Managing Healthcare Costs

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Everyone in America belly aches about healthcare costs. Indeed, the US spends about twice the amount on healthcare as other developed countries and yet our healthcare statistics do not reflect superior quality of care and better health outcomes. And even as we pay a premium price for healthcare, Americans use healthcare services on a less regular basis than foreigners with fewer doctor's visits and hospitalizations.

The annual costs for healthcare have risen much faster than the consumer price index (CPI) by one or two percentage points per year. In 1950, healthcare consumed 4.4 percent of GDP; in 2000, it consumed 14 percent, and in 2016, it consumed 17.2 percent. Most forecasters predict it will continue to gobble up increasing amounts of the American pocketbook. At some level America will need to address rising costs in order to keep American industry globally competitive.

The growth in Healthcare services has been a windfall for the American economy and a true engine of economic growth. If you subtracted the growth in the number of jobs created in healthcare services during the past 25 years, you would have had overall negative job growth during that time frame. In recent years over 11 percent of American workers are employed in just the private sector of health services.

To identify the fat and slack within our healthcare system is not rocket science. However, remedies for this bloated system have been elusive for as long as I can remember. To start my analysis for potential palliation, I will first identify some of the underlying structural and

cultural factors that underpin our healthcare system and then address some specific steps that could be taken to better manage costs.

The Underlying Cultural and Structural Influencers within the American System

Price Inelasticity

Our system of healthcare lacks **price elasticity**. In a capitalistic system competitive forces usually act to deter overpricing and economic profit. But in our system, healthcare does not abide by this 'perfect market' model. Individuals with pressing health problems do not shop around for the lowest cost healthcare provider. They are more interested in access, perceived quality of care and reputation than whether that physician's office charges 120 dollars or 85 dollars for an office visit.

There also exists a huge asymmetry in medical knowledge between the patient and the doctor. A patient may be an adroit shopper but medical diagnoses and treatments are generally a lay person's blind spot. They trust the doctor and are not haggling for a bargain or discount.

This lack of price elasticity is also aggravated by comprehensive health insurance coverage in which the enrollee pays little or nothing and often does not see the invoices for billed charges so as to better understand healthcare costs.

Moreover, the accounting methods within the healthcare system produce a disconnect between billed charges and services rendered. Charges are somewhat arbitrarily set by Medicare and other insurance carriers to reflect the International Classification of Disease (ICD-10 codes) and Current Procedural Terminology (Cpt codes) entered on the charge slips. Most medical bills do not clearly factor in severity of disease, quality of care, outcomes of treatment, counseling provided,

socioeconomic factors and resources consumed in rendering care. ABC (Activity Based Costing) accounting methods that are common in industry are not a part of the vernacular of a hospital's CFO or the accounting department.

I have always been perplexes as to why the patient healthcare consumer is not more cost conscious. In my 35 years of urologic practice, less than a dozen patients sitting across from me as I discussed surgical procedures asked me "Doc, what is it going to cost?" Moreover, physicians who direct about 80 percent of all healthcare dollars likewise have a very limited appreciation of costs. Even at scientific seminars and hospital grand rounds it is rare for cost issues to surface. And with costly new therapies a parallel cost message to the other consequences of treatments is usually glossed over.

In addition to the price inelasticity on this demand side, there is minimal price competition on the supply side as new healthcare facilities and services come on line. Health care abides by Parkinson's Law that, for our purposes, is that if you have capacity it tends to be utilized. When you build duplicate facilities or offer competing services such as new specialty clinics, imaging centers and outpatient surgi-centers you draw patients not only from existing facilities but also generate new demand and referrals. And unfortunately, when a medical service center is underutilized and unprofitable, there is a tendency for the doctors and administrators to encourage the performance of more testing, treatments and return visits on their smaller patient census to pad revenues.

And when you try to place a dollar value on what a quality-adjusted life-year (QALY) of good health is worth in dollar terms, everyone just scratches their heads. Thus, with no price elasticity or constraints on the expenditure of healthcare dollars, this question does not need to be addressed by the consumer or the provider. Indeed, public

policy and American culture avoids this moral issue and any healthcare proposal that even hints at “killing grandma” or accepting of “mercy killing”, makes it an extremely toxic political issue.

Misplaced Pay Incentives

Another structural problem that escalates healthcare costs is the current payment system that rewards production in numbers that incentivizes the healthcare provider to ‘do more rather than less.’ Due to this assembly line model, medical care becomes more of a commodity. To illustrate, the hospital systems in Greater Cincinnati that own about 80 percent of all physician practices mandate or, at least, strongly encourage their doctors to stay within the limits of 15 minutes for an established-patient visit. Physician incomes and incentive pay is linked to this metric and guideline that probably causes physicians to have their healthy patients return more often for follow up than their sicker ones, because it takes less time to hustle well patients through an encounter and stay within the 15 minute time limit.

Physicians dislike these time restraints, and doctors and patients alike complain that it detracts from the doctor/patient relationship. It also imposes added stress on the physician and, not surprisingly, a recent survey of primary care physicians showed that 50 percent of physicians acknowledged burn-out attributable in some measure to this productivity model of office practice.

Emergency rooms, imaging centers, testing labs and treatment facilities are all wedded to this production model that encourages more rather than less. And some patients are complicit in overutilization and insist that ‘everything be done’.

Interest Group Money

Another cultural/structural barrier to real healthcare reform is the money sloshing around in the deep pockets of special interests. Each of the major players in the healthcare market have amassed war chests that open the political doors to the hearts of elected officials. Each has a sizeable cadre of lobbyists that badger, monetarily incentivize, threaten and cajole political candidates. Their web of influence and marketing extends to all levels of government, trade unions, public agencies, nonprofits and the electorate. Their mission is to shield their interests from burdensome regulations, budgetary cutbacks, antitrust, unfavorable publicity and the potential threats from healthcare reform.

Few politicians can hold out against these powerful forces. Prime examples are in Obamacare or ACA where the pharmaceutical industry blocked the ability of Medicare to directly negotiate with the drug industry to lower prices; and the healthcare insurance carriers thwarted competition from the Public Option of Medicare in the State Exchanges. Obamacare probably would not have passed without these compromises that have seriously flawed the legislation.

Lack of Physician and Patient Advocacy

Today, physicians have been relegated to powerless bystanders in crafting public policy. Often, doctors complain that "they have lost the franchise" and indeed, they have in large part due to their failure to organize and speak with a compelling message. Moreover, the American Medical Association and medical specialty societies have neither the means nor coordination to be change agents in transforming the system. And as an unintended consequence, the patient has lost their physician advocate. The ballot box gives the consuming public a voice, but healthcare public policy does not closely reflect the wishes of the electorate. About 70 percent of Americans support universal access to healthcare through Medicare, yet the Republican Congress voted

innumerable times to repeal the ACA even as it was a major step toward universal coverage.

Other Miscellaneous Factors

In the good old days, religious orders ran and staffed many of our hospitals with unpaid nuns and volunteers. Likewise, most medical school and residency teaching was provided by volunteer physicians practicing in the community. Moreover, interns and residents were paid a paltry wage and medical school tuitions and textbooks were quite affordable. There was little medical practice specialization, advertising was unethical and end of life supportive care was usually provided by the extended family in the home setting.

This has all changed. Today, hospitals are staffed with highly paid specialized personnel, the medical schools have large permanent faculties, medical school tuitions and books are expensive and the average medical school graduate shoulders $179,000 in student debt. There are now over 125 medical subspecialties each with their own professional organization. Marketing ads for drugs and medical services clutter all types of media. Today, women have joined the workforce and there are fewer extended families to care for aging seniors in the home, and as a consequence, more seniors in decline go to nursing homes where the care is very expensive.

In summary, these underlying structural and cultural obstacles severely hamper initiatives for real transformational change. Indeed, price inelasticity, misplaced pay incentives, interest group money, loss of physician control and the natural growth in medical training and facilities have created formidable barriers to change. And the intrinsic paradigms of the current system create loud background noise whenever we address specific measures that might help to contain costs and improve the healthcare system.

Now, let's objectively discuss some specific measure that might help to contain costs.

Process of Managing Healthcare Cost

Controlling Drug Prices

A prominent abuser of the system is the pharmaceutical industry. These publically held companies focus primarily on shareholder value and executive compensation rather than the wellness of Americans. With patent protection and reformulations of drugs to extend patents plus tacit price fixing they charge the highest price they can or whatever the market will allow. There has been a rapid rise in drug costs and they consume 10-11 percent of healthcare dollars. In inflation adjusted dollars the cost per person over the 16 years between 2000 and 2016 was $572 versus $1019. This acceleration in costs are projected to continue as newer biological medications and customized therapies for cancer and inflammatory diseases exit the drug pipeline of new remedies.

Drug companies do not disclose how they price their drugs and they enjoy profit margins of about 20 percent. These margins are far above the group of companies in the S&P 500. They also spend more money on direct to the consumer advertising than they do on research and development.

Pharmaceutical Benefit Managers (PBM) are intermediaries to the system and negotiate drug prices for health insurance carriers. The oligarchy of PBMs (Caremark, Express Scripts, and OptumRx) control 80 percent of the market. Their activities also lack transparency and their revenue streams rely on a complex formula of discounts, rebates and offsets that suggest that they are in bed with their suppliers and the healthcare insurance companies rather than being advocates for lower drug prices and the patient consumer.

And comparing prices charged by retail pharmacies is challenging if not virtually impossible. The local pharmacist and even the large pharmacy chains are besieged by a host of drug plans that yearly change formularies, categorized individual drugs according to levels of coverage, switch the list of preferred pharmacies and modify prices. Moreover, drug plans encourage the use of mail order pharmacies to cut costs. Unfortunately, the small local pharmacies with their personalized service are rapidly disappearing,

Of course, it is general knowledge that foreigners pay much less for their medications than Americans. For instance, when my daughter was visiting from Australia an asthma medication refill cost her $378 whereas at home it cost only $39. On the surface it looks as if the US consumer is subsidizing the drug costs for other nations. But the explanation for this disparity hinges on a number of factors. First, foreign healthcare systems competitively bid drug prices as a single purchasing unit from multiple drug companies. Secondly, they buy more generics and bio-equivalents, restrict and competitively bid their formularies and are more accepting of outside suppliers such as India or China.

Some observers suggest that a partial solution to drug costs is to tighten the patent laws and push generics drugs. However, in the American marketplace it is curious that generics are often as expensive as named brands. And in many major classes of drugs such as antibiotics and statins the prices for generics cluster very closely around a single price point. Those drug companies that can capture a sole supplier status on an orphan drug or even an old remedy usually, in an obscene fashion, jack up the price.

The solution to the high cost of drugs is fairly strait forward. You need someone with the ‘buyer power’ and agency to achieve ‘most

favored nation' status when purchasing drugs. The 'most favored nation' objective would be for the buyer to receive the same price discounts, rebates and negotiated lowest prices that foreigners, the VA system and Medicaid receive. In this way, the American consumer would be guaranteed the lowest price. In this new framework it would be necessary to develop a 'competitive' drug formulary that reflected cost, quality and efficacy.

Today, there is only one medical insurance agency in America that is the 1100 pound gorilla with that kind of buyer power to control drug prices. That obviously is Medicare. Medicare must be allowed to negotiate price with drug companies. The drug companies and PBMs will balk but with average profit margins for pharmaceutical companies of 20-21 percent and a healthy bottom line for PBMs, adequate return on investment would remain in place. Additionally, the drug companies might want to trim their budgets for direct to the consumer advertising and limit their quiver of boring television ads and spend more on R&D.

Solving the Transactional Maze in Healthcare

When the digital age arrived it was forecast to streamline medical processes, enhance the efficiency of the healthcare system and decrease healthcare costs. Indeed, IT has a great future in transforming medicine with artificial intelligence, big data, improved digital interconnectivity, Telemedicine, efficient medical record keeping and so on.

But, since the introduction of the Electronic Medical Record (EMR) and an elaborate coding system of DRGs and CPT codes, Information Technology has not lived up to its promise and the 'paperless' office remains a distant dream. And quite to the contrary, Information Technology has increased the transactional costs of

healthcare and, at the same time, made life miserable for the physician and other healthcare workers.

How can you explain this development? I can cite one statistic that is telling. During the 36 years between 1970 and 2006 the number of physicians practicing medicine in the United State increased by 300 percent. At the same time there was a 3000 percent increase in the number of healthcare administrative personnel. Today, running a healthcare business is complicated and requires more qualified staff to handle new services, new facilities, quality oversight, coding, risk management, compliance and documentation. Each of these introduces a tier of transactional expense. As a result I have never heard an administrator mention how IT has decreased the burden of 'paper' work and paper storage.

Record keeping and documentation of the medical encounters has become a nightmare for the medical practitioner. Studies show that about 40 percent of a typical physician's time is spent entering patient data into the EMR and assigning proper codes. This dramatically impacts a physician's productivity to the point where few practitioners can see more than 20 patients a day in the office. Before the electronic era and mandated thorough documentation for reimbursement, many primary care physicians could see 50 or more patients comfortably during office hours. But, Medicare guidelines state that "if it is not documented, it was not done" and the claim will not be paid.

Record keeping software systems such as Epic (used in all Hospital systems in Cincinnati) are very costly to purchase, maintain, secure, update and tweak to implement and modify to keep up with changing requirements and regulations. Mastering the medical coding system is complicated and the submission of insurance claims requires many transactional steps to cope with significant variations in individual

insurance plan coverages including copays, uncovered services, balance billing, plan maximums and multiple coverages. And insurance claims are often denied due to minor errors in submission and often must be revised, resubmitted and appealed. To manage this challenge, doctor's offices and clinics need business managers, coding and billing specialists and Physician Assistants. All of these jobs require specialized training and none are minimum wage positions.

Most employers, even without a Federal Mandate, provide some form of health insurance for full-time employees. This additional layer of transactional expense flows to the Human Resource departments. Annually, the HR specialists must select a plan, budget for the plan, inform employees about the benefits, outline the processes to join and COBRA, make payroll deductions and fill out volumes of paperwork.

Some of the problems with IT in implementing and streamlining healthcare processes will be resolved with time. First, the younger generation is more computer literate and quite handy with their thumbs in accessing information, keyboarding and intuitively understanding software programs and platforms. Vocal recognition software is also improving. Second, information transfer and automation is speeding up and should decrease the number of transactional steps in receiving payment. Third, integrated software systems should help to mitigate the duplications of paper work in history taking, authorization and HIPPA compliance. Sarcastically speaking, this evolution should enable the hospital departments and administrators to hold more boring meetings to fill their days.

From a practical standpoint it is population base medicine with capitation and bundled fees for services that will help to solve the transactional maze that characterizes medicine today. In this optimal model a horizontally integrated system (probably hospital based) would

receive a fixed amount per patient per month using cost averaging derived from a representative patient population. This approach would eliminate a mountain of paperwork and, not surprisingly, realign the incentive system to curb unnecessary or marginal medical care and focus on wellness.

Making Sense of Health Insurance and Managed Care Organizations

In the 1980s, health insurance companies began to flourish and the major insurers morphed into Managed Care Organizations with HMOs and PPOs. The insurance agencies touted Managed Care as a solution to the high cost of healthcare. Allegedly, manage care could put together quality parameters and weed out the over utilizing or bad doctors and put the skids on inappropriate medical care. Unfortunately, managed care companies did not have the tools to define quality of care. But their arrival did decrease costs by cutting the reimbursements to physicians by about 12 percent. Beyond that cost savings, it had no effect but did succeed in introducing new transactional expenses.

Managed Care Organizations have increased the cost of healthcare. On average, when a private health insurance company takes your premium dollar, 20 percent is applied to administrative expense and five percent to profit. Another way of stating this is that just 75 percent of your healthcare premium is paid for the provision of healthcare to patients and the remainder is ‘non-value-added’ to the system. In comparison to the 20 percent administrative expense of private health insurance companies, the administrative expense for Medicare runs about three percent. This disabuses the notion that government programs are always less efficient than private enterprise.

There are several steps that can be taken to mitigate this ‘non-value added’ expense. The simplest, of course, is a single payer system. Also,

if the state exchanges offered the 'public option' of Medicare in competition with MCOs, I feel confident that to remain competitive the administrative expenses and profit margins of MCOs would decrease as a result. Another possibility is to permit insurance companies to transition into agencies that run the back office systems of large vertically and horizontally integrated hospital systems that have the size to directly contract with employers and private individuals.

Reasons for Encouraging Healthy Life Styles

One argument that explains some of the higher costs of healthcare relate to an aging population with more chronic degenerative conditions. Indeed, age and, I should add smoking, are risks factors for most all ailments. Certainly, smoking, drug abuse, crack babies and the fetal alcohol syndrome all impact healthcare costs as has the epidemic of the Metabolic Syndrome consisting of obesity, HPT, high cholesterol and adult onset of Diabetes. In response, more and more physicians are focusing on the survival benefits of a healthy lifestyle with a holistic and integrative medical approach to healthcare.

It costs a lot to die in our society as some 28 percent of medical expenditures for those over age 65 are spent in the last year of life. Of note is the fact that over 70 percent of people express a desire to die at home in the presence of their loved ones and yet about 75 percent die in an institution under the care of strangers.

The healthcare system is geared to the ethics of preserving life at all costs and, for many healthcare providers and families it is difficult to turn off the life support machines, enter Do Not Resuscitate (DNR) orders, and even follow advanced directives scripted by the patient that usually state that he or she does not want heroic measures carried out

should they become terminal and totally incapacitated with no prospect for quality of life.

Medicine is starting to adopt and promote the benefits of palliative care and hospice with the goal of eliminating futile care and providing a maximum degree of comfort and quality of life. Death with dignity is superior to living with severe pain and misery with little or no hope.

I am a believer that a healthy lifestyle extends life, and, remarkably, also shorten the period of decline and disability prior to death. It is a cost saving strategy.

Providing Universal Access to Health Care

Before the Affordable Care Act, about 44 million Americans have no health insurance, and another 38 million have inadequate health insurance coverage. And today medical bills remain the number one cause of U.S. bankruptcies. It is troubling, even disgraceful, that the United States is the only developed country without a universal healthcare program for its citizens. Granted, the uninsured or underinsured 25 percent of our population is generally young and healthy, but due to cost they often delay seeking medical advice and rely on Emergency Rooms as their primary care provider. This delay causes disorders to be more costly to treat because they are detected at a more advanced stage.

Moreover, Emergency Rooms are very high cost providers and notorious for excessive testing and charges. The solution, of course, is a Federal mandate for universal coverage. This would lower healthcare premiums, offer long term savings to the healthcare system and improve our nation's health.

In America, many individuals are confused about the term socialized medicine. In a true socialized medical system the government owns everything including the hospitals and clinics, whereas in a single payor system that is being considered in America, it is a socialized insurance system where the instruments of care are still privately owned.

Reducing Medical Mistakes

According to a recent study by the researchers at Johns Hopkins more than 250,000 Americans die each year because of medical mistakes. I believe the system is safer than what this statistic implies. But mistakes do occur and in most cases they represent 'process errors' rather than lack of the physician's skills, knowledge and abilities. The hospital systems are increasingly focused on continuous process and quality improvement with special emphasis on team based patient care and seamless exchange of information. Medicare has been influential in this increasingly collaborative approach to medical care by linking hospital reimbursements to readmission rates, hospital acquired infections, mortality rates, falls and patient satisfaction. These statistical grades are also used to compare hospital systems. Medical mistakes are costly and with improved fail-safe IT systems and integration of processes, the number of medical mistakes should steadily decline.

Historically, medical malpractice premiums have been a big line item for the practicing physician especially in the specialties of obstetrics, orthopedics and neurosurgery. In the past, medical malpractice litigation consumed about one percent of total healthcare costs. However, today most states have implemented medical malpractice reforms and capped awards and punitive damages and malpractice insurance premiums have declined. This has decreased the use of defensive medicine by physicians to quiet their fears of being sued. Moreover, medical malpractice cases are difficult for lawyers to

litigate and malpractice juries usually side with the defendants. Indeed, few malpractice cases actually go to trial and most valid cases with clear negligence are settled through arbitration.

Maintaining and Improving the Standards of Care

In the past, physician's 'patterns of practice' and standards of care varied considerably and physician decision making often linked to where they were trained, personal preferences and intuition. A few physician outliers could consume two to three times as much in medical resources treating the same patient population as the average practitioner and there were also some physicians that underutilized medical resources. Also some physicians over utilized hospital inpatient facilities with excessive lengths of stay, and the use of general anesthesia and the operating room for minor procedures that could have been carried out in the office using local anesthesia. There was a lack of standards of care, and Evidence Based Medicine was a newly coined concept.

Today the standards of care are more precise and this variance in patterns of practice is not as pervasive. Still, some disease entities such as prostate cancer are over treated and some screening and imaging and laboratory testing for minor complaints are still over utilized. Today, the hospital systems are increasingly putting physician practice patterns under the magnifying glass of performance and comparison with other providers. Moreover, standardized algorithms of care for common disease entities are being developed that physicians are encouraged and even required to follow. This is a positive trend because of the burgeoning amount of medical information that exceeds the capacity of the human brain to remember. This improvement in standards of care may be the entry point for Artificial Intelligence to gain a footing in medical diagnosis and treatment.

Integrating New Technology and Treatments

Almost daily new pharmaceuticals, tests, techniques and surgical instruments arrive on the scene and are approved by the FDA for clinical use. Unfortunately, new arrivals usually increase medical costs because most innovative products or even 'new and improved' modifications of existing technologies are very pricey. The suppliers rationalize these exorbitant prices on the basis of Research and Development expenses; not to mention patent protection and lack of competing products. New discoveries in genetics, inflammatory disease and cancer head the list of transformational technologies. Collectively these advanced technologies are adding terms to the medical lexicon such as precision, tailored and customized medical care for each individual patient.

One overriding problem, of course, is that most innovations are not curative and add just a few months to an often compromised existence. As more of these innovations come online, the society will need to address cost/benefit ratios and how much a year of quality life is worth and still sustainable within the current healthcare budget.

Looking into the future, Information Technology will make medical care safer, more efficient and cost effective. But I do worry about the future. If robotics and artificial intelligence and the 'machines' comes into their own; will it eliminate healthcare jobs and create a real surplus of physicians and will the MD degree still guarantee life-long employment?

Reducing Duplication in the Hospital Systems

The hospitals are a major part of the problem. Each hospital system in Greater Cincinnati has aggressive capital campaigns and amazingly deep pockets to expand and build new facilities that afford complete geographical coverage for each hospital system.

Often many similar clinics cluster in one area and offer identical services. Moreover, each hospital system boasts of state of the art equipment and a superior group of employed physicians.

According to the flood of marketing materials in the media, the five adult hospital systems in Cincinnati have five of the very best cardiac and orthopedic units in the nation and each claim to be the best in Greater Cincinnati. And how many times have you heard on the radio and TV ads that the Cincinnati Children's hospital is ranked number two in the nation by U.S. News and World Report. The range of marketing hype and promotional hyperbole is astounding coming from a not-for-profit sector of the economy. Advertising budgets are primarily directed at retaining and growing market share and not cost/effective health care.

Obviously, not-for-profit hospitals are very profitable and objectively are the epitome of social enterprises with revenues and assets in the many billions of dollars. Despite their healthy revenue streams, hospitals milk millions in donations from foundations, corporations, estates, individuals and drug companies that could better be applied to other nonprofits that help the needy and disadvantaged. The Cincinnati Children's Hospital is like a vacuum sweeper for charitable dollars in the City of Cincinnati.

Hospitals are run just like big businesses in corporate America. I even have difficulty understanding why hospitals qualify as 501-C-3 or charitable entities by the IRS. The redundancy and duplications in the hospital systems across Southwestern Ohio is troubling. And the entire hospital healthcare system within the United States lacks any semblance of central or regional planning. In our region the Certificates of Need (CON) that used to be featured as a constraint on the duplication of facilities has faded into history.

Competition between hospitals is fierce but this does not boil down to lower costs. Insurance carrier pay standardized fees to hospitals and this could be considered price fixing as it does not relate uniformly to quality or quantity of care.

Moreover, payroll expense for hospitals equals 80 percent of revenues and when a hospital is encountering financial difficulties; they can respond by decreasing staffing. They are immune to economic forces that cause most businesses to go out of business.

Having discussed structural problems and more specific cost items in our healthcare system, I will give a brief history of Federal legislation during recent years and then list possible reform solutions.

A Brief History of Healthcare Initiatives at the Federal Level

Across the Westernized world universal health care is almost universal with thirty-two of the thirty-three developed nations providing it; the sole exception being the United States. In recent decades, public opinion has evolved to where the majority of citizens now consider access to quality healthcare to be a right reflecting social justice and morality rather than a privilege. Universal health insurance has become a popular political and party platform issue.

As early as 1945, President Truman called for the creation of a national health insurance fund to be run by the federal government. This fund would be open to all Americans, but would remain optional. In 1965, during the presidency of Lyndon B. Johnson Medicare and Medicaid were enacted. In 1971, President Richard Nixon proposed more limited health insurance reform—an employer mandate to offer private health insurance if employees volunteered to pay 25 percent of premiums, plus federalization of Medicaid for the poor with dependent minor children, and support for health maintenance organizations(HMOs). In 1972, this was followed with a Social Security Amendment extending Medicare to those under 65 who have been severely disabled for over two years or had end stage renal disease (ESRD). In 1974, the Consolidated Omnibus Budget Reconciliation Act (COBRA) was passed to give some employees

the ability to continue health insurance coverage after leaving employment.

In 1993, the proposed Clinton health care plan included mandatory enrollment in a health insurance plan, subsidies to guarantee affordability across all income ranges, and the establishment of health alliances in each state.

In 2003, President Bush signed into law the Medicare Prescription Drug benefit plan that offered prescription benefits for elderly and disabled Americans.

Finally, on March 23, 2010, President Obama signed into law the Affordable Care Act (ACA) that drove the healthcare markets toward a universal health insurance coverage system. It included many provisions including a Federal Mandate and State Exchanges. Unfortunately, the following day, Republicans introduced legislation to repeal the ACA.

My Opinion about the Solutions

The First Steps in Healthcare Reform:

1. Reinstate the ACA or Obamacare in its original form to include:
   a. The Federal Mandate.
   b. Coverage of preexisting conditions
   c. Reconfirm a standardized package of healthcare benefits

Additional Provisions would be drafted by the Congress to include:

1. Permitting Medicare to negotiate drug prices directly with the pharmaceutical companies
2. Strengthen the State Health Insurance Exchanges and offer the Public Option (Medicare) as a competitive offering
3. Mandate Federally subsidized State Medicaid programs

The Longer Term Approach: The Sticky Wicket

1. First, appoint a healthcare Czar. He or she would convene multiple panels and committees of experts with broad nonpartisan representation to piece together the ultimate goals and objectives of an optimal healthcare plan for Americans that would guarantee universal coverage, manage costs and ensure quality of healthcare.

   Salient questions for their consideration would be:

1. How do you transition to a single payer insurance system with the least amount of disruption to the economy and job market?
2. How do you cushion the economic stress and disruption to existing healthcare players and vested interests?
3. How do you integrate population based/capitation models into the healthcare system to control costs and redirect the current 'production model of healthcare' to one that focuses on wellness?
4. How do you research and incorporate into your plan some features of the models that have been successful in other countries?
5. How do you address the ethical issues of rationing of medical care, cost/benefit ratios, and end of life futile care?
6. What are the realistic cost projections for any new plan?
7. Finally, do you have a 'one size fits all' single payor system or a two or three tiered system of healthcare

Most everything in transforming healthcare is fraught with political risk and nothing would be easy. You would need to get some consensus from both political parties and specials interests as to the viability of the changes and then sell it to the preponderance of the electorate. In the current environment this is like an ice cube surviving in hell.

However, I predict that at some point in the near or distant future we will have a single payer capitated system. It will be a long slog probably characterized by a thousand Band-Aids to palliate the system of waste and inefficiency along the way.