How to Fundamentally Transform the National Healthcare System

Kent Holtorf, MD
Holtorf Medical Group, El Segundo, CA

Key Concepts

- Insurance is designed to function for unexpected events and emergencies. It has never worked in any industry as a means to provide for any services that are routine and expected.
- Hospitals, laboratories and drug companies currently charge drastically different prices to groups of patients that are many multiples of reasonable free market prices.
- With an insurance model, the only mechanism of cost control is denial of service as service providers try and manipulate coverage formulas that have little reasonable basis.
- Insurance billing and payment are essentially a game of “charge as much as you can” and see what “gets through” as paid.
- There is no incentive for doctors or patients to control costs or to make reasonable cost effective medical care decisions.

Requirements

- There must be free market consistent pricing to consumers that are clearly posted with no penalties for cash payments at time of service.
- Patients must be able to compare the posted prices and have an incentive to choose value-based therapies.
- Low income subsidies of HSAs should be need-based fixed amounts to use as economically as possible with no “use it or lose it” provision to increase incentives to save money but allow no hassle access to necessary products and services.
- There should be no limit to the amount of personal pre-tax contributions to the HSAs

Results

- Eliminating the huge cost and burden of trying to use an insurance model for routine care will result in dramatic cost reductions of health care delivery that even those without insurance will pay less for a service than if they had insurance.
- Will result in a win-win for patients and providers of healthcare: Patients will have a dramatic increase in affordable healthcare while the huge billing bureaucracy that hospitals, doctors and other ancillary services must currently endure will be eliminated, resulting in greater efficiency and profits for healthcare providers.
- This program can be run in parallel with Obamacare, so Obamacare does not have to be repealed, which may well prove to be more difficult than originally thought.

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Policy makers have accepted the fact that Obamacare is unsustainable in its present form. While there are some good ideas being discussed to replace this flawed program, most of the attention is focused on tweaks to the insurance model and using health savings accounts (HSAs) to supplement insurance coverage with no comprehensive, viable replacement. A free market based alternative can quickly and effectively replace Obamacare or run in parallel with the existing system if repealing Obamacare becomes more problematic than anticipated.

The current system is based upon an insurance model, which is designed to provide coverage of unanticipated emergencies. Insurance is not designed to function effectively for routine care and has never worked in any industry as a method of providing services that are used on a routine basis. This is because it is excessively bureaucratic and the only method of controlling costs in an insurance based model is by denial of coverage and using complex reimbursement formulas. The end users (patients) and providers (doctors) have no incentive to control costs; they both want to get as much as they can from a third party (insurer or government). This flawed model has been pushed on the American people for many years. It has been subject to multiple modifications designed to control costs through new regulations adopted to reduce corruption. However, no amount of regulations will ever be adequate as a cost reduction strategy because increasing regulations inherently drive costs up, which are passed on to consumers. Increasing regulations also disproportionally affect smaller companies, increase corruption, reduce free market competition and serve to bolster the quasi-monopoly market structure that is pervasive in so many sectors of the U.S. healthcare system. This vicious cycle of implementing additional regulations and increasing enforcement measures to police the constantly increasing regulatory burden results in more corruption and collusion, which only further increases costs. There can never be enough regulation and enforcement to fix the system because every attempt to improve the system causes a greater burden on the system and less efficiency. The problem is the basic model.

> **"Insurance is not designed to function effectively for routine care and has never worked in any industry as a method of providing services that are used on a routine basis."**

Cost Predictability

I have been a physician for over twenty years and have seen the medical care in this country seriously deteriorate, with decreasing quality of care and skyrocketing costs. It is particularly frustrating and saddening how increasingly difficult it has become to provide basic healthcare to patients over the last three to five years. There is little predictability for healthcare consumers in this country. Patients are increasingly frightened to use their insurance, as it has become a game where hospitals, laboratories and drug companies charge grossly inflated prices in addition to charging different prices to different patient groups for the same service. There is no set pricing, and if you are paying with cash or have an HSA, you may pay ten to twenty times (or more) what a particular insurance patient is being charged. Patients and doctors have no idea what will be charged until the patient gets a bill a few months later. Generic medications that cost pennies a pill or about $10-$30/month just a few years ago are now hundreds of dollars per month. Routine procedures that were a few hundred dollars two or three years ago are now $20,000-$30,000. Laboratory tests that that were $30 a few years ago are being charged at $300 to $2,000 per test.

Correspondence: Kent Holtorf, MD,
Holtorf Medical Group, Inc.,
(HoltorfMed.com)
National Academy of Hypothyroidism
(NAHypothyriodism.org)
2232 E Maple Ave.
Tel: 310-375-2705
Fax: 310-375-2701
E-mail: KHolt@HoltorfMed.com
(please CC: JenyK@HoltorfMed.com)

In what other industry do you not know the cost of the service before you agree to buy the product or service? If you ask the price of a medication or healthcare service, you almost always receive the same answer, "What insurance do you have?" In what industry does cash at time of service cost many multiples more than utilizing a third party payer? Not only are the prices being billed to both insurance company patients and those using cash pay or HSAs grossly inflated, individuals who are considered fully covered are unexpectedly being saddled with huge bills for seemingly routine services. Services that were 70-90% covered five to ten years ago now have little or no coverage. Patients who are prescribed life-changing medicines that were covered for many years are no longer covered.

> **"In what other industry do you not know the cost of the service before you agree to buy the product or service?"**

What if we had food insurance (food is important, right)? You walk into the grocery store and get a piece of chicken because it is healthy and you believe reasonably priced, but the problem is that the store will not tell you how much the chicken costs (if you push them, they may quote you ten times the usual cost if you want to pay cash). The store will only take your insurance information and say that they will submit it for payment. So you walk out with chicken in hand and go home to cook it and eat it. About a month later, you get a letter stating that your insurance is reviewing the claim. Then a month after that, you may get a bill for a co-pay of $40 (remember the chicken only really costs about $6.00), or they say that the chicken was not covered because it wasn't medically necessary and that a hotdog was the preferred food on your plan so you owe $2,000. Another scenario is that the store might say the chicken costs $2,000, but the insurance company states that they disallowed $1000 (for your benefit) and paid $800 for the chicken so you now owe $200. You are so happy that you have insurance because you only had to pay 10% of the price (not knowing that the chicken should really only cost $6.00). Alternatively, you may also get a bill for $10,000 saying this is not a covered food (this happens all the time in medicine). When you get billed $10,000, you can try to get your doctor to write numerous letters of appeal, which are rarely effective, or the insurance company may settle with you for $5,000. You may have to take out an equity loan on your house or declare bankruptcy. Unfortunately, all these scenarios are commonplace in medicine.

Healthcare savings accounts are good in principle but have fatal flaws and will never work unless accompanied by a few straight forward regulations. One major flaw of HSAs is the fact that there is no one to negotiate prices for those using HSAs, making HSAs users easy targets of overpricing. With the current system, HSA users end up paying three to twenty times more for the same service than insurance companies pay.

With the above food insurance scenario, the charge to the HSA user would be grossly elevated, (either $2,000 or $10,000), which makes the pretax dollar savings and the point of a HSA meaningless. In order for HSAs to work, there must be a way to allow HSA users access to free market pricing and the knowledge of the price of the product or service offered by competing suppliers and providers. Yes, HSAs are a great system, but if and only if the patients can make an informed decision regarding treatments, which includes the ability to know the actual cost of the product or service and have access to those fair market rates.

With such a system, patients will be more involved with their health care decisions, be able to choose treatments that are best for them, and get the treatments at significantly reduced fair market rates. Doctors will get paid immediately at fair market rates that will reduce bureaucracy and the huge costs of collections associated with third-party payers. Hospitals will be able to get immediate payment for the fair market value of all their services with dramatic overhead cost reductions. Drug companies will be able to get fair market value for their medications. Hospitals and drug companies may not initially be in favor of such a model because their revenue model is based on variable "get what you can get" predatory pricing, but their complaints that drastic overcharging is a system that they rely on will be hollow when exposed to the light of day. All that is asked of these healthcare providers is pricing equality and transparency, which is an expected basic right of the consumer in every other industry. In turn, the drug companies and hospitals will be free of burdensome collection efforts to get paid by both insurance companies and patients. There will, of course, be a need for hospitals to take insurance for emergencies, as that is what insurance is for, but they will generally be free of needless denial letters and the need for expensive time-consuming appeals of the constant denial letters.

> **"With the current system, HSA users end up paying three to twenty-fold more for the same service than insurance companies pay."**

How to fix the system

As discussed above, the key is to get the price of the product or service to be available across the board at consistent fair market pricing. The solution requires four main components: **One**, free market pricing; **two**, consistent pricing regardless of method of payment with no penalty (or a discount) for payment at the time of service via check, credit card or HSA, which is a consistent free market principle in every other industry; **three**, the consumer must have knowledge of the pricing, and four, patients must have an incentive to get the product or service at the lower price by being able to compare pricing of different providers of that product or service. None

of these are currently available in the current insurance model so the consumer has no incentive or care about actual cost as long as "it is covered."

Currently, providers, hospitals, laboratories and others providing products or services cannot charge less than a Medicare patient is charged, which is opposite of free market principles. In what other industry are you charged significantly more, sometimes two to twenty times, or more, if you are willing to pay with cash up front? One easy change that would go a long way towards this goal would be to repeal the regulation that providers and suppliers cannot charge cash patients less than they charge Medicare. Many insurance companies and other government agencies have followed suit with such requirements that they get better deals than those paying cash, which has resulted in rampant abuse and escalating costs.

"Thus, the efficiency of the system will effectively be providing comprehensive insurance at a huge cost savings for all parties, including patients, hospitals, doctors and other service providers, by giving a dramatic discount to patients compared to current prices and huge efficiency related cost savings to all healthcare providers."

A provision of the Affordable Care Act requires that insurance companies spend at least eighty percent of premium revenue toward medical claims and activities that "improve the quality of care." This is heralded as a no nonsense way to prevent insurance companies from excessive profiteering, leading to reduced healthcare costs. It should have been foreseen that such a regulation actually reduces the insurance companies' incentive to negotiate lower payments for healthcare products and services because any reduction in costs would have to be compensated by reducing revenue. The role of the insurance companies as a gate keeper of price increases is eliminated because the insurance company makes more profit from a twenty percent margin of a larger number. In order to increase profits, insurance companies must increase prices paid for healthcare so their allowed twenty percent margin is on a larger number. This well intentioned regulation should be eliminated.

To satisfy the first, second and third requirements, patients must be able to shop for products and services and be able to compare prices, which require knowledge of product prices. Thus, there will need to be a requirement that those supplying the product or service post their prices and cannot charge a different amount to consumers based on whether or not they have insurance or which insurance company they use. This should not be difficult, as shortly after such a requirement is in place, many websites will certainly compile the prices and help consumers compare prices to make the best decisions when spending their healthcare dollars. Of course, this requires that pricing be the same for all the insurance patients but equal or lower for cash or HSA payments, as the hospital, laboratory or doctor's office will save significant money without having to submit massive paperwork to the insurance companies and wait for payment that may get denied or have to chase patients for copays that notoriously never come.

To satisfy the fourth requirement of providing an incentive for patients to reduce costs for ongoing care, low-income patients should be given a set subsidy based on need to use in the HSAs for routine medical care as economically as possible. There should not be any "use it or lose it" provisions, as have been in place in the past, so patients can amass a medical nest egg/safety net over time as a reward for being medically frugal and making good value-based medical decisions. Even if a patient's own money was used to fund the HSA, they will be fiscally ahead because the money will be pretax or retroactively tax deductible, but more importantly, the prices will generally be reduced 40-80% compared to prices that are currently artificially elevated by the corrupt and inefficient system. Thus, the efficiency of the system will effectively be providing comprehensive insurance at a huge cost savings for all parties, including patients, hospitals, doctors and other service providers, even before a dollar is spent by giving a dramatic discount to patients compared to current prices and huge efficiency related cost savings to all healthcare suppliers and providers. Thus, cash patients and those using HSAs will pay less out of pocket for routine services than they would if they had insurance. The dramatic increase in billing efficiency will more than offset any reduction in revenue from lower pricing from those providing products or services, including doctors, hospitals, laboratories and other ancillary services.

"Changing Obamacare to another insurance based model that attempts to merely increase competition between insurance companies will do little to improve efficiency and costs compared to Obamacare."

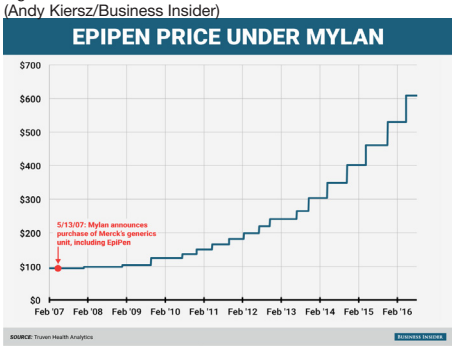
The HSAs are designed to cover all routine and semi-routine expenditures, but it must be understood that the same amount will cover a minimum of three to five times the current amount of services due to the requirement of consistent fair market pricing. A healthcare consumer can also contribute to the HSA as needed to cover routine care. Insurance will be available with a declining copay formula, with higher copays for less urgent services so there is a disincentive to use the costly bureaucratic insurance component. The system is not linear, however, where you have to use the

HSA money until it runs out then you transfer over to the insurance component. If a person has HSA money available and they have the urgent need for care, the insurance portion can be accessed at the different level so catastrophic emergencies are highly covered with a much smaller copay percent as compared to necessary but less expensive and less serious healthcare needs. The goal is to have as much service provided through the efficient HSA model. This will, of course be an evolving system with likely expansion of the HSA portion as the merits come to fruition over time.

Drug Pricing

EpiPen has recently been in the news because it has raised the price of its potentially life-saving drug by 400% (over $600 for a pack of two) over the last several years (see figure 1). The response from the drug company, Mylan, was to offer patients a co-pay card to reduce the out-of-pocket charges for those with insurance but those without insurance will still have to pay the $600. This is actually a generic drug that costs less than a dollar in other developed countries. Even Mylan, however, charges only $69 for a pack of two in France and even less in the U.K. This particular case has become a national outrage, but this has been going on across the industry not only for medications, but also for hospital visits, surgeries, labs, scans, procedures, etc.

Figure 1
(Andy Kiersz/Business Insider)



While I agree with the fact that we need to try to buy American made products, the pharmaceutical industry has abused the fact that they don't have to compete with imported products and have set up a system of monopolies and collusion. As discussed above, there is rampant abuse of drug pricing. Pharmaceutical companies sell the same medications that are made here to other countries for a fraction of the price that the U.S. population must pay even though the medications are made in the United States. Licensed distributors should be allowed to purchase drugs from outside the country and resell here in the U.S. If the drug companies simply provide fair pricing to the U.S. public, this should not be a threat to drug companies' bottom line. Tariffs may be appropriate in some cases and will need to be looked at as whether necessary or not.

> **"Only if free market principles serve as the basis of the new system, will there be a significant reversal of spiraling costs and declining quality of care."**

There has been a false-narrative unleashed by the drug companies about the safety risks of purchasing medications from overseas, but that is really just to protect big pharma's predatory pricing in the U.S. A significant percentage of medications are made in other countries or the ingredients are sourced from outside the U.S. but those are still considered made in the U.S. There would be appropriate regulatory oversight to insure safety and any certified distributor would lose certification if any fraudulent medications were sold in the U.S. Consumers would always have the option to only purchase U.S. medications or could opt for less expensive globally available medications. Unsurprisingly, the majority of Americans feel drug prices are too high and feel that something should be done. A Kaiser Family foundation poll in September, 2016 found that 71 percent supported importation of medicines from Canada, demonstrating the public sees through the false-narrative of safety concerns. Despite this fact, an amendment to allow medications from Canada to be imported into the U.S. was recently defeated 52 to 46 in the Senate. Senators that have received significant donations from pharmaceutical lobbyists overwhelmingly voted against the bill, with most using the safety concern mantra as the reason for voting against the bill. With President Trump's support and influence and being a part of a comprehensive reform of healthcare, this modification should easily be adopted.

> **"The highly inefficient Obamacare will be replaced with an efficient new healthcare system based on transparent free market competition that will result in a dramatic reduction in healthcare costs and empower patients to be active participants in cost-effective medical care."**

Another major reason that drug companies have no downside to massive price increases is that over the past decade, there has been a drastic increase in regulations to limit and eliminate a major competitor of big pharma - compounding pharmacies. While these regulations, of course, come via the FDA and other federal and state regulators and not directly from the major beneficiaries of such far-reaching regulations, there is no doubt that big pharma has major influence and has exerted significant pressure to limit the ability of compounding pharmacies to compete and thereby mitigate the existing medication price gouging. Compounding pharmacies were previously able to supply older generic medications to patients when pharmaceutical companies dramatically raised their prices. While compounding pharmacies cannot generally compete on price with pharmaceutical companies due to economies of scale, they could previously help prevent price gouging. So many regulations have been piled on compounding pharmacies that their costs have skyrocketed, and they now can only

supply very limited amounts of medications, essentially eliminating this important free market price control.

Implementation

It has become clear that repealing Obamacare will not be as simple as previously believed. Collusion and quasi-monopolies are pervasive in the current healthcare system so the powerful beneficiaries of such practices will not easily concede to significant change. Numerous hurdles are being put in place to try to prevent repeal, but this program can be run in parallel with Obamacare, so Obamacare does not have to be repealed. Changing Obamacare to another insurance based model that attempts to merely increase competition between insurance companies will do little to improve efficiency and cost compared to Obamacare. Such strategies can certainly be used for the insurance portion of the new plan but will be of little benefit if insurance continues to be the basis of reimbursement for routine care. Only if free market principles serve as the basis of the new system, as disused above, will there be a significant reversal of spiraling costs and declining quality of care. When implemented, this vastly superior free market based program, which my colleagues are facetiously calling Holtracare (could be titled The Healthcare Transparency and Patient Liberation Act), will naturally overtake and replace the routine care portion of coverage that the insurance model or Obamacare does such a poor job of managing. The highly inefficient Obamacare will be replaced with an efficient new healthcare system based on transparent free market competition that will result in a dramatic reduction in healthcare costs and empower patients to be active participants in cost-effective medical care. The insurance model will remain for emergencies, as insurance is intended to be used.