THE MANUAL–HEALTH CARE 2020: CONNECTING THE DOTS

- Patients
- Employers
- Providers
- Payors
- Government

Greg Dattilo, CEBS
With Dave Racer, MLitt

January - 2020

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There are essentially two ways to lower costs while preserving quality: 1) enhancing consumer choice and improving incentives for consumers to obtain value from their health care decisions, and 2) maximizing competition between providers of health care to provide the lowest cost and highest quality services.[1]

-- Brian Blase - 2019

[1] Blase, Brian. "Health Reform Progress: Beyond Repeal and Replace." Paeonian Springs VA: Galen Institute, September 2019.

January 2020

To Patients, Employers, Providers, Payors, and Government Leaders:

Health Care continues to be a contentious issue for everyone. A 2019 Kaiser Family Foundation report showed that the average annual premium for an employer-sponsored health plan is $20,576, approaching $10 per hour. In my own experience as a consultant to employers, during the fall of 2019, I saw annual family insurance premiums in excess of $33,000, nearly $16 per hour. How did we arrive at a health care system that is truly unaffordable?

From my point-of-view as a 45-year benefit consultant, I witness how important affordable insurance is for individual security and the many powerful, positive effects it has for individuals, families, communities, employers, and society. Across the U.S., individuals see that health care is either their first concern, or most certainly, among their top three when casting a vote.

Clearly, employers and working people want to solve the high price of health care. They feel like the health care system is much too complicated, benefiting Payors (insurance companies) and Providers (hospitals and doctors) at their expense. Government has not engaged to make the health care marketplace any friendlier; instead, it has made it more complicated and unfriendly. Working people would like to purchase health care like everything else they purchase. They want to know the price, description of what they are receiving, and evaluate comments made by other consumers (patients).

Working people and employers are asking providers, payors, federal and state lawmakers to give them the tools to access health care in a consumer-friendly marketplace – then let people manage their own health care. They see themselves as key to the solution of reducing cost, increasing access and commanding better quality care for their dollar.

This manual provides background concerning critical issues, a discussion of the role played by those who can effect change, and it offers solutions. These solutions are not unproven theories that come down from Ivory Tower Academics. They come from the ground level, where each day I am confronted by the frustration of employers and employees, where I try to mediate ever-increasing insurance premiums, and intercede on behalf of my clients for out-of-control provider claims.

My point of view is rooted in the eyes of the working population that depend on private health insurance. *The Manual – Health Care 2020: Connecting the Dots* is practical and untarnished by those that do not want change in the high cost of U.S. health care. I want to give a voice to working people. Hence, this manual suggests health care reforms designed to align five dots that make up the US health care system – Patients, Employers, Providers, Payors, and Government in a new consumer friendly marketplace.

Dave Racer, a premier researcher and great writer, used his skills to help me communicate these ideas. Feel free to contact either of us with your questions and comments.

Be part of the solution.

Greg Dattilo, CEBS
CEO – Dattilo Consulting, Inc.
https://dci-clientserv.com

Dave Racer, MLitt
DGRCommunications, Inc.
https://daveracer.com

https://themanualhealthcare2020.com/

Introduction to The Manual

Health Care 2020, Connecting the Dots, is a manual to guide Patients, Employers, Providers, Payors, and Government toward a new, patient-friendly marketplace. Health Care 2020 implements the same, basic U.S. free enterprise principles that deliver most products and services in today's marketplace, applying them to health care.

Disconnected Dots

- Providers
- Payors
- Government
- Patients
- Employers

The U.S. health care system is suffering from increasingly difficult challenges. The primary problems are:

1. The high cost of care and insurance.
2. Imposed restrictions on patients regarding provider choice.
3. A health care marketplace that is unfriendly to patients.

This manual offers a blueprint to overcome these challenges. It offers a redesigned private health care marketplace that is more affordable, provides patients freedom of choice, and delivers consumer-centered patient care in a healthy, competitive marketplace.

For *Working* People

This manual is specific to the needs of *working people* who have private health insurance – estimated at 218 million Americans.[2] The needs of individuals enrolled in government plans differ from those with private insurance. The manual does not address individuals who are covered by Medicare, Medicaid, or other government programs.

This manual is specific to the needs of *working people* who have private health insurance – estimated at 218 million Americans. The needs of individuals enrolled in government plans differ from those with private insurance.

Working people, through employers or as individuals, pay private health insurance premiums. In 2019 the annual premium for employer-provided family health insurance grew to an average of $20,576 across the United States, according to the Kaiser Family Foundation.[3]

Working people also pay taxes to support the medical bills of those with government health plans – and pay other, hidden taxes as well. These taxes and premiums have put incredible pressure on working people to meet their family and personal needs, and they are asking for relief.

A Different Solution

Health Care 2020's recommendations are different from solutions being currently debated that have created a major political divide. The Health Care 2020 solution draws on the power of creating and

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[2] Berchick, Edward R, Jessica C Barnett, and Rachel D Upton. "Health Insurance Coverage in the United States: 2018." Study. Washington, DC: U.S. Census Bureau, November 2019. https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[3] Unidentified. "2019 Employer Health Benefits Survey." *The Henry J. Kaiser Family Foundation* (blog), September 25, 2019. https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.

sustaining a consumer economy in which patients are drawn to what *they* perceive as the best value in health care. The primary premise rests on the positive outcomes resulting from full price transparency that drives competition like any other product or service in the marketplace. Compared to traditional discussions about health care reform Health Care 2020 offers a different, more consumer-friendly form of transparency. Health Care 2020 allows:

1. Patients a long-awaited, consumer-friendly marketplace where they enjoy maximum freedom to access quality care at a price they can afford.
2. Employers to be able to better afford and use medical benefits to strengthen their workforce, retain and attract workers.
3. Physicians, surgeons, and other medical professionals if they choose, to escape the handcuffs of large health systems and practice independently.
4. A new category of health insurance plans that offers multiple insurance companies easier access into the U.S. health care marketplace.
5. Government, to bridge the two major political parties, with a non-political solution that delivers what working people want.

Health Care 2020 builds on basic economic assumptions common to how nearly all other products and services are bought and sold. It asserts that health care can and should be delivered in an open, transparent marketplace. In such a marketplace, consumers know what they are purchasing, what each provider charges, and have information about quality and customer satisfaction.

Health Care 2020 builds on basic economic assumptions common to how nearly all other products and services are bought and sold. It asserts that health care can and should be delivered in an open, transparent marketplace.

This manual comes from its authors' more than 25 years of study, research, writing, but more importantly, from real-world application of sensible solutions that work for everyday *working* people. Practicality overrides theory in the formation of Health Care 2020.

Comments about Medicare Pricing

Medicare is a national health care payment system. It pays for the health care of more than 55 million Americans, and insurance companies use its reimbursement rates as a reference price for the 218 million individuals with private insurance. Medicare pays at a rate most providers think of as breakeven. The point is that without subsidies from working people and employers who pay inflated premiums for private health insurance, the health care system as we know it today would collapse.

Medicare's allowable payment schedule, which serves as the foundation for calculating provider payments in the private health care marketplace, is relatively stable. This makes possible the use of Medicare's allowable payments to act as a transparent reference price in a redesigned and friendlier health care marketplace – discussed in Chapter 15.

How this Manual is Organized

Successful, consumer-friendly health care redesign requires connecting five critical factors which Health Care 2020 calls "Dots."

Connecting the Dots
- Patients
- Employers
- Providers
- Payors
- Government

- Dot 1: Patients come first. This is the reason for a health care system – the consumers.
- Dot 2: Employers are second. Employers provide most of the funding of the U.S. health care system for 178 million Americans, or more.[4]
- Dot 3: Providers. Working people's medical and mental health needs are served by providers (physicians and hospitals).
- Dot 4: Payors (insurance companies and third-party administrators). Payors collect the financial resources through premiums from employers and individuals to manage and pay patients' health care claims.
- Dot 5: Government. As a regulator, not a competitor, to protect against unfair business practices and ensure that monopolies cannot distort and harm the marketplace.

By better connecting these dots, Health Care 2020 offers uncomplicated and practical solutions that integrate the dots in a consumer-friendly health care marketplace.

This manual is divided into two sections.

1. SECTION I: TODAY'S HEALTH CARE SYSTEM, AN UNFRIENDLY CONSUMER MARKETPLACE, discusses several specific challenges that contribute to the high cost of health care.
2. SECTION II: SOLUTIONS: HEALTH CARE 2020 – CONNECTING THE DOTS, describes how to connect the dots to create a consumer-friendly marketplace that delivers affordable health care driven by competition in price and quality.

Definitions:

There are a handful of Health Care 2020 terms unfamiliar to the general public. These include:

Hidden Tax. The difference in the dollar amount paid for health care services by privately insured individuals compared to the Medicare allowable reimbursable amount, expressed as a percentage.

Medicare-Percent. The percentage related to Medicare reimbursement rates a provider will accept as full payment from private, non-government health insurance plans.

Medicare-Percent Disclosure. A law or regulation that would require all health care providers to disclose the percentage of Medicare they accept as full payment from private, non-government health insurance plans.

[4] See note 2.

Open-Ended Contracts – Promise-to-pay. A contract which providers require patients to sign before receiving services that says *the patient is ultimately liable for any amount the provider charges*.

Payors – An insurance company, managed care company, or third-party administrator that employers use to pay claims for employer-provided group health insurance.

Provider – A common term that designates various entities that delivers some form of medical and/or mental health care. This overbroad term includes physicians, hospitals, clinics, nurses, and other medical professionals – in some cases, support staff as well.

Reference-Based Pricing – A method of determining the reimbursements and payments made to providers that relies on a static base price plus a percentage markup. The most commonly accepted reference price is the Medicare-allowed reimbursement amount.

"Shoppable" Services are those in which the patient has time to plan, to compare providers on price, quality, and other factors consumers feel are most important.

SECTION I - TODAY'S HEALTH CARE SYSTEM – AN UNFRIENDLY CONSUMER MARKETPLACE

Chapter 1: Price Secrecy Allows A "Hidden Tax"

Disconnected Dots

- Providers
- Payors
- Government
- Patients
- Employers

Health Care 2020 is built on a foundation of connecting the dots – Patients, Employers, Providers, Payors, and Government – where all dots are aligned, delivering health care in a friendly consumer marketplace. For this alignment to happen, all five dots must have the same information with the same goals, but that is not true today.

Three dots – Providers, Payors and Government -- know about a secret hidden tax which patients and employers pay. Two dots – Patients and Employers – do not know about the hidden tax, but they pay it and it has made health care progressively more unaffordable.

Health Care 2020 provides the means to connect the five dots so that all can understand the secret hidden tax. Armed with this knowledge, patients and employers will finally be able to shop for health care based on price, quality, and access.

Confronting "Chaos behind a veil of secrecy"[5]

Up to now, the health care industry has kept costs secret, hiding prices "behind a veil of secrecy." Price secrecy is a primary reason health care costs so much in the private market.

The system hides the price of care from patients, and in addition, patients pay a hidden tax that is used to offset the low provider reimbursements paid by Medicare, Medicaid and other government health plans. When private insurance pays more because government pays less, that is the definition of a tax.

Tax- def. (Merriam Webster)

- **a)** "a charge usually of money imposed by authority on persons or property for public purposes [i.e., Medicare, Medicaid]
- **b)** a sum levied on members of an organization to defray expenses" [i.e., private insurance]

Of course, taxes are usually associated with a government levy against taxpayers and taxes are usually paid to a government. Health Care 2020 labels the prices charged by providers to privately insured persons as including a hidden tax – the extra amount someone must pay to make up for the low amounts government reimburses providers. Instead of the hidden tax being sent to a government, the tax is kept by providers to offset the losses they incur by providing care to people who have government insurance.

For example, if a hospital receives $1,000 from the government for a Medicare or Medicaid patient, the hospital will charge a privately insured patient $2,500. This is how the hospital is able to pay its

[5] Reinhardt, Uwe E. "The Pricing of U.S. Hospital Services: Chaos Behind A Veil Of Secrecy." *Health Affairs* 25, no. 1 (January 1, 2006): 57–69. https://doi.org/10.1377/hlthaff.25.1.57.

current expenses to provide care to government- and privately paid patients. If the hospital did not collect and keep the hidden tax, it would have to find a way to pay all its expenses from the $1,000. The lower amount would force the hospital to cut expenses.

If a hospital's patient mix is top-heavy with Medicare and Medicaid patients, it is likely the hospital's hidden tax on privately insured patients will be greater than another hospital that has more privately insured patients.

Example:

> Dave is on Medicare. Dave has a procedure at Mercy Hospital. The hospital charges $3,000. Medicare allows, and the hospital accepts $1,000 as full payment for this procedure. (This is an example of a common billing process where the hospital bills 200-500% or more than Medicare allows.)
>
> Joan has a *private* health insurance policy. Joan has the same procedure as Dave at Mercy Hospital. The hospital charges $3,000. Joan's health insurance company discounts the bill to $2,040 and the hospital accepts it as full payment.

Compare the $1,000 Medicare allows to the $2,040 private insurance allows for the same procedure from the same hospital. Why does the hospital receive $1,040 more for Joan from private insurance? Because the hospital shifts some of Dave's cost to Joan from the lower Medicare payment amount.

The extra $1,040 paid by private health insurance for Joan's care acts like a tax – "a sum levied on members of an organization to defray expenses." Physicians, hospitals and other medical providers rely on this tax to pay their overhead expenses to ensure they can keep offering services to working people with private insurance, and to others. All the members of a private insurance health plan pay more, because Medicare pays less for the same services. This is the reason for the hidden tax.

Documented Evidence of The Hidden Tax

The Congressional Budget Office, in a May 2019 report using 2013 data, showed that "three major insurers' commercial payment rates for hospital inpatient admissions… were 89 percent higher, on average, than Medicare …" allowable reimbursements.

The level of the tax differs depending on location and the data studied, but recent national reports have established that this tax ranges from 89% to 193% based on both hospital and clinical charges for services. Health Care 2020 has also analyzed the hidden tax using data disclosed by primary clinics as a result of the new Minnesota price transparency law (Section 62J.812) that took effect July 1, 2019. Results for 23 primary care clinics are shown in Appendix II. The hidden tax revealed from this Minnesota data ranges from 9% to 182%.

The Congressional Budget Office, in a May 2019 report using 2013 data, showed that "three major insurers' commercial payment rates for hospital inpatient admissions… were 89 percent higher, on average, than Medicare …" allowable reimbursements.[6] This means that when Medicare paid $10,000 for

[6] CBO Staff Authors. "Key Design Components and Considerations for Establishing a Single-Payer Health Care System," the Congressional Budget Office, Washington, D.C. May 2019. P 21.

an inpatient service, those three private insurance companies were paying $18,900 – an 89% hidden tax. People with private health insurance pay that hidden tax in their premiums and out-of-pocket expenses.

More recent data from 2017, published by the Rand Corporation in 2019, found far greater hidden taxes from a major study of large employers that crossed 25 state lines. Rand found that commercial insurance companies paid 204% of Medicare for inpatient hospital care, and 293% of Medicare for outpatient hospital care. The average commercial insurance payments between inpatient and outpatient care, according to Rand, came to 241% of Medicare – for a 141% hidden tax on average.[7]

Whether physician fee-for-service or hospital reimbursements, the providers rely on the hidden tax to make up for the shortfalls of government health plan reimbursements. The Rand study confirms this.

Furthermore, Rand's study showed that the gap (the tax) between Medicare and private commercial insurance reimbursements is increasing. Just since 2015, the gap grew by an additional 5% through 2017.[8] This trend will continue unabated as long as health care consumers are unaware of the hidden tax.

The primary reason for the high price of health care is that the medical industry and insurance companies keep the 141% hidden tax a secret, hiding it behind an incomprehensibly complex set of codes, and insurance company contracts that bar disclosure often called "gag" provisions.

These studies show that the hidden tax varies greatly, even in the same health care market. How is it that insurance companies, who collect the hidden tax in premiums, have been able to hide these variances?

The hidden tax has backfired on insurance companies. This is how the average cost of employer-provided family medical coverage in the United States has become $20,576 (Kaiser, 2019). Patients have no knowledge of this hidden tax, and so, blame insurance companies for the high cost of insurance premiums.

Summary:

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Problem – Misaligned Dots. Three of the dots have knowledge of how secret health care pricing works – Providers (physicians and hospitals), Payors (insurance companies), and Government (Medicare, Medicaid, etc.).

Solution – Price Transparency. The three dots that know about the hidden tax must embrace a new transparent pricing system that fully discloses costs to the other two dots – Patients and Employers.

Problem – The Hidden Tax. Providers collect a higher amount from private patients than from Medicare or Medicaid in order to cover low payments from the government health plans -- a hidden tax.

Solution – Full Transparency. To expose the hidden tax by requiring providers to show the Medicare-Percent they accept as full payment. Health Care 2020 defines as the Medicare-Percent Disclosure.

[7] White, Chapin, and Christopher Whaley. "Prices Paid to Hospitals by Private Health Plans Are High Relative to Medicare and Vary Widely." May 9, 2019. P 19.

[8] Ibid.

Example: Clinic A accepts as full payment from a privately insured person $250 for a 20-minute examination. Medicare allows $100 for this exam. Clinic A is asking the patient to pay the Medicare reimbursement amount of $100 plus an additional $150 – a 150% hidden tax.

Clinic B charges $150 for a 20-minute exam. Medicare allows $100. Clinic B is asking the patient to pay the Medicare reimbursement amount of $100 plus an additional $50 – a 50% hidden tax.

Benefits of Medicare-Percent Disclosure – Consumers will know how much more providers are billing than what Medicare allows, and how much providers will accept as full payment. This will encourage more truth in billing. Patients will be empowered to shop based on price, and through competition will begin the process of reducing prices over time in a consumer-friendlier marketplace.

Chapter 2: Price Secrecy Creates Price Disparity

Disconnected Dots
- Providers
- Payors
- Government
- Patients
- Employers

The previous chapter reveals how price secrecy allows a tax, in the form of higher reimbursements that drive premiums higher, to be hidden from two of the dots – Patients and Employers. The other three dots – Providers, Payors, and Government – know about the hidden tax but hide it from consumers behind a veil of secrecy.

This chapter examines how secrecy makes extreme and sometimes unjustifiable price disparity possible among providers. It shows how price disparity also misaligns the five dots.

A variety of factors drive the pricing of health care services and products. These factors may include practices in remote locations that have more expensive overhead costs, expensive enticements to attract quality practitioners, government and insurance rules and regulations, or whether an institution or practice also trains medical professionals. Certainly, technology has created more ways to treat health problems, and may add overall cost to the system. It may be that one clinic has more physicians than another, and the larger clinic is able to negotiate a higher reimbursement rate than the small clinic. It could be the loyalty of patients to favor one provider over another, or a difference in quality of care.

One critical price factor is an imbalance of patients served who have government health plans that generate reimbursements below an entity's operating expenses; those entities must make up the losses on government plans by charging more to those with private insurance or who pay cash.

In some instances, however, there is evidence of excessive overhead expenses used to justify a high price that is far greater than others performing the same service in the same marketplace. How does a Minnesota provider explain why it requires $43,359 for the same hip replacement performed for $6,666 by a different Minnesota provider (see Minnesota, below)?

Whatever drives the differences in prices, they can be large and price secrecy makes it possible. Nothing, however, justifies hiding the price of care from patients.

> Secrecy makes medical price disparity possible, so individuals often unknowingly pay two to five times more for the same service as their neighbor.

The current system of pricing health care services denies patients and employers their right and necessity to know about this wide price disparity. After all, they pay for it through high health care and insurance costs. Secrecy makes medical price disparity possible, so individuals often unknowingly pay two to five times more for the same service as their neighbor.

Minnesota Discloses Price Disparities

No other industries have the extreme price disparity common to the delivery of health care. For example, Minnesota Community Measurement, in a 2018 report on cost of care, shows an average price variance between providers of 351 percent for 118 common non-emergency health care expenses paid for by private, commercial insurance.[9] The Minnesota experience in price variance is common everywhere.

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[9] Nelson, Gunnar. "Health Care Cost & Utilization - Minnesota." Minnesota Community Measurement, 2018. https://mncm.org/wp-content/uploads/2018/11/mncm-cost-report-2018.pdf.

Minnesota Community Measurement elsewhere reported billed price variance for several specific procedures. The data for a total hip replacement surgery, for instance, showed a range in prices from the lowest billed rate to the highest of 650 percent – $6,666 to $43,359.[10]

Some medical and diagnostic services referenced in the Minnesota reports showed price variances of more than 1,500 percent between the highest and lowest billed rates. Lab tests and diagnostic imaging are among the most extreme examples. These are the types of services that should be among the most "shoppable," if consumers were able to know their price.

A great deal of hospital pricing data is becoming available and it shows a large price variance among providers in the same locales and across state lines. A 2019 Rand Corporation study showed, "The relative prices of hospital care vary widely among hospital systems, from around 150 percent of Medicare at the low end to four times Medicare at the high end…"[11] One of the key points of Rand's conclusions is that prices vary in part because consumers have no price information.

Price disparity especially punishes the 125-145 million individuals with employer sponsored high deductible health plans who have no way of knowing if they are paying 200-500% more than necessary for shoppable health care services. The problem is worse for individuals receiving excessive billings after receiving services from an out-of-network provider. In both cases, patients have no price information from which to make decisions about which provider to choose.

Price disparity especially punishes the 125-145 million individuals with employer sponsored high deductible health plans who have no way of knowing if they are paying 200-500% more than necessary for shoppable health care services.

Chapter 3 discusses the open-ended, "promise-to-pay" contract that providers require patients to sign prior to receiving services. Price secrecy compounds this problem by hiding the price of care to the same patients that are required to agree to pay the bill no matter how much the provider charges.

The following is an example of what today's health care price disparity would look like if, instead of hip replacement, the consumer is purchasing a new mattress and box spring, having signed the open-ended contract.

> Marge goes to Johnson Furniture, chooses a new bed, and signs a contract to buy it. Marge has no idea how much it costs because there are no prices posted. Three days later, Marge climbs into the new bed and enjoys the best night's sleep she's had in years. A few weeks later Marge gets a bill for $2,500 and feels good about it.
>
> Marge's next-door neighbor, Amir, goes to Olson Furniture and does the same – signs a contract, points at the same model bed Marge had purchased at Johnson Furniture, and orders it delivered. Three days later, Amir climbs into the new bed and enjoys the best night's sleep he's had in years. A few weeks later Amir receives a bill for $16,250 (650% more than Marge paid, but neither of them know about it). Amir can't believe his eyes – but he signed a contract and is obligated to pay it.

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[10] Ibid.
[11] See note 7, P 21.

Ironically, Olson Furniture could stay in business, even price gouging like this, if bed pricing worked like health care pricing, shrouded in secrecy.

Reducing the price of care will require complete price transparency with reference to a price that is standard across the health care industry. Then, and only then, can a patient determine whether his or her dollars are spent wisely.

Summary

Problem – Price Disparity Unjustified: Prices for health care services vary widely, but generally, not based on quality. Price secrecy makes price disparity possible, adding no value to the consumer. Instead, it encourages higher prices while only allowing the provider and insurance company to know the facts about this price disparity.

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Solution – Medicare-Percent Disclosure: Require providers to show consumers one number expressed as a percent that would allow consumers to shop among all the providers. That number is the *Medicare-Percent* they accept as full payment.

Consumers will be able to compare the *Medicare-Percent* of each provider in their area. This makes it possible to shop by price with little to no effort. Providers, likewise, will be able to learn the *Medicare-Percent* of their competitors. High cost providers' prices will be exposed by the *Medicare-Percent*.

Eliminating price secrecy allows competition, and competition will reduce price disparity. Competition will also bring about a more consumer-friendly marketplace where patients will know which providers charge the least and which charge the most. Like any other transparently priced product or service, prices will naturally fall as providers compete for patients.

Chapter 3: Unfriendly Consumer Contracts - Promise-to-pay

Disconnected Dots
- Providers
- Payors
- Government
- Patients
- Employers

Chapter 2 explained how price secrecy prevents two of the dots – Patients and Employers – from knowing the price of care. Therefore, the interests of patients and employers are not aligned with the other three dots – Providers, Payors, and Government.

Another factor that misaligns the interests of the five dots is providers' use of an open-ended contract requiring patients to pay whatever the provider charges. Providers require patients to sign this contract before and as a condition of receiving medical care. The provider, however, does not tell the patient anything about the charges until after the services are rendered. This means that the patient could receive a bill weeks after a service and be required to pay it, no matter how much it is.

When a patient goes to a provider for medical care in our consumer-unfriendly marketplace, he or she is required to sign several forms. One of those forms includes a statement that says *the patient is ultimately liable for any amount the provider charges*. The provider, however, does not tell the patient the amount to be billed, or how much above the Medicare allowance the patient is being charged. Signing an open-ended promise-to-pay contract, and not knowing the price, would never be allowed in a consumer-friendly health care marketplace.

There are no other products or services that consumers buy that have the same excessive price variance as health care. If we bought a car the way we buy health care, it might look like this:

> Maria goes to ABC Auto, points at a car, and signs a contract to buy it. Maria has no idea how much it costs, but enjoys the new car feeling as she drives home. A few weeks later Maria gets a bill for $20,000 and is happy with it.
>
> Maria's next-door neighbor, Jose, goes to XYZ Auto and does the same – signs an open-ended contract, points at the same model car as Maria purchased, and drives it home. A few weeks later Jose receives a bill for $100,000 and can't believe his eyes – but he signed a contract and is obligated to pay it.
>
> Ironically, XYZ Auto could stay in business, even price gouging like this, if car pricing worked like health care pricing.

In the consumer-unfriendly health care marketplace, the buyer (patient) does not know the price of care until after using medical services. Unfortunately, the patient has signed a legally binding agreement that he or she will pay whatever the medical provider charges. Here are three examples of the promise-to-pay agreement signed by patients copied from original provider documents:[12]

1. "… I also agree to pay for any balance not paid for by my insurance…"
2. "I agree to pay the hospital for all charges not covered by any third-party payor."

[12] These two examples are quoted directly from two different providers' registration forms. The providers required patients to sign the promise-to-pay form before the patient received care.

3. "Service Terms - Statement of Financial Responsibility: I acknowledge I am responsible for all charges for services provided including any amount not paid by my health care plan(s) other than billing terms and restrictions under a government program."[13]

The medical provider does not disclose the billed price until weeks later. If the price seems excessive to the patient and he or she refuses to pay, the provider can use the open-ended contract to enforce payment. This may include using a collection agency and threatening the patient's credit rating, to collect the full amount of the bill.

Example:

A non-Medicare patient steps up to the receptionist counter and is asked to complete several forms. The patient, who has private commercial insurance, signs the open-ended promise-to-pay forms, including that the patient is liable for any amount that is billed.

Consider a procedure where Medicare allows $1,000.

- The provider bills the patient $3,500, which is 350% of the Medicare allowance, after the service is completed.
- The patient does not realize that he or she is liable for the excessive billing amount until it's too late.
- The provider has the right to collect the full $3,500 when the patient is out of network or doesn't have insurance.
- The provider can use a collection agency as leverage to persuade the patient to pay the full bill with the result of destroying their credit rating, or in some cases, results in bankruptcy.

The open-ended contract adds to the high cost of health care by requiring the patient to sign this obligation to pay without any pricing information or limitation. This practice is a most extreme example of the "unfriendly consumer marketplace."

These are not nickel and dime liabilities. They could add more than tens of thousands of dollars in obligations that the patient is exposed to by the unethical practice of providers not disclosing the price prior to signing the open-ended promise-to-pay contract.

Summary:

Problem: Patients are required to sign an open-ended, legally binding promise-to-pay contract without knowing the cost of care, but that obligates them to pay whatever the provider charges.

Solution:

a) The law should require providers to disclose the percentage of Medicare (Medicare-Percent Disclosure) they accept as full payment for the services being performed.

Connecting the Dots
- Patients
- Employers
- Providers
- Payors
- Government

[13] This is a direct quote from the open-ended promise-to-pay contract offered to a patient at Mayo Clinic, Rochester, MN, on August 5, 2019.

b) Any open-ended contract previously signed by a patient should be made null and void, and any such agreements should be disallowed going forward.
c) The law should require providers to secure a Medicare-Percent Disclosure Form signed by a patient in advance of providing services/procedures when charging in excess of the Medicare allowance.
d) Providers who fail to obtain a signed Medicare-Percent Disclosure Form from a patient before or at the time services are provided, will be limited to reimbursement from a patient or a patient's health plan of no more than the Medicare allowance.
e) If a patient is incapacitated, a provider may not attempt to collect any fees in excess of a certain percent of the Medicare allowance – example, 200% of Medicare – for health care services provided during the time of the incapacitation (unless the patient has previously signed a Medicare-Percent Disclosure Form with the provider).

Chapter 4: The Reason for Price Secrecy - Provider Networks

In Chapter 1, Health Care 2020 examined the hidden health care tax paid by individuals who have private health insurance. Chapter 2 discusses secrecy and price disparity, and Chapter 3, how the open-ended contract forces patients to pay bills over which they have no control.

Next is the reason why price secrecy exists – the *provider network system*.

Disconnected Dots

- Providers
- Payors
- Government
- Patients
- Employers

The common practice of organizing the delivery of health care using provider networks is Managed Care's attempt to align the five dots – Patients, Employers, Providers, Payors and Government – through pre-arranging access to providers at contracted payment rates. Unfortunately, the network system has evolved into a complicated, expensive system that restricts patient choice and drives up the price of health care through price secrecy.

A generation ago, individuals with private health insurance went to the doctor or hospital of their choice. Many individuals had a long, professional relationship with the same physician or at the same clinic. Over time, however, insurance companies have replaced an individual's provider choice using provider networks.

Provider networks are a group of health care providers (physicians, hospitals, etc.) that have a contract with a health insurance company. Network contracts provide care at a discount from the provider's billed rates and providers agree to accept the discounted price as payment in full. Network contracts for years have kept pricing secret with a gag clause that prevents providers and insurance companies from disclosing their rates to patients.[14]

Today, lawmakers are considering ways to increase price transparency. Recently, the federal government issued requirements that hospitals must begin to disclose their prices. This is a great start, and more needs to be done.

For networks to function they must rely on price secrecy. Network price secrecy, however, stifles the ability for patients to shop for medical care and it creates an unfriendly consumer marketplace.

Today, the insurance companies show their negotiated discount in provider networks as a value for their members. What they do not disclose is that health insurance companies actually reimburse providers at a rate above Medicare's allowable amount (there may be rare instances when insurance companies reimburse providers at a rate below Medicare). There is no discount – there is a markup. Network health care pricing is built from the bottom up, not the top down.

Insurance companies create provider networks by negotiating the price they will pay for care. They do not negotiate a separate price for each service. Rather, insurance companies most commonly use Medicare's allowable amount as a reference price, plus an additional percent above Medicare's allowable amount – the Medicare-Percent.

[14] Some states, as has Minnesota, have passed legislation forbidding network contracts from including a gag order. In such a case, the patient may be able to get the contracted price if he or she asks the provider or payor for it.

Networks have created an incentive for providers to price services far above what they accept as full payment. A network contract pays a smaller amount than what the provider bills. This is called a network discount. The higher the billed amount, the greater the network discount, which then seems like a great value to the insured person. In a way, when a provider bills a much higher amount, the insured person sees a far larger discount negotiated by the insurance company – apparently saving the patient a larger sum of money. The network discount delivers perceived value to the insured person.

The network's secret pricing is supposed to reduce the price of care, but it works in an opposite manner. It incentivizes providers to bill at artificially high prices and the health plan is then able to offer a greater discount. Unfortunately, uninsured persons are often forced to pay the non-discounted prices.

Bottom line: Health care pricing is hidden from patients behind a secret contract built on false retail pricing that also limits competition.

Networks Limit Insurance Company Competition

In addition, networks serve to limit the number of insurance companies competing for clients in any given area. Networks are seen by doctors and hospitals as creating additional paperwork burdens that takes time away from patients. Providers naturally resist increasing their administrative costs and can do so by limiting the number of network contracts they will sign. Today, it is nearly impossible for a medium or smaller sized insurance company to persuade providers to join its new network.

In Chapter 13, Health Care 2020 discusses the near monopoly enjoyed by the Big Five insurance companies that insure 82% of individuals with employer sponsored insurance in the private market. Two of those companies, UnitedHealthcare and Anthem, insure about 62% of the individuals in the employer sponsored private insurance market. Federal and state laws and regulations have fueled the formation of these monopolies across the United States.

Many health care reformers support the idea of selling health insurance across state lines, however that has not been possible because of networks. Again, providers do not want to sign new network contracts, and this limits the ability of new insurance companies to enter a market. To overcome this challenge, new insurance products that function without provider networks are necessary– See Chapter 15.

Provider Network Systems Make for Surprise Billings

Consumers receive no pricing information from providers or insurance companies.[15] Instead, the complicated billing and pricing systems used by providers and paid by insurers makes health pricing impossible to understand even for the most sophisticated of consumers.

Using network contracts, the insurance company provides a promise to pay at a specified negotiated rate, but only if the patient chooses a provider from a network contracted by the insurance company. The provider is unable to collect fees that are greater than the network reimbursement rate for in-network services.

Secrecy, however, has created other ways to game the pricing systems. Hospitals that are in a network will often subcontract with specialists and subspecialists that are not in the same network as the hospital. "These can include anesthesiologists, radiologists, pathologists, surgical assistants, and others. In some

[15] Some states, like Minnesota, require price disclosure using Good Faith Estimates but rely on consumers to ask for the information. This is a step in the right direction, but it is a complicated, slow, and too often, an after-the-fact process. Since July 1, 2019, Minnesota has required primary care physicians to display their prices openly in their clinic's public areas. See Appendix II for examples.

cases, entire departments within an in-network facility may be operated by subcontractors who don't participate in the same network," Kaiser Family Foundation reported. A new sub-group category has surfaced recently providing Emergency Room physicians who are not employed by the hospital and may not be included in a patient's network. These subcontracted specialists demand payment at a rate greater than what the hospital's network contract allows.

The patient, generally, believes all charges will be in-network because the hospital itself is in the insurance network. When the insurance company pays the hospital, it pays at its negotiated rates. The services for which subcontractors charge that exceed the hospital's negotiated rate are passed on to the patient, who is obligated to pay them, another example of the current consumer unfriendly marketplace.

Pete's Surprise

In other cases, a consumer may receive services in an out-of-network facility and find themselves facing the full, undiscounted price for care – or face paying a sizable portion above which his or her insurance will not pay. Yet, the consumer-patient will have no idea of the charges until weeks after receiving care, when the "surprise bill" arrives.

> **Example.** This example is based on an actual claim in Minnesota during 2018. Pete[16] had heart surgery at a Minnesota hospital. Like other patients, without knowing the implications, Pete signed an open-ended contract promising to pay whatever the hospital charged for his heart surgery.
>
> The hospital knew Pete was out-of-network, as he had provided the hospital with his insurance card prior to the surgery. The hospital never informed Pete that he was out-of-network and was 100% liable for the total billed amount. Later, when asked why the hospital did not inform Pete of his network status, the hospital administrator said it was the hospital's procedure not to inform the patient, but instead, it is the patient's responsibility to determine their insurance status.
>
> The hospital and surgeon billed the insurance company at 250% of Medicare. The insurance company paid the hospital 140% of Medicare at the out-of-network rate -- $48,629. The hospital expected Pete to pay the $54,749 balance, based on the billed amount of $103,378. The hospital pointed to the open-ended contract Pete had signed as justification to refuse to negotiate a lesser amount with him, instead hiring a collection agency to go after Pete for the entire $54,749 balance.
>
> When confronted about the facts in Pete's case, and informed that Pete very likely would be forced to file bankruptcy, the hospital continued to refuse to negotiate a lesser amount. The hospital knew it stood to receive nothing and Pete's credit rating would be destroyed, but the administrator said, "This is our hospital policy. I am sorry. There is nothing we can do."
>
> In addition to the hospital charges, the anesthesiologist, a subcontractor chosen by the surgeon and hospital, was out-of-network. But again, no one told Pete.
>
> The anesthesiologist billed Pete's insurance company $8,692, 1,315% of Medicare. Had Pete been a Medicare enrollee, the government would have allowed a payment of $661 and the anesthesiologist would have had to accept it as full payment.

[16] Name changed to protect privacy.

> However, Pete's insurance paid 140% of Medicare ($925) as the out-of-network rate as full payment. Pete received a surprise bill from the anesthesiologist for $7,767 with a demand to pay the full billed amount – 1,315% of Medicare.
>
> Pete refused to pay the anesthesiologist's unfair balanced bill, but the anesthesiologist threatened him with collection actions.

This is yet another example of how today's health care is delivered in the most consumer-unfriendly marketplace of any product or service purchased in the United States.

Kareem's Surprise

A second form of "surprise billing" happens when a person has been using an in-network provider over time. The patient receives care thinking that he or she will be covered by their insurance policy at the in-network rate. Later, the patient receives an expensive surprise bill and then discovers that the provider had left the network. The provider never disclosed it to the patient. This true example illustrates the potential financial loss for the patient.

Example. This example is based on an actual claim in Minnesota during 2018. Kareem saw the same Ear, Nose, and Throat specialist as he had for several years. Kareem[17] suffered from chronic nasal blockage. The doctor, in a new type of surgery that took two-hours in an out-patient clinic, performed a procedure to open Kareem's nasal passages. The surgery was deemed a success.

> Then the surprise bill arrived, and for the first time, Kareem learned that the doctor no longer was in his network. The total bill was $40,228. The insurance company paid the doctor $6,114 at the out-of-network rate. Kareem stared at a surprise bill of $34,114. The provider offered to discount this amount to "only" $12,367.
>
> The surgeon eventually learned no one had informed Kareem that his claim would be processed as out of network. Also, Kareem found out that Medicare would have paid $6,864. Kareem used the Medicare allowed amount to appeal to the doctor. Eventually, the surgeon reduced his balanced owed to $750 instead of $12,367.
>
> The final total payment from Kareem and the insurance company added to $6,864 – 17% of the billed rate, and 100% of Medicare's allowed amount.

Again, this is an example of how today's health care is delivered in the most consumer-unfriendly marketplace of any product or service purchased in the United States.

The responsibility should fall on providers to verify that a patient's health insurance policy will cover all related expenses provided to the patient, and whether the reimbursement will be at an in-network or out-of-network rate. If the provider determines that some or all of those services are not covered under the patient's insurance (whether in- or out-of-network), the provider should be required to disclose it to the patient in writing prior to providing care, and attested to by the patient's signature.

Health Care 2020 features a redesigned health system that offers alternative insurance policies without networks as a better way to price and pay for care. Consumers would be freed from surprise billings. Each provider would be required to disclose the Medicare-Percent they accept as full payment. As an added

[17] Name changed to protect identity.

benefit, every other provider could see each other's Medicare-Percent so that they could begin to compete based on price and quality.

Networks are Price-Driven, Not Quality-Driven

One might assume that a health plan with a larger network means the patient will receive higher quality health care. In a larger network, the patient can choose from a greater number of providers, so in that sense, it might result in better quality, but not necessarily so. The larger network indeed could include the best providers in an area, but also several others of lesser quality.

The larger the network of providers, however, the greater the variance in provider prices within the same network. This means that a patient might stay within his or her network but pay twice as much as another person who sees a different provider within the same network and the quality could be less, more, or the same. The difference is the price, not the quality.

Network price secrecy is responsible for this potentially expensive conflict.

> **Example**: There are 100 providers in the Community. Healthy Insurance Company uses its *Copper* Network contract with 30 of the 100 providers that will accept 140% of Medicare as full payment. The insurance company pays these Copper Network providers Medicare plus 40%. This is the least expensive network because it reimburses providers at the lowest amount, but still at a rate 40% more than Medicare.
>
> Healthy Insurance Company also has a Gold Network that pays providers 180% of Medicare. The *Gold* Network will not only include the 30 Copper Network providers (who still receive Medicare plus 40%), but an additional 50 providers. This gives the consumer 80 providers from which to choose. The Gold Network has higher insurance premiums than the Copper Network.
>
> Healthy's Freedom *Platinum* Network allows access to all 100 of the providers. This plan pays the remaining 20 providers at 180% to as much as 300% of Medicare. Consumers can go to whomever they wish in the network, but their insurance premiums are significantly greater than for the Copper and Gold networks.
>
> No information is available to the patient that shows a relationship between the provider's quality and the Medicare-Percent paid in each network. It is quite possible that providers in the Copper Network deliver the best quality care in the community but are paid half of those with the highest reimbursements in the broader Platinum Network.
>
> Healthy's network contracts have a gag clause that creates price secrecy by prohibiting its providers from sharing the percent of Medicare they accept as full payment from Healthy Insurance Company. This means that Doctor A will never know that Doctor B is paid twice as much as *she* is – and neither will the patient know. All the patient knows is he or she pays a lot more for the Freedom Platinum Plan – without knowing anything about the provider price differences.

The privately insured consumer that uses health care has no idea that their preferred clinic receives two times or more than the clinic next door for the same services. As a result, the consumer must pay higher insurance premiums without knowing their clinic's greater reimbursements drive up their own insurance cost.

Networks also create dependency on insurance companies (and other third parties). Without the insurance company negotiating "discounts" on behalf of patients, consumers fear they would have to pay more for care.

Summary:

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Problem:

a. Health care price secrecy is a direct result of health care network contracts between insurance companies and providers.
b. Networks limit patients' choice of providers, and can sever the long term, professional relationship a patient has with a physician.
c. Networks limit new insurance companies from entering the marketplace, thereby reducing competition between insurance companies.
d. Provider networks create surprise billings.
e. Provider networks create price disparity even within the same network.

- **Solution:** Create new insurance plans that do not require provider networks in which fully transparent prices induce competition among health care providers.

  Problem: Patients receive care from out-of-network providers but do not know they are out-of-network.

- **Solution:** Require providers to disclose in writing to the patient when they are not in the patient's provider network. Require providers to disclose the rate they will accept as full payment of Medicare's allowable reimbursement and include all subcontractors in this disclosure.

  Problem: Patients receive procedures believing they are covered by insurance only to find out later there was no coverage. Providers require patients to determine whether the procedure or service is covered by their insurance.

  Solution: Require providers to determine whether the patient's insurance covers the service or procedure and disclose this in writing when they are not covered.

Chapter 5: Unfriendly Consumer Price Complexity

The complexity of health care pricing perpetuates the misalignment of the five dots. Two dots – Patients and Employers – are again outside of the alignment of the other three dots – Providers, Payors, and Government. The three dots created this price complexity that forces patients and employers to participate in a convoluted system which has resulted in a consumer-unfriendly health care marketplace.

Disconnected Dots

- Providers
- Payors
- Government

- Patients
- Employers

Given the high cost of United States health care, it would be expected that providers would deliver it in a friendly, consumer-focused marketplace. Instead, the payment (reimbursement) systems have created an unfriendly consumer marketplace that relies on an incomprehensible maze of billing codes resulting in unimaginable price complexity. According to an article in the October 15, 2019 issue of the *Journal of the American Medical Association*, about 25% of total health care spending is wasted but the "biggest loss is attributed to 'administrative complexity,' about $266 billion or 7%.'"[18]

To receive insurance company reimbursements, providers use thousands of billing codes that make no sense to anyone other than the trained billing coders that report them to insurance companies, and the programmers that write computer language to process the codes.

The United States health care system is becoming more complex and patient-unfriendly as it rapidly evolves with new medicines, devices, and surgical procedures – and more. As these new treatments are grafted into the marketplace, providers require patients to know whether their insurance covers the new procedures and all the other care they receive. This is another clear example of why the health care system is so consumer unfriendly.

Consumer-patients cannot be expected to contact an insurance company to ask complicated questions about procedures in scientific language that is foreign to them. The patient is not able to explain in detail why they have been prescribed a service or procedure. Yet, the current unfriendly marketplace puts the responsibility on the patient to be sure insurance will pay the bill. In a consumer-friendly marketplace, the physician, hospital, or other providers, would determine whether the service is covered by the patient's insurance.

The patient's requirement to guarantee payment is sealed at the time he or she signs an open-ended promise-to-pay contract prior to receiving care. The promise-to-pay contract puts the patient at financial risk for all charges not covered by their insurance policy, but the provider never tells the patient which services are covered, or how much they will cost. If the patient refuses to sign the contract, the provider is not likely to provide the care. This is another example of the consumer-unfriendly marketplace.

Previously, when medical prices were not so complex, a patient could review and understand their doctor and hospital bills. Today's price complexity has made this nearly impossible. Without a comprehensive understanding of the billing code system and medical language, a patient must trust someone else to sort it for them. This, they presume, is done by their insurance company. Yet, the insurance company has no way of knowing whether the patient received the services for which the provider has billed.

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[18] Shrank, William H., Teresa L. Rogstad, and Natasha Parekh. "Waste in the US Health Care System: Estimated Costs and Potential for Savings." *JAMA* 322, no. 15 (October 15, 2019): 1501–9. https://doi.org/10.1001/jama.2019.13978.

Who benefits from the complex billing and pricing system? Not patients, but providers and insurance companies. Providers are protected by the patient's signing of the open-ended, promise-to-pay contract, placing the financial risk on the patient. The patient becomes dependent on the insurance company to sort out and apply all the complex billing codes. As a result, patients and employers are saddled with multiple, incomprehensible prices that do not reveal how much they will pay in a way they can understand.

> The payment (reimbursement) systems have created an unfriendly consumer marketplace that relies on an incomprehensible maze of billing codes resulting in unimaginable price complexity.

Bundled care pricing – An Example of a Consumer-Friendly Marketplace

To create a more consumer-friendly marketplace and overcome price complexity, some savvy medical providers are using baskets of care, sometimes called bundled prices. Bundled prices reduce the complex billing codes and multiple specialist, lab, and scanning bills into one total dollar price. Bundled pricing works well for a number of elective, shoppable procedures.

> **Example**: The orthopedic surgical center has a bundled price for a knee replacement. The single price includes the initial exam, lab tests, scans, the surgeon's and anesthesiologist's fees, facility charges, physical therapy, and all other costs related to the knee surgery.
>
> The orthopedic center knows how complex the health care billing system is, and that it is consumer unfriendly. The center also knows the patient prefers simplicity in billing and would rather have one price for the entire knee surgery from the initial exam to the final therapy bill – and everything in between. The patient does not want any surprise billings.

Some medical care, however, is delivered through a combination of services that do not allow bundled pricing. Health Care 2020 goes beyond bundled pricing to seek a consumer-friendly way to deliver understandable prices for all medical services.

A More Understandable Pricing System

To create a more understandable pricing system, consumers can use the same method insurance companies use to know how much a provider accepts as full payment. Insurance companies pay providers the amount Medicare allows plus a percentage above Medicare the provider will accept as full payment – the Medicare-Percent amount. This process has been kept secret from consumers and the secret has contributed to the high cost of care. Insurance companies and providers keep it complicated because it benefits them, not patients – and patients pay more. Therefore employer-provided family health insurance now costs $20,576 a year on average in the United States.

If providers disclosed what percentage they accept as full payment in relation to the Medicare-allowed amount, it would allow consumers the ability to shop among providers. Instead of multiple, incomprehensible prices, the patient would instead be told the Medicare-Percent amount and they could compare one provider with others.

Summary:

Problem: The way health care is priced has created an expensive, unfriendly consumer marketplace built on price complexity.

Solution: Create a consumer-friendly pricing system to make it easy for a patient to determine and compare prices of various providers by requiring the Medicare-Percent Disclosure.

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Chapter 6: Paying More Because of Monopolies and Practice Acquisitions

Disconnected Dots
- Providers
- Payors
- Government
- Patients
- Employers

Connecting the dots means enacting new health care laws, rules, regulations, and insurance plans that align the best interests of all five dots – Patients, Employers, Providers, Payors, and Government. The current systems for providing care financially supported by complex insurance systems and secret prices, have created incentives for three of the dots to find new ways to grow at the expense of the other two – Patients and Employers.

An ongoing spike in health care prices has contributed to health system consolidation with an expectation that larger systems will produce efficiencies to reduce cost. On the contrary, practice acquisitions have consistently resulted in higher consumer prices.

Yet, hospitals and health systems everywhere have been purchasing physician practices. Health systems that have purchased most or all the medical service provider practices in an area, empowers the system with maximum leverage to demand patients and insurance companies to pay the highest possible reimbursements – these can be two to five times greater than what Medicare allows. These high prices may have nothing to do with the quality of care or improved outcomes, but instead, create a monopolistic marketplace that allows excessive pricing, further driving up the cost of medical care. Bigger means bigger, not necessarily better, and seldom less costly.

Hospital Strategy for Maximizing Profit

Hospitals and health systems offer physicians higher compensation than they can earn in their independent practices for the same amount of work. The increase in compensation is funded by the additional patients that follow the doctor. In addition to bringing patients with them, newly employed physicians refer patients to hospital-based ancillary services. Referred services may include scans, lab service, surgical theaters, physical therapy, etc. The hospital's service providers' fees generally are significantly higher than non-hospital providers.

> "The prices of imaging services in an outpatient hospital setting are, on average, 45 percent higher than the same services performed at a clinic or standalone radiology center."[19]
>
> The variance in price for a lumbar spine MRI without contrast ranged from $216 to $3,372 – a 1,561% difference.[20]

Competitors that offer services at a fraction of the price charged by the hospital systems struggle to stay in business because they get fewer to no referrals from the hospital-employed physicians. Minnesota Measurements provides examples of these price disparities.

> "The cost of imaging services is typically higher (by as much as 240%) in an outpatient hospital setting compared to a clinic setting."[21]

[19] Nelson, Gunnar. "Health Care Cost & Utilization - Minnesota." Minnesota Community Measurement, 2018. https://mncm.org/wp-content/uploads/2018/11/mncm-cost-report-2018.pdf. P 4.
[20] Ibid. P 10.
[21] Ibid, P 14.

> "As a more detailed example, the price of an ankle X-ray can be as low as $28 or as high as $359, depending on where the service is provided. In 2017, the average price paid for commercially insured patients in a clinic setting was $72 and in an outpatient hospital setting it was $226…"[22]

Hospitals know that patients enjoy convenience and take advantage of their preference to stay within the hospital organization for support services. The hospital-employed physicians, by recommending support services in the hospital facility, further contributes to the high cost of care. The hospital prices for these services are higher and kept secret from patients who do not realize they are paying more than they would by receiving the same service outside the hospital facility.

A fundamental fact resulting from a healthy free market in any industry is the existence of multiple competitors competing for customers' dollars. Providing transparent pricing that is freed from the constraints of provider network secrecy is necessary for competition to occur. Hospital practice acquisitions run counter to the idea of competition, instead it forces out competitors, and this is aided by the lack of price transparency. More transparency in a consumer-friendly health system will alleviate many of these problems.

Health Care 2020 supports full price transparency using a Medicare-Percent Disclosure. This new price transparency system will expose the higher prices charged for hospital-based services and allow comparison to the same services delivered outside of the hospital in a consumer-friendly marketplace.

Summary:

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Problem: Some organizational models that federal law approves (i.e. Accountable Care Organizations) allow physicians to refer patients for lab tests, scans, and to specialists within the same health systems/hospitals knowing their prices are higher than other providers.

Solution: Medicare-Percent Disclosure forces providers to show a patient their Medicare-Percent so that patients can shop for services, giving patients an easier way to evaluate providers outside the hospital system.

[22] Ibid., P 14.

Chapter 7: Increasing Quality While Reducing Cost

Hospital-acquired Infections and the Cost of Care

Two of the five dots – Patients and Employers – pay all the cost of private, non-government health care. They pay these costs through insurance premiums, out of pocket expenses, and a combination of several forms of taxation. Yet, the current health care system does not align these two dots' best interest with the other three dots – Providers, Payors, and Government. Aligning the best interests of all five dots is necessary to create a functional, affordable, consumer-friendly health care system.

Consider the patient who has surgery in a hospital and acquires an infection at the point of surgery. Who should pay to provide the patient's medical treatment for this Hospital-acquired Infection? Today, patients and employers pay these costs.

One would expect the hospital to pay all these costs as they do for people covered under a government health plan. This has been the law since 2007.

As it is today, patients with private health insurance and their insurance company will pay the hospital to provide care for infections. In other words, the hospital that caused the hospital-acquired infection during a procedure will be paid twice.

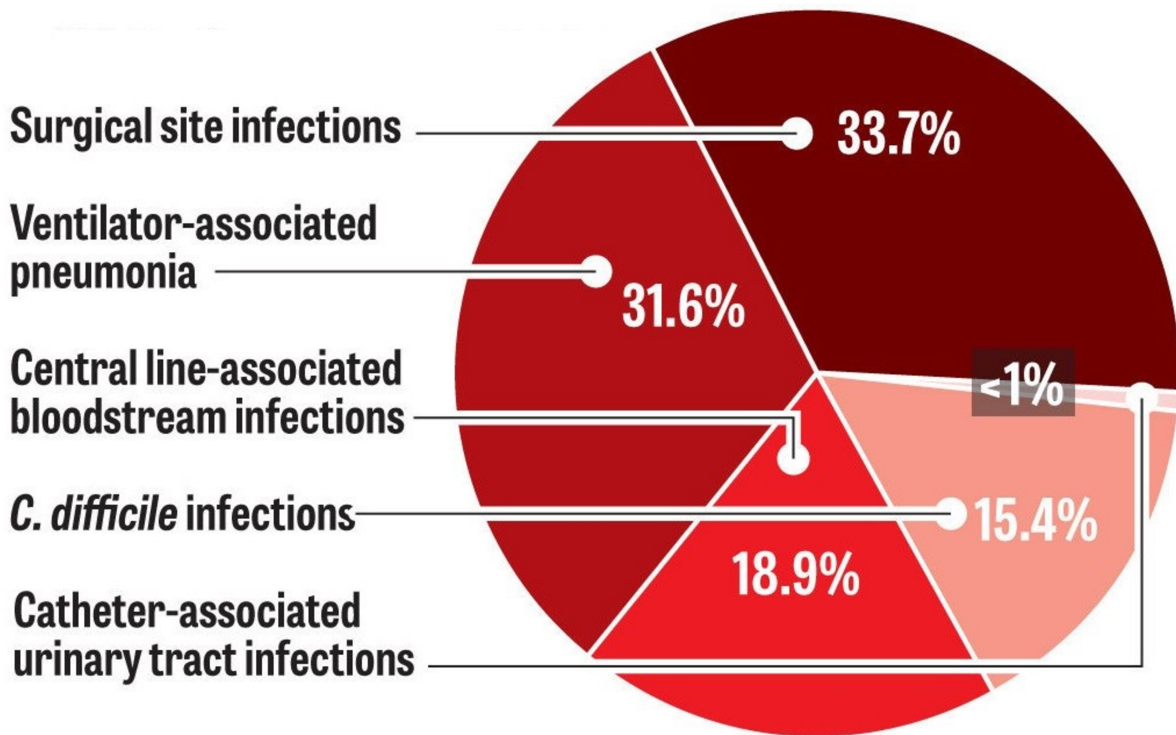
- The patient and the insurance company would pay the hospital for the original surgery.
- The patient and the insurance company would pay the hospital again for treating the infection that hospital staff had caused.

With hospital-acquired infections, there are two standards. When a patient is covered by a government plan, the hospital must absorb the cost of care. For patients with private insurance, they and their insurance company must absorb the cost of care.

When a hospital treats patients covered by government health insurance, it has a financial loss incentive to protect against infection. On the other hand, hospitals caring for patients with private insurance have no financial loss incentive to protect against infection.

Legislators should copy the current laws regulating government health plans regarding hospital-acquired infections and apply these laws to those with private insurance. It's that simple. They should require hospitals to pay for their own mistakes so that private health insurance companies and patients can quit paying claims from hospital-acquired infections.

Remarkably, not only would it help reduce the cost of insurance premiums, it would also improve the quality of medical care. With a financial motive hanging over them, hospitals will clamp down on medical staff, requiring additional measures to protect against infections.



Source: National Institutes of Health (Edward Riojas/MLive.com)

Summary:

Problem: Patients with private commercial insurance currently pay the cost of care for individuals who acquire an infection while hospitalized.

Solution: Require hospitals to absorb the cost by self-insuring for the care necessitated by their mistakes, just as is required by federal law for patients covered under a government health plan.

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Chapter 8: Summary of the Consumer-Unfriendly Health Care Marketplace

Disconnected Dots
- Providers
- Payors
- Government
- Patients
- Employers

At the time of this writing, the five dots remain disconnected. This puts two dots – Patients and Employers – at a disadvantage.

The previous chapters have shown how placing three dots – Providers, Payors, and Government – ahead of patients and employers has produced an overly expensive health system in a consumer-unfriendly marketplace. This has resulted in a system in which an employer-provided family health plan now costs, on average, an annual premium of $20,576.

Health Care 2020 identifies the following eight specific factors that need to be reformed to create a consumer-friendly, affordable health care marketplace:

I. **A hidden tax**.

The health care payor systems hide the price of care from patients, and in addition, patients pay a hidden tax that is used to offset the low provider reimbursements paid by Medicare, Medicaid and other government health plans. When private insurance pays more because government pays less, that is the definition of a tax.

Providers' overhead costs force them to rely on the hidden tax to make up for the shortfalls of care delivered to those on a government health plan. The Rand study confirmed this and that the gap (the tax) between government health plans – Medicare -- and private commercial insurance reimbursements is increasing. This trend will continue unabated as long as health care consumers are unaware of the hidden tax.

A primary reason for the high price of health care is that the medical industry, insurance companies and government keep the hidden tax a secret, hiding it behind an incomprehensibly complex set of codes and insurance company contracts that bar disclosure, often called "gag" provisions.

II. **Price disparity.**

The current system of pricing health care services denies patients and employers their right and necessity to know about the wide price disparity regarding the provision of health care. Secrecy makes medical price disparity possible, so individuals often unknowingly pay two to five times more for the same service as their neighbor.

Minnesota Community Measurement, in a 2018 report on cost of care, shows an average price variance between providers of 351 percent for 118 common non-emergency health care expenses paid for by commercial insurance.[23] Minnesota Community Measurement elsewhere reported billed price variance for several specific procedures. The data for a total hip replacement surgery, for instance, showed a range in prices from the lowest billed rate to the highest of 650 percent – $6,666 to $43,359.[24]

[23] Nelson, Gunnar. "Health Care Cost & Utilization - Minnesota." Minnesota Community Measurement, 2018. https://mncm.org/wp-content/uploads/2018/11/mncm-cost-report-2018.pdf.

[24] Ibid.

Some medical and diagnostic services referenced in the Minnesota reports showed price variances of more than 1,500 percent between the highest and lowest billed rates. Lab tests and diagnostic imaging are among the most extreme examples. These types of services should be among the most "shoppable," if consumers were able to know their price.

Minnesota's experience with price disparity is common to all states and locales.

III. Open-ended promise-to-pay contracts.

One of the most consumer-unfriendly factors facing patients is the open-ended promise-to-pay contract providers require patients to sign before and as a condition of receiving medical care. The provider, however, does not tell the patient anything about the cost of services until after the services are rendered. This means that the patient could receive a bill weeks after a service and be required to pay it, no matter how much the provider charged.

With all other consumer products and services, the individual only signs a promise-to-pay after they know the price.

The open-ended promise-to-pay contract is used to collect undisclosed fees which, if not paid, leads to destruction of a patient's credit rating or to bankruptcy.

IV. Networks rely on price secrecy.

For provider networks to function they must rely on price secrecy. Network price secrecy, however, stifles the ability for patients to shop and it creates an unfriendly consumer marketplace. Provider network contracts keep health care pricing secret with a gag clause that prevents providers and insurance companies from disclosing their rates.

Networks also limit the number of insurance companies competing for clients in any given area.

Health insurance companies reimburse providers at a negotiated rate above Medicare's allowable amount. Insurance companies do not negotiate a separate price for each service. Rather, insurance companies most commonly use Medicare's allowable amount as a reference price, plus an additional percent above Medicare's allowable amount – the Medicare-Percent.

V. Price complexity.

To receive insurance company reimbursements, providers use thousands of billing codes that make no sense to anyone other than the trained billing coders that report them to insurance companies, and the programmers that write computer language to process the codes.

The United States health care system is becoming more complex and patient unfriendly as it continues to evolve. As new treatments are grafted into the marketplace, providers require patients to know whether their insurance covers the new procedures and all the other care they receive. This can put patients at risk for high cost care not covered by their insurance.

Who benefits from the complex billing and pricing system? Not patients, but providers and insurance companies. Providers are protected by the patient's signing of the promise-to-pay contract, placing the financial risk on the patient. The patient becomes dependent on the insurance company to sort out and apply all the complex billing codes. Patients and employers are saddled with multiple, incomprehensible prices, that do not reveal how much they will pay in a way they can understand.

VII. Practice acquisitions increasing the cost of care.

Hospitals and health systems everywhere have been purchasing physician practices. Health systems that have purchased most or all the medical service provider practices in an area, empowers the system with maximum leverage to demand patients and insurance companies to pay the highest possible reimbursements – these can be two to five times greater than what Medicare allows. These high prices may have nothing to do with the quality of care or improved outcomes, but instead, create a monopolistic marketplace that allows excessive pricing, further driving up the cost of medical care.

Employed physicians are "encouraged" by their hospital health systems to refer lab tests, scans, and other ancillary services to providers within the hospital. These referred services may be far more expensive than the same services provided outside the hospital. This adds more cost for patients and employers.

VIII. Hospital-acquired infections.

As it is today, patients with private health insurance and their insurance company will pay the hospital to provide care for hospital-acquired infections. As a result, the hospital that caused the infection during a procedure will be paid twice.

- The patient and the insurance company would pay the hospital for the original procedure.
- The patient and the insurance company would pay the hospital again for treating any infection that hospital staff had caused.

With hospital-acquired infections, there are two standards. When a patient is covered by a government plan, the hospital must absorb the cost of care. For patients with private insurance, they and their insurance company must absorb the cost of care.

Conclusion:

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

These eight current health care factors illustrate many of the problems that contribute to a consumer-unfriendly health care marketplace. They cause the high price of health care, and unaffordable insurance premiums.

There is no other consumer marketplace that is as unfriendly and costly as health care. Health Care 2020 offers an alternative to create a consumer-friendly marketplace. Like any other consumer marketplace, the patient can shop based on price and quality and can make informed choices. It is a place where open competition reduces cost while increasing quality.

SECTION II – SOLUTIONS - HEALTH CARE 2020: CONNECTING THE DOTS

Chapter 9: Introduction to Section II: The New Patient-Friendly Marketplace

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Health Care 2020 offers a new, patient-friendlier marketplace in which the health care consumer will drive the market, demanding competitive pricing with improved quality and outcomes. Secrecy in pricing will be eliminated. The consumer will determine which provider to access for health care instead of relying on the insurance company to choose. Physicians will have an opportunity to escape hospital health system micromanagement. Hospitals will compete, creating better quality at reduced prices. Insurance companies will enter the marketplace, breaking up the current monopolies that have created the unfriendly consumer marketplace. Governments will defer to protecting patients from the practice of unsafe medicine and drugs and enforcing contract law, instead of trying to micromanage the health care marketplace.

Competition driven by health care consumers will mirror the same processes as with other purchases in today's marketplace.

According to Kaiser Family Foundation, in 2019 the premiums for an employer-provided family health insurance plan now averages $20,576 annually – nearly $10.00 per hour for a full-time, 40-hour per week employee.

In September 2019, a Minnesota insurance company informed Greg Dattilo of the new rates for one of his client's group insurance renewals for December 2019. The 29% premium increase his client faced fits the same trend of double-digit increases he saw with other clients. *The insurance company's new billed annual insurance premium for family coverage starting December 1, 2019 increased to $33,503!* This rate computes to more than $16.00 per hour cost for a full-time employee.

Employers and families cannot afford to pay $33,503 annually for health insurance. For this amount of money, a family could pay cash for a 2020 Toyota Camry SE and still have money for insurance, fuel and maintenance.[25]

Employers and families cannot afford to pay $33,503 annually for health insurance. For this amount of money, a family could pay cash for a 2020 Toyota Camry SE and still have money for insurance, fuel and maintenance.

A Kaiser Family Foundation survey of employer sponsored insurance found that 82% of those covered have High Deductible Health Plans – 125 to 145 million individuals.[26] This means that tens of millions of Americans with High Deductible Health Plans (HDHP) are unable to learn the price of health care services in the consumer-unfriendly marketplace. Since 2003, when Congress paired HDHPs with Health Savings Accounts, these millions have been frustrated by their inability to know the price of care.

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[25] https://www.cars.com/for-sale/ Retrieved on 11/14/2019.

[26] Kaiser Family Foundation has determined that employer sponsored insurance covers about 153 million individuals, a commonly accepted number. The U.S. Census Bureau, however, suggests that 178 million individuals have employer sponsored insurance. The difference, Kaiser suggests, could be in KFF's rigid methodology compared to possible double-counting or faulty data collection by the Census Bureau.

Health Care 2020 uses a Medicare-Percent Disclosure requirement as a foundation upon which to build a new, consumer friendly marketplace. This will give the 125 to 145 million Americans with High Deductible Health Plans what they have asked for from the beginning – simple to understand price transparency.

Today, providers are paid according to the Medicare fee schedule for individuals enrolled in Medicare. For individuals with *private* health insurance the Medicare fee schedule is used as a reference price by insurance companies to determine how much they will pay providers.

For example, Medicare allows $100 for the physician's fee for an office visit. The doctor cannot collect more than $100 from a Medicare patient, though they may charge $200 to the patient. Insurance companies negotiate with providers to determine the amount they will pay. The negotiated amount will be the Medicare-allowed amount as a reference, plus an additional percentage. If the insurance company and provider agree on a rate of 150% of Medicare, the provider will accept $150 as full payment, though they have billed the patient $200. The problem is that a patient doesn't know any of this price information, and it prevents him or her from shopping for health care based on price.

Here Is What Needs to Change

Health Care 2020 calls for a Medicare-Percent Disclosure Form to be signed by a patient.

Health Care 2020 calls for a Medicare-Percent Disclosure. The Medicare-Percent Disclosure is a law or regulation that would require all health care providers to disclose the percentage in relation to Medicare they accept as full payment from the patient and/or the patient's health insurance policy. This will give anyone with private health insurance the ability to easily compare the charges of each provider before choosing one. The patient would be able to ask providers, "What percentage of Medicare do you accept as full payment?"

Providers would post their Medicare-Percentage on their websites and in their waiting room. Providers will be required to disclose the Medicare-Percentage whenever asked by phone, email, or any other form of inquiry.

Private Health Information Exchanges and insurance companies will make it easy and convenient for individuals as well as competitors, to find out the Medicare-Percentage of all providers.

Finally, every American will have provider price information. Their next question will be, "Why do you charge more or less than other providers?"

With their Medicare-Percentage made public, the provider will have to differentiate itself from others, especially if their prices are higher. If they cannot show more value than others, they may have to reduce their prices to attract patients.

The Medicare-Percent Marketplace

As providers are required to publicly disclose their Medicare-Percent, prices can become a valuable tool for health care consumers (patients). Patients will be able to shop for medical care based on quality, access *and* price, just as they do with nearly every other purchase they make.

As every provider's Medicare-Percent is disclosed, health care providers will be able to compete. Competition will be created as each provider learns the prices charged by other providers, but also from pressure brought by patients who are price-shopping. Experience shows that price transparency is

necessary for competition to occur, and when competition occurs, prices tend to fall over time. This will be especially true with providers who overcharge when compared to other local providers.

> **Example**:
>
> The variance in price for a lumbar spine MRI without contrast ranged from $216 to $3,372 – a 1,561% difference.[27]
>
> As patients learn they can purchase lumbar spine MRIs for as little as $216 at Clinic A, it creates more business for Clinic A and price pressure on all the other MRI scanning services in the same area. Clinic A would strongly favor the Medicare-Percent Disclosure, but the most high-priced clinics would fight it, preferring to hold on to their high-priced MRIs.

The Medicare-Percent Disclosure Form

Health Care 2020 supports legislation requiring providers to use a Medicare-Percent Disclosure Form to disclose the percentage of Medicare they will accept as full payment. The disclosure form must be signed by a patient before services are rendered (with exceptions made for patient incapacitation).

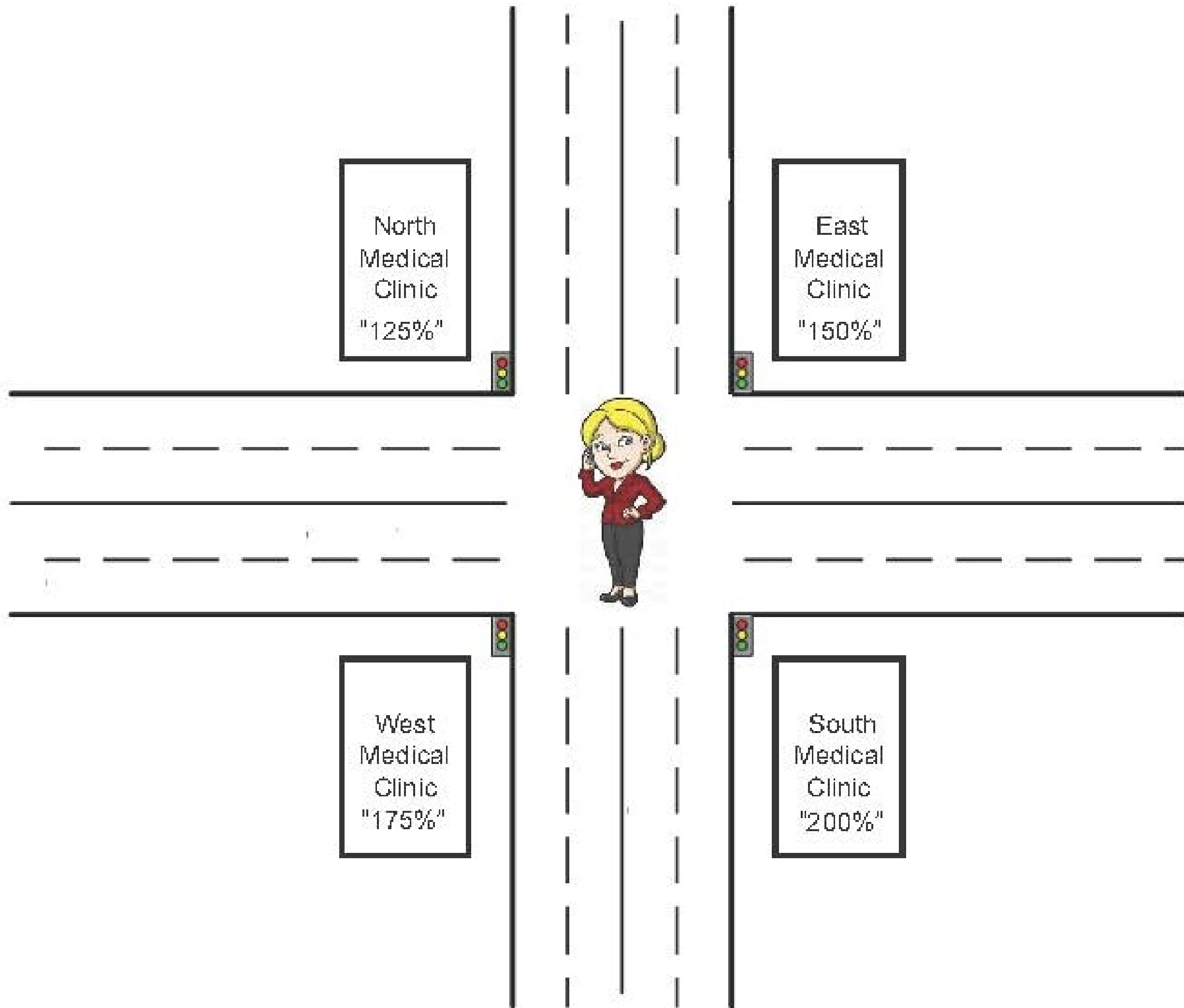
It will be a simple statement such as:

> The Eastside Health Clinic accepts 160% of Medicare, the Medicare allowed amount plus 60% of Medicare, as full payment for services.
>
> Westside Community Hospital accepts 200% of Medicare, which is the Medicare allowed amount plus 100% of Medicare as full payment for services. All subcontractors, specialists, and others that may provide health care at Westside Community Hospital have agreed to accept 200% of Medicare, which is Medicare plus 100% of Medicare as full payment for services.

The Medicare-Percent and Disclosure forms will make it possible for those 125-145 million individuals with High Deductible Health Plans, and everyone else to know the provider's Medicare-Percent before receiving it. This will result in more competition and over time, a reduction in prices. The $20,576 paid today on average for family health insurance premiums will fall once Members know the Medicare-Percent disclosed by their providers.

Health Care 2020 connects five dots – Patients, Employers, Providers, Payors, and Government – to create a more affordable, consumer-friendly health care marketplace. First, we examine how Health Care 2020 changes the consumer-unfriendly marketplace into a consumer-friendly marketplace.

[27] Nelson, Gunnar. "Health Care Cost & Utilization - Minnesota." Minnesota Community Measurement, 2018. https://mncm.org/wp-content/uploads/2018/11/mncm-cost-report-2018.pdf. P 4.


"What percent of Medicare do you accept as full payment?"
North Medical Clinic
"125%"
East Medical Clinic
"150%"
West Medical Clinic
"175%"
South Medical Clinic
"200%"

Chapter 10: Solutions - Patients – Dot 1

● Patients

Health Care 2020 provides tools for a consumer-friendly health care marketplace where patients engage in and help improve their own health care. It replaces a crippled, dying, nearly non-existent health care marketplace.

By connecting the dots, aligning Patients, Employers, Providers, Payors, and Government, through Health Care 2020, patients can become health care consumers. First, they will know the Medicare-Percent for each provider – true price transparency. Next, they will have a new type of health insurance plan that allows them far more control over their own health care – a Reference-Based Pricing Plan (see Chapter 15). The new plan helps the consumer-patient to be more aware of cost, and how their personal health affects their pocketbook.

The redesigned health care marketplace means they will be able to tap into privately-run, Health Information Exchanges, discussed in Chapter 16, where they can learn about prices, quality and outcomes.

The keys to this new health care marketplace are price transparency, competition, information and the empowerment of patients to control their own use of and payment for health care.

The first Dot - Patients

Why are patients the first dot? Consumers drive commerce (the marketplace). A consumer has a need and seeks for a product or service to meet the need. Someone else sees that need and creates the product or service. The consumer decides if the product or service is priced so they can afford it, and if the quality is worth the price. Other suppliers emerge that compete to meet the consumer's need, and the goal is to offer access to quality products or services at the same or a reduced price.

What A Friendly Consumer Marketplace Looks Like

Cell phones and smartphones offer a great example of how a consumer-friendly marketplace works. Everyone, it seems, has a smartphone today. Here is how this consumer-friendly marketplace evolved.

The first cell phone became available in 1984, priced at $3,995, and in addition, you paid for user minutes that were extremely expensive. Having a cell phone available created flexibility in communicating with others. For most consumers in 1984, however, the cell phone's price outweighed the need.

By 1995, the price of a cell phone had fallen to $100, about $30 a month for network access, and calls were 45-75 cents a minute. These prices allowed many new consumers to own and use a cell phone.

Consumer interest and demand built quickly for more affordable cell phones with increased options, beyond just talking on the phone. The first widely marketed smartphone, the Apple iPhone, made its debut in 2007, offering a camera and a host of new features priced as low as $499, so that 6.1 million people quickly purchased one.

Since 2007, several competitors have released their smartphone versions. Apple, however, has continued to maintain a higher price that consumers are willing to pay, while adding numerous features. The perceived value of the iPhone has proven to be popular among consumers despite its higher cost such that today, Apple is able to offer phones for as much as $1,449.

> In a true marketplace, the price is easily accessible, product information is abundant and presented in a consumer-friendly manner, and individuals decide for themselves how much they are willing to spend.

The cell phone story demonstrates what happens in a consumer-friendly marketplace where providers work to meet the needs of consumers with affordable prices and desired product features. The price is easily accessible, product information is abundant and presented in a consumer-friendly manner, and individuals decide for themselves how much they are willing to spend.

A smartphone and a health care service are two different situations. However, the foundation of a consumer-friendly marketplace for one is the same as for the other. The consumer needs to know the *price* of the product or service and have access to adequate, understandable *information*, so that the consumer can determine the best *value* for themselves.

The Consumer-Unfriendly Health Care Marketplace Today

In today's health care system, patients are limited by their provider networks to which providers they may use. They have no provider price or quality information. When a patient tries to find out the price, the answer is a question, "Why are you asking? Don't you have insurance?"

The adverse health care consumer marketplace has nurtured the following inefficiencies in the health care system and resulted in unaffordable health care. This will be fixed with Health Care 2020, as it connects the dots.

In today's unfriendly system:

1. Patients are required to sign an open-ended, legally binding contract without knowing the cost of care, but that obligates them to pay whatever the provider charges.
2. Patients may have an HSA and a High Deductible Health Plan and want to shop, but there's no price information.
3. Providers collect a higher amount from private patients than from Medicare or Medicaid in order to cover low payments from the government health plans -- a hidden tax.
4. Prices for health care services vary widely, but generally, not based on quality – instead based on the level of competition or lack of it. Price secrecy makes price disparity possible, adding no value to the consumer. Instead, it encourages higher prices while only allowing the provider and insurance company to know the facts about this price disparity.
5. Networks limit patients' choice of providers, and can sever the long term, professional relationship a patient has with a physician.
6. Patients sometimes experience a surprise bill.
7. Pricing of health care services relies on an incomprehensible maze of billing codes resulting in unimaginable price complexity.

Creating A Consumer-Friendly Health Care Marketplace

Health Care 2020 offers solutions for *working* people with private health insurance to overcome what ails the private health care system. It describes how to manage one's own health care, and better afford it in a redesigned health care marketplace.

Health Care 2020 will:

1. Replace the unfriendly consumer market with a consumer-friendly marketplace.
2. Control health care cost through competition.
3. Allow a patient to choose their doctor, hospital, medical professionals and suppliers.
4. Reduce the cost of health care and insurance.

Health Care 2020 solutions are covered in detail in other chapters. The Medicare-Percent Disclosure is found in Chapter 13. Reference-Based Pricing Plans are explained in Chapter 15. Solutions requiring legislation are found in Chapter 17.

How Does Health Care 2020 Achieve Market Change?

Health Care 2020 uses a Medicare-Percent Disclosure to:

1. Require complete price transparency in an actual health care marketplace that allows shopping for care based on price, quality, and access.
2. Show how much hidden tax is charged by each health care provider in a community.
3. Reduce price disparity between health care providers, or at least make it possible for consumers to choose based on price.
4. Simplify pricing – reducing price complexity.
5. Prohibit uninformed open-ended contracts that force patients to pay whatever a provider charges.

Health Care 2020 uses Reference-Based Pricing Plans to:

1. Eliminate provider networks and instead, allow consumers to use the provider of their choice.
2. Eliminate surprise billings that threaten a consumer's financial well-being.
3. Break up health care monopolies by making it possible for medical professionals to practice independently if they choose.
4. Establish a new, better way to pay for medical care that relies on price transparency, offers choice of providers, including across state lines.

Consumer-Patients are the first dot Health Care 2020 aligns. Employers are next – they are the primary funding vehicle for private insurance for more than 178 million Americans in the private marketplace.

Chapter 11: Solutions – Employers – Dot 2

- Patients
- Employers

Employer-provided health insurance is foundational to the ongoing success of the private health care system in the United States.

Employment-provided coverage accounts for the largest share of people in the U.S. with private insurance. U.S. Census Bureau data for 2018 reports 178.35 million individuals receive health insurance from employers.[28] In 2017, "… employers paid most of the premium on behalf of employees and their dependents – on average 82% of the premium for single coverage and 71% for family coverage [emphasis in the original].[29]

Employer-provided health insurance is beset by challenges, but it is also the most sought out employee benefit today and has been for the past 75 years. Yet, some employers would like to eliminate this benefit due to its cost and their struggle with making decisions regarding the health plans and networks their employees can access.

Employers realize medical insurance is a differentiator for hiring and retaining employees used to set them apart from competitors. If government were to take over health insurance for employees, however, employers would at least hope that the new health care payroll tax would be less than what is now spent on insurance premiums.

Employers must realize that if government took over health insurance, it does not mean employers will no longer be involved in employee health care.

Employers must realize that if government took over health insurance, it does not mean employers will no longer be involved in employee health care. Consider the Social Security retirement benefit. Employers and employees pay a 12.4% payroll tax to the Social Security retirement fund. Has the government Social Security retirement plan replaced the financial burden of employers providing a private retirement plan? No—many employers offer additional retirement benefits beyond Social Security. Employees know that Social Security will not provide an adequate income. Why would it be any different with government-run health insurance, knowing that it will not be able to cover all medical care?

Even Canada, which has a national Medicare plan for all its citizens, does not cover all health care services, such as prescription drugs and other services. As a result, some Canadian employers provide a prescription drug group insurance plan to attract and retain employees.

[28] Berchick, Edward R, Jessica C Barnett, and Rachel D Upton. "Health Insurance Coverage in the United States: 2018." Study. Washington, DC: U.S. Census Bureau, November 2019. https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[29] Pollitz, Karen, Jennifer Tolbert, Gary Claxton, and 2019. "What's the Role of Private Health Insurance Today and Under Medicare-for-All and Other Public Option Proposals?" *The Henry J. Kaiser Family Foundation* (blog), July 30, 2019. https://www.kff.org/health-reform/issue-brief/whats-the-role-of-private-health-insurance-today-and-under-medicare-for-all-and-other-public-option-proposals/.

U.S. employers must realize the reality is they will find themselves offering health care benefits in addition to a government-run system, plus a new payroll tax to pay for the new government-run system as in Germany and other countries.

If government eliminates employer-based health insurance, it will tax employers to pay for it, but employers will no longer have control, except through attempts to influence politicians. Our current system, however, is too expensive with its $20,576 annual family premium. Employers seek an alternative way to pay for health care.

Health Care 2020 resolves the following issues that challenge employers:

- It creates a more consumer-friendly health care marketplace.
- It exposes the hidden tax, showing why employer cost is so high.
- It controls the annual increases in premiums to no greater than the Consumer Price Index, like other products and services.
- It makes the cost of health care transparent so that employees can shop for the best value.
- It makes HSAs and High Deductible Health Plans more valuable, with the employee's increased ability to shop based on the price of health care.
- It allows new insurance companies to enter the marketplace, creating much needed competition.
- It allows health insurance companies to sell across state lines (because there are no networks).
- It creates more opportunities for physicians to establish independent, private practices, reducing the cost of health care through increased provider competition.
- It reduces government's interference in and control of the private health care marketplace.

Health Care 2020 Exposes Why the Cost is High

Employers and their employees have the most to gain financially from Health Care 2020.

The average annual billed premium for employee-only health insurance, which includes the employer and employee cost, is about $6,590. [30] The employee pays about $1,200 of this total, with employers paying around $5,400.[31] If insurance companies pay providers 200% of Medicare, then the annual billed premium would include a 100% hidden tax – half the premium. Of the $1,200 annual employee share, $600 goes to pay the hidden tax, while the employer's tax is about $2,700. This is only a fraction of the tax paid compared to family insurance coverage offered by an employer.

The average annual billed premium for *family* coverage is $20,576.[32] The employee pays on average $6,015 of this total, with employers paying $14,561. If insurance companies pay providers 200% of Medicare, then the annual billed premium would include a 100% hidden tax – half the premium. Of the $6,015 annual employee share, $3,008 goes to pay the hidden tax, while the employer's tax is $7,281 – more than $600 per month.

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[30] Health care pricing and setting insurance premiums are complex. The Manual uses research from credible sources for its illustrations. Numbers from one report to another vary, based on the date and scope of source material. The conclusions are, however, the same. Health insurance is unaffordable.

[31] Staff. "2018 Employer Health Benefits Survey - Section 6: Worker and Employer Contributions for Premiums." *The Henry J. Kaiser Family Foundation* (blog), October 3, 2018. https://www.kff.org/report-section/2018-employer-health-benefits-survey-section-6-worker-and-employer-contributions-for-premiums/,

[32] Unidentified. "2019 Employer Health Benefits Survey." *The Henry J. Kaiser Family Foundation* (blog), September 25, 2019. https://www.kff.org/health-costs/report/2019-employer-health-benefits-survey/.

Health Care 2020 Creates Employee Financial Incentives

If an employer purchases a medical plan that pays the same rate as Medicare, the premiums would be reduced by 50% when the employer plan currently pays claims at 200% of Medicare. With insurance premiums reduced by 50% employers can offer this plan at minimal or even no cost in employee payroll deductions. Of course, the employee would have more claim liability if they choose providers that charge more than the Medicare rate.

An employer would use the Medicare reimbursement rate plan as a Base Plan offered at no cost to the employees. The employer would offer employees two other plans that might reimburse providers at 150% or 225% of Medicare. The additional cost of these two Buy-Up plans would be paid by the employee through payroll deductions.

The employee now has a financial incentive to find the Medicare-Percent of each provider in their locale. If the employee does not care about the cost of care, they would pay the higher payroll deduction for the 225% of Medicare plan.

Employees that are sensitive to payroll deductions will engage in consumer behavior more aggressively by accessing all the price, quality and outcome information provided from the Private Health Information Exchanges (Chapter 16). These employees will be recognized by other employees as role models in how to become health care consumers in the new consumer-friendly health care marketplace. Employees with High Deductible Health Plans and Health Savings Accounts (HSAs) will finally have the pricing information they have sought for years.

Health Care 2020 Eliminates Employers Burden of Network Selection

Provider networks also contribute to the high cost of employer group insurance. Generally, employers do not like restricting their employees' access to a limited number of providers. As a result, employer health plans often include the most expansive and expensive provider networks in a state. Though choosing skinny networks could reduce their premium expense, employers do not want the pushback they would get from employees – so they pay more for more access.

As discussed earlier, networks contribute to widespread price disparity between providers within a network system. As a result of price secrecy, employees do not know they could purchase health care services at lower cost if they knew the providers' prices. An alternative method of paying for and distributing health care that does not rely on networks and network secrecy would help resolve this problem. Reference-Based Pricing insurance plans create a financial incentive for individuals to seek out price disparity.

The new insurance plans will not have this burden because there are no networks. With the new Reference-Based Pricing insurance policies, employees retain 100% control over whom they will choose to provide care.

Health Care 2020 Reduces Cost by Breaking-up Insurance Company Monopolies

Employers know there is only limited competition between insurance companies in each state and nationally. Reported elsewhere in this manual (Chapter 13), but worth repeating here:

> Today's insurance marketplace nationally is dominated by the Big Five managed care insurance companies, covering 145.6 million lives.[33] This represents 82 percent of Americans who are covered by employer provided private insurance. Two of the Big 5, UnitedHealthcare and Anthem, insure 90 million Americans between them.

Limited competition among national health insurance companies drives up employer insurance premiums. Local-based insurance companies, too, are few. Clearly, to reduce health care cost means increasing price competition between providers and between insurance companies.

The reason for today's monopoly of a few insurance companies controlling health care are networks. Networks prevent new insurance companies from entering the marketplace. Health Care 2020, with Reference-Based Pricing insurance has no networks and removes the blockades that keep new insurance companies from entering the marketplace.

Health Care 2020 Actually Bends the Upward Trend of Future Rate Increases

Employer group insurance is expensive, and the cost trend is upward. During the past 20 years, the Consumer Price Index increased an average of 2.19% per year.[34] Meanwhile, during the same 20-year period, employer health insurance increases averaged 6.1%, or 278% more than the CPI. [35]

Pricing insurance based on the Medicare allowable amounts will control the annual premium increases and makes them affordable over the long term. This is because Medicare premium increases are based on the CPI increases, which have averaged 2.19% per year during the past 20 years.

Consider these savings on a Reference-Based Pricing health plan with increases tied to the CPI. According to Kaiser Family Foundation, an employer's annual health insurance premium for a family plan was $5,791 in 1999. If those premiums had tracked CPI increases per year, as with Medicare, the premiums in 2018 would have grown to $8,591. However, employer sponsored annual health insurance premiums have averaged 6.1% growth in those same 20 years.

Kaiser Family Foundation shows that the $5,791 annual premium in 1999 increased to $20,576 in 2018. Employers paid an additional $11,985 per employee for family health coverage when compared to what it would have been if increases were tied to CPI. The difference in total premium over those 20 years, comparing the amount if it had tracked CPI to the actual increases is substantial - $119,280 per employee family plan.

For an employer with 50 employees who have family health plans, the total difference in annual premium during those 20 years would be $5.96 million greater than premiums tied to the CPI. An employer with 1,000 employees covered under the family health plan, would be paying $119.3 million in additional premiums over 20 years compared to premiums that tracked with the CPI.

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[33] Baltazaar, Amanda. "5 Companies That Dominate Health Insurance in the US." Verywell Health. Accessed August 2, 2019. https://www.verywellhealth.com/the-big-five-health-insurance-companies-2663838.

[34]Staff. "Consumer Price Index Data from 1913 to 2019." US Inflation Calculator, July 19, 2008. https://www.usinflationcalculator.com/inflation/consumer-price-index-and-annual-percent-changes-from-1913-to-2008/.

[35] Staff. "2019 Employer Health Benefits Chart Pack." *The Henry J. Kaiser Family Foundation* (blog), September 25, 2019. https://www.kff.org/slideshow/2019-employer-health-benefits-chart-pack/. Figure 6.

Total Annual Premiums Per Family

1999 Family Premium	2018 Family Premium	Total Premium Based on CPI over 20 Years	Total Actual Premium over 20 Years	Total Amount Premium over CPI Increases
$5,791	$20,576	**$146,838**	**$266,118**	**$119,280**

If we could reduce the premium inflation rate on a family health insurance plan from 6.1% to only 4%, in 10 years the premium for a family plan will still exceed $30,000 per family. There is no choice but to implement Health Care 2020's Reference-Based Pricing health insurance and link the cost of premium increases to the CPI as does Medicare's reimbursement schedules.

Health Care 2020 Equips Employers to Work Together to Reduce Cost

Employers banding together in their respective communities could attempt to negotiate the new payment system, Reference-Based Pricing (see Chapter 15) with area providers. The State of Montana, for example, has done this with their state employees, achieving a nearly 33% cost reduction in hospital payments. Acting in concert, employers have the power to push insurance companies to create new products that rely on Reference-Based Pricing.

Health care providers are sensitive to public perception. If enough employers leveraged their combined influence in a community by exposing the high prices charged by one hospital or health system compared to another, this could result in reduced cost from all providers.

Health Care 2020 points to Reference-Based Pricing health insurance (Chapter 15) as the tool that employers could use to maintain the provision of health insurance but reduce its cost.

Chapter 12: Solutions – Physicians/Hospitals – Dot 3

- Patients
- Employers
- Providers

Health Care 2020 aligns Providers (physicians, hospitals, medical professionals, etc.) with the best interests of consumer-patients in a new patient-friendly marketplace. This new marketplace is built on simplified price transparency, exposing price disparity, eliminating consumer-unfriendly open-ended contracts, a new insurance plan without provider networks, and increased provider competition with better outcomes.

Physicians: Fork in the road

For decades, physicians have been relying on provider networks to bring patients to them, but when patients change networks, doctors lose patients. This disrupts the patient's continuity of care and at the same time, disrupts the physician's practice. As a result, networks have often created an unhealthy working environment for physicians. In response to this, and to increasing burdens imposed by managed care and government regulations, many doctors are opting for employment by health care systems and hospitals.

> Physicians, however, are at a fork in the road. Politicians hear the cries of their constituents and are marching toward government-set prices for all medical care. It is incumbent on those who believe in a private medical marketplace to find better ways to reduce cost and enhance the physician-patient relationship.[36]

Physicians Want Change

(Unless otherwise cited, physician attitudes expressed in this chapter come from the "2018 Survey of America's Physicians."[37])

Government regulation and managed care through insurance companies has produced frustration and stress among many physicians. In answer to this frustration, an increasing number of physicians are opting for hospital and large health system employment. Employment often includes an increase in pay and an improvement in work schedule. These developments have contributed to the 35% reduction in the number of physicians in independent practice in the past five years.

More than 36% of physicians receive their compensation directly or indirectly from hospitals. Friction in the workplace between employed physicians and their hospital employers, however, is high. Many employed physicians indicate this has not necessarily produced a better practice environment.

[36] Dattilo, Greg, and Racer, Dave. "MP C1 0819 Minnesota Physician." Accessed September 5, 2019. http://mppub.com/mp-c1-0819.html.

[37] Norbeck, Tim. "2018 Survey of America's Physicians." Merritt Hawkins - The Physicians' Foundation, September 2018. https://physiciansfoundation.org/wp-content/uploads/2018/09/physicians-survey-results-final-2018.pdf.

"Significantly more physicians (46.4%) indicate that the relationship is somewhat or mostly negative than indicate it is somewhat or mostly positive (31.7%)."

- Thirty-five percent of hospital-employed physicians indicate that hospital employment will not necessarily increase quality or reduce cost.
- Employed physicians report spending nearly 23% of their time doing non-productive, non-clinical paperwork required to comply with internal provider management, government and insurance companies.
- More than half of all physicians (employed and in independent practice) experience low morale and 78% at least sometimes experience feelings of burnout.

As this 2018 physician survey clearly illustrates, there is a need for change in the current health care marketplace. The current medical delivery system is not doctor friendly, just as it is not patient-friendly.

New Physician and Patient-Friendly Marketplace

Health Care 2020 will not resolve all physician issues. It will, however, allow physicians to practice independently if they choose, set their own course, and escape the micromanagement imposed on them by large hospital systems and provider networks.

The Health Care 2020 plan, however, allows physicians to practice independently if they choose, set their own course, and escape the micromanagement imposed on them by large hospital systems and provider networks.

By connecting the dots, Health Care 2020 offers a new option for physicians to escape the hostile environment in which they currently practice. The new marketplace, driven by Reference-Based Pricing health insurance, will open many options for physicians (details are in Chapter 15).

The new Reference-Based Pricing marketplace will feature:

1. Reducing administrative time and providing more time with patients.
2. Freedom to practice medicine without outside interference.
3. Earn fair compensation commensurate with their education, skills, and experience.
4. Respect in the physician community.

As Reference-Based Pricing eliminates networks that previously attracted patients to a physician, doctors will be able to engage in new ways to attract and retain patients. Physicians that deliver what patients want in the new consumer-friendly marketplace will be the most successful.

The new marketplace will empower patients to judge the physician's perceived value and decide for themselves which doctors to choose. Patients will be looking for doctors who:

1. Make doing business with a patient an easy, seamless transaction, aided by easy-to-access information about the physician and his or her practice.
2. Charge competitive, fair prices that are fully transparent.
3. Can refer them to other medical providers who offer the best value and high-quality services – specialists, labs, scans, medical devices, etc.
4. Create a positive patient experience through personal attention – who care about each patient.
5. Give them enough physician-patient time.
6. Have experience, expertise, knowledge – a sense of trust.
7. Enjoy a reputation for good or the best-possible outcomes.

8. Provide follow-up.
9. Have convenient locations and office hours.

Patients will use the new Private Health Information Exchanges (Chapter 16) to search for provider prices and to read the reviews provided by other patients. This will help patients make an informed decision about which doctors or hospitals to consider. Providers, likewise, will be able to read their own reviews and those of others, in an effort to differentiate themselves and to improve their own practices.

In the new marketplace, physicians will be able to compare their own charges with others, knowing that patients will do the same. Physicians will expect patients to question why their Medicare-Percent is higher or lower than a nearby competitor.

An open, healthy consumer-friendly marketplace will also improve quality. A True Example:

> Two young women were diagnosed with ovarian cysts. The 17-year old had a tennis-ball sized cyst, while the 23-year old had a softball-sized cyst. One surgeon removed the 17-year-old's cyst, but in doing so, also removed the ovary. He used a traditional surgical procedure.
>
> Another surgeon removed the softball-sized cyst from the 23-year old but was able to save the ovary. When asked, "How were you able to save the ovary?" the doctor said, "I do it the new way. However, I get paid the same amount as the surgeon who did the 17-year old." The new way took longer but resulted in a better chance for the 23-year old to bear children compared to the 17-year old.
>
> Health Care 2020 makes it possible for the surgeon using the new way to set his Medicare-Percent at a higher rate than the other surgeon. The new marketplace allows for these two surgeons to differentiate their services based on price and outcomes. The surgeon who uses the new way would be able to publicize the fact he saves 95 of 100 ovaries. Patients would have the necessary information to ask surgeons about their success rate in saving ovaries, as well as know the surgeon's Medicare-Percent. Eventually, other surgeons would begin using the new procedure in order to attract and serve more patients.

Health Care 2020 is patient-driven when comparing price and quality. Providers are motivated by inquiring, price-conscious patients to disclose their quality differences, and to justify their charges.

Physicians Creating A Consumer-Friendly Marketplace

One aspect of the current health care system that makes it so consumer-unfriendly is the variety of charges that appear on the patient's final bill for which he or she was never made aware. This means a physician might have a Medicare-Percent of 140%, but the lab to which he or she refers tests is at 1,000% of Medicare. Perhaps the doctor refers patients to a cardiologist who accepts 300% of Medicare – but the patient must wait to see the final bill (or worse, a surprise bill) before knowing this.

So, in the new, consumer-friendly marketplace, as an enhanced service, physicians will want to shop among professionals, subcontractors, and service-providers to whom they can refer their patients. Physicians will be helping to ensure their patients can receive the best value for their health care dollars. This ability for physicians to shop based on price and quality will create a more competitive marketplace.

What characteristics does Health Care 2020 deliver that both patients and physicians want?

1. Full transparency of the cost of care through a Medicare-Percent Disclosure statement.
2. Elimination of being tied to provider network systems.

3. An insurance product that is simple to understand, reduces administrative cost, provides full price transparency understandable to the patient, and pays for care based on how it's paid today -- Medicare plus a percentage above Medicare.

Hospitals and Health Systems, Too

The health system must find a way to mitigate the 1,000-2,000% Medicare-Percent payments levied and demanded by some subspecialists – anesthesiologists are a common example – following inpatient or outpatient hospital procedures. Chapter 4 included this true example of a case involving heart surgery.

> The anesthesiologist billed Pete's insurance company $8,692, 1,315% of Medicare. Had Pete been a Medicare enrollee, the government would have allowed a payment of $661 and the anesthesiologist would have had to accept it as full payment.
>
> However, Pete's insurance paid 140% of Medicare ($925) as the out-of-network rate as full payment. Pete received a surprise bill from the anesthesiologist for $7,767 with a demand to pay the full billed amount – 1,315% of Medicare.
>
> Health Care 2020 makes no attempt here to try to understand why this is so, only observing that it is astonishing, expensive, and injurious to patients – it should be stopped.

Currently, patients have no knowledge of all the subcontractors that may provide care to them during a hospital procedure or stay. Weeks or months later, they are shocked when they see the total charges – more so when they are confronted with a surprise bill. Too often, providers assume patients really don't care about all the extra costs, if they believe their insurance will pay it all.

Laws should be changed to require providers to disclose to a patient whether all the care received for any health event is covered by the patient's insurance plan. Health Care 2020 makes providers responsible to determine if their services, and that includes all subcontractors, are covered in-network or if some are out-of-network.

Providers will need to clearly specify payment terms, not rely on an open-ended promise-to-pay contract. Patients need to acknowledge, by their signature on the Medicare-Percent Disclosure Form, that they understand the terms and the potential costs. Providers would be wise to establish payment terms with patients for balances not paid by health insurance.

Creating A New, Consumer-Friendly Marketplace

These, then, are general Health Care 2020 principles designed to create a more consumer-friendly marketplace when physician referrals and tests are required.

- All providers must disclose their Medicare-Percent to a patient prior to delivering care. This is done three ways: 1) The public posting of the Medicare-Percent so that it can be seen when the patient checks in, 2) when a person makes a request by phone, email, or other common method of communication, and 3) on the provider's website.
- Providers must secure a patient-signed Medicare-Percent Disclosure form (except if the provider accepts Medicare's reimbursement as full payment) before providing medical care.
- When a provider uses its own personnel and support services (labs, physicians, medical professionals, scans, etc.) the Medicare-Percent accepted as full payment must be the same.
- When a provider uses or refers care to a subcontractor, the Medicare-Percent must be the same for all providers involved in the care.

> Health Care 2020 exposes the price disparities in the current health system. It provides, instead, a clear transparency price reference to help patients choose their provider.

Health Care 2020 exposes the price disparities in the current health system. Price transparency should, over time, reduce the high prices charged by some providers. A prime example is the cost of corrective eye surgery using Laser technology. When physicians first performed this remarkable procedure, patients paid as much as $10,000 an eye. Within a few years, the price had dropped to less than $500 an eye in some locales as a result of open price competition and improvements in technology. Unlike much of health care, insurance generally does not cover Laser eye surgery, so patients directly pay the bill and are always aware of the price before undergoing the procedure.

The alternative is that eventually, government will step in and begin to dictate provider rates, and it is certain they will be closer to the Medicare rate than today's prices. The better alternative is an open, consumer-friendly marketplace where competition can settle the price question.

Independent physicians and their clinics, just like hospitals, will ensure their fees and any other fees from facilities to which they refer will agree to accept the same Medicare-Percent as the physician. They, like hospitals, will be required to disclose their Medicare-Percent and those of their subcontractors.

When providers bill an insurance company on behalf of a patient, the Medicare-Percent Disclosure form, duly signed by the patient, must be enclosed with the billing. Failure to do so will limit payment to 100% of Medicare for covered services.

The primary focus of Health Care 2020 is to align the five key elements affecting health care, but always putting the patient first. As much as possible, this means complete price transparency and disclosure of the financial terms required of patients by providers. The new marketplace, friendly to patients, is also friendly to physicians. The best, and most efficient hospitals will benefit in the long term. Health care will become more like other marketplaces so that eventually, families and employers will no longer be burdened by an average $20,576 annual insurance premium.

Chapter 13: Solutions –Payors (Insurance and Managed Care Companies) - Dot 4:

- Patients
- Employers
- Providers
- Payors

Health Care 2020 aligns insurance companies and other third-party payors with the best interests of consumer-patients by replacing today's unfriendly health care consumer marketplace with a reformed, consumer-friendly marketplace.

In 2010, Americans watched as the payors and government became partners through the Affordable Care Act. Government promised Americans the new law would reduce health insurance premiums by 25 percent and allow individuals to keep their doctor. Insurance leaders remained silent.

Since the Affordable Care Act's implementation, as working people continue to see their pocketbooks robbed by the unaffordable cost of health insurance, public opinion polls have begun to show that they think the government may be the *best* option to control the high cost of health care.

With family health insurance premiums averaging $20,576 a year, employers and employees are near or at a tipping point for employer-sponsored coverage. Without a change, industry-watchers believe the next recession will witness the beginning of the end of employer-sponsored health insurance as it is known today – replaced by a Medicare for All system, financed by a new, health care payroll tax, perhaps like Germany's health care system.

Without a change, industry-watchers believe the next recession will witness the beginning of the end of employer-sponsored health insurance as it is known today – replaced by a Medicare for All system.

The Health Care 2020 blueprint will eliminate the barrier that networks create that limit the number of insurance companies offering health insurance. Insurance companies with products that have no networks will offer competitive health insurance policies everywhere in the United States. These insurance policies will be able to be sold across state lines.

This will also reinvigorate the insurance industry through new competitive pressures. These new insurance companies will pursue coverage for working people and provide a consumer-friendly marketplace. A new healthy, private marketplace will thrive on openness, provider competition and a patient-friendly delivery system.

Providers will welcome these new insurance policies as they do away with network contract negotiations and simplify claim administration resulting in more physician-patient time. Without networks, providers will be able to compete in the marketplace to attract and retain more patients.

The Lack of Insurance Company Competition

Compared to other types of insurance, there are only a handful of companies that offer health insurance in each state, and nationally. The following table compares the number of insurance companies by type in Minnesota. This same disparity would be common in all other states.

Table 13-1:
Comparison of Minnesota Insurance Companies - 2018

Minnesota - By Type of Insurance Coverage	Number of Companies
Employer Provided Health Insurance	7
Workers Compensation Insurance	358
Homeowners Insurance	170
Auto Insurance	229
Liability Insurance	460

There is a specific reason for the limited number of health insurance companies compared to property and casualty companies. Delivery of and payment for health care today relies on provider networks. Given doctors' and hospitals' resistance to allowing new insurance companies to create new networks that further complicates their practices and increases administrative expenses, newly minted insurance companies find it impossible to establish their own networks. Without the ability to offer network discounts, new insurance companies know they cannot compete with established companies.

The Results of Networks - The Big 5

Table 13-2 - Total Individuals with Employer-Provided Private Health Insurance - 178 Million[38]
Market Share of Big Five Insurance Companies[39]

Insurance Company	Members (Millions)	Percent of Big 5 Share	Percent of Employer Provided Insurance
UnitedHealthcare	49	33.6%	27.5%
Anthem	41	28.1%	23%
Aetna	22	15.1%	12.3%
Cigna	17	11.7%	9.6%
Humana	16.6	11.4%	9.3%
Total Big 5	**145.6**		**81.8%**

Nationally, the health insurance marketplace is dominated by the Big Five managed care companies (see Table 13-2). Taken together, the Big 5 insurance companies manage the care of nearly 145.6 million lives covered by employer-provided health insurance. [40] This represents 82 percent of the 178 million

[38] Berchick, Edward R, Jessica C Barnett, and Rachel D Upton. "Health Insurance Coverage in the United States: 2018." Study. Washington, DC: U.S. Census Bureau, November 2019, p 3. https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

[39] "Largest Health Insurance Companies of 2019." ValuePenguin. Accessed September 4, 2019. https://www.valuepenguin.com/largest-health-insurance-companies.

[40] "Largest Health Insurance Companies of 2019." ValuePenguin. Accessed September 4, 2019. https://www.valuepenguin.com/largest-health-insurance-companies.

Americans who are covered by employer-provided private insurance. Two of the Big 5, UnitedHealthcare and Anthem, insure 90 million working Americans between them – about half of those with employer-provided health insurance.

The Big 5 companies also manage government-provided health plans, such as Medicare and Medicaid, for tens of millions of Americans. These government health plans generate billions of dollars in service fees for the Big 5 so that they can afford the luxury of being less concerned about what happens with private insurance.

Given their monopolistic position in the established marketplace, the Big 5 still have had no success in reducing the price of health care, and have no financial incentive to do so. Neither have they created a consumer-friendly health care insurance system that allows consumers to see the price of care prior to receiving it. Instead, they lobby against price transparency and continue to increase insurance premiums to pay the inflated cost of health care.

The Big 5 have no incentive to reform their products to create consumer-friendly health care since there is no real competitive pressure from emerging or new health insurance companies. They continue to oppose full price transparency as a result of their network price secrecy, that keeps competition out of the market. Pressure is mounting from consumers – employers and employees – who are tired of paying $20,576 a year for employer-sponsored family health insurance. These consumers will need to persuade elected officials to champion a change that replaces the secret, consumer-unfriendly system of today with a fully transparent, consumer-friendly marketplace.

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Breaking up Monopolies – Allowing Competition

Health Care 2020 makes it possible for new insurance companies to compete with the Big 5. Once providers begin disclosing their Medicare-Percent rate, more insurance companies will enter the market and compete by selling new, redesigned health plans called Reference-Based Pricing Health Insurance.

The new health plans will take advantage of the transparency required of providers and provide patients with the incentive to pay attention to the price of their own health care. As these new policies become successful, more insurance companies will offer them.

Reference-Based Pricing health plans will alleviate the problem with a lack of insurance company competition since they do not rely on networks. As a result, more insurance companies will be able to enter the marketplace and compete with others.

The Medicare-Percent Disclosure

Pricing-transparency will expose deception in the current payment system. Today, the insurance companies show a negotiated discount with the providers as creating value for their members. What they do not disclose is that health plans actually reimburse providers at a rate above Medicare's allowable amount. There is no discount – there is a markup. Coming clean about this fact and sharing the truth with working people is a first step.

A Demonstration of Price Transparency and Medicare-Percent

Minnesota's legislature, in 2018, passed and Governor Mark Dayton signed a price transparency law requiring providers to disclose their prices (MN Statutes, Chapter 62J.812).[41] Restricted to primary care providers, the law specified that beginning July 1, 2019, providers must display their 25 most common procedures over $25, and disclose their billed price, average insurance reimbursement, and the relevant Medicare and Medicaid fee-for-service rates.

Health Care 2020 is collecting the price transparency charts of each clinic in Minnesota. The charts are then expanded to show the prices the clinics report and show a calculation for the network discount, Medicare-Percent, and the ratio of commercial insurance payments to Medicaid fee-for-service rates. (See Addendum II.)

Fairview Clinics Price Transparency

The chart on the left is for Fairview Clinics, as the provider reported them.[42] The top four sections are for office visits of different types. For these services, individuals with private insurance receive a provider network discount of only 7%. Medicare's enrollees' discount averaged 61% -- Medicaid's enrollees' discount averaged 71%.

Fairview's average Medicare-Percent is 256%. This means Fairview accepts as full payment for clinical services from private insurance, an average of 256% of what Medicare allows.

> Example: The chart discloses that for a 20-minute exam for a new patient, Fairview charges $206. The average insurance company reimbursement is $190. Medicare allows $75. This creates a Medicare-Percent of 254% (the amount insurance companies reimburse Fairview compared to what Medicare allows). In other words, at Fairview Clinics, people with private insurance pay on average more than 2.5 times what a person on Medicare will pay for the same service. This indicates a hidden tax of 154% -- the amount above Medicare that Fairview accepts as full payment. Medicaid pays less than Medicare at $56, or 29% of privately insured patients.

There is no way to solve the high cost of health care without exposing the hidden tax (see Chapter 1) and ending the secrecy in pricing. Moreover, a simpler, consumer-friendly system of disclosing the price of medical care must be adopted – the Medicare-Percent Disclosure. By this, each provider would fully disclose to patients the percentage above Medicare's allowable amount that they accept as full payment as shown in the Fairview Clinic example.

The Medicare-Percent Disclosure creates patient-friendly, simplified transparent pricing which will make competition possible. This requires providers to disclose their prices the same as all other products and services do. The way to do this is disclose the percent the medical provider will accept as full payment in relation to Medicare's allowed amount, as in the Fairview price chart posted above. In fact, show everyone, even competing hospitals, doctors, and other medical professionals. Then let patients decide where to receive health care.

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[41] Addendum III includes verbatim MN Statute 62J.81-62J.824, showing how Minnesota has legislature price transparency.

[42] This is a reproduction of a chart produced from data provided by Fairview Clinic on its website as required by Minnesota Law, Section 62J.812.

The Medicare-Percent Disclosure will lead to the launch of new, competitive Reference-Based Pricing insurance policies. These new insurance policies are discussed in detail in Chapter 15.

> If the United States continues on the same road as today, it is not a matter of "if" we devolve into a government-run health system, it is only a matter of "when." Or, we could choose a new road that takes us to a transparent, competitive, patient-friendly marketplace.

Insurance Companies Are at A Crossroads

If the United States continues on the same road as today, it is not a matter of "if" we devolve into a government-run health system, it is only a matter of "when." Or, we could choose a new road that takes us to a transparent, competitive, patient-friendly marketplace.

Today's managed care insurance companies are trying to serve two masters – the consumer and the government. The evidence is in – health insurance is becoming more unaffordable, with employers and employees paying, on average, $20,576 in annual premium for family coverage. The insurance companies are failing working people who own private health insurance, including employers who provide insurance to more than 178 million working people.[43]

Managed care has failed to deliver on its promise to control cost. Instead, it has turned to price secrecy, limiting access, and micromanagement of physicians and hospitals, creating an expensive unfriendly consumer marketplace.

A new, private health care system can benefit new insurance companies entering the market, patients, employers, providers, and government. Insurance companies will remain in business. Patients will have the freedom to choose their own preferred providers and enjoy American quality health care at an affordable price. Employers will be able to reduce their health care cost and invest in other employee benefits, pay raises, or expansion. Providers will be able to set their own prices, instead of government bureaucrats doing it for them through Medicare for All. Government can extricate itself from the toxic health care political debate that has burdened it for the past five decades.

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[43] Berchick, Edward R, Jessica C Barnett, and Rachel D Upton. "Health Insurance Coverage in the United States: 2018." Study. Washington, DC: U.S. Census Bureau, November 2019, P 3.https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf.

Chapter 14: Governments' Real Role – Dot 5

- Patients
- Employers
- Providers
- Payors
- Government

Health Care 2020 aligns Government with the best interests of Patients – especially working people – along with Employers, Providers, and Payors. Government is the referee among the various factions, to protect individuals from predatory practices and from dangerous health care delivery. Government must support public policies that allow the creation of a consumer-friendly health care marketplace. Government policy must point toward reducing the cost of health care and insurance and ending consumer abuse.

Directed at Lawmakers

The remarks in this chapter are especially directed to Congress and state legislators. These lawmakers must support a legislative strategy to accomplish a singular goal – to reduce the cost of health care for working people through a new, consumer-friendly marketplace. Congressional and legislative candidates will be judged by their answer to this question: "How do you propose to make health care affordable for employees and employers?"

Working people are nearing the tipping point. Either lawmakers will support a consumer-friendly market-driven system to reduce cost, or they will go the final mile toward "health care for all" in whatever government-run, single payer form they can sell to voters.

In previous elections, everyone talked about "pre-existing conditions." In this election cycle, the "pre-existing condition" is unaffordable health care.

In previous elections, everyone talked about "pre-existing conditions." In this election cycle, the "pre-existing condition" is unaffordable health care.

Health Care 2020 understands the political Golden Rule – He who writes the rules attracts the gold, and there's gold in the hills of Big Health Care stakeholders. The wise political candidate, however, will be the one who understands that *working people* are paying for all that gold. They will demonstrate their understanding by taking the side of working people instead of those with Deep Pockets.

Health Care 2020 changes the rules by creating universal, simplified price transparency. It does this by mandating all providers publicly disclose the Medicare-Percent amount they accept as full payment. Furthermore, Health Care 2020 bans open-ended patient contracts, replacing them with Medicare-Percent Disclosure Forms.

Reference-Based Pricing Health Insurance, built on the Medicare-Percent Disclosure concept, will provide the financial means for employers and individuals to pay health care bills, with more affordable premiums.

If lawmakers can accomplish these three goals – mandatory Medicare-Percent Disclosure, banning open ended contracts, and creating an environment in which Reference-Based Pricing health insurance can

spread – everything else will fall into place. Competition will increase. Prices will fall. Quality will improve, and providers will find new ways for patients to access care.

Bipartisan Lawmakers Will Pass Laws to Help Working People

Popular belief is that Democrats and Republicans cannot agree on any health care reform. In 2017, Health Care 2020's authors planted the seed for both parties on price transparency legislation. That seed blossomed into a new Minnesota law – Section 62J.812[44] – that passed unanimously (126-0) in the House, and almost unanimously (65-2) in the Senate.

Legislators championed price transparency to benefit working people and employers with private health insurance. This provides a great example of how Republican and Democrat lawmakers came together to help working people. This happened with no support from insurance companies and providers – or their lobbyists.

Passing this new law shows that when lawmakers consider the right kind of health care legislation they can come together on behalf of working people.

The new law requires a "…primary care provider or clinic that specializes in family medicine, general internal medicine, gynecology, or general pediatrics. …"[45] to disclose prices of the top 25 most common procedures for which they charge $25 or more and its 10 most common preventive services. The prices are to be posted in the clinic's reception room and on the practice's website. Price transparency chart examples are found in Addendum II.

The posted prices must include the clinic's billed charge, the average of its commercial insurance reimbursement, the Medicare allowance, and the Medicaid allowance. In this way, patients can compare the price government pays for services to how much clinics receive from individuals and private insurance, and what uninsured patients are often forced to pay.

As legislators become focused on reforms that benefit working people, they will begin to address the common health system abuses that make the current system so consumer unfriendly.

Consumer Abuses

This manual identifies a handful of the most egregious consumer abuses. Health Care 2020 shows that the Medicare-Percent Disclosure and Reference-Based Pricing Health Insurance plans can mitigate much of this abuse.

- Refusing to tell patients the price of care before they receive it.
- Providers requiring patients to sign an open-ended contract to pay whatever they charge, without telling the patient the amount charged until after the services are rendered.
- Price gouging by charging consumers multiple times the Medicare reimbursement rate for care.
- Levying expensive surprise billings with inflated prices on patients who receive emergency care, or who are not informed they are receiving care outside of their provider network.

[44] Chapter 62, Section 62J.812, Minnesota Statutes. https://www.revisor.mn.gov/statutes/cite/62J.812
[45] Ibid.

- Using aggressive, abusive, unforgiving collection systems to force patients to pay these unfair, exorbitant health care bills.

- Hospitals profiting from patients who suffer from a hospital-acquired infection.

- Monopolistic health systems profiting from a lack of competition.

Political Responses

Health care reform today is the first or second most contentious political issue. Political candidates and Congress are offering two divergent ideas.

Democrats

Democrats point toward a more expansive role for the federal government employing two key health plan concepts. Their long-term strategy is called "Medicare for All," a politically palatable way of saying single-payer health care. Recently they have been promoting the "Public Option Health Plan" as an alternative and which is an intermediate step toward Medicare for All.

Both government plans set provider reimbursements at the Medicare rates – or less. Under either plan, medical professionals would face an immediate 30-50% reduction (or more) in revenue when providing care for enrollees in these new government plans. Physicians, nurses, and other medical professionals, whose wages and salaries constitute a majority of overhead expenses, would experience large reductions in pay. Clinics and hospitals would be forced to drastically cut operating expenses, reducing wages and staffing.

Medicare for All

Medicare for All, or what many call "single-payer" health care, would mandate that everyone must be covered by a government health plan based on the current Medicare model. The 55 million Americans currently enrolled in Medicare would share their plan with the other 275 million American residents.

Other countries who have government-run, single-payer systems use an annual global budget to control how much is spent on health care. Global budgets allow these countries to spend far less, as a percentage of Gross Domestic Product on health care, than we do in the United States.

> According to the World Bank, in 2016 the United Kingdom spent about 9.76% of GDP on health care, while Canada spent about 10.53% of GDP on health care – both countries have a government-run health care system. In 2016, the United States spent 17.07% of GDP on health care. Of note, of course, is that the U.S. GDP is 4.5 times larger than both Canada and the United Kingdom combined.

Experience repeatedly shows that single-payer health systems, because of budget constraints, must exclude medical care for those with expensive, chronic and pre-existing conditions to ensure the system can provide care to the greater population**.** Those who suffer most from government-run health systems are individuals with pre-existing or chronic conditions where the cost of care is greatest. These high cost patients are expected to step aside so that the government health system can provide care for an increased number of healthier people. Providing primary care and preventive services is quite affordable for the health system, and politicians

Those who suffer most from government-run health systems are individuals with pre-existing or chronic conditions where the cost of care is greatest.

are proud to announce: "Free preventive care." Chronic care and elective surgery, however, is quite another question.

Anecdotal evidence can, of course, be misleading and may not represent the outcomes of the overall health system. On the other hand, stories such as the following one from Canada, should give U.S. policymakers pause before launching into a government-run health system.

> Canadian Sean Tagert, aged 41, was killed by assisted suicide after health officials decided to cut the funding for his in-home care hours.
>
> Mr. Tagert suffered from Motor Neurone Disease (MND) which is known in Canada as Amyotrophic Lateral Sclerosis (ALS). His illness reduced his ability to move his body, eat or speak, however his mental awareness remained unaffected. Doctors recommended 24-hour in-home care to support Mr. Tagert.
>
> However, Vancouver Coastal Health, initially only offered Mr. Tagert 15.5 hours of care a day, which was then raised to 20 hours a day, meaning that Mr. Tagert was forced to pay $263.50 a day for the remaining care that he needed to survive.
>
> … two Vancouver Coastal Health officials visited his home and confirmed that they were cutting funding for his already inadequate care hours.
>
> After receiving this news Mr. Tagert wrote a number of devastating social media status's which read: "So last Friday I officially submitted my medically assisted death paperwork, with lawyers and doctors, everything is in proper order. It's been a month since I submitted my appeal to the Vancouver Coastal Health patient care quality department. They didn't even respond….Welcome to the great Canadian healthcare system."
>
> Mr. Tagert was killed by assisted suicide on August 6th.[46]

It's ironic that Medicare for All and other single-payer systems would eliminate ObamaCare's prohibition of excluding people with pre-existing conditions from receiving necessary health care. Instead, it cuts funding for those conditions in order to provide less costly care for the general population.

It's ironic that Medicare for All and other single-payer systems would eliminate ObamaCare's prohibition of excluding people with pre-existing conditions from receiving necessary health care. Instead, it cuts funding for those conditions in order to provide less costly care for the general population.

Public Option Health Insurance

A common Democratic Party approach to reducing the cost of health insurance is to offer a Public Option Health Insurance policy. President Obama insisted in 2010 that his proposal, which eventually became the Affordable Care Act, would not include a public option health plan – and it did not. ACA detractors, however, speculated that the public option would eventually surface.

Since 2010, health insurance premiums have spiked so high as to be unaffordable. Democrats have begun to openly talk about solving this with a government-owned health insurance plan – a Public Option.

[46] Staff. "Disabled 41-Year-Old Man Is Euthanized After Funding for Home Health Care Runs Out." LifeNews.com, August 21, 2019. https://www.lifenews.com/2019/08/21/disabled-41-year-old-man-is-euthanized-after-funding-for-home-health-care-runs-out/.

Whereas in the past, most Americans feared a government-run, public option plan, today it is becoming more attractive because of the high cost of insurance. Providers should be especially alarmed by this trend.

The Public Option Health Insurance idea generally calls for government to establish its own health insurance with the same features and benefits of traditional private insurance – but with far less expensive premiums. The critical difference between private insurance and the Public Option is the amount paid to providers. Generally, most of the Public Option plans introduced by state lawmakers pay providers at Medicare rates, or less.

Comparing Private Health Insurance

In contrast to Public Option reimbursements, private health insurance according to the federal Congressional Budget Office (CBO), currently pays an average of 189% of Medicare for privately insured patients. Rand Corporation found even greater differences, with an average of 241% of Medicare paid by private insurance to hospitals across the country. Chapter 1, about the Hidden Tax, explains this in greater detail.

With insurance premium rates based on Medicaid or Medicare-level reimbursements to providers, it is certain Public Option premiums will be far less than traditional private insurance – and attractive to the buying public. When government public option health plans pay providers far less for claims than private insurance, to stay in business, market pressures will force private insurance companies to reduce their provider reimbursements to the same level as the public option plans. Or, more cost-shifting to the private market will occur to make up for the low reimbursement payments of the Public Option plans. Cost-shifting will drive private insurance premiums higher. The Public Option will eventually destroy the private insurance marketplace and set the stage for Medicare for All.

Republicans

Republicans do not want to set the prices providers can charge. They prefer that providers set their own prices, believing that the marketplace will bring pressure to set affordable prices like other products and services. However, when health care prices are kept secret from patients as they are today, the marketplace cannot function.

Republicans support price transparency but without support from health care providers and insurance companies. It is understandable why those who profit from the current secret health care pricing system and high premiums resist price transparency. Furthermore, Republicans face major pressure from the lobbyists representing Big Medicine who prefer the status quo.

On the Republican side of this health care price transparency concept are the 125-145 million individuals with employer-sponsored insurance that have High Deductible Health Plans. This represents tens of millions of voters who are asking Republicans to provide relief from $20,576 a year family health insurance premium.

Premium Subsidies

To offset unaffordable individual insurance premiums, the Health Care Industry, and in general, Republicans, support government paying a portion of the premium through tax credits and subsidies. These subsidies make it possible for the Health Care Industry to continue to increase their prices and profits.

According to a former White House health care adviser, the ACA-era insurance premium subsidies have driven up the price of insurance, and hugely benefited insurance companies and providers at taxpayer expense. “For example, between 2014 and 2019, the benchmark premium for a 49-year-old at 200 percent

of the FPL [Federal Poverty Level] increased nearly $3,300, with taxpayers picking up about $3,150—or 96 percent—of the increase."[47] With government picking up 96% of the increase in premiums the incentive is for providers and insurance companies not to reduce their prices, but to increase them. They have no incentive to change the system and instead, fight against reforms that would reduce the cost.

The increase in cost is paid for by working people, in the form of higher taxes to fund the premium subsidies. They and their employers also pay increasingly more expensive insurance premiums. Either way, working people pay more so that others can pay less with a government subsidy.

To make government premium subsidies more efficient and less dependent on the federal government for administration, Republicans favor government giving block grants to states. Republicans believe that states can design a better system than the federal government for tax subsidized insurance premiums that will fit their citizens' preference.

The Republican Study Committee Recommendations[48]

A group of conservative GOP House members have published "Part 1" of their detailed health reform plan. Titled "A Framework for Personalized, Affordable Care," the plan makes the following recommendations:

- Creating more portability options so that individuals can take their health insurance with them if they move, change jobs, or have a change in status.
- High risk health insurance coverage pools designed to move high cost claims to a different funding mechanism to keep insurance cost down for both healthy and more unhealthy individuals.
- Making the tax deductibility of health insurance premiums the same for those who receive their insurance from employers, and those who buy their own insurance policies.
- Making allowable payments from Health Savings Accounts for a broad array of costs, including insurance premium, and raising the annual dollar amount allowed to be set aside in an HSA.
- Expanding the use of Direct Primary Care, Health Sharing Ministries, and Association Health Plans.
- Creating new niches for Health Status and Limited-Duration insurance.
- Expanding lower cost, telemedicine.

These recommendations bring some needed relief. However, Health Care 2020 goes the next step by targeting the cost of health care directly. It creates a consumer-friendly marketplace that allows individuals to interact with health care as they do in any other consumer market.

A Better Way That Lawmakers Could Benefit *Working* People

Neither the Democrats nor Republicans use the power of a free marketplace to reduce health care prices as the market did decades ago, and which works so well with everything else that we purchase.

Clearly, however, something needs to be done to mitigate the high cost of health care and insurance. The fact is that employers and employees are struggling with an average $20,576 for family health plan

[47] Blase, Brian. "Health Reform Progress: Beyond Repeal and Replace." Paeonian Springs VA: Galen Institute, September 2019. P 11.

[48] Republican Study Committee. "A Framework for Personalized, Affordable Care: Republican Study Committee Health Care Plan Part One." The Republican Study Committee, March 2019. https://rsc-johnson.house.gov/sites/republicanstudycommittee.house.gov/files/RSC%20Health%20Care%20Plan%20-%20A%20Framework%20for%20Personalized%2C%20Affordable%20Care.pdf.

premiums and an average of nearly $7,000 for single coverage. They are at a tipping point. The U.S. is only a recession away from the collapse of the private health insurance system.

Health Care 2020 uses full price transparency with the Medicare-Percent Disclosure and relies on competitive marketplace pressure to reduce the high prices that result from price secrecy. This produces a gradual, orderly price adjustment as the market reacts to the new, transparent way of paying. These are market-driven, voluntary price adjustments, not government edicts.

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Health Care 2020 reduces the price of health care, and the price of insurance, without price fixing or premium tax subsidies. Instead, it relies on full price transparency in a consumer-friendly, competitive marketplace.

Who Would Oppose Health Care 2020?

There are some who benefit financially and/or politically from the high cost of health care. Ongoing price escalation, complexity, and secrecy works in their favor. The Medical Industrial Complex with all its stakeholders continues to push for higher prices and an increasing number of covered benefits. Big Medicine. Big Insurance. Pharmaceutical manufacturers – Big Pharma. Managed Care. It's a long list.

Added to the list of those who want to see health care cost spiral higher are lawmakers who want to implement government-run health care. These legislators realize that by putting government in charge, their political influence and power will also increase. Some, of course, truly believe they can serve all the people with government-run health care but choose to ignore its cost, or the experiences of working people in other countries.

It is ironic to realize that the same people who voted for and so strongly defend prohibiting the consideration of pre-existing conditions will be bringing back pre-existing conditions with government-run health care. Government health systems are notorious for denying care to people with pre-existing conditions when it becomes too costly to keep treating them.

It is ironic to realize that the same people who voted for and so strongly defend prohibiting the consideration of pre-existing conditions will be bringing back pre-existing conditions with government-run health care.

Prior to the passage of the ACA of 2010, in the United States, pre-existing conditions were not always covered by health insurance, but individuals always had the right to receive necessary health care if they chose to pay for it. In government-run systems, like Canadian Medicare, if the system does not allow treatment for a pre-existing condition to be covered, the patient cannot get it and is barred from using their own money. This is one reason why it is common for Canadians to come to the United States and spend their own money to pay for their own care.

Some lawmakers might favor government-run health care for different reasons, such as it generates billions in tax revenue. This gives them more control over a larger portion of the national economy. These lawmakers will justify high taxation as necessary for the delivery of health care to the sick, elderly, and infirmed. Anyone who objects to high taxes will be labeled as cruel, insensitive, and selfish.

Health Care 2020 gives lawmakers who support a private marketplace, a cause with which they can align themselves with working people and the employers who provide their health insurance. These are the

people – voters – who continue to look for lawmakers who will finally solve the problem of high, unaffordable health care cost.

Realigning “Special Interests”

Health Care 2020 aligns government with the needs of working people, employers, providers, and payors. It does this through 1) price transparency, created by the Medicare-Percent Disclosure, 2) prohibiting open-ended payment contracts that require patients to pay whatever a provider charges, and 3) the emergence of new, Reference-Based Pricing Health Insurance.

Lawmakers will be relieved of their constant political battles over health care legislation as the marketplace applies price pressure and sorts providers by value through more transparency in price, quality and access.

The legislative candidates who embrace this new way of providing total price transparency – Medicare-Percent Disclosure – will win. More importantly, working people will win.

Chapter 15: Solution -- Reference-Based Pricing System Connects the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Health Care 2020 offers a new way to pay for health care for those individuals and employers who, 1) wish to reduce their premium and health care cost, and 2) prefer managing their own health care instead of relying on a managed care insurance system to do it for them. Some, of course, will prefer managed care insurance, and if these types of insurance plans are affordable, individuals and employers should continue to make that choice, but strong competition with managed care is desperately needed. Health Care 2020 offers that option.

Health reformers in the 1980s conceived of Managed Care as a tool to control the payment of claims by insurance companies. It placed the insurance companies in the position of managing individual health care by managing medical providers. Managed Care was a response to escalating health care spending and could hopefully control what appears to be wasted dollars. For instance, hospitals had been admitting patients on Friday or Saturday for services that could not be performed until Monday. This created hospital revenue but brought no value to patients – it wasted health care dollars, and that affected insurance premiums.

The insurance companies promised that if they managed the individual's health care, cost and spending would be reduced in the future. Instead, health care spending has been accelerating at two to three times the rate of increase in the Consumer Price Index (CPI). Large employer managed care health plans, as a result, in 2018 averaged $19,865 in billed premium for family coverage across the United States.[49] But according to Kaiser Family Foundation, that family coverage billed premium soared to $20,576 in 2019.

The following table compares two types of health care consumers – those who prefer managed care insurance and those who would like a self-managed insurance policy.

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[49] Rae, Mathew, Rebecca Copeland, and Cynthia Cox. "Tracking the Rise in Premium Contributions and Cost-Sharing for Families with Large Employer Coverage." *Peterson-Kaiser Health System Tracker* (blog), August 14, 2019. https://www.healthsystemtracker.org/brief/tracking-the-rise-in-premium-contributions-and-cost-sharing-for-families-with-large-employer-coverage/.

Comparing Two Types of Health Care Consumers

Person 1 – A person who likes today's Managed Care Insurance Policies	**Person 2 – A person who would like to spend less using a Self-Managed Insurance Policy**
• Does not have an interest in knowing the price of care	• Wants to know the price of care
• Prefers that someone else selects their physicians and hospitals for them	• Prefers to choose for themselves which hospital and physician to use
• Wants a third party to assist the doctor and them with health care decisions	• Wants to be more independent with their own health care decisions
• Prefers to spend more of their money for conveniences offered by managed care health insurance	• Prefers to spend more of their money on something other than health insurance
• Willing to live with limited network provider choices	• Wants multiple provider choices
• Understands that doctors and hospitals must satisfy the managers as well as the patient	• Appreciates that doctors and hospitals must satisfy the patient first
• Quality is determined by someone else	• Quality is determined by the patient
This is all okay. It's their choice.	**This is all okay. It's their choice.**

The balance of this chapter is about a Self-Managed Insurance Policy – the Reference-Based Pricing (RBP) insurance policy. It addresses the high cost of health care through a more complete form of price transparency and introducing marketplace competition to drive down and stabilize costs. It gives consumers control over provider choice and creates a consumer-friendly marketplace to deliver health care.

High Deductible Health Plans & HSAs

In 2003, when Congress passed Health Savings Account (HSA) legislation, the law stipulated that HSAs must be paired with qualified High Deductible Health Plans (HDHP). Many predicted that HDHPs and HSAs would motivate patients to begin shopping for health care based on price. Lawmakers hoped this would create competition among providers in a more open marketplace and over time, reduce the price of health care. This suggests that 125-145 million individuals with employer-sponsored insurance have HDHPs and are motivated to be price-sensitive, but they are without any pricing information in a system that is unfriendly to consumers.

HDHP supporters believed patients would ask "How much does this cost?" before proceeding with care. Those who did ask quickly learned that their providers did not know the price and could not disclose it. The insurance network contracts by which providers were paid included gag clauses that prohibited them from disclosing the price. Insurance companies never told their members with HDHPs about the gag clause.

The new Reference-Based Pricing (RBP) health care system overcomes this obstacle by making provider prices transparent in a more easily understood manner so those millions of consumers with HDHPs can finally access the price of care before using it. Reference-Based Pricing (RBP) Health Insurance policies

take advantage of the Medicare-Percent Disclosure. The new health insurance plans (RBPs) will encourage individuals to shop for care based on price, quality, and access.

Buying Health Care Today

Today we purchase health care differently from any other purchase we make.

- We do not know the price before receiving the care, yet we agree to pay whatever is charged.
- We may pay anywhere from one to many times more than another person for the same care and never know we could pay less.
- Someone else tells us where we must go to see providers.
- We know little to nothing about the quality of care before or after we receive it.

When we make other types of purchases we ask, “What do I need and when do I need it?” We want to know the price and can easily access it. If the price is too high, we look for a better price. Since it is our money, we decide what to buy and where. We can access a lot of information about quality.

> The new Reference-Based Pricing system requires all providers to fully disclose their Medicare-Percent rates – full price transparency.

Price secrecy in health care has nurtured the creation of a secret, hidden tax. The new Reference-Based Pricing system requires all providers to fully disclose their Medicare-Percent rates – full price transparency. The Medicare-Percent Disclosure exposes the hidden tax.

Price disparity is made transparent with the Medicare-Percent Disclosure so that consumers can see for themselves what various providers charge for care. The more light shed on prices, the more provider competition. Competition reduces prices and increases quality.

Preparing the Marketplace For Reference-Based Pricing Policies

Health Care 2020 starts with the Medicare-Percent Disclosure required of all providers who accept insurance reimbursements.[50] This necessary first step exposes the consumer and the payors to pricing realities. Everyone will be able to know what every provider will accept as full payment for services in the private marketplace.

Price exposure will bring pressure on providers to price their services more reasonably, at least to reflect the common pricing of their competitors. It will be harder for a provider to be the highest priced without justifying those high prices.

Private Health Information Exchanges will be able to publicly disclose the Medicare-Percent of all providers and this will drive the insurance companies to do the same. As price disclosure becomes available and easier to understand, as with other products and services in a healthy competitive marketplace, unit prices will fall.

Medicare-Percent Disclosure will help protect patients from surprise billings. Requiring providers to determine ahead of time that the patient’s insurance covers the expense gives patients additional protection against surprise billings.

[50] In recent years, some physicians and surgical services have quit accepting insurance company reimbursements. They require their patients to pay cash for services, whether fee-for-service or as a monthly or annual fee. These are generally known as Direct Pay Practices. Direct Pay Practitioners commonly disclose their prices with a price list for each service. Since they do not accept insurance, these would be exempt from disclosing a Medicare-Percent.

Networks Become Obsolete Under Reference-Based Pricing

The new Reference-Based Pricing system does not rely on provider networks. The patient can go to their licensed provider of choice, resulting in maximum freedom. Since there are no networks, and prices are fully transparent, surprise billings are eliminated.

Today there are only a handful of large insurance companies competing nationally. In many states, likewise, there are only a small number of health insurance companies. It is common that one insurance company controls more than 50 percent of the market in any state. With the Reference-Based Pricing system, new insurance companies will be able to enter health care markets across state lines, creating much-needed competition. More insurance company competition means reduced pricing, with better customer service. These new insurance companies will provide resources to their members to help them become better consumers, instead of trying to micromanage them and their physicians. The insurance companies will communicate to members prices that are lower among providers, creating price competition among providers.

Reference-Based Pricing insurance policies are consumer friendly. Health care prices are simplified as are plan structures. Patient-consumers need only to know the Medicare-Percent accepted as full payment by a provider, and the Medicare-Percent up to which the insurance policy will pay.

The Reference-Based Pricing concept, should it come to dominate payment methods, would also free up physicians to once again consider private, independent, ethics-based medical practice.

What It Is

Reference-Based Pricing insurance policies use the Medicare allowable rate as a price reference. The policy pays providers at a percentage of Medicare, usually higher than Medicare's allowable amount.

The idea is no different from how insurance companies negotiate reimbursements with in-network providers today. Commonly, insurance companies reimburse providers an amount based on a percentage above Medicare – but they keep this secret. With a Reference-Based Pricing insurance policy this is fully transparent.

Health Care 2020 envisions new group and individual insurance plans that set their reimbursements on a value relative to the Medicare-allowable amount plus a maximum percentage of Medicare. The formula looks like this:

Medicare Allowable Amount x Medicare-Percent = Amount Provider Accepts as Full Payment

How does an individual or employer determine how much they will pay in premium? One option is to buy an insurance policy that pays the same as Medicare. This would reduce premiums by 40-50% or more, depending on where the person lives. Or the person or employer might choose to buy a policy that pays 200% of Medicare's allowed amount and the premiums would be much as they are today.

The Reference-Based Pricing Medicare-Percent paid by the insurance policy varies depending on the policyowner's choice of the level of coverage. The individual might choose 100%, 125%, 150%, 175%, 200%, etc. Some will choose a percentage that reflects the most common amounts accepted by providers in a community. Others will choose a rate and then shop for providers that will accept it either as full payment or allow the insured person to pay the difference.

Hospitals, in general, have greater Medicare-Percent charges than physicians in the same locales. The individual is allowed to choose to purchase a Reference-Based Pricing insurance policy that pays a greater Medicare-Percent for hospitals than physicians.

The Reference-Based Pricing-insured person chooses the maximum amount of allowed reimbursements either of two ways:

1. Learn how much providers generally accept in the person's geographic area expressed as a percentage of Medicare. Then buy a Reference-Based Pricing health insurance policy that pays up to that rate.

2. Purchase a Reference-Based Pricing health insurance policy that fits an individual's budget, and then find providers that will accept the Medicare-Percent set in that insurance policy.

Individuals can survey health care providers to learn their Medicare-Percent rate. They eventually will be able to use a Health Information Exchange to find this data.

"What percentage do you charge of Medicare?" the insured person asks.

- Clinic A accepts 125% of Medicare as full payment
- Clinic B accepts 200% of Medicare as full payment
- Clinic C accepts 100% of Medicare as full payment
- The patient can choose the doctor with the Medicare-Percent they are willing to pay. It is their choice.

Reference-Based Pricing insurance policies connect the dots to align the best interests of Patients, Employers, Payors, and Providers and will bring about reforms of Governments' involvement in the financing of health care. The result will be to change from an unfriendly consumer marketplace to a consumer-friendly marketplace.

Health care laws and regulations are incredibly complex and make it hard for insurance innovation. Health Care 2020 requires only minimal legislative changes, outlined in Chapter 17.

Medicare-Percent Disclosure and Reference-Based Pricing Plans

Health Care 2020 recommends that Congress and State Legislatures make it mandatory for all providers to secure a signed Medicare-Percent Disclosure form from a patient before providing services (exceptions are made for vulnerable or incapacitated persons as detailed below). The form must state the Medicare-Percent the provider accepts as full payment for services. The purpose is to create full price transparency and among other things, eliminate surprise billings.

Under the Health Care 2020 plan, when the provider submits a bill to the patient's insurance company, the provider must include the signed Medicare-Percent Disclosure form with the billing. This will establish with the insurance company that the patient knows about and has accepted the provider's Medicare-Percent.

New insurance companies entering a marketplace will have an administrative advantage over the Big 5 insurance companies. The Big 5 claim payment platform is rooted in networks whereas a new insurance company has no platform to change – only to create a new one.

In many cases, the individual's Reference-Based Insurance policy will stipulate a percentage that is greater or lesser than what the provider accepts. A patient may own a policy that pays up to 160% of Medicare, but the provider accepts 130%. The insurance company will reimburse the provider at 130%. Or the provider may accept 200% of Medicare, in which case the insurance company will reimburse the provider at 160%, and the patient will pay the difference, but it will not be a surprise. Providers would be wise to show the patient how much they may owe in addition to the Medicare-Percent the policy allows – the goal is to make this system consumer-friendly.

Unfortunately, in the current marketplace, a small number of providers have taken advantage of vulnerable persons – individuals who are incapacitated. These unethical providers charge patients 500% to 2,000% of Medicare for emergency or ongoing procedures which results in devastating surprise bills that can bankrupt a person.

During August of 2019, Hurricane Dorian made its way toward Florida after devastating the Bahamas. Imagine a worst-case scenario where immediately after the storm, a hardware store demanded $6,000 for a $300 generator from a nursing home desperate to protect its residents from unbearable, deadly heat. That is, of course, illegal. It is certain that not only would the state levy a substantial fine against the store, but once area residents heard about it, they would run the operator out of business.

In the same way as the hardware store, a community should not tolerate any provider taking financial advantage of a vulnerable or incapacitated individual. These individuals are unable to sign any kind of paperwork, and never will know the cost of care until long after service is provided, and they receive a surprise bill. In the current system, when a patient receives care from a provider who is not in the patient's network, the asking price can be two to 20 times greater than the billed rate for a person in-network – and the provider will try to collect the entire fee.

Health Care 2020 recommends that the medical industry must come to an agreement about what is ethical and allowable to charge in the case of incapacitation, where a vulnerable patient or the patient's representative is unable or unavailable to sign the Medicare-Percent Disclosure Form. If the industry cannot agree on a solution, then lawmakers are going to have to set the maximum price, and almost no one thinks that is a good idea. The insurance industry, as well, should offer an optional insurance rider for these sorts of circumstances that will allow for a payment at a percentage greater than the policy's allowable Medicare-Percent.

Partnering to Reduce Prices

As soon as providers begin to disclose their Medicare-Percent, it will drive discussion by employers and individuals who pay private insurance premiums. Knowing which providers charge more would result in patients choosing different providers.

As soon as providers begin to disclose their Medicare-Percent, it will drive discussion by employers and individuals who pay private insurance premiums. Knowing which providers charge more would result in patients choosing different providers.

In communities in which there is one dominant provider, premium-payors (primarily employers) will be able to learn the provider's Medicare-Percent rate. Today, employers only know insurance is expensive, without knowing about prices. By working together, employers and individuals can partner to pressure the provider to reduce their Medicare-Percent rate. This will save the provider public embarrassment and produce goodwill in the community.

Structuring Reference-Based Pricing Health Insurance

Reference-Based Pricing insurance policies are structured like today's policies. That is, they have deductibles and co-insurance with maximum out-of-pocket costs up to the Medicare-Percent specified in the insurance policy. Health Care 2020 does not provide an extensive discussion about plan design. Insurance companies are well-familiar with how to do so. The following example, however, indicates how a Reference-Based Pricing plan might work for an employer and employee.

For example:

> ABC Manufacturing offers employees a Reference-Based Pricing insurance plan that reimburses physicians at 140% of Medicare, and hospitals at 180%.[51] The company offers a $3,000 deductible plan for an individual and $6,000 for a family.
>
> Emily, an ABC employee, found that Dr. Chao, her longtime family practice doctor accepts 175% of Medicare as full payment. Emily knew she would be required to pay the extra 35% if she stayed with the doctor. Emily then contacted Dr. Sosa, a few blocks away, and learned she accepts 140% of Medicare. She looked up all the information she could find about Dr. Sosa concerning quality and patient reports. Satisfied that Dr. Sosa fit her needs at a lesser cost, she changed doctors. No one told her she had to change doctors – she made the decision.
>
> (A year later, Dr. Chao reduced her Medicare-Percent to 140%.)
>
> ABC Manufacturing and their employees enjoy the immediate reduction in their cost of insurance from the new Reference-Based Pricing plan. Since Medicare's reimbursements increases average about 2% each year, the company knows that its insurance premiums going forward will remain more affordable.

How Do Reference-Based Pricing Insurance Policies Connect All the Dots?

Reference-Based Pricing health insurance aligns the interests of patients, employers, and physicians when supported by insurance companies and government regulators, each in their different roles. Reference-Based Pricing insurance will be a market-changer, creating a consumer-friendly marketplace.

Once Reference-Based Pricing plans are fully implemented, with their new Reference-Based Pricing insurance policy, patients will:

- Own affordable medical insurance.
- Choose to receive medical care from any willing provider with no network limitations.
- Know the Medicare-Percent to determine the price of care before receiving it.
- Base a decision on which providers to use on price and quality of care.
- Have better access.
- Enjoy a true doctor-patient relationship.

Employers will be able to offer new Reference-Based Pricing group insurance plans to employees that strengthen the relationship between them, but at reduced cost to both. Employers will be able to:

- Invest premium savings in increased wages, or improved benefits.

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[51] At this point in the evolution of RBPs, some RBP insurance plans use traditional network contracts for physicians. The RBP plans generally apply to facility charges such as hospital in-patient, out-patient, lab and diagnostic testing.

- Enjoy very modest annual premium increases since the reimbursements reflect changes in the Medicare allowable reimbursements (generally about 2% a year).
- Free up capital for growth opportunities or increased profits.

Providers, and especially physicians:

- Once again have a chance to establish independent practices.
- Can accept new patients without all the contractual restrictions of provider network contracts.
- Can reduce overhead expenses related to the administrative expense of networks.
- Can eliminate networks and multiple reimbursement schedules.
- Can practice ethics-based medicine.
- Can spend more time with patients and less time checking off boxes.
- Are freed from top-down, micro-managing third parties.
- Will have control of their own work schedules.
- Can openly compete with other providers, differentiating themselves to attract more new patients.

Insurance companies also gain from these new Reference-Based Pricing insurance policies.

- More insurance companies can enter the local market as there are no requirements for providers to sign contracts.
- Can expand their market across state lines.
- Increases ability to compete.
- Reduces administrative cost.

Why would governments find Reference-Based Pricing insurance plans more attractive? State and federal lawmakers, once they have removed obstacles to Reference-Based Pricing insurance policies, will be able to set aside perpetual battles over health care. Health insurance will be more affordable for taxpayers (voters). They will have more time to attend to other legislative priorities. Reference-Based Pricing insurance plans will require “low legislative maintenance,” unlike the unending squabbles over managed care.

Connecting the dots with Reference-Based Pricing health insurance policies empowers the American marketplace with the information necessary to deliver what people want – access to, quality of, and the affordability to pay for health care in a consumer-friendly marketplace.

Chapter Addendum: Montana

How Montana is using Reference-Based Pricing

Montana decided to implement a Reference-Based Pricing health plan in 2017 for its state employee health insurance benefit. The state had faced a $9 million funding shortfall in its employer health insurance plan, and the legislature ordered state officials to find a way to reduce the cost. Directed by Marilyn Bartlett, the state devised a health plan that would no longer pay providers based on the traditional, complicated, hidden prices that are common to health care. Instead, Montana designed a system that pays providers a percent of Medicare – a Reference-Based Pricing insurance plan.

Bartlett found that some Montana hospitals required as much as 350% of Medicare as full payment. Others accepted less. The Montana Reference-Based Pricing health plan settled on 232% of Medicare as its maximum reimbursement level for hospitals. Hospitals that customarily asked for payments above 232% adjusted their accepted level of reimbursement to align with the Montana state employee plan in order to continue to provide services to plan members.

The Montana State Employee Reference-Based Pricing medical plan set 165% of Medicare as its maximum reimbursement level for physicians.

As a result of adopting its Reference-Based Pricing plan, Montana reduced its employee health insurance benefit spending by $112 million during 2017 and 2018.

Chapter 16: The Private Health Information Exchanges

- Patients
- Employers
- Providers
- Payors
- Government

Health Information Exchanges will be driven by the consumer-friendly marketplace which requires critical information on each provider, made easily accessible and understandable. Most importantly, it gives voice to patients to provide feedback about their providers.

To move from the current consumer-unfriendly marketplace to a consumer-friendly marketplace requires that consumers have easy access to information that is important to them. The most important piece of information, which is currently not available, is the price of care and the ability for consumers to compare the prices of competing providers.

Consider Amazon.com. Would it even be in business if it did not post the price of its products and services? Of course not. At Amazon.com, consumers search for price first, description, quality ratings next, and then what people say about the product.

WebMD.com, RateMDs.com, HealthGrades.com and similar websites offer useful information, but only a small number of people visit these websites and others like them. They do not draw consumers because they lack the most important piece of information – each provider's prices.

Why Is the Price So Important Now?

A transition is occurring with today's co-pay health insurance plans, where consumers are not interested in knowing the price, because their co-pays are the maximum they will pay. These insurance plans are beginning to be replaced with plans where the consumer has financial risk, so that the price of care is more important to them.

Directly or indirectly, all people with private insurance are beginning to care more about and notice the price of health care. 1) Their premiums keep going up, and many people can no longer afford them. 2) Their co-pays, deductibles, and other out-of-pocket expenses seem high to them, and are growing. 3) They are one of the 125-145 million Americans with a high deductible health plan. The latter comprises the greatest number of individuals who currently are concerned about the price of care, and they know that little to no information is currently available.

The current high deductible health plans, and the next generation of health insurance plans – Reference-Based Plans – will rely on the Medicare-Percent Disclosure. The Medicare-Percent Disclosure will be required of all providers. Consumers will be looking for provider pricing information to match their

health insurance payment schedule. The new Health Information Exchanges will meet this need and nurture a new consumer-friendly marketplace.

The New Price Information Websites

Once the Medicare-Percent Disclosure is required of all providers, non-government Health Information Exchanges will become popular overnight, and new ones will emerge, vying to become the Amazon.com of health care. Health Information Exchanges will show the price of care, provider's quality ratings, and report what individuals say about the providers. Naturally, the Health Insurance Exchange will link to the provider's website where the provider would be able to show their credentials, what differentiates them from their competitors and justify their price.

Once the Medicare-Percent Disclosure is required of all providers, Health Information Exchanges will become popular overnight, and new ones will emerge, vying to become the Amazon.com of health care.

Example:

Maria Lopez bought a home pregnancy test and saw a positive result. After sharing the good news with her husband, she decided to look for an OB/GYN doctor nearby.

The Lopez's health insurance policy would pay a physician up to 160% of Medicare.

Maria had heard about a new Health Information Exchange website from a friend at work. On the website, Maria could search for information on all the nearby OB/GYN specialists.

Comparing prices

Maria first sorted her findings by the Medicare-Percent of each physician. She saw that Dr. Kind accepts 200% of Medicare as full payment. Dr. Sweet accepted 175% of Medicare. Dr. Garcia was at 160%, the amount allowed by Maria's insurance policy. Lastly, she saw Dr. Small who accepts 140% of Medicare.

Comparing quality

Next, Maria examined the overall quality ratings of each doctor. She saw that the ratings for several physicians were similar. Dr. Sweet, however, had a lower rating, so Maria began to read Dr. Sweet's patient reviews.

Patient reviews

Maria carefully read the patient reviews about Dr. Sweet. The most common comment was that Dr. Sweet always seemed to be in a hurry. The patients didn't feel as though she had time for them.

As for the other physicians, the comments were mostly positive.

Maria liked the fact that Dr. Garcia, who accepted 160% of Medicare, and Dr. Small at 140% would mean she had no additional out-of-pocket expenses for their services. Then she saw that Dr. Small's office was close to home.

Maria made an appointment to see Dr. Small. After giving birth to her daughter, Maria reported her own experience with Dr. Small on the Health Information Exchange.

Quality Improvement

As patients rate their physicians and hospitals, quality will improve. Just like patients, providers will be able to read patients' comments. Dr. Sweet, for instance, who noticed her patient load had fallen, read that patients perceived that she was too busy to really care about them. Dr. Sweet knew she had to improve her bedside manner so patients would begin sharing more positive comments about her.

Knowing that prospective patients will read these comments, the providers will become more sensitive to the quality of care they deliver. This will, in turn, improve quality, increase competition, and create a more consumer-friendly marketplace.

Sarah, Maria's friend

> Sarah asked Maria about how she found Dr. Small. Maria told her about the Health Information Exchange. Sarah's needs were different from Maria's, in that she had an ovarian cyst.
>
> On the Health Information Exchange Sarah discovered that Dr. Kind, who accepts 200% of Medicare, also specializes in ovarian cyst surgeries. Dr. Kind's website showed that he saved 98% of ovaries because of a new procedure he used.
>
> Sarah read Dr. Kind's quality ratings, and the patient comments. What struck her were the number of women who were like her, who wanted a family and thanked Dr. Kind for saving their ovary.
>
> Sarah, like Maria, had a Reference-Based Health Plan that paid up to 160% of Medicare. Dr. Kind, however, felt his services were worth 200% of Medicare. The more Sarah read about Dr. Kind and realized how important it was to her to have the chance to give birth someday, the less concerned she became about the cash she would have to pay.
>
> Sarah decided it was worth it to pay the additional 40% of Medicare – $460 – to use Dr. Kind and save her chances to bear children later on.
>
> Sarah was grateful that she had Reference-Based Priced health insurance so she could choose her doctor without being told she had to use a network provider. She also liked the fact that she could make the decision about whether she could spend her own money. Mostly, however, she felt satisfied knowing that someday she could still be a mother.

Medicare-Percent Makes Health Information Exchanges possible

Health Care 2020 builds a price transparency solution for the emerging interest of patients and individuals with private health insurance to care about price. These are people who have begun to or know about the link between what providers charge, and how much premium they are paying. The new Reference-Based Health Plans encourage policyholders to shop for the providers with the best Medicare-Percent rates.

As individuals begin to see how their insurance policy provides incentive to know the price of care, and to study quality and access, they will look for information. The private Health Information Exchanges (HIEs) will help them find the best values in their community, much as services like YELP.com and TripAdvisor.com do.

In the Health Care 2020 system, consumer-patients will be able to search for price and quality information. The price the provider will accept as full payment will be easily illustrated by the Medicare-

Percent. The new private market Health Information Exchanges will transparently report each provider's Medicare-Percent. They will allow for patient-sharing about provider quality.

The Health Information Exchange will include information of why a specific provider charges more – or less – than others. With this additional information about pricing made so easily available, providers will become more price sensitive.

Patients will want to know why Dr. Able charges twice as much as the average of other doctors. Dr. Baker will want to explain why he charges half of what other physicians charge. Patients will provide feedback on both.

Consumers will be drawn to the lower priced providers if the quality reports are acceptable.

The health insurance companies that enter the marketplace as a result of the new Reference-Based Pricing health insurance policies, will likely replace the current network-find option on their websites with the Medicare-Percent of each provider.

The Health Information Exchanges will provide patients with expanded information about providers. Then, consumers will be able to compare providers based on price, read patient reviews, and evaluate provider credentials and experience.

Health Information Exchanges will be driven by the consumer-friendly marketplace which requires critical information on each provider, made easily accessible and understandable. Most importantly, it gives voice to patients to provide feedback about their providers.

Chapter 17: Legislative Changes Recommended – Connecting the Dots

Connecting the Dots

- Patients
- Employers
- Providers
- Payors
- Government

Health Care 2020 connects the dots with minimal legislative action required. Members of Congress and state lawmakers are considering a wide range of reforms, but Health Care 2020 limits its recommendations to the ideas expressed in The Manual, while taking no position on other necessary, but important reforms.

As lawmakers adopt Health Care 2020 reforms, it is likely that some regulations may need Congressional and administrative adjustments. Health Care 2020 especially supports the reform of laws and regulations that improves private health insurance for working people.

Health Care 2020 recommends reforms that focus on changing from a consumer-unfriendly marketplace to a consumer-friendly marketplace. There can be no successful, affordable long-term solution without creating a consumer-friendly marketplace.

1. **The Medicare-Percent Disclosure**. Require physicians, hospitals, clinics, labs, scanning facilities, durable medical equipment, and all other providers to publicly disclose the *percentage of Medicare* they will accept as full payment prominently posted near the registration or check-in desk, and on the provider's website.

2. **Medicare-Percent Disclosure Form**. Prior to a person receiving health care services, require the provider to disclose, on a written Medicare-Percent Disclosure Form, the Medicare-Percent accepted as full payment, and to secure the patient's signature on the disclosure form acknowledging the patient has reviewed it.

3. **Eliminate Surprise Billings.** Require all subcontractors (specialists and subspecialists) providing medical care for a hospital and/or clinic to agree to the same Medicare-Percent rate accepted as full payment by the hospital, and/or clinic. This information is disclosed on the hospital and/or clinic's Medicare-Percent Disclosure Form.

4. **Disallow provider and patient open-ended "promise-to-pay" contracts.** Prohibit previously signed or new open-ended contracts that obligate patients to pay whatever the provider charges without the provider first disclosing the Medicare-Percent accepted as full payment.

5. **Require Price Transparent Provider bills.** For all health care services costs, provider bills should include the Medicare allowable amount (in dollars), Medicare-Percent rate (in percent) that the provider accepts as full payment, and the dollar amount the provider accepts as full payment.

6. **Protect incapacitated individuals.** Limit health care charges for any individual who is incapacitated at the onset of receiving that care to no more than a set percent of the Medicare allowable amount, said percentage to be determined by law. The rationale for this price setting percent is to protect against taking advantage of an incapacitated person by charging rates many times more than what Medicare allows. A rate should be set that will provide adequate financial support to the medical provider, but at the same time, protect the incapacitated individual or their insurance company from price gouging.

7. **Hold providers liable for Hospital-acquired Infections.** Require the offending hospital to pay for patient care required as a result of a hospital-acquired infection for individuals with private insurance, just as Medicare and Medicaid require them to do for patients covered under a government plan.

8. **Require providers to verify that they are in network.** For patients who have insurance that uses provider networks, providers must verify that they are in- or out- of the patient's network. If the provider is out-of-network, the provider must obtain a signed disclosure form signed by the patient indicating the patient understands that the services will be reimbursed as an out-of-network benefit before services are rendered.

9. **Require providers to verify that their services are eligible charges covered by the patient's health insurance.** Providers should be required to verify that a patient's health insurance policy will allow, as an eligible expense, the services that will be provided. If not covered, the provider must obtain a signed disclosure from the patient indicating the patient understands these are not covered expenses and what the cost will be.

Appendix I – Hidden Tax Data

This data reflects the self-disclosed prices of 23 health clinics in Minnesota. Section 62J.812 of Minnesota law requires certain primary care clinics to disclose their billed charges, average insurance company reimbursements, applicable Medicare allowed amount, and applicable Medicaid allowed amount. Health Care 2020 analyzed the data for these clinics. This consolidated chart shows the ratios of various data and allows a comparison between clinics.

The table shows that Mayo Clinic in Rochester, Minnesota, has the highest private insurance reimbursement amount among these 23 providers at 282% of Medicare. The hidden tax is 182%. The lowest Medicare-Percent among these 23 providers is Madelia at 109%, or a 9% hidden tax (Chapter 1).

Clinic Price Transparency Chart - Percentages & Hidden Tax

Health System/Clinic	Medicare-Percent	Hidden Tax
Mayo Clinic Rochester Primary Care	282%	182%
Ridgeview Clinic	275%	175%
Park Nicollet	261%	161%
Fairview Clinics (clinic services)	256%	156%
Allina Health Systems	255%	155%
CentraCare Primary Care Clinic	250%	150%
TCO Metro Clinic	244%	144%
Essentia Health - East Clinic	228%	128%
North Memorial Clinics	224%	124%
Mayo Clinic	223%	123%
Essentia Health - Central Clinic	222%	122%
Essentia Health - West Clinic	199%	99%
Children's Hospital Clinic Charges	198%	98%
St. Luke's Hospital Clinic	188%	88%
Children's Community Based Pediatric Clinic	186%	86%
CentraCare Eden Valley Care Clinic	179%	79%
Cayuna Medical Clinics	168%	68%
Fairview Clinics (lab services)	165%	65%
Lake View clinic - Duluth (Member of St Luke's)	137%	37%
Glencoe Regional Health	129%	29%
Parkview Clinic - New Prague	125%	25%
Hennepin Health*	122%	22%
Madelia	109%	9%
Mean	**201%**	**101%**

* Hennepin Health's data included scans that were not covered by either Medicare or Medicaid and skewed the data. Outlier data is not included.

Appendix II – Select Primary Clinic Pricing Charts

The data reported in the following tables reflects the self-disclosed prices of a sample of Minnesota health clinics. Section 62J.812 of Minnesota law, which became effective on July 1, 2019, requires certain primary care clinics – family practice, OB/GYN, and pediatrics – to disclose their billed charges, average insurance company reimbursements, applicable Medicare allowed amount, and applicable Medicaid allowed amount. The disclosure affects the top 25 clinical procedures greater than $25, and the 10 most common preventive procedures performed in the clinic.

These price transparency charts, by law, must be disclosed in the clinic waiting area and on the provider's website, if the provider has one.

Health Care 2020 has randomly selected and included below five charts as illustrative of the great price disparity seen throughout the state. For more examples, contact Health Care 2020.

Description of the Data

The statute requires four payment rates to be disclosed on the tables.

1. <u>The clinic's billed price</u>. This is the "retail" or "Chargemaster" price with which only cash paying patients or uninsured persons will need to be concerned.
2. <u>The average health insurance allowed amount</u>. This is the *average* of all insurance companies' reimbursements paid to the clinic for the disclosed service. The allowed insurance amount can vary with every network contract signed by the provider.
3. <u>Medicare's allowable amount</u>. Most clinical services include private pay options (cash or insurance) and a Medicare allowable amount for that service. Health Care 2020 found that several common services, even office visits, do not have corresponding Medicare reimbursements. When there is no comparable Medicare allowable fee as listed by the provider, we have used black filler on the chart to indicate so, and have adjusted the data accordingly.
4. <u>Medicaid allowable amount</u>. The amount Medicaid reimburses.

Health Care 2020 used the provider's disclosed prices and provided calculations stated as percentages for:

1. The Insurance Percentage Discount (IPD) is the insurance Amount Accepted as full Payment (AAP) divided by the Billed Amount (BA) – commonly known as the insurance companies' network discount. IPD=1.0-(AAP/BA)*100
2. The Medicare-Percent (MP), showing the insurance Amount Accepted as full Payment (AAP) divided by the amount Medicare Allows (MA). MP=AAP/MA*100
3. The Medicaid Percentage Amount (MPA) is the Medicaid Allowable Amount (MdAA) divided by the insurance Amount Accepted as full Payment (AAP). MPA=MdAA/AAP*100

Health Care 2020 is confident in the data on these charts insofar as they correctly reflect the dollar amounts disclosed by providers. A close inspection of provider's charts sometimes revealed provider reporting errors so that in those clinics, the data ratios would be incorrect. One major health care provider, for example, reversed the Medicare and Medicaid allowable amounts – Health Care 2020 adjusted for these errors. Another seemed to create a dollar amount out of thin air and simply plugged it into each Medicare and Medicaid amount.

Since the Minnesota law does not carry a penalty for noncompliance – or sloppy reporting – it is unlikely that providers will correct their errors without public pressure to do so. Health Care 2020 is recommending that Minnesota lawmakers add a penalty provision to Section 62J.812 for incorrect reporting.

Mayo Clinic - MN Primary Care - Rochester

Clinic reporting the top 25 procedures as required by MN Statute 62J.812

Description	Clinic Charge	Average Commercial Insurance Reimburse-ment	Insurance Percent Discount off Billed	Medicare Reimburse-ment	Medicare-Percent of What Insurance Pays	Medicare as Percent of Insurance Paid	Medicaid Reimburse-ment	Medicaid Percent c/p to What Insurance Pays
Aspiration and/or injection of large joint or joint capsule	$320.31	$302.16	6%	$59.18	511%	20%	$41.98	14%
First vaccine or toxoid component administration up to 18 years of age with								
Administration of 1 vaccine	$34.80	$31.77	9%	$16.82	189%	53%	$12.83	40%
Routine EKG using at least 12 leads including interp and report	$155.52	$141.18	9%	$16.95	833%	12%	$12.03	9%
New patient office or other outpatient visit level 2	$225.54	$204.59	9%	$76.10	269%	37%	$58.86	29%
New patient office or other outpatient visit level 3	$304.21	$275.72	9%	$107.29	257%	39%	$82.86	30%
New patient office or other outpatient visit level 4	$451.07	$414.54	8%	$162.82	255%	39%	$125.82	30%
New patient office or other outpatient visit level 5	$566.46	$518.88	8%	$204.48	254%	39%	$158.19	30%
Established patient office or other outpatient visit level 2	$120.64	$109.57	9%	$45.15	243%	41%	$34.87	32%
Established patient office or other outpatient visit level 3	$167.84	$152.11	9%	$74.13	205%	49%	$57.19	38%
Established patient office or other outpatient visit level 4	$267.50	$242.82	9%	$108.56	224%	45%	$83.97	35%
Established patient office or other outpatient visit level 5	$403.87	$367.40	9%	$145.04	253%	39%	$112.15	31%
Patient office consultation level 3	$445.83	$403.70	9%		#DIV/0!	0%	$94.58	23%
Patient office consultation level 4	$634.65	$576.12	9%		#DIV/0!	0%	$141.17	25%
Patient office consultation level 5	$520.94	$473.18	9%	$129.05	367%	27%	$99.88	21%
Initial new patient preventive medicine evaluation age 40 through 64 years	$373.82	$340.18	9%		#DIV/0!	0%	$118.57	35%
Established patient periodic prev med exam infant	$203.52	$182.95	10%		#DIV/0!	0%	$77.56	42%
Established patient periodic prev med exam age 1 through 4	$229.77	$209.07	9%		#DIV/0!	0%	$82.58	39%
Established patient periodic prev med exam age 5 through 11	$240.70	$218.60	9%		#DIV/0!	0%	$82.30	38%
Established patient periodic prev med exam age 12 through 17	$262.61	$238.28	9%		#DIV/0!	0%	$90.39	38%
Established patient periodic prev med exam age 18 through 39	$300.87	$275.35	8%		#DIV/0!	0%	$92.34	34%
Established patient periodic prev med exam age 40 through 64	$300.87	$275.29	9%		#DIV/0!	0%	$98.20	36%
Established patient periodic prev med exam age 65 and older	$411.17	$378.87	8%		#DIV/0!	0%	$105.74	28%
Physician or health care professional patient care by internet (email) related to	$49.00	$34.91	29%		#DIV/0!	0%	—	
Early periodic screening diagnosis and treatment service	$133.62	$0.46			#DIV/0!	0%	—	
Totals and averages	**$7125.13**	**$6367.70**	**9%**	**$1145.57**	**282%**	**35%**	**$1864.06**	**29%**
Totals adjusted when there are no Medicare rates to compare	3538.7	3233.92						

* Mayo's reported data seemed to have a serious flaw that negatively affected their average Medicare Percent. We removed the data to provide a more accurate picture.

Allina Health Systems

Clinic reporting the top 25 procedures as required by MN Statute 62J.812

Description	Clinic Charge	Average Commercial Insurance Reimbursement	Insurance Percent Discount off Billed	Medicare Reimbursement	Medicare-Percent of What Insurance Pays	Medicare as Percent of Insurance Paid	Medicaid Reimbursement	Medicaid Percent c/p to What Insurance Pays
Preventive visits, established patient, ages less than 1 year	$271	$260	4%	$100	260%	38%	$78	30%
Preventive visits, established patient, ages 1-4	$290	$274	5%	$107	256%	39%	$83	30%
Preventive visits, established patient, ages 5-11	$289	$273	5%	$107	256%	39%	$82	30%
Preventive visits, established patient, ages 12-17	$317	$300	5%	$117	257%	39%	$90	30%
Preventive visits, established patient, ages 18-39	$323	$306	5%	$119	256%	39%	$92	30%
Preventive visits, established patient, ages 40-64	$345	$326	5%	$127	257%	39%	$98	30%
Preventive visits, established patient, ages 65 and over	$372	$352	5%	$137	257%	39%	$106	30%
Preventive visits, new patient, ages less than 1 year	$302	$286	5%	$111	257%	39%	$86	30%
Preventive visits, new patient, ages 1-4	$316	$299	5%	$117	256%	39%	$90	30%
Preventive visits, new patient, ages 5-11	$328	$311	5%	$121	256%	39%	$94	30%
Preventive visits, new patient, ages 12-17	$371	$351	5%	$137	257%	39%	$106	30%
Preventive visits, new patient, ages 18-39	$359	$340	5%	$132	257%	39%	$102	30%
Preventive visits, new patient, ages 40-64	$417	$395	5%	$153	258%	39%	$119	30%
Preventive visits, new patient, ages 65 and over	$452	$428	5%	$166	258%	39%	$128	30%
Office visit, established patient, level 1	$59	$56	5%	$23	242%	41%	$18	32%
Office visit, established patient, level 2	$120	$113	6%	$45	251%	40%	$35	31%
Office visit, established patient, level 3	$199	$188	5%	$74	254%	39%	$57	30%
Office visit, established patient, level 4	$293	$278	5%	$109	256%	39%	$84	30%
Office visit, established patient, level 5	$396	$375	5%	$145	258%	39%	$112	30%
Office visit, new patient, level 1	$122	$115	6%	$46	252%	40%	$35	31%
Office visit, new patient, level 2	$205	$194	5%	$76	255%	39%	$59	30%
Office visit, new patient, level 3	$294	$278	5%	$107	259%	39%	$83	30%
Office visit, new patient, level 4	$449	$425	5%	$163	261%	38%	$126	30%
Blood Draw (Venipuncture)	$17	$4	76%	$3	133%	75%	$3	75%
Blood Test - Lipid Panel	$55.00	$25.00	55%	$15.00	167%	60%	$15.00	60%
Blood Test - Basic Metobolic Panel	$35.00	$14.00	60%	$9.00	156%	64%	$9.00	64%
Hemoglobin A1C	$40.00	$16.00	60%	$11.00	145%	69%	$11.00	69%
Totals and Averages	**$7,036**	**$6,581**	**6%**	**$2,577**	**255%**	**39%**	**$2,001**	**30%**

Essentia Health - West Clinic

Clinic reporting the top 25 procedures as required by MN Statute 62J.812

Description	Clinic Charge	Average Commercial Insurance Reimburse-ment	Insurance Percent Discount off Billed	Medicare Reimburse-ment	Medicare-Percent of What Insurance Pays	Medicare as Percent of Insurance Paid	Medicaid Reimburse-ment	Medicaid Percent c/p to What Insurance Pays
URINALYSIS AUTO W/SCOPE	$34	$11	68%	$4	275%	36%	$4	36%
ASSAY GLUCOSE BLOOD QUANT	$33	$21	36%	$4	525%	19%	$5	24%
COMPLETE BLOOD COUNT AUTOMATED	$39	$22	44%	$7	314%	32%	$8	36%
PNEUMOCOCCAL VACC 13 VAL IM	$220	$188	15%	$205	92%	109%	$205	109%
FLU VACCINE,QUAD,IM .5 ML	$27	$18	33%	$17	106%	94%	$17	94%
OFFICE/OUTPT VISIT,NEW,LVL I	$107	$92	14%	$46	200%	50%	$34	37%
OFFICE/OUTPT VISIT,NEW,LVL II	$186	$159	15%	$76	209%	48%	$58	36%
OFFICE/OUTPT VISIT,NEW,LVL III	$269	$230	14%	$107	215%	47%	$83	36%
OFFICE/OUTPT VISIT,NEW,LVL IV	$395	$346	12%	$163	212%	47%	$126	36%
OFFICE/OUTPT VISIT,NEW,LVL V	$491	$439	11%	$204	215%	46%	$159	36%
OFFICE/OUTPT VISIT EST LEVEL I	$68	$45	34%	$23	196%	51%	$17	38%
OFFICE/OUTPT VISIT,EST,LEVL II	$110	$93	15%	$45	207%	48%	$34	37%
OFFICE/OUTPT VISIT,EST,LEVL III	$181	$156	14%	$74	211%	47%	$56	36%
OFFICE/OUTPT VISIT,EST,LEVL IV	$265	$230	13%	$109	211%	47%	$83	36%
OFFICE/OUTPT VISIT,EST,LEVL V	$356	$307	14%	$145	212%	47%	$112	36%
PREV VISIT EST,INFANT	$228	$207	9%	$102	203%	49%	$77	37%
PREV VISIT EST AGE 1-4	$244	$223	9%	$108	206%	48%	$82	37%
PREV VISIT EST AGE 5-11	$252	$224	11%	$108	207%	48%	$82	37%
PREV VISIT EST AGE 12-17	$267	$246	8%	$119	207%	48%	$90	37%
PREV VISIT EST AGE 18-39	$280	$252	10%	$121	208%	48%	$92	37%
PREV VISIT EST AGE 40-64	$301	$268	11%	$129	208%	48%	$98	37%
PREV VISIT EST,65 & OVER	$312	$293	6%	$139	211%	47%	$106	36%
PROSTATE-SPECIFIC ANTIGEN TOTAL SCREENING	$76	$32	58%	$20	160%	63%	$23	72%
INITIAL ANNUAL WELLNESS VISIT	$396	$387	2%	$172	225%	44%	$122	32%
OBTAINING SCREEN PAP SMEAR	$109	$77	29%	$44	175%	57%	$32	42%
Totals and Averages	$5,246	$4,566	13%	$2,291	199%	50%	$1,805	40%

[1] Source: https://www.essentiahealth.org/patients-visitors/billing/minnesota-clinic-service-charges/ Retrieved 9/25/2019

Cayuna Medical Clinics

Clinic reporting the top 25 procedures as required by MN Statute 62J.812

Description	Clinic Charge	Average Commercial Insurance Reimburse-ment	Insurance Percent Discount off Billed	Medicare Reimburse-ment	Medicare-Percent of What Insurance Pays	Medicare as Percent of Insurance Paid	Medicaid Reimburse-ment	Medicaid Percent c/p to What Insurance Pays
Office/outpatient visit new Level 1	$184	$76	59%	$45	169%	59%	$34	45%
Office/outpatient visit new Level 2	$379	$130	66%	$75	173%	58%	$57	44%
Office/outpatient visit new Level 3	$552	$186	66%	$107	174%	58%	$82	44%
Office/outpatient visit new Level 4	$679	$283	58%	$163	174%	58%	$126	45%
Office/outpatient visit est Level 1	$90	$36	60%	$22	164%	61%	$16	44%
Office/outpatient visit est Level 2	$180	$76	58%	$44	173%	58%	$34	45%
Office/outpatient visit est Level 3	$408	$127	69%	$73	174%	57%	$56	44%
Office/outpatient visit est Level 4	$528	$187	65%	$108	173%	58%	$83	44%
Office/outpatient visit est Level 5	$600	$245	59%	$145	169%	59%	$112	46%
Per pm reeval est pat infant	$293	$176	40%				$77	44%
Prev visit est age 1-4	$334	$184	45%				$82	45%
Prev visit est age 18-39	$418	$205	51%				$91	44%
Prev visit est age 40-64	$391	$219	44%				$97	44%
Per pm reeval est pat 65+ yr	$490	$236	52%				$105	44%
Init pm e/m new pat infant	$329	$192	42%				$85	44%
Init pm e/m new pat 1-4 yrs	$360	$201	44%				$89	44%
rev visit new age 18-39	$386	$229	41%				$102	45%
Prev visit new age 40-64	$451	$265	41%				$118	45%
Init pm e/m new pat 65+ yrs	$494	$287	42%				$128	45%
VENIPUNCTURE/Lab Draw	$44	$15	66%	$3	500%	20%	$3	20%
Seasonal Influenza	$127	$39	69%	$39	100%	100%	$53	136%
Immunization admin	$77	$28	64%	$20	140%	71%	$16	57%
Vaccine Admin	$27	$25	7%	$10	250%	40%	$16	64%
PR SUBSEQUENT ANNUAL WELLNESS VISIT	$278	$165	41%	$117	141%	71%	$83	50%
Transitional Care Management <14 days post dc.	$487	$285	41%	$165	173%	58%	$127	45%
Totals and averages	**$8586**	**$4097**	**52%**	**$1136**	168%	**60%**	**$1872**	**46%**
Totals adjusted when there are no Medicare rates to compare	**$4640**	**$1903**						

Madelia Community Hospital & Clinic

Clinic reporting the top 25 procedures as required by MN Statute 62J.812

Description	Clinic Charge	Average Commercial Insurance Reimbursement	Insurance Percent Discount off Billed	Medicare Reimbursement	Medicare-Percent of What Insurance Pays	Medicare as Percent of Insurance Paid	Medicaid Reimbursement	Medicaid Percent c/p to What Insurance Pays
Office Visit, New Patient, 20 minutes	$158.00	$ 113.76	28%	$ 104.28	109%	92%	$ 79.00	69%
Office Visit, New Patient, 30 minutes	$179.00	$ 128.88	28%	$ 118.14	109%	92%	$ 89.50	69%
Office Visit, Established Patient, 10 minutes	$84.00	$ 60.48	28%	$ 55.44	109%	92%	$ 42.00	69%
Office Visit, Established Patient, 15 minutes	$138.00	$ 99.36	28%	$ 91.08	109%	92%	$ 69.00	69%
Office Visit, Established Patient, 25 minutes	$215.00	$ 154.80	28%	$ 141.90	109%	92%	$ 107.50	69%
Office Visit, Established Patient, 40 minutes	$286.00	$ 205.92	28%	$ 188.76	109%	92%	$ 143.00	69%
Preventative Visit, Established Patient, < 1 year old	$92.00	$ 66.24	28%	$ 60.72	109%	92%	$ 46.00	69%
Preventative Visit, Established Patient, Age 1-4	$104.00	$ 74.88	28%	$ 68.64	109%	92%	$ 52.00	69%
Preventative Visit, Established Patient, Age 5-11	$142.00	$ 102.24	28%	$ 93.72	109%	92%	$ 71.00	69%
Preventative Visit, Established Patient, Age 12-17	$154.00	$ 110.88	28%	$ 101.64	109%	92%	$ 77.00	69%
Preventative Visit, Established Patient, Age 18-39	$205.00	$ 147.60	28%	$ 135.30	109%	92%	$ 102.50	69%
Preventative Visit, Established Patient, Age 40-64	$228.00	$ 164.16	28%	$ 150.48	109%	92%	$ 114.00	69%
Injection-Immunization -X1	$38.00	$ 27.36	28%	$ 25.08	109%	92%	$ 19.00	69%
Joint Injection	$101.00	$ 72.72	28%	$ 66.66	109%	92%	$ 50.50	69%
Injection-Non immunization	$121.00	$ 87.12	28%	$ 79.86	109%	92%	$ 60.50	69%
Screening Mammogram	$469.00	$ 337.68	28%	$ 309.54	109%	92%	$ 234.50	69%
Dexa Scan- Screen for Osteoporosis	$525.00	$ 378.00	28%	$ 346.50	109%	92%	$ 262.50	69%
Skin Tag Removal	$162.00	$ 116.64	28%	$ 106.92	109%	92%	$ 81.00	69%
Lipid Panel- lab test	$158.00	$ 113.76	28%	$ 104.28	109%	92%	$ 79.00	69%
Prothrombin Time - lab test	$102.00	$ 73.44	28%	$ 67.32	109%	92%	$ 51.00	69%
Ear Wash	$43.00	$ 30.96	28%	$ 28.38	109%	92%	$ 21.50	69%
CBC- lab test	$176.00	$ 126.72	28%	$ 116.16	109%	92%	$ 88.00	69%
Comprehensive Metabolic Panel- lab test	$317.00	$ 228.24	28%	$ 209.22	109%	92%	$ 158.50	69%
TSH- lab test	$164.00	$ 118.08	28%	$ 108.24	109%	92%	$ 82.00	69%
Venipuncture- blood draw	$60.00	$ 43.20	28%	$ 39.60	109%	92%	$ 30.00	69%
Totals and averages	**$4421.00**	**$3183.12**	**28%**	**$2917.86**	109%	92%	**$2210.50**	**69%**

Appendix III - Minnesota Transparency Statutes – Section 62J

62J.81 DISCLOSURE OF PAYMENTS FOR HEALTH CARE SERVICES.

Subdivision 1. Required disclosure by provider.

(a) A health care provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed to by that designee, shall, at the request of a consumer, and at no cost to the consumer or the consumer's employer, provide that consumer with a good faith estimate of the allowable payment the provider has agreed to accept from the consumer's health plan company for the services specified by the consumer, specifying the amount of the allowable payment due from the health plan company. If a consumer has no applicable public or private coverage, the health care provider must give the consumer, and at no cost to the consumer, a good faith estimate of the average allowable reimbursement the provider accepts as payment from private third-party payers for the services specified by the consumer and the estimated amount the noncovered [sic] consumer will be required to pay.

(b) In addition to the information required to be disclosed under paragraph (a), a provider must also provide the consumer with information regarding other types of fees or charges that the consumer may be required to pay in conjunction with a visit to the provider, including but not limited to any applicable facility fees.

(c) The information required under this subdivision must be provided to a consumer within ten business days from the day a complete request was received by the health care provider. For purposes of this section, "complete request" includes all the patient and service information the health care provider requires to provide a good faith estimate, including a completed good faith estimate form if required by the health care provider.

(d) Payment information provided by a provider, or by the provider's designee as agreed to by that designee, to a patient pursuant to this subdivision does not constitute a legally binding estimate of the allowable charge for or cost to the consumer of services.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this subdivision.

Subd. 1a. Required disclosure by health plan company.

(a) A health plan company, as defined in section 62J.03, subdivision 10, shall, at the request of an enrollee intending to receive specific health care services or the enrollee's designee, provide that enrollee with a good faith estimate of the allowable amount the health plan company has contracted for with a specified provider within the network as total payment for a health care service specified by the enrollee and the portion of the allowable amount due from the enrollee and the enrollee's out-of-pocket costs. An estimate provided to an enrollee under this paragraph is not a legally binding estimate of the allowable amount or enrollee's out-of-pocket cost.

(b) The information required under this subdivision must be provided by the health plan company to an enrollee within ten business days from the day a complete request was received by the health plan company. For purposes of this section, "complete request" includes all the patient and service information the health plan company requires to provide a good faith estimate, including a completed good faith estimate form if required by the health plan company.

Subd. 2. Applicability.

(a) For purposes of this section, "consumer" does not include a medical assistance or MinnesotaCare enrollee, for services covered under those programs.

(b) For purposes of this section, a good faith estimate is not:

(1) a guarantee of final costs for services received from a health care provider; or

(2) a final determination of eligibility for coverage of benefits or provider network participation under a health plan.

62J.812 PRIMARY CARE PRICE TRANSPARENCY.

(a) Each provider shall maintain a list of the services over $25 that correspond with the provider's 25 most frequently billed current procedural terminology (CPT) codes, including the provider's ten most commonly billed evaluation and management codes, and of the ten most frequently billed CPT codes for preventive services. If the provider is associated with a health care system, the health care system may develop the list of services required under this paragraph for the providers within the health care system.

(b) For each service listed in paragraph (a), the provider shall disclose the provider's charge, the average reimbursement rate received for the service from the provider's health plan payers in the commercial insurance market, and, if applicable, the Medicare allowable payment rate and the medical assistance fee-for-service payment rate. For purposes of this paragraph, "provider's charge" means the dollar amount the provider charges to a patient who has received the service and who is not covered by private or public health care coverage.

(c) The list described in this subdivision must be updated annually and must be posted in the provider's reception area of the clinic or office and made available on the provider's website, if the provider maintains a website.

(d) For purposes of this subdivision, "provider" means a primary care provider or clinic that specializes in family medicine, general internal medicine, gynecology, or general pediatrics.

(e) No contract between a health plan company and a provider shall prohibit a provider from disclosing the pricing information required under this section.

62J.82 HOSPITAL INFORMATION REPORTING DISCLOSURE.

Subdivision 1. Required information.

The Minnesota Hospital Association shall develop a web-based system, available to the public free of charge, for reporting the following, for Minnesota residents:

(1) hospital-specific performance on the measures of care developed under section 256B.072 for acute myocardial infarction, heart failure, and pneumonia;

(2) by January 1, 2009, hospital-specific performance on the public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with infection control practitioners; and

(3) charge information, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association.

Subd. 2. Website.

The website must provide information that compares hospital-specific data to hospital statewide data. The website must be updated annually. The commissioner shall provide a link to this reporting information on the department's website.**§**

Subd. 3. Enforcement.

The commissioner shall provide a link to this information on the department's website. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner of health may require the hospital to do so in accordance with section 144.55, subdivision 6.

62J.823 HOSPITAL PRICING TRANSPARENCY

Subdivision 1. Short title.

This section may be cited as the "Hospital Pricing Transparency Act."

Subd. 2. Definition.

For the purposes of this section, "estimate" means the actual price expected to be billed to the individual or to the individual's health plan company based on the specific diagnostic-related group code or specific procedure code or codes, reflecting any known discounts the individual would receive.

Subd. 3. Applicability and scope.

Any hospital, as defined in section 144.696, subdivision 3, and outpatient surgical center, as defined in section 144.696, subdivision 4, shall provide a written estimate of the cost of a specific service or stay upon the request of a patient, doctor, or the patient's representative. The request must include:

(1) the health coverage status of the patient, including the specific health plan or other health coverage under which the patient is enrolled, if any; and

(2) at least one of the following:

(i) the specific diagnostic-related group code;

(ii) the name of the procedure or procedures to be performed;

(iii) the type of treatment to be received; or

(iv) any other information that will allow the hospital or outpatient surgical center to determine the specific diagnostic-related group or procedure code or codes.**§**

Subd. 4. Estimate.

(a) An estimate provided by the hospital or outpatient surgical center must contain:

(1) the method used to calculate the estimate;

(2) the specific diagnostic-related group or procedure code or codes used to calculate the estimate, and a description of the diagnostic-related group or procedure code or codes that is reasonably understandable to a patient; and

(3) a statement indicating that the estimate, while accurate, may not reflect the actual billed charges and that the final bill may be higher or lower depending on the patient's specific circumstances.

(b) The estimate may be provided in any method that meets the needs of the patient and the hospital or outpatient surgical center, including electronically; however, a paper copy must be provided if specifically requested.

62J.824 FACILITY FEE DISCLOSURE

(a) Prior to the delivery of nonemergency services, a provider-based clinic that charges a facility fee shall provide notice to any patient stating that the clinic is part of a hospital and the patient may receive a separate charge or billing for the facility component, which may result in a higher out-of-pocket expense.

(b) Each health care facility must post prominently in locations easily accessible to and visible by patients, including on its website, a statement that the provider-based clinic is part of a hospital and the patient may receive a separate charge or billing for the facility, which may result in a higher out-of-pocket expense.

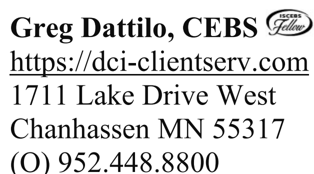
(c) This section does not apply to laboratory services, imaging services, or other ancillary health services that are provided by staff who are not employed by the health care facility or clinic.

(d) For purposes of this section:

(1) "facility fee" means any separate charge or billing by a provider-based clinic in addition to a professional fee for physicians' services that is intended to cover building, electronic medical records systems, billing, and other administrative and operational expenses; and

(2) "provider-based clinic" means the site of an off-campus clinic or provider office, located at least 250 yards from the main hospital buildings or as determined by the Centers for Medicare and Medicaid Services, that is owned by a hospital licensed under chapter 144 or a health system that operates one or more hospitals licensed under chapter 144, and is primarily engaged in providing diagnostic and therapeutic care, including medical history, physical examinations, assessment of health status, and treatment monitoring. This definition does not include clinics that are exclusively providing laboratory, x-ray, testing, therapy, pharmacy, or educational services and does not include facilities designated as rural health clinics. (Passed 2019)

Contact Information & Bio

Greg Dattilo, CEBS 
https://dci-clientserv.com
1711 Lake Drive West
Chanhassen MN 55317
(O) 952.448.8800

Greg Dattilo: Since 1975, Greg Dattilo has served as an employee benefits consultant offering health insurance coverage to thousands of Americans. He is the founder and Chief Executive Officer of Dattilo Consulting, Inc., and ClientServ, LLC of Minneapolis, Minnesota.

A lecturer on insurance and health care issues, Greg is the co-author with Dave Racer of four national books about the U.S. health care system (with more than 150,000 copies in print): *Your Health Matters: What you need to know about US health care* (2006), *FACTS: Not Fiction, What really ails the U.S. health care system* (2007), *Why health care costs so much: The Solution-Consumers* (2009), and *Why health care costs so much: Governments' Real Role* (2010). The two have written numerous other articles on health care reform together.

Dattilo earned the Certified Employee Benefits Specialist (CEBS) designation in 1993 from the University of Pennsylvania's Wharton School of Business. Dattilo was named a Fellow of the International Society of Certified Employee Benefits Specialists in 1995. He earned a bachelor's degree from the University of Wisconsin-Stout, Menomonie, Wisconsin.

In 2011, the Minnesota Association of Health Underwriters (MAHU) elected Dattilo as its President. He also has served as the Chair of MAHU's Legislative Committee.

In 2009, MAHU awarded Greg the John J. Symanitz Award for his outstanding leadership and innovation. He is a member of the National Association of Health Underwriters.

Dave Racer, MLitt
https://daveracer.com
1536 Barclay St, Ste A-1
St Paul MN 55106
(O) 651.330.2792

Dave Racer, MLitt: Dave Racer, MLitt, received his Master of Letters Degree from Oxford Graduate School in 2009. Dave's master's thesis is titled *A Comprehensive Approach to Health Care Reform in the United States: 25 Keys to Understanding the Challenges.*

Dave is a writer, researcher, publisher, speaker, and teacher. He has written and/or edited more than 50 books, 21 of which focus on health care and health finance issues, five, including this publication, co-authored with Greg Dattilo.

Since 2006, Dave has been speaking across the country about health care reform, including reporting on legislative and congressional actions related to the financing and delivery of medical care.

Dave is a member of the National Association of Health Underwriters and its Minnesota chapter, MAHU. He is a member of the Board of Directors of the Minnesota Physician-Patient Alliance, and a healthcare advisor to the Heartland Institute.