The Self-Insured HMO

Healthcare resources are limited. In an unstructured market, the best resources are dedicated to the wealthiest patients who pay high margins to win those resources. The self-insured HMO (SIHMO) is a restructuring of the market that increases equity without sacrificing efficiency. As such, it is a Pareto improvement.

No health provider is required to become a SIHMO. One can remain an independent hospital, medical group, or insurance company. In fact, there are profits to be made by remaining independent.

However, a consistent flow of monthly funds ($100/person in 2018 dollars) from the Earth Dividend will appeal to existing or new healthcare providers. Additionally, any month that the patient visits a SIHMO facility, the facility receives up to 100% of a roughly $20 copay from the Earth Dividend.

In return, the SIHMO maintains a charge-list for all procedures, surgeries, and tests. Because any hospital stay is independent of charges, there is no charge difference between inpatient and outpatient procedures. Any differences in costs between them is due to a failure to break the procedure down into simpler tasks.

The charge list does not contain any entries for diagnosis or prognosis. However, any tests or procedures associated with the diagnostic process are included in the charge-list. Likewise, any treatments associated with a prognosis such as medications, tests, procedures, or surgeries are included.

A voluntary standards group (VSG) will enumerate every test and procedure that must be available to be considered an SIHMO. Failure to support required tests and procedures in-house, or failure to safely and without charge transport patients to facilities where these tests and procedures can be done, will negate the right of a medical facility to be a SIHMO. Tests and procedures that are recommended by the VSG, but are not requirements, must be specified on the VOS (Violation of Standards document), but do not disqualify an SIHMO.

A VSG specifies the complete list of prognoses where SIHMOs must have a treatment regimen on the charge list. The list includes the minimum standard treatment and best-known treatment. To facilitate competition and choice, the list also includes various courses of treatment and their probability of failure. One course of treatment is to provide no treatment beyond providing for patient comfort. This lack of treatment is also associated with a probability, however high, that the patient will not recover. SIHMO failure to support the minimum standard treatment for any prognosis must be specified on the VOS.

In Phase II, minimum standard treatments will not include medications and procedures that are expensive due to legacy intellectual property laws. If this is a violation of state law, a legal challenge has a good chance at success.

Otherwise, Phase II self-insured HMOs might not be possible in the state. After federation, new medical innovations are likely to result in cost savings, rather than cost increases, and minimum level of treatment will tend to involve the latest technology.

One of the charge-list items is for an overnight stay in the hospital. This charge includes the bed, food, and standard nursing care. Deviations of this charge between hospitals can cause significant variance in patient populations.

If beds run out due to a low charge, the SIHMO is responsible for paying the charge of the next nearest SIHMO. A charge that is too high will lead to a large number of independent and even luxury accommodations trebled on the hospital campus.

If this leads to failure to provide treatment, the SIHMO is responsible for paying the charge of the next nearest SIHMO. The VSG will recommend a standard charge for all SIHMOs, such as $100 per night in 2022 dollars. The cost is so low because hospitals are anxious to be awarded the wellness annuity.

While an HMO would seem to be the antithesis of choice, these SIHMOs, to qualify for the distribution (premium) payments, must abide by certain marketplace rules. It requires an explicit charge-list, free care for members, and an agreement to treat any non-member at the charge-list price.

Since the SIHMO is self-insured, the charge-list generates nothing more than a bookkeeping entry when treating its own members. It is a zero-sum game between the insurance arm of the SIHMO and the medical arm.

However, members are not tied to their own SIHMO. They have complete freedom to choose any provider. The insurance arm of the SIHMO must pay the new provider up to 95% of the charge-list price for any treatments enumerated by the VSG under the same prognosis.

If the new provider is more expensive, the patient (or their private health insurance) must make up the difference. If the new provider is less expensive, 50% of the difference between 95% of the charge-list price and the charge by the new provider is rebated in cash directly to the patient.

If the prognosis is for $50,000 worth of surgery and you chose to see your cousin the midwife instead, can you collect $25,000? Yes, but there is a caveat. All or some of the money will be held in escrow for a year based on the probability of failure set during prognosis. If during that time, you require medical services as a consequence of your decision, the escrow account can be charged, per the charge-list.

There is a cost equilibrium because if the charge-list is too high, members will have all their medical care done elsewhere and pocket the rebate. If the charge-list is too low, members of other SIHMOs will choose this SIHMO for their treatment and the SIHMO will be doing many procedures at a loss. The cost equilibrium maximizes innovation and minimizes cost.

There is one other condition on a SIHMO with an inpatient facility. They must provide for weather-protected, gurney-accessible access and egress to the inpatient facility from buildings housing patients on or about the hospital campus.

The housing units may be owned by the SIHMO or they may be owned by nursing collectives in the business of housing patients. This might involve a sanitary and secure underground tunnel with a people mover designed for gurneys. The cost is picked up by the owners of the housing units. However, the SIHMO must not impede this activity and must abide by the rulings of the chancery court. See Wellness Annuity and Trebling a Hospital Dorm.

Doctors might affiliate themselves with one or more SIHMOs to build a patient base. Leading surgeons and specialists might remain independent if they have a sufficient number of patients willing to pay a premium over the typical SIHMO charge list price.

The Federation Payer

The Federation payer receives 17%, or $20 of the monthly $120 healthcare distribution (2022 dollars). The federation payer pays the excess charge for travel emergencies away from the member SIHMO, 100% of a bankrupt SIHMO charge-list for the remainder of the plan year, and half the cost of diagnosis leading to prognosis.

Federation payer funds are used to support Federation equivalents of The Center for Disease Control and National Institutes of Health.

The federation payer maintains a strong presence in the medical VSGs and investigates SIHMO and high-risk provider fraud in conjunction with the independent judiciary.

Diagnosis

50% of SIHMO diagnosis costs are borne by the federation payer. That includes tests and procedures prescribed for diagnosis, as well as rebates for patients who obtain valid test results at cheaper facilities. It also pays 50% of the base cost for patients who test or have diagnostic procedures done at more expensive facilities. It is only logical that tests be prescribed in the optimal order to maximize information and minimize costs.

The federation payer also publishes per-patient expenditure on diagnosis per SIHMO and location, if the SIHMO has multiple locations.

In order to be entitled to reimbursement for treatment, patients must be diagnosed by a diagnostician approved by their SIHMO. However, in the event of an emergency, a certified diagnostician at any facility will suffice for emergency aid provided at that facility. Reimbursement for costly first-aid by non-certified persons must be approved by a court.

The government protected monopoly on diagnosis by the member's SIHMO is required to prevent any quack or charlatan from diagnosing an illness that the SIHMO must pay. However, the VSG specifies terms of a marketplace created to counter bad diagnoses.