



# **HSCRC Implementation of Population-Based and Patient Centered Payment Systems**

**MedChi White Paper Submitted to the HSCRC**

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### **Gainsharing And Other Physician Alignment Programs**

The new all payer model in Maryland creates opportunities for the HSCRC to analyze as many intersecting factors as possible in determining the opportunities and barriers to a gainsharing model of physician payment. The ultimate goal of innovative physician alignment efforts is to determine how to best deliver the Three-Part Aim of better health, better care, and reduced costs. This is a time of great opportunity to research the necessary changes to policies and methodologies when implementing this new system. Many of our current systems can be updated to better align with this new payment model and new systems can be developed to ensure smooth transition to the all-payer system. This paper will focus on how to best structure gainsharing and other physician alignment programs, to properly incentivize the individual physician and to encourage value-based medical practice. Also the necessary changes to health information technology and other connectivity advances that can improve care and reduce costs will be discussed. Finally, this paper will consider the impact of defensive medicine and how it may create paradoxical incentives for physicians practicing under a gainsharing or shared savings model.

### **Creating Value-Based Medical Care**

Value-based care is determined by the patient outcome as relative to the cost of providing care to receive that outcome. Value-based medicine is the foundation of the all-payer system as we move away from volume-based delivery under a fee-for-service arrangement. Proper incentives must be created through gainsharing to align incentives and provide value in the next generation of health delivery and payment models. These incentives should be clear to the individual physician and reflect the effort of the individual physician in practicing value-based care.

The creation and deployment of Integrated Practice Units (IPUs) are one way to use incentives to promote value-based care. IPUs are patient centric, disease specific care models that treat patients with specific chronic conditions in an integrated way for the duration of their illness. The HSCRC should consider developing a gainsharing arrangement that fosters the creation of

IPUs. IPUs will provide true value in the health care ecosystem by providing the vehicles for disease specific population health management that will support and can be integrated into successful Accountable Care Organizations (ACOs) and Patient Centered Medical Homes. By providing centralized care along the entire disease life cycle, education, and guidance IPUs can be more efficient and effective than their primary care counterparts. Also economies of scale can be developed as well as streamlining data collection for public health purposes. The HSCRC should also consider the regulations which will need to be created to support the development of IPUs as well as a governing body for the IPU since integration of currently fragmented entities will require significant financial interaction that does not currently exist in the fee-for-service model. The governing body should have representation from all involved entities including providers, hospitals and others involved in patient care. Most importantly the IPU will be provider driven and disease specific and thus the governing body should elect a physician clinical champion that will drive maximum value in the integrated system. The importance of understanding costs per patient per condition to the system should not be understated. Having an integrated single center of care that sees many patients with the same condition has enough of a patient base with consistent care conditions to accurately determine the actual cost of care per patient. This allows innovation to be accurately fostered or ignored. When there is baseline cost per patient data, new programs can be developed and implemented in any population because their success or failure can be quickly and accurately assessed. Also in an IPU patient outcome research can be conducted, and public health data can be collected more quickly from fewer sources, than research that would need to include all primary care physicians in a region.

IPUs can utilize their large set of patient data to develop evidence-based clinical treatment protocols. Incentives based on these standardized treatment protocols are reflective of the work of all of the individual physicians because their treatment plans and patient population are uniform. This is a major benefit that is not seen in other types of healthcare delivery and when creating physician incentives the problem of lack of uniformity will need to be appropriately addressed.

Any successful IPU will require the development and deployment of a robust information technology platform. It is imperative that the health IT systems that are deployed are optimized so that utilization is optimized by both the patient and provider community. The ideal value-enhancing IT platform will be patient-centric with design characteristics that promote improved communication, allow for the collection of outcome data and the added ability to track patient-centered costs. It is plausible that the appropriate IT platform will be customized to specific disease processes and that IPUs will develop robust systems that optimize value of care along the patient care life cycle.

### **Individually Tailored Incentives**

Gainsharing, shared savings models in ACOs, and other physician alignment incentives through the Alternative Rate Setting Methods structure have been successfully implemented in Maryland in the past. These alternative compensation programs encourage safe, efficient, high quality care. Moving forward, a plan should be developed that impacts physicians at the individual level. The greater the control individual physicians have on the amount of their incentive the greater the incentive for physicians to create individual contributions to cost cutting measures. This careful framework of incentives will lead to more meaningful gainsharing programs that will elicit better outcomes.

An ACO is required to serve 5,000 Medicare beneficiaries. The average physician practice (which may have more than one physician) has an average patient roster of 260 Medicare patients. So conceivably a new ACO would need to have dozens and dozens of physicians to meet the 5,000 beneficiary mark, which is essential to assure statistical accuracy of quality metrics. MedChi Network Services (MNS) is the largest state-designated Management Services Organization (MSO) in Maryland and operates three Advance Payment Medicare Shared Savings Program Accountable Care Organizations (ACOs), providing care management for over 22,000 Medicare beneficiaries. The ACOs have over 80 healthcare providers to care for their beneficiaries. However, cost sharing and shared savings are spread out over the entire ACO. The specific impact on quality of an individual is diminished with the greater number of physicians working in the ACO, the problem of freeriding is obvious and attractive. Specific

quality improvements of a few outstanding physicians are obscured by the general quality measures achieved by the group. Freeriding can be combated with increased teamwork and a strong culture of quality but those measures are harder to implement across specialties and with physicians at different stages in their careers. To avoid these problems hospitals engage in physician alignment activities. One model being an ACO model of clinically integrated provider networks, employed physician models, and independent contract models. The goal of all of these alignment efforts is the same, to align the physician payment with the hospital and hospital payment with the payment system. These models and their integration will be especially important as Maryland shifts to the all-payer model. An all-payer model deemphasizes hospital admissions and the healthcare industry is responding by creating partnerships between hospitals, outpatient facilities and ambulatory care centers. Hospitals are now maximizing services to their patient population rather than maximizing total admissions. To address patient populations physician alignment and developing a network of specialists and care teams is essential. Having physicians in multiple settings with multiple separate relationships with hospitals means that any shared savings will need to be structured to reach the individual physician at their level where they intersect with the all-payer model. There cannot be efficiency in only one segment of the continuum of care.

Physicians who are employed may have different incentives and quality requirements than an independent physician, or a physician working on a contractual basis for a hospital, therefore setting a shared savings program to reward hospital level quality and efficiency won't incentivize physicians in a way that reflects their individual contribution to quality, and will be ineffective.

One way to address this inequality among physicians across a hospital is implementing Clinical Co-management and IPUs. Clinical co-management models allow physicians to retain their autonomy and to link incentives to the quality of care they provide. Clinical co-management works on a contractual basis and is designed to align the incentives of hospitals and providers. Co-management agreements lead to the development of IPU's that provide patient centric, disease specific care that improves outcomes and lowers costs. This model is best suited for

mid-sized hospitals and requires hospitals to relinquish some control but yields clearly-attributable savings and quality metrics, while allowing physicians to focus on innovation and quality. The exact model of physician alignment and incentives will vary and be based on what works best for the individual institution, however, the focus of any program should be on incentivizing at the smallest unit possible so that physicians can reap the rewards of their efforts and do not need to worry about freeriders.

### **Capitalize On The Benefits Of Connectivity And Electronic Health Information**

Creating any new health care delivery model requires aligning that model with current electronic health information requirements and incentives. One way to ensure electronic health record (EHR) adoption in new delivery models and EHR connectivity between a new model like an IPU and current health care practitioners is through the use of CRISP, the state health information exchange.

There are three principal services offered by CRISP: the Encounter Notification Service (ENS), a web-based query portal, and a quality reporting system for hospitals. Each of these offerings has the potential to improve health care quality: ENS notifies the appropriate caregiver of specific adverse events such as emergency department visits, the portal allows providers to access real-time data such as lab results, and the hospital reports give institutions data from multiple facilities for better quality improvement. In addition to these, CRISP provides direct messaging to facilitate the secure transfer of patient data.

The notification and portal services offered by CRISP are essential pieces of transitional care management. They would also be essential in the adoption of an IPU system where a chronic condition is being treated in the IPU but an acute condition is treated elsewhere. One barrier to total adoption of these services, however, is the additional demands these services place on independent practices. While most physicians agree that access to real-time data is helpful, the workflow required to log onto multiple systems and manually transfer information is often too resource or time-intensive to be done consistently. The HSCRC should consider what can be done to streamline this process as well as what incentives can be levied to encourage using this necessary service.

One way to encourage integration is by harnessing the existing integration of ACOs that are already serving as physician-led health care hubs for their communities. ACOs provide an explicit incentive for participating providers to utilize all available care management and IT services. Also, ACOs contribute a fixed panel of nurses, social workers, technologists, and other personnel that are able to assist practices with coordination. Finally, the IT infrastructure used to measure quality, analyze populations, and share data with CMS can also be used to perform similar functions with a state-designated health information exchange (HIE). The health hubs are currently performing the following roles: clinically integrating independent practices, coordinating services between disparate care settings, analyzing population health indicators, and recording/ reporting quality measures. Connecting the IT system of the ACO hub to the state-wide HIE would further the efforts of the entire community to achieve the CMS three-part aim. It would also provide additional information to the HIE, which can then be used by providers across the state.

### **Last Mile Connectivity**

We know how essential interconnectivity is in providing non-redundant, efficient, timely care. However, there are large gaps in connecting HIE and EHR along the continuum of care. Community-based, primary care practices lag in both HIE connectivity and EHR adoption in general. Also nursing homes are not eligible for the incentives that have spurred EHR adoption in hospitals or ambulatory practices. They also care for patients that demonstrate a high risk of readmissions after transitioning from an acute care facility. Technology would actively support documentation and data-sharing to aid in transitions of care, as well as providing monitoring for patients that pose a risk for reentering a hospital unnecessarily. CRISP successfully connected all 47 acute care hospitals in the state to the HIE, but the entire industry is experiencing connectivity issues between state-wide exchanges and ambulatory providers. Incentives should be extended to those areas of care that are not eligible and more should be done to help community based primary care practices that are time and resource poor implement an electronic health record.

## **Create Efficiencies In Billing Procedures**

Healthcare documentation, billing and reimbursement methods are still largely old-fashioned, despite computer advances. The economics of delivering services could be changed if billing procedures were integrated into the patient's EHR. Today, 15-30% of our healthcare dollars are spent on administrative expenses. Cost savings would be significant if billing, one of the most labor intensive administrative processes, could become a streamlined component of EHR.<sup>1</sup>

## **Defensive Medicine**

Defensive medicine occurs when a physician alters clinical decision making due to the risk of medical liability. Unfortunately, defensive medicine is a ubiquitous part of medical practice with 90% of physicians consistently reporting that they engage in defensive medicine. Defensive medicine can be "positive," where a physician will request extra testing, referrals, or medications due to fear of litigation; or "negative" where a physician will avoid treating a patient seen as "high risk" of complications or litigation. Physicians also may restrict their scope of practice to reduce their risk of litigation. The cost of defensive medicine has been estimated at anywhere from \$54 billion to \$650 billion a year or between 5% and 34% of healthcare expenditures. States with limited tort reform or those seen as having a particularly hostile plaintiffs bar can lose physicians who will choose to elsewhere. Texas saw a decrease in obstetricians in each of the three years before implementing comprehensive tort reform, resulting in a total loss of 14 obstetricians over the three years. In the year following the reform legislation they saw an increase of 192 obstetricians. Restricting your physician population and physicians self-restricting their patient population can severely impact patient access to competent medical care.

When shared savings programs and physician alignment models encourage efficiency and cost savings in a state without tort reform, it can create a paradox of incentives. Physician buy-in for medical models that encourage less intervention is directly contrary to a defensive medicine model where the fear of litigation requires more intervention. It is essential when creating legislation that allows for shared savings models to adopt tort reform measures that allow

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<sup>1</sup> For additional information on utilizing electronic health records to streamline billing processes see Appendix A



physicians to practice value and evidence-based medicine without the fear of destructive litigation. It is also equally important to invest in the CRISP programs above that encourage real-time sharing of records and test results that can reduce redundant non-defensive medicine.

### **Conclusion**

To implement a gainsharing or physician-payment model it is important to evaluate the opportunities for improving the interoperability of electronic health records and encouraging physician alignment models that reflect the individual contributions of physicians. It is also a time to address challenges to the system. Incomplete tort reform will impact the buy-in of individual physicians who are currently in a system where providing extra services, even when not medically indicated, was the safe and economically beneficial care plan. The HSCRC should finally evaluate the merits of IPU and consider creating a system that allows these innovative delivery models to become a dominant model for treating chronic conditions.

Appendix A:

## **Healthcare System Reform: Health Card Billing, Payment and Electronic Medical Records**

### **Concept Overview**

*Problems:* The cost of health care and insurance continues to go up, leaving more and more of the population uninsured; the administrative and overall cost of health care in the U.S. is very high while measures of the effectiveness of our healthcare are below those of other advanced countries. Providers and their staff spend a lot of time and expense figuring out each person's unique coverage situation in order to correctly bill and collect for services. We are not using the most modern billing and payment systems despite all our advances, and as individual providers computerize with unique systems, a lack of inter-operability and standardization of systems communication will further increase costs. Healthcare professions are less attractive to our brightest graduates, eroding the quality of care for our future generations.

*Solution:* Develop and implement a health card (simple magnetic stripe credit card style) for over the web patient identification, registration, payment, and Electronic Medical Records with standards and a program that can be implemented in a step-wise fashion on a voluntary basis by the insurance and health care industries, with government leading the way.

*Benefits:* Reduced administrative costs and reduced direct costs will allow our healthcare dollars to go further by decreasing the cost of delivery of healthcare to all without the need to go to a single payer system. The government money saved can go to fund care for the uninsured and under-insured; the private funds saved can be used to reduce costs, to improve benefits or both. Healthcare satisfaction, delivery and quality are expected to improve. Extensive and comprehensive data will be available for research to advance healthcare.

*Goals:* Measurable improvements in: time and cost to access care, benefits and records; quality of care; reduction in the cost of care or at least a slowing of the rate of increase of the cost of care; improved access and delivery of care, especially to those without benefits now.

## Details

Healthcare documentation, billing and reimbursement methods are still largely old-fashioned, despite computer advances, yet the technologies are available now to make a significant impact on healthcare and the economics of delivering services if standards can be implemented to allow inter-operability and compatibility of systems for record keeping, billing, payment, and reporting. Once developed, in the near future, patients will carry insurance or health cards similar to their current credit cards. The cards do not need to be “smart” or have any more data than the magnetic stripe of a regular credit card. The patient will present this card (or the number) when they are seeking any type of health care service. Medical staff will swipe the card through an inexpensive reader attached to their computer (or the data could be entered manually without a reader). If the patient provides the proper password, and / or their fingerprint or other biometric access, the screen will pop up with the patient’s name, demographic information, insurance coverage, deductibles and co-payments. With password protection the healthcare provider will have access to the patient’s online computerized comprehensive medical record and history. If the patient gives an additional password, or if the patient has it keyed into their primary password, the provider will also be able to upload a computerized record of his or her patient interaction and billing information to receive immediate claim adjudication and payment. The data on the magnetic stripe will be interpreted across the internet to connect to the proper data base(s) to provide the information and complete the transaction. At the conclusion of the patient’s visit the provider’s staff will enter a code to indicate the appropriate charges on the computer, and just like a credit card purchase, the transaction will be approved and paid within one minute or less! The screen will indicate any co-payment which the provider should collect on the spot and show the payment that has just been placed directly into the provider’s bank account electronically. Similarly if pre-authorization and payment information is needed for a planned procedure, it can be obtained in real-time in seconds instead of hours, days, or weeks.

At some point in the future the health card and a credit card for retail purchases might be combined. Only one card would be needed to make a health transaction for insurance and co-pay, both could be authorized in succession, and with regular retail use, consumers would be less likely to lose their health card. Health Savings Accounts (HSAs) could also be integrated and accessed.

With this system providers will not need to spend precious time waiting to obtain past records of care or benefits; they will not need to have patients return for another visit because they lack data about what has already been done; they will not have to repeat costly lab tests or procedures because results are not available when the patient needs treatment; providers will not need to send multiple reports into (the black holes of) insurance companies to get approvals or reimbursements. Providers will have immediate online access if the patient provides the password(s), to allow the provider to view the current and past medications, diagnoses, allergies, lab work and details about past specific treatments. For those providers who use additional software including electronic medical records packages, providers will be able to upload information about their treatment to the patient's file for future reference and to enable payers and reviewers to extract whatever information they need to approve the care and to audit treatment.

Government required reporting can be accomplished with a few clicks on line without re-entering data, enabling accurate and rapid gathering of critical information regarding any illness or treatment of concern.

In addition to regular access, emergency rooms and other facilities will be able to make use of emergency contact, next of kin, living wills, durable power of attorney, and key medical information which could be available with special passwords coming from secure facilities and terminals at times when the patient might not be able to provide the regular password(s).

New types of research that are not possible now will be able to supplement current investigation techniques. Aggregate data stripped of identifying information will be available on secured lines to enable authorized researchers to access the entire insured population, or specific subsets, for data regarding patient care, prescriptions, diagnosis and treatments.

Supercomputers at academic centers can crunch this data to advance our healthcare knowledge. Researchers with appropriate password access will be able to track patient recidivism and use other concrete measures to evaluate the adequacy of different treatments and providers. Prompt evaluation of results of differing treatments for the same type of condition will be available so that authorized researchers and officials can then make important new information rapidly available to the treatment community. Authorized investigators will be able to access provider records if patients and providers allow it, facilitating online audits by government or private payers when necessary, without disrupting the provider's practice.

If providers have an electronic medical or health records (EMR or EHR) package, providers will be able to document the care they provide electronically; providers will be able to write prescriptions and transmit them to pharmacies electronically, and with the abundance of wireless networks coming in the future, providers could, with password protection, access their own charts electronically through portable devices while they are on the go and on call.

Colleagues could sign out lists of patients electronically to each other, and providers could have password protected access to these records as well. So when Mrs. Jones calls in saying that she needs a refill of the narcotic for her terrible back pain, the provider will be able to check in a few seconds if this is so and if one or more other doctors are also prescribing for her, check what medications she is actually on and what quantities have been filled, when and where.

This vision of the future is within our grasp; the technologies already exist. Today most providers have computers and access to the internet; for only \$500 one can purchase a very powerful computer system, and the price, power and quality of software is generally reasonable. With a large number of providers using the systems described, its cost would be negligible, especially when compared to the long range savings. Incentives could encourage large software companies to donate the software to the public good or developers might contribute to an open source code like Linux. A basic version to view and transmit insurance, demographic, billing and payment information should be available at no cost on the web or at very low cost with additional medical records functions being available at varying costs, according to the different packages and services chosen from a variety of commercial vendors.

Software can facilitate ICD (diagnosis) and CPT (procedure) coding of healthcare interactions to maximize both reimbursements and the quality of data in the system.

Government grants should be utilized to establish the criteria, security features and format for the data exchanges, records, billing and payments and to create and implement the first pilots. We already have certain aspects of electronic billing for healthcare visits and e-prescribing as well as electronic reporting of hospital visits (through the Health Services Cost Review Commission in Maryland), but the systems are not integrated, the data is barely or rarely accessible, and the resulting payment processes are slow even though they are better than pen and paper. Security and encryption techniques are now sophisticated enough to sufficiently deter unauthorized access when coupled with strong password protection and a network of authorized computers for transactions. The computer systems offer better control over access to records than paper and photocopies, with traceable records and logs holding those with access accountable.

The "big brother aspects" are acceptable tradeoffs for the accountability providers should deliver to the public and for all of the benefits that government, business, providers and patients will reap for their practices and for our community. Providers will be able to once again be more doctors and practitioners and less paper pushers and administrators. All of this technology is available to us today and is within our grasp if providers and consumers encourage our insurers, legislators and government officials to standardize the systems to allow us to begin implementing this type of health card network for our country's healthcare. (A national task force has begun to develop standards for EMR's and the current Stimulus Package takes this another step forward.) Maryland has been a leader in healthcare before, and there is no reason why such a system could not start here in Maryland in one or more locations as a test bed for the rest of the country. While this proposal is not specific to any specialty, it can encompass the confidentiality needs of all patients and assist all healthcare providers in improving their practices. With less cost to collect payments, and less time spent on administrative duties, providers will eventually be able to see more patients for less money throughout the entire healthcare system and/or provide better, more comprehensive care.

Since 15-30% of our healthcare dollars are now spent on administrative expenses, an estimated savings of 10% to 15% would be substantial (in excess of \$333 Billion per year) and allow us to provide care to many, if not all, who are now uninsured or underinsured. Preventive care and research would be facilitated. We would have a healthy health system and would expect healthier and happier citizens, businesses, industry and healthcare providers. Some of best young people are no longer selecting healthcare due to dissatisfaction with the current systems of delivery and payment; this would be a large step towards correcting this situation.

### **Suggested Implementation Steps**

Now: Federal, State &/or county legislatures establish a steering task force with paid leadership and support staff to implement the following, including to develop enabling legislation to deal with system creation, funding, liability, security, confidentiality, etc.:

- a. Federal legislators set up grants to states and counties for up to 10 demonstration projects.
- b. Counties and States apply for grant monies to develop demonstration systems for the country.

Year 1: Formation of task forces with stakeholders from the community to develop system design and specifications: include physicians, dentists, pharmacists, other healthcare professionals, legislators, lawyers, hospitals, nursing homes, residential facilities, pharmacies, laboratories, public and commercial insurers, HMO's, universities; federal, state, and county officials; software and hardware vendors, credit card and data bank service providers, organizations, members of the public and other stakeholders.

Year 2: Completion of system legislation, funding, specifications, programming and testing, utilizing existing systems and standards as much as possible, for:

- Patient registration and identification - including a unique patient identification number to be issued at birth or first health care registration or insurance provision
- Billing and payment

- Electronic prescriptions (Significant progress has already been made in this area.)
- Confidentiality, security and encryption
- EMR (Electronic Medical Records)– including coding of diagnoses and procedures
- Model legislation is enacted to implement the system and to facilitate identification, prosecution, and adequate penalties for any who abuse the system.

Years 3 to 10: timelines for government and private sectors to implement the system:

- Government employees' coverage must meet these guidelines in 3\* years
- Medicaid must meet certain of the standards in 3\* years, all in 4\* years
- Medicare hopefully can be convinced to meet certain standards by 5\* years, all the standards by 7\* years
- Large insurers (over \$X Millions a year) selling insurance in a region or state must meet certain standards by 5\* years, all the standards by 7\* years
- Medium insurers (over \$Y Millions a year) must meet certain standards by 7\* years, all the standards by 9\* years
- Small insurers (over \$Z Millions a year) must meet certain standards by 9\* years, all the standards by 10\* years
- Consider timeframes for providers and pharmacies to voluntarily adopt the technology and timeframes for mandatory use of part, then all of the systems

System specifications and details are made public and available. (The process should be open to the public.)

Insurers and vendors develop, test and implement the systems with the help of volunteer providers.



Once the system is in place for the providers and insurers who agree to participate, others will, I believe join in before the mandated times once the benefits are visible and known in the community as there will be pressure to adopt technology which saves time and money while improving the quality of care.

Provide Federal grant money to:

- Pay expenses of hardware and software (or software adaptation) of testers and early adopters
- Pay for training and support of the systems
- Set up the “health card” credit card type clearing houses and data banks
- Study the costs /benefits to prove its worth and indicate areas that may need improvement

For the current uninsured population hospitals and clinics should be funded to facilitate generating registration cards and EMRs to help track the needs and better understand the costs of coverage that are required for this group as we move towards a program of coverage for all.

Acknowledge that the standards and systems developed should be dynamic, not static, so that the system should be started as soon as possible, recognizing that when significant improvements are available, they should be made. Nevertheless, major changes should be backward compatible when possible and to reduce system costs upgrades can every 2 to 3 years for major changes if needed, while minor updates could be more frequent and ideally could downloaded for free over the internet.

### **Measurables**

1. Administrative cost of each health care dollar
2. Provider time to register a patient
3. Provider time to determine patient benefits
4. Provider time to collect payment for an episode of care

5. Provider cost to collect payment for an episode of care
6. Provider time spent on reimbursement related issues
7. Provider time spent on obtaining records
8. Provider time spent on documenting patient care
9. Quality of documentation according to established guidelines
10. Government cost, time and expense in funding required care and obtaining mandated health care information
11. Government, industry and private providers' time & cost for audits patient satisfaction with:
  - i. quality of care
  - ii. access to care
  - iii. cost, payment and reimbursement for care
  - iv. access to and confidentiality of records
12. Cost of grants, support, & equipment to implement system
13. Reduced emergency room cost and time to access patient data
14. Improved provider and patient ability to access data
15. System-wide savings
16. Increase in number of services provided per provider (efficiency)
17. Reduction or elimination of uninsured possible due to savings
18. Reductions in mortality and morbidity
19. Reduction in the cost of care or at least slowing of the rate of increase of the cost of care.

### **Cost to Implement**

Direct cost to government would be minimal, especially when compared to the savings. The initial cost will be the funding of task forces and pilot projects, perhaps \$100 Million or more. The major costs, as currently envisioned, are borne by the health insurers (including

government payers) who already keep most of the data needed – the insurer or third party intermediaries, and electronic records companies will need to adapt their systems to be able to be online, real time and to interface by standard, secure protocols; Federal grants should facilitate this process to enable significant nationwide savings annually. If the savings were only 10% of the cost of healthcare, this would be in excess of \$333 Billion / year. It is difficult to assess the cost of this process until the standards are developed, and there will certainly be differences depending on the systems in place at each company. There may be industry resistance to making this investment in the future of health care, but ultimately the insurers and administrators would save money as claims processing will be automated. Human intervention will be needed only for monitoring, maintaining, improving and auditing the systems. Some may even predict that payers will be reluctant to implement systems that reduce the time payers get to keep funds to make money on the “float” on the healthcare payment dollars. Change can be difficult, but in this case it can also be very rewarding – there is significant competition in the health marketplace and there should be substantial demand for any system which can save an estimated 10-15% on the cost of purchasing and administering benefits – both publicly and privately. I believe once a few have demonstrated the success of the system, others will voluntarily invest to avoid being left behind. The ones who will save and gain the most will be those who take the risk to be the first in the demonstration and pilot projects.

The estimated savings are also hard to quantify and can be debated, but are based on reports of the cost to administer systems in other countries where a single payer streamlines the process. The proposed system would provide the benefits of a single payer while allowing multiple payers to remain. The remaining “inefficiencies” and costs would come from disparities in coverage for various types of illnesses across different policies and payers – to avoid cost shifting this can also be addressed by portability of coverage, elimination of pre-existing conditions, and researching the data that will be available to model the necessary changes to have minimum mandatory benefits.