HealthCare Reform 2.0

Beyond the Partisan Divide Lies Pragmatic Solution

We have evolved a belief that we have a system for the delivery of healthcare but, it's not a system at all. It is a collection of self-predatory practices and methods that promulgate massive increases in costs, erosion of effective checks and balances and exponential unintended consequences.

Only by actually developing a system that addresses our mythical beliefs, puts reasonable systemic checks and balances on our wants and desires and reallocates the delivery and cost of care can we hope to achieve what we seek.

A system to make available affordable effective care for all, an efficient and cost effective safety net and significant reductions in the cost of care to individuals, and to America, can be created. This paper outlines what we need to do to realize such a solution.

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TABLE OF CONTENTS

HEALTHCARE REFORM 2.0

BEYOND THE PARTISAN DIVIDE LIES PRAGMATIC SOLUTION

EXECUTIVE SUMMARY

It is now crystal clear that the methods, some would say madness, that we have promulgated over the past 200 years to define the mechanisms to provide needed healthcare to Americans have both worked spectacularly, and miserably, depending on your perspective and measures. America's healthcare system has become a collection of practices, methods, and mechanisms that neither integrate nor properly manage the efficient, effective and appropriate level of care that citizens need nor does it provide an appropriate method to deliver the care we want.

During the same 200 years, our overall understanding of America and our expectations of services have significantly shifted. We now expect significantly more from our country – and by extension its governmental structures: federal, states and commonwealths – than we did at its founding. We no longer value the role of tolerance in compromise as we once did. This has led to a frozen governmental structure where we are trapped between two ideological extremes. Everything we now attempt to do becomes locked in an all or nothing outcome based approach. The latest healthcare legislation, and more recent proposals, can be seen as the culmination of this dysfunctional approach.

For a variety of historical reasons, all seemingly reasonable and appropriate at the time, we have adopted a series of changes, often in the form of rules and laws, to try to affect corrections to one part of this non-system or another. All of these approaches, in the parlance of medicine, have affected the symptoms of the disease but they have not cured the underlying fundamental problems.

In order to correctly define an effective, cost efficient, and appropriate healthcare system for all Americans, we must first address the fundamental issues, disconnects, and problems of our historical non-system. In order to begin to actually address the needed fundamental fixes – therefore deal with the disease not the symptoms – we need to first identify and agree on what the fundamental problems are.

As a result of the recognition of this two-step need, this paper is divided into two sections: Problems and Solutions.

PROBLEMS

America has a largely mythical set of beliefs about our healthcare system. While we have collectively often agreed on a set of goals, our system has failed to develop methods or legislative fixes to achieve any of them. When we have failed to achieve the goals, we have simply reset them and rewritten our history. We have historically adopted a mindset, that only through legislation, both state and federal, can we develop a system to provide the healthcare that we need. We have adopted concepts, based more on sound bites like "single payer," that confuse ideological beliefs with real solutions because this frees us from having

to deal with the messy details. Sound-bite solutions are always easier to sell to the American people at a political level.

We have a flawed understanding of the actual cost of the healthcare we receive due to a false healthcare economic structure. We have constructed a measurement, funding and delivery system that is now self-propagating, self-predatory and inaccurate in the extreme. This leads us to believe that our healthcare system is much worse than almost everyone else's on the planet; and that because we are the greatest, most prosperous nation on the planet, we can somehow afford to continue to demand and receive more of what we want – It's not, we aren't and we cant.

We believe we have cost effective, efficient and appropriate roles and responsibilities for the various providers in the healthcare continuum – We Don't!

We believe that technology has played a key role in the cost efficient delivery of care we need – for the most part it has not. Technology has delivered many significant gains in viability and quality of life but often the cost has been exorbitant.

We believe that the care that is available to us today has advanced so far in the past 50 years that modern healthcare can cure us of almost anything. We believe that providers have the education, training and available knowledge to deliver not just the care we need to survive but the care we want to have a better quality of life; and our additional wants do not add much to the cost – They can't, they don't and they do!

We either believe the government should control and deliver to us all the care we want equally, regardless of our individual contribution, effort or lifestyle; or we believe that the government has no role in our lives and it should all be on us for what we need and want – the answer lies somewhere in the middle, likely best bifurcated somewhere between our needs and our wants.

We believe that Employer Sponsored Insurance (ESI) and managed groups and networks have lowered healthcare costs, brought us some level of increased benefits and as a result we have been insulated from rising costs and prices due to greed – they have not!

We believe co-pays and deductibles are both the necessary effect of rising costs and somehow have helped lower our cost of care, as seen in the premiums we pay; and also have been a vehicle for us to become more responsible in our utilization of services – they have not!

We believe that the current system can lower care costs and reduce our incidence of financial collapse by transference of these costs to the government, or someone else – they won't!

We believe that the affordability of government's payments for services through Medicare and Medicaid is somehow fixable and can be sustainable – it's not!

We believe that most of the money we spend on care goes to effective treatment – it doesn't!

We believe that the programs we have demanded our government put in place to help the poor and middle class have actually helped the poor and middle class – they have not!

We believe that we cannot fix the effect of litigation on the rising cost of healthcare without penalizing the patients that are truly harmed – we can!

The problems section provides some level of detail on the interaction of these problems, how they have come to be, and how they often combine to amplify negative results.

SOLUTIONS

This paper describes a set of solutions integrating systemic practice, controls and mechanisms to achieve resolution of and solutions for the problems identified. In addition to delivery of the original bipartisan goals;

- Available & Accessible Coverage for All (100 percent of Americans)
- Affordable Coverage for Americans
- Affordable Coverage for America
- Minimum Standard of Care
- Affordable Coverage Regardless of Pre-Existing Condition
- Affordable Coverage Regardless of Disease State
- Reduction of Overall U.S. Cost of Care
- Reduction of the Individual Cost of Care
- Ensure Coverage for the Underserved
- Provide an Effective Safety Net

A number of additional integral and specific goals have been added to assure a number of other necessary solutions to the fundamental systemic problems identified. Here are some examples;

- A solution that converts "Patients" from inactive recipients of ineffective health services, to active Participants in the selection, management, delivery and prevention of care.
- Assures price certainty, cost transparency, and full care portability
- Requires No Deductibles, no Co-Pays, no hidden fees – all cost easily defined, certain and accountable
- Provides full cost disclosure for all parts of healthcare, no hidden reimbursement systems, no rebates and no self-propagating cycles that obscure full and true cost
- Assures coverage regardless of pre-existing condition or disease state
- Delivers a system with checks and balances that select for reduction of overall U.S. cost of care as well as reduction of the individual's cost of care
- Allows no government "Death Panels" instead provides a representative citizen group of participants, facilitators, providers and sponsors that are empaneled to determine what constitutes basic health needs, treatments and therapies and establishes effective payment rates for providers under basic LifeCare Plans
- Assures appropriate, effective, and efficient delivery of basic health needs
- Effectively balances care outcomes expectations to healthcare's ability to deliver effective services.
- Delivers the ability to seek the provider(s) of their choice
- Transforms employers from the provider and manager of healthcare through Employer Sponsored Insurance to focus on wellness and prevention and facilitator to

help employees both afford basic health needs, LifeCare plans and effectively plan and save for Quality of Life Advantage services.
- Improves Participant outcomes

The resulting solution describes an effective single, but bifurcated, market system that appropriately, effectively and cost efficiently delivers the care all American people need to maintain survival, viability, and productivity to themselves, their family and community while preserving choice. Basic care that is needed for survival. Viability, and productivity will be delivered through a simple, cost effective and efficient system called the LifeCare Plan market. LifeCare Plans will not only provide a national standard of coverage assuring access, affordability and effective care, it will also form the basis of our national safety net in the same core system with no need for networks, deductibles, co-pays or fees. Integrated into the needs based system is a choice based market to provide high-value, accessible and market driven services based on the additional care that people may want and desire – the Quality of Life Care market. Both systems will be tightly integrated to provide increases in accessibility, significant reductions in cost, transparent pricing, full transportability and full coordination of all care and benefits across all available sources.

The LifeCare Plan basic care solution forms the basis of our needs based system. This system is designed to deliver our basic healthcare needs targeted at survival, viability and deliverable value to self and society. LifeCare Plans will be described by a group of citizen peers representing all of the four constituent groups needed in the healthcare continuum; Participants, Facilitators, Providers and Sponsors. While convened by the federal government, this group will maintain its integrity as a representative body working on behalf of the constituents they represent in developing a fair, cost effective, and efficient needs based delivery system. This group will establish the coverage scope and limit of the LifeCare Plan. The group will reallocate the roles and responsibilities of the providers in the healthcare continuum, they will determine the best practice protocols for all services delivered under LifeCare Plans, they will establish the reimbursement rates for the defined best practice procedures and will approve new protocols that may, from time to time, be developed with, or without, technology that improve the cost effectiveness, efficiency, survival, viability or productivity of those that receive care under this LifeCare Plan system

All insurance companies that wish to offer health insurance will be required to offer this LifeCare Plan. All plans offered will be the same. Insurers will be able to establish their own premium price for the plan they offer. Since all payments will be fixed, insurers will have no need for care networks. All licensed providers will be eligible to receive payment from any plan. All LifeCare Plans are fully transportable and follow the participants throughout their life, geographic residence or place of employment. All members of a specific insurer's LifeCare Plan will be in the same actuarial pool – no further division will be allowed. The incentives for employers to pay for insurance will be replaced with other incentives for employers to provide simple stipends to better help employees pay for LifeCare coverage, and better plan for additional coverage they may want now or later in life though Life, Health and Wellness Saving Accounts, similar to current HSAs.

LifeCare Plans will form the backbone of the national safety net and will more effectively maintain continuity of care providers to participants and to significantly lower costs due to duplicated/unnecessary services and fraud. The LifeCare market is tailored to provide the

high volume, low margin, highly efficient care necessary to provide survival, viability and productivity to self and society that we need as individuals and as a nation. This system removes the government from the direct provision of care and payment to providers; and replaces it with a system where the government provides premium payment support in an improved and coordinated system that allows for full coordination of care and benefits across all available sources; improving outcomes, access, cost effectiveness, responsibility and accountability.

Recognizing that Americans also demand choice, and that choice based markets exist in every other healthcare system in the world, whether it is government provided or not, this solution provides for a Quality of Life Care market. The Quality of Life Care market is the source of all desired healthcare beyond what is provided by the LifeCare Plan. While the LifeCare Plan market is a combination of some market driven forces and tight controls through systemic checks and balances, governmental oversight, and practice regulations, the Quality of Life Care market is much more weighted toward a free market approach.

Both systems are funded by an integrated system of employer incentives and Employee Life Health and Wellness Savings Accounts. These accounts provide a lifetime individual savings opportunity with tax incentives for compliance and penalties for non-compliance. It is anticipated that these accounts become the prime funding source for the purchase of the healthcare items people want and desire beyond what is defined as necessary in the LifeCare Plan market. People will be able to effectively save for care they may want in their elder years or pay for Quality of Life Care Advantage Plans offered by health insurance companies.

Finally, both markets are integrated into a single point of access and administration providing full coordination of care and benefits across all available sources. This system – proposed to be resurrected from the existing federal healthcare exchanges infrastructure – will additionally provide the backbone connection between Participants, Facilitators, Providers and Sponsors. Among many other benefits, the core of this system will provide a true Participant centered transaction system, improving accountability, improving participant outcomes, allowing for a better allocation of roles and responsibilities across the care continuum, lowering cost of care due to duplicated services, waste, fraud and abuse, and bringing the patient more in control of their own health. This system will make it simpler and easier for Participants to find access to the care they need, find the myriad of programs that they may be eligible for to reduce payments, allow for a simple one dynamic form system to apply and become eligible for all care and monitor and manage their care needs as their personal circumstances may change. The same system will also offer benefits to Providers and Facilitators by improving access, knowledge and information flow and tighter integration between the two in order to better manage the care of the Participants they share. This system will also offer better knowledge of, and access to, a wider range or programs and Sponsors to share the cost of coverage for any specific Participant's needs. Sponsors will also find significant benefits including the reduction in program's wasted dollars from duplicated and unnecessary services due to lack of provider coordination; and fraud and abuse due to the silo effect of the current system.

While we are sure that few will disagree with the bulk of the items described above, the devil is in the detail. Some of this detail is in the pages that follow. We hope the summary gives you enough information to read further.

In closing, the author wants to point out that while there is a strong tendency to describe these solutions as “the solution,” we all must recognize that in part, it has been the search for “the solution” that has helped damn all the prior efforts throughout our history. The other main driver of failure was the current unwillingness to flex any ideal solution to accommodate the needs or desires of others. The author believes that none of these ideas are inviolate and that they can likely be improved. If we are to gain the healthcare system we need, we now, for the first time, should undertake to define an efficient and effective healthcare system. To do so, we must remember in the words of one of our founding fathers that “it is thus compromise on the basis of tolerance for others’ opinions that lead us to good solutions . . .”

INTRODUCTION

Clearly, America is caught at a crossroads. We are now trapped between two ideological positions. Neither can find ground for compromise because as a nation the art of tolerance has been lost. I often say, "The only thing that we, as Americans, tolerate today is intolerance!" The principal of tolerance was a key characteristic that made America the leader of the free world it became.

> It is thus compromise on the basis of tolerance for others' opinions that lead us to good solutions . . .
>
> **—Benjamin Franklin**

As Franklin said, tolerance of others principals, convictions and ideals is what forms the basis for effective compromise and leads us to good solutions. It is with this as a guiding principle that this paper is offered.

What follows will be a set of principles, that encapsulate solutions for the issues and goals that have been laid out by both sides of this debate repeatedly over the past six years, beginning with the authors first encounter with a major Senate bill in 2007, and as identified in the authors reading of every formative bill from each committee whose work ultimately contributed to, or argued against, the final legislation for better or worse since then.

There is a solution. The solution will require quite a bit of work, much debate and a healthy dose of tolerance. In the end, we can find compromise that will yield a much simpler, stronger, efficient and appropriate system for Americans to get the care they need in crisis and the care they want by choice. It is in the assured concept of an effective safety net for all, integrated with American's need for choice that holds the key. Both simply cannot exist without integration as they become predatory and consuming of each other. They must exist in a manner that systemically provides certain controls, checks and balances. Price certainty, transparency, portability and effectiveness need to be codified as requirements of any solution. At the same time, effective allocation of appropriate regulation, oversight and responsibility at the federal, state and individual level also need to be integrated into any system. Any solution must provide an effective safety net for all the helpless while filtering out the clueless – who inadvertently significantly increase costs and utilization of scarce resources – and the fraudsters – who purposely game the system in order to inappropriately receive disproportionate and unnecessary gain while also consuming available resources from those who desperately need them. Finally, the solution should at its safety net, basic care level, provide the same access, scope and treatment options for all regardless of income or means with no additional hidden costs, taxes, fees or shifting of costs from one system to the other.

This can be done! It can be done relatively simply, effectively and in concert with the existing trends in care and treatment as are currently unfolding due to the adverse selection

pressures that are part of the historical healthcare system and part of the Affordable Care Act as well as preserving some of the benefits that are also being derived from the ACA law.

This paper will first attempt to identify, define and explain the issues inherent in the current system and the problems that they have caused in the prior system as well as in the ineffectuality of the PPACA and other proposed solutions. Next the paper will outline the proposed components of the solution with what we hope is just enough detail to assist the reader in understanding the dynamics of the solution and the innate checks and balances built into the solution components.

To achieve the goal that we seek, will require a Franklin style compromise, either from a renewed interest in bipartisan, bicameral solutions in Washington DC or from the real power-base of America, the American People.

H.E.L.P.S BIPARTISAN GOALS

The author's first interaction with what would ultimately become the *Patient Protection and Affordable Care Act*[1] began with the Senate bill in 2007. The current genesis of the interest, and to some extent the approach, in healthcare reform was started with the Health, Education, Labor and Pensions committee in the senate. Most of this bill was discarded during the process of debate and development by the myriad of committees who seized the opportunity to remake the American healthcare system to fit their own ideals.[2] The 2007 bill would never have won significant support in the GOP but the initial set of bipartisan goals still illustrate areas where all should find agreement and, if necessary, compromise through tolerance.

ORIGINAL GOALS

- Available & Accessible Coverage for All (100 percent of Americans)
- Affordable Coverage for Americans
- Affordable Coverage for America
- Minimum Standard of Care
- Coverage Regardless of Pre-Existing Condition
- Coverage Regardless of Disease State
- Reduction of Overall U.S. Cost of Care
- Reduction of the Individual Cost of Care
- Ensure Coverage for the Underserved
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[1] – and the follow on legislation, Health Care and Education Reconciliation Act which attempted to repair some of the systemic issues that were a result of the unique method of passage in the PPACA

[2] The 2007 bill while similarly flawed as the succeeding legislations, in the opinion of the author, was at least constructed with an eye to a more acceptable bipartisan solution and addressed some issues in a more systemic manner.

Still to this day, rhetoric aside, these are basic points of agreement. The disconnection has been in the method of their provision. While not part of the original outlined goals, it has also been clear that the additional provision of choice must be baked into any solution. While the idea of a national state healthcare system has been talked about repeatedly, all know that Americans, schooled in the free market, will also require choice. Without a strong integration of choice in any final proposal, Americans will not embrace an imposed solution regardless of the mandates or incentives. Choice must be built into the solution and integrated in a way that the exercise of choice does not become the method of payment-transfer for otherwise unsustainable expansion of basic benefits that in the end only benefit the professional politicians who propose them. We have seen this in the current system over the past 40 years where the innate cost shifting of unsustainable Medicare/Medicaid cost has translated into ever lowering and unaffordable reimbursements to providers which has led to significantly increasing private insurance premiums to provide adequate income for providers to offset the losses incurred from the inadequate Medicaid/Medicare payments. What has in effect exacerbated an already false healthcare economy where processes are undiscernible, costs unknowable and value undefinable for everyone involved – the patients, the facilitators, the providers, and the payers.

PROBLEMS

PROBLEM WITH LEGISLATIONS

Whether it was the original 2007 bill, the various pieces of legislation that came from the myriad committees in the house and senate, the PPACA and HCER that codified the current law, or the recent Burr, Coburn, Hatch Patient Choice, Affordability, Responsibility, and Empowerment Act (Patient Care Act) or the many other proposals that have come forth from both sides during the past 6 years, they all have shared a common set of underlying flaws that have doomed their ability to accomplish the original goals. All have taken the approach to provide for expansion of existing wants for care, without addressing the fundamental myths of what our modern health care continuum can effectively deliver. They have not addressed the underlying disconnect between what we all want from care and that which we can afford. They perpetuate the confusion in all of us between what we need and what we want and systemically provide equal weight for both at delivery and payment. They have not addressed the structural & administrative defects, extraneous costs, unnecessary costs & duplication of efforts and the unnecessary consumption of resources that the current methods and integration of care across the health care provider continuum exacerbate, stimulate and inculcate. Finally, none of the bills address the fundamental flaw in our healthcare system – it's not a system at all!

Patching process to treat symptoms is never a solution, never works and never finds the efficiencies to cost less and provide better. It is simply the easiest and most expedient. Further, adherence to unobtainable and unrealistic ideological tenants similarly will doom legislation and solutions. Unfortunately, this has been the case with most of the proposals that have come forth. Much of the problems in the current system are a result of hundreds of historical modification made over the past centuries that while effective for the need at the time, have cemented in many unintended consequences and conflicting rules, processes, costs and inefficiencies. Lastly, all of the proposed solutions have tried to leverage the familiar, and existing structures, infrastructures, systems, roles & responsibilities, methods and demands. In doing so, they have exacerbated the negative effects and the unintended consequences have far outweighed the tangible benefits. We have reached a point that no legislative fix will deliver us a sustainable, effective healthcare solution. It is time for a broader, simpler approach that goes back to fixing the fundamental problems and delivers on the original goals.

HEALTHCARE FOR ALL

Reaching back to the 1930s we have heard repeatedly that what people want is a Federal Single Payer system. Today, this ideal is held out as *the* thing that will provide *the* cure for what ails America's healthcare system. While oft cited, single payer is more of a sound-bite than a reality. Most who refer to Single Payer, lose the argument for single payer rapidly. This is not because what they want are bad things, it is because they have grabbed a sound bite that upon objective scrutiny doesn't support the goals they actually seek. The goal of single payer is to provide access to care for all, at the lowest possible cost with highest efficiency. These are noble goals and for the most part achievable. But, it is not the fact that there is only a single entity paying for everything that realizes these goals.

As I said, the concept of single payer is a pragmatic misnomer. When asked the following questions, it is clear that the notion of only one person paying is not what people really seek.

- Do you only want the federal government to pay for any and all healthcare procedures, medications, services etc? In other words, the states should not chip in money for things they may want to provide inside their states? This answer is – No!
- You want philanthropies and charities to stop providing services for free, or to stop providing programs that grant funding for specific diseases like HIV/AIDS or obesity, or diabetes, or cancer? Answer is usually – No I'm not saying that.
- You want drug companies to stop providing Patient Assistance Programs to pay for medications for people that can't afford them? Again, the answer predictably is – No!

One can ask many more questions about volunteers, NGOs, nonprofit clinics etc… In the end, what is clear is that people are seeking not a "single" payer after all, they want a single point of administration for all payments. Even this simple idea is only a part of what is needed to reduce fraud, waste and constrain cost. If Federal Single Payer was such a good system of control we never would have had $480.00 toilet seats, $89.00 hammers and many other overly expensive purchases. There is a role for the Federal government but there is also a role for free market forces and what is needed is a solution to balance the two.

Cost effective, affordable, price certain & transparent healthcare for all is achievable, and the effective solution is both simple and pragmatic. The solution will not only mimic the ideal of a single payer system it will apply free market forces that will continue to assure low cost efficient care to all in a fair and open manner and deliver the basic care that all people need and deserve. It will also integrate a free choice market that will allow participants to acquire additional care and options based on their own industry, achievement and priority of their own wants.

OTHER NATION'S SYSTEMS ARE BETTER - COST LESS

In short, they aren't and they don't! America's healthcare systems real costs are not measurable accurately nor are they able to be compared to other countries due to the systemic vagaries of the American system. We now estimate that the current Healthcare spend, for this year (2014), will top $3.8 trillion dollars. But this number is not a real calculation of cost. This number is assembled from reports that combine invoiced costs in some cases and actual reimbursements in other cases. Prices invoiced are historically highly inflated to compensate for a number of other hidden charges and do not reflect a fraction of what is actually paid. The problem is there is no real understanding of what is finally paid for any of these services. Invoiced rates receive actual payments of only about 22 cents on the dollar and sometimes much less[3]. Even the recorded reimbursement rates are inaccurate due to numerous mechanisms in this system. The following is just one example and this shows the effect of rebates in the nation's pharmaceutical system's real cost and pricing. Simply, many levels along the supply chain get money back from pharmaceutical companies based on the volume that they purchase in a given period. Effectively, they pay more for the

[3] Actual reimbursement rates include a number of hidden costs and backflow amounts that artificially inflate the invoice and reimbursement price.

product at the time of sale but if they reach a certain volume of purchases, they get money back from the manufacturer. These rebates flow back to pharmacies, Pharmaceutical distributors, hospitals and others often months after the actual purchase, dispensing and sale of the product. There are complicated formulas that account for how much money goes back into the supply chain post purchase. In itself, this obscures what is really paid into the system for the product. Rebates in true consumer market retail systems are not a problem because the price we consumers pay is the price we accept. But when the payment is made via a government program and not based on our own discretion and the government is mandating rebates back to itself, these rebates are a big problem! Lest we blame Pharma for this, as some method to hide pricing and make hidden profits, this is not the case. Pharmaceutical manufactures did not create this system – our government did. The biggest players in pharmaceutical rebates are the federal and state governments who demand rebates from Pharma for the drugs their benefits programs proscribe to their program participants.[4]

This example is of the California AIDS Drug Assistance Program (ADAP). Spending about $500 million per year for drugs for HIV/AIDS patients that meet their eligibility criteria you would assume that the true cost of the medications is the $500 million that California spent for the drugs. But, you would be wildly wrong! The $500 million is paid from three main sources. About 50 percent of the funding is provided to California through the federal Ryan White Care Act program – a significant portion of these funds come to the federal government from mandatory pharmaceutical rebates paid by the manufacturing company to the Center for Medicare and Medicaid Services (CMS). This government mandated rebate program assesses a rebate ranging from 17 percent to no more than 100 percent of the Average Manufacturer Price (AMP). These rebates flow back to CMS months after the provision of the medication to the program participant, purchase and payment to the pharmacy that dispensed them and processing of the claims to the state. Of the remaining 50 percent of the $500 million, this is provided by California. Slightly less than ½ of these funds are derived from the CA general budget fund (about $230 million from state taxes) the other, slightly more than ½, come from a "Special" Fund in the CA budget that is where similarly mandated rebates are paid to California by pharmaceutical companies that provide medications to participants in the CA ADAP program. Somewhere between 1/3 and ½ of the funds that are counted as payment for these medications are just artificially inflated pricing that is collected at the time of payment, flows to the manufacturer and then flows back to the state to begin the false economic cycle all over again. So, in the case of California, the true cost of the drugs provided by the ADAP program to participants is at least 1/3 less than the reported $500 million number.

A similar governmental backflow funding mechanism that generates false cost data is seen in a number of the PPACA fees structures. When fees are assessed on the costs of premiums

[4] Sources - Medicaid Drug Rebate Program - Http://Www.Medicaid.Gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Medicaid-Drug-Rebate-Program.Html, Payment For Covered Outpatient Drugs - Http://Www.Ssa.Gov/OP_Home/Ssact/Title19/1927.Htm, And 340B Drug Pricing Program & Pharmacy Affairs - Http://Www.Hrsa.Gov/Opa/Index.Html

that are then collected and used to pay for the subsidies in premiums you have a similar self-propagating and expanding cost driver.[5]

Another issue that exists in comparing U.S. healthcare spend, against let's say England or France, is that America counts all healthcare including Medicare, Medicaid, private pay, insurance, self-insurance, military and retail care through all channels of care. We do not have one system, we have many, and we count all of them indiscriminately. Most countries with central governmental healthcare are only counting the official governmental healthcare system numbers. They often do not recognize that there are also private choice based systems for people that want to buy care and can afford to purchase directly from providers outside of the governmental system. These national numbers are often significantly underreported when compared to our own.

So when we see comparisons of the cost of care in America as compared to other countries we are never looking at apple to apples comparisons, and we must realize that the number we claim we actually spent is not a true and accurate number. Taking all these corrupting factors into consideration, and eliminating the partisan bias on either side, it is highly likely that the U.S. healthcare system will fall in the upper third to middle of other nations as to cost, outcome and efficiencies. What is unequivocal is the U.S. will rank at the highest percentile for options and choice.

In order to address this problem, and to get to the point where we can truly drive effective decision making on both the "safety net" basic care side and the choice based quality of life side, we have to make changes to how these convoluted and hidden funds flow. In most cases simply eliminating them. A simple solution as contemplated by this paper can deliver low cost basic life care needs, effective choice for quality of life wants and real accountability as to what we spend and get for our money.

ROLES OF THE PLAYERS

Healthcare requires many players to help match people in need of care, to the services they require and the source of funding that is available. Today we think of the people that need the care as Patients. We have people that provide the care – we call them providers. In most cases we have a third party pay for a substantial part of the care and we call them payers. This system has evolved over 200 years. The evolution had little to do with meeting the needs of the "Patient" and in most cases changes were made to preserve or protect the business practice of one of the other constituents in the supply chain.

We have evolved a system where any transaction, regardless of the relative value, must be attended to, or signed off, by the single most expense person in the chain – the doctor. We have a system where the bulk of the doctor's activities are directed at the processes that least needs their training, expertise and innate expense and, almost insidiously, provides the lowest available compensation for the bulk of their time. In many other health supply chains

[5] In some cases the same effect can be seen in taxes that are assessed on a specific category of services that are then used to pay for the same category of services. Complicating this adverse driver is when the government uses mechanisms like Quantitative Easing to create new currency specifically to pay for services in these mechanisms.

in the world, pharmacists, nurses, nurse practitioners, therapists, and others carry more responsibility, accountability and liability, and provide more appropriate training and cost-level care for the situations encountered. As a side effect, they also provide easier and more rapid access to basic care. Conversely, America has developed a system where the most expensive person in the chain must attend to the least valuable and least important duties with equal weight, accountability and liability. It simply makes no sense. It is one of the many reasons that healthcare is so expensive. None of the legislation proposed so far has offered anything to change this paradigm. Yet, a solution to this problem is a necessary part of access and cost control as we move forward to the development of an effective healthcare delivery solution.

The doctor is one leg of the healthcare delivery system. There are four different constituent groups that must integrate into any solution to provide the basis for effective, efficient, fair and appropriate care. While all the proposals have focused on the activities of the providers and the people paying the bills, with the exception of a set of promises unrealistically expanding consumers wants and expectations. The consumers of care, those we call patients, have little accountability or responsibility for their own life or quality of life. It's time we recognize the integrated role of the four legs of the healthcare stool and develops a solution that effectively reintegrates their functions, realigns their incentives, oversees their accountability and responsibility and manages the information flow between the parties to accomplish one of the major needs of healthcare reform – reduction of cost.

ROLE OF GOVERNMENT

Government has a key role to play. The federal government is best suited to play the role where it can provide some economy of scale, monitoring, and assurance of compliance, and regulatory functions that lean more toward effective integration and resolution of issues between states, their systems and laws. State government should be responsible for the effective provision and compliance of services within the states. In this modern highly mobile world there must be integration of the regulations among the various states to assure transportability, effectiveness and transparency of care as well as the simple provision of care by the relative cohorts across state lines. States should be responsible for the control and access rules to data of entities within their states but it is up to the federal government to assure the interoperability and transportability of the data between the various states.

The federal government also has a key role in the integration of services and the promulgation of systems that improve care for all in all states through agencies that provide national monitoring and compliance related activities.

States also have a role to play in determination of the care and administration of services provided within the states, but they may not do it in a way that increases costs among the states or that significantly increases the cost of administration of a combined system within the states.

Neither states nor the federal government should be the direct provider, contractor or payer of care for the population except for military care.

HEALTHCARE SUPPLY CHAIN ROLES

1. Participant – Historically we have called the end customer of care the 'Patient' because they needed to be patient.[6] These patients, more often than not, are passive objects where providers routinely dispense procedural services in order to maximize revenue regardless of actual need, benefit or outcome. We recommend that we change the name of the healthcare consumers in this new solution to 'Participants.' In this solution, Participants are actively engaged in the entire process of treatment, they are the core determinant – or they can engage a Facilitator, described next – for the services they receive, they must make active decisions in the care process for the basic life care services they need. Participants may purchase expanded choice based care if they have taken active steps to manage their life choices in a manner that makes available funds for optional quality of life purchases they may want.
2. Facilitators – these are people that help Participants find, qualify, and access services they need or want but they do not provide services directly in the scope of care being sought.[7] Some Facilitators, are trained and paid for their services, and others are untrained and often simply volunteer. Regardless, they all share the burden of privacy and discretion as well as some other characteristics, both legal and ethical. Facilitator subgroups have very specific sets of roles, responsibilities and requirements – like maintaining the privacy of Participant information that they share across the spectrum of providers. Facilitators interact with all other players in the supply chain and provide certain value to the other constituent groups as well.
3. Providers – these are the people that provide care to Participants.[8] It is in this area where significant efficiencies and gains can be made by a re-examination of the rolls and responsibilities, and authorities to practice in a variety of areas. A realignment of rolls will significantly free currently constrained resources and drastically lower the cost for low level routine and frequent care. Realignment will also significantly free current access limits.
4. Sponsors – these are the people that pay the bill when it is due for the services delivered by the providers.[9] Sponsors have access to funds and create programs by establishing eligibility requirements – program constraints.[10]

[6] Participants may include, but are not limited to, the rich, poor, middleclass, underserved, homeless, helpless, disabled, prisoners and parolees i.e. every American.

[7] Facilitators, can be case workers, social workers, parole officers, neighbors, faith-based workers, volunteers, family members, friends and neighbors to name a few.

[8] Providers include, Doctors, Nurses, Nurse Practitioners, Therapists, Pharmacists, Emergency Medical Technicians, and others.

[9] Sponsors are the payers and include entities like, insurers, philanthropies, NPAs, NGOs, faith based organizations, charities, and volunteers, municipal, state and federal programs.

[10] Program Constraints determine what kind of participant is eligible to receive payments and under what circumstances the funds can be used to pay for the services required by the participant.

MANDATORY COORDINATION OF CARE AND BENEFITS ACROSS ALL AVAILABLE SOURCES

Numerous studies, like the 2009 Thompson Reuters, *Healthcare Analytics* study, by Robert Kelley, have shown that of each healthcare dollar, almost 60 cents of every dollar is wasted in two principal categories; Fraud and Abuse (20 cents) and Duplicated Services/Unnecessary Care (39 cents). While other studies have effectively flipped the estimate of cost between these two categories, all estimate that approximately 60 cents on every healthcare dollar is lost within these two categories. Where the actual loss occurs is moot because the same fix will accommodate both with equal effect.

Requiring a solution where all available benefits are matched to all people in need and simultaneously matching all available care to the same person in need in a truly participant centered transaction system will allow for single point of administration, simplifying identification of available programs and resources by Facilitators and Participants. Such simple access can be provided through a dynamic single form enrollment and eligibility solution continuously evaluating individual eligibility and need against all available program criteria and constraints, matching to available Providers and assuring Sponsors that their payments are not going for duplicated services. Such a solution will reduce unnecessary utilization, expense and limit fraud.

Correctly identifying all sources of reimbursement allows for an equalized allocation of benefits solution, spreading the cost among the various programs that the participant is eligible for according to predefined formulas, in conjunction with payer of last resort systems that preserve governmental resources for only those with no other options. For Providers, this also helps them identify other potential reimbursement pools for any individual Participant and eliminates their inadvertent double dip for the same service paid by multiple payer sources.

This same solution, innately provides for a Participant centered virtual care group management model. In this way, every Provider, Facilitator and Sponsor are aware of all the other members of the group working to help each individual participant. In effect, they become a virtual care group enabled to coordinate efforts to maximize the outcome for the individual in need. All care and benefits are appropriately managed, tracked and spread to effectively yield the best outcome for the fewest dollars and resources used.

Instead of taking the approach to scrap the development of the exchanges[11] we propose that the system be re-purposed to provide this coordination, resource listing, program eligibility, virtual care group management and single point of administration application service. This alone can reduce the national healthcare expenditure by at least 1/3.

[11] – currently estimated at almost $1 billion in expenditure

ACCESS TO INSURANCE REGARDLESS OF PRE-EXISTING CONDITION OR CHANGE IN DISEASE STATE

A major tenant of all the significant legislation since the H.E.L.P. bill, and despite the attacks from the edges, all parties agree that people should have access to affordable insurance (or affordable care) without regard to pre-existing condition (PEC) or change in disease state.[12] The debate has been in how to do this so it was fair to all, did not raise costs in employer and small group pools to unaffordable levels and provided adequate care to those in need.

The problem with the current system and proposed legislations are that they preserve the idea of segmenting these significantly sicker than average people into something called high risk pools and having the massively higher premium costs subsidized to make them appear affordable. High Risk pools bury the cost in a maze of extraneous revenue streams – taxes, fees, penalties, other funding sources – and provide a false understanding that somehow the rest of us are not paying for these sicker than normal individuals. They also allow insurers or others to cost shift losses to the procedures characterized by these disease states and help offset punitive reimbursement reductions in other areas. In the end, they continue to obscure the real costs, hide the effect to the individual and the economy; and lend the false belief that somehow these costs have been reduced when often the opposite is true.[13]

The belief has been that if we segment the sicker patients into separate pools then we can somehow alleviate the cost from the rest of the insured or, at least, lower the cost burden. It also allows us all to believe that our premiums are lower so we are not bearing a disproportionate cost for the sicker people. None of this is true. It is a Zero – Sum Game! High Risk pools increase the administrative costs, reduce the economy of scale, reduce the effect of wider actuarial spread, make patient mobility more difficult, and increase the likelihood of cost shifting. In effect they significantly raise the costs of care and make us pay for it via hidden methods.

The solutions proposed below, will spread these costs more effectively, lower the overall cost of care, make these premiums as affordable as any others, transparently allocate the cost of care and provide full transportability and price certainty.

PROBLEMS WITH NETWORKS

As the ACA has been implemented an already existing problem with "networks" has become exacerbated. Networks arose as a mechanism for insurers to drive down their costs by negotiating with groups of doctors and establishing a defined set of price discounts for services to lower costs. This was an extension of a historical practice. One key way to reduce costs, has been to carve out providers – or geographies – where costs were higher. Insurers,

[12] Loss of coverage due to changes in disease state can be more simply described as having your policy cancelled because you actually got sicker than the plan expected you to.

[13] Further, the current system establishes many high risk pools with specific criteria and plan rules and make movement between these pools even more difficult than between regular insurance pools. Each of the high risk pools created have different actuarial calculations and as a result have wildly varying premium costs.

in effect, simply selected the cheapest providers and dropped those who were at the higher end of the price spectrum. If a doctor wanted to continue as part of the system they were forced to reduce payment.

In the current ACA system being implemented, many doctors and hospitals are now not part of the networks that the so called metallic plans provide access to. This has caused much complaint, particularly for those who have had their previous plans cancelled and have been left without their customary care giver or local hospital as part of their new plan.

Networks have been important in the modification of the old system because insurance plans were for the most part non-transportable. Since most insurance was derived from Employer Sponsored Insurance (ESI) and since all insurance plans are defined and regulated within individual states, the concept of specific networks for specific plans has historically made sense. Further, due to the promulgation of numerous laws governing health information, physicians have often been forced into specific contracts with a large number of insurers in order to actually submit the claim and necessary information to support the claim. One of the main problems in the current and historical system is embedded in the arcane, convoluted and disintegrated connection between, patients, providers, facilitators and sponsors that evolved from historical practice, legislation and decisions made as far back as 1800s. The current mess has developed into a mechanism that has hurt patients, been significantly inconvenient, fostered corruption, increased costs and cost shifting, and provided inappropriate levels of compensation or balance across the healthcare provider system. While some procedural driven specialties have made significant gains and profit, others, and specifically general practitioners, have become unprofitable and unsustainable. Almost perversely, the very providers that have been drawn to healthcare because of a desire to serve the underserved and take care of the most fragile among us through community based DSH Hospitals[14] have found themselves and their institutions in a position that they simply can no longer take care of the underserved population exclusively. These dedicated providers are now finding that in order to get the better reimbursements they need to reduce the poor and underserved population – where improving outcomes can be close to impossible

[14] DSH stands for Disproportionate Share Hospitals – this is a program that funds hospitals that treat indigent patients. DSH Hospitals are waking up to the problem with the PPACA. The PPACA aims to reduce: Funding for the Medicaid DSH program by $17.1 billion between 2014 and 2020; Aggregate Medicaid DSH allotments by $0.5 billion in 2014, $0.6 billion in 2015, $0.6 billion in 2016, $1.8 billion in 2017, $5 billion in 2018, $5.6 billion in 2019, and $4 billion in 2020; and Medicare DSH payments initially by 75 percent and subsequently increase payments based on the percent of the population uninsured and the amount of uncompensated care provided.

PPACA further requires the Secretary to: Develop a methodology to distribute DSH reductions in a manner that (1) imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments; (2) imposes smaller reductions for low-DSH states; and (3) accounts for DSH allotments used for 1115 waivers effective October 1, 2011; and determine the best way to implement the cuts in a way that will target states that direct the lowest percentage of DSH allotments to hospitals with high volumes of uninsured and Medicaid inpatients. The 16 states considered "low DSH states" will be reduced by 25%, and all other states will be reduced by 51%.

DSH Hospitals have now also realized that the method by which compensation is tied to improving outcomes places them at significant risk for further loss of funding through the normal Medicaid/Medicare methods due to the characteristics of their populations.

due to non-health related factors and significant comorbidities – and adjust their patient mix to attract more affluent patients where they can affect outcomes and increase revenue to sustainable levels. This is directly opposite to the goals of the ACA but it illustrates the unintended consequences of developing solutions without understanding the innate systemic problems.

In order to provide full transparency, portability, price certainty, effective and fair compensation to providers, efficient safety net, wide access to effective care for all, provider choice and affordability, any solution needs to address these issues and eliminate the needs for networks if possible. Such a solution should have the goal of facilitating connections and services between any Participant, any Sponsor, and any Provider. This can be done and as you will see with many additional benefits and much lower cost.

PROBLEMS WITH CO-PAYS AND DEDUCTIBLES

Commensurate with the evolution of the historical system, copays and deductibles have emerged as a standard and expected part of our care system. The prime justification has been they provided a mechanism to drive some level of patient accountability. It has been felt that a material co-pay level would help incentivize patients to limit their utilization of services and the imposition of deductibles would further incentivize the insured to better manage their life to prevent the need for care in the first place.

Of course, these were not the only benefits seen by Providers, and Sponsors for these mechanisms. They also allowed for cost shifting and in some cases gradual reductions of benefits. They have allowed insurers – and to a great extent employers – to pretend to offer additional benefits without actually shouldering the financial costs. There has been a gradual creep of increases in benefits covered under so called ESI, over the past 50 years. As an example in the 1970s people received a more basic level of insurance coverage. Weighted to more catastrophic illness and with significant caps on total costs. Then it was typical to not include other services like vision, dental, sex reassignment, wide spread medications, routine visits, and preventive medicine to name a few. As employers sought ways to compete for the better employees, they used the promise of expanded employee benefits to do so and to offer, at first to key employees then later almost all the rest, more competitive benefits.

At first the collectivization by grouping a number of employees together in an employer pool provided for group purchase discounts and larger employers were able to offer better benefits. But soon, this advantage was consumed with rapidly expanding benefits offerings. Employer A offered vision. Employer B responded with vision and dental. The original vision add-on might have included new glasses ($50.00 frame allocation) every two years. Soon it included the cost of the examination, and new glasses every year ($100.00 frame allocation). Next, benefits increased to include expanded dental coverage. Each year, employees demanded better coverage – more things covered, and each year employers responded by demanding more from their insurance plan for their employees and insurers responded by adding more covered items into the policies and raising premiums.

As policy costs grew, at first employers just assimilated the cost and reduced what they offered new employees in salaries. Employees didn't notice the salary reductions they saw the expanded benefits as offsetting the slightly lower salary offer. The continual demand for

more benefits moved beyond the concept of just good basic healthcare in order to maintain life and production at work, to items that were more weighted toward quality of life and desired care.

Along the way, employers needed a mechanism to offset the rising costs, and insurers, under fire for escalating premium costs to employers and reducing reimbursement rates to providers, responded with the idea of deductibles and co-pays. These provided an effective way to hide the effects of the increase in demand and obscure some of the reasons as to why costs were rising. As people asked for more, or as the providers invented new and more expensive ways to treat illness, accident and diseases; costs were shifted to the employee and the provider payment was reduced by the insurance company. This was then predictably picked up by the patient in the form of co-pays.

While this may seem a good solution on the surface, it is anything but good in the overall systemic view. This method has allowed a continual increase in demand for services beyond the need for basic life care to include many items that are in the quality of life – want – category.[15]

The system now places an undue burden on the employee or insured as the routine deductibles, without subsidies – costing as much as $12,000.00 for a family of four – can alone bankrupt many families. The concept of affordable care practically goes out the window. But it need not be this way.

Our solution, is based on eliminating this corrupting system and bringing transparency to cost and pricing. It builds in effective systemic checks and balances so that the Quality of Life Care wants are segmented from the Basic Life Care needs. It reduces costs by recognizing that the Basic Life Care side needs to provide adequate care, at low cost, to a Participant. It recognizes that the Providers will need to develop a high volume, low margin highly efficient mechanism to effectively provide this type of care. The same solution also recognizes that many Participants will want to get more than basic care and provides an effective system to deliver the higher value based care effectively and relatively affordably with much more choice and access. The solution also integrates both systems to eliminate the ability for costs to be shifted between these two systems to hide the effects of benefits creep. Additionally, we recommend doing away with deductibles and co-pays entirely. In the proposed system Participants will be amply motivated to effect healthy life management and to make appropriate care choices and the true costs will be clearly visible.

PROBLEMS WITH THE COST OF SERVICE

Healthcare costs too much. This is the single unifying statement from everyone that enters into the debate of healthcare reform in America. We all believe that it costs too much because we have seen a continual escalation of cost increases in recent years. Mostly, our personal

[15] It has actually provided the opposite of an effective check and balance system. It has provided a method for our wants to transcend our needs and to bury the consequences of these decisions by obscuring the costs in a manner that makes us think there is some other root cause like insurer greed, or provider overcharge.

experience is evident either in what we pay for premiums, or how much of an increase we have seen in plan deductibles, and co-pays.

One other major influencer to our belief that healthcare costs too much is the continual barrage of stories in the media like the ones usually about an exorbitant hospital invoice that a person received for a procedure.[16]

There are three prime pathways through which healthcare providers get paid, sometimes these occur in combination.

1.) **Actuarial Method** - From a monthly premium payment, typically to an insurance company, that theoretically accrues over time in a fund – paid directly by an individual or their employer. When a service is rendered by a provider, an invoice is generated – usually at an exorbitant list price due to how the discount structure has evolved over time –the invoice is sent to the insurance company who either applies the contracted percentage discount rate to the invoice for the procedure, or pays the pre-negotiated rate for the procedure.[17]
2.) **Governmental Direct Payment** - Fees and taxes are collected by the U.S. Government, through Medicare payments and a variety of other sources either deducted from earnings.[18] These dollars are paid directly to providers for services rendered through these federal and state programs. Providers are reimbursed based on either a published reimbursement schedule or through a discount from usual and customary regional prices, discount from Average Wholesale Price (AWP), discount from Wholesale Acquisition Cost (WAC), or though some other arbitrary discount or reimbursement formula.
3.) **Self-Pay** – An individual receives services from a provider, the provider submits an invoice to the individual and the individual provides payment from their own funds, or from a special fund account like Health Savings or Flexible Spending account.[19] It is typical that even with insurance coverage, due to the deductible and co-pays

[16] Recent articles have reported of people receiving invoices ranging from $14,000.00 - $40,000.00 for an appendectomy. Another recent article decried the absurdity of a bill that equated to $500.00 per stich for the repair of a laceration of a cut to an eyebrow at a San Francisco based hospital. But in most cases, these stories are not representative of what has been typically paid for the services – unless if it was a Self-Pay patient.

[17] As stated earlier, the average reimbursement rate for the invoiced price of a service is typically less than 22 cents on the dollar. In the case of some items, like laboratory charges, the reimbursements can be significantly less than 22 cents on the dollar. We have seen documented lab bills of $450.00 that were reimbursed at $88.00.

[18] Collected through payroll taxes, assessments on insurers, or employers, Social Security taxes, premium payments for Medicare Part B & D plans, Medicaid, federal or state tax appropriations and special disease-state federal and state programs like AIDS Drug Assistance Programs (ADAP) funded through the Federal Ryan White Care Act mentioned earlier.

[19] Additionally, some patients contract for the service from the provider and arrange a payment mechanism to break the expense into easier payments sizes over a period of time.

individuals must provide, that some form of Self-pay is provided for most services rendered.

The non-integrated combination of these three systems has evolved over time as a result of attempts to fix issues in the disconnected and disjointed systems of the past. As a result, the current system causes huge problems when you try to accommodate the needs of the four cohorts in the current healthcare continuum; Participant, Facilitator, Provider and Sponsor.

PATIENTS

Actuarial Method Patients, in the current system, both before the advent of the PPACA and today have little connection to the cost of care, particularly those that have Employer Sponsored Insurance (ESI). The payments made at the time of service as Co-Pays are sold as a method to help engage the patient and limit over-utilization. The hidden reason they were enacted was to offload part of the rising cost to the individual divesting the responsibility either from the insurer or the employer, sometimes both. As a result, many patients are not engaged in controlling the cost of care. In fact, often they are incentivized to become hyper consumers. Many will opt for expensive treatments, often more elective than required, while employed.[20] Patients in the actuarial model often see the large difference between the billed price of the services and the actual payments often driving the false belief that the employer has negotiated fantastic savings. In some cases, depending on their plans, providers have recourse to the patient for the unpaid amounts. Regardless, the large disconnection between the amount charged and the amount paid tends to increase the perception that Healthcare costs too much.

Government Direct Payment Patients have even less connection to the provision of services and associated costs. With less incentive to manage the cost, even with the recent increases of Co-Pays for Medicaid patients, the utilization of services through these programs trends towards the more expensive care modalities.[21] Patients in the direct payment model often have no feedback as to the price of the services provided nor what the real cost of their services were.

Self-pay Patients are often presented with the "retail" bill for services. Most Self-Pay patients are not aware of what the usual and customary reimbursements for services typically are.[22] Historically, providers have not expected the self-pay patients to pay the full price of the invoice. Many would freely negotiate the payments over time and often forgive or forgo payment on significant portions of their bills. In the past 15 years, this forgiveness has become less evident as the Governmental direct payment model has continued to cut the actual payments to providers, including hospitals, to unsustainable levels. For a number of

[20] These patients are trained to see healthcare as a benefit from their employer and motivated to gain as much benefit as possible by using the services as often as possible.

[21] A recent study of rates of utilization of Emergency Rooms for care after the expansion of the availability of Medicaid showed an increase, as opposed to an expected decrease, in the utilization of ERs for basic care.

[22] As stated before, providers, including hospitals, usually expect to receive much less in real payment than what they are charging for services.

years the providers compensated for the continuing decline in the percentage or reimbursement by simply increasing the price of the invoiced amount so they could maintain the level of the actual payment received. As pricing system shifted to offset this adaptive mechanism, many providers moved to accepting the unsustainable level by increasing the cost to the actuarial side and the self-payer.[23] This has resulted in the current conditions that a Self-Pay patient faces. *As an example, a provider will expect the Self-Pay patient to pay the full invoice for his child's, non-ruptured, minimally invasive laparoscopic appendectomy of $14,000.00 or more when they are receiving only $8,500 for the exact same service through either Insurance or government direct systems.*

None of the Patients in any of these methods have an effective way to know what the charges will be, who is getting paid what, what the effective cost should be or how to manage the services to reduce cost. Further, the effect of the current systems, for the most part, take the real cost out of the equation. With the exception of the true self-payer, Patients are motivated to get as much service as possible at the time of treatment. Many of the procedures provided today are less driven by what is needed to repair the problem, provide continued viability and maintain productivity for employment, family and society; they are more often driven by additional items that are wanted for better quality of life, individual self-esteem and happiness – massively increasing costs. While this is perfectly acceptable in a true Self-Pay environment – if the self-payer can manage and afford the treatment – it is not likely as acceptable when the cost of the wanted Quality of Life care is disproportionality past off to others in the system, driving up costs for all.

The solution as proposed later in this paper provides corrections to these problems.

FACILITATORS

Facilitators today are unable to correctly, cost effectively and efficiently to match the needs of Patients to the skill level, efficacy, and efficiency of providers. They are unaware of all of the potential payers for services for their patients. They have no mechanism to manage the available resources in an effective manner and no way to eliminate the innate duplication of services and double payment for services from the various programs.[24]

Facilitators often only interface with a select few providers and payers. They spend far less time helping the patients manage their needs and issues and most of their time fighting the disconnected massive bureaucracy of forms, eligibility criteria, and availability of scarce resources. Whether they are insurance brokers helping match patients who need insurance with appropriate programs, case workers trying to match needy underserved with available federal, state municipal programs, programs from both non and for profit entities or faith based Non-Governmental Organizations (NGOs) trying to help true Self-Pay patients avoid bankruptcy and destruction of their family due to a catastrophic illness or accident; the current system of silos and conflicting eligibility criteria, regulations and legislation makes

[23] As the losses on government direct payments have increased, the willingness, or ability in some cases, for providers to demand more from insurers and self-payers has also increased.

[24] Further, the incentive in the current system is for the facilitators not to even try to eliminate the duplication of services and benefits, or the double dipping of payments across similar programs, methods and payers.

effective navigation impossible and the incidence of waste, inefficiencies and inequities massive.

Once again the solution as proposed in this paper accommodates these issues and provides an effective and efficient mechanism to address the problems.

PROVIDERS

Providers both before the PPACA and after are faced with a daunting task of maintaining a business without the ability to plan, budget, control expenses, estimate revenue, find coverage, or assure profitability.[25] While many think the main problem in healthcare can be traced to profit motives in the providers of care, the healthcare sector is largely no longer profitable.

With increasingly rare exceptions, Providers, simply have no way to predict what they will be paid for the services they provide on a day to day basis. Due to practice rules and regulations, providers are unable to control patient mix and are both ethically and legally responsible to interface and be responsible for every single interaction that is had with any patient encountered. It has been argued effectively for years, but perhaps not appropriately, that anything that is remotely tied to human health requires a doctor to be involved. For over a century this has seemed like a good idea although the original motivation was driven more for business than health reasons. Few physicians today believe that their time is cost effectively spent on many of the interactions they have with patients.

Much of the basic life care dispensed today, particularly on the routine diagnostic side, is done by nurses and to a lesser extent nurse practitioners – because there are fewer of them. In many countries, routine procedures are done by pharmacists in a pharmacy setting including attending to simple wounds, applying stitches and dispensing routine medications. Our current system puts the most expensive provider directly in the cost structure for the least impactful and least effective treatment options. After many centuries, many providers have finally come to the conclusion that they simply cannot spend the bulk of their time seeing patients for things where they cannot effect a change in outcome by treatment. Yet, our existing system – extended and complicated under the PPACA – requires them to continue to act in this ineffective role.

Complicating matters are the PPACA's methods of tying reimbursement levels to the practice of outcomes based payments as a means to improve care effectiveness. Once again, with a view from 40,000 feet, such a practice make perfect sense. If we want to improve the care that providers are giving, we should attempt to tie compensation to an improvement in outcomes. This appears to make perfect sense, but it belies the systemic problems that are built into the current system.

As an example, Hospitals that treat the poor, the disenfranchised and the underserved – many of them referred to as Disproportionate Share Hospitals (DSH) – now are faced with a dilemma. Their initial reaction to the PPACA during its legislative debate was extremely

[25] As stated before, with the exception of certain specialties, much of the healthcare provider universe is not profitable, or is having large fluctuations in the viability of their practices.

positive and welcoming. Today as the rules are taking shape and implementation is taking theory to realty, they now realize that the tie between treatment outcome improvement and their patient population will be rapidly problematic.

DSH hospitals often treat the sickest, the weakest, and the most fragile among us. Their population often has extensive co-morbidities. It is not atypical for DSH hospital's patients to be homeless, drug addicted, hepatitis C, HIV positive, malnourished, and mentally ill. They often suffer from a combination of many of this list of comorbidities along with other diseases. Due to these combinations of factors, effectively managing a long term positive outcome of the patient is close to impossible. As such, many of these institutions are now realizing that if their compensation is to be tied to improvement in outcomes they will need to adjust their patient mix to have less of their traditional population and more of a better controllable and affect-able population. Since DSH hospitals often do not have adequate capacity for their existing population, this could mean that many of these fragile patients will be selected out of available slots due to the fiscal realities of the current compensation structure.

Providers are faced with declining reimbursement structures in almost all of their current reimbursement mechanisms. They have to employ a pricing system that continually inflates their invoice prices with no certainty of reimbursement or reimbursement level. They are forced to participate in groups and networks that limit their ability to work with others outside of their network system due to price and HIPAA regulations. They have self-pay patients who are increasingly facing disproportionality higher bills and the provider is limited in his ability to reduce their payment because in so many other places in their business they are losing money.

Since the implementation of the PPACA, which has significantly exacerbated this problem, many providers, in contravention to the guidance from the AMA, have abandoned all other forms of reimbursement except for Self-Pay and have moved to retail or concierge practice. They no longer are willing to accept compensation other than from the patient and they have accordingly adjusted their rates downward to more accurately reflect what they actually expect to be paid. Many patients are migrating to providers in this rising payment model. The PPACA, due to its high deductibles and limited networks, is further simulating patients to choose this option. As more patients realize that they will have to spend on average $3,000.00 in deductibles before they can get coverage under their ACA metallic plans, more physicians will find it simpler and more profitable to abandon insurance and government reimbursement models[26]. Estimates are that almost 50 percent of physicians have already moved, or are likely to move, to a direct payment model and forego any form of direct insurance, or government payment. This is also not a good thing for easy access to healthcare from the other parts of the care continuum.

The proposed solution provides a simple and effective fix for these issues and will assure Providers, like Patients, price certainty, affordability, and access.

[26] Based on recent conservative estimates the Total Available Market for deductible paid services exceeds $558 billion – no wonder many docs are opting in to retail practice.

PAYERS

The current system, exacerbates the silo effect or the various payers. The promise of Electronic Medical Records (EMRs) and Electronic Health Records (EHRs) does little to fix these problems. While we use the term Patient Centered often in the current descriptions, this is more a result of the recognition that managing care from the patent perspective is a better way.[27] The issue is that under the current system, even with a more universal EMR, the centricity of the data, practically, and legally, is limited to within the institution that creates and houses it. A true patient centered system places the patient as the center point of the data and transactions. In effect, and in principal, all the data in the system, regardless of the point of storage, or creation, is located by query of the patent as the center point. In effect, the patent is the owner of their integral life care data. They are the query point, and their systemic rules define the access, and accountability. Neither the prior system, the PPACA, nor any of the proposals submitted to date address this systemic issue.[28]

The result for Payers is that while they may have a significant amount of data on a Patient at any point in time, they seldom have all the information they need to qualify the Patient's eligibility for the current procedure. Further, Payers are often at a loss to effectively determine what other sources of reimbursement are available for the procedure delivered by the Provider. Payers routinely are paying for services that have also may be, or may have been, paid for by another Payer.[29]

Payers find their ability to help the population is limited and the costs associated with providing services extremely expensive. In order to effectively manage costs in the current system, Payers must develop and maintain expensive networks. Significant resources are expended in annual negotiations of pricing, conditions of payment, drug formularies, review of each and every claim, appropriateness and effectiveness of procedures provided, screening and review of other potential payment sources, and investigation of fraud. Payers, must review every claim because they do not specifically have control over what services are actually delivered by the provider to the patient and the line where the service delivered moves beyond LifeCare needs to Quality of Life wants that may not be covered.

Finally, Payers have no method of integrating the eligibility criteria for the services they choose to reimburse except through complex and duplicative form based applications. This is not only expensive to the Payer to facilitate, it provides an innate avenue for fraud and abuse as it is completely disconnected from every other payers system.[30]

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[27] The recognition that patient centeredness is a better way does not acknowledge that the current system, as being implemented under the PPACA and HIT regulations, is still not truly a patient centered system.

[28] Note: the Participant does not need to be active in this role as the system establishes accepted defaults. Also the Participant can designate or may have designated for them, a Facilitator to manage these decisions.

[29] This duplication of services and double dipping, as stated earlier, consumes about 40 cents of each Payer's healthcare dollar.

[30] As stated earlier it also is a compounding factor for all of these problems for Patients, Facilitators and Providers.

OTHER COST DRIVERS

Many factors have driven the ever increasing cost of healthcare in addition to the disconnected mechanisms described above. Earlier in the paper we discussed the various mechanisms of subsidy and rebate that collectively work together to not only obscure the true cost but to significantly increase cost as tacitly seen in the system.

The increasing application of, and reliance on, technology has paid a huge role in the rising cost of care. Due to the obscurity of pricing and the inability to derive direct comparisons of price to either value or performance, many technological solutions have significantly increased costs of care without an underlying gain in efficiencies on need driven outcomes. Many of the applications of technology have been focused on improving Quality of Life as opposed to gains in either viability or productivity of life itself.[31]

The methods we chose to deal with the rising cost of care, along with other factors, forced fundamental changes in our economy back in the early 1970s. The mechanisms that were adopted to free our economy to support these rising costs also have had a direct and measurable effect on the rise of healthcare cost itself. The current nature of how we now create currency in the economy has fostered a disproportionate allocation of funding to healthcare related expenses and stimulated part of its rise as a percentage of GDP.

As mentioned before, the role of ESI at decoupling our connection to the true expense of care also has fostered a rapid expansion of our own expectations as to what we expect from care. This has primarily evidenced itself in the increasing desire for quality of life coverage that is providing an increasingly disproportionate allocation of funding to pay for our individual wants over our individual needs.[32]

THE ROLE OF THE ECONOMY AS A COST DRIVER

Perhaps this single most upsetting realization that comes from a correct understanding of how the three payment methods have combined to corrupt the overall system, can be seen in the following flow description as to how rising prices have in effect stimulated the rise in prices.

The author apologies in advance, as the following circular systemic funds and cost flow mechanism is very difficult to describe and may require a few reads to fully understand. As you will see at the end of this section, it is much simpler to understand the general negative effect that this mechanism has evolved to exert on our entire economy today.

In 1972, as President Nixon entered his first term he was faced with a familiar problem to many of the succeeding presidents. He was out of currency in the federal coffers. The nation

[31] – Often with significant increases in cost for all.

[32] This even shows up in our recent political rhetoric when we say that the most prosperous nation on earth should be able to take care of our poor. But, our true level of prosperity is highly suspect.

was tied to the gold standard and as a result unable to simply add more currency without a significant effect on the ability to continue to import products.[33] Nixon removed America from the gold standard [34] and successfully remediated his short term cash concerns. Let's look at how the historical and current healthcare payment mechanisms, described above, conspired over time to ineffectualize any potential healthcare fix.

Some of President Nixon's prime needs for short term currency were Medicaid, Medicare and Tricare – military – health care costs. As Nixon and the Federal Reserve, in cooperation with the banks, began to flow more new money into the economy, a disproportionate share of this new money was diverted to pay for these rising costs. At the beginning, as the new money disproportionately flowed into the healthcare industry and was paid through governmental direct payment programs, more services were created to be provided. As more money was injected, services and costs rose to absorb the new money.

As costs rose, government's big drivers for the need for cash to pay for the government's direct services also rose, stimulating increases in fees and taxes to cover the increase in cost. As taxes rose, employees initially demanded more benefits increasing employment costs and decreasing manufacturer's competitiveness in the world market. Imported goods rose, exports declined, and trade deficits continued to accumulate causing the need for more taxes and fees to fund the increasing cash needs of the federal government to subsidize healthcare costs and to subsidize U.S. industries so they could raise employees' salaries and benefits to pay for the increasing costs of services without pricing our goods beyond the reach of U.S. citizens who made them. As employers swallowed the increasing costs, and subsidies began to increase, U.S. workers and employers took the increasing GDP and stock market as indications that the economy was growing. As we saw the economy apparently grow, we employees demanded more benefits, after all we surely could afford them because we are the most prosperous nation on earth.

About half way through this period, beginning in 1972, even with a number of other economic "fixes" the ability of the government to add more new currency to cover the ever expanding cost of healthcare provided through the government direct payment mechanism began to decline. The federal and state governments, struggling to keep pace, began to reduce the rates of reimbursements under these programs. In order to keep pace, providers began the process of increasing cost to the annuity based reimbursement models and self-pay mechanisms to offset these lower payments. Payers increased the premium costs to individuals and employers to absorb the rise in service cost. To both hide the increase in cost and to soften the blow of the increase in deductibles and the creation of Co-Pays that

[33] The cause for the lack of currency was varied, accumulating trade deficits, accumulating federal general budget deficits from a variety of programs like the wars on drugs, poverty and Vietnam and rising unfunded costs of Social Security, Medicare and Medicaid.

[34] – causing a worldwide economic crisis referred to as "Nixon Shock"

employers wanted, payers convinced employers to again increase plan benefits.[35] Similar increases in programs were also seen in government programs.[36]

The increase in services and costs to employers and insurers, the increase cost to the individual by deductibles and Co-Pays, the increase in benefits costs to employers lowering salaries and salary increases to employees and the increase of taxes and fees to the government to provide additional revenue was compounded with yet another deleterious dynamic – the rapid increase in the amount of newly created valueless currency to pay for these rapidly rising costs also began a significant loss of effective buying power in the middle-class.

As patients were able to buy less with the same effort, more subsidies were needed to offset the loss of buying power. Needed items in healthcare became more unaffordable requiring even more money to be created and applied though continually expanding subsidy programs stretching beyond the poor and into the middle class.[37] In what has become a familiar vicious cycle, more federal money, disproportionally entering the economy for the purchase of healthcare, has stimulated an increase in the cost and availability of healthcare services, driving increases in healthcare premiums, and the resultant shifting of costs as before, in turn increasing the demand on the government, who responded by increasing taxes fees and special charges, causing increases in the creation of new currency to inject money back into the economy to pay for the rising disproportionate percentage of care costs component of the economy.

This cycle has been repeated over, and over, since 1972. It is one of the fundamental flaws in how these self-predatory and self-propagating systems operate, and it is one of the main reasons why the PPACA, The Burns, Coburn Hatch CARE bill and all other proposals are doomed to failure at containing costs.

This self-predatory and self-propagating cycle is not simply confined to healthcare. It is now, primarily due to the mechanisms in force in our existing economy, the cause of our declining middle class. As it has expanded beyond just healthcare costs, it has also become much simpler to describe as a generally negative economic phenomenon. Let us start with a few definitions:

Poor – people that are unable to survive without some form of societal assistance or subsidy

Rich – people that have income and assets in excess of what they need to survive and thrive day to day

[35] – adding more covered items like expanded vision and dental as well as other more quality of life coverage like sex reassignment surgery, breast reconstruction and augmentation after mastectomies.

[36] In Medicaid, expansion included items like drug treatment programs, additional HIV/AIDS therapies, and many others, in Medicare additional treatments were added like hip, knee and other joint repair and replacement, and many additional items.

[37] What started as programs based on federal poverty level (FPL) for qualification, soon became a series of additional programs that offered subsidies up to over 400 percent of FPL.

Middle Class – people that are not eligible for subsidies because they are able to survive on their income level and do not have sufficient assets to hedge against the loss of buying power.

In the current dynamic, as costs have increased, the Poor have been relatively sheltered because the government has responded with increasing subsidies and new programs to offset the loss of buying power brought on by the significant increases in currency in the economy.

The Rich have been able to invest their excess assets in the stock market and other mechanisms to hedge against the loss of buying power from the increase of new valueless currency.[38]

And the Middle Class? They have neither been eligible to receive subsidies[39] nor do they have the excess assets in order to provide some hedge against the loss of buying power from the significant rise in currency with no corresponding rise in national asset value. So the Middle Class have been crushed by the very systems we have put in place to try to help the poor, and now being redirected to try to help the middle class.[40]

This paper proposes a solution that helps to decouple these self-propagating, self-perpetuating and self-predatory systems when it comes to the significant cost driver in the general economy – healthcare costs.

SUMMARY

In summary we have significant problems in estimating, managing, measuring and discriminating healthcare in order to accurately count and control our cost of services. It has been functionally impossible historically and neither the PPACA nor any other proposals have addressed the systemic problems. As stated earlier in this paper, one of the big issues we face is the simple accuracy of what we believe we are paying for care. These problems are systemic and they cause significant deleterious effects throughout the healthcare supply chain. These systemic disconnects cause all proposed solutions to not only fail but often to significantly amplify the unintended consequences. Further, the underlying issues in the historical healthcare system have negatively affected our economy and caused similar structural changes that now further amplify the negative effects forming a vicious cycle of economic decline.

The solution proposed in this paper recognizes the root cause, incorporates fixes to these problems and provides effective systemic controls to eliminate, or significantly reduce, duplicated services, fraud and abuse while more efficiently and effectively allocating these limited resources and spreading the burden across the widest Sponsor base. This should also

[38] Depending on how many excess assets they have to invest, they either have been able to lower their loss of buying power, keep pace with the loss or in some cases significantly benefit from a disproportionate capture of these new dollars as they have been injected into the economy – mostly through the stock market.

[39] – except in the case where subsidy eligibility has been expanded to encompasses their income and asset level which renders them newly poor by definition

[40] Of course once the mechanism is applied to the members of the middle class their dependency on the subsidies, by definition, pushes them into the category of poor.

have a significantly positive effect on the negative dynamic in the economy and lead to some models for other systemic fixes.

PROBLEMS WITH CURRENT HEALTH SAVINGS ACCOUNTS

While recent history has been focused on implementing some mechanism to provide individuals with an incentivized way to provide for the ever increasing costs of catastrophic illness and rising care costs, those enacted through Flexible Spending Accounts (FSAs), Health Savings Accounts (HSAs), and High Deductible Health Plans (HDHPs) have been framed to limit the amount of money that qualifies for deductibility and to restrict and/or channel the flow of these funds to favored programs or expenditures – as is the case with HSAs and HDHPs.

Overall the long term benefits of these accounts has been less about real affordability and more about a way to soften the blow of the shift in healthcare costs from employers, or insurers back to employees or plan purchasers. If the intent is to better help individuals plan for healthcare purchases and reduce the stress of unplanned illness and accident expenses; then the plans should allow for much higher limits and should allow people to be able to carry over unused balances to truly prepare themselves for uncovered expenses today and in later life as well.

The current limits in the amount able to be saved under the existing legislation often does not even cover the basic deductibles for many families. Further that which is saved must, for the most part, be used within the plan year so the ability to build up a 'nest egg' to offset future costs is unnecessarily restricted. How can plans alter the restrictions on what procedures are covered in later life to save money for all policy holders in the plan if the individual is not in a position to offset the desired services costs not covered under their plan later in life through tax advantaged savings? They can't and won't. The current system places the focus and access for later life care squarely on insurance plans and Medicare. This shifts the extremely weighted costs for elder care disproportionality across all the plan holders in the form of increase premiums, co-pays and deductibles weighted, as we know, towards the younger purchasers.

The solution contemplated in this paper will shift the focus on method of payment to a balance, weighted toward the individual and to Life Health & Wellness Savings Accounts (described later). Unlike the existing trend-line this solution will shift basic life needs expense to insurance and premium payments. This solution will not cost shift the healthcare wants and expenses of elderly patients to the shoulders of the younger healthier patients. It is designed to actualize the cost for care for an individual across their entire life so they share the same burden over time for their own healthcare needs and place their additional healthcare wants squarely on their own shoulders through either the purchase of Quality of Life Care Advantage policies or savings through tax deductible Life Health & Wellness Savings Accounts with no life time savings limit.

PROBLEMS WITH GROUPS

The current plans and legislation all perpetuate the concept of groups as a method to gain advantages of increased benefits via the spread of risk across the collection of individual

policies and the ability to leverage group purchasing to get lower cost for more benefits. There may have been a period where such leverage worked to the advantage of the individual, groups and the nation, but no longer. We believe that these systems in general, and grouping in specific, conspire to set up a self-defeating system where continual expansion of coverage beyond Life Care needs into Quality of Life wants, and the artificially reduced sizes of the actuarial pools even in large company pools of 20,000 or more employees conspires to increase rates due to the impact of aging and sicker individuals across these pools and an upward spiral of demands for increases in benefits from the group due to the belief that they can get more because of their buying power. Further, as our population continues to age and companies continue to offer insurance to pensioners and retirees, the effect of the increased cost of older actuarial groups does not get evenly spread.

Current near retirees, even if they have been in the same insurance plan at the same company, are now receiving benefits not contemplated when they entered the workforce. So even if the actuarial basis for their premiums in the 1960s and 1970s were effectively calculating a premium to support the services they expected to receive today – which they were not – the increases in benefits demanded today and the massive increase in cost have overwhelmed the funding and forced a transference of the expense to the premiums of new enrollees.

This paper offers a solution where the fiscally unhealthy and unmanageable group policy basis is eliminated. The proposed solution disincentives employers from being in the employee sponsored insurance business and instead incentivizes employers to support employees purchasing their own basic LifeCare insurance to cover their basic healthcare needs and supports employees in establishing and growing their own Life Health & Wellness Savings Accounts to pay for Quality of Life Care Advantage plans or to save and pay for the additional services they want throughout their life.

PROBLEMS WITH LIABILITY MANAGEMENT

It is no revelation that part of the issues with unaffordable healthcare and loss of providers over the past 40 years has been the rise in health related litigation. Malpractice insurance has risen astronomically during this time frame and it has become routine to see lawyers soliciting membership in one class action suit or another against pharmaceutical companies, insurance companies, or medical device manufacturers. Outside of class actions, individual suits are routinely brought against providers where the patient either had an adverse reaction, a negative outcome or in some cases were simply not satisfied with the results they received.

Clearly these suits come in two distinct categories; suits where there was clear wrongdoing, negligence, fraud or damage done as a result of the action by one of these types of plaintiffs, and those suits where there was no wrongdoing, negligence, fraud or sometimes no real damage. In a significant portion of these cases, the litigation has been brought forward, and even won, with the basis of the health issues rooted in the purposeful behavior and conscious choices by the plaintiff.

The paper will not attempt to make either a rationalization for these lawsuits or a criticism of the lawsuits and awards. Too often such debate is mired in the financial interests of the

parties involved on the one side and the heartfelt sympathy and anxiety for the plaintiffs harmed – in realty or otherwise. In the end, some of the fixes need not address this debate, although real reform must establish some effective limits and help protect the helpless while limiting the expense brought by the clueless and denying action to the worthless i.e. fraudsters.

Prior to addressing the needs for real tort reform, there are some systemic areas where we can address the issues of better, more appropriate and more effective liability management. In the current practice of healthcare, most if not all decisions relating to treatment and medications are made by one person in the chain, the doctor.[41]

In about 1863, when private physicians were losing their livelihoods to competing modalities of care, the rising influence of patent medicines and other treating institutions and professions, the AMA was formed with the express goal to "preserve the business and practice of private physicians." This was, at the time, a noble goal and by 1912, the AMA was firmly in control over the education and licensure of physicians, hospitals and doctors.[42] In doing so it was felt that only the type of practice as proscribed by the members of the AMA – allopathic medicine – was scientific and effective and should be "legal." All other forms of medicine; homeopathic, eclectic and osteopathic among others, were declared unscientific, ineffective and illegal therefore un-licensable.[43] Like most things in our history this has delivered both positive and negative results. Any other provider of care; nurses, therapists, pharmacists etc. have been relegated to a supporting role and often second class status.

The downside of this evolution for patients has been that the cost of care has unnecessarily significantly risen and there has been little ability to readdress roles and responsibility allocation across all the providers in the healthcare continuum. Doing so could increase access, lower cost and in many cases provide even more effective care. There are some cynics that will also state that the current system also limits gains in outcome. The downside in the evolution of the form of practice and system for physicians – now doctors – has been that they share almost sole responsibility and liability for anything that happens with a patient regardless of its source or cause.

There are many additional reasons why much of the attribution of liability to doctors has been improperly applied, one reason worth noting is that our modern expectation of the skill, ability, and capability of modern medicine and its practitioners is vastly removed from the

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[41] As discussed earlier, this is often not the most cost effective person to address the largely unmanageable routine procedures associated with most providers practice. A large percentage of a providers time is now allocated to seeing and managing cases where there are few, and sometimes no, effective treatments or medications. Cases where the nurse or in other cases nurse practitioner has already identified the appropriate mode of treatment – often more along the line of, "take two aspirin and call us in the morning" mode – yet, the doctor is required by both practice and law to not only spend time but to accept the full liability.

[42] –in the 1800s doctors and private physicians did not do the same job, see the same people or receive the same training.

[43] Along with this effort came the practical effect that only the Physician/Doctor was able to treat, proscribe, and in some cases, be compensated for the provision of healthcare.

reality of the care that even the best can possibly deliver. Therefore, in many more cases than we expect, patients are receiving little or no gain by the application of treatment[44] and in a very significant number of cases patients are actually harmed by receiving treatment.[45] In January of 2008, Peter Orszag, the Congressional Budget Office director, reported to the Senate Budget Committee that more than $700 billion of the then $2.9 trillion in annual spending did nothing to improve a patient's health and even produced harm.

Unfortunately, the practice of medicine is still much more art than science. Data suggests that even with the significant technological advancements, and improvements to medical education over the past 100 years doctors still get it wrong about one-half of the time.[46] Only about 20 percent of clinical practice treatments are backed up by solid controlled trial evidence of effectiveness (Kumar, MD, MSc, MPH & Nash, MD, MBA, 2010). Yet, in excess of 85 percent patients that visit a doctor, and who are not harmed as a result of treatment, report they feel better and/or are cured.

How can there be such a large disconnect between the statistics of care and our impressions of care? We often confuse the body's innate ability to heal itself in a given period with a beneficial effect of a visit to the doctor and the provision of their services or medications. We have been trained to believe that the doctor can cure anything and that technology has solved for all but the most deadly diseases. We have unobtainable expectations of the ability of doctors to cure us of almost anything. And, not simply to cure us, but to repair us. Not simply a repair to an "as good as new" level, but to a level better than we were before we ever got sick or injured. As a result, we also have evolved to a point where, for many, any service provided that is even remotely less than our expectation can equally be seen either as a reason to sue or in many cases equivalent to "winning the lottery." Due to the current systemic practice rules, doctors share a disproportionate burden and the mere fact that the doctor is in the care chain amplifies what both lawyers and their plaintiff/patients are betting they can win in the medical liability lottery.

This paper contemplates a reallocation of roles and responsibilities that is more widely spread across the healthcare provider continuum. Altering who is deemed capable and responsible for the delivery of care in a more efficient and effective manner will not only shift the roles and responsibilities of doctors to areas where their significantly more detailed and expensive education is necessary to affect a better outcome, more cost effective and reduces both the innate liability, it should also reduce the size of awards from litigation.

The same technique to reduce the roles and responsibilities, and the innate liability of care provided by doctors, should also improve their ability to manage their business practice, by

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[44] – Dr. Elizabeth McGLynn reported in 2009 that 45 percent of the time physicians dispensed the wrong care (McGlynn, Asch, & et.al., 2003)

[45] – the Institute for Health Improvement reports 15 million cases (Institute for Health Improvement) of medical harm per year, according to the CDC 1.7 million Americans are victims of hospital acquired infections resulting in an estimated 99,000 deaths (Klevins, Edwards, & et.al., 2007)

[46] Dr. Norman Scarborough reports in his paper *Medical Misdiagnosis in America 2008: A Persistent Problem with a Promising Solution,* "there have been multiple autopsy studies that have uncovered frequent clinical errors and misdiagnoses, with some rates as high as 47 percent" (Scarborough, MD, 2008).

adjusting the percentage of low cost reimbursements for low skilled procedures and services that will now be provided by others in the healthcare service chain. While in the 1860s it was seen as necessary to limit the roles and responsibilities of nurses, pharmacists and others in order to preserve the businesses of private physicians, today this same practice is part of the root cause of why so many physicians simply cannot afford to continue to practice.

This paper provides a solution to improve physicians business models, more efficiently and effectively provide care and access to patients, significantly lower the cost of providing care to providers, and lowers the cost of the acquisition of care to the individual and to America.

SOLUTIONS

The solutions presented in this paper are based on the recognition that before a solution can be integrated, first, the fundamental core issues must be identified, understood and agreed upon.

Having outlined the fundamental issues in the preceding section, the following solutions integrate systemic practice, controls and mechanisms to achieve resolution and solution for those issues. While the authors has included a moderate amount of detail to help frame or support the efficacy of the solution, this paper should not be seen as a complete list of all the items that may be designed into any of the areas described below.

Having looked at the historical system for the provision of care under earlier forms of insurance, self-pay, government programs, the current PPACA and more recent proposals and bills, the fundamental flaws in the design of the historical and current ideas are clear. We have evolved a belief that we have a system that is not a system at all. It is a collection of self-predatory practices and methods that promulgate massive increases in costs, erosion of effective checks and balances and exponential unintended consequences.

The author has developed this set of solutions to address the historical and current issues and to provide the simplest and most effective system to achieve the following goals:

- Deliver on the promise of available, affordable, effective and easily accessible care covering basic health needs for all (100 percent of Americans) – LifeCare Plans
- Provide integrated choice driven, available, effective and accessible care covering the additional services that Americans want – Quality of Life Care Advantage plans
- Assure a cost effective, fair, and easily accessible Safety Net for all Americans
- A solution that converts "Patients" from inactive recipients of ineffective health services, to active Participants in the selection, management, delivery and prevention of care.
- Assures price certainty, cost transparency, and full care portability
- Requires No Deductibles, no Co-Pays, no hidden fees – all cost easily defined, certain and accountable
- Provides full cost disclosure for all parts of healthcare, no hidden reimbursement systems, no rebates and no self-propagating cycles that obscure full and true cost
- Assures coverage regardless of pre-existing condition or disease state
- Delivers a system with checks and balances that select for reduction of overall U.S. cost of care as well as reduction of the individual's cost of care
- Allows no government "Death Panels" instead provides a representative citizen group of participants, facilitators, providers and sponsors that are empaneled to determine what constitutes basic health needs, treatments and therapies and establishes effective payment rates for providers under basic LifeCare Plans
- Assures appropriate, effective, and efficient delivery of basic health needs
- Effectively balances care outcomes expectations to healthcare's ability to deliver effective services.
- Delivers the ability to seek the provider(s) of their choice

- Transforms employers from the provider and manager of healthcare through Employer Sponsored Insurance to focus on wellness and prevention and act as a facilitator to help employees both afford basic health needs, LifeCare plans and effectively plan and save for Quality of Life Advantage services.
- Improves Participant outcomes
- Integrates the two market based solutions by providing a single system of resources for Participants, Facilitators, Providers and Sponsors to fully effectively coordinate all care and benefits needed by Participants across all available sources. This system should:
    - Provide Participants
        - a central place to identify and register their care needs
        - automatically apply for all benefits with a single dynamic entry system
        - source, review, compare and select Facilitators and Providers
        - manage access to their information and provider network
        - provide access through a true Participant centered system between all Facilitators, Providers and Sponsors with adequate security, information needs and access controls
        - Match all needs to all appropriate and available resources in a least cost tiered method approach
        - Assure checks and balances to inform, enforce and secure privacy controlled interactions among their virtual care team.
    - Provide Facilitators
        - An effective and low cost system to assist Participants in sourcing, applying and accessing all needed resources.
        - A mechanism to appropriately identify appropriate payment resources by matching the participants needs to Sponsors registered program eligibility criteria
        - A systemic mechanism to identify potential Provider and Sponsor conflicts and areas of potential duplication of services and benefits
        - Mechanisms to help identify and report fraud
    - Provide Providers
        - An effective and low cost system to appropriately match their services to Participants needs
        - A mechanism to assist in establishing fair, effective and competitive pricing.
        - Improved ability to manage patient mix and reallocation of services to other Providers
        - An efficient and effective way to identify, qualify and integrate their services with additional Sponsors to expand the opportunity for payment.
    - Provide Sponsors
        - Effective and low cost system to identify and integrate Providers with the Sponsor's program Participants via a much simpler and drastically lower cost model.

- A fair and effective system to eliminate duplication of payments due to the unknowing duplication of services by Providers
- An effective mechanism to identify and reduce or eliminate duplicated payments due to fraud and abuse
- An effective mechanism to manage the provision of multiple services by multiple providers through multiple programs with effective balancing of roles responsibilities and cost
- Allows for new ways to spread cost of services via;
    - Balancing of payments across all eligible programs
    - Payer of last resort systems
    - Negotiated share of cost settlement
- Innate validation of most comorbidities across Provider sources
- Elimination of Silo Effect

LIFE CARE & QUALITY OF LIFE CARE

The core of this system recognizes and builds upon the existing trend-line in health care where physicians are self-selecting to practice either in the low cost, high volume basic care model based on Insurance and government pay systems or to move from this mode of payment to a purely self-pay, more retail approach.

Over the past 30 years or so many public health officials have spent huge amounts of money and resources attempting to eliminate disparity. For some, the past few years have been the culmination of a number of revealing moments. A more recent example of this revelation was shared by Diana Dooley, the Secretary of the Health and Human Services Agency for the State of California, shortly after her appointment to this post, Ms. Dooley gave her first speech to an audience at the Hilton Hotel across the street from the state capital. Ms. Dooley is a very effective speaker and has spent her life strongly engaged in helping improve the lot of the underserved and the poor of California. One would be hard pressed to find a more caring and effective administrator. What was striking about this speech was her acknowledgement that for most of her career she had focused her prime efforts, funding and policies on eliminating disparity. She then exclaimed that she, and others like her, had been wrong. That eliminating disparity, more often than not had the opposite effect and that instead of attempting to eliminate disparity, we needed to recognize its role and construct systems to effectively manage disparity.

The lessons learned over the past hundred years of healthcare provide the basis for the realization that to effectively provide what is needed to solve the aforementioned problems is a single but bifurcated system that recognizes that disparity must exist, and effectively manages the disparity without it becoming either an out of control drain on the economy or providing a mechanism for inappropriate loss of the basic LifeCare that people need to survive and be productive of themselves, their families of their businesses. Further, one

cannot simply decide that all assets should be allocated only to provide the most basic care for all and eliminate the ability to have choices for the things people want.[47]

The core of the proposed system are two disparate systems that are still tightly integrated with effective free market pressures, appropriate governmental monitoring, and combined checks and balances. The main core of the system is a basic LifeCare plan, focused on equal access, treatment, and cost to all Americans and is the prime source for all care needed to provide viability, and production.[48] A second system provides for individual care wants beyond basic care needs. This Quality of Life Advantage market will be a distinctly separate mechanism of reimbursement, pricing and access to care, but both systems will be accessible through a central national access system. While the LifeCare plan system provides for the required care needed to keep people alive and productive to themselves, family, community and business at the highest efficiency and lowest cost; the Quality of Life Advantage system will provide access to the additional things people want and desire and allow for a more free market approach to pricing, access, and options. Another key component of these two systems is an integral method to provide affordability to all for both the basic LifeCare they need and the Quality of Life additional items they may choose and want. All people will thereby be assured of LifeCare as it forms the Safety Net, and all those who want to self-actualize, benefit from hard work, life choices and sacrifice will also have the ability to purchase the things they want through the same central system that provides economy of scale to both without the ability for costs to be shifted between the two models and costs to be duplicated.

LIFECARE PLAN

LifeCare forms the core of a market and system to deliver our basic healthcare needs targeted at survival, viability and deliverable value to self and society. There will only be one type of LifeCare policy offered by every insurance company that chooses to be in the health insurance business. All policies, regardless of the insurer, will be identical in scope, extent of treatment and coverage. Each covered need, as determined by the LCTPP (described later), will have a recommended best practice treatment guideline and published payment amount. With only rare exceptions, treatments will be standardized. Providers will not be bound to the recommended treatment and may alter the treatment at their discretion but the payment to the provider under the plan will remain the same.[49]

[47] Despite the rhetoric of both sides, there are no such systems in the world, even in the most dogmatically controlled communist nations. The governmental single payer systems most often touted by some are also matched with some form of private choice system – often not acknowledged as legitimate by the government. As stated earlier these free market choice systems are often not acknowledged and often not even remotely integrated into the public national health care system, so real comparisons are lost and continually expanding disparity and inefficiencies are generated.

[48] The LifeCare plan market also forms the basis of the national safety net for all Americans.

[49] It is also possible that there may be some stronger liability reduction incentive for Providers to adhere closely to recommended best practice treatment guidelines. There may also be regional modifications in the published price for payments based on cost of living and there may be COLA adjustments over time as established by the LCTPP group described next.

Plan scope, extent of coverage, recommended best practice and payment pricing that constitute LifeCare needs policy limits will be set by a bi-partisan national governing body – LifeCare Treatment, Practice and Payments Group (LCTPP group) – composed of representatives from the four key healthcare constituent groups; Participants, Facilitators, Providers and Sponsors.[50] Guidelines for the definition of plan coverage will be established to ensure that the included treatments will represent effective care to assure viability, and productivity. Treatment guidelines in LifeCare will be established to assure adequate coverage for all Americans and will be structured in a way to stimulate a practice modality and business model that is predicated on a high efficiency, high volume, and low cost effective care delivery model. Since we are also integrating a choice based system, the LifeCare system can be appropriately restricted in terms of treatments and therapies more appropriate to selection and payment via physician and patient choice.[51] Optional treatments and therapies can be accessed via the Quality of Life plan system.

The LCTPP group will also be responsible for redefining the roles, responsibilities, and practice guidelines for all providers to better effect efficiency, cost effectiveness and balance across the healthcare provider continuum. The LCTTP is to be constructed and governed so as not to be construed as a, so called, "death panel". It is anticipated that the extent of options for certain treatments and therapies will alter with age and remaining productive years as a measure to control extraneous and expensive costs. This will help reduce the currently significant care costs that occur in our aging population in the last five years of life, without reducing options for survival and viability.[52]

Basic LifeCare plans can be purchased in any state or territory from any qualified insurance provider in the U.S. regardless of their state of origin. It is anticipated that once purchased, the basic LifeCare plan will follow the individual throughout their life and be the basis for all basic services received until their death. The current law that allows parents to maintain coverage of their children till age 26 will be continued. Individuals will be strongly

[50] There will be multiple representatives from each of the groups and each of the disciplines within the groups. For example, Participants, will include representatives from a fully representative economic, ethnic, geographic and disease-state sub-groups. Facilitators, including representatives from the various sub-groups; faith based, social workers, case workers, family/friends, guardian-ships, parole/probation, volunteer and public service, etc. Providers will include representatives from physicians/doctors, nurses, nurse practitioners, pharmacists, therapists, and representative subspecialties within these groups.

[51] This is not to indicate that there cannot be multiple treatment options in the best practice guidelines nor that Participants and Providers are unable to deviate from the defined treatment protocols. However, deviations from the defined best practice guidelines will not be able to generate increased payments under LifeCare plans.

[52] In other words, as the LCTTP group establishes the approved best practice treatments there may be differences between the extents of treatment options for certain injuries and diseases covered for a 40 year old than there will be for an 80 year old with the same injury or illness. As an example, these restrictions on treatments and therapies are weighted towards certain procedures that in an 80 year old would be more geared toward improving Quality of Life. Additionally, this is not meant to restrict access in the elderly to treatments and therapies that would improve material survival or viability.

encouraged – but not mandated – to purchase their LifeCare policy at the age of 27, or upon initially entering the workforce, whichever is earlier, through an integrated set of incentives.

Premium payments for LifeCare policies will be primarily established based on the age of the Participant at the time of purchase and the premium will remain the same[53] as long as the policy remains in force and is not allowed to lapse. Should the policy lapse, due to non-payment, fraud or abuse, then the policy may be reinstated at a rate representative of the price based on the Participants age at reenrollment. Material early purchase incentives will be in the form of the time based pricing model with significant increases in premium costs weighted in the first few years of policy purchase.

As an example only – not to be construed as an estimate of actual premium costs – the premium for the initial year purchase price at age 27 may be $250.00 per month and would remain at this level – subject to COLA adjustments, for the rest of their life, at the age of 30 they may rise to $300.00 per month and would remain at this level – subject to COLA adjustments, for the rest of their life; and by 35 years old they may have risen to $450.00 per month and would remain at this level – subject to COLA adjustments, for the rest of their life. When seen in the light of how employer incentives will be constructed (described later) this is expected to provide significant incentive for early purchase.

There will be no price or additional benefits incentives for groups, either regionally or employer based. All LifeCare plan holders will be counted in the same actuarial group. *As an example only, every holder of a LifeCare plan purchased from BlueCross of Pa will be members of a single BlueCross of Pa. actuarial group regardless of where they live, their age, disease state etc*. The goal of this provision is to provide the largest spread of cost across the total population of that group. Insurers will have the incentive to gain the largest actuarial group and this will bring free market competition to lower the plan costs to the lowest level in order to gain the largest actuarial cost spread. Additionally, since the payments for services are fixed, insurers will not need to negotiate with physicians and/or groups and as such there are no need for networks. All qualified Providers will be able to submit claims to all plans for services rendered and receive the published price payment. Doctors will be better able to project their business. Insurers will be able to simplify their claim review process, and the entire reimbursement system should become simpler, faster and more cost effective. Participants will be able to keep their doctor regardless of Sponsor and have a much wider range of providers to choose from. Costs will be clear, transparent and certain and statistics will be measurable, accurate and consistent. Informed decisions based on comparisons of service, efficacy and value will be finally attainable.

It is expected that providers that choose to practice in the LifeCare market will design and focus their business model and practice around the delivery of such needs based care, and will evolve the design of their practices toward high volume, high efficiency, lower margin

[53] Premium payments may be subject to annual Cost Of Living Adjustments that may be set by the LCTPP group.

routine treatment modalities. To be competitive in this type of business model Providers will focus their practice at the efficient and effective delivery of this kind of care.[54]

As stated earlier, all costs for LifeCare plan treatments will be published and standardized so there will be full price certainty and transparency. There will be no allowed rebates, fees or self-targeted taxes that backflow into the overall cost of care and obscure the true cost of care.[55]

All programs from all sponsors[56] will be integrated into the LifeCare plan system through the national Single Point of Administration Full Coordination of Care and Benefits across all available sources system (SPAFCCB system) described below. This will help make sure that all options for payment are coordinated and applied fairly and completely, based on eligibility criteria and constraints while reducing duplication of services, cost shifting and fraud.

It is anticipated that current laws will change to alter the provision that requires Hospitals to treat ER patients regardless of their ability to pay. A LifeCare plan card will be required for payment for all hospital services. This is not designed to remove treatment options or to cause unnecessary harm to those that, for some reason, have not obtained LifeCare coverage. Hospitals will continue to be able to provide treatment to all that show up on their doorstep. That will be accomplished though the SPAFCCB system. Hospitals, presented with a person that is not a LifeCare plan Participant will be able to immediately provisionally enroll those individuals in a LifeCare plan. Initial provisional coverage will be assured under the LifeCare Safety Net provision.[57]

The incentives for the application and development of technologies in the LifeCare system will be driven by the need to continue to provide improved outcomes at lower costs of current approved best practice treatments. Technologies that improve the current treatment and improve viability at the same or lower costs will be rapidly integrated into the LifeCare system. Technologies that add significant costs without an offsetting gain in survival, productivity or value to self and society will not likely be adopted as new treatment methods

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[54] While they may also participate in the provision of Quality of Life wants based care, it will not likely be the main focus of their practice. To some extent this system is designed to form a bifurcation between these two practice modes, so that pressures to achieve maximum efficiencies and low cost are principally directed at the basic LifeCare needs market. Further, this split in practice modalities is designed to minimize or eliminate cost shifting and to maximize price certainty, portability and transparency.

[55] – As is currently the case with both the PPACA and most other congressional proposals.

[56] – whether they are insurance based, governmental programs like the Ryan White Care Act, AIDS Drug Assistance Program, Pharmaceutical Prescription Assistance Programs, philanthropic programs, faith based, volunteer, charitable, etc.

[57] Under this system, it is anticipated that the federal government will, at some point, no longer be in the business of contracting for, or paying directly for, the provision of care services to individuals. All care provided through federal coverage systems – with the exception of military coverage through Tricare – will be transferred at some point into the LifeCare plan system eliminating one of the big drivers of continually increasing costs, and lack of price certainty and transparency. Existing Medicaid and Medicare systems would transition to this system over time with multiple options for active plan participants to continue under their existing system or to affect immediate transfer at their choice.

in the LifeCare plan market. Those technologies will be able to be adopted into the Quality of Life market.

LIFECARE PLAN SAFETY NET PROVISION

The LifeCare solution is designed in a manner to provide affordable coverage and the means to pay for this coverage for most Americans though their earnings and/or an employer incentivized life health and wellness stipend system. Yet, it is clear that regardless of the incentives and encouragement, not all will be either able to comply, or in some cases act responsibly to obtain, and pay for coverage. The current healthcare system has significant cost drivers due to three prime cohorts, the helpless, the clueless and the fraudsters. An effective safety net must be established to cost effectively help the helpless, reduce the cost effect of the clueless and eliminate, to the largest extent possible, the exorbitant cost of the fraudsters.

People that are helpless, due to loss of job, income, or means to pay, are protected in this system. Should a person have a LifeCare plan or suffer a loss, or catastrophic event, that renders them unable to pay for their LifeCare plan they will become eligible for full or partial LifeCare plan premium support. Upon eligibility, they can immediately and automatically register their needs and apply for assistance through the SPAFCCB system (described below) to have their existing LifeCare plan premiums covered, in whole or in part, through one or more available Sponsors. Under the payer of last resort system, the federal government will act as the final backstop for all American citizens for LifeCare. There should be no reason for any LifeCare plan holder to ever have an interruption of coverage under this system. If responsibly managed, either by the Participant or their authorized Facilitator, LifeCare premium payments should continue with no interruption of plan benefits and no resetting of premium costs due to lapse of coverage for reasons of non-payment.[58]

Except for the permanently disabled, or others the government designates as eligible, all individuals that receive federal premium support will receive the aid during their eligibility period as a loan until such time as they are no longer qualified as eligible. Upon regaining the means or ability to pay for their plans, or other loss of eligibility, individuals will be expected to begin repayment of the outstanding loan balance. Payments will be calculated and amortized across the remainder of the individual's effective productive life. *As an example only, a 34 year old individual that received premium payment support for 2 years due to loss of employment would, upon loosing eligibility due to reentering the workforce and again meeting the minimal income or means tested requirements would begin to make monthly payments on the principal and interest charged, from the date of the initial premium payment support loan through the expected payoff date. The monthly payment would be spread out over 372 months (31 years times 12 months) assuming a 65 year effective productive life.* Individuals will be incentivized to pay off the outstanding balance earlier due

[58] People that currently qualify for full assistance under federal programs due to disease state, disability, or other eligibility criteria will continue to receive the same eligibility in the LifeCare plan system via the same SPAFCCB system with the federal government acting as the final backstop assuring coverage.

to the general effect of accruing interest. If regular payments are not made, outstanding payments and balances may be collected.[59]

QUALITY OF LIFE CARE

This solution recognizes that regardless of official recognition of their existence, choice based healthcare systems exist everywhere in the world to accommodate the care wants of people that can afford them due to savings, increased productivity or hard work. Systems that do not incorporate a method to account for the provision and delivery of such care develop self-predatory, self-propagating and disparate systems that negatively impact Participants, Facilitators, Providers and Sponsors.

Quality of Life Care begins where the LifeCare plan ends. While the LifeCare system is predicated on high volume, highly efficient, pre-fixed low cost routine treatment modalities with some free market effects to lower cost, Quality of Life providers will evolve to be more market driven in nature. Quality of Life care will be where individuals get the additional care and treatment they desire based on their own individual priorities, desires and choice.

Quality of Life Providers will build their practices around the provision of value-based services to individuals above and beyond LifeCare's basic needs services.[60] The Quality of Life market system is designed to incentivize those that wish to practice in this value-based market to design their business model around the provision of a higher priced, potentially lower volume, high perceive value-based, more retail driven model.[61]

Participants can choose to pay for Quality of Life Care services at the time of service through any means acceptable to the provider(s). They can pay for Quality of Life services through their tax free Life Health & Wellness Savings Accounts or they can purchase Quality of Life Advantage plans from any qualified health care insurer.[62] Insurers will be barred from charging more than published plan cost to any holder of LifeCare plans purchased from another insurer, but they will be able to offer bundled discounts to their own LifeCare plan holders.[63] All insurance payments will be provided to Participants directly or through electronic funds transfer to their Life Health & Wellness Savings Accounts. In this solution,

[59] First from Tax Refunds due and if refunds are not due then from the outstanding balance of Life Health & Wellness Savings Accounts as described below. If, at end of life, there is still an outstanding balance, the remaining balance will be collected, as are taxes, from the remaining estate of the individual.

[60] Quality of Life providers will also likely offer LifeCare services but typically are not expected to provide these services on a standalone basis.

[61] Pricing for services delivered though this model will be required to be fully itemized. No hidden fees, or rebates will be allowed. Participants will have the ability to pay exactly the same price for services purchased either directly to Providers individually or collectively though one provider or group – like a hospital acting as an aggregator. All providers will have their prices published in the SPAFCCB system.

[62] Since all LifeCare plans are exactly the same in coverage and reimbursement, and there are no networks of providers, Participants can purchase any Quality of Life Care Advantage plan from any insurer, regardless of who they purchased their LifeCare plan from.

[63] Providers will in no case be able to receive payments directly from insurers.

the Participant is always the center of any health related transaction whether financial, or informational.

Unlike, LifeCare plans where the premium cost is tied to the age of the policy holder at the time of purchase and remains relatively constant throughout the plan holder's life, Quality Of Life plan pricing and terms will largely be driven by the free market. The exception may be in some constraints that may be established by the various states who choose to regulate additional services provided to their citizens above that which is provided by the basic LifeCare plans. *As an example only, a state may require for the citizens of the state, in the case of a mastectomy, reconstruction of the breast must be included in the insurance plans offered in the state. Since the LifeCare plans must be the same for all everywhere and in this example it is assumed that breast reconstruction is not included in the LifeCare plan coverage – only the effective removal of the cancer and treatment – the state would require the insurer to offer this, and any other additional coverage items deemed required by the state, in a state based Quality of Life care plan bundle.*[64]

Technology development will be stimulated in the Quality of Life market based on its ability to feed improved quality of life outcomes, higher perceived value, and other discriminant benefits beyond simple efficiencies and lower costs. The integration of both of these market systems should provide the best environment for venture and government funding of both types of R&D activity to continue and grow.

LIFE HEALTH & WELLNESS SAVINGS ACCOUNTS

The solution establishes new tax-advantaged Life Health & Wellness Savings Account (LHWSAs) as the principal means for consumers (whether employed or not) to manage their coverage and health-care. Features include:

- Two flavors analogous to conventional and Roth IRAs.
    - Conventional LHWSAs (contribution limits means-tested) with the same investment and taxability rules as conventional IRAs.
    - Roth LHWSAs (no means testing) – same investment and taxability rules as Roth IRAs.
- Current HSAs can be grandfathered or converted to LHWSAs
- Unlike HSAs, LHWSAs can be used to pay insurance premiums for LifeCare plans, Health & Wellness programs and/or Quality of Life Advantage plans and services.
- More liberal limits than current HSAs on annual contributions with no lifetime cap.
- Modestly more liberalized spending than HSAs for products/services not normally covered by even Quality of Life Advantage plans (cosmetic surgery, sexual reassignment, cosmetic dentistry, etc.).

[64] One advantage to this approach, beyond the obvious economic, efficiency and certainty benefits earlier stated, is that the additional coverage options that may be required by the state will be itemized and clearly identifiable as to their benefits and costs so Participants will be able to clearly compare costs to perceived value of services delivered. It is anticipate that free market forces will work in this case to continue to bring down real care costs.

- Balances remaining in a LHWSAs at death can be passed down to beneficiaries (like IRAs) motivating elderly Participants, and their Facilitators, not to spend excessively in the final years of life.
- Contributions to LHWSAs by employers, Participants and through transfers from IRAs, as well as by direct deposits from the federal government (as premium subsidies) and Quality of Life payments, will be encouraged as the principal means of paying for all care services.
- Initially larger catch-up transfers beyond LHWSAs annual contribution limits from IRAs, employers and/or employees to stake an LHWSAs will be allowed
- Means-tested larger contributions in case of catastrophic illness can be considered.
- Direct deposits of federally-funded LifeCare plan premium support loans for displaced workers, disabled or other eligible individuals.

EMPLOYERS HEALTH & WELLNESS STIPEND

As discussed in the problems section, our history of unplanned expansion of Employer Sponsored Insurance (ESI) has had some benefits to workers but it also has come with significant unintended consequences and has created the current system dynamic that has contributed mightily to the significant increases in cost of care for Americans and America. While ESI is no longer good for the system nor for the economy nor competitiveness of employers; some form of incentive is required to motivate people to make provisions for their life's needs and to adopt behaviors and make life choices that not only lower costs and improve productivity for employers but improve the lives of Americans as well. In this solution, employers continue to play a key role and will continue to be recognized economically for voluntarily doing so.

Under this solution, employers will be able to either receive a tax credit or a deduction from earnings for monthly Health & Wellness Stipend amounts provided to employees for the purchase of health and wellness related expenses. To keep the cost of adoption of this system by the government and employers to a minimum, the employer will receive this tax benefit regardless of how the employee actually utilizes the funds.

If the employee transfers the funds directly to their LHWSA and/or uses these funds to pay for LifeCare plan or Quality of Life Advantage plan premiums, or other qualified health and wellness services, the employee enjoys the same tax free advantage of the stipend as the employer. Should the employee choose not to use all, or part, of these funds in the proscribed manner, then the employee will be assessed taxes at the employees effective tax rate and in addition will be assessed a penalty equal to the employees tax rate in order to, in-part, offset the employer's tax deduction for the percentage of funds not used as proscribed. The idea is to incentivize the employer but not penalize the employer if the employee does not comply and to minimize the cost of implementation. Further, it is designed to stimulate the employee to act in a more responsible manner and better plan for their current and end of life needs.

It is anticipated that given the average current cost of ESI contributions for employees today, and recent polls of employees as to what would be an acceptable stipend if they were to lose ESI from their employer, an effective stipend would likely be in the $500 per employee per

month range.[65] Under this scenario, elimination of ESI costs and replacement with a monthly employee Health and Wellness Stipend would not only reduce employer costs but would provide better more cost effective and personal choice delivered coverage to employees as well as contribute to an overall lowering of employer's costs.[66]

As an example only, Company A offers a $500.00 Health & Wellness Stipend to all employees. John Doe has chosen to receive his stipend as a direct deposit in his LHWSA. John only uses the funds in his LHWSA to pay for his LifeCare Plan premium, and for direct payment of Quality of Life services to providers or for qualified wellness programs. John participates in a qualified wellness program that also includes a non-smoking program at a cost of $25.00 per month with certification. As a result instead of the regular $250.00 per month LifeCare premium payment that John, along with all of his 27 year old peers, paid at sign up, he gets a nonsmoking deduction of $25.00 and a fitness credit of $20.00 as long as he maintains his nonsmoking and fitness certification. At the end of the year, John has not spent all of the stipend collected and has accumulated $2,500.00 as the tax free balance in his LHWSA. As a result, John and his employer both receive full tax deductibility for these funds. Mary M. Q. Contrary also works for Company A and receives the same stipend of $500.00. Mary has chosen not to set up a LHWSA to receive the funds but instead collects them as an itemized addition in her pay check. Mary's monthly LifeCare plan premium payment is $250.00 and each month she writes a check to her insurance company. Mary has not chosen to spend any additional funds on qualified health or wellness services and has not purchased a Quality of Life Advantage plan. Mary has chosen to use the additional money to trade in her old car and get a new one and absorb a bigger monthly car payment. At the end of the year Mary, has only spent $3000.00 of the $6,000.00 she received in stipend on qualified care. She is now responsible to pay taxes on the $3,000.00 portion of the stipend that she has not used for qualified care and has not deposited in a LHWSA. Mary earns $92,000.00 per year and is taxed on the unspent amount at the rate of 28 percent. She will also pay a penalty of 28 percent making a total tax and penalty liability of 56 percent of the unqualified $3000.00. Mary will pay taxes of $1680.00 for the $3,000 she received in stipend that was not used in a qualified manner.

A key part of the proposed solution is to make the LHWSA the prime vehicle for health and wellness related payments and to stimulate, train and incentivize employees to see this option as their prime method not only to pay for current needs, and wants, but to properly prepare for the additional services they may desire in later life when they are no longer an active member of the productive workforce.

[65] What the actual number may be will ultimately be driven by the limit of deductibility each month granted to employers who choose to offer employees a Health and Wellness Stipend, recruiting pressures and market demands.

[66] It is not anticipated that Employers would be restricted to offer the same stipend amount to all employees. It is anticipated that the deductible monthly amount limit would be the same for all.

SINGLE POINT OF ADMINISTRATION FULL COORDINATION OF CARE & BENEFITS SYSTEM (SPAFCCB)

We have spent in excess of $750 million in creating Healthcare exchanges at the federal level alone.[67] Recent proposals have advocated abandoning the exchange system altogether. This solution does not take that approach. It plans to preserve this investment and repurpose the infrastructure, much of it currently technically consistent with the future roles as described.

The key to integration of the LifeCare and Quality of Life Care market systems are the repurposing of the current HealthCare Exchange infrastructure to provide for a single point of administration incorporating full coordination of care and benefits across all available sources. Doing so will not only effectively support better integration of the various cohorts in the care continuum, it will also provide the innate checks and balances to reduce the waste inherent in the current and historical system. It is anticipated that as much as 40 percent of the healthcare spend and service utilization can be saved just by effective coordination of care and benefits. This will not only save money it will also free resources to cover more patient needs. It is also well documented in various studies that better coordination of care significantly improves outcomes and lowers costs.

The system, as proposed, would tightly coordinate and integrate the needs, resources and functions of four cohorts; Participants, Facilitators, Providers and Sponsors as described earlier. Each cohort will have an appropriate workflow to reflect the type of services they provide, the specific classifications of information they need to integrate to accomplish their job, the specific legal and disclosures required for the work they perform and the roles and responsibilities associated with their work.

Participants, beyond simply sourcing LifeCare plans, Quality of Life plans and services, will also be able to find appropriate providers and benefits programs that they may be eligible for, automatically. Participants will fill out one dynamic form that will automatically match them with any plans, programs and benefits they may need. The goal of this dynamic form system is to eliminate the need to apply to each program with a different form and to repeatedly enter the required information multiple times. With this single point of administration system, all required static data points are entered once and then matched with the eligibility requirements and constraints of all programs. Participants will be able to source providers based on their participation with various programs beyond LifeCare plans. They will be able to review information about providers, review participants feedback, review appropriate metrics and results and view Providers registered information including education, mortality and morbidity rates, Participant feedback, specialties, and Quality of Life services pricing in order to compare one Provider and their services with another to make informed decisions. Participants will be able to communicate with any, and all, of their virtual care group to coordinate their care across providers and facilitators. Participants will also be able to effectively calculate their planned care expenses with any and all eligible benefits programs beyond basic LifeCare.

[67] Other estimates place the total cost including expenses within the insurance industry and other entities at well over $3.8 billion.

Facilitators, will enter the system by registration of the services they wish, and are qualified, to provide.[68] This system will improve Facilitators ability to offer their services to Participants, they will be able to better source services for their managed Participants, easily manage eligibility, and enrollment to programs and benefits, easily schedule care with providers and manage relationships and coordinate care across a number of providers to reduce duplication of services and fraud. Finally, the system will make it easier for Facilitators to help manage the transition of Participants between Providers, programs and Sponsors. This should lower costs, improve efficiencies, reduce Participant anxiety, and improve outcomes.

Providers, will enter the system by registering their services. Providers will be required to publish a list of their services, background education and other information in a standard dynamic form system to facilitate rapid matching and informed comparison between Participant's needs and Sponsor's program requirements. Providers will benefit from integration into a wider network of Sponsor programs and payers for the services they provide. Further, the integration of Providers into true Participant centered virtual care groups, as described next, will help Providers improve outcomes and reduce unnecessary and duplicative services across providers.

Sponsors, will benefit primarily by the reduction of the silo effect endemic in the current systems. Sponsors will enter the system by describing their offerings – programs – and entering the description of the program, its benefits, and the criteria for eligibility and program constraints. Further, Sponsors will be able to establish criteria as to when and how their program dollars get provided to Participants and paid to Providers through a number of allocation structures including, shared responsibility benefits.[69] These systems in addition to lowering waste, fraud and abuse, help Sponsors manage their funds to provide a balance between the maximum provision of care and the maximum number of participants served.

There are many additional areas where this type of system will provide benefits. Let's highlight three main benefits;

1. Saving money through reduction in duplicated services, unnecessary services, fraud and adverse reactions due to lack of coordination of care and benefits
2. A more appropriate spread of available resources freeing access to services and funds to pay for them across the widest possible need

[68] If they work on behalf of a Provider or Sponsor they will immediately be associated with the entities and programs they are already integrated with. If unaligned, Facilitators will fall into two basic categories; those with some form of recognized certification, like case workers, social workers, parole officers etc, and uncertified Facilitators like friends, family members, legal guardians etc.

[69] – where each Sponsor provides an equal portion of payment divided across all eligible programs, Agreed allocation structure – where groups of providers agree to specific percentages of payment based on negotiation and agreement between Sponsors, and Payer of Last Resort – where the allocated available funds are dispensed in sequence from a tiered and prioritized list of Sponsors covering the services provided until the total service cost is covered. Typically, in payer of last resort systems the last two payers, after all other programs sponsored funds are utilized are state sponsored programs followed by federal sponsored programs.

3. An improvement in patient outcomes through a better coordination of care and the incorporation of true participant centered virtual care groups.

This solution is designed in a manner whereby the federal government will provide the infrastructure to each state and citizen free of charge.[70] The federal government will develop and maintain the base level system infrastructure, storage infrastructure and the points of access. Each of the individual states will have the option to control their state level data, rules and access. States will have the option to augment their data structures to accommodate their specific state requirements.[71]

The system will be designed such that the federal government need not have innate access to any specific data at the state level except with agreement with the various states. The federal government will have the ability to extract de-identified Participant, Facilitator, Provider and Sponsor information and make this available to all states, individuals and academic institutions for research and comparison of services purposes. The federal government will be limited to access full patient information, except in its role as a Sponsor consistent with the role of Sponsor and need to know access of any Sponsor.

TRUE PARTICIPANT CENTERED TRANSACTION

The SPAFCCB system described in the forgoing section has at its heart a truly participant centered transaction system. The current regulations, and practice models claim that they offer patient centered systems. While they can make the claim of patient centeredness for patients within their institutional systems, they are only patient centered within the institutional system. Once a patient is out of the care network, or in many cases out of the institutional system, true patient centeredness is lost. Current systems do not take a transaction centered approach. They take an institutional IT or information system centered approach.

The system proscribed is a true Participant Centered System with the transactional center of access to all resources, programs, payments and information that of the Participant. In essence, every Participant as they work with Facilitators, Providers and Sponsors are consciously admitting these individuals and institutions into an exclusive virtual care group. In doing so, and based on systemically proscribed access permissions, these members of the virtual care group are able to interact with each other, coordinate their activities specifically with this Participant and share information based on permission and need to know relating to the care, benefits and combined outcomes of the Participant.

All data, regardless of physical storage location, is, in effect, the individual Participant's data. Access to the data may be initially set by the defaults within the system, but the

[70] –no access or maintenance fees charged to either states or participants

[71] Such state based changes may not restrict transportability, comparability or access of required information between users in any cohort in any state.

Participant may have the ability to override access and remain largely in control over access and storage location of data.[72]

In this true participant centered system the Participant becomes the sole source of all information requested by members of the virtual care team.[73] As they currently do, each member of the team may physically house some of the Participant's data. They can either simply be a location where the data is stored – as the original source or as one of a number of backup points – or they can be the authoritative source for the information.

With each member of the virtual care group able to access the data they require immediately, there is no longer a need for every provider to have every piece of participant information as they do today. Providers, and Sponsors will be able to effect full business transactions for claims and payments without having to physically collect and house all of this information. This approach can support existing electronic medical records systems but they may not be required for this level of coordination.

As an example only, Let us say the participant, John Doe, has four members in his Virtual Care Group, his general practitioner, his urologist, his dermatologist and his LifeCare policy insurance company. In this scenario, John has an enlarging prostate, his GP has referred John to the urologist. The urologist has been monitoring John for a number of years. When John goes for his 6 month checkup the urologist conducts a digital exam and a urine collection for a number of chemical analysis and orders a blood draw for PSA. The urologist is the authoritative source for this PSA data and is liable for the integrity and accuracy of this data in any resulting diagnosis that incorporates this data. The GP has no need to also conduct PSA tests as the PSA data is always immediately available to the GP when he is interfacing with John as he is a member of the virtual care group. There is no need for the urologist and the GP to be in the same practice group, or in the same network. They do not need a contractual relationship to share this information because in no case do they facilitate the exchange of this information. If the GP needs to know John's PSA all he needs to do is electronically poll or "ask" John. As an approved member of John's virtual care group, the request is received by John's systemic presence and John requests the data from the authoritative source – known by John's electronic presence – John's urologist. The urologist's system, recognizing this as a legitimate and authorized request, immediately forwards the data to John's electronic presence who forwards the data to the GP. There are no HIPAA complications because John is the source of the exchange of data in every case. John's electronic presence is the only location for the map of all John's electronic data regardless of source. And, John has control over his information, within certain limits. John can move providers and electronically move his data along with the change in provider.

This system will reduce data storage requirements, network traffic due to the current need to synchronize massive amounts of data across all the various data storage locations, cost of data maintenance, and data liability. It will also improve data integrity and significantly

[72] Except in the case of prisoners and parolees

[73] This is not necessarily a central storage based medical record system, but nothing in the design prohibits this type of system.

reduce certain duplicated services that the current system continues to initiate due to HIPAA and due to lack of effective care integration and Provider data needs.

FUTURE OF MEDICARE AND MEDICAID

It is anticipated that the proposed solution will over time subsume Medicaid and Medicare systems. As earlier stated in the problems section Medicaid and Medicare were systems started as solutions for the problems of the day and to meet specific needs criteria and constraints. Over time, they have expanded and grown to incorporate an ever expanding series of objectives. This has led these programs to become further disintegrated from the rest of the current healthcare system and as described earlier has created a very unhealthy set of dynamics that has led to significantly rising, yet unobtainable, expectations for care and massively rising costs. It is the continued assumption that these existing systems must be maintained that has forced most, if not all, of the historical and proposed solutions to fail to address these fundamental problems and to fail the American people.

This solution has been proposed to incorporate the requirements and the delivery of care that is consistent with the needs of the populations served under these programs while lowering the role of government in the provision of these services, lowering costs and improving accountability. It is anticipated, that over a period of three to five years, these programs will be subsumed by the LifeCare and Quality of Life Care market systems.

REFERENCES

Institute for Health Improvement. (n.d.). *Frequently Asked Questions about the 5 Million Lives Campaign.* Retrieved from http://ihi.org/IHI/Programs/Campaign/Campaign.htm?Tabid=6.

Klevins, D. M., Edwards, M. J., & et.al. (2007). Estimating Healthcare-Associated Infections and Deaths in U.S. Hospitals. *Public Health Reports March-April*, 122(2):160-166.

Kumar, MD, MSc, MPH, S., & Nash, MD, MBA, D. (2010). *Demand Better: Revive Our Broken Healthcare System*. Bozemon, MT: Second River Healthcare Press.

McGlynn, P. E., Asch, M. M., & et.al. (2003). The Quality of Healthcare Delivered to Adults in the United States. *The New England Journal of Medicine*, 348:2635-2645.

Scarborough, MD, N. (2008). *MEDICAL MISDIAGNOSIS in America 2008: A Persistent Problem with a Promising Solution.* Franklin, TN: Premerus.

ABOUT THE AUTHOR

Thomas W. Loker is a businessman and author with almost 40 years of experience in a variety of industries ranging from science & healthcare, to computers, technology and devices. His latest book is *The History and Evolution of Healthcare in America: The untold backstory of where we've been, where we are, and why healthcare needs more reform*. Amazon says of Tom's book:

> *"From the beginning of mankind, health and health issues have played a major role in life, but the issues and care have evolved enormously from the time when the first settlers set foot in America to the present. In The History and Evolution of Healthcare in America, author Thomas W. Loker provides a historical perspective on the state of healthcare and offers fresh views on changes to Obamacare.*
>
> *Insightful and thorough, The History and Evolution of Healthcare in America offers a look at*
>
> - ✓ *What healthcare was like at the birth of the nation*
> - ✓ *How the practice of providing healthcare has changed for both caregivers and receivers*
> - ✓ *Why the process has become so corrupt and expensive*
> - ✓ *What needs to happen to provide both choice and effective & efficient care for everyone*
> - ✓ *Where we need to most focus efforts to get the biggest change*
> - ✓ *What is now needed to get control over this out-of-control situation*
>
> *Loker narrates a journey through the history of American healthcare—where we've been, how we arrived where we are today, and determine where we might need to go tomorrow. The history illustrates how parts of the problem have been solved in the past and helps us understand what might be necessary to solve our remaining problems in the future."*

Tom is one of the few people who has not only read the Patient Protection and Affordable Care Act in its entirety, he has read the companion legislation, and he has read almost all proposals and draft legislations from the myriad of committees that were combined into the final bill. Tom has extensive experience in healthcare benefits administration to underserved and difficult to manage populations has met with numerous members of congress on healthcare reform related issues and provided congressional briefings on effectively serving underserved populations, reducing cost through effective coordination of care and benefits, true patient centered transaction systems, and much more.

Tom served as Chief Operating Officer for seven years with a company that manages complex public-funded healthcare benefits for low-income and underserved populations. He is an active board member in both for-profit and not-for-profit companies. Tom has written numerous articles in the areas of healthcare, technology, politics and the economy, published by California Political Review, Lead-Zine, and others. He has been a quoted expert in numerous stories by NBC-universal, Workforce Management Magazine, Managed Care Advisor, Managed Care Magazine, Menlo Park Patch Newspaper, Physicians Money Digest,

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Prior to *The History and Evolution of Healthcare in America* Tom as also published *Delusional Ravings of a Lunatic Mind* – a collection of essays about healthcare, the economy and politics, available at Amazon, Barnes and Nobles, and other bookstores and with his son Aleck, *Calistoga Ranch: A Photo Collection* – a photo essay of pictures from the Napa Valley area of California focused on Calistoga Ranch, available at Blurb. Com. You can find Tom online at: www.loker.com and tloker.wordpress.com