

***The 14 Page  
Solution to  
Health Care Reform***

***Informedhealthplan.com***

***The Total Packaged  
Fully Thought Out Plan***

## *Executive Summary*

### *“Informed Decision Health Care Plan”*

**Major points only – Please see detailed plan.**

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- A. Providers:**  
**Post all fees and qualifications**
  
- B. Health Insurance Companies:**
  - 1. Contribute to two pools:**
    - a. Uninsured pool**
    - b. Catastrophic pool**
  - 2. Pay providers posted fees**
  - 3. Sell plans that vary only by co-pay amounts and criteria and threshold amounts required for mandatory second opinions**
  - 4. Encourage savings plans**
  - 5. Portable State to State plans**
  - 6. No pre-existing illness clauses**
  - 7. No more restrictive provider networks**
  
- C. Attorneys:**
  - 1. Tort Reform**
    - a. Caps for pain and suffering.**
    - b. Police themselves via a “practical” new definition of frivolous suit which will have reasonable penalties if all 3 criteria are met**
  
- D. Patients (Below age 65):**
  - 1. Shop price and quality**
  - 2. Pay something for each piece of healthcare no matter how little**
  - 3. Have a “Living Will”**
  - 4. Second opinions for non-urgent care over a “patient selected” threshold amount**

**E. Hospitals:**

- 1. Post all fees and expect to compete on price and quality.**
- 2. Establish and run outreach clinics funded via a fund called “Uninsured Fund.” See detailed plan**

**F. Government:**

- 1. Define terms (urgent, non-urgent, and catastrophic care) and regulate system as provided by this new legislation and not beyond**
- 2. Leave Medicare ALONE!**
- 3. Proportionally fund two pools of funds along with substantial contributions from insurance companies and state government, etc.**
  - a. Uninsured pool**
  - b. Catastrophic pool**
- 4. Expand Cobra and health savings plans**
- 5. Transparency for all health related revenue sources**

**MEANINGFUL REAL, COMPREHENSIVE AND PRACTICAL  
HEALTH CARE REFORM**

**“Informed Decision Healthcare Plan”**

**Goals**

*To provide patients the freedom of choice.*

*To bring prices down and connect people with their money.*

*All parties who affect medical costs and medical care must participate.*

- I. Providers: Doctors, Hospitals, Physical Therapists, chiropractors, etc.  
(all providers)**
- A. Require all providers of medical services to:**
- 1. Post all of their fees and charge only those fees to all patients and all payers (using descriptions and current codes).**
    - a. Make all fees easy to understand. (Like all other commodities)**
    - b. Agree to have one and only one fee for each service.**
    - c. Describe all fees in pamphlets, faxes, waiting room, posters, websites, etc. (all fees must be in a meaningful order of frequency).**
    - d. Describe all fees in the order of their most common services to their least common services.**
    - e. Post the single most appropriate, fair, reasonable, and realistic fee that they must accept for that given service and that they expect to be paid each time they perform that service regardless of who they bill or who ends up paying. (No one will set these fees but them.) Each provider will then quickly adjust to the true market forces of supply and demand.**

**THE LAW OF SUPPLY AND DEMAND WILL QUICKLY TAKE OVER.**

- f. Agree to provide their fees to all patients at all times and most importantly before their appointment and require signature of the patient (Like HIPAA)
  - g. Utilize already established CPT codes with the same unbundling rules that currently apply.
  - h. Re-affirm or change their fees on an annual basis.
  - i. Understand all laws to end price fixings as it affects them and expect to be prosecuted if found guilty.
2. **Post their qualifications**; credentials, malpractice history, practice history, most frequently performed procedures, complication rate, etc.
  3. **Post fees and qualifications** on uniform sortable websites to be maintained by the government.
  4. Be responsible to verify and update their information annually.
  5. Expect to be prosecuted for conspiracy to commit insurance fraud in cases where practice patterns reflect abuse or excessive treatment, particularly when litigation or entitlement programs are liable for medical bills. (Enhanced prosecution of medical, legal mills)
  6. Bill all care defined to be catastrophic care to catastrophic pool.
  7. **This plan will eliminate pre-authorization/precertification and referrals, along with all the bureaucracy and costs associated.**

**II. Health Insurance Companies:**

- A. Provide catastrophic insurance separately delineated as a specific portion of the premium charged and provide such catastrophic funds to national catastrophic pool. Based on some proportion to be shared with the government and other voluntary supporters, this pool will pay for all catastrophic care.
- B. Pay 100% of all care of their insureds that fits the government definition of urgent care with no copy or no 2<sup>nd</sup> opinions necessary.

Provide a portion of their premium **(line item clearly and transparently)** for **uninsured care to go to a pool along with government funds to support hospital outreach clinics** to cover their share of medical care for the poor. This pool will receive their funds as well as government funds and payments from patients based on a uniform means test as well as charitable contributions.

- C. Provide insurance for non-urgent care; **(90% of medical care is non-urgent)** with 1% to 25% co-pay **(depending on the specific policy)**. Co-pays are to be paid on **all bills**. **(No care can be completely free if a patient has insurance. We all must have “skin in the game.”)** Even if the co-pay is very small, it must be applied to all bills.

Whatever the copay that the patient selects, the **hospital charges** (for elective, non-urgent care, the much larger portion of medical bills) will be one-quarter of the selected copay (e.g., a \$10,000 hospital bill would require only \$250 from the patient if he had a 10% co-pay).

As people attempt to decrease their small portion of their own bills **(and now have the tools to do so)**, they will automatically decrease the insurance company’s larger portion of the bills. The fees will drop substantially within the first several years of the institution of this new law: **“Free Market.”**

Insurance companies will therefore have to sell policies on the basis of only two criteria:

1. % of copy the patient chooses;
2. Threshold amount for non-urgent services that require a 2<sup>nd</sup> opinion (see Section IV under ‘Patient’)

All other issues that obstruct care will disappear (networks, providers, deductibles, provider negotiated fees, mandatory IME’s, need for referrals, need for authorization, etc.) Finally, patients will be able to compare and shop insurance.

- D. Deductibles are to be historic. No more deductibles. **(Deductibles serve to only cloud issues and prevent patients from understanding true costs)**
- E. Must sell **Medical Savings Insurance Plans** substantially less than HMO or PPO types of plans. **(In other words, incentives to encourage people to purchase)**. Savings plan insurance is critical, and are already in place. The laws governing such plans are not to be changed.

- F. No exclusions for pre-existing conditions (no more cherry picking).
- G. No differential between group or individual plans (no more games).
- H. All plans must be portable state to state and regulated at the federal level (**like so many other industries**). This means that any state licensed provider can see any patient (as it should be).
1. At first, contracted and subcontracted networks must be cross credentialed or related in such a way as to be seamless to the patients, state to state. (No more networks or at first invisible networks)
  2. Therefore, the Patient, the System and the Free Market will replace the insurance companies/providers behind closed doors negotiations (Transparency and Free Market will be allowed to work properly).
- I. Extend Cobra substantially.
- J. Simplify plans so that they can be understood by all patients. (EOB's should have two columns, what you paid and what they paid.)

**This plan will eliminate pre-authorization/precertification and referrals, along with all the bureaucracy and costs associated.**

- K. Track and identify and provide information for investigation and prosecution of the appropriate agencies when patterns of behavior are detected that suggest medical/legal insurance fraud (**doctor, patient, carrier, or attorney**.)
- L. (Optional)  
A single healthcare payer for all health care (other than Medicare), no fault (auto insurance) and worker's compensation requiring carriers to reciprocate and subrogate behind the scenes among each other (**so no other laws will need to be changed**) all at the same posted fees. Re-separate indemnity payments from medical care. All the same rules apply for indemnity payments. Handle through carrier to carrier transactions behind the scenes.

- **The precipitous drop in car insurance costs and in workers' compensation premiums will be realized immediately and this will be a huge boost to the economy.**
- **Employer's premiums for workers' compensation insurance will drop.**
- **All purchasers of auto insurance will enjoy large and immediate savings.**
- **Hundreds of millions of dollars will be saved.**

**Summary:** Insurance companies will compete on two key parameters:

1. Premiums associated with a given copay, 1% to 25%. The higher the copay, the smaller the premium.
2. Premiums associated with a patient selected 2<sup>nd</sup> opinion threshold. The smaller the threshold, the lower the premium.
3. All urgent care provided at 0% copay.
4. Insurance companies will require patients to pay only half of their selected copay, whatever that is, to hospitals or surgicenters for non-urgent care.
5. Insurance companies will pay 100% of urgent care costs. They are relieved of all catastrophic costs.

**III. Attorneys:** Two legs to simple, real tort reform.

**Fact I:**

*30% of tests and care is originated by doctors who feel that they have to protect themselves from malpractice litigation.*

**Fact II:**

*15% of providers as well as hospital fees are devoted to cover malpractice premiums.*

**Legislation 1:** Caps on pain and suffering

(Suggested \$250,000 to \$450,000) full reimbursement for true losses (wages, future care, etc). This has been tried and has worked in every State where it has been tried.

**Legislation 2:** Penalties for filing frivolous malpractice lawsuits

1. Penalties not to exceed the true court costs (the waste of judicial time), but penalties are necessary; however, they must be fair.
2. Penalties to be split in reverse of contingency fee. (If the lawyer agrees upon a win, take 30% of the proceeds from the case. Then the lawyer is to pay 70% of the penalty and the patient pays 30% if the case is determined to be frivolous.)
3. The government to create a new practical definition of frivolous which is different from the legal definition. Call it "Practical Frivolous" and let it be covered by the attorney's malpractice insurance and composed of three criteria:
  - a. This new definition of frivolous is made up of 3 criteria. All three must be confirmed frivolous and all three must be in agreement with each other.

**Criteria #1:**

Lose the litigation. Had to be lost before a jury (no cause verdict).

**Criteria #2:**

Medical Peer Review Panel must find that the provider was not at fault.

Panel to be selected randomly from a pool, outside of the jurisdiction of the medical provider that was sued, and made up of 3 defense medical experts and 3 plaintiff medical experts and one randomly selected blindly from the same pool of an equal number of defense and plaintiff experts.

**Criteria #3:**

Legal Peer Review made up of a panel of three randomly selected defense attorneys and three plaintiff attorneys and one selected blindly from the same pool of an equal number of defense and plaintiff attorneys. Each panel of attorneys to be selected from different jurisdictions and freshly appointed for each case. (Very similar to Medical Peer Review)

4. All expert witness' testimony in all malpractice cases is to be published on the internet and reviewed for scientific validity; review comments permitted on website.

Periodic review of the comments to be undertaken by each state medical licensing board who will consider disciplinary action against expert witnesses if certain high threshold criteria are met and where truthful evidence based and scientifically supported testimony is brought into question.

5. Lift prohibition against suing HMO's.
6. Substantial penalties should be imposed for encouraging clients to seek unnecessary medical treatment to enhance their probability of winning their litigation. Prosecution should be against the attorney as would any criminal case for conspiracy to commit insurance fraud.

(Attorneys must police themselves better than they have in the past. The cost to all of us is too high if they do not.)

#### IV. Patients: (Below age 65)

- A. Require second opinions for all non-urgent procedures over a certain amount ; with no restrictions on a patient switching doctors. (Good for patients, good for doctors and good for the system.)

1. Patients to select the second opinion doctor for consultation in the same way and for the same posted fee as the patient selected the first doctor.
  2. Patient select their 2<sup>nd</sup> opinion threshold amount when they purchase their insurance. This will vary according to their choice. (The higher the threshold, the higher the premium; the lower the threshold amount they choose, the lower their insurance premium.) Insurance companies will want to encourage 2<sup>nd</sup> opinions as a means of lowering their costs.
- B. Shop for cost and quality to save their own money (via copay) in the same way as they would shop for any other item; by becoming knowledgeable and shopping price vs. quality (all of which is now readily available to them and will lower costs enormously).**
- C. Complete and sign a living will of their choosing to address how they wish to be treated.**
1. The wills are a requirement.
    - Generic wills to be offered at a fixed minimal cost or free.
  2. The will describes a variety of circumstances and options regarding heroic methods of extending life under a number of circumstances. (Much as they do now).
  3. They will include options for organ donation if they so desire. Their personal living will can be changed and re-signed in the same way they are now.
  4. Family and estates will be responsible for outstanding bills. No differently than they are today.
  5. A generic will, generally agreed upon and well written, will apply as a default “living will” for all those who have not signed their own personal will.
  6. Living wills will be readily available to health care providers via internet and other forms of communication.

**Summary:** The need for pre-authorizations/precertifications, primary care referrals, as well as all other paperwork and delays will be eliminated. This will in turn eliminate the bureaucracy and associated costs. All catastrophic care will be billed to the catastrophic fund with 0% copay to the patient. All urgent care will be paid for by their insurance company with 0% copay to the patient.

**This plan will eliminate pre-authorization/precertification and referrals, along with all the bureaucracy and costs associated.**

## V. Hospitals:

A. All hospitals will establish and run outreach clinics funded by the government via a specific formula. (**Many already have.**) (This will provide for incredible savings by reducing the overloads in emergency rooms while at the same time providing appropriate and timely care to all people), but not much different as occurs now, but with much less waste of resources.)

B. These clinics will:

1. Cover all specialties provided in the hospitals.
2. Provide only non-urgent care.
3. Care for all people with and without insurance. Copays apply if the patient has insurance. A means test will apply in place of a copay if the patient has no insurance.
4. Provide a uniform means test to all patients so they pay according to what they can afford.
5. Post their clinic fees for care like all other providers.
6. Charge the same fees as they posted and pay their doctors the same fees as they have posted.
7. Obligate providers and their staff to man these clinics. (**Since providers will be paid the same fees that they receive in their private practice (the fees that they posted), serving in these clinics will actually be desirable since the doctors will have less overhead.**)

C. The funding formula for these clinics can be a combination of;

1. Federal government funding perhaps 50%.
2. Private insurance funding from a pool (like uninsured motorists) listed separately as an identified portion of everyone's premium, perhaps 10% labeled "uninsured care."
3. Charitable contributions from individuals and charitable organizations (**fully tax deductible to donor**).
4. State government.

*(All Revenue sources designated by federal and state governments, clearly identified and transparent)*

- D. Hospitals will now be able to redirect non-urgent care to their outreach clinics and unload their Emergency Rooms, and still make some profit from their outreach clinics. The outreach clinics will compete with each other.
- E. Hospitals will collect one-quarter (1/4) of the patient selected copay for all inpatient care; no more than one-quarter (1/4) of the copay for insured patients for non-urgent care will be billed for all in-house care.
- F. Hospital will bill all uninsured patients for in-house non-urgent care based on a means test. (The same means test used in the outreach clinics. They will pay half (1/2) of the means determined amount of copay.)
- G. Hospitals will bill all catastrophic care to the “Catastrophic Pool.”

## VI. Government:

- A. Fully define “terms”(for all to know and abide by) clearly;
  1. Catastrophic, urgent (life saving or limb saving care), which all together presently represent only **10% of current medical costs.**
  2. Non-urgent care –which is ALL care not defined as urgent or catastrophic. **(This currently represents 90% of medical costs.)**
  3. All care determined to be catastrophic care is to be paid for by the catastrophic care pool for all patients whether they have insurance or not (without having to pay any copay). The fund will pay 100% of such care.
  4. The means test that clinics and hospitals use to delineate what patients who have no insurance and appear for care at hospital outreach clinics will have to pay, if anything.
  5. Define “practical frivolous” exclusively for medical malpractice cases (see III. Attorneys).
 

[Litigation that failed and that has been found to be frivolous by both medical and legal peer review panels (as described earlier.)]
- B. LEAVE MEDICARE ALONE; tax whoever you have to, but do it transparently and identify the source of revenues.
- C. Investigate and prosecute cases of suspected fraud, system abuse, or over treatment especially as it is related to medical/legal cases and other types of criminal behavior that is stealing from the system. **(Laws already in place but not vigorously enforced.)**

- D. Design and manage 2 important websites that will include ALL providers of medical care. One for fees and one for qualifications; both sorted by any of several variables.
- E. Lift prohibition against suing HMO's.
- F. Fund, in combination with state government, hospital run outreach clinics through a pool to be formed titled "Uninsured Care Pool."

This pool will be funded by a combination of:

- Federal Government
- State Government
- Private Insurance companies
- Philanthropic Organizations
- Patients who access these hospital outreach clinics according to a uniformly applied "means test"

- G. Fund in combination with insurance carriers and state governments a pool titled "Catastrophic Care Pool."
- H. The government must clearly identify the revenue sources and taxes being levied to support this "Uninsured Care Pool" as well as the "Catastrophic Care Pool."
- I. Expand and devise health saving plans for employees and individuals.
- J. Extend Cobra and provide tax credit for individuals who purchase healthcare insurance to the same extent as groups of employees enjoy when they purchase health care through their employers. (This biased government tax supplement should be removed so the playing field can be equalized and blind to where the insurance was purchased.)
- K. Enact tort reform as described under attorneys.
- L. Direct and regulate hospitals and patients to abide by definitions of catastrophic and urgent care. Require hospital emergency rooms to direct all care determined to be "non-urgent care" to their outreach clinics or to their private doctors.

This will allow hospital Emergency Rooms to take care of only urgent and catastrophic care and redirect all other care. This will save millions and yet provide appropriate care to all – the uninsured and the insured.

1. If the patient presents to the Emergency Room and needs urgent care, the Emergency Room provides it and:

- a. Bills the insurance carrier if the patient is insured (no copays are to be billed or paid by the patient for urgent care or for catastrophic care). If admitted, the hospital bills go to the carrier or the Catastrophic Pool. The patient will be asked to pay nothing – no copay, no means test.
  - b. Bills the Catastrophic Pool if it is catastrophic care (patient is admitted or not). If admitted, hospital bills the Uninsured Pool if patient is uninsured. Again, patients pay nothing for emergency or catastrophic care whether they are insured or not.
- 2. If the patient presents to the Emergency Room and requires non-urgent care, the Emergency Room is not to initiate care, but rather redirect that patient (whether insured or not) to:
  - a. Their outreach clinic at which time a means test will be applied, if they are uninsured.
  - b. Their private provider if they are insured where they will pay the copay that they selected when they signed up for their insurance.
- M. **Eliminate pre-authorization/precertification and referrals, along with all the bureaucracy and costs associated.**
- N. (Optional)  
Regulate subrogation mechanism to expedite a true one payer system to incorporate;
  - 1. Worker's compensation indemnity.
  - 2. Auto Insurance.
  - 3. Federally mandated programs, etc. (So that there is only one payer and mechanism for healthcare for all people regardless of when or how they were injured or how they contracted a certain illness)
- O. Regulate health care insurers to conform to these new rules.

## **SUMMATION OF THE BENEFITS OF THE INFORMED DECISION HEALTHCARE PLAN**

1. **RE-CONNECT** people with their money.
2. Allow the **FREE MARKET** to bring down prices.
3. **RE-INSTALL** meaningful **COMPETITION** among all providers.
4. Promote a means for people to **SHOP** value for healthcare.
5. **“EMPOWER CONSUMERS.”**
6. Allow people to have **FREEDOM OF CHOICE.**
7. Allow **PEOPLE TO DECIDE** what they need and how much they want to pay.
8. Allow people to decide what **QUALITY OF LIFE** means to them.
9. **REDUCE FRAUD AND ABUSE** in the system.
10. Provide a mechanism for real **TRANSPARENCY.**
11. **REQUIRE SOMETHING OF ALL PARTICIPANTS.**
12. **ACCESS TO ALL, BUT NOT COMPLETELY FREE** to anyone.
13. **DEFINE THE TERMS “URGENT CARE”, “CATASTROPHIC CARE” AS DIFFERENTIATED FROM “ELECTIVE CARE”**
14. **PRESERVE PROGRAMS THAT WORK**
  - Such as **PREVENTIVE PROGRAMS.**
  - **HEALTHCARE SAVINGS PLAN**
15. **STOP HIDDEN OUTRAGEOUS FEES.**
16. **STOP DIFFERENT FEES FOR DIFFERENT PAYORS.**

**CHANGE FOR THE BETTER.**

## Our Current Healthcare System Is Flawed

(nformedhealthplan.com)

### THE “INFORMED DECISION HEALTHCARE PLAN” FIXES IT

- Patients are disconnected from cost of care, most are afraid to even ask the price, and others don't care because it is free to them or a third party pays.
- People do not have freedom to choose their healthcare providers based on quality and price, the scope of service is poorly defined, and there is limited competition among providers.
- Insurance coverage is inconsistent and there are too many opportunities for fraud.

#### Reform is not a question, it is a necessity.

- The **Informed Decision Healthcare Plan** uses technology to create transparency, clarity, and competition to empower the patient.

#### THIS PLAN DOES THAT

- If people can navigate the maze of purchasing a house, a car, or a refrigerator when given the pertinent facts, people **CAN** purchase healthcare when given the pertinent facts.

#### THIS PLAN DOES THAT

- Consumers **CAN** shop” for healthcare and “vote with their feet” by accessing a searchable internet database for elective care with clearly defined prices posted by all providers.

#### THIS PLAN DOES THAT

- We **CAN** remove bureaucracy and delays instead of creating more bureaucracy and delays.

**THIS PLAN DOES THAT**

- We already pay for the uninsured through an ad hoc system that charges \$4 for an Aspirin. We **CAN** efficiently provide quality care for the uninsured.

**THIS PLAN DOES THAT**

- We can reduce fraud, abuse, and unnecessary procedures.

**THIS PLAN DOES THAT**

- We can significantly reduce costs.

**THIS PLAN DOES THAT**