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FOR YOUR INFORMATION
The Idaho Statesman
Boise, Idaho
Thursday Sept. 14, 2017
by Audrey Dutton

Insurers need help, and doctors must assume more risk, Democratic ex-legislator says

John Rusche is a former Democratic legislator from Lewiston who rose to minority leader in the Idaho House. He is also a retired pediatrician and a former health-insurance executive.

When it comes to our broken health care system, Rusche says he has "looked at this rare gem from many different directions."

He has seen firsthand the effects of delayed medical treatment, poor health education and poverty.

He knows what drives health costs, having spent 11 years as chief physician for Regence BlueShield of Idaho.

He knows the politics that led the Legislature to allow the creation of a state health insurance exchange but block a Medicaid expansion to cover low-income adults — both optional parts of the Affordable Care Act, or Obamacare

He believes there are short-term solutions to some problems that persist with the ACA. He believes there are long-term solutions to make health care more affordable, effective and accessible to everyone.

Rusche tells a story about a patient who went to the hospital with chest pains. A cardiologist did a full workup. Everything looked OK, so the cardiologist sent him to a gastro-intestinal specialist. "Maybe you ought to go see somebody else," that specialist said. The man finally went to a family physician, who talked to him about his life.

"He was going through a divorce and was at risk of losing his job," Rusche says.

It turned out all that anxiety in his life was just causing physical discomfort.

So Rusche agrees with the widespread advice that people get set up with primary care doctors, nurse practitioners or physician assistants.

Beyond that, he proposes these steps:

1. Everyone must buy insurance

I think everybody has to play because, sooner or later, everybody is going to use the services. You can do that with a single-payer [system], but I don't think that would fit the U.S. very easily.

You can do that by requesting a mandate, or providing a tax support for a certain level of coverage ... We do that a little bit with our state indigent program. But that kind of leaves a gap if you don't have a big enough claim, and certainly [for continuing medical care] after the fact.

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I think the biggest bang for the buck is the reinsurance of the high-risk pool, together with cost sharing, so that everybody plays.

2. Give health insurers more certainty

If we're not going to a common, regulated system — and I don't think we are, near-term — then we have to stabilize the market.

From my time in the insurance industry, I know insurers have to be able to predict their risks. They have reserves in case they miss the estimate, but if they cannot plan, they can't tolerate a lot of uncertainty.

So reducing the uncertainty and stabilizing the insurance market is part of that — spreading out risk, making large pools instead of small pools, and making sure everybody is playing.

Also, you could separate out individuals you've identified as likely to cost [the most and put them in] a high-risk pool, which is Alaska's approach.

Or you can do it by reinsurance, and that's Minnesota's approach.

The difference in a high risk pool is the insurance company cedes the lives and the premium to some other entity, some other financial pool, and most of those have some form of general governmental and tax support.

Health market graphic

Currently, the failure of the feds to follow through with [federal assistance for health insurers] is just ... here, you go out with a product that you expect will have this degree of risk-sharing or risk-support, and then lo and behold, when you go out into the marketplace, they defund it. Like, I'm going to build a house and then not pay the builder?

3. Force doctors, hospitals to control costs

[As a doctor] I thought a lot about cost, but I was not the highest-grossing physician in the practice, either.

Shift the financial responsibility, and not just the delivery responsibility, to providers.

This would need some standardization and policies [to make it less chaotic if] you're a provider, and you have a bunch of different benefit plans, and you don't know how much you're going to be responsible for, or the patient is going to be responsible for.

If you have a shift in risk, then providers have a strong reason to participate in that [cost-sharing] identification — but also to manage care to the best clinical and financial outcome. If you have three choices of knee-replacement hardware, you choose the one that has the best clinical performance but also is less expensive.

PHARMACEUTICALS ADSA montage of U.S. magazine advertisements for prescription medication. John Rusche says this direct marketing to consumers increases health care costs by pressuring doctors to prescribe brand-name drugs. Drugmakers spent more than $5 billion last year on promotion.

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Same with pharmaceuticals. Prior to a lot of the direct patient advertising, you didn't get quite as much of the pressure to prescribe what people saw on TV as they do now. Much of the world doesn't allow direct advertising from pharma. But, again, to counter that, the prescriber should have some knowledge and interest in what the cost-side-effects are. That is one of the benefits the risk-sharing model would bring.

4. Make insurers cover preventive care

I think [insurance] should have first-dollar coverage for U.S. Public Health Service-recognized preventive services, like those available under the Affordable Care Act.

I think the benefit package should incentivize the use of primary care. That doesn't necessarily mean you need a gatekeeper but certainly a difference in copay.

And if you're going to assign [financial responsibility to health care providers], it certainly is easier if you have a physician to be the chief consultant.

5. Health care data must be transparent

I think there has to be a way to get data and information so you know what works, and the system knows what works, and the consultant has a basis for [making recommendations].

What is the data on effectiveness, satisfaction, cost, days in hospital, percentages of surgeries that have complications? That should be [available to patients].

But to get that data, people have to share it. Data can't be considered a trade secret or a possession of either the health plan or the clinic or the hospital. It has to be made available to the consumer.

That's the only way that market forces can be effective in health care. Absent a knowledgeable patient — either knowledge on their own from understanding the data, or knowledge from the primary care provider who's paid for the best financial and clinical outcome — I think it's going to be very hard to get market forces working in health care.

You can't say, "We'll allow the free market to work," and not give the conditions in which the free market can work.

6. Patients, take control

I think they should stay current on proven screening and preventive care. Get immunizations. Do breast and colon-cancer screening. Have your blood pressure taken and, if it's high, take your blood-pressure medicine. Use your primary care provider as a consultant.

Believe health and health-financing experts. Anecdotes make poor health policy.

I'd also apply that [advice] to the Legislature. The tendency to say, "oh, false news" or "alternative facts" and ignore the vast body of knowledge and expertise is very detrimental.

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7. Recognize that health isn't just 'personal responsibility'

Most of the burden of disease is not a personal choice. Most of the time, you don't choose to be hypertensive. You don't choose to be diabetic. Genetics, environment and certainly poverty are really strong predictors that you don't really have a choice about.

You do have a choice about whether you take your blood-pressure meds. You would get end-stage renal disease or a stroke from [not taking them].

But there aren't a lot of people who have an opportunity to have exercise, to have a good diet. Poverty is a real issue. Oftentimes, people say, "That's personal choice. They choose not to exercise." Well, they work two jobs, and they can't afford a gym membership, or they live in a place where food choices are pretty limited.

And people are affected by advertising, otherwise they wouldn't [make bad choices]. As much advertising goes into pushing meds [also] goes into pushing high-fat, high-sugar fast foods.

Edited for length and clarity.

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