

The US Healthcare System 2010

Problems, Principles, and Potential Solutions

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Introduction

Ten years ago, the US healthcare system was declared "broken," and it has not improved. Fixes promised by managed care have not materialized. Premiums are rising. Hassles for patients and physicians abound. Nearly 45 million Americans are uninsured.

Over the next decade, these problems will worsen and new challenges will arise. Although new technology will increase efficiency, the cost of new tests and treatments will outweigh the savings. As physicians get better at treating problems, they will lengthen patients' lives and increase the number of people requiring care. As baby boomers age, these new patients will demand top-quality care "their way."

As costs rise, the status quo will not be acceptable to employers. Some will eliminate benefits for new hires. Others will get out of the insurance business entirely, contributing some funds to coverage costs but no longer providing coverage themselves. These changes will cause the number of uninsured citizens to grow. The result will be an increasingly disenfranchised middle class. They—and employers—will vote for radical change.

In my role as a citizen rather than as the president of the American College of Cardiology (ACC), I have developed a proposal to transform our healthcare system by the year 2010. This proposal outlines 6 problems, 6 principles for addressing them, and potential solutions.

Problem 1: Uninsured

Principle 1: Universal Coverage

Any viable plan for the future must be based on universal coverage, and the "2010 plan" guarantees every American enrollment in a basic health plan of his or her choice (not necessarily a health maintenance organization). Like automobile insurance, healthcare coverage would be required. Family members could use different plans and change plans annually. Previously uninsured citizens would receive income-related payments (probably vouchers) to cover the cost of enrollment in a basic plan.

Problem 2: Pure Government System not Acceptable

Principle 2: Public-Private Partnership and Competition

My proposal represents a public-private mix that Americans will prefer to a pure government system. Using the model of the Federal Employees Health Benefits Plan, regional agencies would use quality and cost data to produce catalogs of approved plans. Private physicians, who could belong to multiple plans, would deliver care, and the private health plans would compete on quality and cost.

National coverage guidelines, which would rely on public input and the Agency for Healthcare Research and Quality, would be based on cost-effectiveness and other criteria. Most citizens' health needs would be covered by the basic plan, but they could pay extra for supplemental coverage.

Problem 3: Restriction in Choice of Health Care and Job Opportunities

Principle 3: Alternative to Employer-Based Insurance: Individuals Can Choose Their own Health Insurance

Today's employer-based insurance system restricts individuals' choice of insurance, and many people are locked into jobs for fear of losing coverage. My proposal provides options for alternatives. (1) Employees could either accept job-based insurance or ask employers to send their portion of premiums to regional agencies that would provide an array of plans. Income-adjusted federal tax subsidies would cover the remainder of their premiums; families under 100% of the poverty line would receive full subsidies. Citizens would then arrange their own insurance the same way they arrange automobile insurance. (2) Employers with more than 10 employees could be required to either provide coverage or to pay the regional agency for each employee. (3) Employers would then get out of the healthcare business entirely, which would allow them to concentrate on business. They would pay the regional agencies the premiums.

Problem 4: Administrative Nightmares for Patients and Physicians

Principle 4: Administrative Simplification: Access Past the Office, to the Doctor

The 2010 plan simplifies the healthcare system. An electronic medical record with tight security would incorporate the physicians' dictated (or written) notes into patients' records. The software would also bill plans automatically using a fee-for-service system for physicians.

This proposal also eliminates preapproval requirements. Using ACC/American Heart Association and other evidence-based guidelines as models (or even using the plan's own "best practice" protocols), each plan would embed its own guidelines in patients' electronic records. Instant feedback would be available.

Payments to plans would also be simplified. Plans would receive from the regional agencies severity-adjusted premiums representing the median costs for patients with specific conditions, as automatically downloaded from the electronic medical record. "True-up" adjustments would be made each quarter for new patients and patients no longer in the plan.

Problem 5: Quality of Health Care Is not Consistently Measured, Reported, Understood, or Used in Decision-Making

Principle 5: Quality Will Become Increasingly Important; Emphasis on Patient-Physician Relationship

By 2010, patients will be able to create their own personalized report cards from the Internet; for those who cannot do it themselves, a new "quality interpreter" business—similar to H & R Block—would flourish.

In the next 10 years, outcomes for common conditions will be increasingly similar across plans. As a result, plans would compete on the basis of innovations in prevention and care. More important, they will compete on physician-patient relationships. Quality would be a 2-way street: healthy behavior could win patients lower co-payments or premiums.

Problem 6: Financing

Principle 6: New Expense for Uninsured Paid by Redirecting Current Revenue, New Revenue, and Increased Efficiency

Guaranteeing basic health care for all will be expensive. Covering the uninsured would cost an estimated \$88.6 billion in today's dollars.

Over the next 10 years, a number of possible ways of paying for the uninsured will become apparent. In the 2010 plan, 4 potential sources of revenue could more than cover the costs; some are more palatable than others. These include the following:

1. Federal and state governments already pay \$23.5 billion for non-Medicaid services to the uninsured.
2. Even a two-thirds reduction in bad debt and charity care (currently spent on the uninsured) would save \$17 billion.
3. Insurance premiums paid by employers with more than 10 employees that currently do not provide health care could fund \$43.9 billion.
4. Automation, elimination of preapproval requirements, and other innovations could increase billing efficiency by 50% and could save insurers \$27.2 billion, hospitals \$17 billion, and physicians \$6.9 billion.

With the 2010 plan, patients would gain guaranteed coverage access, choice, and improved care; those with potential heart disease would particularly benefit from universal coverage because they would have access to preventive care. Businesses could concentrate on business, not benefits. Even those contributing toward employees' coverage for the first time would benefit thanks to healthier employees. Insurers would

benefit by receiving payments that are based on the severity of patients' conditions. Physicians could spend time on patient care rather than administrative tasks.

How do we get there? We can push for electronic medical records, severity-adjusted premiums, and the collection of data for evidence-based medicine; we can also help our patients recognize true quality. Most important, we can acknowledge the need for change in the system. Unless physicians get involved, we will have to live with the choices others make for us. We must do something.

For more information, visit the ACC Web site at <http://www.acc.org>