# CITIZEN CENTERED HEALTHCARE

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Free Markets Free People
A Framework Publications Whitepaper

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# INTRODUCTION

**The current healthcare market suffers** from a lack of competition and pricing transparency. Limited consumer options allow the providers and insurance companies to unfettered pricing power. The consumer has very limited ability to shop for medical services based on price and quality.

Halle Tecco, in her book "Massively Better Healthcare", states "The U.S. healthcare system is so vast it's fair to ask whether it's really a system at all, or more like a patch work of many systems stitched together." She goes on to say "it's so large, if U.S. healthcare were it's own economy, it would rank as the fourth-largest country in the world." She makes a great point about the vastness of healthcare.

Many consumers feel it doesn't serve them and the costs are overwhelming. Insurance helps but its cost is overwhelming too. The costs have risen at a significant rate every year for several decades. Massively expensive healthcare is the same as no healthcare at all.

Americans are competent consumers. We know how to research what we buy. When we are empowered, we know how to get the most for our money and we can sniff out a bad deal very quickly. In aggregate, the consumer is a powerful force; a force that has been negated in healthcare.

The intent of this document is to present one perspective on how to rebalance the pricing power in healthcare. It is written from a consumer's perspective; a citizen's perspective. It is not intended to evaluate the effectiveness of any one healthcare philosophy or treatment. Many have written about these topics in the past and many will in the future.

This document covers some information about stakeholders and how they interact. It covers ideas about healthcare provider pricing as well as pharmaceutical and medical device pricing. It covers ideas about the pricing of insurance and medical plans. It covers some thorny issues the industry faces with some resolution ideas.

As a self-governing people, we must decide to take the initiative to solve our problems. That's the way freedom works. Playing the victim surrenders our freedoms and allows an autocratic elite to rule our lives.

# STAKEHOLDERS

In the book "Overview of the US Healthcare System" The authors, Whitney Hamilton and Thomas A. Clobes, define five (5) key stakeholders:

1. **Healthcare Consumers** – The recipients of healthcare services. Also known as patients, insureds, citizens, individuals.
2. **Insurers and Payers** – The entity that insures or pays for healthcare services render to the consumer. Examples are private insurance companies, government programs (e.g., Medicare, Medicaid), and self-insured employers that finance healthcare services. Insurance companies are also known as insurance carriers.
3. **Healthcare Providers** – All the individuals and organizations that provide healthcare services to the consumer. Examples are Physicians, nurses, hospitals, clinics, and other healthcare professionals and organizations that deliver direct patient care.
4. **Medical Suppliers** – The companies that supply and distribute medical supplies, devices, and medications.
5. **Policy-Makers and Regulators** – The Federal, State and Local Authorities that establish rules to protect the health of the population and ensure safe healthcare delivery. Examples are Department of Health and Human Services (HHS), the Centers for Medicare and Medicaid Services (CMS), and state health departments.

Most other sources of information about the healthcare industry define a similar list. This list is generally accepted as the stakeholders. Let's talk about the concept of agency.

Agency is the ability to make decisions and act independently. Agency is a key part of freedom. Do healthcare consumers have agency in our medical system?

The customer is person who pays you. Product offerings and customer satisfaction efforts focus on the needs of the payor. Businesses who listen to and are responsive to their customers survive and thrive.

In healthcare, the stakeholder that pays is the Insurer or Payer. They work with the provider to make decisions about the consumer's healthcare. Payers fund the medical provider directly without seeking the consumer's approval.

In addition, the insurance company requires advance authorization of most surgeries and treatment plans. The patient does not have much say. In fact, if the patient objects to a course of treatment they can lose access to care. The insurance company decides how much the Healthcare Provider or Medical Supplier gets paid, under what conditions, and when the payment will happen.

So, the answer is No, the patient does not have agency. US Citizens have no agency in their healthcare system.

Many doctors adhere to professional ethics and build good relationships with patients; some don't. Suppliers focus on insurance and regulatory approval, and patient outcomes are a lower priority. The incentives work against the focus on patients. Appointments are cut short. Health data unchecked.

One fundamental problem is that the Consumer and the Payer are separate stakeholders. Is there another industry with a stakeholder profile like this? I don't know of one. Again, the patient has no agency.

Another problem is that Employers are not considered to be a stakeholder. Employers with 50 or more employees are required to offer health insurance with minimum essential coverage. Smaller employers struggle to hire quality employees if they do not offer health insurance.

Many employers are self-insured. Third-party administrators (TPA) manage healthcare for these employers, and many have reinsurance coverage for large claims or spikes in medical costs in a given year. TPA provide actuarial services to estimate the costs on a monthly basis per employee. These function like premium. Aetna and Cigna are examples of companies that offer TPA services.

Employers are stakeholders, full stop. Employee health is critical to businesses and other organizations. Employers, like consumers, do not have a say in the care that is provided or the cost of the care. They do not have a review point on the effectiveness or quality of care. Employers are impacted by the general health of the US population.

In conclusion, the stakeholders who have the decision authority and most of the power do not have a vested interest in health outcomes.

# PROPOSAL

**The proposal is** to change the rules to bring more balance between the stakeholders. Consumers need more agency, options, transparency, and decision authority. The new rules would impact provider and supplier pricing, consumer options for insurance coverage, premium cashflow, claim cashflow, and information available to consumers. It would increase accountability. The eight (8) tenants of the proposal are:

1) Standardized, publicly available, pricing
2) Consumers approve billing
3) Public eligibility for large group plans
4) Health accounts for premium, care, and claims
5) Health insurance carrier as primary insurer
6) Perpetual, all-inclusive coverage with limited premium increases
7) Standardized outcome and patient satisfaction process
8) Uninsured people receive care with accountability

These will fundamentally shift the balance of power among the stakeholders, put downward pressure on prices, and provide more transparency. It will enable consumers to shop and decide on their care; providers would have more funding assurance, so they can focus on care. And insurance companies can focus on managing risk.

Let's expand on each tenant.

## STANDARDIZED, PUBLICLY AVAILABLE, PRICING

Medical pricing needs to be simplified and have rules that enable supply and demand to optimize pricing. It also needs to be transparent with published prices for all products and services. Providers need to give good faith, up-front estimates for significant procedures like surgeries and courses of disease treatments. A new pricing model would categorize medical prices into 8 groupings, three (3) for providers, two (2) for suppliers, and three (3) aggregate services. These are summarized in Table 1.

| # | Type | Description | Pricing | Regulator |
|---|---|---|---|---|
| 1 | Provider | Doctors and other Licensed Professionals | Time | State |
| 2 | Provider | Facilities: operating rooms, hospital beds | Time | State |
| 3 | Provider | Medical Tests – Facility Based<br>Medical Tests – Lab Based | Product | State<br>Federal |
| 4 | Supplier | Pharmaceuticals | Product | Federal |
| 5 | Supplier | Medical Devices | Product | Federal |
| 6 | Aggregate | Medical Procedures | Product | State |
| 7 | Aggregate | Disease Management | Treatment Course | State |
| 8 | Aggregate | Emergency Services | Time | State |

*Table 1 – Medical Pricing Categories*

Pricing Rules:

1) Everyone pays the same price
2) Prices filed with regulators
3) Price is all inclusive
4) Billing is separate from diagnosis codes
5) Prices made public
6) Claims paid on the filed price
7) Aggregate services provide good-faith estimate up-front

Everyone pays the same price and the price is filed with regulator. If a provider or supplier discounts their price, the filed price would be adjusted to the discounted price. The provider or supplier would be required to issue refunds for payor or customers who paid the higher price. Insurance companies would pay claims based on the list price not a separately negotiated price.

Prices would be available to the public and filed with a regulator. Providers, facilities, facility-based medical tests, and aggregated services would be filed with the state regulators. Medical Devices, pharmaceuticals, and remote lab-based tests would be filed with the federal government.

The prices could be updated only once per year and be subject to a review process. The review process would allow individuals, advocates, insurance companies, regulators, government agencies, and employers to provide written objections. Also, some rules may apply to price changes. One rule might limit price increases for products and services without competitors. Regulators would finalize

pricing.

Pricing is all inclusive. Professionals would be priced by the hour. The rate would include all the supporting, non-medical administrative staff, the cost of medical office facilities, and all incidental supplies that are not pharmaceuticals or medical devices. Billable time is time dedicated to one patient focused on care activities including diagnosis, consultation, and treatment.

Facilities like operating rooms would be priced by time in use. The hourly rate would include equipment, surgical tools, nursing, administrative staff, and incidentals. Pharmaceuticals and medical devices would be separate line items. A similar all-inclusive model would apply to hospital beds, recovery rooms, and nursing home rooms.

A medical test is a procedure or test used to check your health, diagnose a disease, or monitor a condition. Tests can range from simple physical exams and blood samples to more complex imaging like X-rays and MRIs. Complicated tests that require a surgical procedure like a biopsy would be considered a Medical Procedure instead rather than a test.

Each test would have a specific price, and the price would include all incidentals, equipment, and labor hours to execute the test. It would also include the professional expertise to interpret the results. If the test is facility-based like an MRI, then each company, facility, and test could have only one price. For tests that are not facility based, like a blood test with a remote lab, the company and product can only have one price globally.

Pharmaceuticals would be priced by the product and adjusted proportionally by the dosage. Each company and product could have only one price globally. Similar rules apply to Medical Devices. Rebates to retailers or claim processors would become illegal.

An aggregated healthcare service combines services, facilities, and products into a bundle. These are medical procedures, disease treatment, and emergency services. Each of these would provide a price. Emergency services would provide an hourly rate that is all-inclusive. The bill may include the hours of usage along with pharmaceuticals and medical device line items. Medical procedures would bundle a surgeon, operating room, medical devices, and pharmaceuticals to deliver one operation. Disease Treatment would work the same way.

Healthcare pricing is out-of-balance. This plan would bring structure and

simplicity. It would enable the free market to function. Where monopolistic pricing power exists, it provides a way for all stakeholders to have a say and empowers regulators to act. This will provide downward pressure on prices.

## CONSUMERS APPROVE BILLING

Today, when a significant medical expense happens, the bill is sent to the insurance company, and the insurance company pays it without consulting the patient. The patient does not have an opportunity to review it for accuracy. Frequently billing details are not shared with the patient bypassing a significant check and balance.

Let's move to a new process that elevates the patient's role, providing the bill to the patient first. The bill would be required to include the details of all services and products along with the price calculation. The patient would then review it for accuracy and approve it. It would then be sent to the insurance company and the governing body.

The amount the patient approved would be charged to the patient's Health Account and settled within a few days. The provider would be paid quickly. The insurance company would then process the claim and deposit the claim amount into the Health Account. (more on the Health Account later)

Disputed items would be withheld from payment and claims processes. A dispute process would include information requests, service quality inquiries, and delivery validation. The provider and the patient would attempt to work through the issue. If not, a formal dispute process would be used involving the regulators and the insurance company.

The billing information sent to the regulators would be used for analysis and compliance. This information would also be released to the public with patient identifying information redacted.

## PUBLIC ELIGIBILITY FOR LARGE GROUP PLANS

Coverage choice is currently very limited. People with insurance through their employer have limited choice among a few carriers and plans. People that secure health insurance independently have one or two carriers in many states. Some areas have a few more but still quite limited.

Group Health Plans cover employees of a particular company or government

group. Many people like these plans because the coverage is good and the deductibles and the cost to the employee is reasonable. Large employers have the leverage to negotiate with carriers for lower premiums. Small employers and individuals have no leverage.

To level the playing field let's increase the options for everyone. Thousands of Group Health Plans exist. Nearly every private employer has one. Government employers have them.

The proposal is to transition all group plans with over 5,000 people into publicly available plans. Individuals would be able to join the Employer Plan of their choice. Each of these plans would transition to a separate legal entity while remaining sponsored by the employer. The plan for all government entity employee plans would transition this way also. Employers continue to subsidize their employees' healthcare as they have been.

The choices available to everyone would greatly expand. So, anyone could join the Federal Employee Health Plan or the US Congress Health Plan. Each Fortune 500 US company would have a publicly available health plan. State employee plans would be available to residents of the State and city employee plans would be available to residents of a city.

Employers who offer to subsidize health care for their employees would be required to provide the same subsidy to all employees regardless of their health plan choice. So, if a Microsoft employee chose the Apple Health Plan, Microsoft must provide the same health plan subsidy they do to other employees.

Health plans premiums would be flow through the Health Account. The employer would deposit the amount withheld from the employees pay and the subsidy amount into the Health Account. The Health Plan would withdrawal the premium from the Health Account. This increases the transparency of the premium and subsidy. Everyone would know what the plans cost, not just their share.

## HEALTH ACCOUNTS FOR PREMIUM, CARE, AND CLAIMS

Health Savings Accounts exist today and many people have them. These accounts would play an expanded role and work as a clearing account for premiums and claims. Medical Expenses would be paid to providers from this account, and claims would be deposited into it.

Employers and employees would deposit premium dollars into the Health

Account, and the insurance company would draft the account for the premium amount. It would work the same way for self-employed and other individuals not associated with an employer for health insurance.

This expanded Health Account would have a debit card to pay for medical expenses. Only certain types of vendors would be able to charge the card. These vendors would have active filing with a State or the Federal Government. These are authorized medical vendors.

## HEALTH INSURANCE CARRIER AS PRIMARY INSURER

Determining financial responsibility for health care expenses can sometimes delay or prevent vital, lifesaving care. This is especially true for car accidents and workplace injuries. In some cases, the patient cannot make decisions because they are incapacitated.

The proposal would define the individuals Health Insurance as the primary coverage regardless. If it is later another person or business has liability, the individual's health insurance company would pay the claim, then subrogate to the liable party. This would allow the provider to focus on care instead of how they are getting paid.

## PERPETUAL, ALL INCLUSIVE COVERAGE WITH LIMITED PREMIUM INCREASES

For individuals and small employers, the threat of non-renewals is real. Substantial premium increases function the same as non-renewals. Such events can threaten the ability to sustain the business as a going concern. It can lead an individual or family to bankruptcy. Perpetual coverage would end this. Coverage would only be canceled for non-payment of premium. Premium increases would be limited over any 12-month period.

An insurance company would be required to pay claims for all licensed, registered providers. Same is true for any FDA approved pharmaceutical or medical device. Carries would be able to define a list of exceptions. Regulators would have authority to overrule the exception. This is all-inclusive coverage.

Just like health products and services, Health Insurance Plans need to have transparent pricing. The plans would file their premiums with the State. Plans offered in multiple states would file premiums with each state. So, the Federal

Employee plan would file with all 50 states. Same for the US Congress Plan.

Plans would also provide supporting information in determining their premium amounts. Examples might include cost numbers for medical incidents by region, the price assumptions for various services, and overhead costs. This information is vital to understanding trends in our health and associated costs.

## STANDARDIZED OUTCOME AND PATIENT SATISFACTION PROCESS

Effective systems have checks and balances. The Healthcare system lacks these. It is difficult to get a second opinion because appointments are not available in a timely manner and Doctors are reluctant to contradict one another. Dissatisfied patients have few avenues to express themselves.

The proposal is to provide a customer satisfaction survey with each medical bill. It would cover topics like, did the Doctor take adequate time to evaluate my health, listen to my concerns, and evaluate the health data I provided? Did the Doctor and staff treat me with respect? Was my medical issue addressed? Was the billing clear and accurate? Was the Doctor knowledgeable in the field and did he provide relevant health information?

Consistent and insightful surveys can provide valuable information. Patients can review this to raise quality concerns and switch providers. Insurance companies and regulators can use these to evaluate trends with specific doctors, facilities, and providers.

Pharmaceutical and device manufacturers would also have surveys associated with their medical bills. This can answer questions about effectiveness, quality, and side effects. Surveys would be filed with regulators.

Surveys provide good information about the patient's experience. Outcomes are different, these involve a professional evaluation of the results of medical treatment. It would involve an evaluation by a medical doctor and may include additional medical tests.

The proposal is to establish a group of medical professionals and services offerings that evaluate outcomes. These providers would have separate billings and be covered by insurance. Significant treatments would require outcomes evaluations. Examples are surgeries, physical therapy, and pharmaceuticals treatments lasting more than 90 days.

Outcome evaluations would be independent and blind. The provider of outcome services would not be known by the original service provider, and vice versa. The outcome report would be filed with the regulators and used to evaluate the courses of treatment, the quality of products, and the provider's execution.

Survey and outcome information would be made available to the public with patient identification redacted.

## UNINSURED PEOPLE RECEIVE CARE WITH ACCOUNTABILITY

There are many reasons that an individual may not have health insurance. This can present a problem if the person shows up at a medical facility needing urgent or emergency care. Medical Professionals need to focus on the care and not on getting paid. And patients want them to focus this way also.

The individual or their family member would be given an opportunity to sign up for a Health Insurance and a Health Account. The individual would be required to meet some basic requirements such as clear identification and US Citizenship. Policies issued this way would have some special rules. Claim payments may be delayed and it may have premium surcharge.

If the individual refuses and they cannot pay the bill, the provider can detain them and issue them a citation to appear in court. The judge can assess the situation and require payment or request State assistance and case worker. The State would pay the provider. Those with addictions and mental health issues can be enrolled in a recovery or care program.

Every year people from other countries receive health care services without paying for them. Who bears the cost? Everyone, through higher taxes and healthcare costs. Hospitals should be able to provide emergency care without bearing the brunt of the cost.

The proposal is to define clear procedures to enable the provider to be paid. It would allow the individual to pay for the care at point of service. If the individual is not a US Citizen and doesn't provide payment, the hospital would detain the individual and contact the US Immigration Service.

US Immigration would work with the Visa sponsor to cover the cost. The Visa approval process should require proof of health insurance. If neither of these options are available, US Immigration would pay the bill and start deportation proceedings and request payment from the country of origin.

The provider would file this bill with regulators including a non-citizen designation and its payment status. This would be made available to the public with patient identifying information redacted. It is important for regulators and the public to quantify these costs.

# CONCLUSION

This proposal rebalances the power among the stakeholders in Healthcare. It is Citizen Centric. Regulators play an expanded role in collecting information and making it available to the public. Regulators enforce a pricing scheme that enables the free market to set prices. Regulators are not setting the prices, providers and suppliers are. The process enables other Stakeholders to influence prices. This replaces the super-secret negotiations between payors, providers, and suppliers.

Summary of benefits:

- Consumers gain agency
- Providers get paid faster
- Insurers focus on risk mitigation, process efficiency
- Small business employers, employees and individuals gain options
- Insurers set premium rates based on predictable pricing
- Consumers can shop with better price and quality information
- Transparent pricing enables free market to set prices
- Providers can focus on care rather than how they get paid

This Framework Publications whitepaper seeks to start a conversation about how this can work better for the American people. Constructive, fact-based feedback is welcome.