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# Direct Payment Universal Health Care System: A Novel Model for Reform

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**Abstract**

The costs of delivering healthcare in the USA continue to escalate despite recent attempts at reform. Although there is some support for a Single Payer system, there is significant disagreement on how to implement such a system in USA, especially a system run by the federal government that has often politicized healthcare coverage and delivery.

Consequently, we have proposed a different healthcare system, a direct payment System (DPS) which will assure universal coverage, decrease administrative costs, allow insurance companies to function as fiscal intermediaries, allow stability and ease of coverage for all employers, and provide uniform and reasonable reimbursement for all procedures. We believe it is a novel solution that will provide all of the cost savings of a single payer system without the negatives of a government administered system. We have formed a citizen's advocacy group in an attempt to institute this system in the State of Florida as the initial site.

**Keywords:** Health care; Health care quality; Health care costs

## Background

Since the last quarter of the 19th century advocates have advanced health care reform proposals for government-based programs to provide access to health care for all. Reforms in the United States started with President Harry S. Truman and his proposed universal health care system in 1945 [1]. President Lyndon B. Johnson advanced health care expansion in 1965 with Medicare and Medicaid providing health care to those over 65 and the poor, respectively. President Barack Obama passed expanded health care to those under 65 with the Patient Protection and Affordable Care Act of 2010 (ACA). With an overriding purpose to lower federal government spending on health care, the ACA was phased in gradually by 2014 and fully implemented by 2016 [2].

Efforts to improve health care quality and patient satisfaction started upon passage of the ACA. It established the Hospital-Acquired Condition Reduction Program and the Hospital Readmissions Reduction Program; to improve health care quality and lower health care costs [3].

## Health Care Reform: Status Summary

In 2014 when the ACA took full effect, there were 277.220 million [4] Americans with some form of health insurance coverage, representing 88.3% of the nation. By 2016, the most recent year for which there is available data, 290.872 million, or 91.4% of Americans had coverage [4].

In 2014, 16.338 million Floridians, or 83.4% had health insurance coverage. By 2016, 17.750 million people, or 87.5% had coverage. While the number of insured has risen and the number of uninsured has fallen, the number of uninsured Floridians remains well above the national average. Between 2014 and 2016, the number of uninsured dropped, and the rate declined. For 2014, the uninsured percentage was 16.6%, or 142% of the national average, by 2016, the uninsured rate fell to 12.5%, or 145% of the national average. Florida has fallen further behind based on recent data [3].

## Closing the Gap: Moving Forward

The issue of the uninsured lingers, and solutions range from repealing the ACA to passing a single-payer model along the lines of Canada or some European nations.

President Donald Trump and congressional Republicans failed to repeal and replace the ACA in 2017. President Trump's goals of more coverage, better benefits, and lower costs will be difficult to achieve under current conditions.

## Health Care Goals: More for Less

With no uniform agreement on the horizon, advocates of health care reform champion a single payer model to provide universal coverage at lower costs. Some studies have noted the large administrative costs incurred by U.S. health insurers. The U.S. had high administrative costs, comprising over 30.85% of all health care costs.

The main argument for single payer systems is the significant administrative cost reductions and savings prescription medications due to direct negotiations with the pharmaceutical producers.

On a national scale, administrative savings from health care expenditures are estimated at 14.91% on a weighted average basis producing annual administrative cost savings of $503.27 billion. Savings on prescription medications are estimated at 3.35% on a weighted average basis producing total savings of $113.08 billion. Combined, the savings total $616.35 billion at the national level [5].

## A Novel Solution: Direct Payment Universal Health Care System

There are four major healthcare system models. The Bismarck Model originated in Germany in 1883. It established a system of payroll deductions to fund non-profit insurers providing universal coverage. The Beveridge Model started in post-WWII Europe. The system provided coverage through tax payments and government operated clinics and hospitals. The National Health Insurance Model combined elements of the Bismarck and Beveridge Models. This system developed in Canada in 1947. All citizens pay into a government run insurance program and deal directly with health care providers. The fourth model is an Out of Pocket payment System which is the default model in countries that do not have a formalized healthcare system like the United States [6].

We propose a new model known as Direct Payment Universal Health Care System (DPS).

It is a direct payment system because a Regional Third-Party Administrator (RTPA) would be the direct payer not a government agency. The RTPA would be selected by competitive bidding.

The DPS would be funded by a universal health care fee paid by all artificial persons and natural persons falling under the definitions of eligible residents. Although DPS could be a national healthcare system, we feel it is best implemented as a state-wide system in its initial phase while still leaving the Medicare and Medicaid systems intact.

The DPS would be administered by a Citizens Health Board (CHB). The CHB would be compromised of residents appointed by the Governor and Legislative Leaders to provide a geographic distribution of members and a cross section of individuals with health care expertise, as well as health care consumers. The CHB would develop the essential health benefits under the DPS and determine the reimbursement rates for licensed providers.

The CHB would set the universal health care fee to cover the costs of total health care. Employer and employee cost sharing would follow customary ratios. Self-employed individuals would pay 100% of the fee and disadvantaged citizens would pay based on means testing.

The DPS would have the following components:

1. Universal Coverage for all eligible residents not covered by Federal Plans or Medicaid.
2. A single policy covering all medical care deemed necessary by the CHB.
3. Funding through a universal health care fee paid by all artificial and natural persons.
4. All employers, regardless of size, would enrol all employees in FCP.
5. All self-employed persons would enrol in FCP.
6. Coverage for disadvantaged citizens with the health care fee based on means testing.
7. Community Based Reimbursement Rates for health care providers.
8. The CHB would negotiate the same rates with health care providers.
9. FCP administrative costs would be capped annually by the CHB.

Table 1 summarizes the major healthcare systems and the countries that have adopted them.

| Model | Financing | Countries |
|---|---|---|
| Beveridge | National Government | Great Britain, Spain |
| Bismarck | Universal Multi-Payer | Germany, France, Switzerland |
| National Health Insurance | Single Payer | Canada, Taiwan, South Korea |
| Out of Pocket | Individuals | Africa, South America, India |
| Direct Payment System | Third Party Payer | Proposed USA |

**Table 1:** Summary of the major healthcare systems and the countries that have adopted them.

## DPS: Costs

A major goal of all single payer systems is to lower costs. Several factors help explain higher costs in the U.S., among them, higher physician fees, a focus on specialist services at the expense of primary care, and greater use of advanced technology in medicine.

A recent study, authored by Stephanie Woolhandler, MD and David Himmelstein, MD, was published in the April 2017 edition of Annals of Internal Medicine. Under the title, "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs," it noted the large administrative costs incurred by U.S. health insurers and providers, including coding, billing, and similar activities. Compared to other countries with a single payer system, the U. S. had the highest administrative costs, which totaled $1,091.700 billion and comprised 32.34% of all Health Consumption Expenditures of $3,375.4 billion. The article addresses four areas of administration including insurance overhead and public program administration, hospital administration and billing, physician office administration and billing, and other administration [5].

Table 2 shown below presents the magnitude of the estimated savings, on a national level, from the 2017 study published about single-payer reforms [5].

The chief argument in support of single payer systems is the significant cost reductions. Major efficiencies would accrue from changes in the administrative procedures associated with a single payer system. Those efficiencies would come from the development of uniform reimbursement codes for digital processing of payment requests from health care providers. This advancement would expedite the payment process and reduce the window for reimbursement to 14 days. Coupled with those savings are cost reductions on prescription drugs resulting from direct negotiations with the pharmaceutical producers.

Table 2 data for administrative savings from health care expenditures, insurance overhead, public programs, and prescription drugs, are used in conjunction with the CMS data for 2017 projected Health Consumption Expenditures of $3,375.4 billion to develop weighted average factors to be applied for further analysis. Listed below are details on the savings from each area outlined in Table 2.

For the category of insurance overhead and administration of public programs, expenditures totalled $323.3 billion which equalled 9.58% of health consumption expenditures. Health care reforms deliver estimated savings of 68.0% for a weighted average of 6.51% in reduced health consumption expenditures or $219.74 billion.

The hospital administration and billing category expenditures were $283.9 billion which equalled 8.41% of health consumption expenditures. Reforms provide estimated savings of 52.6% for a weighted average of 4.42% in reduced health care expenditures or $149.19 billion.

| Estimated Administrative and Prescription Drug Savings Under Single Payer Reform, 2017 | | | |
|---|---|---|---|
| **Sector** | **2017 Spending Without Reform, $ (Billions)** | **Savings with Single Payer Reform, %** | **Savings available to expand and improve coverage under single-payer reform, 2017, $ (Billions)** |
| Insurance overhead and administration of public programs | $323.3[1] | 68.0 | $220.0[2] |
| Hospital administration and billing[3] | $283.9 | 52.6 | $149.3 |
| Physicians' office administration and billing[4] | $187.6 | 40.1 | $75.3 |
| Other Administration | $296.9 | 19.9 | $59.0 |
| Total Administration[4] | $1,091.7 | 46.1 | $503.6 |
| Outpatient prescription drugs | $362.7[1] | 31.2[5] | $113.2 |
| Total administration plus outpatient prescription drugs | $1,454.40[1] | - | $616.8 |
| [1]From National Health Expenditures Amounts by Type of Expenditure and Source of Funds: Calendar Years 1960-2025 in projections format (www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE60-25.zip) | | | |
| [2]Based on the assumption that insurance overhead would decrease to 2.2% (overhead in traditional Medicare program according to the 2016 Medicare Trustees' report) and that the share of expenditures covered by insurance would increase from the current value of 74% to 80%. | | | |
| [3]Based on data from reference 4 applied to the national health expenditure accounts estimate of 2017 hospital spending. | | | |
| [4]Based on data from reference 3 applied to 2017 national health expenditure estimate. Total administration estimates include additional administrative savings for nursing homes, home care agencies, non-physician practitioners, and employers. | | | |
| [5]Assumes no savings for Medicaid, U.S. Department of Veterans Affairs, and other federal government programs that already receive discounts; 50% savings on brand-name drugs; and no savings on generics, which account for approximately % of prescription drug spending. | | | |

**Table 2:** Presents the magnitude of the estimated savings, on a national level, from the 2017 study published about single-payer reforms [5].

The physicians' office administration and billing category expenditures of $187.6 billion equalled 5.56% of health consumption expenditures. Reforms create estimated savings of 40.1% for a weighted average of 2.23% in reduced health care expenditures or $75.27 billion.

Other administration category expenditures totalled $296.9 billion which equalled 8.80% of health consumption expenditures. Reforms produce estimated savings of 19.9% for a weighted average of 1.75% in reduced health care expenditures or $59.07 billion.

Total Administration expenditures of $1,091.7 billion equate to 32.34% of health consumption expenditures. Reforms bring aggregate of savings for the various categories of 46.1% or savings of 14.91% on a weighted average basis, which translates into reduced health consumption expenditures of $503.27 billion.

Another appealing aspect of health care reform is the ability to negotiate directly with the producers of outpatient prescription drugs and equipment. Based on Table 2, total outpatient prescription drugs totalled $362.7 billion for 10.75% of health consumption expenditures. The direct negotiation of prices on prescription medications is estimated to result in estimated savings of 31.2% for a weighted average of 3.35% in reduced health care expenditures or $113.08 billion.

Total expenditures for administrative activities plus outpatient prescription drugs total $1,454.4 billion, or 43.09% of $3,375.4 billion in health consumption expenditures. Total savings with health care reform is estimated at $616.35 billion, which represents a savings rate of 42.4% or 18.26% on a weighted average basis. That weighted average equals the 14.91% for total administration plus 3.35% for the outpatient prescription medications [5].

## DPS: Employer Cost Sharing

Currently, the cost sharing is variable among employers. DPS would establish a minimum shared by employers of 60% of the annual fee and employees would share the remainder cost. However, a means testing would be applied to individuals who are not able to afford the cost sharing.

## Advantages of DPS

DPS would produce operational savings by simplified billing and administrative procedures for health care providers and a reduced scale and scope of operations for health insurers. The ability to negotiate directly with pharmaceutical makers and other health care companies would produce additional cost savings when implemented state-wide.

DPS would extend coverage to the uninsured and improve coverage for those with inadequate insurance. Under DPS, the tremendous cost savings in health care could provide relief to the taxpayers of each State with reduced pressure on the financing system for Medicaid.

Another critical factor is the potential reduction in operating costs for businesses which currently provide health care to their employees. These cost savings would also be realized by self-employed persons currently with health care coverage directly purchased in the private market. The workers compensation system would see relief with the removal of medical care from that system leaving only indemnification from lost earnings DPS would slow the growth in the costs of healthcare.

## National or State Reform: The Pathway to Progress

The political climate in America makes it improbable that any healthcare would be adopted by the US Congress and signed by the President. Many states are pursuing unique solutions for potential reform. In Florida, we believe the path forward consists of grass roots efforts to amend the Florida State Constitution utilizing the collective right of the citizen initiative and referendum process under Article XI, Section 3, which is reserved to the people.

A grassroots advocacy forum, Floridians Advocating Insurance Reform (F.A.I.R.) has been formed to draft language for amending the Florida Constitution. The ballot language and ballot summaries must be incorporated into a petition form to be signed by registered voters. When an initial threshold of approximately 80,000 signatures are gathered and validated, the sponsors of the effort may petition the Florida Supreme Court for review of the proposed Constitutional Amendments. If approved by the Court, the ballot measures would require approximately 800,000 validated signatures. If collected by February 1, 2020 the ballot measures would be accepted by the Florida Supreme Court for presentation to the voters of Florida for approval at the November 3, 2020 General Election.

If Florida adopts DPS, it would lead the nation by addressing its specific health care problems and change health care in the U. S. forever. It would also provide a model for other states to implement their own DPS system.

## Conclusion

With the enactment of the ACA in 2010, there was momentum for meaningful healthcare reform in the USA. However, since that time there has been a retreat from and further inertia at the federal level to enact any significant healthcare legislation. Although there is some support for a Single Payer system, there is significant disagreement on how to implement such a system in USA, especially a system run by the federal government that has often politicized healthcare coverage and delivery.

Consequently, we have proposed a different healthcare system, a DPS which will assure universal coverage, decrease administrative costs, allow insurance companies to function as fiscal intermediaries, allow stability and ease of coverage for all employers, and provide uniform and reasonable reimbursement for all procedures. We believe it is a novel solution that will provide all of the cost savings of a single payer system without the negatives of a government administered system.

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