Ten years ago, the U.S. healthcare system was declared “broken.” Since that time and especially in the last year, during my term as president of the American College of Cardiology (ACC), it has become increasingly apparent to me that the system has not improved: The fixes promised by the health maintenance organizations have not materialized; healthcare premiums are again on the rise; hassles for patients and physicians abound; and there are now almost 45 million people uninsured—about the same as the entire population of Canada plus Australia. Problems that 10 years ago were considered to affect only isolated parts of society now are beginning to encroach on all of us. In the next 10 years, the current and accelerating trends with costs and the uninsured will reach a critical juncture. Major change in the system will be required.

TRENDS LEADING TO THE NEED FOR A NEW HEALTHCARE SYSTEM

Increasing costs. New technology will allow efficiencies in medical care, such as the virtual home visit, and a better understanding of “necessary care” will emerge, thus decreasing utilization. However, these savings will be dwarfed by expenses generated by new tests, technologies, and treatments increasing the cost of caring for each patient and each potential patient. In the next 10 years, a magic bullet aimed at preventing diseases such as atherosclerosis may be developed, but surely it will be expensive.

As we become more skilled and experienced at treating disease, we are lengthening our patients’ lives. For example, patients who would have previously died from a myocardial infarction, congenital heart disease, or congestive heart failure are being treated successfully and going on to live many years, increasing the pool of patients who will need our care. Likewise, during the next few decades, the baby boomers will be in need of care for heart disease and many other chronic conditions. These patients are going to need the type of quality care they will receive from specialists, and the baby-boom generation will demand that level of quality despite additional costs. Quality will be expensive.

The infrastructure costs associated with these advances will be unprecedented, led by information systems and the utilization-control bureaucracy attempting to keep a lid on costs.

With the recognition that many so-called “added benefits,” such as some types of treatment, can be demonstrated to be “cost-effective,” their use will increase. The value of providing these benefits will be irrefutable, but concomitant costs will continue to rise.

Increasing numbers of uninsured. As costs continue to increase across the board, employers will have no choice but to take steps to contain the cost of their employees’ healthcare. As has already begun, some employers will decrease the number of full-time employees on their rosters; some will pass more of their healthcare costs on to their employees; and some will get out of the healthcare business entirely, opting instead to make a defined-dollar contribution to their employees’ coverage. Also exacerbating the problem is the ever-more-mobile society in which we live; with this mobility will come the desire to change jobs. The long-term benefit to the employer of providing health insurance will decrease. It is likely that fewer new employees will be given healthcare benefits, providing worsening “job lock” for those who remain. The outcome of these changes will be an enlarging pool of uninsured adults and their children. Increasing numbers of uninsured citizens will in turn cause further cost shifting to the insured, thus creating a vicious circle.

The results of these trends will be an increasingly disenfranchised, uninsured middle class, who will cast their votes—along with employers—for a radical change in the system.

A NEW U.S. HEALTHCARE SYSTEM FOR 2010

I would like to propose a new healthcare system for the U.S.—not for this year’s presidential campaign and not even for the next year but rather for 10 years from now. The U.S. is not ready for a new system yet, but the trends described above will lead to broader incremental changes that eventually will make our current system insufficient; a fundamental change will then be required. I write as a private citizen and am not espousing the policy of the ACC. However, it is appropriate for the president of the
Table 1. Problems and Principles

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ACC to propose such a change; we are a large group of physicians ultimately concerned with the welfare of our patients and the systems that serve them. I will identify six current problems with the current healthcare system in the U.S. and principles for addressing these problems (see Table 1). Although I will also propose potential solutions as examples, it is the principles that are most important.

**Problem 1: Uninsured**

**Principle 1: Universal Coverage**

Any viable plan for the future needs to be based on universal coverage. The 2010 plan would guarantee an adequate level of coverage for all Americans. Healthcare coverage would be required, just as automobile insurance is. Each citizen would be enrolled in the private health plan of his or her choice; each family member could use a different plan and could change plans annually.

Each previously uninsured American would receive an income–related payment (most likely a voucher) to cover the cost of the basic plan; the maximum payment would be equal to the cost of any local plan and would change with the cost of that plan.

**Problem 2: Pure Government System Not Acceptable**

**Principle 2: Private–Public Partnership; Competition**

The 2010 plan represents a unique public–private mix that I believe the American public will find to be a much better alternative than a straight government system. For the base case covering all Americans, the model is the Federal Employees Health Benefits Plan (FEHBP): There would be a number of private health plans (with vertical integration as appropriate), each competing on quality and cost. Physicians could work for multiple plans; and there would be a mandatory point-of-service option wherein a patient would pay a slightly increased fee to see a physician in another health plan (for example, a cardiologist in one plan and an ophthalmologist in another). Similar to the FEHBP, national coverage guidelines for the base case would be developed using not only cost-effectiveness criteria but also equity and other considerations important in 2010. Regardless, the benefits package would be the same or better than Medicare benefits at the time. The cost of the benefits for the base case would be formula–based with multiyear goals, aimed at a rational increase in the healthcare budget provided for the basic plans. In 2010, the coverage guidelines would be determined by an independent, nongovernmental agency. Conceptually similar to the Federal Reserve, this agency would receive input from citizens as well as reports from the Agency for Healthcare Research and Quality.

Following federal guidelines, regional agencies (like regional FEHBPs or the current state employee plans—but for all citizens) would use data on both quality and cost-effectiveness to choose health plans and would provide a catalog of approved plans and quality data. Similar to the FEHBP, the regional agency would use federal guidelines to pay health plans; by 2010, the premium would be “severity adjusted.”

In the base case, coverage and access would be provided for all Americans. Unlike a government system, care would be delivered by private physicians in private health plans that would compete on cost and quality.

Although most people’s health needs would be covered in the basic plan, those who desire supplemental plans could choose to pay for them. Benefits and fee schedules for these plans would be determined in the free market. The structure could be variable, with some even acting as a management services organization for a group of private practitioners. All supplemental plans would be required to submit the same quality data as the basic plans.

Medicare and Medicaid would become assistance programs focusing on helping the elderly, the poor, and the disabled to choose plans and to interpret quality data, perhaps coming to the patient’s home; they would provide true access to healthcare, even helping patients to obtain transportation to sites of care.

**Problem 3: Restriction in Choice of Healthcare and Job Opportunities**

**Principle 3: Alternative to Employer–Based Insurance; Individuals Can Choose Their Own Health Insurance**

In today’s system, individuals often find their choice in health benefits and job choices restricted. Many people find themselves locked into their jobs for fear of losing their own or their children’s health coverage.

At a minimum, the 2010 plan would provide an alternative to the employer–based system. Employees who wish to
opt out of the type of coverage that their employer provides could have their employer’s part of the premium (which could continue to be tax deductible) sent to the regional agency. Employees could apply for a federal tax subsidy (after providing documentation of the employer contribution), probably a voucher, to cover the remainder of the base premium. This subsidy would be income-related, such that those earning less than the federal poverty level would not pay for healthcare. For example, if the total adult premium were approximately $2,150 per year, then the employer contribution might be $1,750, and the employee portion $400. The employee could apply for a federal tax subsidy of up to $400, depending on income. For the unemployed, the income-related subsidy voucher would include the portion otherwise paid by employers. These individuals would then arrange for their own health insurance in the same way that they already arrange their automobile insurance.

Given the federal subsidy to the employee, it is possible that employers would decide to make no contribution to their employees’ healthcare, thus losing this revenue to the system. Therefore, it will likely be necessary to require employers either to provide insurance coverage or to pay the regional agency for each employee. From an equity standpoint, it seems reasonable that all employers (perhaps exempting the smallest employers, with 10 or fewer employees) should contribute, as is the case elsewhere in the world. Employers would be allowed to provide additional tax-deductible payments above the base, allowing employees to buy into supplemental plans.

In one eventual scenario, employers would be entirely out of the healthcare business, with those that have more than 10 employees paying their portion of the premium to the regional agency. Employers could still use wellness programs to attract and retain employees. Individuals, whether employed or not, would pay the individual (tax deductible) portion of the premium, with the federal subsidy voucher covering part or all of the remainder, depending on income. This premium would be the same for all base plans in the region—one rate for adults and one rate for children. This scenario would eliminate the need for employers to maintain a costly benefits infrastructure, allowing business to concentrate on business. Although this seems like a swan dive from the high board today, in 2010, it may be like stepping into the water.

**Problem 4: Administrative Nightmares for Patients and Physicians**

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

The 2010 plan also would end the administrative nightmares that both patients and physicians currently face. Each patient would have an electronic card (like a credit card) containing encrypted information about his or her medical history, the health plan, and any supplemental benefits to which he or she is entitled. Each time a patient visited a healthcare provider, his or her universal electronic medical record would be updated, with strict confidentiality rules. Software would incorporate what was dictated (or written) into the record and would automatically bill on a fee-for-service basis for physicians, and by diagnosis-related groups for hospitals. The plan would in turn pay automatically and on the same day—with no pre-approval.

Physicians within each health plan could develop local protocols or guidelines based, for example, on the plan’s “best practice” as collected automatically by the electronic medical record; these might provide a rational basis for local application and continued improvement in guidelines prepared by the ACC and the American Heart Association or other national organizations. In 2010, these guidelines could be embedded in the electronic medical record. Although they may not cover all areas, they would deal with the majority of conditions. If, for example, a physician dictated an order to admit a patient, and the admission did not fall within the guidelines, then the patient could still be admitted but a flag would appear in the electronic medical record, and the physician would be asked to indicate the reason for not following the guideline—including “I think the guideline is wrong.” After a number of such instances, case abstracts and the reasons could be e-mailed to 10 physicians in the same specialty and the same plan. These physicians would provide input, perhaps noting that the guideline needs to be changed; their input would be automatically e-mailed to the guideline-writing committee. If, however, the 10 physicians believed that the guideline was applicable to the cases, then the physician would be informed. After a certain number of times in which peer review indicated a continuing problem, any one of a number of steps could be taken. Unfortunately, in any fee-for-service environment, some degree of oversight such as this will be necessary. In addition, random samples of the top 10 percent and bottom 10 percent of utilization could be audited. The continued need for health plans is justified by making them the locus for quality improvement.

Each health plan would receive from the regional agency, according to national standards, a monthly severity-adjusted premium (remember that this is in 2010). For example, if the plan had 73 patients with heart failure, then it would be paid the median premium for those patients with heart failure—not for the cost of caring for each patient. The information required for the severity adjustment would be downloaded automatically from the electronic medical record. Every three months, there would be a retroactive “true up” wherein appropriate premiums for new patients were paid (for example, a premature infant), and those who died or left the plan could be subtracted. Therefore, there would be no need for “cherry picking”—adverse selection would not occur.

Health plans thus would compete on cost as long as they could deliver care for less than the severity-adjusted premium. They also would compete on quality: The regional
agency would give a federally approved “quality bonus” for the achievement of certain benchmarks; by contrast, the regional agency could disqualify plans with low quality. This is very different from many current health maintenance organizations, for which cost is the major driver.

This system of administrative simplification would eliminate many billing costs, simplify the quality infrastructure, and decrease the need for complex compliance programs—especially because the bill would be tied directly to the medical record.

Problem 5: Quality of Healthcare Is Not Consistently Measured, Reported, Understood or Used in Decision Making

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

Perhaps most important, I’m convinced that the 2010 plan will improve the quality of healthcare in the United States. By 2010, “quality” will be understood and measured. The national citizen health agency, with much input from the public, in partnership with healthcare organizations (for example, the Agency for Healthcare Research and Quality, the Joint Commission on Accreditation of Healthcare Organizations, and the National Committee for Quality Assurance as well as physician organizations, such as the American Medical Association and the ACC) would establish quality parameters; all health plans would be required to submit such data to local agencies. The electronic medical records would make these submissions automatically, eliminating any need for retrospective chart review. By 2010, it is likely that much medical process and outcomes data will be similar across health plans (for example, mortality for coronary bypass surgery); therefore, competition among plans will be based on the ability of physicians to innovate—both in caring for the most challenging patients and in keeping well patients healthy. Perhaps most important, competition will be based on how individual patients rate the physician’s ability to interact with them—the patient–physician relationship—focusing on the basic reason we all went into medicine.

Each individual would have the ability to fashion a personalized report card comparing physicians and plans on the items that matter most to him or her. The data for building these report cards would be available on the Internet. For those seeking advice about what these quality parameters mean, a new business will emerge—the “quality interpreters” (similar to H & R Block for taxes). Quality would be a two-way street: Individuals would be rewarded for healthy behavior—they could have no co-payments or lower premiums for the next year.

In 2010, as now, quality will need to improve. Research about how to improve patient care would need to be funded centrally (for example, by the Agency for Healthcare Research and Quality). Furthermore, much improvement in the quality of health comes from medical schools, where students continually push their physician teachers and researchers provide advances to their physician colleagues. This interdependency of missions directly improves the care of patients and ultimately improves the health of the nation. This justification seems appropriate for centralized funding of undergraduate and graduate medical education.

Problem 6: Financing

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

Obviously, guaranteeing basic healthcare coverage for all Americans—including the millions who currently lack any health insurance at all—will be expensive. National estimates for covering the almost 45 million Americans who currently lack insurance would be $88.6 billion in year-2000 dollars ($33.75 million adults at $2,152/year = $72.6 billion; 11.25 million children at $1,426/year = $16.0 billion).

Over the next 10 years, a number of possible ways of paying for the uninsured will become apparent. At least four potential sources of revenue could more than cover the cost estimated in 2000; some of these will be more palatable than others:

1. The federal and state governments currently pay $23.5 billion for the uninsured in non-Medicaid costs. This expense would be subsumed.
2. Hospital bad debt and charity care should disappear, although a conservative estimate would be to reduce it by two-thirds, or $17 billion (from 6 percent to 2 percent of $424 billion).
3. Insurance premiums paid by employers that have more than 10 employees and do not currently provide healthcare coverage could fund $43.9 billion.
4. The increased efficiency earned by drastically simplifying the healthcare system would also reduce costs. The automated billing by physicians and health plans, elimination of pre-approval, automated quality review and reporting without retrospective chart review, and the reduced need for compliance programs would save money. It can be argued that over the next 10 years, much will be spent to create these systems, and the savings in efficiency already will be realized. I believe that the real savings will not occur until there is coordination of billing and quality as outlined in this plan. It is at that point that a further 50 percent could be saved in certain areas of administrative costs—amounting to approximately $27 billion in private insurance plans (from 9.3 percent to 4.6 percent of $537 billion), $17 billion in hospitals (from 8.0 percent to 4.0 percent of $424 billion), and $6.9 billion in physician offices (from 8.0 percent to 4.0 percent of $173 billion). These calculations reducing administrative costs to approximately 4

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percent are actually conservative; current Medicare administrative costs are 3 percent.

Of course, the new system will need to incorporate other current healthcare spending. The current out-of-pocket individual expenses would be covered by the individual’s contribution to the premium (the remainder after the income-related federal subsidy voucher). The financing of current government programs, such as those supporting state and county hospitals, would need to be included, as would current employer payments for healthcare premiums.

2010’S WINNERS

Most important, patients would come out of this plan as winners. They would be entitled to choice and would be guaranteed coverage; those with potential heart disease would particularly benefit from universal coverage because they would have access to preventive care. Our patients would be freed from “job lock” and would be spared the hassles of paperwork and pre-approval requirements. The plan’s emphasis on high quality would improve the care they receive and their relationships with their care providers. No longer would “How am I going to pay when I get sick?” dominate their thoughts about healthcare.

Employers that get out of the healthcare business would be spared the administrative nightmares so often associated with offering healthcare coverage and would no longer be subject to the vagaries (and related premium increases) of catastrophic healthcare utilization. Small businesses (with more than 10 full-time employees) that might not be offering coverage could be required to pay something but would benefit from having covered, and therefore healthier, employees. Those with 10 or fewer employees would not be required to pay.

Insurers, too, would benefit. The plans would receive payments based on the severity of their patients’ conditions. They would reap the rewards of “online” medical management, thus improving the quality of care. Competition, a mainstay of America, would remain. A supplemental, “second tier” would be available for health plans to offer in the free market.

Our medical schools and teaching hospitals would benefit from finally having a rational payment system.

Finally, we physicians would benefit from the plan’s universal coverage (knowing that all of our patients can receive healthcare); physicians also would be relieved of many of the administrative hassles that consume so much of our time today (for example, paperwork, pre-approvals) with the continued benefit of prompt fee-for-service payment. The plan’s emphasis on quality would make us even more proud of our work and its outcomes, including improved relationships with our patients and improved health—our ultimate goal.

WHAT WE CAN DO TODAY

As physicians, we can start moving toward this new system today by piloting new programs that get us there. Most of these ideas can be started now: We can develop and use electronic medical records with embedded quality and payment systems; we can support efforts at severity adjustment for premiums; we can gather and analyze process and outcomes data, improve patient care, and create guidelines based on the evidence; and we can teach our patients to recognize quality. Those of us who are employers can pilot efforts toward defined contribution of premiums and the infrastructure to support it—allowing our employees to choose their own healthcare. We can urge our states to develop programs for all citizens similar to those available to state employees; these would be the models for the regional agencies.

Most important, we can acknowledge the need for major change. We can support significant incremental reform; however, I believe that we will eventually need a new system. I challenge the ACC to debate these principles, modify them, and develop better potential solutions. Unless we physicians get actively involved in reforming our healthcare system, we’ll have to live with choices others make for us. We must do something.

I welcome your thoughts about healthcare reform and the 2010 plan. Please feel free to write to me at Heart House, 9111 Old Georgetown Road, Bethesda, MD 20814-1699; fax me at 301-897-9745; or e-mail me at pres@acc.org. I acknowledge the invaluable effort of William Falk and Kathy Boyd in this work.

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