Health-Care Costs

A Resource for Employers and Employees

There is no silver bullet to reduce health-care costs. However, there are actions we can all take to contain costs, and it is up to us to fight back. The best defense is education — understanding where health-care costs come from and what we can do about them. Progress will not occur overnight, but it will be a slow and steady process and a cultural shift over the next decade.

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Introduction

Health-Care Costs and What You Can Do

PROBLEM: The cost of health insurance is always a top concern for small and medium-sized businesses, and it is not going away. According to the federal government total spending on health care is forecast to increase at least 5.4 percent annually for the next 10 years. As the cost of insurance spirals upward, employers in many cases have no choice but to shift more costs onto their employees and increase the use of high-deductible plans. For the employee, premiums, co-pays, deductibles and out-of-pocket costs may increase. If you do not have a high-deductible plan now, you may have one soon. Consider the facts:

"Twenty-eight percent of all covered workers and 45 percent of those in small companies have high-deductible plans with a $2,000 or higher deductible requirement. Both are significant increases from 2009 when 7 percent in all companies and 16 percent of small company workers had $2,000 deductible requirements."

— The Keckley Report, Survey Result: U.S. Employers taking Health Matters into their Own Hands, September 30, 2019

According to the Internal Revenue Service (IRS), here is what you could pay with a high-deductible health plan (HDHP) for 2021.

- An annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage.
- The annual out-of-pocket expenses (deductibles, copayments, and coinsurance but not premiums) do not exceed $7,000 per person for self-only coverage or $14,000 for family coverage.

The cost of health care drives insurance premiums. Often, the cost of the premium is all the employer focuses on while the employee focuses on the amount taken out of his paycheck. For some, that is the beginning and the end of their understanding of health-care costs and health insurance premiums.

Where does your health insurance premium dollar go?
"America's Health Insurance Plans (AHIP) tapped research firm Milliman to examine 2014-2016 data gathered from commercial health plans – coverage that people get through their jobs or buy on their own in the individual market – to take a closer look at how the premium dollar is spent:

- 23.2 cents – Prescription drugs
- 22.2 cents – Doctors
- 20.2 cents – All other costs at doctors' offices and clinics
- 16.1 cents – Hospital stays
- 4.7 cents – Federal, state and local taxes."

— "*Where Does Your Health Care Dollar Go? AHIP Has the Answer," May 22, 2018 Business Wire*

SMC and the MBA calculated 13.5 cents goes to the insurer and of that 2.3 cents is profit. AHIP did not include those figures.

SOLUTION: There is no silver bullet to contain health-care costs but there are actions we can take. Nothing will happen overnight. It is a cultural shift that will take place slowly over the next decade.
Here are the five main drivers of health-care costs:

1. Increased utilization due to aging, population growth and social disparities
2. Unit prices for drugs, devices, specialty care and hospitals
3. Volume-based incentives for providers (meaning the more they do the more they get paid)
4. Lack of transparency re: prices, costs, business relationships: and,
5. Consumer ignorance and passivity

— "Reining in the Costs of Healthcare: Strategic Considerations for Small Businesses,"
Paul Keckley Ph.D., National Small Business Association, March 20, 2019

Although employers and employees cannot do much about Nos. 1 - 4, they can act on No. 5. Consumers are ignorant and passive because for years we have been shielded from the true cost of health care by the "third party payer" system, meaning that the insurer pays the bills. That model changes with high-deductible health plans (HDHPs). You pay more of the bill so it is in your best interest to learn where the costs come from and what you can do about them.

The more you know the more you can engage in your own health care. As HDHPs become more common, you will have more decision-making power along with more responsibility and accountability for costs and choices. The best defense is arming yourself with knowledge. There are several key concepts that will make health-care costs easier to understand.

- The health-care marketplace does not operate like other marketplaces. We buy without knowing the price ahead of time.
- More health care is not necessarily better health care. Sometimes more is not needed and can be harmful.
- More expensive health care is not better health care. Cost and quality are not related. When we pay more for a product, we expect a better product, but that does not necessarily apply to health care.

Another key concept is that it is up to us to fight back and challenge health-care costs. All the players in the health-care system, including the federal government, are happy with the status quo because it is a cost-plus system. Everyone adds on their cut – for drugs, hospitals, insurers and physicians – while small and medium-sized businesses end up bearing an inordinate amount of the costs. The U.S. government pays less than the actual cost of Medicare and Medicaid. Those unpaid costs do not go away. They are shifted onto those in the commercially insured market.

We must educate ourselves about health-care costs so we can make more effective decisions about our own health and do our part to contain health-care costs.

Revised December 22, 2020

I. Shopping for Services

Resource Links for Consumer Education & Learning About Health Conditions

Choosing Wisely is an initiative of the American Board of Internal Medicine. Beginning in 2012, national organizations representing medical specialists have asked their members to *identify tests or procedures commonly used in their field whose necessity should be questioned and discussed*. Their goal is to encourage a national dialogue around avoiding unnecessary medical tests and treatments by promoting conversations between physicians and patients by helping patients choose care that is:

- Supported by evidence
- Not duplicative of other tests or procedures already received
- Free from harm
- Truly necessary

Physicians and consultants alike agree that the Choosing Wisely approach to the problems of overuse, underuse and misuse is important in helping control unnecessary, wasteful and potentially harmful procedures.

The site is easy to use and navigate and has lots of resources for patients and employers.
Here is the suggested starting place: *https://www.choosingwisely.org/.*

> From the Mission tab, click the link **"Things Providers and Patients Should Question."**
There, you will find complete lists of recommendations by different medical societies. For example, by clicking the society name The American Society of Family Physicians, you can read about **"Twenty Things Physicians and Patients Should Question."**

> Next, from the Mission tab, click the link **"Patient-Friendly Materials."**
The materials listed were developed in partnership with medical specialty societies to help patients engage their health-care provider in conversation and empower them to ask questions about what tests and procedures are right for them and what may be unnecessary.

For instance, *http://www.choosingwisely.org/patient-resources/low-back-pain/* for "Treating Lower Back Pain" has information about the condition on the website and a PDF download.

How Choosing Wisely Helps Employers
The resources can help employers educate their employees about avoiding overtreatment and how to engage in conversations about appropriate care with their physician. See *https://www.choosingwisely.org/how-can-i-implement-choosing-wisely-in-my-workplace/.*

Learning More About Health
These sites are organized differently than Choosing Wisely and make for interesting browsing. Each organization is renowned for their expert care and world-class facilities. Their sites cover symptoms, diseases, conditions, tests and procedures, drugs and supplements, and healthy lifestyles.

- https://www.hopkinsmedicine.org/health/
- https://www.mayoclinic.org/
- https://my.clevelandclinic.org/

Resource Links for Consumer Education & Shopping for Services

The first step is to check your insurance carrier's website for shopping tools. The tools available vary by carrier.

Get the right care at the right time and in the right place. These services may save you time and cost less at different providers:

- **Blood tests** – Consider an independent lab instead of the hospital.
- **Imaging tests,** such as X-rays, CT scan, MRI, ultrasound, or nuclear medicine scan, consider an independent imaging center instead of the hospital.
- **Childbirth** – Consider an independent birthing center instead of the hospital.
- **Surgery that does not require a hospital admission** – Consider an Ambulatory Care Surgery Center (ASCs). They provide cost-effective services and a convenient environment that is less stressful than what many hospitals can offer.
    - **To check on the quality of ASCs** – Consider the Leapfrog Group search tool. Hospital ratings can also be checked there at https://ratings.leapfroggroup.org. The Leapfrog Group is powered by the goal of saving lives by reducing errors, injuries, accidents and infections. They focus on measuring and publicly reporting hospital performance through their annual *Leapfrog Hospital Survey*.
- **Urgent care centers** – Consider an urgent care center if you have a non-life-threatening emergency. They treat injuries or illnesses requiring immediate care but not serious enough to require an emergency room visit. Examples include broken bones, sprains, cuts, asthma, dehydration, etc.

OR

- **Emergency rooms** – Use the emergency room if you have life-threatening symptoms such as difficulty breathing, shortness of breath, chest or upper abdominal pain or pressure, fainting, sudden dizziness etc.

OR

- **New retail clinics** – Some states now have health-care walk-in clinics available inside retail stores. Check your insurance coverage first. Offerings may include primary care, optometry, counseling, audiology, fitness, nutrition, X-ray, dental, lab services and pharmacy all under one roof. They often have pricing lists. Some examples include CVS, Walmart and Walgreens.

Why should you shop for services?
Studies have found that cost and quality vary significantly (300 percent or more) across hospitals and within hospitals.

"The negotiated rates that insurers pay hospitals and other health-care providers often vary widely. In Ohio, the average price of a pregnancy ultrasound in Cleveland was $522, almost three times the $183 charged in Canton, Ohio, just 60 miles away, according to a 2016 study in Health Affairs. These negotiated rates are typically closely held secrets, often shielded by contractual gag clauses."

— The Wall Street Journal, "Hospitals, Insurers Set to Resist Price Transparency Proposal," Stephanie Armour and Anna Wilde Mathews, March 11, 2019.

Shopping for Procedures – HealthCare Bluebook** at http://www.healthcarebluebook.com/
This site has an explanation of transparency and lets you try a free tool that allows you to see the range of pricing for many procedures. For instance, a search based on a Pittsburgh zip code and a bilateral digital screening mammogram resulted in a price range of $171 to $903 or higher with a fair price of $230 including the physician and technician. A phone app is also available. Searches can be done on hospitals, physicians, x-rays and imaging, labs and dental, etc.

A search for a prescription drug, metformin, yielded three prices at three locations. With the free tool, you can search for drug prices that in some cases links to **GoodRX** for discounts. Doctor and facility names are not available with the free tool.

Employers can join for a fee and have access to much more detail.

Shopping for Drugs

GoodRX Discount Drug Coupons** at http://www.goodrx.com/
The coupons cannot be combined with health insurance, Medicare or Medicaid, but they can be used in place of insurance for example, when the discounted drug is cheaper than your co-pay.

This site features shopping for prescriptions by store and cost and has coupons for a discounted price. No membership or signup is required. Try entering your existing prescription with number of tablets and milligrams. They claim they can do the following:

- Collect and compare prices for every FDA-approved prescription drug at more than 70,000 U.S. pharmacies.
- Find coupons to use at the pharmacy; and,
- Show the lowest price at each of the pharmacies near you.

***Note: We would like to hear about your experiences with **HealthCare Bluebook** and **GoodRX**. This information was taken from several online sources but not our own experience. Contact Eileenanderson@smc.org*

Assistance from pharmaceutical companies – Patient assistance programs are run by some pharmaceutical companies to provide free medications to people who cannot afford to buy their medicine.

Rxassist Patient Assistance Program Center — https://www.rxassist.org
RxAssist helps patients learn about ways to use pharmaceutical company programs and other resources to help reduce medication costs. Explore the Patient Center at https://www.rxassist.org/patients

RxAssist offers a comprehensive database of these patient assistance programs and a FAQ (frequently asked questions).

Shopping for Providers – CMS Open Payments Data

- https://openpaymentsdata.cms.gov/

- https://openpaymentsdata.cms.gov/search/physicians/by-name-and-location
  On this site, you can see if your doctor has received any money or gifts from drug companies and equipment makers.

PENNSYLVANIA HEALTH CARE COST CONTAINMENT COUNCIL (PHC4)

The Pennsylvania Health Care Cost Containment Council – A trusted independent health care data resource at *http://www.phc4.org*

What is PHC4?

- PHC4 is an independent state agency charged with collecting data from PA hospitals and ambulatory surgery centers — data that is essential to understanding health-care quality and costs.
- PHC4 is governed by a 25-member board of directors representing business, labor, consumers, health-care providers, insurers and state government.

What does PHC4 do?

- Visitors to PHC4's website download more than 800,000 copies of health-care quality/cost reports each year.
- PHC4 informs the public of important trends in health care. Recent examples include increases in hospitalizations for opioid overdose and substance-related admissions for new mothers and babies.
- PHC4 provides data to state government to meet statutory, regulatory and grant obligations. Last fiscal year alone, PHC4 filled data requests from fellow state agencies valued at $135,000. PHC4 also provides data to many of PA's top universities to help them pursue critical academic research goals.

Why is PHC4 Important? PHC4's Public Reporting Saves Lives and Health-Care Costs

- PHC4's reporting of opioid overdoses has shed important light on dramatic increases in hospital admissions for overdose of heroin and pain medicine among PA adults, new moms and newborns.
- PHC4's public reporting has been associated with lower mortality rates when compared to other states *(American Journal of Medical Quality, 2008; Medical Care, 2003).* Further analyses estimated that PHC4's public reporting in six treatment categories prevented 1,500 deaths in one year.
- Lehigh University researchers recently found that PHC4's online reporting of heart surgery data led hospitals to commit additional resources to saving more patient lives — and achieved an 8- percent to 10-percent reduction in patient mortality.
- Overall mortality rates in PA hospitals dropped from above to well below national averages between 1998 and 2017. PHC4 estimated a savings of 72,000 lives and $2.8 billion in hospital charges could be attributed to this trend.
- Between 2012 and 2017, mortality rates in Pennsylvania hospitals decreased significantly in 12 of 15 major illness categories studied in *PHC4's Hospital Performance Report.*
- In part due to PHC4's public reporting, mortality rates for heart bypass patients have dropped more than 50 percent since reporting began in 1992.

Shopping on PHC4 website

Under the Reports Tab, you can link to Common Procedures and see hospital results for knee replacements, hip replacements, spinal fusion and others. Results are organized by hospital and show number of procedures performed, complications and average hospital charge. See http://www.phc4.org/reports/commonprocedures/18/.

CARES ACT EXPANDS FSA AND HRA ELIGIBLE ITEMS

The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) passed by Congress on March 27, 2020 expanded the list of eligible items that can be purchased from medical flexible spending accounts (FSAs) and health reimbursement arrangement accounts (HRAs).

Over-the-Counter (OTC) Medicines – Previously, these OTC medicines listed below were only eligible from FSAs and HRAs if a medical provider wrote a prescription.

- Allergy medicine
- Antacids
- Antibiotic products
- Anti-diarrhea medicine
- Cold/cough/flu medicines
- Cold sore remedies
- Cough drops/throat lozenges
- First aid cream/Neosporin
- Headache medicines
- Laxatives
- Motion sickness pills
- Pain relievers
- Visine and other eye products
- Smoking cessation
- Special diaper rash ointment
- Wart remover treatments
- Menstrual care products

What is an FSA?
A flexible spending account is a special account you put money into that you use to pay for certain out-of-pocket health care costs. You do not pay taxes on this money. This means you will save an amount equal to the taxes you would have paid on the money you set aside. Employers may make contributions to your FSA, but it is not a requirement.

Possible Employee Disadvantage: The IRS places a limit on how much of the unused funds can be rolled over into the next year. Any unused funds over the limit disappear.

What is an HRA?
A health reimbursement arrangement is an employer-funded account that helps employees pay for qualified medical expenses not covered by their health plans. Your employer sets aside a fixed amount of money in your HRA each year for you to use. Only your employer can put money into your HRA unlike other health spending accounts. The money is available to you at the beginning of the year and, based on your employer’s plan, unused funds may roll over into the next year.

Special Note: The amount of funds set aside is controlled by the employer and is not tax-deductible for the employee.

What is an HSA?
A health savings account (HSA) is a medical savings account available to those enrolled in certain, qualified high-deductible health plans. The funds contributed to the HSA are not subject to federal income tax at the time of deposit. Unlike the FSA, HSA funds roll over and accumulate year to year. HSAs are owned by the individual, which differentiates them from company owned HRAs.

Employee Advantage: The employee owns the account and the funds.

For a more complete explanation, click
https://www.sbam.org/wp-content/uploads/2020/05/Kushner-Brochure-0719.pdf.

MEDICAL WASTE AND OVERTREATMENT – USE YOUR CHOOSING WISELY WALLET CARDS!

What is medical waste?
Health care is big business in the United States, with costs approaching 18 percent of the country's gross domestic product (GDP). But a new review of estimates published in the ***Journal of American Medicine Network*** from October 7, 2019 found that nearly $1 trillion of annual spending can be considered medical waste!

— *"Waste in the U.S. Health Care System, Estimated Costs and Potential for Savings,"*
William H. Shrank, MD, MSHS1, https://jamanetwork.com/journals/jama/article-abstract/2752664

Another article estimated waste between $760 billion and $935 billion, which is about 25 percent of the $3.8 trillion in total U.S. spending on health care in 2019. The authors reviewed 71 estimates from 54 publications, government reports and other sources written between 2012 and 2019 to calculate their estimates. See the link below for a very clear breakdown of forms of medical waste.

— "*New Study Estimates U.S. health-Care Waste Costs Nearly $1 Trillion Each Year,"*
Keith A Reynolds, October 9, 2019
https://www.medicaleconomics.com/view/new-study-estimates-us-healthcare-waste-costs-nearly-1-trillion-each-year

What is overtreatment?
"From duplicate blood tests to unnecessary knee replacements, millions of Americans undergo screenings, scans and treatments that offer little or no benefit every year. Doctors have estimated that 21 percent of medical care is unnecessary — a problem that costs the health-care system at least $210 billion a year. Such "overtreatment" is not just expensive. It can harm patients."

— *Kaiser Health News, September 27/2018, KHN Conversation on Overtreatment*
https://khn.org/news/khn-conversation-on-overtreatment/#:~:text=Doctors%20have%20estimated%20that%2021,It%20can%20harm%20patients.

"Over 80 percent of surveyed physicians cited fear of malpractice as the top reason for medical overuse… . The majority of the physicians who responded to the survey said they believed that at least 15 to 30 percent of medical care is not needed… . Breaking down the types of unnecessary medical care, survey respondents reported that **22 percent of prescription medications, 24.9 percent of medical tests, 11.1 percent of procedures and 20.6 percent of overall medical care delivered is unnecessary.**"

— **"***Unneeded Medical Care is Common and Driven by Fear of Malpractice, Physician Survey Concludes, Patient Demand and Profit Motives Also Factor In,"*
Johns Hopkins Medicine, News and Publications, September 6, 2017
https://www.hopkinsmedicine.org/news/media/releases/unneeded_medical_care_is_common_and_driven_by_fear_of_malpractice_physician_survey_concludes

"Professional societies and other health-care organizations have focused on campaigns to address the unnecessary medical care issue. Initiatives such as **Choosing Wisely…** focus on reducing unneeded tests and procedures and are endorsed by multiple physician societies and have increased awareness of appropriateness in testing and treatment." — https://www.choosingwisely.org/

What can the consumer/patient do? This is an area where the consumer/patient can take action. Carry a **Choosing Wisely** card in your wallet and use it. Download a card here and become an informed consumer by asking your provider these five questions.
See https://www.choosingwisely.org/wp-content/uploads/2018/03/5-Questions-Wallet-Card_3.5x2-Eng.pdf.

Five questions to ask your doctor before you get any test, treatment, or procedure
1. Do I really need this test or procedure?
2. What are the risks and side effects?
3. Are there simpler, safer options?
4. What happens if I do not do anything?
5. How much does it cost, and will my insurance pay for it?

II. Insurance Basics

Resource Links from the Pennsylvania Insurance Department

What is the Pennsylvania Insurance Department (PID)?
The Pennsylvania Insurance Department, https://www.insurance.pa.gov, is a Cabinet-level agency and its main functions include:

- Auditing insurance companies' finances
- Issuing licenses to insurance industry individuals and companies
- Regulating insurance policies and rates
- Assisting consumers through education and complaint mediation.

Find an overall view of health insurance here:
https://www.insurance.pa.gov/Coverage/Pages/Health-Insurance.aspx

The PID has a clear discussion of health insurance coverage and surrounding information such as how to buy it for those of working age, older adults and children. There is also information about Pennsylvania's Medical Assistance (Medicaid) program, special enrollment periods, health insurance rates, information for employers, how health insurance works, and Pennsylvania's health insurance exchange.

The PID has an excellent health insurance glossary:
https://www.insurance.pa.gov/Coverage/Documents/Health/Health%20Insurance%20Glossary.pdf

Here are several important terms:

- Co-insurance
- Co-pay
- Deductible
- Formulary
- Health savings account (HSA)
- High-deductible health plan
- In-network provider
- Out-of-network provider
- Out-of-pocket maximum
- Premium
- Preventive care services
- Primary care provider (PCP)
- Qualified health plan (QHP)

The PID also has resources to help consumers understand their health insurance. The Health Insurance Literacy Section has 12 short videos, which make the subjects lively and engaging and cover key elements:

- Health-Care Costs You Should Know
- Prescription Drugs
- What is an EOB?

See www.insurance.pa.gov/literacy.

The PID also has a series of videos to help consumers and advocates understand what benefits they are entitled to for mental health and substance use disorder treatment:
See www.insurance.pa.gov/parity.

MEDICARE 101

Eligibility: Generally speaking, it is the first of the month in which you turn age 65. If you are younger than 65 and on Social Security or Railroad Retirement Board disability benefits, eligibility starts after you have received benefits for 24 months. ***Medicare may be very complicated for employers and employees. For more detailed information related to your specific situation, contact Medicare or your insurance agent.***

Failure to enroll in Medicare when someone is eligible will result in penalties unless certain circumstances exist.

Employers should understand when Medicare is primary and when it is secondary. Please check with your agent for more information.

When someone turns 65, they have an "initial enrollment period" during which they can enroll in Medicare Part A and/or Part B and D. For those who continue to work beyond age 65 this is important. Everyone needs to "register" for Part A (hospitalization) during this initial enrollment period at age 65. It does not cost anything additional since this coverage was paid for from one's Medicare taxes while working. This coverage then becomes secondary (depending on the size of the employer group) while the individual is still working and covered by their employer's plan.

Employees – Before you select a Medicare advantage plan, make sure that you select a primary care provider (PCP) in your network. Even if they are in the network, check to see if they routinely visit your hospital of choice or if they rotate with other PCPs and only visit your hospital of choice once per month.

MEDICARE Parts
Part A: Hospitalization — in most cases this has already been paid by taxes during your earning years.
Part B: Medical and surgical — premium paid to Medicare is based on household income.
Part D: Prescriptions — coverage may be purchased from insurance carriers; Supplement (Medigap) policies may also be added; and
Part C: Medicare Advantage plans cover Parts A & B and generally include Part D coverage plus may provide extra benefits (see chart below).

MEDICARE supplement (MEDIGAP) VS MEDICARE Advantage (Part C)

The information below may differ in some respects in states other than Pennsylvania.

	Medigap	**Medicare Advantage**
Multiple plan designs	YES	YES
Provider network	Generally, no, use any licensed provider	YES
Medicare-required preventive care	Covered at no cost	Covered at no cost
Cover Parts A & B of Medicare	YES, in concert with Medicare	YES, in place of Medicare
Prescription coverage (Part D)	Need separate plan	Generally included
Coverage outside the US	Limited	Included

Eligibility to purchase	Initial enrollment period without underwriting, after that it may be underwritten, and coverage may be denied or rate surcharged	Initial enrollment period or annual enrollment period, no underwriting
Vision, dental, and hearing benefits	Generally, no	Included in some plans
Fitness center benefit	Generally, no	Included

COBRA

As a rule, COBRA is a federal program that mandates most companies with employee medical benefits must make those benefits available to a covered employee who leaves of their own accord or via a furlough. Those companies with 20 or more full-time eligible employees are subject to the law. The company has a 30-day window to make the benefit and cost of the plan available to the former employee and any covered dependents, each receiving his/her own letter of eligibility. The former employer is under no obligation to pay for any of the continuing cost, and an administrative fee may be charged if the COBRA coverage is elected. The former employee is given 45 days to accept or reject the offer of continuing coverage, and to pay the full premium retroactive to the date of coverage termination. That allows for no lapse in coverage.

Prior to the introduction of the Affordable Care Act (ACA), COBRA was generally the only way someone with medical issues could be assured of having coverage. The downside to the COBRA recipient is that they must pay the full premium with no employer contribution. As a result, COBRA is often only elected by those with medical conditions. The ACA provides another alternative for individuals, as it is a guaranteed issue program — as long as the former employee enrolls for coverage within 63 days of his or her employment termination. This is referred to as a Special Enrollment Period and is critically important. If someone fails to enroll during this period, he or she will not be able to enroll until January 1 following the next open enrollment period of November 1 through December 15.

In Pennsylvania, a Mini-COBRA plan was signed into law in 2009 to cover businesses in the two to 19 employee category. The Insurance Department website has a template that was posted for companies to use in notifying terminated employees of their rights to continue coverage.

Federal COBRA benefits can be maintained for up to 18 months (there are some exceptions for additional time). The State Mini-COBRA can be maintained for up to 9 months (some exceptions are available for an extended time).

It is important to understand that the COBRA plan will follow the employer plan. In other words, the employee will be enrolling in the same plan they had through their employer. This means that if an employer changes their benefit plan at renewal, the COBRA plan will also reflect those changes (i.e. carrier, deductible, copays, etc.). Some who are offered COBRA may elect to enroll under an ACA plan, as it would provide them with the opportunity to change carriers or benefit plan designs that better meet their specific needs. The COBRA option could be advantageous to those who have already contributed toward a plan year deductible, or for those who would experience a higher rate or lower benefits in the individual market.

Those considering COBRA should also review their ACA options by visiting www.healthcare.gov or by speaking with a local agent who writes individual health plans. The employer's current broker may also offer coverage in the individual market.

It is important for employers to remain compliant with COBRA regulations to avoid fines levied by the IRS that can be significant.

COBRA also applies in the event of the death of the employee, termination for other than misconduct, reduction in hours, divorce, or legal separation, if one becomes entitled to Medicare, and if their child ceases to be considered a dependent.

ISSUE: INTEGRATED DELIVERY NETWORKS (IDNs)

What is an Integrated Delivery Network (IDN)?
IDNs generally consist of hospitals, physicians, clinics, etc. with the primary focus being the continuum of health care, from cradle to grave. By maintaining this holistic approach, it is believed that the IDN will be able to improve the quality of care and control costs. Many IDNs take this one step further by also offering their own branded health insurance product, competing directly with traditional health insurers. IDNs may also be referred to as Integrated Delivery Systems (IDS).

IDNs in western and central PA include UPMC - University of Pittsburgh Medical Center/UPMC Health Plan; Allegheny Health Network/Highmark, Inc.; and, Geisinger Health System/Geisinger Health Plan.

Why do we need to know about IDNs?
It is important for the consumer/patient to understand that many new insurance plans have narrow networks of providers because IDNs use their own providers.

PROS:

- IDNs can establish standards of care (protocols) for providers to follow that should result in better outcomes (and lower costs) including:
    - Reduced re-admissions,
    - Fewer infections; and,
    - Some hospitals realizing that there are certain procedures that they should not do.
- IDNs strive to make sure that they have a provider base that will allow a patient to receive preventable care, acute care, and everything in between, with patient records being readily available for all providers to access.

- IDNs, as an insurance carrier, compete directly with other insurance carriers to create a more competitive market, which should ultimately result in more affordable premiums.

CONS:

- IDNs may be perceived as having a conflict of interest if they are both the insurance carrier and the provider (i.e. challenging the ordering of unnecessary procedures such as tests).
- IDNs may offer benefit plans that require very narrow provider networks that are made up of providers owned and managed by the IDNs.
- IDNs may result in seeing patients steered from smaller, low-cost community hospitals to larger, higher-cost facilities owned and managed by the IDN, which could result in higher reimbursements (higher costs to the insurance carrier).
- Physicians are leaning toward selling their practices to IDNs to get out of “office practice management” to focus strictly on medicine, but this is also resulting in a change in how they practice medicine.
- IDNs have not always resulted in a reduction of health-care costs.
- IDNs sometimes result in a shift of services being offered in a community-based setting to that of a larger regional facility. This is not usually more convenient for the patient.

What is still needed?
The jury is still out as to the level of success that IDNs have had in the overall reduction in health-care costs.

ISSUE: TELEMEDICINE

***MYTH # 1 – Telemedicine** is very limited in what it can offer to consumers.*

FACT: Through the use of electronic communications and software, clinical services are provided to patients without the need for an in-person visit. Telemedicine is frequently used for follow-up visits, managing chronic conditions, managing medications, specialist consultation, and a host of other clinical services that can be provided remotely via secure audio and video connections. Telemedicine offers a host of benefits:

- Less time away from work.
- No travel expenses or time.
- Able to avoid inclement weather.
- Available for "after hours" care (when PCP office is closed).
- Less interference with child or elder care responsibilities.
- Able to avoid long waits for scheduling appointments (i.e. dermatologist).
- Privacy; and,
- **No exposure to other potentially contagious patients.**

***MYTH # 2 – Telemedicine** is appropriate for emergencies as it can provide quicker help.*

FACT: Telemedicine ***is not*** appropriate for a true emergency! Any situation that requires immediate hands-on care should be handled in person by a trained medical professional. This would include situations like heart attack/stroke, lacerations with heavy bleeding, allergic reactions where breathing is becoming difficult and broken bones.

***MYTH # 3** – I can accomplish the same by using the internet to research my health conditions.*

FACT: Telemedicine provides far more than Internet services like WebMD, which is good for providing general information (i.e. symptoms). Telemedicine allows you to actually discuss your symptoms/issues with a health-care provider in real time. They can then diagnosis your condition, discuss treatment options, and even issue prescriptions, if needed.

POINTS TO CONSIDER:

- More insurance companies have incorporated Telemedicine benefits into their plans, often times with a lower copay than an in-person doctor's visit.
- Telemedicine reduces health-care costs for both the consumer and the insurance carrier. The average telemedicine visit costs $79, the average doctor's visit costs $149, and the average Emergency Room visit costs $1,734. (2019 insurance carrier webinars)
- Smart phones can be used to send pictures for providers to review (i.e., rash on skin for dermatologist to evaluate).

III. Legislative Proposals

Association Health Plans

How do Association Health Plans work?

- Association health plans (AHPs) are group health plans that employer groups and associations offer to provide health coverage for employees.
- AHPs allow small employers to band together to purchase the types of coverage that are available to large employers. This spreads out risk to create less expensive plans.

Cost Savings

- Health insurance has remained one of the highest costs of doing business for employers. As well intentioned as the drafters of the Affordable Care Act (ACA) were, we cannot ignore that in the first five years after AHPs were discontinued, 25 percent of small businesses providing health insurance were no longer financially able to provide this benefit and that number has grown. Small employers account for a substantial share of U.S. employees making up 47.5 percent of the country's total employee workforce.
- In a recent report, health-care research firm Avalere has projected that association health plan premiums will have significant savings advantages over alternative insurance options. They predicted that association plan premiums will be "between $1,900 to $4,100 lower than the yearly premiums in the small group market and $8,700 to $10,800 lower than the yearly premiums in the individual market by 2022."
- In January 2019, the non-partisan Congressional Budget Office (CBO) analyzed the effects of AHPs. It was determined, once implemented, 20 percent (roughly 1 million people nationally) of those enrolled in health insurance coverage under an AHP will be newly insured for the first time. Most importantly, the CBO estimates premiums for AHPs will be roughly 30-percent lower than the premiums employers and their employees currently pay under the "small group market."
- Currently, 30 states allow for AHPs in some form.

Legislation

- PA House Bill 555 and PA Senate Bill 235 would provide employees of small businesses similar health insurance options employees of larger businesses enjoy. Simply put, this legislation would allow businesses with less than 50 employees to aggregate together to form an AHP and purchase health insurance on the large group market the same way businesses with 51+ employees currently do.
- On June 19, 2018, the U.S. Department of Labor (DOL) expanded access to affordable health coverage options for America's small businesses and their employees through AHPs, as a result of President Donald J. Trump's Executive Order "Promoting Healthcare Choice and Competition Across the United States."

IV. Good to Know

End-of-Life Care

"No one wants to die. But the truth is everyone's life will someday come to an end. It's important to think about what you want, and what you want to avoid."

— *www.closure.org, The Jewish Healthcare Foundation, Pittsburgh, Pennsylvania*

What is End-of-Life Care?
End-of-life is the care given when someone is approaching the end of life due to life-limiting illness. Quality care at the end of life addresses a patient's physical comfort, daily care, and emotional and spiritual needs. The goal is to control pain and other symptoms so the patient can be as comfortable as possible.

End-of-life care includes both hospice and non-hospice palliative care.

- **Palliative care** is called end-of-life care even though it can be offered to people still seeking a cure or recovery, specifically because treatment can negatively impact quality of life. Palliative care works to alleviate pain and manage the obstacles to a good quality of life while the patient is undergoing treatment for a serious illness, chemotherapy, surgery or treatment in an intensive care unit (ICU).

- **Hospice care** is for someone who has decided they are no longer seeking a cure. Hospice provides a way to monitor and address the entire spectrum of end-of-life care needs and helps coordinate professional and family caregiving. It can be provided in a variety of settings: the patient's home, assisted-living residences, nursing homes, hospitals and hospice-care facilities.

Making decisions
A palliative and hospice care team can help the patient establish treatment goals and provide guidance through important decisions. The decision-making is intended to honor the wishes of the patient, optimize his or her quality of life and support the family. Some of the harder decisions may include:

- When and if to discontinue disease treatment.
- When to remove life-support machines, such as ventilators and dialysis machines; and
- Where to receive hospice care.

Studies demonstrate that this person-centered approach improves care and the quality of people's lives in their last days.

— *Adapted from the Mayo Clinic*,
https://www.mayoclinic.org/healthy-lifestyle/end-of-life/in-depth/cancer/art-20047600

Decision making can be troublesome.
When a loved one is the near end of life it can be difficult to make decisions in the patient's best interest. It is difficult to grasp the impending death. The pull would be to decide what the family wants but they may not agree and ultimately it may not be what the patient wants. This can result in over-treatment or under-treatment because family members may differ over the main goal. Is it to keep the patient alive, no matter what it takes, or is the quality of life at that time more important?

There are other more complicated instances when the patient is no longer able to make decisions or have any input.

Fortunately, there are legal documents that can help people make decisions in advance to avoid such problems. See the next section **Pennsylvania Advance Health Care Directives and Power of Attorney.**

There are also organizations such as the Jewish Healthcare Foundation that provide resources and education.

"Closure is an education, planning and outreach effort, developed by the Jewish Healthcare Foundation, focused on end-of-life care. Its goal is to redefine quality care for people with life-threatening illness by raising expectations and empowering them to seek a different health-care experience — one that aligns with their values, beliefs and wishes, as well as their health status."

— www.closure.org

"Closure helps consumers and healthcare professionals with easy-to-access, simple-to-understand information and resources to make informed decisions about end-of-life care…

Closure has two key components: Closure Community Conversations, which are designed to launch discussions about end-of-life issues within a neighborhood, and Closure 101, a curriculum of lessons developed to educate consumers and healthcare professionals about end-of-life issues and options. Both can make more informed decisions about end-of-life care through a curriculum of educational lessons dealing with an array of complex end-of-life issues including important questions to ask your doctor, advance planning and the Medicare Hospice Benefit… .

Closure is not going to make talking about death any easier. Nothing can do that. But their resources and tools will make the process of determining what's wanted at end-of-life less difficult and confusing."

Pennsylvania Advance Health Care Directives and Power of Attorney

What is an Advance Health Care Directive and why should you have it?

An advance health care directive, also known as living will, personal directive, advance directive, medical directive or advance decision, is a legal document in which a person makes provision for health care decisions in the event that, in the future, he/she becomes unable to make those decisions.

What happens if you do not have an Advance Health Care Directive?

Generally, the medical professionals and healthcare facilities will do everything in their power to extend life regardless of whether you would want those extraordinary measures taken or if they are even reasonable. This could add additional pain, suffering and a severely reduced quality of life.

What is a Health Care Power of Attorney and why should you have one?

You, the principal, who issues the power, can name your health-care agent and document your preferences. Usually the health-care agent is someone close to you, the principal, such as your spouse or a close relative. The goal is to deliver the security of knowing that someone you trust will handle medical decisions when you are no longer able to communicate. They make the medical decisions for you.

What happens if you do not have a Health-Care Power of Attorney?

The problem arises when you are no longer able to make your own decisions and no one else has been designated by you to deal with those issues. That leaves the decisions in the hands of the medical professionals and health-care facilities who as stated above will do everything in their power to extend life regardless of whether you would want those extraordinary measures taken or if they are even reasonable.

Where can these documents be found?

- https://www.upmc.com/-/media/upmc/patients-visitors/patient-info/advance-directives/documents/pa-advanced-directive.pdf by UPMC

- https://www.acba.org/portals/1/pdf/LivingWillPowerofAttorney.pdf
Allegheny County Bar Association or similar organization

- Search the internet for “health care power of attorney”

- Your lawyer

ISSUE: SINGLE PAYER OR MEDICARE-FOR-ALL

MYTH # 1 – Health care is better in other countries that have universal coverage or single payer.

FACT: It is easy to cherry pick a few specifics that may show other countries having better health care, but you need to also look at the following:

- Most health-care technology and specialty pharmaceuticals are developed in the United States. These do not become available in some countries for many months, or years, after being available in the United States. Will future advancements be lost or delayed as corporate incentives disappear?
- Wait times are real in most single-payer countries (primary, specialists, surgeries, MRI, etc.) and would not be acceptable in the United States. According to the Fraser Institute, the median wait time for orthopedic surgery in Canada is about 39 weeks. — *“Waiting Your Turn: Wait Times for Health Care in Canada,” 2019 Report, The Fraser Institute*

MYTH # 2 – Health care is cheaper in other countries that have universal coverage or single payer.

FACT: How do you compare the cost of health care? Do you consider the premiums, copays, coinsurance and taxes? What about malpractice?

- Universal coverage will require taxes to increase to pay for the care.
- Costs will increase as utilization increases (no “skin in the game” to prevent this) – this will result in higher taxes or rationing of care.
- Malpractice in other countries is far different than in the United States.
  - Awards in Canada are capped at around $350,000 and around $400,000 in the United Kingdom. In the United States, we see Powerball-sized awards.
  - Judges often hear the cases versus juries (less emotion).
  - The loser of a case often must pay the legal fees of the winner (discourages frivolous suits).
  - Reduces the number of “unnecessary” tests that are requested more as defensive medicine.
- Rationing of care is real and is a result of costs exceeding the budget established for healthcare.

POINTS TO CONSIDER:

- Many doctors would decide to retire instead of conforming to a new system.
- Many small hospitals would close or become clinics due to funding cuts.
- There would become fewer choices in coverage levels or where you seek care.
- **IT WILL NOT CHANGE THE HUMAN LIFESTYLE!**
- **IT WILL NOT LOWER THE COST OF HEALTH CARE!**

FACT: In 2010, Danny Williams was the premier of Canada's easternmost Province of Newfoundland. He needed heart valve surgery but could not get it in Newfoundland. Guess where he went for his care? Not in Canada under the Canadian health system. Instead, he chose to get care at **Mt. Sinai Medical Center in Miami, Florida**. This is a powerful message regarding the Canadian health system, and how it compares to care in the United States. In 2019, Mick Jagger had heart valve surgery in the United States. Why not in the U.K. if their health care is better?

Read more at
https://www.usnews.com/news/best-countries/articles/2016-08-03/canadians-increasingly-come-to-us-for-health-care

Some small employers are leaning toward Medicare-for-All as they feel it will place them on an equal playing field with other employers as far as their health-care costs. However, they do not fully understand the over-all impact that would result from this.

Alternative, Complementary and Integrative Medicine

Alternative, complementary and integrative medicine can be used for multiple reasons and among the most important is the treatment of chronic pain.

A Center for Disease Control and Prevention (CDC) report on chronic pain estimates that it affects nearly 50 million U.S. adults. Unfortunately, the treatment for chronic pain is often opioids. Ironically, a 2018 CDC report found 67,367 drug overdose deaths occurred in the United States and synthetic opioids are the main driver of drug overdose deaths. That is why it is important to look at other solutions to chronic pain.

Alternative and complementary medicine refer to treatments outside of the mainstream and are gaining acceptance. Doctors are now combining these techniques with conventional treatments. This takes advantage of evidence-based conventional and alternative medicine practices to improve health and treat illness.

Alternative medicine includes some forms of therapy that have been practiced for centuries such as acupuncture, homeopathy, naturopathy, Chinese or Oriental medicine. It also includes:

- **Body –** The body can fully focus on healing an injury/illness if by touch the other parts can be brought back to good health. Examples: chiropractic and osteopathic medicine, massage, Tai chi, and yoga.
- **Diet, herbs and supplements –** Dietary and herbal approaches attempt to balance the body's nutritional well-being.
- **Energy –** Some people believe external energies from objects etc. directly affect a person's health. Examples: electromagnetic therapy and Reiki.
- **Mind –**There is a strong connection between mind and body. Studies find that people heal better if they have good emotional and mental health. Examples: meditation and biofeedback.
- **Senses –** Some people believe that touch, sight, hearing, smell, and taste, can affect health. Examples: art, dance, music, visualization, guided visual imagery

Complementary medicine is when therapies are used along with traditional medicine. Alternative medicine is when they are used in place of traditional medicine.

Integrative medicine combines conventional and complementary medicine in a third step and emphasizes a holistic, patient-focused approach to health care and wellness. It can include mental, emotional, functional, spiritual, social, and community aspects and treats the whole person. Researchers are exploring the potential benefits in different situations:

- **Pain management for military personnel and veterans.**
- **Symptom relief for cancer patients and survivors.** Doctors, cancer nurses and researchers are interested in the idea that positive emotions can improve health.
- **Programs to promote healthy behaviors.** Many therapies focus on relaxation and reducing stress, which can calm emotions, relieve anxiety, and increase a sense of health and well-being.

When considering any treatment, do your own research and learn about the risks and benefits. Gather information from reliable sources and check credentials. Talk with your doctor especially if you take medications and have chronic health problems.

The **NIH National Center for Complementary and Integrated Health** conducts and supports research and provides information about complementary health products and practices.

COVERAGE of SERVICES NOTE: *Most of the options above are not covered by health insurance plans with the exceptions of limited coverage for some chiropractic and acupuncture services. Make sure you check your insurance plan's Summary of Benefits and Coverage for coverage details or call your carrier to determine level of coverage.*

PREVENTIVE CARE, CHRONIC DISEASES AND HEALTHINESS

Check your insurance carrier for healthy lifestyle programs. They may have programs to encourage preventive care and wellness, provide health coaches to work with certain chronic conditions.

Preventive Care

Preventive health is services that include check-ups, patient counseling and screenings to prevent illness, disease, and other health-related problems. Many of those services have no copayment, co-insurance, or deductible. The services can include:

- Blood pressure, diabetes and cholesterol tests
- Many cancer screenings, including mammograms and colonoscopies
- Counseling on such topics as smoking cessation, losing weight, eating healthfully, treating depression and reducing alcohol use
- Regular well-baby and well-child visits, from birth to age 21
- Routine vaccinations against diseases such as measles, polio or meningitis
- Counseling, screening, and vaccines to ensure healthy pregnancies
- Flu and pneumonia shots

— U.S. Department of Health & Human Services, Preventive Care, https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html

Although no-fee preventive services are available not all take advantage of them. That along with poor health habits – unhealthiness – leads to the following staggering figures:

"According to the Center for Disease Control, six in 10 Americans live with chronic disease with soaring costs for each accounting for 75 percent of total health-care spending in the United States. Poor health habits – unhealthiness – is the root cause."

— The Keckley Report, Time to Take Our Health Seriously? January 13, 2020

About Chronic Disease

Chronic diseases are defined broadly as conditions that last one year or more and require ongoing medical attention or limit activities of daily living or both. Chronic diseases such as heart disease, cancer, and diabetes are the leading causes of death and disability in the United States. They are also leading drivers of the nation's $3.5 trillion in annual health-care costs.

— Center for Disease Control, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), https://www.cdc.gov/chronicdisease/about/index.htm

Many chronic diseases are caused by a short list of risk behaviors:
- Tobacco use and exposure to secondhand smoke.
- Poor nutrition, including diets low in fruits and vegetables and high in sodium and saturated fats.
- Lack of physical activity.
- Excessive alcohol use.

See https://www.hhs.gov/healthcare/about-the-aca/preventive-care/index.html.

What is healthiness?
Paul Keckley, Ph.D. defines healthiness for us.

It's how people live their lives.

It's individual habits, daily practices and choices people make with their time and money. Some call it wellness.

At the heart of healthiness/wellness is a simple notion: it's taking care of yourself or neglecting yourself.
- Healthiness is about physical and behavioral health (i.e., anxiety, stress, and mood).
- It's about relationships, roles and surroundings at home and work that impact an individual's sense of purpose and predispose some to addictions.
- It's about mind and body in every stage of life.

Keeping people healthy and out of hospitals, emergency rooms, doctors' offices and pharmacies is good business for everyone.

Learn more here: https://www.thehealthy.com for **The Healthy**: **Healthy Living with Expert-Backed Advice**. This site is dedicated to health and wellness. Get real, expert-backed advice for your most important health questions and problems. It includes advice for your mind and body, including tips about self-care, nutrition, exercise, and happier relationships, as well as how to deal with common conditions and health challenges.

V. The Future

EMERGING TECHNOLOGIES & INNOVATION

How can data and emerging technologies be used to improve the health-care system and cut health-care costs?

To contain costs and improve results we need the tools of the information age and new health technologies. They can be utilized to reduce cost and enhance the quality of care and access. They can replace hospital stays with the monitoring and management of patients in their own homes. Smart phones and watches with sensors can monitor all vital signs. Having data available along with the ability to communicate enables many new kinds of interventions. Professionals can assess the patient users and determine where they need the most help. One of the most promising of the new technologies is artificial intelligence.

What is Artificial Intelligence (AI)?

AI is the ability of a computer program or a machine to think, learn and grow smarter. They work on their own without being encoded with commands. Computer systems can perform tasks that normally require human intelligence, such as visual perception, speech recognition, decision-making, and language translation.

AI can reduce preventable medical episodes in several ways:

- Automate reminders and help patients take medication within a specific timeframe.
- Identify people at high risk – AI can discover those in need of medical intervention and trigger medical staff alerts to create custom care plans.
- Deliver personalized dosage recommendations – AI uses data based on each patient's unique body chemistry and associated environmental factors.

Pain Management:

What is a (transcutaneous electrical nerve stimulation) TENS device?
A (TENS) unit is a device that sends small electrical currents through the skin to target body parts. These currents relieve pain. Some TENS units are designed for use in a health-care facility while others are for home use. Quell brand wearable TENS technology is calibrated to the patient's body and can be personalized to their therapy needs. It is an FDA-approved Class II medical device for symptomatic relief and management of chronic pain and available without a prescription.

Cardiac Rehabilitation Monitoring:

Some organizations are using virtual cardiac rehab programs for patients. The programs combine a wearable mobile app such as a smartwatch, best practices and a care management program. The program can be done at home via remote monitoring, which makes it easier for the patient to receive the services.

Some devices track health metrics such as stress level and heart rate. Previously, this type of tracking performed by a provider was considered too cost prohibitive. This new rehab monitoring technology may cut costs in areas such as costly hospital readmissions. The average readmission cost for any diagnosis in 2016 was $14,400, according to an article in Becker's Hospital Review.

— "Discharge Algorithm Could Save Hospitals $860 Per Care Episode," June 18, 2019

Chronic Disease Monitoring:

AI can be used to monitor chronic diseases such as heart disease and diabetes. Diabetics can wear a device that measures blood glucose levels, and it triggers an alert when a person needs help staying on track with medications. It can deliver a personalized recommendation for the patient. The system gathers medical data, pharmacy labs data, biometric data and combines them into a dashboard that is accessible through an online interface. The ability to carefully monitor chronic diseases lowers overall costs.

THE JOB CREATORS NETWORK (JCN) PERSONAL HEALTH MANAGEMENT ACCOUNTS

The Job Creators Network Foundation, https://www.healthcareforyou.com/policy-guide/, developed a framework for health-care reform using Personal Health Management Accounts (PHMAs). PHMAs will do the following:

I. Protect those with pre-existing conditions.

- Employees with PHMAs can buy their own health insurance with tax-free dollars and will not have a lapse in coverage when changing jobs. This addresses some of the problems of continuing coverage for those with pre-existing conditions with a job change.
- Gives states the authority to regulate and create an insurance market to drive down costs for most patients. States can create guaranteed coverage pools to protect patients with pre-existing conditions.

II. Lower drug prices.

- Now $250 billion/year goes to pharmacy benefit managers (PBMs). Instead, money should be returned to patients to lower their costs for drugs and medical devices.
- Repeal the legislation that exempts PBMs from penalty for violating federal anti-kickback law.
- Many recent increases in drug list prices are due to rising rebates.

III. Lower insurance premiums through increased choice and price transparency.

- Current regulations prevent short-term and association health plans while Essential Health Benefits drive up costs.
- When an industry has choice and competition there are lower prices and more innovations.
- Allow states to create an insurance market where individuals can purchase what they need from a catastrophic plan to a “Cadillac” plan. This will generate choice and competition and drive costs down.

IV. PHMAs give patients more control over their health-care dollars.

- Increase the maximum tax-free dollar contribution employers can contribute directly to employees’ PHMAs will remove business owners from the insurance business. PHMA plans are portable so employees take it with them from job to job.
- Employees can use pre-tax dollars to pay for health care and save for future health care. This gives them the same tax benefits enjoyed by corporations.
- Now only employees with certain types of high-deductible plans can have health savings accounts. The employees’ option to have a PHMA should be available no matter what insurance plan they have.

V. Put patients in charge by removing barriers that separate them from their doctors.

- Electronic Health Record regulations require doctors to spend about 50 percent of their time on paperwork instead of patient care. This data is used to monitor both patient and physician behavior.

- Regulations are driving physicians out of private practice. Fifty-three percent of doctors are now employed by hospitals. They are beholden to their employer rather than the patient.

VI. Expand Direct Medical Care to increase choices and lower costs.

- Using PHMAs will give patients greater access to Direct Medical Care that offers families all their primary medical care needs for one low, monthly membership fee with no insurance or middlemen.
- Patients can get access to their regular doctors at any time through call, text or telemedicine.
- For medical expenses such as surgical centers, labs and imaging, Direct Medical Care means transparent cash prices. This allows patients to price shop, lowering costs.
- Cash prices are often cheaper than what insurers can offer.

VII. Reduce defensive medicine to remove costs from the system.

- Physicians often order every conceivable test to protect themselves against possible lawsuits — increasing costs by tens of thousands of dollars without necessarily raising the quality of care.
- Limiting physicians' malpractice exposure will control these costs, resulting in lower costs for patients.

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