Project Proposal

Prepared for: Joint Task Force on Universal Health Care

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Proposal number: 1

Objective

No one goes without life and limb saving healthcare because of costs or barriers navigating insurance. No one goes bankrupt from life and limb saving healthcare.

Goals

Provide easily accessible and understandable healthcare coverage for basic life and limb saving conditions.

Solution

Create a healthcare system that works for everyone. With Single Payer, Private Insurance, HSA and Cash Pay options.

I worked for an on-call ER surgeon in the Portland metro area. I analyzed health insurance claims, collected medical bills and navigated prior authorizations for five years. We got prior approval and billed about the widest range of CPT and icd9/icd10 codes possible, through just about every insurance company and hospital in Portland/Oregon.

Almost everyday someone screamed, cussed me out and cried to me on the phone or in person. Our patients were dealing with cancer, chronic wounds, injuries and other needed surgeries. Patients were overwhelmed with medical bills and couldn't afford time off work. We often had to fight to get bills and procedures covered. Even then people were drowning in copays, coinsurance and deductibles.

I've seen so many individuals and families who thought they were doing okay in life become crushed by circumstances out of their control.

This affects us all.

We need a healthcare system that works for everyone.

Amy Erdt
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BUDGET

STAKEHOLDERS:

If we help stabilize healthcare, it increases support for small businesses, individuals and families. This will reduce poverty and increase community well-being and productivity.

Given access to the data, I can help crunch real numbers as needed.

Description	Quantity	Unit Price	Cost
Team	Unknown	Unknown	Priceless
Total			**Worth it.**

Solutions

■ Single Payer and Private Insurance Section:

Everyone is on one single payer health-insurance plan that covers 'set' diagnosis & treatment/procedure codes (icd10 and CPT codes). Example: cancer is covered, but a typical benign mole removal is not covered under the public plan. We already have an "above/below the line" prioritized Medicaid list. And Medicare sorts covered and non-covered items. We could certainly hash out a workable public plan.

Require all doctors and hospitals to see a certain minimum % of Single Payer Plan Patients in their overall practice. Doctor/hospital tax breaks for publicly billed codes, billed to the single payer option. (Some States don't require hospitals to pay taxes so we'd need to fix that.)

New doctors & hospitals would be required to take a higher percentage of public-plan billable appointments. A doctor who *only preforms cosmetic services would be exempt.

Established/experienced/highly trained, doctors & hospitals (possibly who've earned a better results record) can collect more expensive pay rates from contracted private plans, cash pay and HSA options... and would be allowed to set aside a % of their practice for patients who choose those options.
People (Or employers) who want to, may buy additional private insurance plans, for non-covered codes or higher payable rates, for publicly covered codes.

Contracted rates through private insurance companies would mirror how they already work.... *Except, minimum and maximum charge/payable rates would range from the lowest public plan option amount, to 5x's higher. Or would have a 5x's span for all codes not covered by the public option. This helps restrict insurance companies from artificially inflating charge rates by yo-yo'ing payable amounts.

Public plan pay rates calculated by the RVU, GPCI & CF system. (Don't ask, it's a complicated, flawed, well thought out way to factor the physician fee schedule.) There are some valid concerns with the RVU system. We'd like to see some different ideas where doctors, insurers and state ombudsmen would reevaluate the fee schedule every two years to adjust pay/charge rates by location & cost of living location.

We'd (this was written with input from lots of medical billers and thousands of community member's discussions) like to see hospitals, clinics and facilities move away from paying clinicians based on productivity/billable RVU's. This model often encourages tests and procedures to be ordered that wouldn't otherwise be and pushes quantity over quality care. It also ultimately increases costs for healthcare.

Private insurance policies can offer tailored plans like they do now. Some economy plans might just cover codes not covered by the public option. Some Cadillac plans would pay higher contacted rates for publicly covered and non-covered codes. Some policies would come with deductibles, co-insurance, copays and outta pocket maximums.

■ **HSA & Cash Pay Section:**

Assign lifetime tax deductible HSA (Healthcare Savings Account) & RSA (Retirement Savings Account) at birth. Cash-out options if a specialty doctor signs off on 12 months or less - terminal diagnosis. Patients at the end of their life, with particular disease progression can cash out accounts and 'live it up' if they want.

Lifetime HSA's & RSA's stay with the person, not grouped by employer. Optional investment account vs regular savings.

HSA plans can be used to pay for medical bills, private insurance deductibles, co-insurance and premiums. As well as supplemental healthcare costs and lost wages do to an illness or injury.

Employers can contribute to earn tax breaks or they can continue offering investment retirement accounts or *bonus private insurance plans.

Tax deductible contributions to HSA/RSA for individuals/family/friends/employers/wills/gifts. Able to will to another HSA or RSA at death. (We could also offer tax funded bonuses for low income savers, every five years for meeting Savings Goals. This would help keep Social Security solvent) Limit HSA/RSA contribution amounts/types to prevent fraud.

That's a system that we all can contribute to.

Where we all get access to a public plan but still have the choice to pay out of pocket, use private insurance or our HSA accounts.

Patients, doctors and hospitals would have forms to agree which option would be billed. If the patient is unconscious etc. (emergency care for instance) the bill would automatically go to the public option account... unless a spouse or parent etc. wanted to use private pay/insurance for a particular specialist/hospital.

This system encourages competition and innovation between doctors, hospitals and insurers. It also encourages doctors and hospitals to take public payments for the tax breaks and positive social duty. For example, a skilled, experienced, educated, expensive surgeon could reserve 40% (or whatever maximum % allowed) of their cases for private pay patients. Or potentially pay a fee, to wave taking in public plan patients.
Ideally we would include basic dental and mental/emotional health coverage as well.

EHR (Electronic Health Records) and PM (Practice Management)

One of the biggest things we can do to *Reduce healthcare costs AND increase quality/safe care, is create a universal EHR (Electronic Health Records) and PM (Practice Management) billing, prior/retro authorization and insurance coverage check system.

Right now it's a patchwork of disorganized/dysfunctional systems and procedures for obtaining, reading and charting records, authorizations, checking coverage and submitting/following up on claims.

This creates barriers to safe, efficient, effective treatments because patient and insurance information is delayed or time consuming to obtain/read/chart.

A difficult and convoluted overall system helps private insurance companies because the more challenging it is to check coverage, authorization, and claim status, the less they end up paying out for more expensive procedure codes.

A universal EHR & PM system would also help prevent billing fraud because everyone would have one place to check for charges to public accounts.

Currently we already have lots of different EHR & PM software being used by all different doctors, hospitals, insurance companies and managed care organizations.

These all come with the same data encryption and security risks but don't offer the benefits of one universal system. A standard EHR and PM system for our country would create the access needed for effective and efficient care. It would also greatly reduce charting time for doctors, nurses and support staff.

Healthcare professionals often have to learn different programs or search for patient/insurance information in all different formats. Imagine every time you read a book, publishers print it differently. Sometimes left to right, down, up, sideways on the page etc.

When healthcare professionals have to spend time re-learning where basic chart items are it increases risks and costs for patients.

These industries are huge and probably won't like their market being reduced or changed. They need to adapt.

This isn't business, it's personal.

Our health and the health of our loved ones is our biggest asset in life. We need the best healthcare system and that means some powerhouse players will need to step aside or adapt for the benefit of our country as a whole.

Doctors and hospitals are required to keep records for a certain amount of time. Those software companies can make second party applications for backup data storage and retrieval. Or possibly we could require a set structure for charting, plan coverage info and submitting claims, that the existing software companies would have to adapt to and create a filter to feed information to one main system that's accessible to healthcare professionals and patients. Obviously, different types of access for different users.

Facing illness, injury and lost wages from forced time off work, shouldn't be compounded by stacking medical bills.

We can talk about prescription prices in a separate proposal because that's a whole different can of worms.

There are tangible policy changes that can happen now. For instance: Force doctors, hospitals and insurers to process all claims in the ER and ICU as 'in-network'.

Currently if an on-call specialist is called in to treat a patient, there's little ability for a patient to avoid getting charged out of network. That's wrong and should be fixed ASAP.