



The U.S. Healthcare System

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OVERVIEW

This analysis will identify the benefits and problems with the current healthcare provider and payer systems in the United States. It will also provide a roadmap to a restructured model. Fragmentation and redundant cost layering in both systems are the primary reasons why any new health insurance initiative will not contain skyrocketing costs nor significantly improve healthcare for all Americans. The bottom line is that both provider and payer systems in the United States, as a whole, are extremely cumbersome/inefficient, are structured into a poor service delivery model and the once claimed status of “best in class” health system in the world is now a myth. To understand where the provider and payer systems are today, one has to look at major factors/trends on how they evolved.

MAJOR TRENDS

1. Healthcare Delivery System

The healthcare delivery system from the early 20th century until approximately 1960s was very basic, primarily consisting of family doctors and hospitals. People sparingly went to the doctor or hospital since these visits were paid out of pocket or insurance plans had high deductibles. Most health insurance plans were for “major medical” incidents and/or were granted via larger employers. Generally, one had to be very sick to utilize medical services in the first place. All vaccinations and such were administered via federal programs and were viewed as a societal preventative benefit. Hospitals were run as non-profit organizations, received a majority of their operating capital from the federal government via grants and private donations as a secondary supplement.

Today, a much smaller portion of hospitals derive the majority of their operating capital from federal grants and many hospitals are run as “for profit” businesses due to federal spending cuts or regulatory avoidance. Over time, Americans have adopted less healthy eating habits and lifestyles which can be correlated to more trips to the doctor. Americans also used to stay away from public areas and lacked mobility when they became sick. Compared to today, people rarely stay home when they are sick and are also highly mobile. This usually results in spreading an illness very quickly nationally/internationally. This directly correlates to more people getting sick across state and national borders- i.e cost. From the 1960s to present, health insurance plans expanded coverage for more events while insured people started scrutinizing the need to go to the doctor less and don't stay home when sick.

Furthermore, payers are attempting to contain cost by setting reimbursements that are statistically and transactionally determined. Providing the best service for the patient is not their focus since payers are all about processing claims against insurance plans to remain solvent and not about providing healthcare. The providers are all about providing healthcare and sustaining a viable business, where all “encompassing” service is not a focus nor are complicated patients served well. For a doctor to be profitable on a person who walks in the door with 5 health issues, he/she attempts to break down those issues into separate visits in order to make money. The more patients they see, the more money they make or quicker they break even for the month - it is a simple

business model based on patient volume and corresponding insurance reimbursements. If the doctor were to spend 30-60 minutes per patient to listen to and troubleshoot all 5 problems, he/she would be operating at a loss since plans/payers do not pay claims based on number of items treated or level of complication. This creates its own fragmentation to treatment, breeds poor service delivery and poorly scales for complicated patients.

2. Insurance Regulation

All insurance regulatory bodies since the late 1800s were created by each state, meaning that originally there were 50 different ways to regulate companies that provided insurance. Also NAIC, National Association of Insurance Commissioners was formed where all states participated in membership. In the last 15 years or so, NAIC has taken a very active role in trying to nationally coordinate and unify regulation across all insurance segments. However, every state regulator still has to contend with getting unified legislation passed in his/her state legislature. The bottom line is that many strides have been made in nationally unifying regulation across states, but much more work needs to be done. The prior lack of central coordination from inception fostered an environment for a variety of health insurance companies and products to locally enter the market along with all of the different local payer systems and provider networks that went along with them. In the last 10-12 years, some local and regional payer and provider consolidation has occurred, primarily pressured by rising healthcare costs and/or federal grant funding cuts to providers.

3. Provider Market Regulation

Individual state legislation was created to encourage market competition, prohibit monopolization and price fixing for providers of healthcare. Where the legislation exists, it prohibits or makes it more difficult to standardize on regional managed care systems. Health insurance policies typically have a large list of providers they will cover, but if the listed providers do not have a business relationship between them it causes its own problems pertaining to medical record synchronization, service fragmentation and redundant tests/imaging. For instance, if a person goes to their primary doctor and has to see a specialist or get an x-ray, the person is referred to a different location with its own claim system and the primary care physician will only receive the written evaluation if there is an existing business relationship between the two providers.

Even when there is a business relationship, where the primary care physician receives the written evaluations from multiple sources, it usually leads to no one taking a comprehensive look at complicated/multiple problem patients. Furthermore, when an individual has to take time off to courier his/her radiology films to a specialist, the broken process takes a double toll on business. There is a cost business in productivity lost while employees are taking extra time courier their film and businesses are also co-paying health insurance premiums. The individual also takes a hit to their leave balances by taking extra time off to courier the film. This is poor service model that business and individuals pay good money for. In the last 10-12 years, there has been expansion of the business relationships that exist between providers but it still does not

address model inefficiencies in the claim, billing, duplicate record, duplicate tests, duplicate radiology, payment processes and service fragmentation.

4. HIPAA Regulation

Federal HIPAA legislation was passed in 1996. This legislation was enacted in order to help protect an individual's health information while allowing it to be passed between payers/providers. The legislation was an attempt to pave the way for payers, providers and clearing houses to transmit health record information while protecting the patient's privacy. It also gave patient access to their medical records, something that was rarely done in the past. However, HIPAA has created its own legal obstacle to solving or gaining efficiencies in the existing healthcare delivery model by not clearly defining where legal liability for the data resides. "Who owns the data?" is a common question when viewed from a legal liability perspective. Among other things, HIPAA also mandates that providers keep logs of who views an individual's medical records, requires policy, procedures and process be implemented to comply with the legislation. Federal and State governments are exempt from complying with HIPAA.

5. The Uninsured

In the U.S. there exists a large pool of approximately 47 million uninsured people that do not have healthcare insurance coverage and use the emergency room for healthcare or those individuals receive no healthcare at all. There are federal laws that require hospitals that receive federal funding to treat everyone who walks in the door whether they are insured or not. So if an uninsured person has a sinus infection or broken arm and goes to an emergency room they will get treated at the hospital's expense - or partial expense depending if charitable affiliate programs cover a portion of the medical care. Also buried within the "uninsured" figure are people who are considered high risk (i.e. expensive) due to major pre-existing health conditions or severely adverse health habits. So, the insurance companies/employers may reject covering them due to the higher cost of including the person in their health insurance pool.

This group is commonly referred to as the "high risk pool" and politicians theorize that if health insurance were mandated (i.e. require every person/employer to pay for health insurance), then it would allow for the uninsured/high risk pool to be covered at an affordable price. There is some truth to this argument, but depending how the insurance plan is structured, mandating coverage will have adverse impact to an individuals take home pay and/or raise a business's overhead cost. Potentially eroding the business's ability to compete locally, globally and will cause the price of their goods/service to increase. There are other systemic problems in the provider and payer systems that should be addressed in conjunction with any new insurance programs. Otherwise, adding even more people to the fragmented processes would amount to "throwing gas on the fire" of already skyrocketing healthcare costs.

Furthermore, statistics indicate that large percentage of healthcare cost and spend is attributed to the last five years of a person's life. In the past, people would just die - literally- without measures to keep them living longer, trauma response systems, early detection, long term care, etc. So advances in treatments, drugs and procedures that

extend life which are quite amazing, have a direct correlation to the higher cost of healthcare and insurance. The “end of life” kicker to cost/price of healthcare is not really addressed in the payer/provider systems universally. Long term care health insurance and facilities are an attempt at reigning in some of the costs, but only for one segment of the “end of life” population. Americans who do not require long term care, but are frequently in/out of the hospital, require many medications, frequent periods of extended hospital care, etc are not addressed. So the “end of life” kicker is something that providers/payers and individuals know about, are unprepared for and the additional costs seem to not be reflected in any of the projections - broken out on its own cost line. The argument is “if it is buried in the numbers, how can it successfully be addressed”...without dumping elderly from health plans or creating asset liquidating poison pills to pay for “end of life” healthcare- similar to Medicaid requirements. One major medical incident can easily devour \$50,000 - \$200,000 of a person’s assets dependent on the type of insurance coverage they have. For instance, Medicare is 80/20, so 20% of the bill is the individual’s responsibility.

6. The Pharmaceutical Industry

In the last 20 years, the pharmaceutical industry has grown exponentially. In the past, bringing drugs to market was primarily handled through government sponsored research, usually conducted in universities, research clinics and/or a handful of drug manufacturers/distributors. That was the pipeline. Venture capital and investment banks have invested heavily in the pharmaceutical industry trying to find new cures and the patents that go along with them. Once a patented drug makes it through the rigorous testing process to market, the companies push to get doctors (providers) prescribing and insurance plans (payers) approving the drug as an eligible treatment- which is primarily how the pharmaceutical company gets paid. This process in and of itself is not bad, leads to innovative cures and spawns economic development.

Unfortunately, there is quite a bit of pressure on management within pharmaceutical companies to hit astronomical revenue targets and has bred a few bad practices. Marketing prescription drugs directly to consumers in order to indirectly pressure doctors via the patient to prescribe the new drug or lose business, is a bad practice. Some pharmaceutical companies create incentives for doctors to prescribe their drugs or pharmacies to fill prescriptions via marketing agreements that provide rebates back to the doctor or pharmacy. Some drugs have mysteriously made it through the rigorous, federally regulated testing process with skewed data - possibly influenced by pressure on the pharmaceutical company to hit astronomical revenue targets and/or a failure of the Food And Drug Administration to properly police the manipulation/errors. This has lead to adverse health events for individuals, fatalities and/or drugs being pulled from the market. The bad practices or regulatory failures just add to the confusion and lack of trust in the healthcare system. However, it does not mean pharmaceutical companies are bad or that FDA regulation should be eliminated. Both need to get back to their basic mission- finding cures that have been properly vetted before reaching the market, while investors and corporate boards need to lower their growth/revenue expectations to realistic projections.

7. Health and Human Services (Federal Agency)

The final major influencing factors are programs from the federal agency, Health and Human Services (HHS) which include its subdivisions of CMS (Medicare and Medicaid). With Medicare, State government participation is via grants that fund complimentary state based Medicare programs and CMS administers all provider claim processes and payments. Medicaid is administered by each State, where claims and payments to providers are administered by state - federal participation is via grants that fund State Medicaid programs. Some efforts from these programs tend to overlap when focusing on services for economically or geographically disadvantaged people. Overlap equates to inefficiency and customer confusion. Furthermore, HHS began the NHIN (National Health Information Network) which spawned RHIO (Regional Health Information Organizations) initiatives. RHIO's main purpose is to provide a method to exchange health information (claims and records) between regional providers/payers. In concept, RHIO is good but the initiative has already experienced many failures from not having a standard business model to financially support a RHIO or viable transaction networks to pass the information. Capability to design working business models are thwarted by regional issues, confusion about data transport standardization, lack of record standardization, lack of leadership (politically and corporate) and the usual business and political turf wars that occur when change is initiated. RHIO in its current form also encourages more fragmentation in process and business models, but does provide data and transmission standards. Every state/region can have its own unique business model and its own (entirely) unique processes which can add to the existing confusion in the healthcare system. There is opportunity for the RHIO concept to work if a "cookie cutter" solution/model is implemented, but many, many healthcare provider/payer system components and standards need to be addressed.

8. National Spending on Healthcare by Source Of Funds

Important Statistics from the CBO 2007 Long Term Healthcare Outlook (U.S. Congressional Budget Office).

Spend Type in 2005	Cost in Billions	Percent
Private Spending (private insurance, etc)	\$1,013.5	54.5%
Public Spending (Medicare/Medicaid, other)	\$847.3	45.5%
Total	\$1,860.9	100%

It is important to note that the CBO's most current industry data in November 2007 is 2 years old and prior to the Medicare Part D prescription drug program. However it does stress an important point that the federal government was already paying over 45% of the total health care spend in the U.S and as Baby Boomers retire, that number (\$847.3B) is expected nearly double by 2017 in some industry projections. Thus, some projections peg the U.S. government spend to approximately 65% of total U.S. healthcare spend of nearly \$4 Trillion dollars by 2017! More recent figures from Medicare/Medicaid for 2006 (provided in 2008) include Part D and have bumped the government share by 2%, totaling 47% of total healthcare spending.

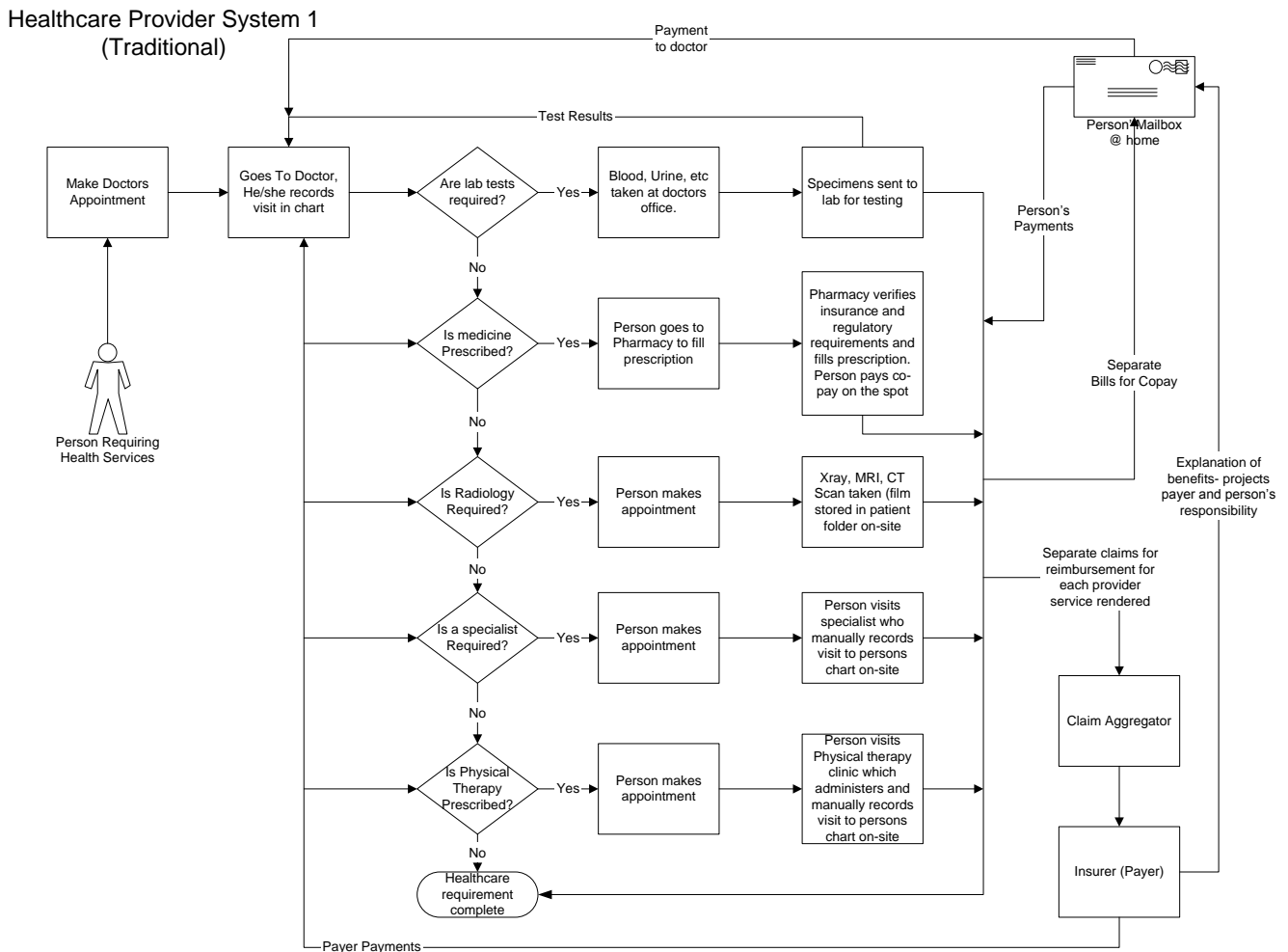
Basic Provider/Payer Systems

(Variations can and do occur in the marketplace)

PROVIDER SYSTEMS/MODELS

1. Healthcare Delivery System 1 – Traditional

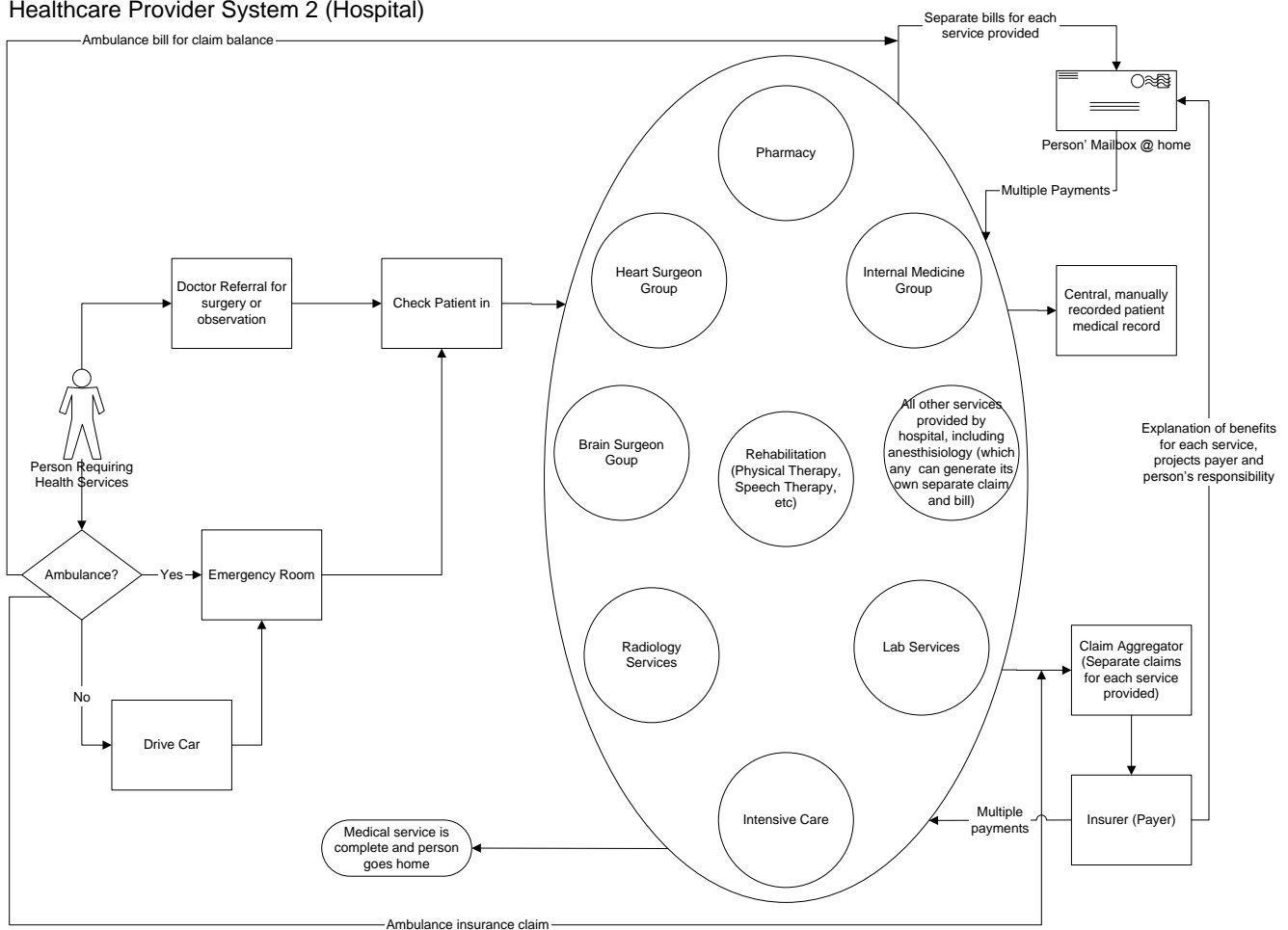
HIPAA can be an obstacle between the different healthcare providers for maintaining one master medical record. Thus, it requires the individual to coordinate the process of keeping their record current at their primary care physician. However, if a business relationship exists between providers, then patient information can be passed between them. All appointment scheduling and re-scheduling is done by the individual per healthcare provider and provider locations are usually geographically separated. It is important to note that a complicated or long term condition that does not require hospital stay, creates a tidal wave of claims, explanation of benefits, bills to people and checks back to providers for more than routine doctor visits. Complicated medical conditions/patients stress this model of delivery and results in poor healthcare- i.e. this model does not scale well. This system is very inefficient in delivery and costs are layered in billing, claims, record management, overhead (operating) costs per provider and payer payment processes. (Full size diagram at end of this document)



2. Healthcare Provider System 2 – Hospital

This system is a little more efficient in delivery but very inefficient pertaining to cost layered in billing, claims, record management, overhead (operating) costs per provider and payer payment processes. It is important to note that many hospitals are leasing space to different medical groups based on specialty or service but do not unify/lever business processes for them. Thus, creating multiple claims, bills, payments processes and explanations of benefits per hospital visit. A complicated hospital stay creates a tidal wave of uncoordinated, fragmented business processes which directly correlate to very high processing overhead for provider/ payers. However, it is better equipped to handle short term complex/severe medical problems and surgical needs. Hospitals also tend to send patients home right after surgery in an effort to contain costs – urged by what will or won't be reimbursed by insurers (payers). HIPAA tends to not be as big a factor in this model since business relationships already exist between providers contained within the hospital. (Full size diagram at end of this document)

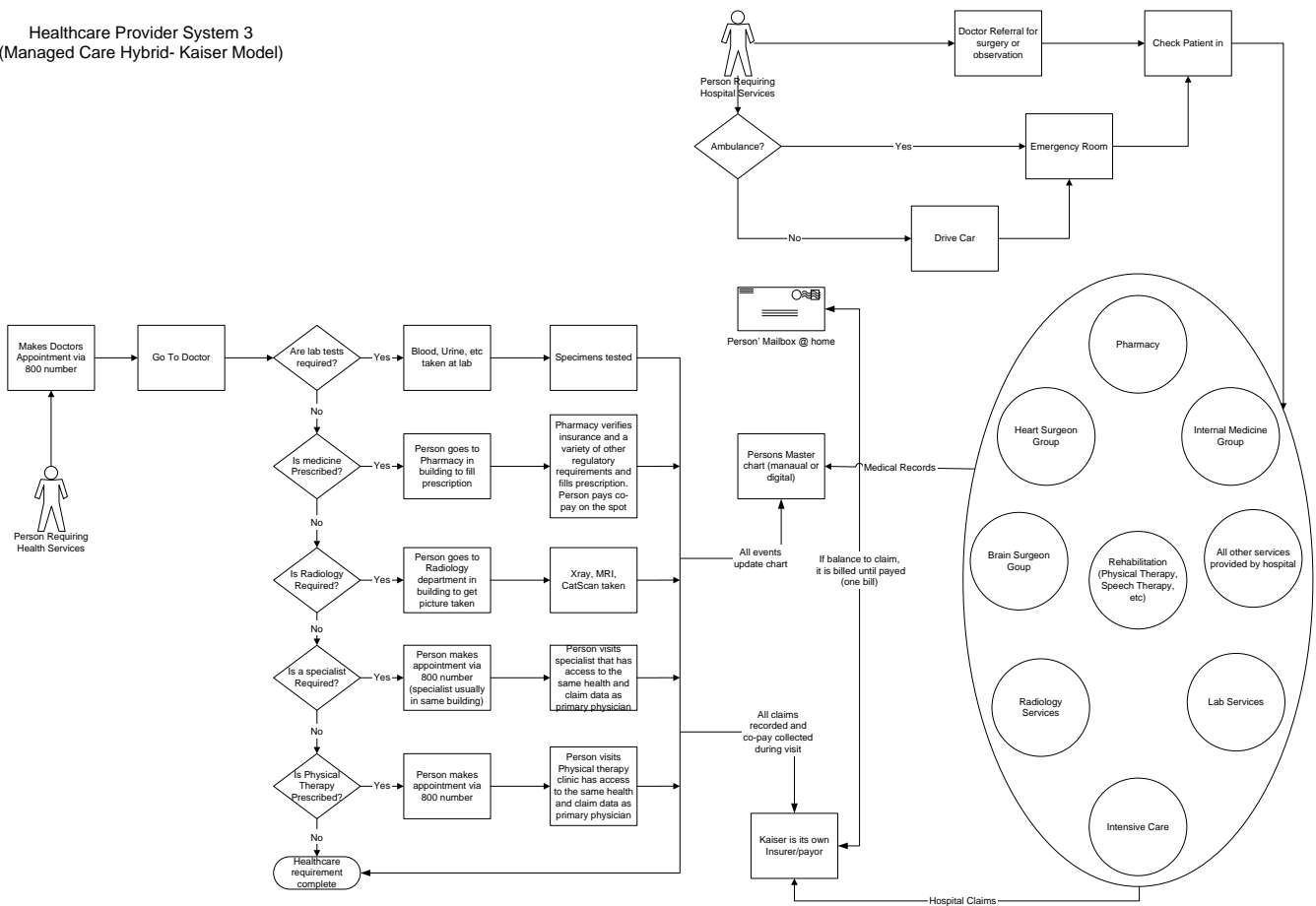
Healthcare Provider System 2 (Hospital)



3. Healthcare Provider System 3- Managed Care

All appointment scheduling is done by the individual to one master 800 phone number. It is important to note that even though many of the process are the same as in the Traditional/Hospital Systems, they are typically contained within one building or hospital, serviced by a single 800 scheduling number, billing, claim, patient record, explanation of benefits processes and overhead is reduce by grouping provider services. This model is very efficient in delivery and cost. This system scales well and meets the needs for approximately 80%-85% of all healthcare required by individuals. Extremely complicated patients or rare disorders/diseases can stress this model of delivery but it has a higher threshold of the type of complicated patients it can accommodate as compared to the separated Traditional and Hospital Systems. There is no HIPAA obstruction since all health delivery processes, claims and the payer are contained within one system. University clinics and hospitals are striving towards a managed care model. Typically university hospitals are better prepared to diagnose and treat complicated patients and rare disease. (Full size diagram at end of this document)

Healthcare Provider System 3
(Managed Care Hybrid- Kaiser Model)

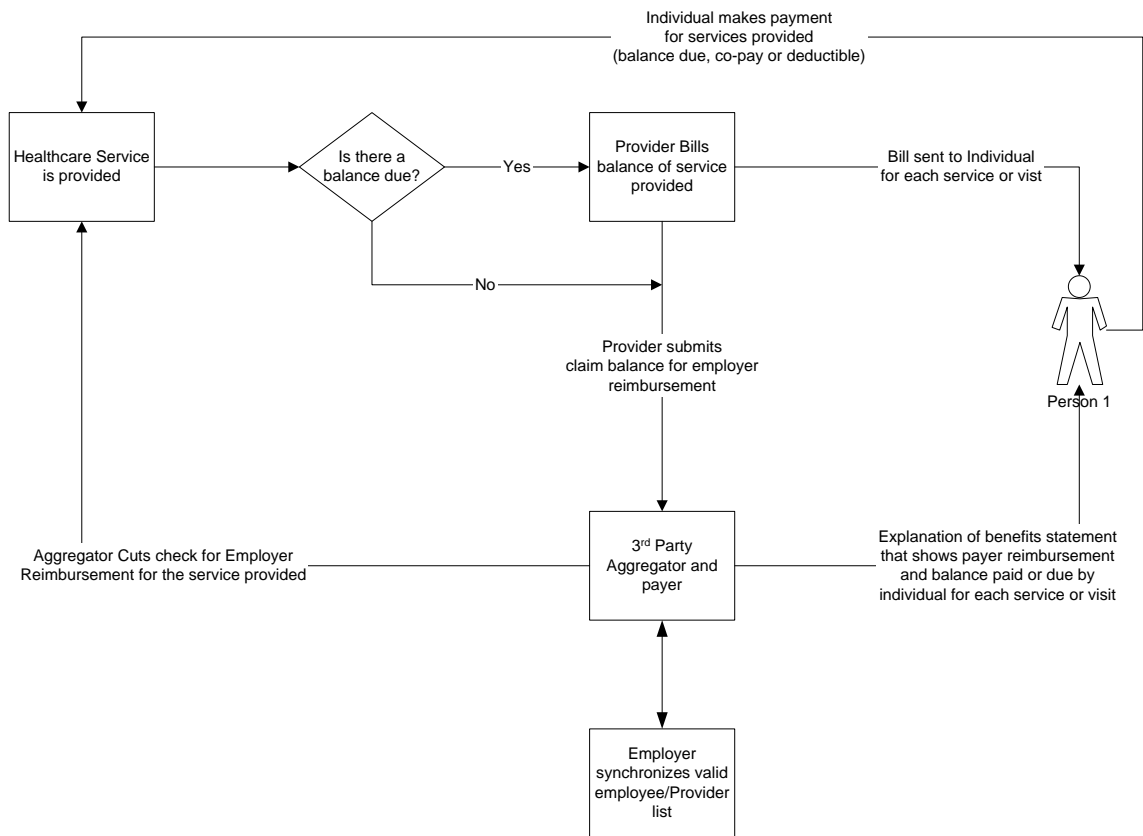


PAYER SYSTEMS/MODELS

1. Healthcare Payer Model 1- Employer

Claims and payment of service must be synchronized across potentially four systems- provider claim system, provider billing system, 3rd party aggregator, employer. In certain cases, the Employer will approve the claim reimbursement in the aggregators system either manually or electronically via a portal. Inefficient from the individuals perspective if bills and explanation of benefits statements are generated for more than one provider per incident. Third party claim/payer aggregators are utilized and only the very largest employers can afford this approach in an effort to contain costs. This model is cumbersome, inefficient and does not scale well, but it has appeared to help produce benefits in short term containment of healthcare costs for large employers. Not a long term nor an industry wide solution. (Full size diagram at end of this document)

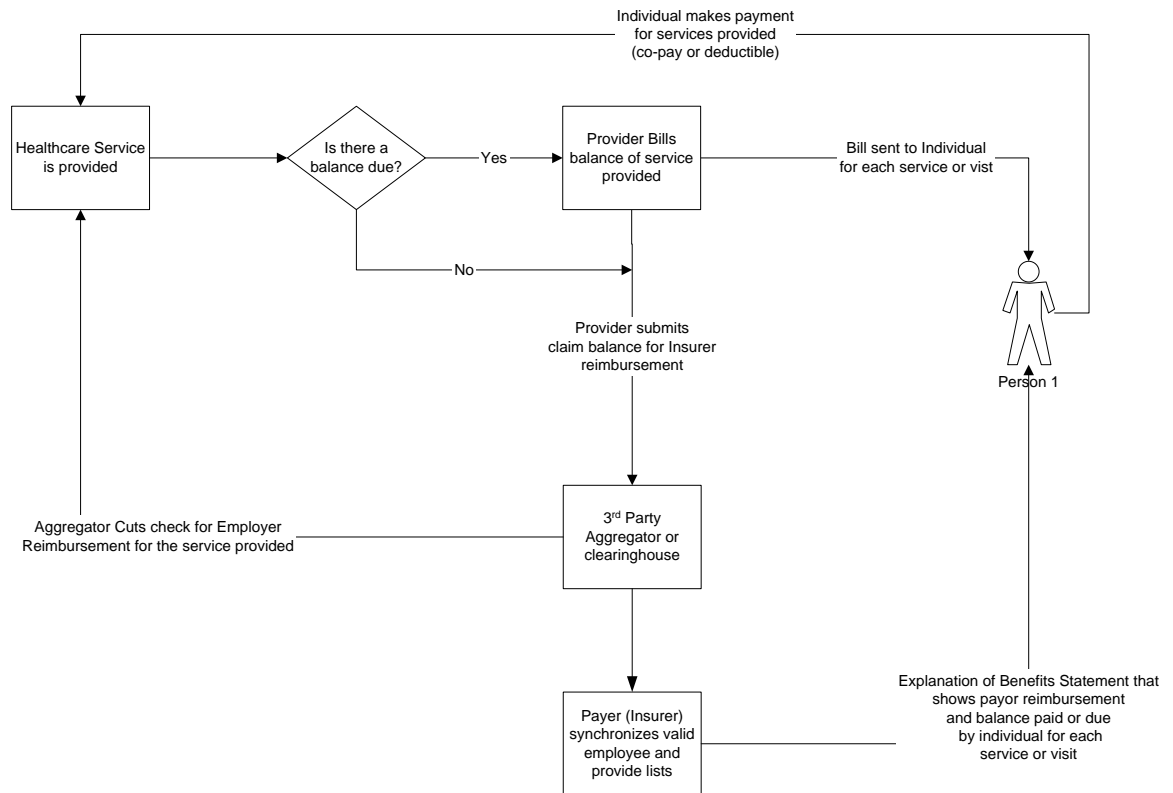
Healthcare Payer Model 1 (employer)



2. Healthcare Payer Model 2- Traditional

Claims and payment of service must be synchronized across potentially four systems- provider claim system, provider billing system, 3rd party aggregator, payer. Responsibility for fixing rejected claims usually falls on the individual and requires them to weed through many confusing statements to verify payments. Inefficient from the individuals perspective if bills and explanation of benefits statements are generated for more than one provider per incident. Third party claim/payer aggregators are another layer of cost in the process- the process is paying their profit margins on top of profit margins of the actual insurance company. This model is cumbersome, inefficient and does not scale well. (Full size diagram at end of this document)

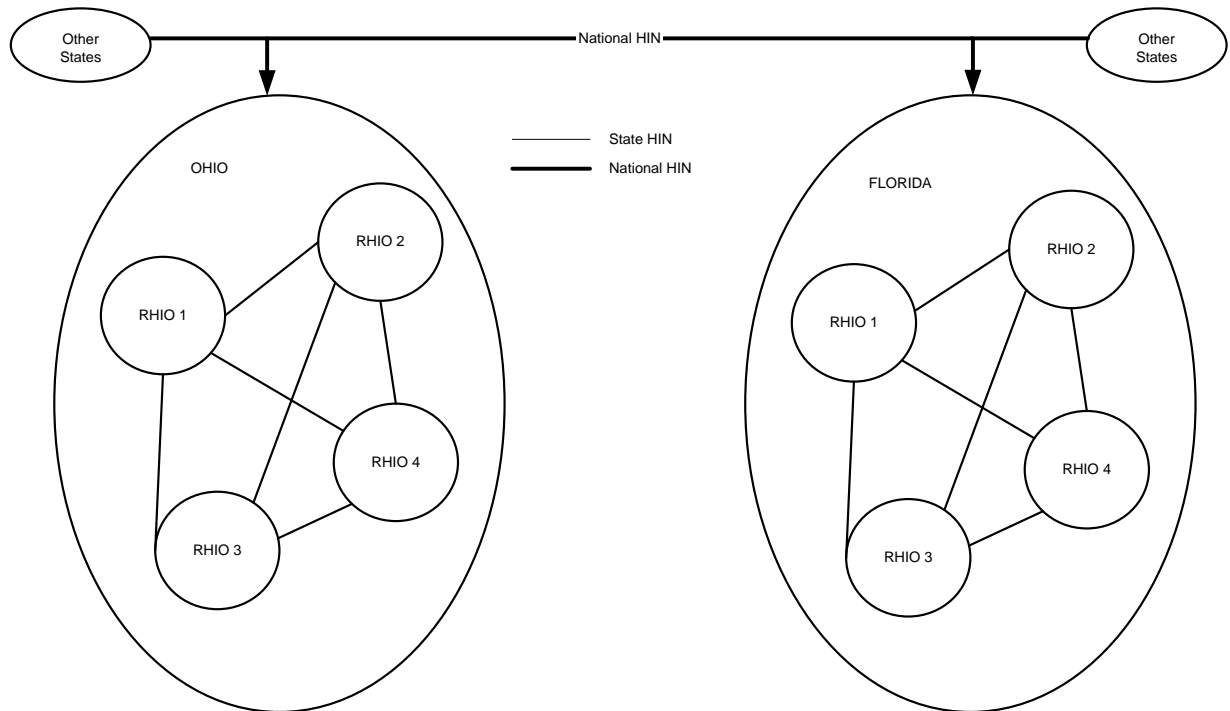
Healthcare Payer Model 2 (Traditional)



RHIO – REGIONAL HEALTH INFORMATION ORGANIZATIONS (or HIO)

The proposed RHIO network model (HIN) is envisioned to help regional providers exchange health record/claim data and are similar in concept to the networks that were developed by banks to support a national ATM system. There are defined RHIO data standards but they have not been adopted in mass nor is their consistency to how a RHIO (HIE) should be set up, managed or what business model should be used. Past technology initiatives (non-healthcare) have failed for lack of a solid business model or inexpensive tools for all parties to utilize/integrate. There is always a grave underestimate of the business cost/need for all parties to incorporate multiple, competing or new emerging standards and technologies. As of today, the only thing that scales in this model is the physical network component and nothing else. The Public Health Data Standard Consortium is working an EDI standard, ANSI ASC X12N 837, which is an electronic format for health claims. HIPAA may also be a limiting factor to exchange data or accept liability of data ownership depending on how a RHIO is structured. If implemented, RHIO could have an impact in providing healthcare rural areas and there appears to be many states attempting to fund or lever network infrastructure to help make this occur. However, without a viable business model, these efforts will be forever subsidized/sponsored by State and Federal spending. There is also resistance in metropolitan areas to jump on the RHIO band wagon where healthcare provider business relationships and networks are more established. (Full size diagram at end of this document)

RHIO Vision (Regional Health Information Organizations)



CONCLUSIONS

The requirements placed on the existing U.S healthcare system has exceeded the systems ability to operationally and financially accommodate them. It is out of alignment. The U.S. needs to re-invent or restructure its healthcare provider/payer systems from an existing, established but fragmented and expensive model. The federal government needs to be in one of the leadership roles since it already accounts for over 47% of total healthcare spend. The good news is that many of the required primary future components already exist or are currently reaching the market and there appears to be a “group will” (citizen, political, corporate) to fix it. The bad news is corporate America, venture funding, investment banks, federal/state agencies and politicians have to walk in lockstep during the restructuring process. That has rarely occurred in our recent past, but it is not impossible – the creation of NASA and HHS are prime examples of government and industry working together to solve a problem. As with any change, there will be sacrifice and compromise among existing businesses, citizens, politicians. The federal government could go a long way at reigning in spending by becoming more efficient in their payer processes/models, negotiating volume discounts on care/prescription drugs (Medicare Part D), consolidate the number of prescription drug plans offered (Medicare Part D) and possibly providing best practice incentives to providers. Citizens need to take responsibility when they are sick by limiting exposure to others, practicing good hygiene and lead healthier lifestyles.

There needs to be an understanding that insuring everyone, government sponsored or otherwise, will not contain rising healthcare costs. This action alone will not drive the cost of healthcare down but will exacerbate it. Remember, as a whole, the current delivery (provider/payer) system of healthcare is broken from the perspective of most patients and operating at a premium cost in real dollars to society, business and government. There is a societal need to insure the uninsured 47 million people living in the U.S., but that solution is not straight forward.

Creation of a federally sponsored, health insurance plan could lead businesses that currently offer private health insurance to slash costs by moving employees onto the federal plan. If these two actions consecutively occur in the marketplace, it could instantaneously eliminate private insurance/payers all together - an unintended consequence - and would balloon any initial federal cost estimates for the program. Certain corporations have already executed a similar maneuver for retired or minimum wage employees by eliminating health benefits and moving them onto Medicare/Medicaid. In addition, requiring participation by all will place a burden of paying monthly premiums on lower wage employees and small businesses. In the case of small business, raising their operating overhead and which would trigger product/service price increases or put them out of business. These scenarios should not be used as an excuse to do nothing, but they should be considered in any new insurance strategy. Government funds for the ominous Baby Boomer Medicare/Medicaid financial deficit and/or providing federally sponsored health insurance can only be derived one of several ways. Improve federal government efficiency to reduce operating costs or cut other programs then divert saved money to insurance plan(s). Collect more taxes by raising the taxable income ceiling for Medicare/Social Security or impose new health insurance premiums. A third option would be doing a combination of all the above.

One strong argument for a national or consolidated regional insurance plans is portability. With the extreme economic expansions and contractions in the last 18 years, large numbers of employees moved around between different companies usually locally or regionally. This movement is accompanied by changing company sponsored insurance plans, creation of an insurance coverage gap between jobs and requires the employee to change his/her entire provider network. It is up to the employee to move their medical records, bring doctors up to speed, etc. By having a national or regional insurance and provider strategy, it would cause less disruption to the patient (customer), since it reduces or eliminates the possibility of changing providers.

As stated before, if RHIO or HIO (Health Information Organizations) are to be successful nationally, they need to follow a cookie cutter solution in business and transactional models.

Several private health record solutions/portals have emerged in the past year from two major technology corporations, but they are too new to be an industry standard and do not address an industry adopted, standard method for synchronizing records or claims by providers or insurers. Also, these solutions shift the burden of record management to the individual- who is not well versed in healthcare. A mistake by the individual in providing the wrong document(s) to providers or insuring the record is kept current, will directly result in degradation of healthcare or fatality. It can lead to duplicate testing, imaging, etc- cost.

Efficient procurement and supply chain practices should be implemented to achieve cost savings. Levering the buying power of regional providers, automated procurement systems that include supply chain order integration should be a goal.

Private investment may want to consider a consolidation strategy in the pharmaceutical industry. Fragmentation in venture funding also leads to fragmentation or duplication of effort once/if products reach the market. This duplication also increases overall industry operating costs, etc. The results would be larger pharmaceutical corporations with broad market focus and should lower risk of failure (ie loss of venture investment) while leveraging operating expenses via combining them (ie reduce the cost of R&D). Markets can still be capitalistic in nature, executed with a little more vision and organization.

Regulatory action may be required to assist in transformation, but necessity can only be determined by a regulatory review, by state, that defines where support and gaps exist pertaining to restructuring or if health regulation is better pursued federally. Federally regulated versus state regulated versus capitalistic/competitive insurance/provider markets has been a long protracted political battle. All three arguments have their pros and cons. There may need to be some compromise in health insurance regulation between all three in order to expedite transition to what ever the new systems will be. However, the ideological reason that markets lack provider/payer competition caused by over-regulation is not really the primary cause of skyrocketing costs. Again, it is process fragmentation (inefficiency) and redundant fixed operating costs across all systems caused by everything else cited in this paper.

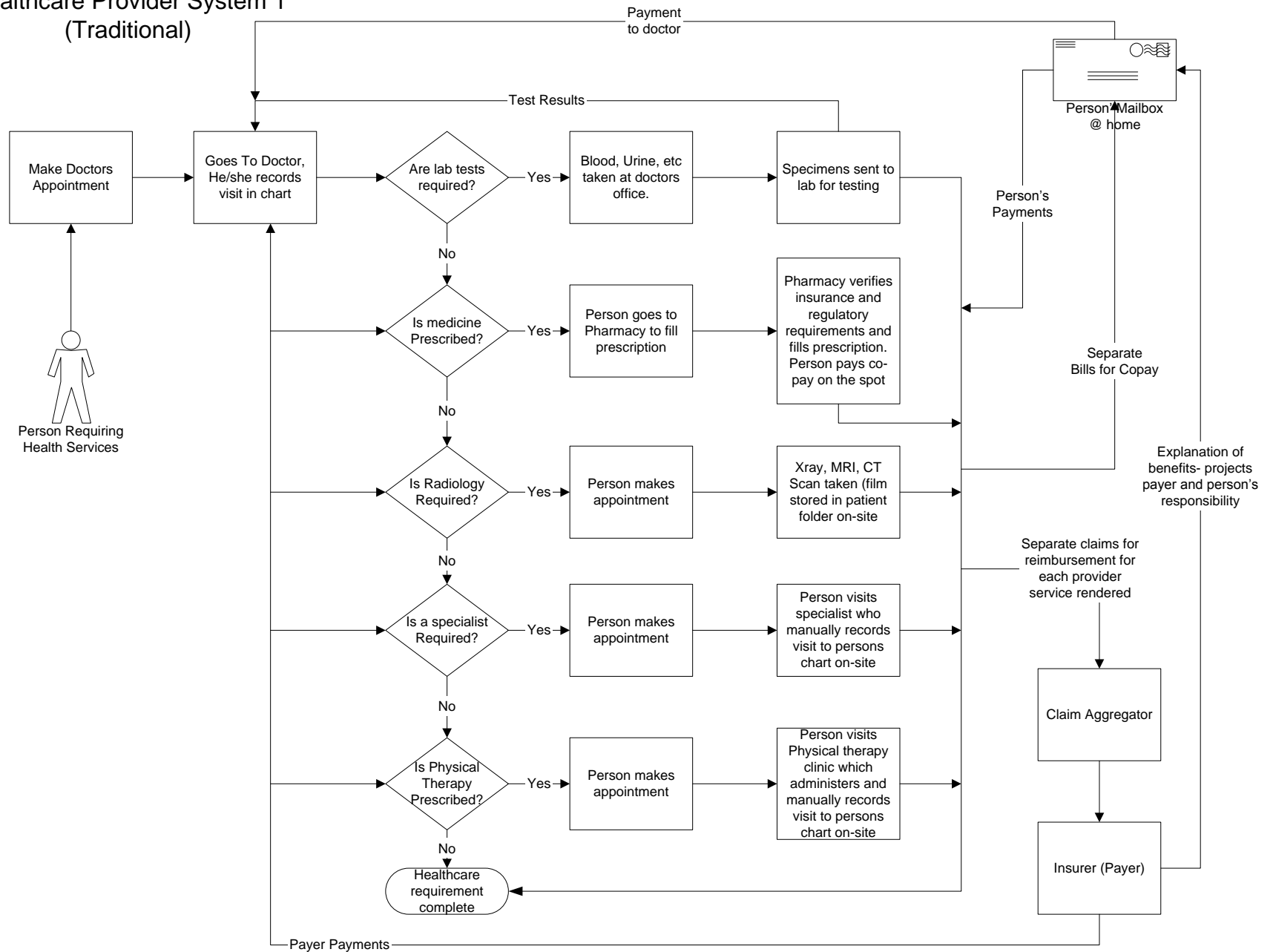
There is opportunity for regional consolidation of private or non-profit payers and claim processors in order to contain or reduce costs in the marketplace. Possibly dividing the U.S. market into 4-6 regional quadrants, but further analysis would be required before taking such an action. There is also opportunity for further consolidation of healthcare providers, but this is a much more complicated segment due to the sheer number of providers. Surely, any of the regulatory or market shaping suggestions may send the pure capitalist, providers/payers and pundits “over the top” but they must be considered as part of due diligence. All parties must focus on solving the problem and not cling to ideology or imaginary turf that prohibits a real solution. Shared sacrifice for long term gain should be everyone’s mantra.

There are localized bright spots in the provider sector to give some hope that they “get it” from a business and service perspective. The problem is they are very localized, there is not broad industry coordination of effort and if one does not have access to those systems, then they are suffering from poor delivery of their expensive healthcare.

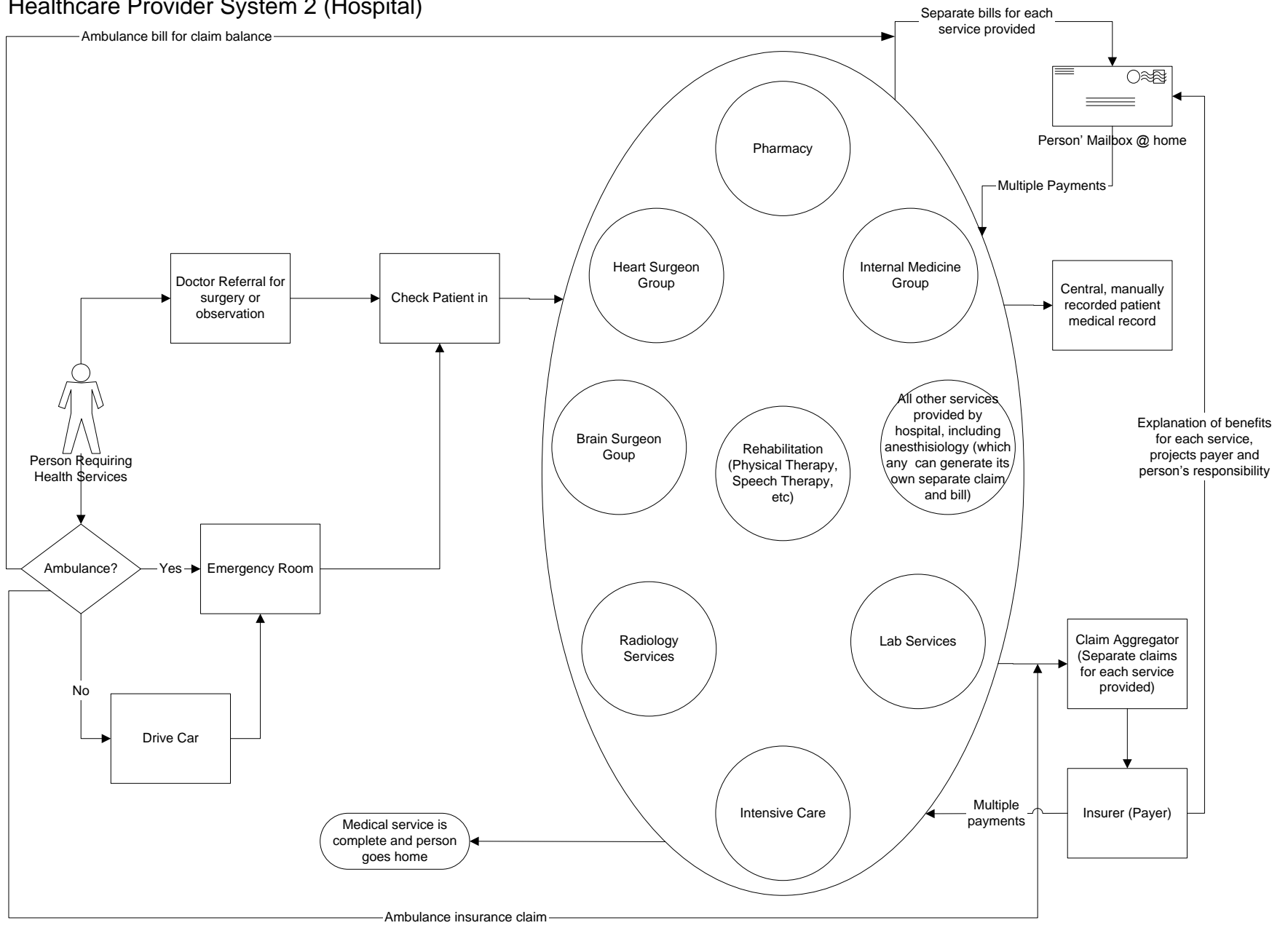
Providing quality, service oriented, affordable healthcare for all U.S. citizens is a worthy cause. It is also reasonable for business and government to expect/implement efficient healthcare provider/payer systems that contain healthcare premiums and cost.

FULL SCALE DIAGRAMS

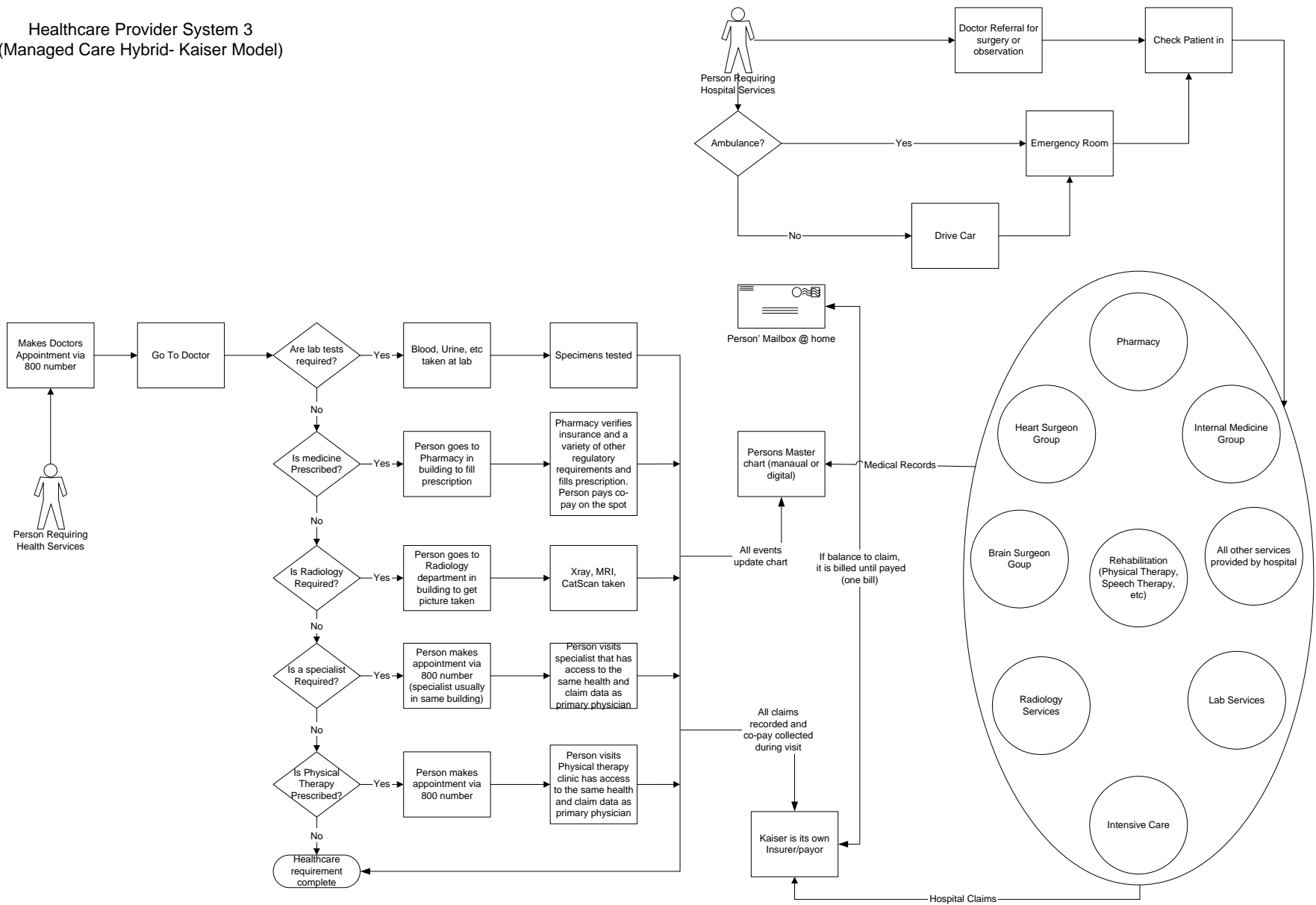
Healthcare Provider System 1 (Traditional)



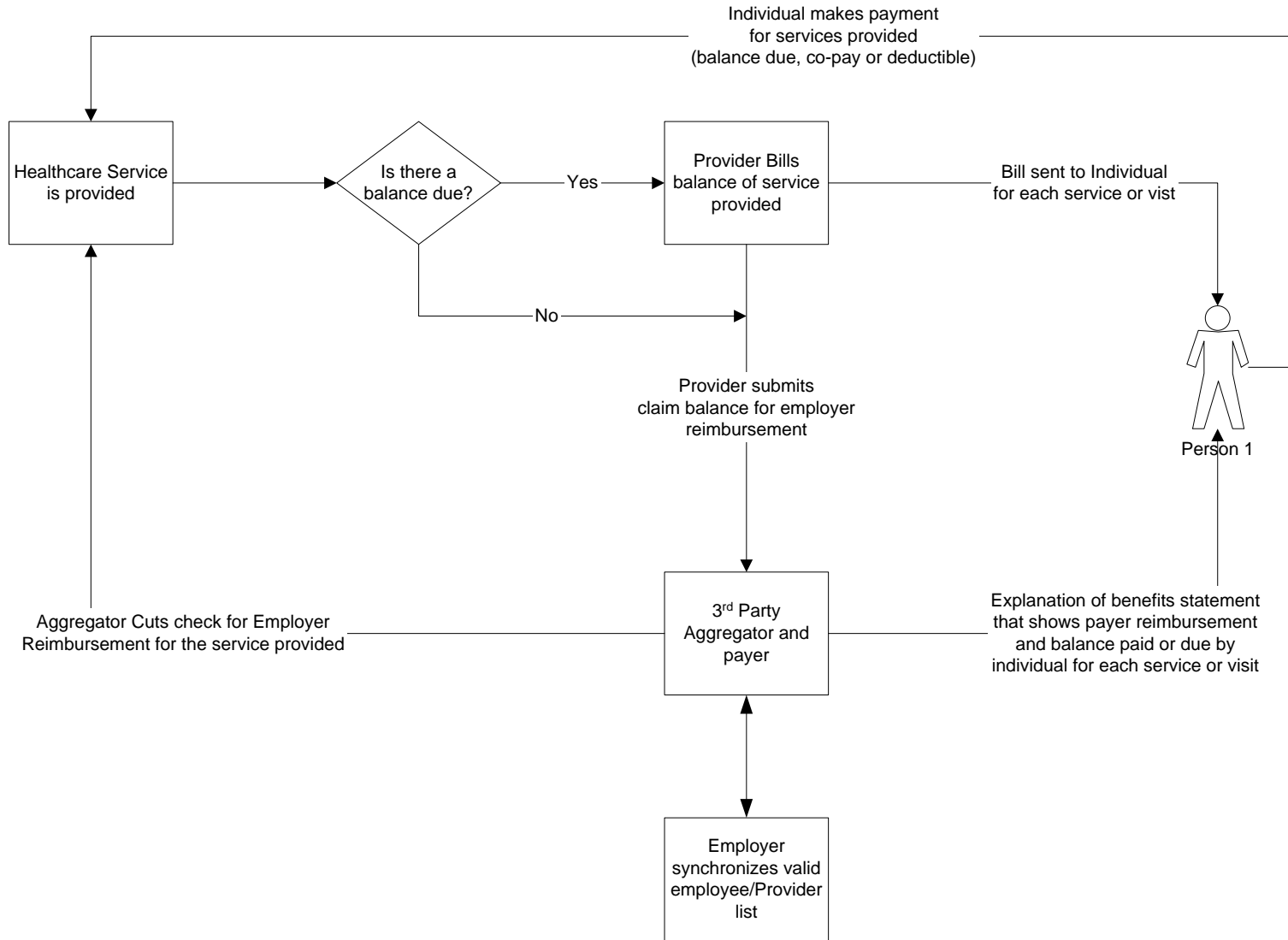
Healthcare Provider System 2 (Hospital)



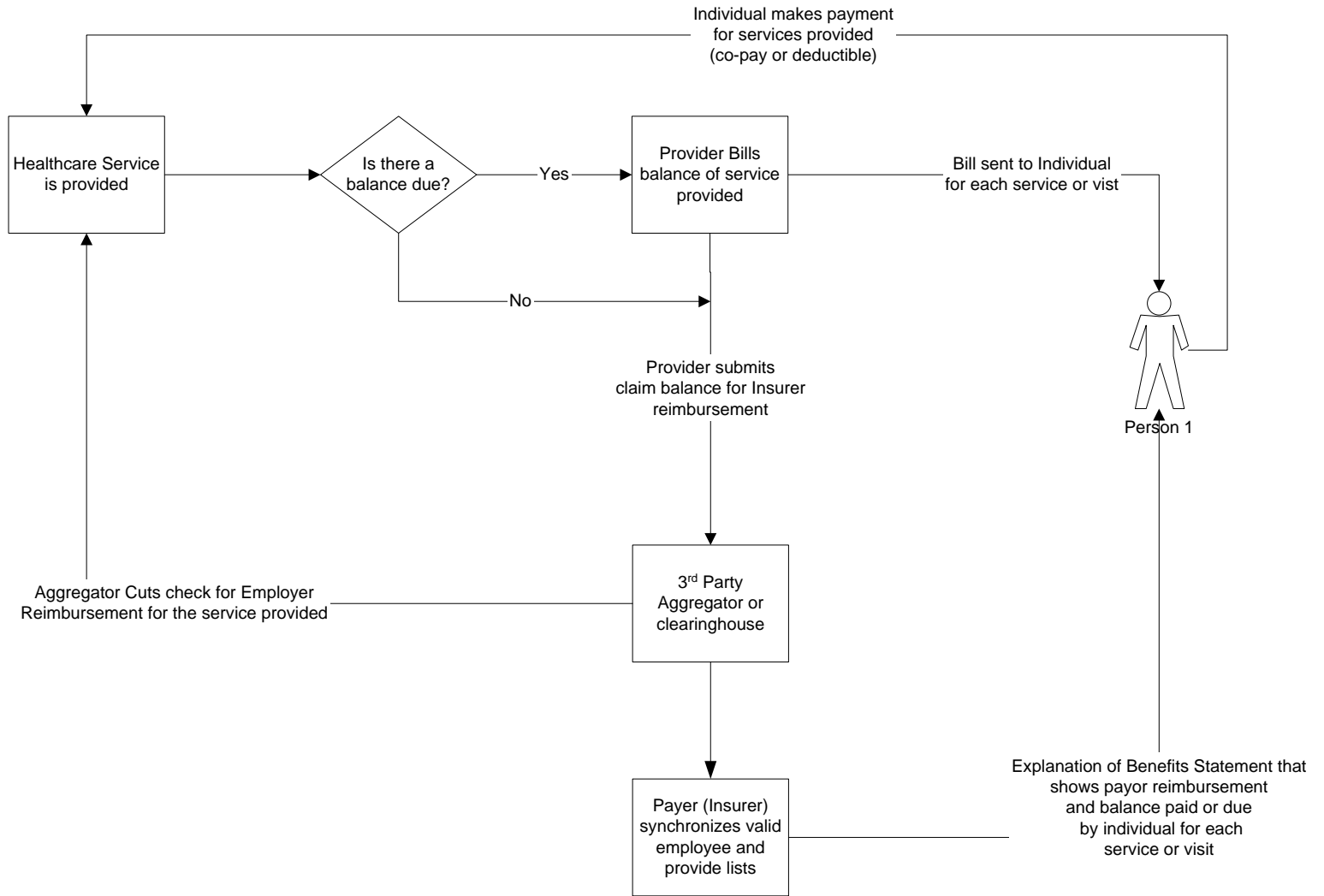
Healthcare Provider System 3
(Managed Care Hybrid- Kaiser Model)



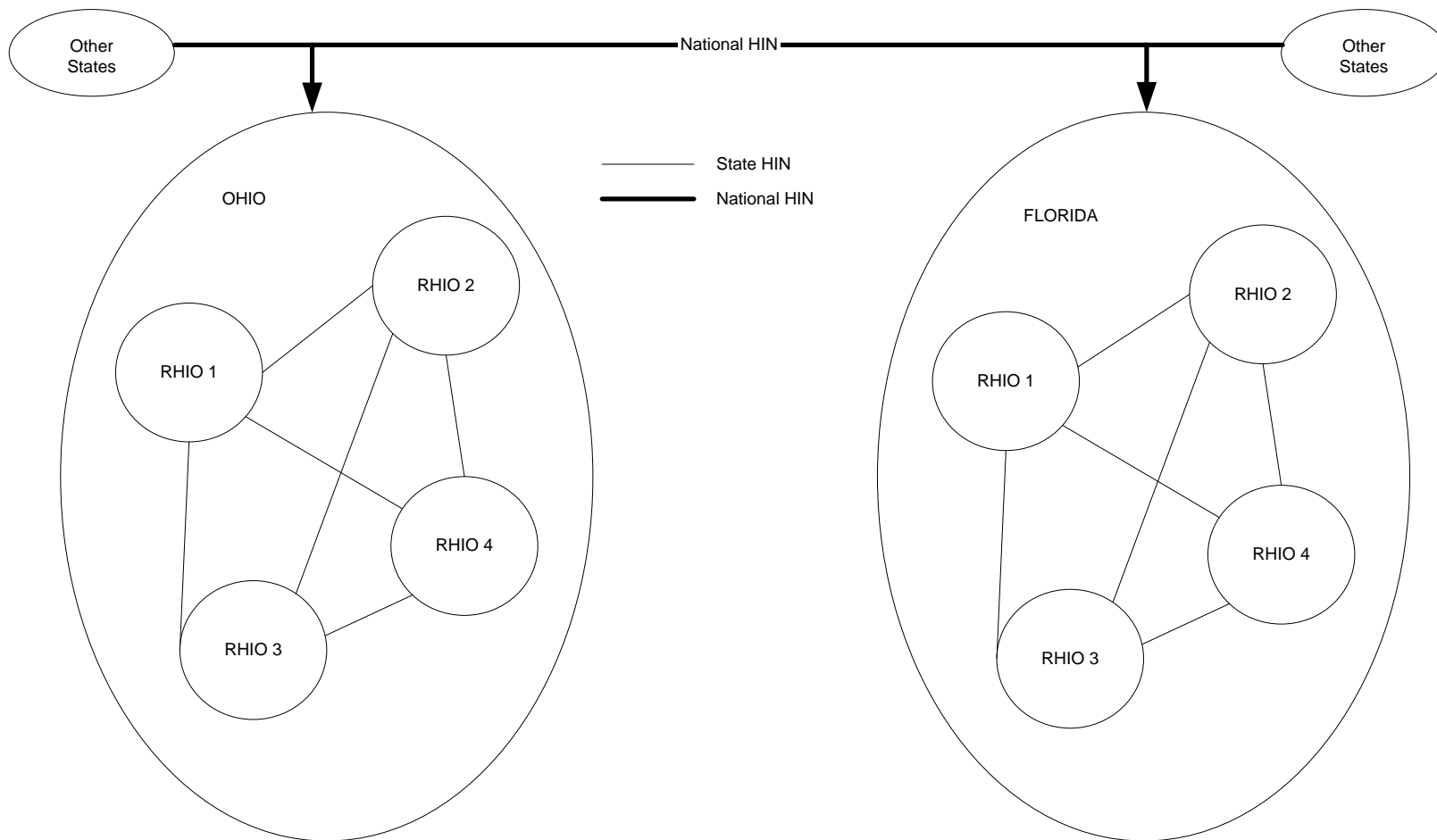
Healthcare Payer Model 1 (employer)



Healthcare Payer Model 2 (Traditional)



RHIO Vision (Regional Health Information Organizations)



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8. All provider and payer system processes were obtained from participation by the author and/or his senior relatives in the various models over the past 10 years.

ABOUT THE AUTHOR

Tim Ameredes has 17 years of experience in leading roles where he streamlined business operations and/or aligned IT in corporate, government, higher education industries. Witnessing market actions or provider issues that adversely affected retired relatives began his quest of monitoring the healthcare industry. The adverse actions were as follows. An increase in monthly private insurance premiums paid by \$300/month in one case of a retired teacher and completely eliminating two other relative's pension/healthcare benefits by a profitable international steel manufacturer in the other case (resulting in that relative being moved to Medicare). A 40 day hospital stay for one parent while the other parent was having a hip replaced- both were buried in claim paperwork. Coordinating healthcare services as Power of Attorney for an aunt with dementia. Their ages were 78, 78, 83, 84 and 84 at time of the poor service actions. Fortunately, all are still living.

This paper is not intended to make a political statement but rather to offer a different viewpoint to the existing healthcare crisis in the United States. Future U.S. healthcare solutions need to take into account this viewpoint in order to achieve success in providing quality service and containing rising healthcare costs over a shorter period of time.

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