healthcare provider

Allows Private insurance more profit
- Less overhead
- Less risk

Less of a burden to employers
- No Need to pay for Tier 1 coverage
- Private insurance is optional
- Private insurance should be cheaper
- May save on pensions

Portable
- Tier 1 and Tier 2 will be fully portable from job to job and state to state

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