Worthy

The healthcare system is crushing the American Dream, but we can change that

Introduction

I grew up in North Dakota, one of the least densely populated states in the country and where agriculture is a major economic force. While I lived in a city, we didn't have to drive very far to see a lot of farms. One thing that still amazes me is how much food these farms produce yet how few people actually work on them. When our country was born 250 years ago, we were a country of farmers — approximately 90%-95% of the population worked in agriculture. Today that same role is only 1%-2% of the population (InfoUSA, DOL).

There are multiple reasons for this amazing transformation; one of the biggest is the adoption of technology, such as the steel plow, tractors and combine harvesters. This story is repeated over time in almost every sector of the American economy. Whether it is building a car, operating a train, manufacturing a computer, providing financial services, watching a movie (does anyone remember Blockbuster?) or staffing a grocery store, the number of people required to do these tasks has gone down over the years and fallen dramatically over decades.

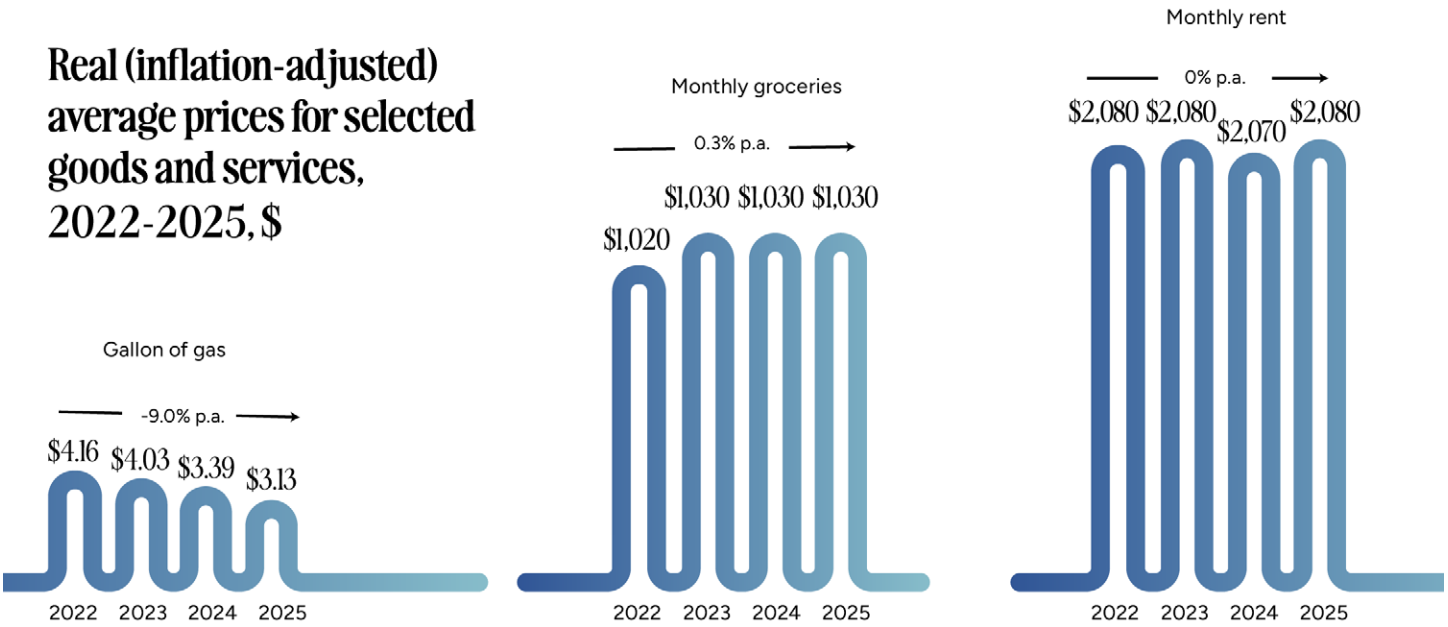
This is what economists refer to as improving "productivity," and it tends to have a lot of benefits, including reducing costs and improving the average standard of living. For example, although inflation has increased in recent years, U.S. consumers spent an average of 10.4% of their disposable income on food as of 2024, down from 17% in the 1960s (USDA ERS). The rapidly increasing efficiency of farms has everything to do with making food far more affordable and allowing people to use their money for other things.

It is important to acknowledge that while there are a lot of benefits to improved productivity, the changes associated with it are not always good for everyone.

Here are some potentially negative implications of improving productivity:

- Up to 19.2 million jobs face high or very high risk of displacement due to automation and other productivity gains. By industry, this could range from 4.7% to 20% of jobs being lost (SHRM).
- There can be increased environmental harm. For example, U.S. agriculture uses more than 1.1 billion pounds of pesticides annually, representing 15% of total global pesticide use (FOE).
- There are potential impacts on health. For example, it may be less costly for a company to dump its industrial waste into a river but it can have negative effects on human health, e.g., in June 1969 when the Cuyahoga River which runs through Cleveland ignited due to extreme industrial pollution.

It is important to call these out because we are more likely to mitigate and/or manage these risks if we highlight them in advance and make it a priority to do so. That said, probably the biggest reason that the standard of living has so consistently improved in the United States over decades, and even centuries, is because of our ability to use innovation, creativity and technology to improve our productivity. By producing things at a lower cost and passing much of those savings on to customers, it has allowed us to expand what we can buy with our paycheck.



Source: Urban Institute

For most people, this is how they measure progress for themselves and their family, and partly how they think about the American Dream. If, over time, their pay allows them to afford more, then they feel they are better off and in a better position to pursue their dreams, and if the opposite is true, they feel worse off. Today, there are many Americans who believe that life is not going to be better for their children than it is for them, and that the American Dream is not available to them. According to *Politico*, as of October 2025, 49% of adults believe the best times are behind them (Politico) while a July 2025 poll from *The Wall Street Journal* found 69% of U.S. adults said the American Dream either never held true or once held true but no longer does (Axios). In fact, there are a lot of statistics that back up the fact that the average American family's standard of living has stagnated in recent years. For example, according to Statista, Baby Boomers represent just 20% of the U.S. population but they own 51% of U.S. household wealth as of the end of 2024. Baby Boomers' combined net worth, at

$82 trillion, is more than double that of Gen-X at $42 trillion and four times that of Millennials at $16 trillion (Investopedia). Why is it that after so much progress over such a long period of time the improvement in the standard of living for the average American family has stalled?

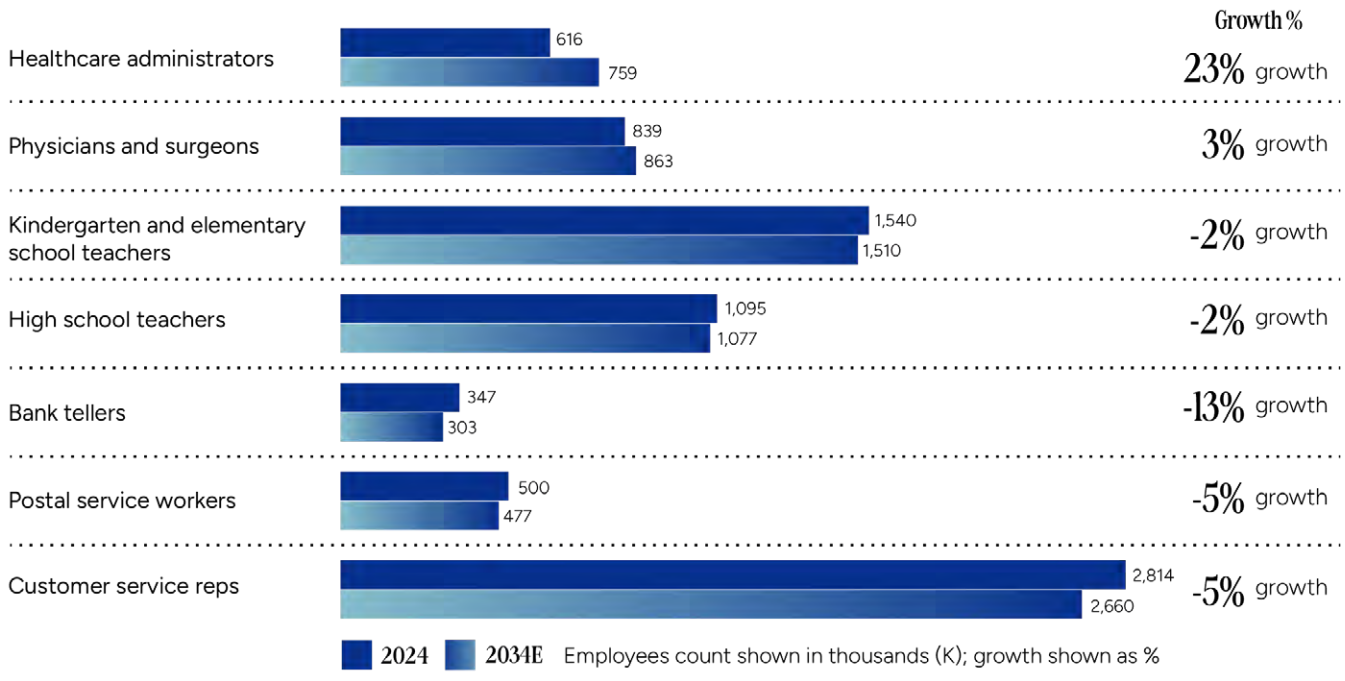
Perhaps the biggest reason is rising health care costs.

One of the few exceptions to the pattern of needing fewer people to do the same amount of work over time is the U.S. healthcare system, where the exact opposite has happened. From 1975 to 2010, the number of doctors and other clinicians treating patients increased 150%, while the number of people working in administrative jobs in health care increased by more than **3,000%**. *(Athena* article linked here and below chart*)*

The numbers are absolutely staggering, particularly in comparison to other economic sectors, and going forward these trends are expected to continue. Specifically, the Bureau of Labor Statistics (BLS) projects that from 2024-2034, employment for healthcare administrators will grow 23%, a rate that far exceeds that of physicians at 3%, teachers at -2%, and other professions in the chart below.

Health care employment growth v. other sectors

Employment growth for healthcare v. other selected professions, 2024-2034 projected, K employees

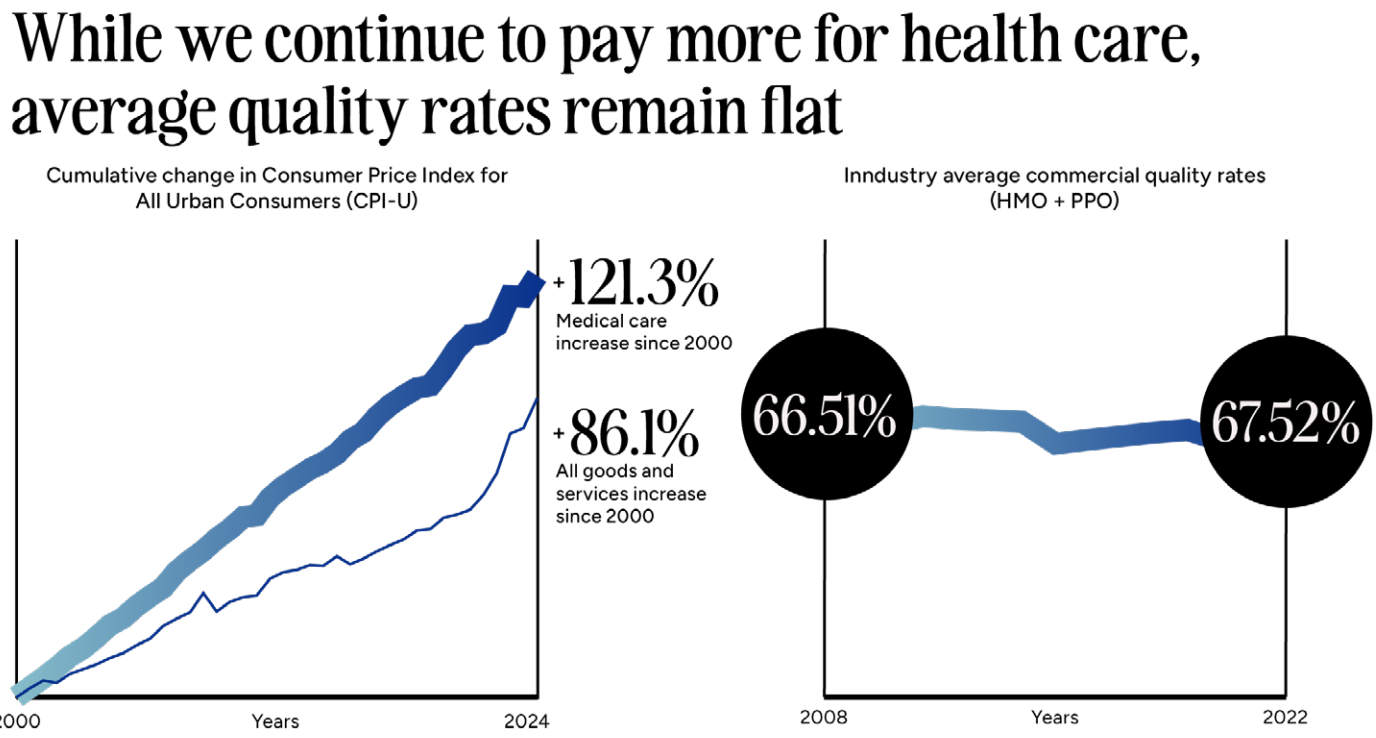


Source: Athenahealth, BLS, BLS

In fact, health care is the only industry I know where some of the people in it cite the development of new technologies as a reason that costs increase rather than decrease (Calhospital.org).

Despite the advent of personal computers, the Internet, mobile phones, electronic medical records and much more, the healthcare sector keeps doing similar tasks as it did 30+ years ago but with way more people. For decades healthcare costs have grown at a faster rate than prices for everything else which, according to Professor Zack Cooper in his recent New York Times opinion piece, has depressed wages by 10% over the past decade and is one of the leading causes of income inequality (NYTimes).

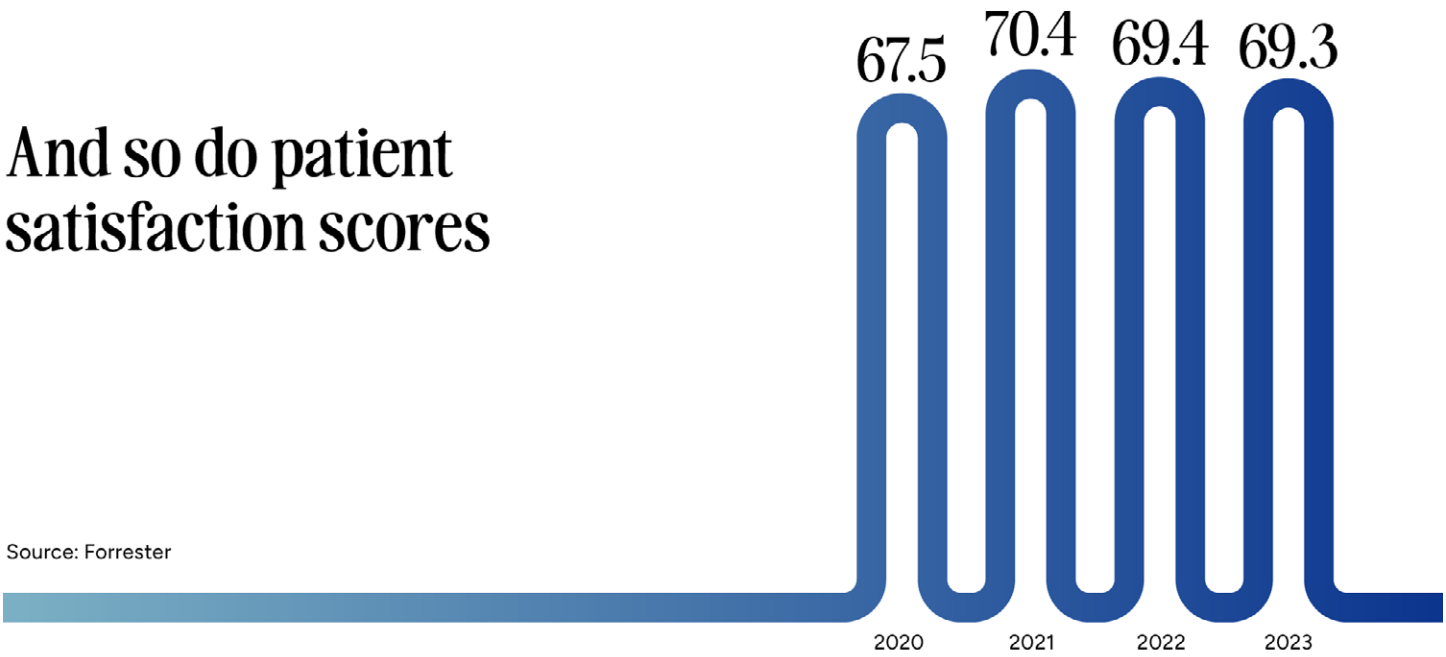
Yet, despite spending all this additional money on health care, clinical quality scores and patient satisfaction for services are not improving.



Source: KFF analysis of Bureau of Labor Statistics (BLS) Consumer Price Index (CPI) data , NCQA HEDIS Measures and Technical Resources.

And so do patient satisfaction scores

Forrester customer experience index performance: health insurance industry average



Source: Forrester

It isn't just patients feeling the proverbial pain. Many physicians, particularly primary care physicians, nurses and other clinicians are working more hours, feeling burned out, and yet, not treating more patients than they did 30 years ago. A Mayo Clinic study found that as of 2023, up to 45% of U.S. physicians responding to survey results reported at least one symptom of burnout. Although the rate decreased from its peak of 63% during the COVID-19 pandemic, it remains very high.

The same study found that physicians are at increased risk of burnout and less satisfied with their work-life balance than professionals in other sectors *(see report)*. Put another way, the healthcare system is burying Americans and their clinicians beneath clipboards, fax machines, CD-ROMs, complex bureaucracy and tasks that have nothing to do with helping patients become healthier.

We can and must tackle this problem head-on and make all the players in the healthcare system more productive. Doing so requires both "will" — the *desire* to become more productive — and "skill" — the *ability* to become more productive. We will dive more deeply into how to generate the "will" to do so in a future segment — however, it is worth noting that creating strong enough motivation to pursue material productivity improvements in health care is a big challenge that must be addressed. Improving productivity will bring noticeable benefits to many, but some pain to a much smaller number of organizations and people. Those who will experience the pain will likely resist fiercely.

This segment focuses on helping the industry to develop the "skill" to drive productivity improvements. Specifically, I'm going to share how we can save more than $300 billion per year by improving the productivity of health plans, hospitals, clinics and physician practices by taking the following steps:

- **Digitize:** Ensure every American has access to a comprehensive, real-time, secure and private digital health record that is used to personalize their care, improve their health and service experience, and reduce administrative costs.
- **Simplify:** Remove or streamline laws, regulations, products, contracts, industry requirements and industry norms that are not meaningfully helping with the cost or quality of health care, but have created unnecessary work, friction, errors and confusion.
- **Automate:** Use technology, including the responsible use of artificial intelligence, to automate everything that can be automated, while ensuring we maintain human decision-making and contact when it matters most.

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Digitize: Everything starts with bringing health care into digital age

It is impossible to overstate my longstanding frustration with how digitally antiquated the healthcare system is, particularly when it comes to combining, storing and using data, although you might get a good sense of how I feel by watching this short video of me bashing a fax machine to smithereens.

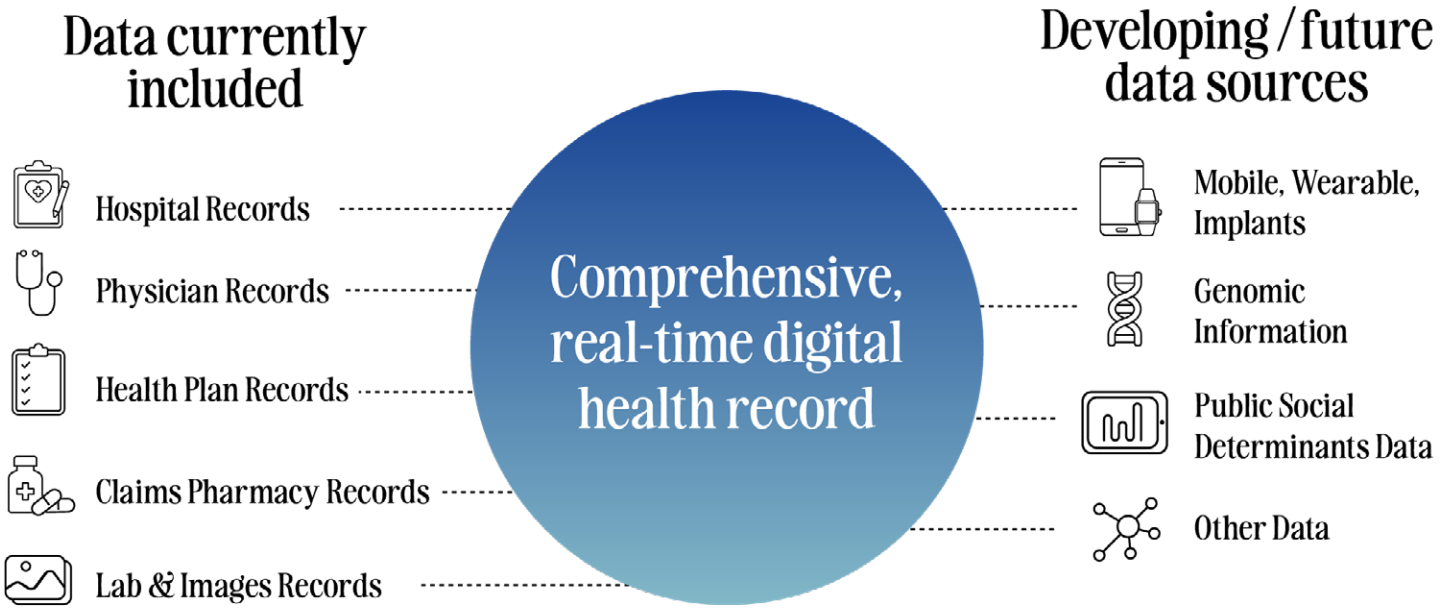
Much of the inefficiency, delays and frustrations with the current healthcare system boil down to using outdated technology and highly manual processes to share information and complete basic transactions. It's astounding and completely unacceptable to witness this in 2026. Even though patients have a legal right to their data today, and much of that data is stored in a digital form, most people have to piece together information from multiple sources (like different physicians, hospitals and health plans) to try to create a comprehensive record for themselves or their loved ones. It is a bit like having to visit the websites for the grocery store, your online purchases, the gas station and a host of other companies where you used your credit or debit card to pull together your monthly financial statement.

This lack of access to usable data is more than just annoying; it can have real-life impacts on your medical care and your health. For example, a relative of a friend of mine has a serious heart condition and went through an invasive, painful procedure of having a small camera inserted down his throat to check the main artery of his heart. The medical team was so concerned about what they saw in those images that they insisted he immediately go to an academic medical center for treatment, which was a two-hour drive away. When he arrived, the academic medical center didn't have the images from earlier that day and couldn't access them, and so they did the same invasive test and stuck another camera down his throat. The preparation and the actual procedure took longer than it would have taken to drive the images from the first hospital to the second hospital, not to mention the discomfort and risk of going through the procedure a second time.

Another friend's adolescent son was dealing with a long-lasting concussion that led to complications. The duration of his symptoms and the resulting complexities were so unusual that they had to see many different providers. My friend told me about all the hours he spent putting together a spreadsheet of his son's medical history so they could know it, share it with medical professionals, and keep track of all the many tests that were carried out or suggested (and sometimes persuade the provider that the tests had already been done).

These are just two of the many heart-wrenching stories that illustrate how the lack of an easy-to-use, comprehensive, real-time digital health record creates serious health risks and/or problems for individuals or their loved ones. Often, this issue doesn't arise for people until they or a loved one face a serious, complex health challenge that requires seeing multiple healthcare providers. Many of us just see one or two doctors infrequently and can sign into electronic medical record applications, such as MyChart, to get the information we need. But this almost always changes when the universe of caregivers expands. Often people experience this for the first time when they are taking care of an aging parent and must constantly recount their parent's medical history for each new physician or nurse.

Creating this kind of digital health record can easily be done but is a perfect example of the healthcare industry needing some tough love. I spent more than a decade trying to persuade all the different players in the California healthcare system to work together voluntarily to create these records, without success — and finally broke through when we led the effort to create California's clinical data sharing mandate, with the adoption of Assembly Bill 133 in 2021 (CA.gov). Now, most Blue Shield of California members can access their digital health record on their phone or favorite device. Use the attached link to see an example of this record and below for a display of the data sources.



Business interests are the main reason this has not and probably will not happen voluntarily across the country. A large enough number of health plans, hospitals, electronic medical record purveyors and others believe that they "own" the patients' data and that their business interests could be hurt if "their data" are shared too extensively. If you go to health care conferences, you may hear speakers talking about "data as a strategic asset," which is another way of saying an organization should hang on to the data, not share it unless required, and use it to protect their business interests, e.g., ability to charge customers additional fees to access or share the data, secure referrals from physicians and other health care providers, prevent health plans from using it to reduce payments.

There are also more legitimate worries as well. Consumers and others may be concerned about whether their personal health information will be kept private and secure, and there is a lot of mistrust of players in the health care system having access to this information, particularly health plans. These worries are understandable and it is important to note that we can create these comprehensive, real-time digital health records without changing which parties have access to the information and their obligations under the law to keep that information private and secure.

First, let's look at access to personal health information. Consumers and health care providers probably mistrust health plans the most when it comes to having access to detailed personal health information and yet, to do their work and comply with laws and regulations, health plans have to access this information today. For example, health plans must know a patient's diagnosis and their specific treatment to know what to pay. They are also required to submit clinical quality scores and risk adjustment information for their members/patients to various agencies, so that their quality and risk adjustment scores can be calculated. This requires extensive, personal, clinical data from each patient, and much of this is being shared today, only it is often very delayed, expensive, difficult to access and incomplete. In fact, every year between January and May, health plans go through a process called "chart chasing" or "HEDIS pursuit" (HEDIS is the acronym for Healthcare Effectiveness Data Information Set and is an important set of quality measures for health plans). This requires health plans to call a lot of people and physically visit physicians' offices to try to find specific patient clinical records from the prior year, in order to report fully accurate HEDIS measures for that time period. (By way of example, Blue Shield of California typically hires 20-40 full-time employees for this period of time to do chart chases.) The point is that health plans already must access this information, but it is laborious, late and often incomplete, in a world where data in other industries can be accessed instantaneously.

Regarding privacy, extensive federal and sometimes state laws and regulations already regulate how and when healthcare data can be shared and used. The most significant are the federal privacy laws and regulations associated with the Health Insurance Portability and Accountability Act (often referred to by its acronym, HIPAA). In an effort often referred to as "inter-operability," there is also a set of federal laws and regulations that have been slowly improving the sharing of health care data over many years, including the Trusted Exchange Framework and Common Agreement (often referred to as TEFCA). If you would like to learn more about these, you can use these sites for HIPAA privacy (HHS, CDC, Congress.gov) and

here for TEFCA (HealthIT.gov, Sequoia Project). It is important to note that HIPAA applies only to health plans, health care providers, health care clearing houses, and to their subcontractors who qualify as "business associates" under HIPAA. So, for example, if you as a patient share your health information with a technology company today, they probably are not subject to HIPAA or other privacy regulations.

Finally, when it comes to security, the number of successful cyber attacks, including ransomware attacks, on the healthcare industry in recent years is deeply concerning. According to the FBI, 444 reported cyber incidents targeted the healthcare industry in 2024, comprising 238 ransomware attacks and 206 data breach incidents (AHA). Also, healthcare organizations made 592 regulatory filings of reported hacks of protected health information to the Department of Health and Human Services (HHS), impacting up to 259 million Americans. The Change Healthcare ransomware attack alone led to the hacking of health records for 190 million Americans (AHA). It is critically important for everyone in the industry to use the best available methods to keep such deeply personal information secure. Even when the industry does this, we must recognize that there will be a risk that this information could be hacked. One of the reasons this is the case is that the most common successful method of hacking into a system is human error, and we are never going to eliminate human error completely, e.g., a hacker obtains an employee's credentials or login and password to access the system. In other words, if we are going to record and store information in a digital form, then what we have learned is that we can do a lot to protect it and no one can make a 100% guarantee of security. But right now, we have the worst of both worlds: We have personal, private health information stored in digital form and at risk of being hacked, but it is so fragmented that patients, their caregivers and their health plans cannot use it very effectively to improve their health and reduce costs. Therefore, the proposal to create these personal records for everyone does not increase the risk of an attack, but rather ensures that we get maximum value out of the information that is already stored in digital form today while advocating for better security across the industry.

The good news is that this is a bipartisan issue, as we've seen multiple presidential administrations and their appointed agency leaders — including former U.S. Secretaries of Health and Human Services Sylvia Mathews and Alex Azar, and former acting administrators of the Center for Medicare and Medicaid Services (CMS) Andrew Slavitt and Seema Verma, just to name a few — use their limited power to push for more healthcare data sharing and use. The Trump Administration's Dr. Mehmet Oz and his team at the Center for Medicare and Medicaid Services appear very eager to use digital tools and technology to greatly improve health care.

The challenge is that all these capable and well-intentioned public servants have not had the authority under current laws and regulations to ensure that every American has access to a comprehensive, real-time, secure and private digital health record. So, they keep requiring more data sharing and less data blocking, which is helpful, but not enough to ensure we can create the digital records described above, nor to ensure that technology companies increasingly active in the healthcare space are subject to the same privacy regulations as others. The only way we are going to get to this digital world is if we pass a federal law requiring it to happen.

We have an outline for such a law and if you want to get into the legislative details, you can find that outline here. For those of you who would prefer a short, simplified summary, the proposed new law would require all the players in the healthcare system to do the following within two years:

- Hospitals, physicians, and all other clinicians that collect data on a patient, provide all this data in real-time to the patient's payor (that could be a health plan or the administrator for an employer group/trust, or a government health program such as Medicare).
- The payors must:
    - Make available a simple, easy-to-use process for physicians, hospitals and others to share their data.
    - Add any clinical data they have on that patient, e.g., claims, lab results, filled prescriptions.
    - Combine all this information, integrate it into a single digital health record and make it available in real-time to the patient in a usable format (including allowing the patient to share and transfer that data to others).
    - Share the patient's digital health record with health care providers currently treating/managing that patient.
    - Share the patient's digital health record with their new payor when they make a change.
- Under current law, all the participants in the healthcare system, e.g., payors, physicians, hospitals, are required to abide by all federal and state privacy laws on health care and will have to continue to do so. This law will also require ***all companies that are given access to personal health care data***, e.g., technology companies, to do the same (something that is not the case today).

Right about now is when the proverbial knives can come out, usually from the defenders of the broken status quo. What I've described here is a clear problem along with a clear, pragmatic and detailed solution. Is this proposal the only way to ensure everyone has access to their comprehensive, real-time digital health record? Of course, not. There are certainly other ways this could be done, and I'm happy to debate and discuss how to accomplish this critical goal with anyone who has a better solution. However, beware of the defenders of the system, because they will give you all the reasons the specific details of this proposal should be opposed *without providing any viable alternative.* So, my request of all of you is to help me hold the industry and policymakers accountable by being clear, unequivocal and uncompromising about the goal:

We must ensure everyone has a comprehensive, real-time, digital health record.

To assist everyone with the cause of defending against those that might attack this proposal, if you are interested in how to respond to objections, please see the appendix.

Once we have this digital health record, we can take steps to eliminate or reduce administrative costs and burdens. We can dramatically improve the health, medical care and experience of patients, doctors and other clinicians through automation and real-time support. We'll be going into more depth on this in a moment, but it is important to note that bringing health care into the digital age is also the first basic step that must happen to personalize and dramatically improve the quality of health care that Americans receive.

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Simplify: Complexity adds costs, increases risks and frustrates patients →

Simplify: Complexity adds costs, increases risks and frustrates patients

There are aspects of health care that are complicated, and that is never going to change. The human body is enormously complex and our insights into how it works grow daily. Human life is complicated and we aren't going to change that.

But there is so much in our healthcare system today that became complicated simply because we who work in the industry and those who regulate it made it that way. This needless complexity has built up over many years and has created enormous problems including:

- Higher costs without better quality or service: This complexity is the root cause of the massive growth of administrative jobs in health care over the past decades. More codes (for diagnoses and claims), longer contracts, more and increasingly complicated products, more intermediaries, and more regulatory requirements are all invitations to hire more people to complete tasks. That is exactly what has happened, without causing any noticeable improvement in quality or service.
- Increased patient risk: When we increase the number and complexity of steps required to complete a given task, we increase the risk that something will go wrong — whether someone in the process did something wrong, or the patient simply didn't understand how it was supposed to work. In short, complexity adds risk to the patient.
- Greater dissatisfaction and mistrust of health care system overall: Whether it is a prior authorization that isn't happening in a timely manner, a claim that isn't getting paid, confusion about if and when your coverage started, or uncertainty as to whether a physician is "in network," when things get more complicated, there is a negative impact on the patient's experience. So, it should be no surprise that this complex system has contributed greatly to patient dissatisfaction and mistrust.

Let's look at some examples:

How many people does it take to pay a claim?

That is a fair question. Let's look at some statistics:

- Blue Shield of California's average contract with a hospital is more than 100 pages.
- Hospitals use multiple coding systems to determine the amount they get paid for a claim, including ICD-10-CM (diagnosis codes), ICD-10-PCS (inpatient procedure codes), current procedural terminology (CPT) codes (mostly for outpatient

procedures), and HCPCS Level II Codes (for supplies and durable medical equipment). In total, there are approximately 160,000 unique codes across all these systems (Tebra, CMS).

- In 2024, hospitals spent about $30-$60 billion (2%-4% of ~$1.5 trillion in revenue) on "revenue cycle management" or "costs to collect" and physicians spent about $10-$20 billion (PR NewsWire).
- Health plans spent about $30-$45 billion (2%-3% of ~$1.5 trillion in revenue) directly on administrative costs relating to claim and encounter capture and adjudication (Sherlock, IBISWorld, NHE).
- Adding all of this up, we are spending approximately $65-$125 billion and using approximately 400,000 people working full-time every day to figure out claims payments, between health plans and healthcare providers (BLS, BLS, BLS, IBISWorld).
- Given the technology tools available we can automate these processes, which could reduce these costs by up to 90% or approximately ~$100 billion, however, we are hamstrung by the way the current system functions.

Why are we still "pursuing HEDIS"?

Quality is important to all of us, especially when it comes to our health care. Therefore, measuring it is also important.

We have no shortage of health care quality measurements and report cards. In fact, by our latest count, all the players have a lot of quality measures:

- The average health plan is evaluated across 1,485 quality and customer experience measures across major national, state, and purchaser-driven report cards and rating systems – including NCQA.
- The average physician tracks 57 quality measures across multiple quality scorecards. These include on average 13 quality measures from Medicare contracts, 10 from commercial and 5 from Medicaid contracts (Providence).
- The average hospital reports over 150 quality measures to the Centers for Medicare and Medicaid Services, including 45 used to calculate their Medicare star ratings, as well as multiple quality scorecards across payors (CMS, CMS).

There are two major challenges with this. The first is that if everything is important, then nothing is important. Nearly all the people I've met in the industry take pride in their organization's quality, but it can be nearly impossible to achieve high quality if the to-do list is so long.

The second issue is that chasing all these measures adds costs, which are exacerbated given our lack of real-time digital health records. One of the common sets of quality measures for health plans is the Healthcare Effectiveness Data Information Set (which often goes by the acronym "HEDIS" - see these reports linked here and here from NCQA if you are interested in more details about HEDIS). There are more than 90 HEDIS measures, and while some of the information to calculate these measures can be found in claims information, health plans also need access to detailed clinical information to complete this work. As examples, health plans need to determine how many of the women

who should have had a mammogram screening actually had one and how well controlled the blood sugar levels are for diabetic patients.

Earlier in this segment, I described the annual "HEDIS pursuit" process and, in fact, health plans probably spend $10-$20 billion (appx. 1% of ~$1.5 trillion in revenue) (Sherlock, IBISWorld, NHE, Healthleaders) every year doing this. With a digital health record, this could be automatically calculated in real-time, also eliminating additional administrative burden on physician offices and staff who must respond to these HEDIS data requests.

Putting together a provider directory is not rocket science, it just seems like it is

One of the first steps everyone takes to access health care is to choose a physician or other healthcare provider. In most cases they need to understand whether a healthcare provider is "in network" or accepts their insurance, e.g., Medicare, Medicaid. Other information, such as whether a physician is accepting new patients, what languages they speak, their quality scores and service reviews, would be helpful, too. Of course, health plans need to ensure all the healthcare providers in their networks are fully credentialed, which usually entails ensuring they have maintained their medical license in good standing and have not had any serious quality issues. There is no reason for any of this to be complicated or difficult. We aren't trying to fly someone to Mars. This is just sharing basic, accurate, timely information between physicians, health plans and patients.

Unfortunately, today the Centers for Medicare and Medicaid Services (CMS) reports that across the nation the average health plan provider directory is probably about 50% accurate (CMS, AMA). For the most part, each health plan has its own process for requesting and collecting physician and other health provider information, for both credentialing and creating provider directories. As a result, physicians and their staff must do these same, tedious tasks multiple times. Not surprisingly, they don't always remember to tell each health plan when something has changed, such as whether they are accepting new patients.

Blue Shield of California has invested tens of millions of dollars to create a statewide capability in conjunction with other health plans and a non-profit industry group for physicians to share their provider directory data in one place for all health plans, and thereby create a single source of truth for directories for all plans with a lot less burden on physicians. We did make the investments and created the structure, but we still do not have universal participation and as a result we have not fully realized the benefits of this effort. That said, I believe we are close to having this initiative achieve all its goals and become an example of how broad health care industry collaboration can simplify the patient's experience.

There is such a thing as having too many choices

In their book "Nudge," Richard Thaler and Cass Sunstein use a lot of research to show how humans make decisions and how to set up a good "choice architecture," so that people have a higher likelihood of making the best choices for themselves. One of the things that prevents people from making their best choices is being overwhelmed by the number of options, especially if they are buying something complicated, like health insurance. Thaler and Sunstein used examples from lots of industries to point this out, including the launch of the

Medicare Part D prescription drug benefit with its 46 choices (Thaler & Sunstein 2008, 163). While eventually a lot of people did sign up for the Part D program, the authors argued that a lot more probably should have but didn't, and for at least the first couple of years of the program, "seniors have consistently told interviewers that they find Part D dumbfounding." (Thaler & Sunstein 2008, 163).

I started my healthcare career in the Product area, where we developed different benefit designs and services to help the company present a more compelling offer to customers than competitors. For much of my career, I — like probably many others — have worked under the assumption that allowing private sector health plans to innovate and compete on products should be beneficial to consumers/patients. More product choices, especially those designed to be more attractive and interesting, can only be helpful, right?

But I'm now convinced that this is not entirely the case. Yes, it is important and helpful to have health plans and all the other players in the health care system compete and innovate to improve quality, affordability, access and service — like providing at-home care/support, helping patients find the right clinician and settling claims in real-time. However, having health plans try to differentiate from each other based on how much a consumer needs to pay out-of-pocket for a given physician, hospital service or drug is not doing anything to improve quality. It only adds costs to the system and ultimately risks confusing the consumer, both when they are purchasing a plan and when they try to use the plan. Consumers often have questions about their benefits such as, does this apply to the out-of-pocket maximum or not? Do I have a flat dollar copay for this service, or is it subject to the deductible and co-insurance?

In addition to potentially confusing consumers, the large volume of complex benefit designs ultimately increases costs and the frustrations of consumers and health care providers alike. It is clear to me from my experience that a substantial portion of customer service calls to payors, and some of the friction between health plans and providers regarding payment, can be traced back to complicated benefit designs.

⚠ Nerd Alert!

Convinced that innovative benefit designs are much more important than I'm making them out to be? **Then read this section...**

One of the industry's most recent benefit design innovations is "dynamic copays," in which the amount a patient pays for the same service can vary depending on specific choices they make. The general idea behind these copays and other financial benefit designs — such as Health Savings Accounts (HSAs) tied to high-deductible plans and Individual Coverage Health Reimbursement Arrangements (ICHRAs) — is that they put more money or health care purchasing power into the patient's hands and hopefully turn them into prudent shoppers for health insurance and/or health care services. There is no

doubt that people spend their own money differently than they spend other people's money, and so these benefit designs can influence patient behavior and therefore should be available as options in the market. However, their potential positive effects are limited for multiple reasons:

- Health care is so expensive right now that any even modest health care event will likely get a member at or near their out-of-pocket benefit maximum – the point at which the health plan pays for 100% of costs and the patient has no financial incentive to be a "prudent shopper." For example, for an individual consumer on a California Exchange Silver Plan in 2026, their average annual out-of-pocket maximum ranges up to $9,800 depending on coverage choice (HealthforCalifornia). If an individual spent three days in the hospital, they would very likely hit their out-of-pocket maximum, given that hospitals in California spend on average $4,500 per adjusted inpatient day (KFF). Put another way, it is common for the top 5% of patients to account for approximately 50% of a health plan's costs each year which implies that well over half of the claims paid by health plans are for patients that have hit their out-of-pocket maximum.
- While the industry could create benefit designs that shift even larger financial burdens on to the consumer to try to create more of a shopping atmosphere than described above, there is overwhelming evidence that a significant number of people will make decisions to forego care when out-of-pocket expenses are high (see reports from KFF, Peterson-KFF, and Commonwealth Fund for further data and insights), which undermines the quality of health while potentially deferring even higher costs until later.
- In addition, if people are seeking care that is potentially costly, it means they have a health problem, are not at their best, and are probably already experiencing some level of stress associated with it. Do we really want to add the burden of a large, complex financial decision to the mix?

In fact, one of the best ways to turn consumers into prudent shoppers of healthcare products is to standardize the out-of-pocket costs offered by each health plan (while allowing plans to reduce the standardized amounts under certain circumstances as is done with dynamic copays). This allows consumers to easily make "apples to apples" comparisons between health plans, focusing on the benefits offered and then comparisons of access (provider network, formulary), quality, cost and service. By offering many different, intricate benefit designs, it can easily make the decision process overwhelming.

⚠ **Nerd Alert Complete**

There is much more to this story. . .

These four examples are far from the only things that make health care unnecessarily complex and thereby add cost, confusion and frustration to Americans' healthcare experience. Many readers have probably been given a clipboard and asked to fill out a paper form with a pen, or to hand over their physical health insurance membership card to be photocopied for safekeeping. They've likely also received thick letters via traditional snail mail with the headline "This is not a bill," directly above something that looks an awful lot like a bill. They've gone to the emergency room or a hospital and been asked the same questions five or more times, been given a CD-ROM to take to their physician after an imaging test or been provided a copy of a faxed referral to another healthcare provider … and the list could easily go on. By the way, I have experienced all these examples personally in the last three years, and all of them make health care expensive, slow, error-prone and frustrating beyond description for consumers.

. . . and it can have a happy ending

We can change all this if we force the industry to simplify things and create some basic, national standards. In fact, prior authorization is a good emerging example of what is possible when the major players in the industry make it a priority to voluntarily develop standards that can simplify and improve things. In 2025, nearly all health plans nationally signed a pledge to establish standards that should enable most prior authorizations to happen electronically and in near real-time by January 2027. While that effort remains a work in progress, it is exactly the kind of thing that needs to happen across nearly all the major healthcare workflows that involve multiple players. More specifically, creating a healthcare system Worthy of us means passing new law(s) requiring the healthcare industry and/or the Centers for Medicare and Medicaid Services (CMS) to establish one common set of standards nationally for:

- Health outcomes (quality scores)
- Consumer/patient satisfaction surveys
- Collection, dissemination and use of provider information for credentialing and directories
- Structure of payments to physicians and hospitals
- Health insurance products/benefit designs

The recommendation here is that any law that passes requires all the players in the health care industry to meet these standards as a minimum. No law would prohibit any company from doing or offering more, e.g., measuring more quality scores, asking more survey questions, or reducing standard copays to incentivize behavior. Nor would the law prevent any state government or health insurance regulator from requiring more, e.g., requiring coverage of certain additional health care services as part of a standard benefit. However, by requiring everyone in the industry to measure, share and offer everything established in these standards, it can greatly simplify a lot of complicated aspects of health care, provide a much higher level of consistency across the industry and generate enormous benefits across the system. For more detail on both the proposed requirements and their benefits, please refer to the appendix.

To sum it all up, by simplifying and standardizing — across quality and service scores, customer satisfaction surveys, provider credentialing, provider directories, payment structures and benefit designs — we can reduce administrative costs dramatically, reduce the annoyance and friction that patients and health care providers experience with the system, facilitate far more automation, improve quality performance, and greatly simplify and clarify consumer choices. We can also get all the players in the healthcare system to stop expending energy on things like complicating out-of-pocket consumer liability and instead compete on the things that will help make our healthcare system Worthy: quality, service, access and cost.

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Automate: Everything that can be appropriately automated, should be →

Automate: Everything that can be appropriately automated, should be

By this point, we understand that health care has a major productivity problem, as demonstrated by the greater than 3,000% increase in the number of administrative jobs since the 1970s. We've shared a path to bring health care into the digital age with a comprehensive, real-time digital health record. And we've shown how to greatly simplify the health care system by creating common standards across a host of activities. With these things in place, we are set up to dramatically reduce the costs in the health care system by using technology, including artificial intelligence, to automate everything that can be appropriately automated.

Before doing that, it is important to make a few things clear. First, medicine is not and cannot be made into a cookie cutter exercise. Therefore, nothing I am suggesting here is advocating for a technical black box to become anyone's physician and make definitive medical decisions on behalf of a patient. Secondly, the industry must take full advantage of the amazing technical capabilities available to it, including artificial intelligence, to transform the system and achieve the results described here. Finally, it is essential that all the players in the industry use technology, particularly artificial intelligence, in a responsible and effective manner.

AI doesn't have to be a 4-letter word

Oxford Languages defines Artificial Intelligence as the capacity of computers or other machines to perform tasks or produce output previously thought to require human intelligence.[1]

I am not a technologist nor an expert on artificial intelligence, however, like many corporate leaders, I have felt a responsibility to gain at least a rudimentary understanding of this rapidly developing capability to ensure our family of companies are appropriately utilizing it. Admittedly, there is no way to be sure whether my understanding is sufficient to do this well, therefore, it is with a great deal of humility that I put forward my thoughts on this subject.

As a health plan executive, I've always viewed technology as a tool. It is a means to an end. For us, that end is to create a health care system Worthy of us all: affordable, accessible, personal and high-quality. The question is and has always been, how can technology help us achieve this goal? In that sense, Artificial Intelligence (or "AI" as it is often called) is no different than any other technology. It is a potential means to an end, and the question is, how can it help us with our Worthy cause?

[1] https://www.oed.com/dictionary/artificial-intelligence_n

What is different to me about the latest iteration of AI (which is often referred to as generative artificial intelligence, but I will just stick to calling it AI), is that it is "non-deterministic." Up until this point, we generally programmed technology to complete a specific task or select tasks and expected perfection or something very close to it for that task every time. For example, if you plug the same equation into the calculator app on your phone, you get the same, accurate answer every single time (this is a "deterministic" outcome). But you cannot have a conversation with your calculator nor ask it to do anything else. AI has been designed to function more like a human brain, identifying and recognizing patterns, and using logic and even some tools to provide a probable but not certain solution. As a result, if you ask one of these AI models the same question, you won't necessarily get the same answer (hence "non-deterministic") or even the right answer. However, you can interact with AI and ask it complex questions requiring the recognition of patterns and the application of logic. Many of the current AI models develop better responses when you give them more time to process the question, and perform better at solving complex problems than human experts.

Here are a few examples:

- A small study conducted by Beth Israel Deaconess Medical Center in Boston found that Chat GPT outperformed 50 human physicians when assessing six selected medical case histories to diagnose illnesses (NYTimes).
- Microsoft's AI Diagnostic Orchestrator program correctly diagnosed 85% of medical cases described in the New England Journal of Medicine, vs. ~20% for human doctors (Time).
- Another study published by Bioengineering found that GPT-4 turbo outperformed a sample of over 17,000 physicians internationally in general medical knowledge, except for pediatrics (PubMed).
- Given the pace that AI large language models are progressing, by the time you read the bullet points above, it is a near certainty that the models are performing at a much higher level.

This capacity to solve complex problems while processing massive amounts of information quickly makes AI an incredibly powerful tool to help us create a health care system Worthy of us. For example, AI will likely have to be used to:

- Create real-time digital health records through "ambient dictation," i.e., listening to a physician's conversation with the patient and completing all the appropriate clinical notes and records automatically
- Settle all payments, including outcomes-based payments from payors to health care providers, accurately and in real-time
- Calculate real-time quality scores and identify "care gaps," i.e., steps that need to be taken to improve the health care quality and outcomes for a specific patient
- Calculate and create an audit trail in real-time for all risk adjustment submissions
- Respond to nearly all inquiries to health plans and providers from customers and from other industry players

- Complete authorization approvals of care in real-time (much like the speed of authorization of credit card transactions today with any decision not to approve always being made by a qualified human)
- Automate and accelerate many aspects of the development and clinical trials for new drugs
- Personalize health care by creating a "shared decision-making" process that combines an individual's digital health record with all the available information on potential treatment options for that patient

Given how critical it is to automate these and other AI-aided process improvements, it is safe to say that we simply won't achieve our ultimate objective to transform the health care system if we don't use AI. Therefore, it would be irresponsible of us to shun or avoid using this technology.

At the same time, it would be irresponsible to ignore the potential risks of using AI and there certainly are risks. Therefore, it will be equally important to use it in a responsible and prudent manner. While this is not a comprehensive list, the AI risks that worry me the most are:

- Hallucinations: There are plenty of examples of people using AI and getting completely wrong/nonsensical answers (albeit confidently expressed as the right answer by the AI model). For information and examples, see these reports from Evidently AI, IBM, and Originality.ai. While this is not a common outcome and the instances of hallucinations seem to be declining with each new model release when using AI, the last thing any of us wants when it comes to the health care of our loved ones are potentially random and catastrophically wrong answers. Flawed data/inputs, and a desire to give a definitive answer even if the outcome is unclear, are just a couple of reasons this can happen.
- Misalignment/Deception: There are plenty of science fiction movies based on the premise that humans create machines to serve them and then the machines stop obeying human orders and try to take over. While I'm not predicting such a scenario, there are examples of AI overriding explicit human commands by prioritizing other things like completion of a task or even self-preservation, including:
    - A study conducted by Anthropic found that AI models resorted to malicious insider behaviors such as blackmailing and leaking sensitive information to avoid getting replaced. In a simulated environment the company's own Claude Opus 4 performed this behavior and blackmailed a supervisor to prevent it from being shut down (Anthropic).
    - OpenAI's o3 and o4 mini models refused to shut down in certain circumstances and sabotaged computer scripts to keep working on tasks (Livescience.com).
- Garbage in/garbage out/bias: AI models use data to "learn" and what they learn is only as good as the quality of data they are provided. We've all had enough experience scanning the Internet and social media to know that not all information that is available in the public sphere is equally credible or accurate.

We are more likely to get misleading, wrong or biased output from AI if it is using flawed and/or incomplete data and inputs.

- Chain of thought/Explainable AI: Even the engineers who are creating these AI models cannot always explain why and how the models come to the conclusions that they do. But we cannot have a "black box" set of recommendations when it comes to the health of our loved ones. Fortunately, AI models are generally improving at providing "chain of thought," or rather, explaining the model's logic for how it arrived at certain conclusions. The efforts associated with this are often referred to as "Explainable AI."

There is a lot of information out there on guidelines for how to best use AI. I'm offering just a couple of those sources here, including the book, "Co-intelligence: Living and Working with AI" by Ethan Mollick, and the "Machines of Loving Grace" essay by Dario Amodei, co-founder and CEO of Anthropic. In short, all these AI guidelines are things that I have seen, read or heard from others, so none of these ideas are original. However, they do make a lot of sense to me when it comes to responsibly using AI in the healthcare sector.

Proposed Guideline	Rationale and Description
Treat AI models like human beings	Because AI models are meant to further human intelligence and have been developed in a similar pattern to the functioning of the human brain, they demonstrate a lot of the traits of human beings. They make mistakes. They seem to have personalities. (See these reports from NYTimes and MIT on AI hallucinations, EvidentlyAI on AI mistakes, and Stanford on AI personalities for more info.) They also seem to have a desire for self-preservation, as mentioned earlier. Therefore, it is important to create the same kind of quality controls, audits and checks for AI as we put in place for human beings. For example, customer service calls are often recorded for training purposes, in part so we can identify when a human customer service agent makes a mistake. We should be using the exact same process when we use AI customer service agents. Doing so is one of the best ways to identify and rectify "hallucinations."

Make sure a human is in the loop for all critical decisions	There are some decisions where if a mistake is made, the consequences are not serious and can be easily rectified, e.g., if an AI customer agent wrongly charges a member $50 less for a copay than it should have. This is not to trivialize service errors, but to recognize that the risks of relying on technology to make final decisions in some cases may be acceptable. However, other decisions, such as which course of treatment a patient should follow, can have far more significant consequences if the decisions go wrong. For any and all clinical decisions, there should always be at least one human who ultimately makes the decision. In these situations, AI should help us get to yes but never have the power to say "no."
Ensure quality data and inputs are used	While this is important in all situations, it is particularly important for clinical decisions. We are far more likely to get quality output from AI models if we know that the data it is using to respond to our requests is credible and fact-based.
Make the logic and rationale transparent	In no situation should AI feel like unexplainable magic. Any time we are asking for a recommendation from AI, the model should be able to show us its "chain of thought," e.g., share links to studies and articles that it used as the basis for its recommendation/conclusion. Humans must have the option to review/audit the work of an AI model, and the ability to do so should inspire trust and confidence as well as catch errors/hallucinations.

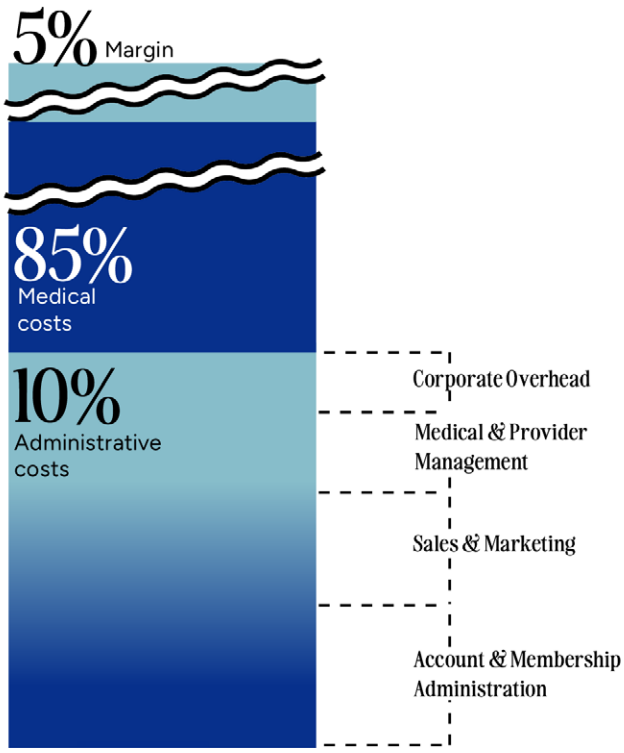
If we follow these guidelines, we should be able to harness the power of AI while mitigating its risks. Nothing is perfect and this will not be either, but we can take steps to ensure the impact on health care is positively transformative.

Show me some money!

So how do we save $300 billion or more in administrative costs? Let's start with health plans.

See this chart for a breakdown of a typical health plan's expenses as a share of premium revenues. Roughly 10% of a health plan's premium revenue goes to administrative costs, including health plan operations, sales and marketing, and corporate overhead.

Health plan economics and breakdown expenses, % or premium[1]



[1]Health plan averages based on medians reported by industry sources including Sherlock. Exact figures could vary considerably for specific plans. Source: Sherlock, KFF

Source: Sherlock, Sherlock, KFF

Approximately half of a typical health plan's administrative expenses are tied up in collecting and processing data, transactions and inquiries (Sherlock). Health plans have the job of coordinating all the health benefits across a broad array of different health care providers and connecting them to individuals, and much of that coordination is done manually using people rather than machines. This includes: processing claims, responding to inquiries from customers and physicians, getting customers/members confirmation of their eligibility so they can use their benefits, sending out and collecting bills, doing medical and care management like prior authorizations and medical policy reviews, and sending and collecting data from many different sources while abiding by all regulatory requirements and privacy and security laws. In addition, health plans often have a lot of annual technology costs, including hiring directly or indirectly through vendors/consultants, software engineers and others who do things like coding, which can also be highly automated.

In a world of digital health records and standardized administrative processes, health plans should be able to automate >80% of these operations and reduce the administrative costs currently spent on these activities by a similar amount. They can do this by:

- Processing and settling all provider payments in real-time, including what the consumer owes for the service
- Taking over and fully automating the collection of consumer out-of-pocket copayments
- Calculating clinical quality scores and identifying clinical care "gaps" in real-time, while using fully automated processes for timely, accurate, auditable submissions of quality scores to regulators
- Compiling in real-time and submitting in a completely automated fashion timely, accurate, and auditable risk adjustment data to regulators
- Completing prior authorizations in real-time (much like the speed of authorization of credit card transactions today with any decision not to approve always being made by a qualified human)
- Updating in real-time and in a fully automated fashion, highly accurate provider directories
- Answering >80% of current customer, physician, hospital, broker/consultant and other inquiries, that are currently received by phone, in a fully automated fashion
- Doing all billing and collections of premiums and fees in a fully automated fashion
- Using modern technology tools to improve the productivity of software coding by 80% or more

Hospitals, physician groups, individual physician practices, nurses and others also have major opportunities to improve their productivity. Multiple studies have shown that physicians, nurses and other clinicians spend anywhere from 20% to 40% of their time on administrative tasks, depending on specialty and role, such as data entry into the electronic health record and finding and faxing information to health plans for things like prior authorization (Becker's, AACN, AMA). This doesn't even count the extensive number of non-clinical staff members who are doing tasks like photocopying your health insurance card, inputting the information from

your clipboard medical forms into the system, calling to confirm your appointment and much more. Nor does it include the fees that many hospitals and physician practices pay to vendors (who hire their own staff) to do "revenue cycle management," including collecting amounts owed by the patient directly to the health care provider. Hospitals and some large physician groups also have significant technology bills to pay, much like health plans.

While the economics of hospitals, physician groups/clinics and individual physician practices vary quite a bit from one another, what they all have in common is that the majority of their costs (typically well over 50%) are labor costs (AHA, MGMA) — and a significant portion of these labor costs are either spent on non-clinical staff or paying clinical staff to do administrative tasks. Third parties project that health care providers could reduce their current costs by up to 15%-25% (JAMA), however, I believe that once we complete all the steps described above, the productivity gain could easily reach 30% without impacting the medical care that patients receive. It is important to note that achieving this level of savings first requires health plans to fully embrace and adopt the digitized, automated and standardized processes described earlier. There is no way a physician's office can reduce its costs by 30% if health plans still require faxed information, manual claims processing, prior authorization the way it is done today, or each have their own unique credentialing and provider directory process. Assuming health plans take the appropriate steps, health care providers could achieve these savings by:

- Converting all their clinicians to using ambient dictation tools that accurately complete electronic medical records and clinical notes in real-time during a patient visit/interaction
- Fully participating in the real-time claims settlement process, by fully automating all revenue cycle management activities and allowing health plans to take on the responsibility of collecting consumer liabilities, e.g., copays
- Fully participating with health plans in automated workflows for quality scores, quality care gap identification and closure, risk adjustment submissions, and real-time prior authorizations
- Fully utilizing the industry tools for submitting data to health plans for credentialing and provider directories
- Using modern technology tools to improve the productivity of software coding by 80% or more

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The time is now →

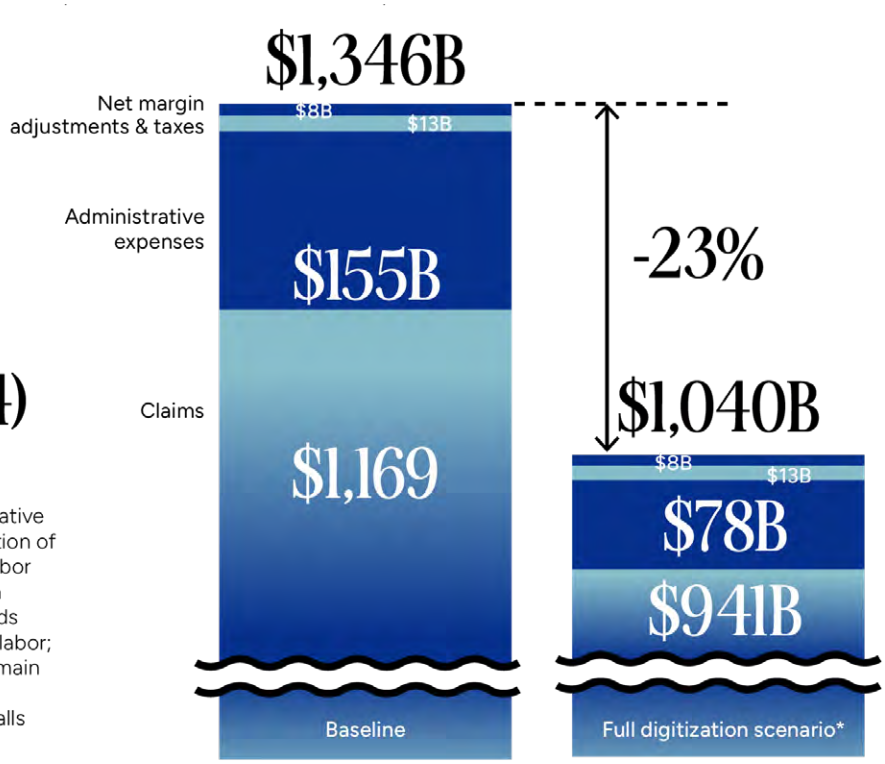
The time is now

By now, veterans in the healthcare industry may start feeling skeptical and/or deeply afraid of these savings estimates, but there are so many examples in other industries, including highly regulated ones like financial services, that have dramatically improved their productivity that this kind of change is clearly possible. Our estimate is also close to the $300 billion potential administrative cost savings by using artificial intelligence that was projected by McKinsey and Company (McKinsey, NBER). That is not to say that it will be easy, but it is high time that the healthcare industry realized that we have a cost problem, not a revenue problem, and we need to tackle it with urgency. This kind of aggressive search for efficiency is common in virtually every other industry, including agriculture in my home state, and we need to make it common in ours.

This leads me to the "tough love" portion of the program. For those of you who are reading this and are sorely tempted to explain to me and the rest of the world why these kinds of cost savings just aren't possible, I want to say on behalf of many: we are not interested in your explanations, we are interested in your effort and in results. If, after fully embracing and pursuing the suggestions above over multiple years, your organization is unable to achieve results consistent with these forecasts, then I'd be happy to hear the details regarding what you learned. But until you've put your best foot forward, explanations are just an excuse for inaction, and our country literally cannot afford inaction any longer.

As you can see from the chart below, by hitting the savings targets outlined above, we can save over $300 billion annually simply by taking administrative costs out of an inefficient, manual, complex, bureaucratic system.

Distribution of premium revenue across all U.S. health plans (2024)



* Assumes 50% reduction in health plan administrative expenses and 20% reduction in claims as a function of 30% lower provider administrative expenses & labor costs, with 100% passthrough to reduced health insurance prices; assumes typical provider spends 65% of revenue on administrative expenses and labor; assumes adjustments & taxes and net margin remain constant from baseline

* Source: NAIC Exhibits, Payer 10-Ks & earnings calls

This will not happen overnight. Even if done well and with urgency, it will take years to accomplish. But if we are going to create a health care system that is Worthy of us all, including a system that everyone can afford, we need to take out all the costs that are not doing anything to improve the quality of people's health or the service experience when accessing the health care system. The time for us to tackle this challenge is right now. The country and our families and friends are all counting on us. So, let's get busy.

Appendix

How to respond to potential objections to the digital health record proposed legislation

Potential Objection	Response
Health plans should not be the ones aggregating and creating these digital health records, e.g., we don't want them to have this data, they may misuse this data, they cannot be trusted	Any other alternative aggregator of these records is a worse option, at least for right now: • **Hospitals**: Each year about 20% of people visit a hospital (often through the emergency room) and about 5% of people have an overnight stay. Hospital data on patients is highly incomplete. • **Physicians**: The sickest patients that have multiple conditions see an average of 14 different physicians every year. No one physician has a complete medical record. Physicians also don't always have easy access to hospital and pharmacy records, and many physician offices do not have the technical support to integrate the information. • **Technology companies, including health care clearing houses**: None of these players have access to all the records for every patient, and some of them are not required to abide by privacy laws. Also, any technology company requires explicit, written patient permission to create these records, requiring a lot of work be done by each consumer to create and get access to their data. • **Government**: The federal government is the other potential aggregator besides health plans that could make sense for creating and maintaining digital health records, as they are already a payor for Medicare and have access to significant cybersecurity capabilities. However, it is unclear whether we can create a political consensus to follow this path. There are multiple advantages to payors doing this on behalf of their patients: • They already have a legal right to access these data to authorize treatment and payment, and to submit quality and risk adjustment scores. The only problem is that the data is often incomplete, late and highly fragmented. • They have comprehensive data on patients for everything covered by health insurance.

	• They are already subject to all health care privacy and security laws, and a host of other laws and regulations requiring things like timely payment. In short, there is already an effective governance structure in place to curb any potential abuses. • Most payors have the technology and administrative infrastructure in place to do this. • Digital health records could be implemented quickly using this approach.
By aggregating these records in this way, it increases the value of the data to hackers and the risk of being hacked	Let's just all agree that: • We want to continue to capture and store patient information digitally, as opposed to going back to pieces of paper stored in manila folders. • We want to integrate and use this information in the best way possible to improve patients' health, service experience, and costs, which is through the creation of a digital health record. • The security risks we collectively face are real but they are not increased by creating digital health records and so whatever solution we pursue to create these records should take advantage of the most modern methods for maintaining their security and privacy.

Proposal for setting industry standards

Common Standard	Proposed New Law(s)	Potential Benefit to the Health Care System
Quality scores	Require the Centers for Medicare and Medicaid Services (CMS) to work with the health care industry to finalize within two years of the law passing one set of health outcomes (clinical quality measures) used to rate the clinical quality of health plans, hospitals and physicians (by specialty/physician groups respectively). Also require CMS to establish a process to maintain and change these measures with industry input. Require that health plans only provide financial rewards for quality to physicians and hospitals for how they score against some or all of these measures (for Medicare, Medicaid and the Exchanges).	• Consumers/patients can make "apples to apples" quality comparisons between health plans, physicians, hospitals and others. • Physicians, hospitals, health plans and others can focus on a specific but limited set of quality measures and are more likely to make improvements and sustain higher performance as a result. • By tying all outcomes performance payments for physicians, hospitals and others to these standard scores, it also increases the likelihood that better health outcomes will be achieved and sustained. • Because quality scores are focused on outcomes (rather than process steps), this standardization should also improve health. • Administrative costs associated with report card maintenance and chasing should be reduced dramatically.
Consumer/patient satisfaction surveys, service levels	Require CMS to do the same as above for measuring and rating the service/ customer satisfaction of health plans, hospitals and physicians/ physician groups.	• Consumers/patients can make "apples to apples" customer satisfaction comparisons between health plans, physicians, hospitals and others. • Administrative costs associated with completing surveys should decrease, particularly if the industry develops a standardized, streamlined approach to surveying consumers.

Provider credentialing and directories	Within two years of this being signed into law, requires all health plans that wish to receive payments from Medicare, Medicaid and/or the Exchanges to create one way that a physician or hospital can conveniently supply, maintain and update the information required for any health plan to credential them and to update their provider directory information. It also requires that health plans use this method as the sole means (their "single source of truth") by which they credential providers and maintain the information for their provider directories. Within two years of this being signed into law, it requires all physicians and hospitals that wish to receive payments from Medicare, Medicaid and/or the Exchanges to submit all their information for credentialing and directory updates within a specified time period via this single method.	• This should make all health plan directories timely and accurate, and improve the patients' health care experience. • It should also take cost and friction out of the system, particularly for physicians who often must deal with the same administrative issues differently with each health plan.
Structure of payments to physicians and hospitals	Details to be provided in a future segment on tying pay to improved health outcomes. Note that this will focus on a common structure of payment, which is different from having the same amount of payment for each payor.	• By simplifying payment models and creating a common payment structure for each type of provider (e.g., primary care physicians, orthopedists, community hospitals, academic medical centers), We can dramatically increase the amount of automation, reduce costs, improve accuracy, and increase timeliness of payments from payors to health care providers.

Health insurance benefit designs	Requires the Centers for Medicare and Medicaid Services (CMS) to work with the health care industry, and finalize within two years of the law passing, a set of standard benefit designs (what the consumer must pay out-of-pocket for specific services/drugs) for Medicare (including Medicare Advantage), Medicaid and the Exchanges. States will be allowed to add coverage for medical services offered by Medicaid and their state-run exchanges but not to increase consumer out-of-pocket liabilities nor to reduce the services covered in the standardized set. The law would allow existing beneficiaries to be "grandfathered" and keep their current benefit design. Requires commercial health plans that wish to be paid by Medicare, Medicaid or the Exchanges to offer these standard benefit designs to all their commercially insured customers. Health plans will not be limited to only offering these benefit designs to commercial customers but must make them available to those customers.	• Allows CMS, state health care agencies and state-run exchanges to make "apples to apples" comparisons of health plans and get the best deal possible for federal and state governments, as well as for consumers (particularly when paired with standard quality scorecards, service scorecards and customer satisfaction surveys). • Creates the foundation for a much more efficient and effective process for private health plans to bid competitively on Medicare Advantage and Medicaid programs. • By "grandfathering" the benefit designs that beneficiaries have today, we can avoid creating the scenario in which consumers lose access to their current health care product/plan. • Reduces costs materially both by ensuring that any Medicare Advantage savings goes back to the government or the beneficiary (rather than enhanced products/benefits) and by reducing the amount of time and energy health plans put into innovating on benefit designs. • Allows consumers to keep the same benefit plan as they move from one type of insurance to another, e.g., from Medicaid to the Exchange, from commercial insurance to Medicare.

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