While it's uncertain what will happen with the ACA this year and healthcare policy in general, it's clear something needs to be done, says one doc.  

Source: Physicians Practice

A new year always carries the promise of change, but 2017 is already shaping up to be an exceptionally transformative year, especially for the medical community. The election may be over, but with cabinet appointments and policy changes gearing up, it won't be long before we start to see an impact on every aspect of public life, ranging from foreign affairs to infrastructure spending. One of the most hotly debated changes pertains to the future of our healthcare system. Throughout his campaign, Donald Trump repeatedly promised voters to "repeal and replace" the Affordable Care Act (ACA), and he has started to make good on that vow by appointing Rep. Tom Price to head the Department of Health and Human Services. Only time will tell whether Trump's changes will have the intended effects, but it is clear that something needs to be done.

Healthcare costs are simply too high. According to a poll conducted by the Harvard T.H. Chan School of Public Health, "more than a quarter of adults in the U.S. say health care costs have caused serious financial problems for them or their family." Furthermore, healthcare now accounts for more than 16 percent of the U.S. GDP and exceeds $1.5 trillion in costs. To keep up, the government has expanded regulations, which has increased costs without helping to improve patient care.

Though our health system has evolved into a confusing conglomerate, it started out as a very simple, straightforward idea. It was born in the heart of Texas back in 1929, when Justin Ford Kimball, a Baylor University official, was designated to lead Dallas hospital units. Kimball offered teachers the opportunity to contribute fifty cents a month to a fund that would guarantee them up to 21 days of care at Baylor Hospital. The "Baylor Plan" exploded in popularity, which encouraged planners to offer community-wide plans. These community plans eventually came to be known as the Blue Cross Plan.

Not much changed until the 1940's, when insurance started to become employer-based. This marked a notable shift, because those health benefits were exempt from individual federal, state and city taxes, which created a huge advantage for employer-sponsored group health benefits. It didn't take long for this to lead to a notable expansion in coverage, which gave an unprecedented amount of power to insurance companies, who soon learned to exploit the concept of risk.

In 1965, the federal government intervened, intending to provide coverage for individuals without employment, such as seniors. This marked the birth of Medicare. Unfortunately, Medicare has been poorly administered over the years, and we are now seeing it suffer from $200 billion in losses per year due to wasteful spending, abuse and fraud.

That was just the beginning, and since then government interference has further complicated and distorted our health system, with the Affordable Care Act being a prime example. The ACA relies upon the participation of insurance companies in order to fulfill its promise of reducing the number of individuals who have historically been too poor or sick to access coverage. However, with key insurance companies like UnitedHealth, Aetna and Humana leaving ACA exchanges, hundreds of thousands of Americans are now confronted with losing their plans and rising premiums.

The insurance giants leaving ACA exchanges say they are doing so because they aren't making enough of a profit, and their departure is forcing the remaining insurance providers to demand sharp price increases to stay afloat. Government data shows that monthly insurance premiums for popular plans on HealthCare.gov will be increasing by an average of 25 percent this year. Meanwhile, the same insurance companies leaving the ACA exchanges are working on merging with each other, which would give them even more power and further reduce competition. Anthem and Cigna announced their intention of merging in July of 2015, and are currently working on receiving regulatory approval for the $48 billion deal. If they merge, they would have over 53 million members and make more than $115 billion annual revenue. Based on membership, the new company would be the largest insurer in the country.
A federal judge recently blocked the $37 billion merger between Humana and Aetna due to concerns that it would harm consumers, which does not bode well for the Anthem-Cigna merger. In fact, former Attorney General Loretta Lynch has said, "If these mergers were to take place, the competition among insurers that has pushed them to provide lower premiums, higher-quality care and better benefits would be eliminated."

I agree with AG Lynch that competition helps to drive innovation and transparency while lowering costs. While the Affordable Care Act has inadvertently caused the opposite to occur, taking steps to enhance competition between insurance companies is one major way to help to lower premiums and lead to better patient care.

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