The Health Care Crisis In The United States
My Vision For A Better Future

by William R. Lane

While there are many issues in health care, the single most significant issue is cost, both in terms of the cost today and in terms of the growth in cost over the past several decades. We need to:

- Increase the ability of all citizens to purchase health care services (or health insurance that in turn purchases health care services).
- Decrease the growth in the cost of health care.

The Cost Problem

The cost of health care varies significantly from one person to another with the healthiest people having a very low cost and the least healthy people having enormous health care costs that almost no one could afford out of their normal discretionary spending. Two ways have generally been proposed to cover all people:

- A government run program with all citizens automatically enrolled.
- A legislative mandate that everyone must purchase insurance (individually or through their employer).

One of the most significant issues with a government program is that such programs tend to manage costs by forcing providers to accept the government stipulated price per service. When government budgets are tight, the provider reimbursement can be squeezed. Medicaid is an example of a program that in theory provides excellent coverage, but in practice it is hard to find a quality provider that will accept the very low government set rate.

The problem with a mandate is that—for a lower income individual—the annual cost of a comprehensive health insurance policy is a very significant portion of their annual income. An equivalent problem remains if you require employers to purchase the health insurance for their employees. The mandate adds to the annual cost of each employee and increases the likelihood that employers will eliminate the lower paying jobs entirely.

Risk Adjusted Financing

To me, the best solution requires government involvement in the funding of health insurance, but not in the management of health care providers and their prices. I would implement a system whereby the federal government implements a new tax that is progressive on individuals and progressive on employers' payrolls. The money collected must be kept separate from all other federal funds, and except for a reasonably small reserve for adverse circumstances, the money must be allocated back to all individuals. The allocation to individuals, however, is not paid in cash to the individuals, but is paid to the insurance company, HMO, Blues plan or employer self-funded plan that provides the individual his or her insurance coverage. It is also paid back in a very special manner. The payment for the oldest and sickest people is the highest and the payment for the youngest and healthiest people is the lowest. In actuarial terms, this is called "risk adjustment." In practice, this means that a health plan (or an employer with their own self-funded health plan) is not at a financial disadvantage if the individual they are covering is not healthy. This is important because a serious complaint against health plans is that they tend to seek to insure only healthy people. By removing the extra cost of a chronic medical condition, the health plan no longer has a reason to avoid such people.

With these payments, all health plans would be required to accept all applicants regardless of their health status, and there would be little or no reason for the health plan to reject high-risk applicants.

Risk adjusted payments are based on what medical condition the individual has and how long it has been since the condition required serious intervention. For example, for people with a heart condition, one factor is how long it has been since their last heart attack. For people with cancer, one factor is how long it has been since they have been in remission. In my vision of this system, I would pay a reasonable amount for the cost of care in the year of the

diagnosis of a serious condition, or a serious intervention, but I would pay somewhat higher than needed for the next few years (when costs tend to decline on their own). The reason for this approach is to encourage the health plans to find ways to retain these people in their plans and to keep them healthy. The more a health plan can actively work with their insureds to reduce future heart attacks, the more money the health plan may make.

Simplified Provider Reimbursement

I have a chronic medical condition called Type II Diabetes. I go to my physician three times a year and, based on how I am doing, he has a number of tests performed. I later get bills from my physician, from the laboratory who performed the tests, and sometimes even from another physician who reviewed the laboratory results. Imagine if you were to purchase a new car, and then a month later you received a bill from a tire company for the tires on your new car, and then another bill from a glass company for the windshield. We would never pay such bills for a car, but we routinely pay similar bills for health care.

Some people have suggested that individuals would better manage their own health care costs if they would negotiate with their providers. Under our current system, this is impossible because you don't know in advance who is going to bill you or for what services. In fact, patients rarely even know how much their own physicians are going to charge them for their current visit.

I would change the system by having all health care providers charge a fixed percentage (or multiple) of a fee schedule set by the government. Medicare already has such a fee system for both physicians and hospitals. Providers could charge whatever percentage they wanted, but they must publicly state the percentage they will use, and they must give a three-month advance posting for any changes in the percentage. Similarly, the government could change their schedule, but the government must give a six-month advance posting of what the new schedule will be.

Thus, when I would go to a physician, the doctor might charge me 85 percent of the government schedule or 175 percent of the schedule. But, at least I would know in advance what the percentage would be. And if I wanted to know what the office visit would cost, I could look up the government schedule on the Internet and do the math.

I would also make another very significant change in billing. I would require that all services ordered by a physician (or hospital) in conjunction with that doctor visit or that hospital stay must be:

1. Billed through the physician or hospital as a part of their total cost.
2. Billed together, not a series of separate bills.
3. Billed at a payment rate that is no more than the stated percentage payment rate of the physician or the hospital.

Thus, if you go to an 85 percent payment rate physician, then the lab work ordered by that physician must be billed by that physician and paid at no more than the 85 percent rate. What the physician pays the lab who did the work can be anything. Paying the lab is now the physician's cost, not the patient's.

This one change would force the physicians and the hospitals to be in charge of the work which they have ordered. It would not, however, apply to a prescription drug prescribed by the physician (but not supplied by the physician). In this case, the patient is free to go to any pharmacy. The pharmacy, in turn, will have a posted percentage of some government schedule for prescription drugs. Each patient can then seek a lower cost pharmacy or can pay a higher cost for prescriptions in return for greater convenience.

The physician does not have to order services as they currently do. They could prescribe them as they do with drugs and let patients choose their own laboratory for the services. This would not be feasible for someone staying in

a hospital, however, where such services would have to be billed by and through the hospital.

In such a system, health insurance could pay for all providers at all prices or, for a lower premium, could pay up to a specified percentage of the government schedule. People who were willing and able to go to providers with a lower percentage could reduce their costs because their health insurance premiums would be lower, but they would still get all needed services. People who wanted to be able to use any doctor or any hospital could either pay the extra themselves, or could buy a health insurance policy with a higher percentage rate of benefit. This would begin to put real pressure on providers to keep their prices as low as possible while still providing acceptable health care services.

Fifteen hundred words are not enough to describe all of the changes I would make, but just these changes would go a long way to make our health care system affordable and available.

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