



Healthcare Affordability Evidence Brief

TeleCARE · The PHIERS 80/20 Care Principle · CMS-scale access · measurable savings

Prepared for George Jones and the California Black Chamber of Commerce
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This brief explains the healthcare proposition behind PHIERS's proposed Chamber demonstration and federal pathway. It separates evidence from model assumptions, public-program savings from private-sector savings, and modeled potential from savings actually measured.

Bottom line: PHIERS's current working model identifies more than \$2 trillion in potential annual healthcare savings when public-program and private employer opportunities are modeled separately and then combined. The model is not a claim that those savings have already occurred or are guaranteed. It is the economic case for implementation, measurement and public accountability.

1 The proposition

Healthcare costs too much because the system often pays comprehensive-coverage prices for people whose immediate needs are primarily routine, preventive and low-acuity care. PHIERS proposes a voluntary TeleCARE-first pathway that lowers the cost of appropriate routine care while preserving comprehensive protection for needs TeleCARE cannot meet.

The federal pathway

PHIERS is asking Congress to authorize HHS and CMS to make qualified TeleCARE available now as a voluntary routine-care option wherever applicable CMS-supported traditional coverage is offered. This is not a request for a narrow pilot. It is a request for broad availability, with outcomes and savings measured at scale.

The Chamber pathway

The California Black Chamber demonstration can begin without waiting for federal legislation. Interested businesses, workers and households would voluntarily indicate demand; qualified providers and prescription channels would compete; and PAM would document commitments, prices, access, participation, savings and results.

What TeleCARE is—and is not

- **TeleCARE** is qualified virtual access for appropriate routine, preventive and low-acuity needs.
- **It is not** a substitute for hospital, emergency, specialty, in-person or catastrophic care when those services are needed.
- **The working market benchmark** is approximately \$49 per month, or about \$600 per year, for routine TeleCARE access. Provider competition must establish the actual offer, services and price.
- **No Chamber business** or household would be asked to enroll before the provider, qualifications, service limits, price, privacy duties and contractual roles are disclosed.

2 The PHIERS 80/20 Care Principle

The PHIERS 80/20 Care Principle is a planning rule: separate the large share of people whose current needs can often be met through lower-cost routine care from the smaller, higher-need group that must retain comprehensive services. The principle does not assume that the same person always stays in one group. Needs change, and people must be able to move to the level of care they require.

National spending is highly concentrated. AHRQ's Medical Expenditure Panel Survey has repeatedly found that a small share of people accounts for a large share of healthcare spending. PHIERS uses an 80/20 scenario to test what becomes possible when lower-need care is delivered at a much lower routine-care cost while higher-need protection remains intact.

Operating rules

1. Participation is voluntary.
2. Clinical needs—not the savings target—determine when in-person, specialty, hospital or emergency care is required.
3. Savings must be measured from actual payment and utilization data, not inferred from enrollment alone.
4. Public-program savings and private-sector savings remain separate in reporting.
5. Recovered resources must be protected and their use reported through PAM.

3 The national expenditure environment

CMS reports that U.S. health spending reached \$5.3 trillion in 2024, or \$15,474 per person. Medicare spending was \$1.118 trillion; Medicaid spending was \$931.7 billion; and private health-insurance spending was \$1.645 trillion. These are the funding pools in which better routine-care delivery, purchasing and payment design can create meaningful savings.

2024 funding source	Spending	Why it matters
Medicare	\$1.118 trillion	Congress and CMS shape benefits, payment and plan rules.
Medicaid	\$931.7 billion	Federal and state governments oversee benefits and managed-care rates.
Private health insurance	\$1.645 trillion	Employers and households can benefit from lower-cost voluntary options.
Out of pocket	\$556.6 billion	Lower prices can provide direct household relief.

The expenditure totals establish the scale of the opportunity. They do not, by themselves, prove the PHIERS savings estimate. The estimate below is a scenario model built from population, payment and cost assumptions that must be tested against actual implementation data.

4 Public-program savings model

Medicare Advantage

MedPAC reports that Medicare Advantage enrolled about 34.9 million beneficiaries in 2025 and that 2026 capitated payments are expected to average \$16,242 per beneficiary, including rebates. PHIERS

models 80% of approximately 35 million enrollees using a \$600 TeleCARE-first routine-care pathway while maintaining comprehensive protection for higher-need care.

Working scenario: 28.0 million × (\$16,242 – \$600) = approximately \$438 billion annually.

This is the strongest component because it begins with an identifiable capitated payment. Real savings would depend on the authorized payment design, risk adjustment, transition rules, retained benefits, actual utilization and the share of the capitation amount that can lawfully be recovered rather than retained elsewhere in the system.

Medicaid

CMS reports \$931.7 billion in Medicaid spending in 2024. The working model uses approximately 84.3 million enrollees and a blended spending proxy of about \$11,057 per enrollee. Applying the 80/20 scenario produces approximately \$705 billion in potential annual savings.

Working scenario: 67.4 million × (\$11,057 – \$600) = approximately \$705 billion annually.

This is a planning estimate, not a national Medicaid capitation rate. Medicaid rates vary by state, eligibility group, risk cell and delivery system. A production actuarial model must replace the blended proxy with weighted managed-care rates and separate fee-for-service utilization.

Traditional Medicare fee for service

The working model uses an approximately 33 million-person fee-for-service population. Because fee-for-service pays for care actually delivered, PHIERS does not apply the full Medicare population average to low-utilizers. It applies a utilization-concentration proxy: the lower-spending 80% accounts for approximately 15% of spending. After a \$600 routine-care cost, the resulting working estimate is approximately \$66 billion annually.

This is the least certain public-program component and requires Medicare-specific expenditure-decile analysis before being used as a budget score.

Public-program component	Working potential	Model confidence
Medicare Advantage	\$438B	Higher: based on a published average capitated payment.
Medicaid	\$705B	Moderate: blended national proxy; state/rate-cell work remains.
Traditional Medicare FFS	\$66B	Preliminary: utilization-concentration proxy.
Public-program subtotal	≈ \$1.21T	Scenario total; not a realized or guaranteed saving.

5 Private employer opportunity

The private-sector opportunity is distinct from government savings. Employers already finance coverage for a large population and face rising benefit costs. If a lawful marketplace or employer-funded pathway allows workers and families to choose qualified lower-cost routine TeleCARE while retaining appropriate comprehensive protection, employer and household spending can fall.

The working model uses 154 million people with employer-sponsored coverage, 2024 private-insurance spending of approximately \$7,466 per enrollee, an 80% routine-care cohort and a \$600 TeleCARE cost.

Working scenario: 123.2 million × (\$7,466 – \$600) = approximately \$846 billion annually.

This amount is private employer/insurance spending potential—not CMS savings. It depends on voluntary adoption, plan design, employer contributions, exchange and tax rules, coverage adequacy, utilization and actual negotiated prices.

Combined addressable opportunity

Funding pool	Working potential	Reporting rule
Public programs	≈ \$1.21T	Report as modeled Medicare/Medicaid opportunity.
Private employer coverage	≈ \$846B	Report separately as private-sector opportunity.
Combined	≈ \$2.05T	Combine only after clearly separating the two sources.

PHIERS therefore describes the current model as “more than \$2 trillion in potential annual savings.” This formulation is supported by the working scenario while avoiding the false implication that every component has the same evidence strength or that the savings have already been captured.

6 Prescription purchasing

Lower-cost prescription channels provide an additional lever. A 2022 peer-reviewed analysis estimated that Medicare Part D could have saved up to \$3.6 billion in 2020 on a set of generic drugs by paying Mark Cuban Cost Plus Drug Company prices. A separate oncology analysis identified additional potential savings for selected cancer and supportive-care drugs.

PHIERS does not add a broad, unsourced “top five conditions” drug estimate to the \$2.05 trillion model. The prescription opportunity should be measured drug by drug, using identical dosage, quantity, eligibility, dispensing and shipping assumptions. Where drug savings overlap with insurance-spending reductions, they must not be counted twice.

7 How the Chamber demonstration works

6. The Chamber convenes interested businesses and helps define the business questions worth answering.
7. PHIERS conducts a minimal demand census that does not collect diagnoses, medication names or medical records.
8. PHIERSale presents the aggregated opportunity to qualified TeleCARE and prescription providers.
9. Providers compete on qualifications, access, services, price, privacy and terms.
10. Participants decide voluntarily whether to enroll or purchase.
11. PAM records the offer, commitments, participation, prices, access, utilization, savings and reported outcomes.
12. Results determine what should be improved, expanded, rejected or presented to government.

8 Measurement framework

Measure	What must be recorded	Why it matters
Demand	Businesses, eligible people and voluntary interest	Establishes bargaining scale without collecting health records.
Access	Wait time, provider availability, hours and language access	Tests whether lower cost still produces usable care.
Utilization	TeleCARE encounters and appropriate escalations	Shows what the pathway actually handles.
Cost	Quoted, contracted and paid amounts	Separates advertised prices from actual spending.
Savings	Comparable baseline minus actual cost	Prevents enrollment from being mislabeled as savings.
Quality and safety	Resolution, follow-up, escalation and complaints	Protects people from savings that reduce necessary care.
Equity	Access and results across	Shows who benefits and where gaps

	participating groups	remain.
Reinvestment	Amount recovered, holder, authority and use	Makes the Affordable Cascade auditable.

PAM's role

PAM is the public accountability layer. It should distinguish what was projected, promised, contracted, paid, saved and reinvested. It should preserve the original model and later publish actual results without rewriting the original baseline.

9 Responsibility and data boundaries

- The Chamber would not become the provider, insurer, pharmacy or custodian of patient health information.
- PHIERS would not diagnose, prescribe, deliver clinical care or hold medical records through the initial demand census.
- Qualified providers and other regulated entities would retain their own licensing, clinical, privacy, security and HIPAA responsibilities.
- Any later exchange of protected health information, contracting, fiduciary responsibility or payment administration would require separate written agreements and appropriate legal review.
- Only the minimum information required for an approved purpose should be collected, with disclosed access, retention and reporting rules.

10 Decisions the working conversation should make

13. Is there enough Chamber interest to design a voluntary demand census?
14. Which businesses, workers and household members should be included in the first estimate?
15. What minimum qualifications must a provider meet before receiving the opportunity?
16. What baseline will be used to calculate actual savings?
17. What information may PHIERS, the Chamber and providers access?
18. What results must PAM publish, and at what minimum reporting threshold?
19. What must be true before anything is offered to Chamber businesses?

Appendix A Working calculations

Component	Calculation	Result
Medicare Advantage	$35.0M \times 80\% \times (\$16,242 - \$600)$	\$438.0B
Medicaid proxy	$84.3M \times 80\% \times (\$11,057 - \$600)$	\$705.0B
Traditional Medicare FFS	Proxy low-spend cohort baseline less $26.4M \times \$600$	\$66.0B
Public subtotal	$\$438B + \$705B + \$66B$	\$1.209T
Employer-sponsored	$154.0M \times 80\% \times (\$7,466 - \$600)$	\$845.9B
Combined	$\$1.209T + \$845.9B$	\$2.055T

Rounding produces the public formulation “more than \$2 trillion in potential annual savings.” The model must be refreshed when enrollment, expenditure, capitation, utilization or provider-price inputs change.

Appendix B Source register

- 1. CMS National Health Expenditure Fact Sheet.** 2024 national, Medicare, Medicaid, private-insurance and out-of-pocket spending. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/nhe-fact-sheet>
- 2. CMS National Health Expenditures 2024 Highlights.** Enrollment and spending highlights, including private health-insurance enrollment. <https://www.cms.gov/files/document/highlights.pdf>
- 3. CMS National Health Expenditure Data.** Historical tables, per-enrollee data and methodology. <https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data>
- 4. MedPAC March 2026 Medicare Advantage Status Report.** MA enrollment, average 2026 capitated payment and rebate information. https://www.medpac.gov/wp-content/uploads/2026/03/Mar26_Ch12_MedPAC_Report_To_Congress_SEC.pdf
- 5. CMS 2026 Medicare Advantage Rate Announcement.** Official 2026 Medicare Advantage capitation and payment-policy documentation. <https://www.cms.gov/files/document/2026-announcement.pdf>
- 6. CMS Medicaid Managed Care Rate Development Guide.** Framework for actuarially sound, state-specific Medicaid managed-care capitation rates.

<https://www.medicaid.gov/medicaid/managed-care/downloads/2026-2027-medicaid-rate-guide-022026.pdf>

7. AHRQ MEPS Statistical Brief 546. Evidence that healthcare expenditures are concentrated among a small share of the population. https://meps.ahrq.gov/data_files/publications/st546/stat546.shtml

8. Potential Medicare Part D Savings on Generic Drugs. Peer-reviewed estimate of potential Medicare generic-drug savings at Cost Plus prices. <https://www.acpjournals.org/doi/10.7326/M22-0031>

9. CMS Medicare Telehealth Trends. CMS telehealth utilization definitions and data resources. <https://data.cms.gov/medicare-summary-of-use-of-care/medicare-telehealth-trends>

10. IRS Employer Shared Responsibility Provisions. Current federal requirements affecting employer coverage design. <https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions>

Appendix C Claims discipline

Use: “The PHIERS working model identifies more than \$2 trillion in potential annual healthcare savings when public-program and private employer opportunities are modeled separately and then combined.”

Do not say that PHIERS has already saved \$2 trillion, that the amount is guaranteed, that all modeled savings are government money, or that \$600 replaces comprehensive healthcare. Actual implementation must establish participation, payment changes, utilization, access, quality and verified savings.