6-2-26

Subject: RE: Final notice: 7 to 9 PM MPPA's zoom meeting tonight on new idea on how to increase the quality, accessibility and affordability of U.S. medical care.

Thanks for the opportunity to comment on Mr. Allen's analysis of our health care system and proposals for a major change in the way society will assure financial access to health care services.

The article is very interesting and makes a good contribution to the discussion of needed changes.

In my opinion this contributes because it is well written, it reflects an understanding of the nitty-gritty of the current system, it reflects research and knowledge of alternative ways to organize professionals to serve their patients, and it talks about goals (establishing a good health system) and criteria to ascertain whether we have that (Quality, Choice, Accessibility, and Affordability).

I can relate to this because I have been chasing the same rabbit for 55 years, and recently I have been developing my analysis and suggestions for change in a book project, so I bring my bias to this analysis. My positive impression relates to our shared approach: we must identify the societal values that should be manifested in our health care system, and we should design our system to strengthen and advance those values.

I agree that affordability is a key objective, but I think of "affordability" as "financial access," so I believe access includes financial access. Access also relates to geographic access, and it also depends on availability (adequate supply), so the discussion of "access" is broader than affordability, and we should be concerned about all sorts of access issues.

I also believe that Quality is a separate value, and I think Mr. Allen did a very nice job in the perspective he brings to that issue . . . an outcome analysis. I think that a discussion of this should also get into "in-puts," education, management, etc.

I refer to "choice" as "Pluralism," and I agree that this, too, is a very important value . . . a quality that is completely dead in our current arrangement.

I believe our values, values that should be manifest in our system, also include ALTRUISM, PRIVACY AND AUTONOMY (patients and professionals). Hence, I would suggest this work needs to be expanded.

Mr. Allen does point out that his financing approach will move us out from under the Corporate Practice of Medicine, which I think of as a return to PROFESSIONALISM and the essential feature of professionalism, ALTRUISM. Altruism is the value reflected in the Anti-Kick-back/ Stark/ Fraud and Abuse laws, so he is into this. But there should be more.

I also agree with putting insurance under the microscope. Employer-based? Individual? Scope and intensity of regulation – premiums, underwriting, claims practices, benefit design, solvency???

On the other hand, I tend to disagree with the idea that financial reserves are dead capital. If they are, the reserves are too high. Adequate reserves are merely what we need to assure solvency (the ability to pay claims) and capacity for growth, so if there is excess money just sitting there, I would be suspicious of fraud.

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In my opinion, there is another over-arching policy issue that should be explicitly addressed: the role of government. I think that role must be specific. It should include the role of a convener for standard-setting; a role as arbiter in the event of disputes – over quality and otherwise; as a neutral, objective regulator; as a safety net for people in need; and as the fail-safe in the event of system collapse. These essential functions preclude government involvement in being the system, or favoring a part of the system over other models. Those involvements would present a CONFLICT OF INTEREST WITH THE FUNCTIONS THAT ONLY THE GOVERNMENT CAN DO.

In terms of the specific means of enhancing financial accessibility, using the income tax code as a means of paying people, I respectfully submit that I have a lot of problems with this.

First, in my opinion this level of involvement would be contrary to my point of view on the role of government.

Second, I see the proposal as an extension of the premium subsidy under the ACA, with which I have problems because it expands the tax power into a weird and dangerous place. The idea of taxes, in my opinion, should be limited to raising revenue to fund the trillions of dollars of stuff that the government does; I do not think this should be expanded to some sort of "negative tax," like the Obama-care subsidy . . . a negative tax for premium payments which means money paid out to a person for insurance, and now, doctors fees, hospital bills, home health care, etc. etc. It mixes up revenue with expenses in a way with which I disagree.

And, what if the person who needs health care is not a taxpayer?

Third, as the foregoing may indicate, I do not understand the proposal, and I try not embrace things that I do not understand.

Fourth, if I do understand it, I have three additional concerns: (1) it is incomplete, in that it is simply cash out, until the end of the year; I fear that there is no natural drag on spending until it is too late; (2) if one has a health problem that turns into a nightmare financial problem, this will compound that with a gargantuan IRS collection initiative problem; the IRS has and uses vast powers to collect taxes. With this proposal a sick person with a lot of bills may have his/her problems magnified by having their bank account or house seized on top of it; and (3) even if it is manageable, and even if it does not pose a catastrophic tax collection problem, in my opinion it goes beyond the proper role of government . . . this is beyond safety net for those who need some help and puts the government into the role of day-to-day financing.

Thanks for the opportunity to weigh in. I love the fact that there are new ideas, and we are trying to work toward specific goals to achieve something better.

John Diehl