The Expanding Medical and Behavioral Resources with Access to Care for Everyone Health Plan

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Healthcare Professionals for Healthcare Reform is a group of physicians and others interested in health care reform who, recognizing the urgent need for change, convened to propose a universal health care plan that builds on the strengths of the U.S. health care system and improves on its coverage, efficiency, and capacity for patient choice.

The group proposes a tiered plan, the core of which (Tier 1) would be lifetime, basic, publicly funded coverage for the entire population on the basis of the best evidence about which therapies are considered life saving, life-sustaining, or preventive. Optional coverage (Tier 2) would be funded by private insurance and cover all therapies considered to help with quality of life and functional impairment. Items considered to be luxury or cosmetic (Tier 3) would generally not be covered, as is the case under the current system.

The entire system would be overseen by a quasi-governmental, largely independent organization known as “The Board,” which would resemble the Federal Reserve and interact with U.S. Department of Health and Human Services agencies to oversee implementation and coverage.

By building on the current health care system while introducing other features and efficiencies, the Expanding Medical and Behavioral Resources with Access to Care for Everyone (EMBRACE) plan for universal health insurance coverage offers several advantages over alternative plans that have been proposed.

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THE EMBRACE 3-TIER SYSTEM

The EMBRACE system would be composed of 3 tiers of coverage.

Tier 1, the base level, would cover the entire population from cradle to grave. It would include all medical, surgical, and psychiatric therapies considered to be life-saving, life-sustaining, or preventive on the basis of the best evidence (from the medical literature and expert opinions).

A government-subsidized account similar to Medicare would provide the funds, with the elimination of all other public insurance. The method of raising this revenue could be similar to the present funding of Medicare (such as the Federal Insurance Contributions Act tax) and Medicaid, but because businesses should receive substantial savings after initiation of this plan, additional sources of revenue may be considered. These could include payroll taxes (indexed to salary), a tax on businesses on the basis of the number of employees (and their wages), or a combination of these. Because the number of items covered by Tier 1 in this new system would be substantially less than what Medicare and Medicaid currently cover, funds would be available to redistribute to achieve universal Tier 1 coverage. We believe that this should be a revenue-neutral redistribution of public funding.

Tier 2 would cover all therapies considered to help with quality of life, as well as some diagnoses or services that do not have sufficient evidence for a Tier 1 indication.

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...
an oversight board (see next section), similar to the Medi-
gap Plans A to L now stipulated by the Centers for Medi-
care & Medicaid Services (5). Although each insurance
carrier would not have to offer all the plans, the offered
plans would cover all the services stipulated by the board.
A major advantage of this approach is that consumers (ei-
ther employers or individuals) can compare the price of the
plans.

Tier 2 plans can be broad (covering most Tier 2 ser-
dices) or can be customized for specific groups, such as a
geriatric plan that covers extended care facilities but not
fertility care; a heavy laborer plan that includes chiropractic
therapy; or a worker’s compensation plan purchased by
employers, employees, or unions.

Tier 3 would apply to all medical and surgical issues
considered luxury or cosmetic, such as radial keratotomy or
botulinum toxin treatments. Funding for Tier 3 would not
be covered under the EMBRACE system—as in the cur-
rent system—and all bills would go to the patient.

Pharmaceuticals will have similar tier assignments for
medical coverage: Tier 1 would include formulations and
therapies that treat or prevent serious illnesses and would
mostly be paid for by public funds or be heavily subsidized.
Tier 2 would apply to drugs and therapies that enhance
quality of life and would be covered by private insurance.
Tier 3 would be for luxury items.

OVERSIGHT

Our proposed system would be overseen by a panel of
physicians and other health care professionals, public
health experts, and economists who specialize in health
care, known as “The Board.” The Board’s mission would
be to promote the health of Americans in a socially respon-
sible and economically sound way. Similar to former Sen-
ator Tom Daschle’s recently proposed “Federal Health
Board” (6), it would be a quasi-governmental organization
that resembles the Federal Reserve, which should make it
less beholden to political pressures. It would be headed by
a chairperson who would be appointed to a 10-year term
by the president and require Senate confirmation.

The Board would have oversight of the Centers for
Medicare & Medicaid Services and input into the U.S.
Food and Drug Administration and the National Institutes
of Health. Using already established Diagnosis-Related
Group, Ambulatory Payment Classification, and Interna-
tional Classification of Diseases codes, the Board would
decide which diagnoses and services are covered by Tier 1,
2, or 3 on the basis of medical importance (by using evi-
dence-based data, including practice guidelines developed
by expert medical panels, Cochrane Library reviews, and
other sources), public health considerations, and economic
effect. These assessments would be updated periodically.

The Board’s authority to direct the National Institutes
of Health and the U.S. Food and Drug Administration
would allow it to direct research that focused on the ther-
apeutic issues that it needs to achieve its mission (to im-
prove the health of the country and reduce costs). For
example, if evidence supporting a particular treatment is
based on expert consensus, the Board may direct the U.S.
Food and Drug Administration (for a medication or de-
vice) or National Institutes of Health (for an intervention)
to request applications for studies that will allow better tier
determination.

Among the prerequisites to the implementation of this
system would be delineation of the specific relationships
between the Board and existing agencies within the U.S.
Department of Health and Human Services, in particular
the U.S. Food and Drug Administration and the National
Institutes of Health. Some reorganization of these govern-
ment agencies might be warranted to optimize interagency
interactions.

BILLING

To address the excessive overhead involved in claim
submission by providers and insurance companies, the
Board would create a universal reimbursement form that
would be implemented electronically by using a Web-
based tool available to hospitals and physician offices. This
form would be the only form of billing for all providers
and would be Internet-based and simple to use. Form data
would be transmitted to a central billing system, which
would decide whether the condition or service is Tier 1,
Tier 2, or Tier 3. Tier 1 services would be reimbursed
directly to the provider. Tier 2 services would trigger a
computerized search for insurance coverage; if insurance is
found, the insurance carrier would be billed and if not, the
patient would be billed. Bills for Tier 3 would be sent
directly to the patient.

To help with questions about the assigned tier for a
particular service, the central billing system would have a
billing inquiry feature available to providers and consumers
to allow inquiries about tier assignment in advance.

ADVANTAGES OF THE EMBRACE SYSTEM OVER
SINGLE-PAYER MODELS

Ideally, a single-payer model would accomplish the
goals of improving the health of the nation with a uniform
and universal system of health care delivery. One such pro-
posed system is the “Physicians for a National Health Pro-
gram” model. Proposed in 2003 (7) and introduced to
Congress in 2007 as H.R.H. 676 (8), the plan advocates an
expanded Medicare system that would exclude all private
insurance payers and eliminate all for-profit hospitals and
HMO-type providers.

Like our proposal, the Physicians for a National
Health Program plan would provide patients universal ac-
cess to approved medical care that would be paid by a
national health insurance agency. However, if the desired
treatment or service in the Physicians for a National
Health Program system is not approved, patients will most likely find ways outside of the system to obtain that service. As in other countries with a single-tiered health care system, use of unapproved services may lead to a de facto multitiered system (9). In these latter systems, parallel outside enterprises often grow, become private, and compete with the publicly funded system—usually to the detriment of both.

The EMBRACE plan encourages private (Tier 2) participation for services that are not publicly financed. The existence of this integrated private tier would allow for fewer covered services in Tier 1, which in turn would reduce the public financial burden. In addition, allowing all the tiers to be part of the same system would allow patients to see the same provider for all services and render all services subject to the same ultimate oversight. Politically, a system that continues to allow private, for-profit insurance and some degree of free market forces would be more viable than a system that attempted to control or eliminate them.

Our plan preserves many of the favored features of the present system, such as a provider’s ability to offer all services even if they are Tier 2 or Tier 3, which would keep the new system more familiar to the patient and provider and in turn facilitate the transition to it.

CONCLUSION

The EMBRACE plan offers universal coverage for essential health care and promises to reduce mortality and morbidity and encourage preventive care. The increased efficiency of the system should allow hospitals to reallocate funds to other services, such as health information technologies, and allow health care professionals more clinical time. For the patient, the system offers universal coverage for basic health care needs, transparency for Tier 2 coverage, and complete portability of all insurance coverage. Employers would be relieved of the financial burden of coverage for most services but retain the option to offer Tier 2 coverage as a benefit to employees. Finally, insurance providers would benefit from the elimination of the financial risks associated with Tier 1 services, and the system at large would benefit from centralized billing and a reduction in administrative overhead.

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