

# Patient's Right to Save

## The Next Generation of Price Transparency

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# Introduction

Price transparency exists in all functioning markets. Whether buying a pound of bananas, a plane ticket, or a personal training session, consumers make decisions based on the price and expected benefits of goods and services. And American consumers regularly compare prices between grocers, airlines, and trainers to find the best combination of price, quality, and availability to meet their needs. The American healthcare market, however, has historically failed to disclose prices before a patient's treatment, making it nearly impossible for patients to shop for care. To remedy this, policymakers and thinkers have long advocated for "price transparency" in healthcare.

Many proponents claim that transparency will spur patients to engage with the market and make better healthcare spending decisions. Advocates for consumer-directed healthcare point to greater patient financial responsibility, coupled with price transparency, as a way to make healthcare function more like other markets.

Healthcare price transparency has matured from its earliest stages, but the healthcare marketplace needs additional reforms to help price transparency fulfill its promise. Transparency is a step in the process, not the goal itself. While transparency alone can offer benefits, a fully functioning market needs price transparency and patients motivated to find high-quality, low-cost providers to serve as a catalyst for better healthcare decision-making by patients, providers, and payers, alike.

A true healthcare market that incentivizes patients to be healthcare consumers will organically lower healthcare prices. The Patient's Right to Save Act does not take away options from patients or cancel their current health plans. Instead, it gives patients and their doctors more care options by creating a functioning market. It gives patients more certainty on prices ahead of time and frees patients to seek treatment from more affordable providers without facing insurer network discrimination against less expensive care. It does not blow up the status quo, or involve a government takeover of healthcare, instead, it aligns incentives to naturally change the health system to be more transparent, accountable, and competitive.

The Patient's Right to Save Act accomplishes this all by building off existing federal cash-rate disclosure rules and successful public and private programs that reward patients when they seek out more affordable health services.

This article begins with a survey of the problems behind unsustainable healthcare price growth; identifies challenges that prevent a functioning marketplace in healthcare; proceeds to outline a market-based reform to encourage patients at all levels of spending to utilize healthcare price transparency tools; and finally predicts possible benefits of this approach vis-a-vis alternate policy approaches to cost containment.

The Patient's Right to Save Act is price transparency 3.0.

## PATIENT'S RIGHT TO SAVE:

# 3 Steps to Ensure a Market in Healthcare

### STEP 1:

Cash Disclosure

### STEP 2:

Lower Cash Prices Count  
Toward Deductible

### STEP 3:

Post Deductible:  
Lower Cash Prices Trigger Savings Incentives  
for Patient, Insurer, & Third-Party

# Problem: Rapid Healthcare Price Growth, with No End in Sight

Healthcare prices are at record levels and continue to grow. Merely having health insurance doesn't guarantee protection against overwhelming medical bills. Despite 91% of Americans having health insurance, almost half of insured adults report difficulty paying out-of-pocket costs, while one in three patients report not being able to cover their deductible.<sup>1</sup>

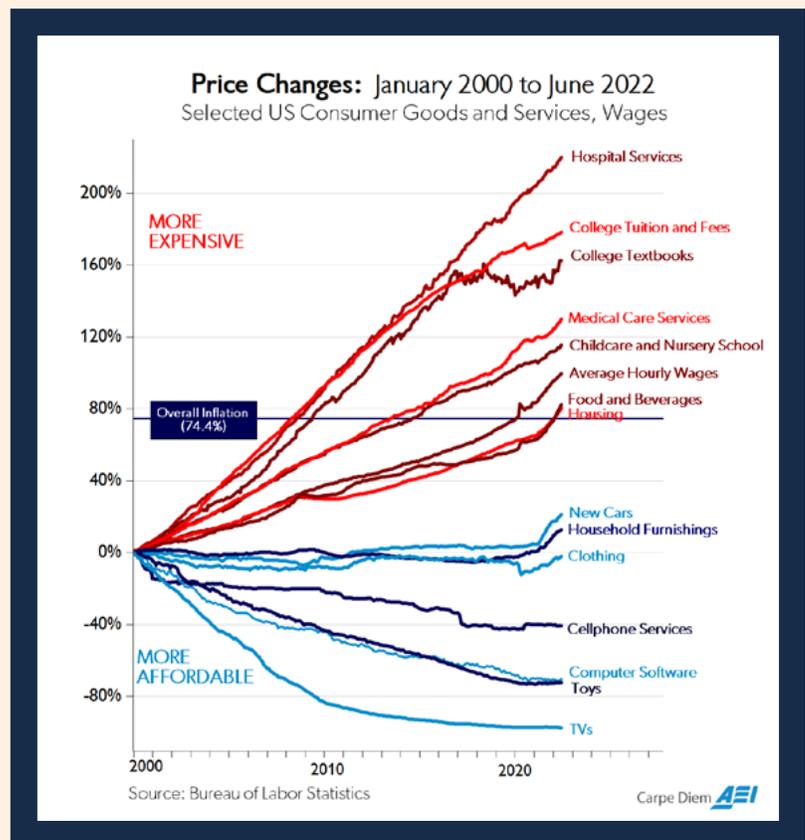
In 2020 both private and public insurers spent \$4.1 trillion on healthcare. Healthcare expenses have spiraled out of control and even families making over \$120,000 have started to put off care because of cost.<sup>2</sup>

Current laws and systems have allowed health spending to outpace general inflation for decades. The price of hospital services has increased by over 200% within the last 20 years. Medical services surpassing 120%. Meanwhile, the price of TVs, cell phone services, and clothing have all decreased. Absent dramatic change, healthcare will be a significant drag on America's economic future. Hospitals and other large providers will continue to consolidate, increasing their regional market power. They will employ a larger percentage of health professionals and create higher barriers for independent providers to compete, which will increase the prices that patients and insurers must pay.

Employee salaries will remain stagnant, and employers will struggle to hire new staff or reinvest in their business. As rates go up, more middle-class Americans and small employers will drop coverage and may go uninsured.

The status quo promises further healthcare price inflation which would only exacerbate patients avoiding care. If left unchallenged America's physical and economic health will suffer.

To lower prices and contain health spending, some propose a single-payer system or price controls. While well-intentioned, research has shown such policies will add trillions of dollars to the federal debt, reduce disposable income for vulnerable families, stifle market innovation, do little to control total healthcare costs, and still fail to improve overall healthcare quality or outcomes.<sup>3</sup>



1 Audrey Kearney, "Americans' Challenges with Health Care Costs," KFF, July 14, 2022, <https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs/>; Katherine Keisler-Starkey, "Health Insurance Coverage in the United States: 2020," Census.gov, June 9, 2022, <https://www.census.gov/library/publications/2021/demo/p60-274.html>.  
2 Gallup Inc., "2021 Healthcare in America Report," Gallup, April 7, 2022, <https://www.gallup.com/analytics/357932/healthcare-in-america-2021.aspx>.  
3 Tom Church, Daniel L Heil, and Lanhee J Chen, "The Fiscal Effects of the Public Option," Hoover Institute, January 27, 2020, <https://www.hoover.org/research/fiscal-effects-public-option-o>.



## **Cause: Healthcare Marketplace Lacks Features of Functioning Market**

### **Patients Lack Real Choice and are Not the Real Customer**

In the automotive market, drivers may shop from a plethora of manufacturers (e.g., Chevrolet, Dodge, Ford, Hyundai, Jeep, Toyota, etc.) all competing to provide a wide array of vehicles. Buyers can go to any seller in the country, and even have the ability to pick a car that helps them obtain a better auto insurance premium.

### **Patient's Choice is Limited**

By contrast for those with health insurance, patients have little choice over their care options and are herded towards a preselected set of health providers in their general area. Plan designs incentivize patients to seek care from only “network” health providers, even if the network provider’s price or quality is not the best option around.

These health insurance networks are often hyper local, may have narrowed provider choice, and yet frequently contain higher cost options that do not deliver better outcomes. If the automotive market mirrored the current healthcare insurance system, auto insurers might only agree to insure particular makes and models purchased from preferred dealerships, even if customers preferred a less expensive brand or a different body style.

Additionally, small employers that provide insurance coverage generally offer limited plan choices. In many cases, all employees will be offered the same insurance plan even if the health needs of a 27-year-old single worker are vastly different from a 50-year-old with a family. Returning to the car analogy, the Prius might not fit all the 50-year-old’s family, but they have no other option to pick from.



## Patients Lack Information

Markets that work have a ready supply of information available to consumers. Consider the ultra-competitive grocery market. In the grocery marketplace, stores compete for business on multiple metrics including product cost, product quality, selection of goods, customer convenience, and customer experience. Grocery stores advertise regularly to attract customers, constantly evaluating the mix of products to ensure they align with current market demand, reward customer loyalty, and vary prices to move inventory.

Before walking into a grocery store, customers can check the price for every item they intend to buy on an app or use the shelf price tag to quickly compare prices between alternative products in the same store or the same product at other grocery stores in their area.<sup>4</sup> Many grocery stores even publicly compare the price of a “basket” of groceries from their store with the same basket at a competitor’s store. Most customers spend their own money for the full cost of every item they purchase and can save even more money by changing the mix of products they buy or the store they buy from. Additionally, consumers can find discounts provided by the store and third parties (newspaper ads, rebates, coupons, etc.).

On the other hand, in healthcare, patients typically lack even the most basic information about prices or quality. Health systems rarely compete under typical market pressures, insurers create networks that limit customer choices, and the most expensive procedures often cost the patient the same amount of money regardless of how much the insurance company pays. Unlike buying groceries, when patients have an expensive year of healthcare, a third-party insurer provides a backstop shielding the patients from the full price of care. The unusual nature of the American healthcare marketplace stems from patients facing multiple barriers that keep them distant from decision making.

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4 PYMNTS, “Grocers Can Tap into Price Comparison Apps,” PYMNTS.com, April 17, 2018, <https://www.pymnts.com/news/retail/2018/basket-online-grocery-shopping/>.

## Conventional Health Plans Keep Patients Disconnected at Every Level

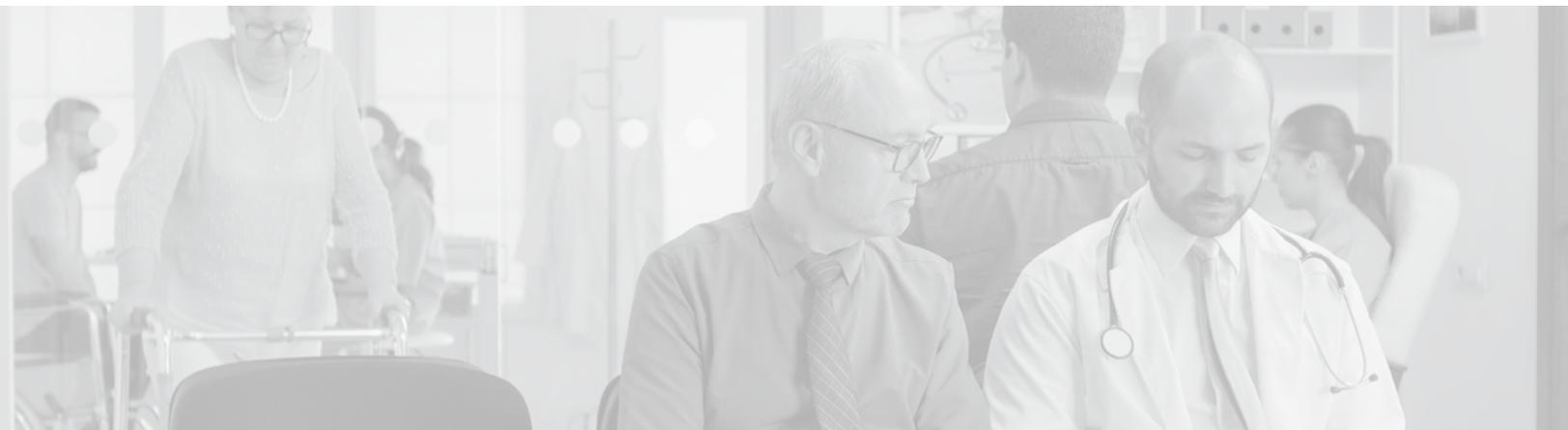
Most Americans receive heavily subsidized health insurance coverage either through their employer or the government, which masks the true cost of the coverage. In addition, the Affordable Care Act (ACA) requires insurers to pay the full price of many preventive and primary care treatments, meaning the bulk of care a patient receives in a given year requires little out-of-pocket contribution and no knowledge of the underlying price.

Selection of a health insurance plan is often outsourced to the employer's human resources department which may have a completely different set of interests that don't reflect the needs of an employee's particular health needs. An employer's decision for group health insurance is usually based on striking a balance between offering comprehensive health plans to attract and retain talent, affordability for the company, and getting a desirable tax write-off.

These pressures often encourage employers to prioritize one goal over another and can hurt a patient in the long run. For example, if an employer focuses on offering a comprehensive health plan, they tend to purchase group plans with broader networks that can have very high-cost providers, which in turn increases premiums and employee out-of-pocket costs over time.<sup>5</sup>

By contrast, if employers instead focus on controlling costs when picking a health plan, they will often buy into a plan with narrower networks where employees may not be able to get coverage to see the specific provider they want to see.<sup>6</sup> Regardless of employers' priorities, the current workplace sponsored healthcare coverage model discourages patients from shopping around, doesn't exert market pressure on health systems, and often rewards health plans that are not incentivized to lower-costs.

Insurance companies may tout the "consumer" nature of their plans, but the plans themselves are not designed to encourage normal consumer behavior as we would expect outside of the healthcare industry. For example, a patient may pay the same copay for an MRI at two different locations with one priced at \$200, and another priced at \$900. If a patient pays the same \$100 copay at both locations, the patient has no incentive to save their insurer money by choosing the less costly MRI, and many will pick the \$900 option not realizing that it will lead to higher premiums the next year.<sup>7</sup>



- 5 Leemore S. Dafny et al., "Narrow Networks on the Health Insurance Marketplaces: Prevalence, Pricing, and the Cost of Network Breadth: Health Affairs Journal," Health Affairs, September 1, 2017, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1669>; "Report of the Merged Market Advisory Council - Massachusetts," accessed August 16, 2022, <https://www.mass.gov/doc/final-report-of-the-merged-market-advisory-council/download>.
- 6 Erica Hutchins Coe, Jessica Lamb, and Suzanne Rivera, "Hospital Networks: Perspective from Four Years of the Individual Market Exchanges," McKinsey & Company, July 1, 2021, <https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/hospital-networks-perspective-from-four-years-of-the-individual-market-exchanges#>.
- 7 Additional evidence of patients not picking lower cost options can be found in: Michael Chernenow et al., "Are Health Care Services Shoppable? Evidence from the Consumption of Lower-Limb MRI Scans," National Bureau of Economic Research, July 2018, [https://www.nber.org/system/files/working\\_papers/w24869/revisions/w24869.rev0.pdf](https://www.nber.org/system/files/working_papers/w24869/revisions/w24869.rev0.pdf).



Even worse, when a patient reaches their deductible and/or out-of-pocket maximum, many plan designs remove or weaken any reason to consider shopping around for care. The RAND Health Insurance experiment, started in the 1970s, found that care utilization and annual spending by patients increases as a patient's out-of-pocket responsibility goes down.<sup>8</sup> From a patient perspective, in the short run, it might feel good to have bills "covered" by insurance, but it can lead to wasteful utilization and higher costs in the future.<sup>9</sup>

Conventional health coverage reserves price negotiations to insurers, who are balancing the interests of many parties, and do not always prioritize the most affordable prices. That may be why rising prices are the primary driver for increasing premiums.<sup>10</sup>

Further complicating the process is that insurers are only incentivized to negotiate down rates so far. Under current law, insurers may only retain fifteen to twenty percent of revenue for overhead and profit. If total spending goes down, the total amount of profits and overhead must, likewise, fall. But as total spending increases, insurers get to keep a larger amount of money under this Medical Loss Ratio (MLR).<sup>11</sup> Put another way, the insurers' incentives are not fully aligned with the patient's interests.<sup>12</sup>

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8 Robert H. Brook et al., "The Rand Health Insurance Experiment: What You Need to Know," RAND Corporation, December 6, 2006, [https://www.rand.org/pubs/research\\_briefs/RB9174.html](https://www.rand.org/pubs/research_briefs/RB9174.html).

9 B. Segal, Jodi, "Factors Associated with Overuse of Health Care within US Health Systems." JAMA Health Forum. JAMA Network, January 14, 2022. <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2788097>.

10 Sara Collins, David Radley, and Jesse Baumgartner, "State Trends in Employer Premiums and Deductibles, 2010-2020," Commonwealth Fund, January 12, 2022, <https://www.commonwealthfund.org/publications/fund-reports/2022/jan/state-trends-employer-premiums-deductibles-2010-2020>.

11 Jim Blachek, "When Figures Lie: Medical Loss Ratio May Be Increasing Premiums," BenefitsPRO, November 25, 2021, <https://www.benefitspro.com/2021/11/25/when-figures-lie-medical-loss-ratio-may-be-increasing-premiums/?slreturn=20220716165139>.

12 Health insurance regulations, like MLR, encourage insurers to reimburse larger medical bills as they get to keep a larger amount of money when their total spending goes up. Insurers are required to spend 80% - 85% of their premium revenue on medical bills. If the insurer spends a smaller percentage on medical care, insurers must pay back the difference to patients in the form of a rebate. At first glance, this may appear to be a consumer or small employer protection, but these rebates end-up costing both parties more in the long-term. For instance, if an insurance company collects \$100 in premiums, they have to pay out \$80 on care, and can keep \$20. But if an insurance company collects \$200 in premiums, they must pay out \$160 on care, but can now keep \$40 profit. Thus, insurers can avoid having to pay rebates, while simultaneously increasing margin/profits, by paying for higher priced medical services to ensure they more easily hit the medical spending target. Put another way, as premiums go up due to higher prices, insurers get to keep more money for administration or profit.

Since patients tend not to shop around for services based on price and some payers are incentivized to pay more for medical costs, many providers are free to charge whatever the insurer is willing to pay out.<sup>13</sup> Additionally, with hospitals consolidating at an increasing rate, health systems have the potential to gain a larger market share and demand higher reimbursement rates from private insurers in network negotiations, further driving up the total cost of care.<sup>14</sup>

Not all insurers are inclined to pay high medical bills and some will seek to contain costs for clients, like small businesses. To combat increasing insurance premiums and deductible growth insurers will narrow their networks by reducing the number of providers a patient can see.<sup>15</sup> While these narrow networks try to push out high-cost providers, they usually still center around expensive hospital systems, in part to meet network adequacy regulations.<sup>16</sup>

In many markets, large name-brand hospital systems with market power use anti-competitive contract provisions to force insurers to include every provider in their system regardless of price or quality.<sup>17</sup> Large hospitals can also pressure insurers to cut reimbursements to independent or community hospital options over concerns about referral patterns, which can force less expensive options for patients out of the insurance network.<sup>18</sup>

Thus, patients often face healthcare limbo either way: they are harmed by narrow networks that still contain high-cost health systems and reduce patient care options, or they are harmed by wider network plans that come with higher premiums, and much higher out-of-pocket costs for patients.

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13 Ateev Mehrotra et al., “Americans Support Price Shopping for Health Care, but Few Actually Seek out Price Information: Health Affairs Journal,” Health Affairs, August 1, 2017, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1471>.

14 AHIP, “How Hospital Consolidation Hurts Americans,” AHIP, August 26, 2021, <https://www.ahip.org/news/articles/how-hospital-consolidation-hurts-americans>.

15 Tracy Anderman, “What to Know about Narrow Network Health Insurance Plans,” Consumer Reports, November 23, 2018, <https://www.consumerreports.org/health-insurance/what-to-know-about-narrow-network-health-insurance-plans/>.

16 Karen Pollitz, “Network Adequacy Standards and Enforcement,” Kaiser Family Foundation, 2022, <https://www.kff.org/health-reform/issue-brief/network-adequacy-standards-and-enforcement/>.

17 Katherine L. Gudiksen et al., “Mitigating the Price Impacts of Health Care Provider Consolidation,” Milbank Memorial Fund, September 23, 2021, <https://www.milbank.org/publications/mitigating-the-price-impacts-of-health-care-provider-consolidation/>.

18 Ann O’Malley, Amelia Bond, and Robert Bereson, “Center for Studying Health System Change,” Center for Studying Health System Change, Issue Brief No. 136, August 2011, <http://www.hschange.org/CONTENT/1230/>.

## Price and Quality are not Correlated

Americans can roughly evaluate the quality of a car based on its performance, features, independent reviews, awards, and the maintenance report of a make and model year. This readily available information, both from the auto manufacturers and dozens of independent market participants gives consumers the power to make wise choices. Generally speaking, a higher price point means higher quality. In healthcare, it's a completely different dynamic.

Unlike cars, it is extremely difficult for patients to gauge the quality of care they receive and research has repeatedly shown that higher-priced care is not correlated with higher quality.<sup>19</sup>

Because prices are hidden, health systems regularly charge significantly different rates for the same services. Medibid, an online marketplace to compare healthcare costs, evaluated knee replacements in Tennessee and found that prices varied more than 1600%.<sup>20</sup> Even more disturbing, Medibid found that most providers that offered knee replacement above the median price averaged only 2 -3 quality stars in the Centers for Medicare & Medicaid Services (CMS) quality rankings, while those under the median regularly had 4 -5 stars, implying higher quality care and better outcomes.<sup>21</sup>

The disconnect between higher prices and better healthcare outcomes has been found time and again.<sup>22</sup> The unevenness of outcomes is distressing, especially for any patient that mistakenly assumes higher prices correlate with higher quality care.

## Paperwork and Bureaucracy Drive Up Costs and Increase Physician Burnout

Insurance companies and healthcare providers have been playing a billing tug of war for years, each trying to game the system in their favor. Different treatment codes can make a huge difference in the amount insurance companies pay. For example, if a patient seeks care for heart failure, but the visit ends up being coded as an acute exacerbation of the condition, insurers are compelled to offer a higher reimbursement rate than if the visit was simply coded as heart failure.

The result is more hours and costs that healthcare providers spend just billing. Medical paperwork costs the United States hundreds of billions of dollars a year with each primary care physician spending almost \$100,000 just to get paid each year.<sup>23</sup> That means insurers, providers, and patients, all spend more for every treatment to compensate for the cost of billing.<sup>24</sup>

Some providers reduce administrative costs by offering discounted cash rates. Essentially, some providers have been offering patients a significantly discounted rate for services in the hope patients would voluntarily pay out-of-pocket, which allows providers to be paid faster and avoid the cost of billing insurers.

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19 Eric Barrette and Kevin Kennedy, "The Price-Quality Paradox in Health Care," Healthcare Cost Institute, April 2016, [https://healthcostinstitute.org/images/easyblog\\_articles/109/Price-Quality-Parado\\_20200109-192229\\_1.pdf](https://healthcostinstitute.org/images/easyblog_articles/109/Price-Quality-Parado_20200109-192229_1.pdf).

20 Tennessee State Data, Vimeo, Medibid, 2019 <https://vimeo.com/366385547>

21 Ibid.

22 Mark A. Unruh and Robert Tyler Braun, "Physician Prices and the Cost and Quality of Care for Commercially Insured Patients: Health Affairs Journal," Health Affairs, May 1, 2020, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2019.00237>.

23 Vivian S. Lee, and Bonnie Blanchfield, "Disentangling Health Care Billing," JAMA (JAMA Network, February 20, 2018), <https://jamanetwork.com/journals/jama/article-abstract/2673128>.

24 Phillip Tseng et al., "Costs Associated with Physician Billing and Insurance-Related Activities," JAMA (JAMA Network, February 20, 2018), <https://jamanetwork.com/journals/jama/fullarticle/2673148>; Elisabeth Rosenthal, "Those Indecipherable Medical Bills? They're One Reason Health Care Costs so Much," The New York Times (The New York Times Magazine, March 29, 2017), <https://www.nytimes.com/2017/03/29/magazine/those-indecipherable-medical-bills-theyre-one-reason-health-care-costs-so-much.html>.

## Historical Problem of Price Transparency Facing Consumer Directed Healthcare

The call for price transparency in healthcare is not a recent movement. Even before the ACA numerous studies claimed that healthcare prices could be lowered by offering patients more readily available pricing information; especially when consumer-directed healthcare plans first started hitting the market in the early 2000s.<sup>25</sup>

As Health Savings Accounts (HSAs) emerged, researchers and policymakers began to ask if giving patients more out-of-pocket responsibility could lower the price of healthcare. HSAs incentivized patients to evaluate the value and quality of the care they received and to be cost-conscious consumers. However, in practice, patients with HSAs often found it difficult to shop for care because the necessary information was either unavailable or very difficult to access. In the absence of pressure on providers to publish their rates, patients could not compare prices and form a reference for quality based on that price.

The responsibility of increasing cost-sharing for patients, unfortunately, came paired with additional responsibility for patients to fight with providers to get a clearer picture of the true price behind their healthcare-- all the while many patients were fighting illness.

Price transparency has become a bipartisan movement, with many recent actions that demonstrate that fact. For example, the federal No Surprises Act, which protects patients from surprise medical billing, and requires an advanced explanation of benefits had bipartisan support and was signed into law in 2020. Additionally, the CMS rule compelling hospitals to disclose all their service rates was finalized in 2020 and became enforceable last year.<sup>26</sup> Finally, the new federal tri-agency price transparency rule for insurers went into effect July 1, 2022.<sup>27</sup> While these reforms are steps in the right direction, they still only are price transparency 2.0 level reforms. The reforms still fail to undo the perverse incentives that remain under traditional health coverage to disconnect patients and their doctors from more control of their healthcare options.



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25 Laurence Baker et al., “Consumer-Oriented Strategies for Improving Health Benefit Design: An Overview,” PubMed (U.S. National Library of Medicine, July 2007), <https://pubmed.ncbi.nlm.nih.gov/20734511/>.

26 “Transparency in Coverage, CMS-9915-F,” U.S. Department of Treasury, 26 C.F.R. § 4, U.S. Department of Labor, 29 C.F.R. § 2590, U.S. Department of Health and Human Services, 45 C.F.R. § 147 and 158. (October 29, 2020), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Transparency-in-Coverage-9915F.pdf>

27 “Fact Sheet Transparency in Coverage Final Rule Fact Sheet (CMS-9915-F),” CMS, October 29, 2020, <https://www.cms.gov/newsroom/fact-sheets/transparency-coverage-final-rule-fact-sheet-cms-9915-f>.



**Solution:  
Create a Real  
Healthcare  
Market with  
Price  
Transparency  
3.0:  
Transparency  
that Pays**

The Patient's Right to Save Act is a new policy prescription that can address the challenge of rising prices by restoring functionality to the healthcare marketplace. A true healthcare market that incentivizes patients to be healthcare consumers would organically lower healthcare prices. The Patient's Right to Save Act does not take options away from patients or cancel their current health plans, instead, it gives patients and their doctors more care options to choose from by creating a functioning market. It gives patients more certainty on prices ahead of time and allows all patients to be treated equally by more affordable providers without facing insurer network discrimination against less expensive care. It does not blow up the status quo, or involve a government takeover of healthcare, instead, it aligns incentives to organically change the health system to be more transparent, accountable, and competitive.

The Patient's Right to Save Act accomplishes this all by building off existing federal cash-rate disclosure rules, price transparency initiatives, and successful public and private programs that reward patients when they seek out more affordable health services.

## Price Transparency 3.0

Price transparency 1.0 requires insurers to estimate a patient's out-of-pocket cost for treatments when they seek care from an in-network provider. This information is meant to help patients gauge how expensive care will be. And for patients using their health savings accounts to pay out-of-pocket their deductibles in high deductible health plans, this information was necessary (but not sufficient) to encourage consumerism as envisioned in the RAND health insurance experiment. However, there are limits to this approach. Cost-sharing gimmicks can cover up higher underlying prices.<sup>28</sup> Patients have no insight into the real prices being paid, and once patients exceed their deductible, they often have little incentive to shop for more affordable care, as the savings will accrue to the insurer.

Price transparency 2.0 reveals the real prices of what is being paid by insurers to health systems or providers. New federal rules require both hospitals and insurers to disclose prices, and the federal No Surprises Act even requires that providers send patients an advanced explanation of benefits. This kind of price information is most helpful to those within their deductible trying to compare care options and small companies trying to figure out if they are getting good deals for care on their current insurance plan.

But even this level of disclosure may not change patient behavior.<sup>29</sup> That's because price transparency 2.0 still does not fully align patient incentives to use price information to shop for the best value of care. Most patients still want to max out their deductible if they expect more medical bills in a year to ensure their insurance "kicks-in" to get their money's worth after paying so much in premiums.<sup>30</sup> As a result, most patients prefer to see in-network providers whose services count toward the patient's deductible, even if those providers are more expensive than other options.

Patient's Right to Save is price transparency 3.0.

First, the Patient's Right to Save Act requires providers to publish their "cash price" for care, giving patients the total price of care and allowing them to compare price across all options in a community—not just those inside the walls of one insurer's network.

Second, the Patient's Right to Save Act directs insurers to recognize cost-effective care regardless of network status by giving the patient full credit toward their deductible if the care is more affordable than the lowest negotiated in-network option. This permits a patient to shop for the best price by bypassing any network limitations that may drive up system-wide costs. Insurers that already pay competitive prices will be unimpacted.

Third, once a patient exceeds their deductible, the Patient's Right to Save Act will trigger a savings incentive to a patient, if the patient continues to utilize care that is below the lowest negotiated in-network option. A patient can use a third-party app or tool to facilitate finding a better deal, make appointments for them and file any paperwork, and in return share a portion of their savings with that company.

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28 Scott Haller, Barbara Anthony, & Kalia Webb "Study Finds Patient Cost for MRI Largely Unrelated to Overall Price or Insurer Contribution at 14 MA Hospitals," Pioneer Institute (Pioneer Institute, February 26, 2019), <https://pioneerinstitute.org/featured/study-finds-patient-cost-for-mri-largely-unrelated-to-overall-price-or-insurer-contribution-at-14-ma-hospitals/>.

29 Sunita Desai, Laura A. Hatfield, and Andrew L. Hicks, "Association Between Availability of a Price Transparency Tool and Outpatient Spending," JAMA Network (JAMA, May 3, 2016), <https://jamanetwork.com/journals/jama/fullarticle/2518264>.

30 Sunita Desai et al., "Offering a Price Transparency Tool Did Not Reduce Overall Spending among California Public Employees and Retirees: Health Affairs Journal," Health Affairs, August 1, 2017, <https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1636>



# 3 Steps to Create the Marketplace with the Patient's Right to Save Act

## Step #1: Require Cash-rate Disclosures at All Locations

Providers in and out of an insurer network will often accept a lower rate if patients will pay cash, 39% less on average.<sup>31</sup> Right now, to obtain these cash prices, patients must call or visit each provider and request a price quote. The Patient's Right to Save Act requires every provider to publish their discounted cash price for services on the provider's website, and to update their prices regularly

Requiring providers to list cash prices will help fuel existing and new patient-friendly tools to help patients find the best deal, especially if those prices vary by time of day, day of the week, total quantity needed, office location, or for various amenities provided during a treatment. A good way to imagine these tools is to think of the existing airline ticket search tools.

Some states like Texas already have disclosure provisions, but the provisions often only apply to certain providers under particular circumstances.<sup>32</sup> States should extend to all providers the CMS hospital cash disclosure rules.<sup>33</sup>

The Patient's Right to Save Act would create, for the first time, an incentive for more affordable providers to advertise their less expensive prices to save patients money. Providers have balked at transparency requirements in the past because they impose a burden on providers without an opportunity to prosper from rate disclosure.<sup>34</sup> However, because the Patient's Right to Save Act rewards patients who shop for high-value care, providers can use their own unique value proposition of a competitive cash rate to attract new patients, reduce their own paperwork burdens, and secure instant payment for their services.

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31 Lawrence Van Horn, Arthur Laffer, and Robert L. Metcalf, "The Transformative Potential for Price Transparency in Healthcare: Benefits for Consumers and Providers," HMPI, December 2019, <https://hmpi.org/2019/12/09/the-transformative-potential-for-price-transparency-in-healthcare-benefits-for-consumers-and-providers/>.

32 Tex. Hea. Saf. Code Ann. § 324.001 (Supp 2009), <https://statutes.capitol.texas.gov/Docs/HS/htm/HS.324.htm>.

33 "Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public," Federal Register, November 27, 2019, <https://www.federalregister.gov/documents/2019/11/27/2019-24931/medicare-and-medicaid-programs-cy-2020-hospital-outpatient-pps-policy-changes-and-payment-rates-and#p-982>.

34 Melanie Evans, Anna Wilde Matthews, and Tom McGinty, "Hospitals Still Not Fully Complying with Federal Price-Disclosure Rules," WSJ (The Wall Street Journal, December 30, 2021), <https://www.wsj.com/articles/hospital-price-public-biden-11640882507>.

## **Step #2: Deductible Credit for Lower-Cost Cash Options**

Most patients pay cash from their pocket for the first thousand dollars or more of their healthcare each year since the vast majority of health insurance plans have a deductible. Before exceeding their deductible, patients use their own money for every dollar they spend on healthcare. When a patient finds a better deal using an app, website, or by themselves, the patient should receive in-network credit (i.e. toward a patient's deductible *and* out-of-pocket maximum). The Patient's Right to Save Act guarantees patients in-network credit when they pay cash for a service that is below the lowest negotiated in-network price.

Insurers may disclose their lowest negotiated rate, but if they don't, patients will be able to compare their cash prices to averages calculated from a state All Payers Claims Database (APCD) or another source of claims chosen by the state's Commissioner of Insurance. This average may mean more patients qualify for the savings incentive, and therefore encourage insurers to simply disclose their lowest rates.

The insurer would give credit equal to the cash rate or the lowest rate in-network, whichever is lower, as this could allow a patient to pick a more expensive cash care option if they want, but the patient would need to pay the difference and the insurer would not be forced to recognize that extra cost. This maximizes patient choice (which is a major concern for patients) and insulates insurers from having to pay more, while preserving the greatest opportunities to lower the price of care.

## **Step #3: Incentivize Patients to Keep Shopping for More Affordable Care After Paying Their Deductible with Rewards**

Patients should have an incentive to find cost effective, high-value care, even when the insurance company is paying the majority of the bill. The best incentive is a financial reward to a patient who continues to make price conscious decisions after reaching their deductible. Once the patient has paid their full deductible, insurers generally cover the majority of additional spending. Under most cost sharing plans designs, every dollar of savings the patient finds stands to save the insurance company 75 cents or more. Under the Patient's Right to Save Act, for cash rates still below the lowest negotiated rate, the patient receives a savings incentive. This guardrail ensures the insurance company only pays a savings incentive when the insurer saves money.

Insurers should split the savings with 50% going back to the patient. The total savings will be equal to the difference between the cash cost of care and the lowest negotiated rate. Patient's Right to Save allows patients to use third-party tools and share a portion of that savings with the third-party to make it as easy as possible for patients to find the best deals.

The savings incentive option and deductible credit would only be available for services that the insurer already covers. At the state level, this reform would apply to those with individual and small business insurance. The reform saves money, helps affordable independent providers, and creates a market by incentivizing more affordable providers to enter the market, or to advertise their deals to attract more patients.

The savings incentive would encourage companies to build tools that help patients easily find more affordable care. Companies that can simplify this process will share in the savings incentives. In other words, they don't get paid unless the patient saves money. This properly aligns economic incentives to create an active market in healthcare. A similar business already exists with companies like Trim that only get paid when they save the consumer money.

# Benefits: Price Transparency and Aligned Incentives can Drive Down Costs Without Sacrificing Patient Health

More government control of health coverage cannot fix rising costs in the current healthcare system while maintaining timely access to world class innovative care. Americans need a remedy that simultaneously empowers patients' choice, organically lowers prices, and protects future innovation to deliver higher quality care for less. Unlike other proposed reforms, the Patient's Right to Save Act creates a real market in healthcare where patients for the first time have the opportunity to meaningfully vote with their feet. When patients have a financial incentive to find the best price for the highest quality treatments, they can justify taking time to compare prices across providers. And when third-party patient tools can be used to find high-value providers, more patients will use these tools to compare their options. Ultimately, by aligning incentives and requiring price transparency, Patient's Right to Save will give patients the opportunity to receive in-network credit for care, and earn savings incentives after their deductible, all while the market exerts downward pressure on the highest priced providers for the first time.

## Patient's Right to Save Helps Many

### Patients with Chronic Conditions

Many patients do not reach their deductible, but chronically sick patients are another story. The patients who need frequent and expensive treatments (e.g., drug infusions, dialysis, insulin, etc.) tend to pay the most out-of-pocket and pose the largest cost for insurers to cover.<sup>35</sup> Under the Patient's Right to Save Act chronically sick patients will be rewarded for shopping and their insurers will simultaneously benefit from the additional savings.

The savings incentives in the Patient's Right to Save Act reward patients with psoriatic arthritis, Crohn's disease, or dialysis, who will consistently meet their annual deductible for treatment, if they identify lower-cost care options. Put another way, patients with chronic conditions can recoup their out-of-pocket spending and receive money to pay for future medically necessary care.

Ultimately, the Patient's Right to Save Act aligns incentives so patients who need more care and often pay the largest sums can benefit the most under the reform. In a post-ACA world, many insurers have struggled to maintain reasonable premiums while accommodating patients with pre-existing conditions. Patient's Right to Save will enable insurers to better support these more expensive patients with severe chronic illnesses.

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<sup>35</sup> Maria Marabito, "Out-of-Pocket Costs of Brand-Name Drugs Remain High for People with Chronic Conditions," Healio, January 7, 2022, <https://www.healio.com/news/primary-care/20220107/outofpocket-costs-of-brandname-drugs-remain-high-for-people-with-chronic-conditions>.

## Small Businesses

The Commonwealth Foundation surveyed small businesses nationwide about the largest concern or challenge they face, nearly 37% of business owners identified providing competitive and useful health benefits as their number one issue.<sup>36</sup>

The price tag to provide employee health coverage is immense for businesses starting out and has proven to be a constant struggle. The cost of health insurance affects all employers, but small businesses often pay more for less coverage, which makes it harder to recruit and retain talent. To compete with larger employers, small employers are pressured to offer health insurance, even as the benefit incurs a larger share of their bottom line.

The Patient's Right to Save Act offers new opportunities for small businesses to save money for themselves, employees, and their insurers. Small business owners could potentially leverage these savings to secure better premium rates or lower deductibles for their employees. Additionally, the in-network deductible credit and savings incentive components of this reform will give small business employees more options for providers, as under the status quo many are limited to only those in the one plan offered to them.

## Private Practice & Independent Doctors

Nearly 7 out of 10 physicians are employed by hospitals or large medical groups.<sup>37</sup> The number of independent health professionals that could provide more competitive rates has been steadily decreasing as they struggle to attract patients away from large hospitals, fight to stay within insurance companies' networks, and struggle to secure better reimbursement rates.<sup>38</sup>

Medicare claims data from 2010–2016 indicate that annual physician payments averaged \$114,000 more per doctor when billed by a hospital than when billed by a doctor in an independent practice.<sup>39</sup> This trend of doctors abandoning or refusing to go into business for themselves is costing patients more and is allowing hospitals to go unchallenged as they raise prices.

The Patient's Right to Save Act will create a direct opportunity for independent providers to attract new patients, and overcome consolidation pressure from hospitals. The deductible credit and the savings incentive features of Patient's Right to Save will strongly encourage patients to seek out private practices that set their rates below the lowest negotiated rate. The providers who offer the lowest rates will be rewarded with patient volume.

## Insured Patients

Paying for healthcare takes a bigger slice of families' disposable income every year. From 2008 to 2018, a typical family of four with a large employer plan saw their combined annual out-of-pocket cost (including premiums, deductibles, copayments, and coinsurance) rise by nearly 67% (\$4,617 to \$7,726) while their employers' premiums and other costs rose 51% (\$10,008 to \$15,159).<sup>40</sup>

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36 Rhett Buttle, Katie Vlietstra Wonnemberg, and Angela Simaan, "Small-Business Owners' Views on Health Coverage and Costs," The Commonwealth Fund, September 9, 2019, <https://www.commonwealthfund.org/publications/issue-briefs/2019/sep/small-business-owners-views-health-coverage-costs>.

37 Laura Dyrda, "70% Of Physicians Are Now Employed by Hospitals or Corporations," Becker's ASC Review, July 1, 2021, <https://www.beckersasc.com/asc-transactions-and-valuation-issues/70-of-physicians-are-now-employed-by-hospitals-or-corporations.html>.

38 Kerry Dooley Young, "More and More Doctors Abandoning Private Practice," WebMD (WebMD, May 27, 2021), <https://www.webmd.com/health-insurance/news/20210527/more-and-more-doctors-abandoning-private-practice>.

39 Post B; Norton EC; Hollenbeck B; Buchmueller T; Ryan AM; "Hospital-Physician Integration and Medicare's Site-Based Outpatient Payments," Health Services Research (U.S. National Library of Medicine, February 2022), <https://pubmed.ncbi.nlm.nih.gov/33616932/>; Zack Cooper et al., "Hospital Prices Grew Substantially Faster than Physician Prices for Hospital-Based Care in 2007–14," Health Affairs Journal, February 1, 2019, <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05424>.

40 "New Analysis of Large Employer Health Coverage: The Cost to Families for Health Coverage and Care Has Risen More than 2x Faster than Wages and 3x Faster than Inflation over the Last Decade," The Kaiser Family Foundation, August 15, 2019, <https://www.kff.org/health-costs/press-release/new-analysis-of-large-employer-health-coverage-the-cost-to-families-for-health-coverage-and-care-has-risen-more-than-2x-faster-than-wages-and-3x-faster-than-inflation-over-the-last-decade/>.

These costs are all the more significant for smaller businesses and patients who buy insurance on their own. This increasing financial burden has led many lower and middle-class Americans to drop their coverage. Without a generous government or employer subsidy, many find it hard to afford basic plans. Even for those that have coverage, it does not equate to access to care as they face large out-of-pocket spending. Increasing cash price disclosure will help both those with and without insurance. Patient's Right to Save offers them a reward if they seek out high-value care.

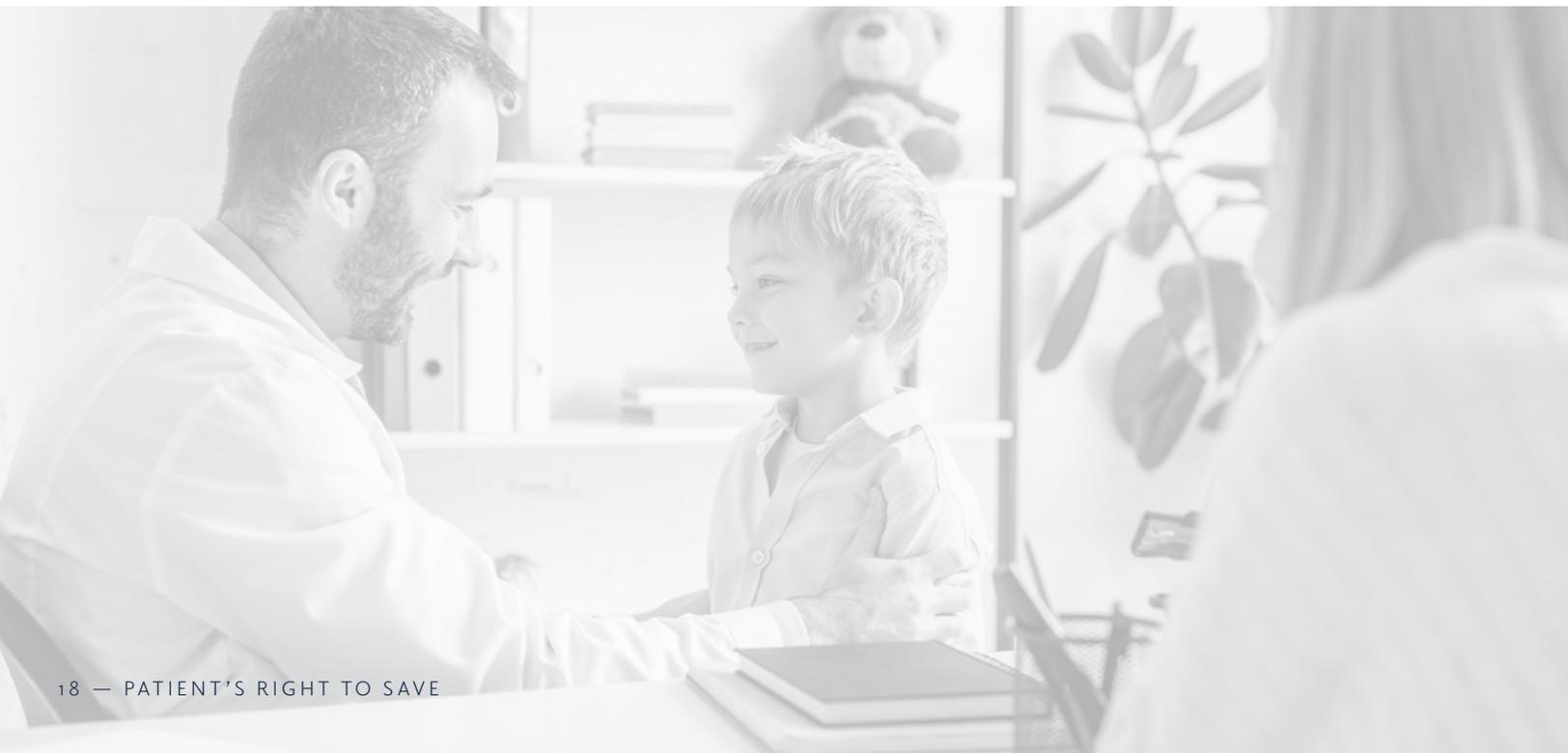
## Uninsured Patients

With increased price transparency, uninsured patients will have more certainty in how much care costs and are more likely to seek needed care, thus creating another layer of market competition. Over time this competition should result in insurers lowering premiums. As premiums lower, more uninsured residents are able to afford insurance.

## Patient Friendly Shopping Tools

Similar to Trivago comparing hotel and lodging rates, there are already cash-based price comparison services on the market, for example Sesame Health, Pratter, and Medibid. Historically, the cash market has been small, but it is growing, and would explode if cash prices were more readily available. Many other price transparency companies would likely enter the cash based market, companies such as Healthcare Bluebook, TALON, and Turquoise Health. Cash disclosure can also help those on nonconventional coverage such as health care sharing plans, or Farm Bureau plans.

The Patient's Right to Save Act would require all provider types to disclose their cash rates and therefore increase the amount of data and care options that consumer tools can offer to patients. These companies only get paid under Patient's Right to Save if the patient saves money, so incentives are aligned in favor of the patient. Also, these companies can further serve patients by setting up business models where they find the cash options below the lowest in-network rate for patients, make appointments, and file incentive claims to the patient's insurers. In exchange for the service they provide companies can take a small percentage of the savings incentive. The infrastructure to contrast prices for healthcare services currently exists but the full potential has not been tapped.



# Demonstration of Potential Savings Under Patient's Right to Save

## CASE STUDY 1 | MRIs

### Meet John

John is a 55-year-old man who injured his knee playing basketball and needs an MRI. Here is an illustration of John's insurance plan design.



John's insurance requires him to pay out of pocket for some of his care. He has a \$500 deductible, 20% coinsurance after that, and a \$8,700 out-of-pocket (OOP) maximum. This means he is responsible to pay the first \$500 of his medical bills each year and 20% of his bills over \$500 until John pays \$8,700 total (once John's total healthcare spending is \$41,000 for the year). Once he pays \$8,700 in a year, his insurance will cover 100% of future medical bills.

### Status Quo | Patient pays more, doesn't seek more affordable care

For illustration, under the status quo, John may have the option of selecting between two treatments: a more expensive in-network MRI that costs \$904 (A), and a less expensive out-of-network MRI that costs \$400 (B).

If John chooses the expensive in-network MRI (A), after a \$500 deductible and coinsurance John will end up paying a total of \$581, while his insurer pays the remaining \$323.

#### OPTION A: Cost \$904 More expensive care, in-network provider



Even though the out-of-network MRI (B) costs less, John would get no credit towards his deductible for picking this option, so he is unlikely to do so. If he did, he would pay \$400 out-of-pocket while his insurance pays \$0. This lack of deductible credit often drives patients to pick the higher-cost option in order to get credit for their out-of-pocket expenses, even though it is not the economically optimal decision. This drives up total spending, costs patients more out of pocket, and drives up premiums the next year, all while reducing incentives for providers to offer care at competitive rates.

**OPTION B: Cost \$400 More affordable care, cash provider**



**After Reform | Incentives are aligned for the patient, insurer and third party to find more affordable care**

Under the Patient’s Right to Save Act, John has more care options and can seek higher value care without penalty, if he chooses to do so.

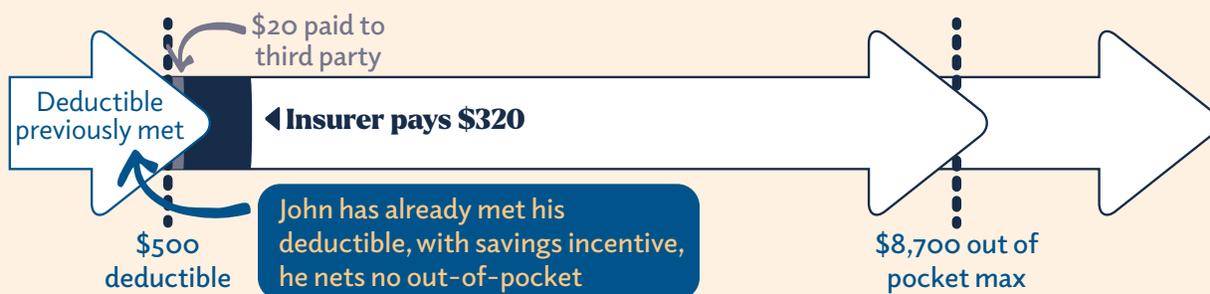
Under (C), John has not paid his deductible yet, so he would pay \$400 for the MRI, but now he gets deductible credit so more of the potential future treatment may be covered at the coinsurance rate. John’s decision incentivizes providers to offer more services at competitive rates.

**OPTION C: Cost \$400 More affordable care, within deductible, cash provider**



Under (D), John has already paid his deductible for the year for other treatments. He is still motivated to seek high-value care because he can qualify for an incentive payment. He can now pay the \$400 at the time of the MRI, and with the lowest negotiated MRI costing \$600, his insurance company will then reimburse John \$100, half the savings. This saving covers more than John’s \$80 coinsurance cost. Even if John contracts with a third party to handle all of the paperwork and pays them 20% of his savings incentive, John would still be better off as his remaining portion of the savings incentive still covers his cost sharing.

**OPTION D: Cost \$400 More affordable care, after deductible, cash provider**



Contrast this shopping incentive to John’s perverse incentives in the status quo. Once John exceeds his deductible, the \$904 in-network MRI only costs him \$181 out of pocket and inches him closer to the OOP maximum while the \$400 cash MRI both costs more today and does nothing to his total spending toward the OOP maximum. Just like in (A) John would have less of a reason to shop since there is no incentive payment, absent such incentives, there is no motivation for a third-party to help him save money either.

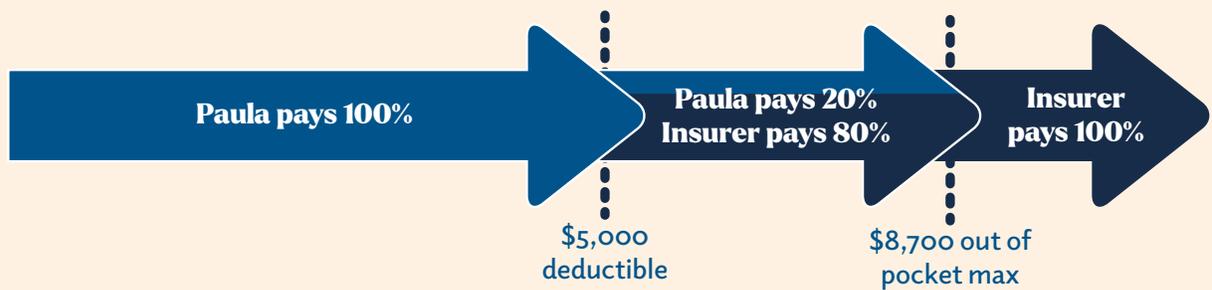
Under the Patient’s Right to Save Act, incentives align for John to save money, the insurer to save money compared to the expensive status quo of (A), and for high-value providers to keep prices reasonable and obtain more business.

John, or any other patient, is better off under any circumstance under the Patient’s Right to Save Act compared to the status quo, and because it saves money, premiums can go down over time.

## CASE STUDY 2 | DRUG INFUSIONS

### Meet Paula

Paula is a 42-year-old woman with Crohn’s disease. Paula needs infusions every 8 weeks to treat her condition.



Paula’s health insurance plan is similar to John’s but has a \$5,000 deductible, 20% coinsurance once she exceeds her deductible, up to a \$8,700 OOP maximum.

### Status Quo | Patient pays more, doesn’t seek more affordable care

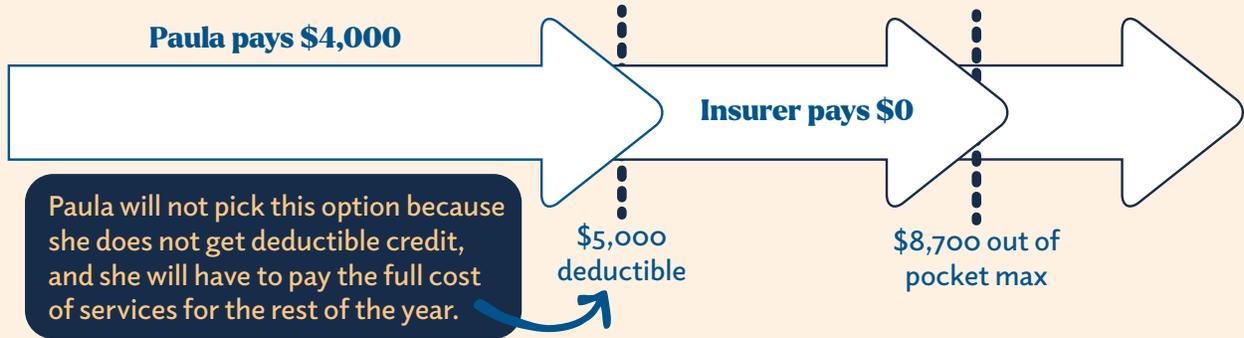
Paula requires 6 infusions a year to treat her condition. The infusions can be very expensive, but prices for the same treatment can vary widely by location. When she started getting treatment, the cost was \$40,000 per infusion, so she was guaranteed to exceed her deductible and OOP during the first visit (A).

#### OPTION A: Cost \$40,000 More expensive care, in-network provider



She found out about a clinic offering the same infusion down the street for \$4,000 (B), but it was a cash pay option. Given the frequency and cost of the infusions, she has no incentive to see that provider under the status quo, which will drive up overall spending, and premiums for everyone the next year. At the end of the year her insurer will pay \$231,000 for her infusions.

**OPTION B: Cost \$4,000 More affordable care, cash provider**



Incentivizing Paula under Patient’s Right to Save can reduce wasteful spending by \$176,000 dollars a year for her infusions.

## After Reform | Incentives are aligned for the patient, insurer and third party to find more affordable care

Under the Patient's Right to Save Act Paula and her insurer can save significant money by aligning incentives.



Paula continues to see the cash provider for \$4,000, six times this year, and the lowest in-network rate is \$20,000. At the end of the year Paula will come out ahead \$32,000 because of the incentive payments she gets back as she has helped avoid significant waste. This is true even if she shares a portion of her savings incentives with a third party who helped her find the cash deal, made her appointment, and handled all the paperwork for these medically necessary services. Paula's savings can help her afford her premiums and other out-of-pocket expenses for treating her chronic condition.

While some may try to argue that the Patient's Right to Save Act "adds" to insurer spending because of the incentives, the only real apples to apples comparison is to the status quo. Under the status quo, the insurer would be spending \$111,300-\$231,300 depending on where in-network the care is being received. Rarely are patients at the lowest in-network rate option.

Even if a patient was at the lowest in-network option, the insurer would still have avoided \$56,000 of waste, but more likely would be avoiding \$176,000 in unnecessary spending. This is all to say the incentives are finally aligned to save both patients and insurers money, without any negative impact on quality.



## Cash Prices Work

Two good examples of health providers that rely on cash rates are LASIK surgeons and the Surgery Center of Oklahoma. LASIK eye surgery is often considered an elective procedure, meaning insurers won't cover it and surgeons have to directly bill patients. In order to attract business and beat out competitors, LASIK surgeons will offer very competitive cash rates that are affordable to average Americans. Many also offer quality guarantees, so if a rare corrective follow-up is needed, they will cover it at no additional cost. LASIK is one of the few areas of healthcare where prices have gone down, and quality has improved over the last few decades.<sup>41</sup>

The Surgery Center of Oklahoma, a standalone surgery center, does not take insurance, and decided to enter into a “direct pay model.” The Center offers cash rates for services that most patients pay out-of-pocket. Instead of paying for an army of administrators to haggle over reimbursement rates with insurers, the Surgery Center of Oklahoma has been able to hold its prices flat for years, and even reduce some. The direct pay model has allowed the Center to maintain the same \$19,00 price for knee replacements, while some hospitals in Dallas, Texas have raised prices to \$61,585.<sup>42</sup> Having cash prices more readily available will allow patients to access medically necessary services more often and for less.

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<sup>41</sup> ARSC. “How Expensive Is LASIK?” Refractive Surgery Council, August 12, 2022. <https://americanrefrativesurgerycouncil.org/lasik-isnt-as-expensive-as-you-might-think/#:~:text=But%2C%20it%20turns%20out%2C%20that,was%20just%20ten%20years%20ago>.

<sup>42</sup> Haley Sweetland Edwards, “What Happens When Doctors Only Take Cash,” Time (Time, January 26, 2017), <https://time.com/4649914/why-the-doctor-takes-only-cash/>.



## Conclusion: States Should Embrace the Patient's Right to Save Act

States should embrace the Patient's Right to Save Act as a meaningful healthcare reform that benefits both patients and insurers while organically lowering prices through more conventional market dynamics.

The first step states can take towards embracing Patient's Right to Save is to require cash rates for any service to be published. Requiring cash disclosures would benefit both the insured and uninsured.

States should also require insurers to grant in-network deductible credit if the patient chooses treatment that costs less than the lowest negotiated rate put forth by the insurer. This would help end discrimination for patients who seek high-value care regardless of location or network status.

Finally, states should encourage insurers to grant patients and a third-party of the patient's choice a savings incentive post-deductible if the patient continues to seek high-value below the lowest in-network negotiated rate.

Insurers that have secured competitive rates will be unaffected as patients will have little opportunity to find higher-value care. Patients stuck in plans with very high rates will have a lifeboat to more affordable care, which is often the difference between them seeking needed care, putting it off, or receiving no care due to concerns over costs.<sup>43</sup>

The beauty of the Patient's Right to Save Act is that no patient is forced to use a certain provider or loses access to their current provider. Patient's Right to Save just opens the door to more care options. The Patient's Right to Save Act creates meaningful market incentives in healthcare while holding big insurers and hospitals accountable to deliver value to patients. Unlike many past health reforms that promise savings and don't deliver, the Patient's Right to Save Act only kicks in when savings are possible. Millions of patients, small employers, insurers, and doctors will be better off for it.

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<sup>43</sup> Gallup, Inc. "West Health-Gallup 2021 Healthcare in America Report." Gallup.com. Gallup, April 7, 2022. <https://www.gallup.com/analytics/357932/healthcare-in-america-2021.aspx>.

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