I haven't published anything on here in a long, long time.. Thought it would be fun to start up again. I wanted to give some stream of consciousness thoughts on how I think we can "fix" the economics of healthcare.. Hopefully I make a lot of folks think and make a lot of folks in the industry think harder.

Healthcare is a very simple industry made complicated.

I'm not talking about the relentless search for better ways to care for patients. Whether its surgery robotics or better bandaids, the quest to improve care is vitally important.

What I'm referring to is the complication of the industry in search of margin dollars. I won't go down the list of who is trying to grab what and how. The starting point is "What Should it Look Like ?"

What Healthcare Should Look Like

Hypothetically, It should look like 1955 (I picked this year because of Back to the Future :). Patients go to providers for care. Providers provide that care. Patients get a bill and if they can afford it, they pay that bill. That's it.

The ONLY question in healthcare should be "How should care for people who can't afford to pay for their care be paid?"

Before we start that discussion, let's do a very, very simple back of the envelope discussion of the cost of healthcare in this country, but we will work backwards to the amount of money needed to pay for care for people who can't pay themselves

The total cost of care by most estimates is around 5 Trillion dollars. How do we cut that number ? The following is purely my opinion. But I don't think I'm far off, if we could get everyone in the industry to participate, which is unlikely, but not impossible.. So call me a dreamer.

Transparency – I'm not talking about publishing the price of procedures and care like Cost Plus Drugs does with meds or that hospitals provide on their websites. That won't work because everyone bundles and upcodes and plays games in order to extract as much revenue from whoever is paying as possible. The price is a function of too many variables

Bill of Materials – Instead we need to publish the Bill of Materials, at cost, for every thing that is used when providing care. From consumables to doctors, nurses, or anything that is directly attributable to care, EXCEPT for items that are Capital Expenditures and overhead

- Any equipment, real estate, facilities, power, generators, personnel not providing care and their associated benefits will be segregated.
- Show the actual cost the hospital paid for the bandaids, the sterile water, the fully burdened with benefits doctor, nurse, PT, and anything else that is used specifically for the care of that patient, rather than being shared.
- We will save the how we deal with Cap Ex and Overhead for the end

- **Gross Margins** – Instead of providers including their gross margins in the pricing for consumables and direct costs, which creates a lot of distortions, like $20 aspirins, just have the provider show their margins. It is up to them what their mark-ups are, but the key here is that it's really easy to compare the costs that hospitals pay for consumables, doctors, nurses, therapists. Those are efficient markets for pricing. You can make a phone call and get real costs. **Reducing the variance between providers to the markups they choose to charge makes the market far more efficient and competitive.**

Publish Contracts

- Healthcare contracts with big providers are COMPLICATED. They aren't just lists of terms and prices. They have equations in them that take a math major to begin to evaluate them. The only way these become simplified, and the only way the people paying for their care turn this into an efficient market is if those contracts are published for all to see

Remove Insurance Companies From the Equation

- **All Payments are Cash Pay** – The cost of administering and managing payments is astounding. **Many estimates are 20 to 30 percent.** Most of that is because of the never ending battle between Insurance companies and providers and patients to collect money We could add another **10 percent to account for fraud, overbilling and upcoding and upcoding**. Across 5 Trillion dollars. That's real money.
- **Cash Pay Reduces Pricing** – Almost every single provider offers lower pricing for cash pay. Multiple studies have shown savings anywhere from 20 to 70 percent. It's astounding how much additional cost is added to the system because of the complexity insurance companies introduce. Which makes perfect sense.. If a provider can eliminate all the costs associated with collections and more by 20 to 30 percent, they can and should cost less for care
- **Insurance Companies** Remember, we are working backwards to who pays what patients cant pay for. It will not include insurance companies

Lets Do the Basic Math So Far

- 5 trillion – Saving on Overhead – Savings on CashPay
- 5,000,000,000,000 – ((.25+.25)x 5,000,000,000,000) = $2.5Trillion Savings and Cost.
  - This is before accounting for savings we can get on pharmaceuticals by doing similar things.. It won't be 50 percent, but it could be more than 20 percent

What About All the Overhead by Providers?

- In 99 percent of businesses in the world, companies mark-up their costs to generate gross margin dollars to cover all their overhead. This industry should be no different. The change of course, and one of the hard parts of implementing any plan like this is getting providers, particularly big systems to go along.
- My guess, and this is a guess, is that one of the biggest problems that our country has, that other countries do not, is that there is a CapEx arms race. Every system wants to be bigger than the next. They want the latest "Machine that goes ping", they want to spend a ton of money on branding to compete. On the good side of the arms race, again, just my opinion, is that it allows Doctors who are great at their jobs to earn a premium. I'm in the camp that Doctors and Nurses are vastly underpaid. This approach would hopefully move margin from the owner to the actual care provider.
- I think that unless there is significant competition in a market, this inflates prices. All we have to do is look at facilities fees trends and site neutral issues to start to understand this.
- **One other note. The starting number for total healthcare expenditures includes the current gross margins of providers.. So while we are asking them to publish those numbers, we are not assuming they are going to go lower**

5. **Pharmacy – Pharmacy is about 11 percent or $550b**. I think these can be reduced at lest 20 percent with this level of transparency. Down to $440b, but thats on a look back basis before considering GLP1s. So I wont include it in any numbers below

Now for the Big Money Question.

- Who pays for the care patients can't afford to pay themselves ?
  - First we will assume that medicare and medicaid stays the same. No operational changes. We will be able to save money by going back to traditional Medicare across the board and using Third Party Administrators and Pass Through PBMs rather than the way its done now. But we will assume the amounts and programs generally stay the same. We federally spend 847b on medicare and 570b on Medicaid. Subtract those numbers from 2.5T and **we are down to about $1.1 Trillion for non Medicare/caid spending**

7. I'll open it up for feedback. How should be pay for the $1.1 Trillion that is effectively for everyone under 65 ? There are 160m employees who get insurance from their jobs. Divide that and its $6,875 per employee per year. But not all those people make a lot of money. But we also know that employers pay at least 70 percent of premiums.
   - What if employers pay what would have been their share of premiums to the feds, who can now just use Medicare payment processing to cover the cash pay bills from providers your employees use ? And that money can also be used to cover the costs of the uninsured ? (We took the total cost of care and divided it into the number of employees with insurance).
   - Is it smarter to have employers give raises to replace what would have been their share of premiums, and letting each individual pay more in taxes on their increased incomes and maybe a 1 or 2 percent premium, to cover the cost of care for the uninsured and contribute to medicare shortages ? Then like above, providers would send the bill to Medicare who would pay them.
   - Should the government get in re-insurance business like they and states effectively are for flood and disaster insurance and let employers pay what would have been their insurance premiums into an HSA, and to the feds for reinsurance, and let employees use their HSA accounts up to their reinsurance amounts, with the employers paying amounts between the HSA and fed re-insurance ?
   - Do we let employers stop paying for insurance, pay employees more. Leave it up to the employees to determine how to use that money ? What if they can't afford the bills ?
   - Just a reminder these options only work if the top changes are made.
8. **The whole point is that if you reduce the top line cost of healthcare expenditures in the USA by changing how we pay for care, making it truly transparent, and aligning the interests of providers, employers and patients, our options expand dramatically**
9. I did all of this in about 90 minutes. So its far from perfect. I just wanted to get my blog started again (thanks to a social commenter who asked), Feel free to rip it apart. That's how change happens