**Freedom Health Plan**

1. **Unleashing the Funds**

In order to reinvent our health care system, we have to ensure that there are funds available for the new plan. This requires us to separate healthcare from employment by stipulating that employers would no longer provide health insurance for their employees. However, there MUST be a key requirement that the employers would be required to funnel 80% of their “healthcare savings” back to their employees in the form of higher wages and salaries.

What most people do not understand about health insurance that you receive through your employer is that the employer often pays 60% - 85% of the cost of the monthly premiums (77.7% for single plans[[1]](#footnote-1), 72% for family plans[[2]](#footnote-2)). Some employers pay higher percentages, some pay lower percentages. These numbers are the national averages. Nationally, it costs an average of $530.67 per month for a single plan and $1,557.25 per month for the family plans. If you have health insurance premiums coming out of your paycheck and your deductions over the course of a month do not equal these amounts, that’s because your employer is paying the rest of that monthly premium for you.

So, if you have $500 coming out of your paychecks each month, via payroll deductions, your employer is probably paying $1000 per month towards that monthly premium, totaling $1500 per month in premiums for your family plan. Obviously, if employers no longer provide the health insurance, the company will be saving a TON of money. But, we would require that they funnel the majority of those savings back to their employees via raises in wages and salaries.

It may sound complicated, but it isn’t. Businesses file taxes and they itemize all of their expenses. The company only needs two numbers to calculate how much this raise would be.

A = Total Annual Cost of Healthcare Premiums Paid on Behalf of All

Employees Combined

B = Multiply “A” by 0.8 (which is 80%) to get the Amount of money

going back to employees

C = Total Number of Hours Worked per Year by All Employees

(regardless if they had the employer insurance or not, regardless of whether they were even eligible) (This also includes FT, PT, Temp, Seasonal, Hourly, Salary, etc.)

Formula: B/C = Amount of Raise per Hour for each Employee in

the company

This means that EVERYONE in the company gets a raise. If your manager gets a $2 per hour raise, so do you. If the employee is a salary employee, the “per hour” raise is simply multiplied by 2080 (40 hrs/week \* 52 weeks/year). In this scenario, the salary employee would get a $4,160 per year raise, or about $80 extra per week.

Based on my calculations, it appears that the average employee would get about $2 - $4 per hour raise. Even with a mere $2.50 per hour raise, this translates into an extra $400 per month or an extra $5,200 per year!

However, that is not where the benefits end. Not only would you get a raise, but you would no longer have health insurance premiums being deducted from your paychecks. So, if you currently have $500 being deducted from your paychecks during a month, that money is also back in your paycheck. Adding your $400 per month raise and the $500 you are saving on premiums, you have an extra $900 in your pocket each and every month. Of course, you don’t have health coverage either. But, hang in there. We will get to that in a moment.

Another requirement under the Freedom Health Plan is that these new wages and salaries are required to be the new baseline for the company’s wages and salaries. This protects the employee in the event that he or she is making $15 per hour, then goes up to $17 per hour after the changes, but gets fired so the company can hire someone else at your lower, former wage of $15. The new wages and salaries will be required to remain the same, or higher, for all future employees.

End Result: Average American worker will have an extra $900 per MONTH in his or her pocket!

1. **Major Medical & Health Savings Account = 2 Part Health Care**

Since people will no longer have health insurance through their employers, they need coverage from somewhere else. We can completely re-invent HealthCare.gov as an “information only” website that has all the valuable information every American would need. It would consist of at least three different sections (possibly more) – Major Medical, Health Savings Accounts, and Health Care Blue Book. Let’s go through each one of these.

1. Major Medical Plans

 The first section of HealthCare.gov would be for Major Medical plans. You would be able to go into this section of the website and compare Major Medical plans side by side, based on searchable criteria, like deductible, premium amount, coinsurance, maximum out-of-pocket, lifetime limits, and so forth.

 When you find the plan you like best and which suits your needs best, click on the link for that plan. Instead of you applying through the government (middle man), you are re-routed to that insurance company’s website and the page specific to that particular plan. Then you purchase that Major Medical plan directly from the insurance company.

 First, all of the Major Medical plans would need to be “Nationwide Plans”, which means that you can use that insurance anywhere in the United States. You will not be limited geographically to only one location. We are a much more mobile society in the 21st century, so we need Major Medical that fits with our mobility.

 Second, these Major Medical plans would cover any dependent up to age 26. This provides coverage for adult children who are in college and still building a foundation in their lives and it will act as a transition from “mom & dad’s plan” to getting onto the adult child’s own Major Medical plan.

 Third, these Major Medical plans cover all of those big health care expenses – accidents, heart attacks, emergency room visits, expensive tests, and so much more. These Major Medical plans would NOT normally cover office visits, routine labs and x-rays, most prescriptions, and other minor health care products and services. They would only cover the BIG expenses.

 Fourth, whichever plan you choose, you can stay with that plan for as long as you would like, even your entire life, if that’s what you want to do. It would be like your cell phone carrier or auto insurance company, where you can change anytime you want, but you don’t have to change. For many people, they would choose once and stay with that plan for their entire life, never again feeling the need to re-evaluate their options. Under our current system, most people have to re-evaluate their health insurance every year. This plan is truly a one-and-done choice, unless you decide to shop around for a better deal at some later date.

 According to Trusted Choice, Major Medical plans range from $30 - $300 per month, with the average premium being $176 per month.[[3]](#footnote-3) Even if you get the $300 per month type of Major Medical Plan and use part of your extra $900 to pay for it, you will still have an extra $600 each month in your pocket.

1. *Transparency*

 The health insurance companies have to report their rates to the government annually to be on HealthCare.gov portal. This provides full transparency, including who the contracted providers are for that particular plan.

1. *Basic or With Riders*

 Although this is only Major Medical coverage, without preventative or routine care benefits, the insurance companies would be permitted to offer “riders” for the Major Medical plans. These “riders” would cover additional services, but with additional costs. The riders would be completely optional for the consumer, but often pricey. Examples of riders would be: 1) 3 office visits per year for an additional $20 per month, 2) 5 mental health visits per year for an additional $30 per month, and so on. This would ease the transition from the insurance model to this new health care model for people who are nervous about this new health care system and want the security of preventive insurance.

1. *Pre-existing*

 People with pre-existing conditions cannot be turned down. People with pre-existing conditions would pay a little more, but that would be capped at 50% higher than the regular premium. So, if the regular price for a particular plan is $200 per month, the person with a pre-existing condition would pay $200 - $300 per month for that plan. This allows the burden of high risk people to be shared among all people (with pre-existing and without pre-existing), but with the high risk patient taking on a larger burden than the patients without pre-existing. This is a compassionate, but fair burden sharing.

 Pre-existing would no longer be a lifetime sentence under the Freedom Health Plan. If the patient has not needed treatment for at least 5 years, the patient’s former diagnosis is merely a part of the patient’s medical record and history, but no longer considered a pre-existing condition for coverage. The patient would no longer pay the higher premiums and would have his or her monthly premium reduced to the regular (base) level.

 The patient would have to continue with regular check-ups and exams to document that the pre-existing condition no longer exists. Two prime examples are below:

 Childhood asthma: The patient battled with asthma as a child, but as he or she grew up, he or she “outgrew” the asthma. Maybe the patient changed his or her lifestyle to reduce the effects of asthma, reducing the incidents and/or severity of the attacks. If the patient continues regular check-ups, but has not needed any treatment for at least 5 years, the condition is considered “resolved” and is no longer a pre-existing condition.

 Cancer: The patient is diagnosed with cancer and gets treatment. The cancer, thankfully, goes into remission. The patient keeps going to his or her oncologist for check-ups and tests, but the cancer remains in remission for over 5 years. The patient requests that the oncologist share the records regarding the check-ups and test results with the insurance company so the patient can get the lower (base) rates again.

1. *Lapse in Coverage*

 People who have gone 60 days or longer without a major medical plan would pay up to 50% higher for their plans for 12 months. This is to encourage people to get and maintain a major medical plan. After the 12 months of higher rates, the rate would drop back down to the regular (base) monthly premium.

1. *Incentive for HSA and Preventive Maintenance*

 Consumers who also show that they have a HSA and have at least one (1) physical per year are eligible for a 10% discount on their premiums for 12 months, renewable each year.

 This encourages consumers to maintain a Major Medical Plan, a HSA, and engage in prevention by having regular checkups.

 The discount rate is “flexible”, meaning that we could make the discount a little higher, but anything lower than 10% would be too nominal (small) to be an incentive for preventive care and investment into an HSA.

1. *Tax Deductible*

 The premium payments are tax deductible when you file taxes each year.

1. *One Caveat*

 Some people may think that they would only need the inexpensive Major Medical plan and not get an HSA, relying on going to the emergency room whenever they need care. To discourage this costly practice, there would be one caveat built into this plan. Hospitals would be allowed to deny non-emergency services IF the patient can reasonably get care from a doctor’s office and it is during normal business hours.

 There would be exceptions to this rule, such as when the condition is not critical, but it is after normal office hours (defined at Monday – Friday, 8am – 4pm) AND the condition runs the risk of becoming critical by the time normal business hours resume.

 An example would be someone who has been suffering with symptoms of the stomach flu and has not been able to eat or drink water for hours, not seeking treatment because he or she thought it would pass. Now, the patient is showing symptoms of dehydration (dizziness, lightheadedness). If it is 10am on a Tuesday (and not a holiday), the emergency room would be able to deny care and advise the patient to go to a doctor’s office. However, if it is 10pm on a Friday night, the emergency room would be required to treat the patient because this situation has a great likelihood of becoming critical before a doctor’s office will office in 2 ½ days.

1. Health Savings Accounts

 The second section of HealthCare.gov would be for the Health Savings Accounts (HSAs). These are basically a bank (savings) account that you manage. In this section of the HealthCare.gov website, you compare HSAs side-by-side, based on the criteria that are important to you (interest rates, services covered under that HSA account, minimum amount to sign up, minimum balance needed to maintain account, penalties, fees, etc.).

 Again, when you find the HSA you want and click on it, you get re-routed to that financial institution’s website and the page specific to that HSA. You set up your HSA with that financial institution, not through the government. They will send you a card that looks like a credit card, but it will have “HSA” on it.

 You can contribute as little or as much as you want and as frequently or seldom as you want. You can even use part of your income tax return to fund it for the year or part of the year.

You get to choose how you want to fund your HSA. Families that need more office visits, labs, x-rays, prescriptions, and other minor health care products and services would need to put more money into their HSA to ensure that there is enough to cover those expenses. If you have a fairly healthy family that doesn’t go to the doctor much, doesn’t require many prescriptions, you may not want to put as much into your HSA. It’s highly personalized.

 The great thing about the HSAs is that you get to use it for a much broader assortment of health care products and services. Just some of the products and services that you can use your HSA for include (but are not limited to):

Office visits Labs X-rays

Prescriptions Band-Aids Ointments

Gauze Gym Memberships Essential Oils

Chiropractor Care Acupressure Acupuncture

Therapeutic Massage Homeopathic Physicians

Premiums for Major Medical Plan OTC Medication (Tylenol, Advil, etc.)

Vitamins, minerals, and supplements Copays for MM Plan

Deductible for MM Plan

 The bottom line is that it is your money and you have the exclusive right to determine what medical products and services you want to spend it on. Your care no longer will be dictated by some insurance company.

 To use your HSA, you swipe your HSA card and the “medical” products and/or services are deducted from your HSA and paid to the provider. If you are at the grocery store and buy Tylenol and groceries, you swipe the HSA card first and it deducts the cost of the Tylenol, leaving the grocery balance, which you pay for like you do now.

 You get to manage your HSA just like you manage your other expenses in life – food, utilities, and housing, to name a few. Of course you need a nifty tool to help you make those health care decisions such as who is the best provider for YOU. We will get to that in a moment. But first, the details of the HSA account:

1. *Interest*

 The HSA would be an interest-baring account. This money can grow for you.

1. *Rolled Over*

 The HSA can be rolled over from year to year, allowing the consumer to accumulate a large sum over time. This would allow young adults to contribute monthly for decades, and if used sparingly, it would result in plenty of money to cover out-of-pocket health related expenses in the later years of his or her life, when much more medical care will be needed.

1. *Merged / Divided*

 The HSA can be merged (such as when two people marry) and divided (such as in the event of a divorce, where the HSA would be divided based on the divorce agreement or judgment by a divorce judge).

1. *Willable*

 The HSA can be willed to beneficiaries. This way, the money is never “lost”, but can continue to be used by whomever the consumer chooses, even after death. The amount being willed can all be transferred to the beneficiary’s HSA account, or it can be split between the beneficiary’s HSA and a cash payment. However, at least 50% of the willed amount must be transferred to the beneficiary’s HSA, with 50% or less being available in cash payment.

 An example would be if John Doe dies with $80,000 in his HSA, leaving it to his 2 children. Each child gets $40,000, of which at least $20,000 must go into the child’s HSA account. However, the child would be able to take any amount up to $20,000 in cash payment, with the rest going into the child’s HSA. Child #1 may want $10,000 in cash and put $30,000 in his HSA, while his sister (child #2) may want $20,000 in cash and put $20,000 in her HSA.

Minor Beneficiary: If a beneficiary is still a minor, 100% of the amount the beneficiary has been willed needs to be transferred into the minor’s HSA account to ensure that the minor has funds for medical purposes.

1. *Adjustments*

 The consumer can adjust his or her contributions at any time, giving themselves the ultimate in flexibility.

1. *Pauses in Contributions*

 The consumer can even stop making contributions without affecting the HSA account. The money is still there and available, can be used for products and services, and will never be lost or restricted, unless there is a lack of funds.

1. *Tax Deductible*

 The contributions to the HSA are tax-deductible.

1. **Medicaid: From Service Provider to Funds Provider**

Medicaid would go from providing health care services to providing the money for health care products and services. Medicaid recipients would receive a monthly “award” amount based on income and family size, but the family would manage those funds just like everyone else. The Medicaid recipient would have a Major Medical plan that he or she chooses, and have a HSA that he or she chooses.

Medicaid would pay the premium amount for the recipient’s Major Medical plan and put the remaining balance into the recipient’s HSA. As an example, if the Medicaid recipient is “awarded” $580 per month, and the recipient has a Major Medical plan with a $300 per month premium, Medicaid would pay that $300 premium directly to the insurance company and deposit the remaining $280 into the recipient’s HSA account.

Consumer Control: The Medicaid recipient would manage his or her own HSA just like everyone else. There would not be a special Major Medical plan, or HSA, for Medicaid recipients. Medicaid recipients would have the same options to choose from as everyone else. The only difference is that the government is making the payments and/or deposits.

Seamless & Non-Discrimination: This makes it possible to keep the same Major Medical plan and HSA account throughout your entire life. You can change jobs, go on Medicaid, go off of Medicaid, continue to change jobs, and have the same Major Medical plan and HSA account. This provides seamless coverage throughout life. Because there are no special plans or ID cards for the Medicaid recipients, providers would not be able to tell if you funded your HSA yourself or if Medicaid funded your HSA. This eliminates discrimination based on economic status.

Breaking Point: There is one caveat that would also need to be in place, which is a “breaking point” for Medicaid’s contribution to a recipient’s HSA. If the recipient has at least $5,000 in his or her HSA, that month’s contribution is forfeited. For example, if the recipient usually gets $200 per month deposited into his HSA each month, but has $5,010 in his HSA on June 6th (his disbursement date), Medicaid will not make the June deposit into the HSA (but they would still pay the premium on the Major Medical Plan). But, if he goes to the doctor or gets a prescription during the month of June and by July 6th, his HSA is at $4,900, Medicaid will make his $200 July deposit into his HSA, but he would not get the “back pay” from June because that was forfeited.

The point of that is to ensure people have plenty in their HSA, but without the government (taxpayers) helping people who do not need the help. For most people, having at least $5,000 in your HSA is enough to handle most medical needs.

We can provide a minimum of $500 per Medicaid household, with the average Medicaid household receiving $750 per month (between Major Medical premiums and HSA deposits). This puts Medicaid recipients right on par with other working individuals who are self-funding their Major Medical and HSAs. But, the real beauty of this is that we can provide this at half the cost of Medicaid.

In 2017 (most recent data), we spent $581.9 BILLION on Medicaid.[[4]](#footnote-4) In September 2018, there were 73,420,626 people enrolled in Medicaid.[[5]](#footnote-5) This is a cost of $7,925.56 per Medicaid recipient ($660.46 per month per person). With the average American household of 2 – 3 people, that would be an average monthly Medicaid household cost of $1,320 – $1,981 (avg. $1651). This is about twice the monthly household amount under this proposed plan.

In essence, we would be providing much better health care to our Medicaid recipients, but at half the cost, saving taxpayers approximately $290.95 BILLION per year! Doesn’t better care for half the price sound good for everyone?

There would be some additions to the requirements for Medicaid though.

1. Drug Testing

As long as the recipient is on Medicaid, the recipient would be subjected to spontaneous drug testing. If the recipient tests positive, he or she would be directed to treatment programs (paid for by Medicaid) in order to continue receiving benefits. The goal is to help out those who are going through rough times, not to finance an addiction. Yet, we will provide the assistance needed to help the person recover from addiction. This is not meant to be a punishment, but to act as an aid to achieving better health.

1. Job Seeking & Volunteerism

All adults (non-disabled, non-pregnant, and capable of working), must prove attempts to find employment, and commit to volunteer a minimum of 10 hours per week. The volunteer jobs can be coordinated through the recipient’s case worker.

This keeps the Medicaid recipient engaged in society and helps them to maintain a work ethic. It also combats depression that can set in after prolonged unemployment.

1. Time Limits

We would also have the option to set time limits for receiving Medicaid to discourage people from becoming reliant on Medicaid. The goal is for able-bodied adults to work and contribute to society as a whole. Medicaid is a tool for helping people through life’s rough patches.

1. **Special Circumstance Patients**

Although this plan would provide great coverage for the normal family, there are some people that have much higher monthly health care costs and the typical HSA amounts would not be enough to cover their health care costs. I refer to these patients as “special circumstance patients”. People who have high monthly health care expenses would apply for “Special Circumstance Medicaid” to assist them with their higher costs, even if they would not qualify for regular Medicaid.

If your monthly medical costs are high, you apply for this specialized “Medicaid.” Even if you do not qualify for regular Medicaid, you may qualify for this Special Circumstance Medicaid because it is based on your needed medical costs minus (-) your reasonable contribution to your HSA. If your costs are $1000 per month, but you can only afford to put $300 into your HSA each month, you would get a “special circumstance” Medicaid award of $700 - $800 deposited into your HSA each month that you qualify. You would still provide your typical $300 deposit into your HSA.

This is a supplemental plan, specially tailored to those with higher health care needs. This either supplements your personally funded HSA or it may supplement your regular Medicaid. Either way, you WILL be taken care of one way or another.

But, how will we be able to pay for these extra payments? Since we are saving over $290.95 Billion per year on regular Medicaid, we can use some (maybe $30 Billion - $50 Billion) of that to fund this specialized, supplemental Medicaid. Yet, we will still save a LOT on Medicaid.

1. **Medicare**

Medicare has four parts for it. Part A is the hospitalization/major medical part, for when you go into the hospital or need expensive treatments. Part B is for most other medical care (office visits, labs, x-rays, etc.). Part C is just a combo plan that includes Part A and Part B. Part D is the prescription plan, for all of your prescriptions. Since Part C is a bundle of Parts A & B, we don’t have to specifically address it. We will stick to Parts A, B, and D.

Medicare costs for Part B for 2017 was $309 Billion.[[6]](#footnote-6) Medicare costs for Part D for 2017 was $100 Billion.6 In 2017, Medicare Parts B and D combined cost taxpayers $409 Billion.

Medicare serves a vital need in the community by providing health care for our elderly. We can save money without touching Medicare. Medicare stays exactly the same as it is now, but with one simple caveat. You cannot sign up for Medicare Part B or Medicare Part D if you have at least $5,000 in an HSA account. However, you can sign up for Medicare Part A, regardless of how much you have in an HSA.

However, once your HSA account dips below $5,000, you sign up for Medicare Parts B & D. Notice that you “sign up”, not “apply”. You do not need it “apply”, as long as you are Medicare eligible under the age qualifications, you are already eligible. It’s just a matter of the amount in your HSA account.

This is not a limit on Medicare recipients. No benefit is being taken away. For example, if you have $10,000 in your HSA, you use that to pay for your office visits, labs, x-rays, and prescriptions. But, before that HSA is fully depleted, you are already on Medicare Parts B & D. You are simply using your HSA first, saving taxpayers billions of dollars each year.

How will this affect Medicare in the future? In the beginning, not much will be affected. But, as time marches on and the years pass, fewer and fewer people will need Medicare Parts B & D, for longer periods of time in their twilight years.

Example 1: John and Sue are 60 years old. They will be Medicare eligible in 5 years. That’s not a lot of time to build an HSA account. They may have $3,000 in their HSA by age 65. At age 65, they sign up for Medicare Parts A, B, & D because they do not have more than $5,000 in their HSA. They are basically unaffected by the one and only change to Medicare by this bill, just as the current recipients are unaffected.

Example 2: Jim and Mary are 45. They have 20 years before they become Medicare eligible. They are able to put $400 per month in their HSA, totaling $4,800 per year. They use an average of $1,500 per year for their medical expenses. They are saving $3,300 per year in their HSA. Since they have 20 years until they are Medicare eligible, they will have saved $66,000 (principal only, interest would make this significantly higher) in their HSA by the time they are Medicare eligible. If Jim and Mary are in good health, eat right, and exercise, that $66K could last 5 – 10 years before it gets down to only $5,000 left. Jim and Mary just saved taxpayers over $60,000 over the past 5 – 10 years. That may not seem like a lot, but when you multiply it by millions of people, it begins to add up to significant savings for the taxpayer.

Example 3: Mike and Kate are 25 year old newlyweds. They are just starting out in life after college. They contribute about $300 to their HSA each month in anticipation of well-baby and well child visits in the future. They are contributing $3,600 per year and use an average of $1,500 per year over the next 40 years (less during childless years and during empty nest years, more during childrearing years). That’s a savings of $2,100 per year for 40 years, or $84,000 (principal only, interest would make this significantly higher) in their HSA at the age of retirement. Mike and Kate will save the taxpayers from more than half of their post-retirement medical expenses!

Now, this could be even higher if Mike and Kate increase their HSA contributions, have lower costs over the years, inherit any HSA money from their parents, and of course, there is the interest that will accrue over this time period, which has not been factored in.

All future amounts are calculated in today’s dollars, because even as costs may go up due to inflation, incomes typically also go up, making it possible to contribute even more per month. All amounts would be expected to increase in similar fashion.

Reducing Medicare Premiums:

Medicare recipients pay monthly premiums for their Medicare Parts B, C, and D out of their monthly Social Security checks. These recipients have already paid into Medicare for decades, and now that they are seniors they have to pay again in order to have Medicare. This is an assault on our elderly.

The 2019 premiums for Medicare Part B range from $135.50 – $460.50 per month.[[7]](#footnote-7) The average estimated monthly premium for Medicare Part D for 2019 is $33.19.[[8]](#footnote-8) This is a combined monthly premium of $168.69 - $493.69 per month. The average Social Security monthly benefit for a retired worker is $1414.37.[[9]](#footnote-9)

This reduces our seniors’ meager $1,414.37 income to around $1,245.68 per month. This is an annual $14,948.16, which is approximately 11.6% below the federal poverty level for a household of 2 people.[[10]](#footnote-10)

This Freedom Health Plan will make Medicare more solvent as time goes on, ensuring that we take care of our seniors even better in the future than what we are currently. Many of our seniors are living in poverty already. Charging them for Medicare (which they have already spent decades paying for) is kicking them when they are down. Our seniors deserve to be treated better, with more honor and dignity.

1. **Managing Your Health Care**

 As we leap into the 21st Century with advanced technology, we can now bring that advanced technology into the field of healthcare, to give the 21st Century Family the resources to make healthcare easier, and more affordable.

 The first tool, Health Care Blue Book, provides you with the information needed to find the absolute best provider for YOU, but at the most reasonable cost. The second tool, Telemedicine, incorporates a wide variety to technologies to make access to health care providers easier and make that access more mobile, for the busy family on the go.

 Both of these modern tools allow for the cost of health care to decrease, while improving access to providers. Providers are better able to manage their time, so they can treat more people in less time. Everyone wins.

1. Health Care Blue Book

The third section of HealthCare.gov would be “Health Care Blue Book”. This is where you can compare providers of health care services. You go to this section of “HealthCare.gov” and put in the criteria that matter to you and your family, such as zip code, distance you are willing to travel outside your zip code for health care, and a type of service. This pulls up a list of all the providers in that geographical area and lists them by the prices that they charge for that particular service.

Above the list of providers, there is a bar that shows the lowest amount and highest amount charged for that service in that geographical area. It also lists a “fair market value” for that service. The providers in the provider list would be color coded. It would look a little like this:



 The providers in the green section charge “at or below Fair Price”. The providers in the yellow charge “slightly above Fair Price”. And the providers in the red charge “Highest Price”. As you can see from the example above, the range is $39 - $101+, with the Fair Price at $58.

 Price is not the only way to choose a provider. There are many other criteria that each of us has for choosing a provider. The consumer can click on any of the providers listed below the Price Bar and a “pop-up window” comes up with additional information about that specific doctor. Some of the additional information would include, but not limited to:

Provider’s name Office address Office phone number

Office fax number Accepting new patients Languages spoke

Year he/she became licensed Year he/she finished residency

Where he/she went to school Ratings & Reviews from other patients

 This makes it possible for every American to find the best provider that fits that American’s specific criteria, but also at the lowest cost. All of us want the best at the lowest cost. This would make it possible to do that with health care.

 You no longer have a limited list of “contracted providers” to choose from. You can choose ANY provider in your geographical area. This tool makes it possible for you to find the perfect provider for you, but at the lowest cost.

 The providers that charge the most would not have as many patients, encouraging those “expensive” providers to either, 1) justify their excessive rates, 2) lower their rates, or 3) go out of business. Regardless of what they do, this lowers the cost of healthcare products and services to a market-sustainable level that makes providers and patients happy.

1. Telehealth Service

An emerging and growing segment of the health care industry is telehealth services. Telemedicine and Telehealth services is defined as “the use of electronic information and telecommunications technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration. Technologies include videoconferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.”[[11]](#footnote-11)

It includes Live Videoconferencing (2-way audiovisual link between the patient and provider). This is a much more cost effective way to manage health care costs. The savings could be as much as $100 each time you use telehealth services instead of an office visit with your doctor.

“Looking at the commercial market, this study found that the average estimated cost of a telehealth visit is $40 to $50 per visit compared to the average estimated cost of $136 to $176 for in-person acute care.”[[12]](#footnote-12)

“Patient issues are able to be resolved during the initial telehealth visit an average of 83 percent of the time.”12

This is just another form of savings for the American family trying to save on the cost of healthcare.

1. **CONCLUSIONS**

By overhauling the entire system, we are able to drive down costs to a market-sustainable level, provide savings for businesses, employees, the government, and even the providers. The headaches of choosing a health plan every year are gone, as are the majority of paperwork in the providers’ offices. Most providers get paid at the time services are rendered. We cut out the middle man which only served to drive up costs. We are providing the same level of care for our poor as we do for our workers. We are saving taxpayers hundreds of billions of dollars each year. We are taking care of the high risk people and the people with high health care needs. Pre-existing conditions are no longer a life sentence. We make health care more accessible for the busy, modern family. We eliminate discrimination based on Medicaid status. We protect and insulate our seniors from high premiums and are beginning to treat them with the dignity and respect they deserve. We overhaul healthcare to make sense in the 21st century. Common sense, user-friendly, seamless, low cost, compassionate, modernized, and wholesale healthcare for everyone! That’s the Freedom Health Plan!

1. The Henry J. Kaiser Family Foundation, Average Annual Single Premium per Enrolled Employee for Employed-Based Health Insurance: 2017, <https://www.kff.org/other/state-indicator/single-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed October 7, 2018. [↑](#footnote-ref-1)
2. The Henry J. Kaiser Family Foundation, Average Annual Family Premium per Enrolled Employee for Employed-Based Health Insurance: 2017, <https://www.kff.org/other/state-indicator/family-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>, accessed October 7, 2018. [↑](#footnote-ref-2)
3. Trusted Choice, <https://www.trustedchoice.com/health-insurance/coverage-types/catastrophic-major-medical/>, accessed October 8, 2018. [↑](#footnote-ref-3)
4. Centers for Medicare & Medicaid Services, “NHE Fact Sheet: Historical NHE, 2017”, <https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html>, accessed January 28, 2019. [↑](#footnote-ref-4)
5. Medicaid.gov, Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data, September 2018, <https://data.medicaid.gov/Enrollment/2018-09-Updated-applications-eligibility-determina/hbh7-cy5y/data>, accessed January 28, 2019. [↑](#footnote-ref-5)
6. Henry J. Kaiser Family Foundation, *Medicare*, Cubanski, Juliette and Neuman, Tricia, “The Fact on Medicare Spending and Financing”, Figure 2 (“Medicare Benefit Payments for Part A, B, and D, 2007 and 2017”), <https://www.kff.org/medicare/issue-brief/the-facts-on-medicare-spending-and-financing/>, published June 22, 2018, accessed October 25, 2018. [↑](#footnote-ref-6)
7. Medicare.gov, Part B Costs: How Much Does Part B Cost?, <https://www.medicare.gov/your-medicare-costs/part-b-costs>, accessed January 28, 2019. [↑](#footnote-ref-7)
8. Medicare Matters, National Council on Aging, How Much Does Medicare Part D Cost?, <https://www.mymedicarematters.org/costs/part-d/>, accessed January 28, 2019. [↑](#footnote-ref-8)
9. Social Security Administration, Research, Statistics & Policy Analysis, “Monthly Statistical Snapshot, December 2018”, Table 2: “Social Security benefits, December 2018”, citing: Social Security Administration, Master Beneficiary Record, <https://www.ssa.gov/policy/docs/quickfacts/stat_snapshot/>, accessed October 25, 2018. [↑](#footnote-ref-9)
10. U.S. Department of Health & Human Services, “HHS Poverty Guidelines for 2019”, in effect as of January 11, 2019, <https://aspe.hhs.gov/poverty-guidelines>, accessed January 28, 2019. [↑](#footnote-ref-10)
11. The Office of the National Coordinator for Health Information Technology (ONC), “Telemedicine and Telehealth”, <https://www.healthit.gov/topic/health-it-initiatives/telemedicine-and-telehealth>, accessed October 25, 2018. [↑](#footnote-ref-11)
12. Yamamoto, Dale H., “Assessment of the Feasibility and Cost of Replacing In-Person Care with Acute Care Telehealth Services”, December 2014, accessed October 25, 2018. [↑](#footnote-ref-12)