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50 IDEAS TO MAKE HEALTH CARE MORE AFFORDABLE, ACCESSIBLE AND EFFICIENT

*A grassroots initiative by U.S. Congressman Kevin Brady
Member, House Ways & Means Committee*

Last summer I launched an initiative called *50 Ideas to Improve Health Care*.

I did so because, honestly, I don't know anyone who doesn't worry about health care. Whether it is a parent of a child who needs it, a senior who depends upon it, a business person paying for it, or a medical professional providing it - concerns about health care are growing daily. Can we afford it? Will it be there when we need it? What does the future hold?

America is at a critical crossroads.

Health care is becoming too expensive for many families. Nearly 47 million Americans have no insurance during some part of the year, including more than five million in Texas. Others who do have coverage pay \$1,500 more a year for those who don't. Our country faces a terrible shortage of nurses and other medical professionals. Medical mistakes are costing lives and billions of dollars a year.

Washington is the largest single buyer of health care, yet many hospitals and medical professionals lose billions of dollars from low - and slow - government reimbursements. Fraud within government health care is far too common. Many Americans turn to risky health care outside our country's borders. The system is costly, confusing and frightening.

The challenge gets greater in the future. This year, more than 77 million baby boomers begin to retire. They will enter Medicare soon after, which generates a staggering prediction from government experts: Within eight short years, by 2015, health care costs will consume 50% of the entire federal budget. That's greater than national defense, homeland security or education. And most states will spend half of their budgets on health care as well.

As a member of the Ways & Means Committee of the U.S. House of Representatives, a committee that handles Medicare and tax incentives for health care

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and research and development, it is clear that we must face these huge challenges now, and decisively. Delaying action further will only lead to broken care and broken budgets.

Sadly, Congress is gridlocked. It has accomplished little, and struggles for new ideas. We need to look outside Washington for the answers.

Out of frustration at the lack of meaningful progress on health care in our nation's capitol, I embarked on an intensive six-week grassroots campaign to hear directly from the very people in Texas who are most involved: patients, families, small businesses and health care professionals.

I asked them a simple question: What would you do to make our health care system better, more affordable, and more efficient? I told them we would listen carefully and identify 50 of the best ideas we heard. And I promised them that we would draft some of these ideas into legislation for Congress and the Ways & Means Committee to consider.

It was American Idol for health care (without Simon).

Turning Into a Listening Machine

Throughout August and September of 2007, I criss-crossed east and southeast Texas. On many days we hosted five to seven health care events.

I held listening breakfasts with senior citizens and small business owners, and working lunches with community leaders, hospital executives, medical researchers and biotech and medical device innovators. I toured nursing schools, elderly homes, free community clinics, doctors and physician assistant's offices, union hall clinics, Native American health care centers, imaging centers and emergency

rooms. I examined urban and rural community hospitals, rehab and specialty hospitals. I met with the doctors, nurses, hospital and medical workers who man the front lines of health care in America today.



I questioned the leading minds in the Texas Medical Center, including at MD Anderson Cancer Center, Baylor and Texas Children's Hospital. I held a public meeting titled "Can We Cure Cancer within a Decade?" with the renowned cancer leader and head of the U.S. Food and Drug Administration, Dr. Andrew von Eschenbach.



I led town hall meetings and telephone town hall conversations where we reached into the households of 50,000 families in the 8th Congressional District. We set up a special website, then encouraged the public to give us their best ideas and take an online poll on which direction they want to see America move in health care.

Nearly 6,000 people volunteered their ideas or participated in the online poll.

One major Houston television station - KPRC Channel 2 - even hosted a telethon one evening during its 5 p.m. and 6 p.m. news hours. The telephone banks, manned with college students from Montgomery College and Sam Houston State University, took calls from viewers for two hours. Our goal was not to raise money but ideas. And we did - by the hundreds. The callers were excited and vocal, to say the least. Finally, someone was asking their opinion!

Major Impressions

During this crash course on health care in Texas, I can't say I became an expert. Health care is too complex for that. But I experienced the remarkable depth and breadth of a health care system and how it works in the real world, for real patients, delivered by real medical providers.

Hospitals Visited -

Orange Baptist Memorial Hermann
Walker County Hospital
Health South Specialty Hospital
Memorial Hermann System Community Forum
Hearthstone Assisted Living
Livingston Hospital
Memorial Hermann The Woodlands
St. Luke's Community Medical Center
East Regional Hospital CEO Meeting
Memorial Hermann Baptist Orange Beaumont
Conroe Regional Hospital
Texas Children's Hospital
Texas Medical Center
M.D. Anderson

Town Hall Meetings -

Orange Town Hall
Trinity Chamber of Commerce
Walker County Chamber of Commerce
Montgomery County Chamber of Commerce
The Woodlands Rotary
Hardin County Chamber of Commerce
San Jacinto Chamber of Commerce
The Woodlands Kiwanis
Magnolia Chamber of Commerce

Non-Traditional Health Providers -

Bio Houston
Medical Group Management Assoc.
Conroe VA Clinic
Tyler County Nursing School
Oak Ridge Community Clinic
Heart of Montgomery County/Provider Access Network
Alabama Coushatta Health Clinic
Mead WestVaco Union Health Clinic – Evadale, TX



I observed a system that routinely performs remarkable medical miracles, but is severely hindered by a fractured payment system and crushed under the weight of costly and often contradictory regulation.

America has the best health care fundamentals in the world. We have the technology and we have highly-skilled workers. But we don't often have the best outcomes for patients. It's not for lack of money. With the exception of those in the research community, most health care professionals stated in one form or another, "We have enough money in the system, the problem is how we allocate it."

Clearly we are in need of thoughtful and significant reform.

I learned that we simply cannot regulate efficiency in medicine from Washington, D.C. And I learned that many of our health care professionals sincerely believe someone else is making all the money in the system.

What America needs is a new generation of informed consumers no longer handcuffed to their company for their health care. Prevention matters - saving lives and money - yet so few of our incentives reinforce that. We need to move from a system of "sick care" to health care, with a renewed focus on prevention. These changes cannot happen overnight, but we must begin now, and we can begin by identifying common-sense steps to change.

Observation #1: - You can't legislate efficient health care from Washington, D.C.

Through its reimbursement practices – mimicked by private insurers – the federal government carries a good measure of blame for fracturing America's health care system into a million pieces. Efforts to contain cost have resulted in "procedure-oriented" medicine, with practitioners reduced to "checking the boxes" or further gaming the system to receive a fair reimbursement on cases that do not fit into existing bureaucratic boxes.

Federal cost reductions in one area often lead to higher costs in others. For example, recent Medicare cuts now force patients with primary immune deficiency disease (those without a developed immune system) to receive their life-saving treatment in hospitals – yet for a person with a compromised immune system, a hospital is one of the most dangerous places for them to be. The result is sicker patients and higher Medicare costs.

Low government reimbursements for office visits have denigrated the basic function of a doctor: diagnosis, treatment

and ongoing patient care that is delivered in and between office visits. As one frustrated physician told me, "If a doctor can't make a decent living seeing and treating patients in our office, we're all doomed."

The more I delved into our health care system, the

Since 2000, health insurance premiums for family coverage have increased 87 %



more revealing that comment became.

Fewer and fewer doctors are willing, or can afford to see our seniors under Medicare. We rarely reward doctors who take the extra effort to assign care managers to patients, especially those with chronic illnesses. The unintended consequence of low doctor reimbursement is that we have forced doctors, especially primary care doctors, to seek other sources of revenue that now compete with community hospitals.

In another example of Washington's confusing and often contradictory reimbursement scheme, it is common for a health care provider to receive an incentive - higher reimbursement - to keep a patient in the hospital. At the same time, the hospital receives an incentive to get the patient out of the hospital. Resources are rarely aligned toward the patient, resulting in unnecessary tests, duplication of services and gaps in the continuum of care.

To remedy this situation, some hospitals are running pilot programs on the concept of "gainsharing." These programs test how we can better align the interests of doctors and hospitals so that the patients receive the best care.

The answer is not more regulation. The current effort to save costs and attain healthy patients by directive and regulation isn't working. Health care is simply

too individual and too tailored to fit into the most sophisticated of regulatory boxes. The solution lies in aligning the providers and the reimbursements toward the patient in such a way as to encourage better health outcomes and smarter use of medical dollars in achieving it. If we can stretch our health care dollars by giving providers more flexibility to work together toward a healthy patient – and let those same providers share in a portion of those savings – why wouldn't we? The ultimate savings will make health care more affordable for all.

Observation #2 - America needs to move from a sick-care system to a health care system.

The need for better preventive care was a common, universal theme voiced by patients, businesses and medical providers. For all the recent efforts highlighting prevention, as a nation we are still far too reluctant to spend a dime to prevent a problem, but will readily spend a dollar once the patient experiences health care problems.

Studies repeatedly bear out this premise - so much so it is hardly necessary to document them all. In cases ranging from diet and physical fitness education starting with school-age children, to dental hygiene, nutrition, pre-natal classes and check-ups, to early intervention to discourage smoking, alcohol and

Absent reform, Medicare is anticipated to consume 37.1 percent of all federal tax revenue by 2030



drug abuse, to chronic illnesses - prevention works. Yet so few of our health care dollars are devoted to it.

One pilot program demonstrated that mandatory prenatal classes at one U.S. company produced healthier babies and reduced the birth costs by 86%.

On the flip side, a young man at the Livingston town hall related that he and his wife had emptied a good portion of their savings to come up with the \$2,000 co-payment for a colonoscopy test and reading. His point was simple: if we are encouraging people to actively seek preventive medicine why are the common tests so expensive, even to those with insurance? Mammograms have now come down to a reasonable price and are widely credited as an effective tool for early detection of breast cancer. Why aren't other early detection tests more reasonably priced?

When it comes to the role of insurance in incentivizing prevention, one source, a financial leader at a highly respected non-profit medical institution in the Texas Medical Center, made the interesting point that constant "churning" of health care policies makes investment in preventive medicine unprofitable for insurers. Unlike auto insurance or property insurance, where there are clear incentives for prevention as well as positive conduct, there is almost no long-term relationship between health care insurers and their clients in America. People frequently change jobs, move to other states, switch to their spouse's insurance, experience life-changing events – so continuity is rare. It is not uncommon for small businesses to change carriers every two

years to take advantage of introductory pricing with new companies – solely to keep costs low enough to be able to provide workers with coverage. Why would an insurer invest in preventive care when the rewards are reaped by a future carrier?

Observation #3 – It's time to cut the umbilical cord that ties health care insurance to the workplace.

If we want more Americans to be covered throughout their lifetimes, people need to have the freedom to buy health care from plans across America, receive the same tax breaks as business, and be able to take that plan anywhere with them in life.

People no longer work for a company for forty years and retire. Fewer and fewer businesses are offering health insurance – down to 60% among the major companies. Many of the uninsured are between jobs with little chance to afford an individual health care policy. Most, but not all, health care plans are heavily regulated at the state level and are limited to the state, creating a patchwork of health care across America.

Government needs to allow the development of a "worker backpack" that allows workers to take their retirement and health care plans anywhere they go through life, whether it is to another company, home to raise children, to be part of a start-up company or to start their own small business.

Individuals need to have the option of a federal tax credit or deduction that gives them the same tax advantage as companies who offer health insurance



to their workers. And Congress needs to permit national lines of health insurance, sold across state lines, available to individuals and families at competitive prices.

To even put a finer point on it: Most Americans would never allow their company to decide which clothes they wear or what type of car to drive. Yet workers routinely accept the health care options companies offer, whether it fits their needs or not. As a result of third-party payers, health care users are less interested in the total cost of care and tend to focus on simply the extent of deductibles and co-pays.

Quality health care depends upon an informed consumer – which will never occur if employers are calling the shots.

Observation #4 – To inform consumers, let’s pull back the curtain of mystery on medical pricing.

Ultimately, one of the key solutions to our health care problems lie with an informed consumer. Today, many Americans know there are three or four different prices for every treatment, depending on who is paying for it (Medicare, Medicaid, private insurer, managed care or cash). And they are confident this “cost shifting” is landing squarely on their backs.

It is virtually impossible to determine the cost of medical care. In meeting after meeting, I heard from Texans of every age and walk of life who want to be able to go online to compare the cost of medicines at each pharmacy in their community. They want to be able to compare the prices of treatments and tests at doctor’s offices. They want to know which hospitals have the lowest infection rates. They want to know which surgeons have the best outcomes for surgeries and illnesses that apply to their situation. Yet, they are virtually in the dark.

The public often points to Lasik surgery as one example. Because it is paid for by the consumer, cost and quality matter. Prospective patients are able to shop around, compare prices, outcomes and qualifications of the doctors.

As a result, the cost of Lasik surgery has dropped significantly over the past decade, with new generations of technological advances surfacing regularly. The result: better quality for less cost. All because the consumer can compare and choose.

This thirst for health care knowledge – and empowering consumers with the information to make decisions that prevent illnesses and reward efficient treatment – could well be the most influential change to improve the long-term prospects of America’s health care system.



Government, physicians and other health care providers need to heed the cry of consumers. It is time to pull back the curtain of mystery on prices, tests, treatments and surgeries.

Its time for America to produce a new generation of informed health care consumers.

Observation #5 - Paperwork is squeezing the life out of patient care. Let's set a national goal to limit overhead to 5% by 2013.

Overhead and regulation is squeezing out precious health care dollars for patients. By some estimates, medical overhead runs as high as 20% - diverting hundreds of billions a year from patient care.

Increasingly complicated government and private care coding for reimbursement, mandated data collection, myriad forms and definitions by private insurers and managed care companies, varying eligibility for different government assistance programs – the sum of it is crushing the health care system in America.

One hospital confided that their registration clerk must open 14 different program screens on their computer to admit one patient to the hospital due to different government and private insurance requirements. No wonder it takes so long to be admitted!

In another example, the U.S. Centers for Medicare and Medicaid Services recently revised the rules for how hospitals must inform patients of their rights prior to discharge. Rather than providing

the information at admittance or during their stay, hospitals must now inform the patient within certain hours before discharge. But since discharge days can change depending upon the health of the patient, the same process and signature forms are repeated time and again. One rural hospital in east Texas complained they were forced to hire one full-time clerk simply to comply with this new regulation. This hospital, by the way, is fighting to get back to financially breaking even. They needed those dollars for patient care, not paperwork to satisfy the federal government.

The government, medical community and insurance community must come together to reduce unnecessary paperwork, standardize claims and definitions and avoid duplicative data collection if we are to reduce the average overhead to 5% within the next five years, by the end of 2013.

Patient care is more important than paperwork.

Observation #6 - Technology: "savior" or "enemy" of affordable health care?

Members of Congress are repeatedly told technology is the savior of health care in America. On paper in Washington, it is.

But during the *50 Ideas* initiative we heard a different story. A story of physicians, hospitals and patients struggling to move into electronic medical records, digital diagnosis and expensive state-of-the-art testing, imagery and surgery technology that should save money and improve quality over the long-term. But when they do, they discover that their expensive



investments in technology often produce little benefit or prove ineffective without uniform standards to share and transfer critical patient information.

One exasperated doctor at a physician roundtable, after investing \$250,000 in medical records and digital diagnosis, only to discover it raised rather than lowered his cost of care, told me, “technology is my enemy.” Another doctor in a state-of-the-art clinic, where most of the technology provided immense savings and error-free treatment (it was a uniform program required for all medical personnel and physicians throughout the clinic), declared “technology is our savior.”

One hospital system told me they are spending millions of dollars establishing an electronic medical records system throughout all of their facilities – but at the end of the day will likely be unable to send their patient’s information to a neighboring hospital a block away due to different data and software standards.

Other observations...

Hospitals: I tried to visit a broad range of hospitals because they are critical to health care and critical to a community’s existence, especially in our rural areas.

Hospitals find themselves in the crosshairs of health care in America today. Often they are squeezed by low government reimbursement and often conflicting government regulation, faced with a demand for the latest, most expensive technology, struggling to recruit nurses, technical staff, emergency room

physicians and medical specialties - all the while representing the cutting edge in medical technology and serving as the laboratories for medical miracles performed everyday. To top it off, they also serve as a safety net for many of the 47 million Americans who have no health insurance - including a growing number of illegal aliens.

At each facility I visited, I was truly amazed by what modern medicine is capable of accomplishing. But such miracles have a high price, and at each hospital I heard one consistent theme – “we struggle daily to keep our doors open.” Four factors surfaced: unreimbursed “charity care,” low reimbursement for services, the high cost of malpractice insurance for emergency and specialty physicians, and the shortage of qualified medical personnel, especially nurses.

Under law, hospitals must treat all patients regardless of ability to pay. This results in hospitals being forced to write-off significant percentages of their revenue to unreimbursed, or “charity care.” Furthermore, Medicare and Medicaid reimburse hospitals less each year, cutting deeper into their bottom line. And finally, the cost of medical malpractice insurance continues to pressure hospitals financially, costing facilities millions in premiums each year.

Hospitals are further pressured by a rapidly increasing demand for nurses. According to the American Hospital Association, there are presently 118,000 vacant RN positions nationwide. This situation is only expected to get worse as the Health Resources and Services Administration recently projected that the nursing shortage would grow to



more than one million nurses by 2020. The single biggest contributing factor is that our nursing schools simply do not have enough trained faculty to keep up with demand. In 2006, U.S. nursing schools were forced to turn away 42,866 qualified applicants due to an insufficient number of qualified faculty. Consequently, nurses are overworked and “burning out.” When this happens, patient care suffers.

Small Businesses: Most Americans continue to receive their health care through their employer. As the cost of health benefits increase, fewer small businesses can afford to provide coverage to their employees. In 2006, only 45% of businesses with three to nine employees offered health insurance. Though some of these individuals will purchase their own health coverage, or enroll their children in the Children’s Health Insurance Program, many do not and have no other choice but to rely on our already overcrowded and financially stressed hospital emergency rooms.

I visited with small businesses and Chambers of Commerce throughout east and southeast Texas and heard about the difficulties they face. These businesses want to provide their employees health benefits, but simply cannot afford to do so.

Non-Traditional and Innovative Health Providers: Not all that is happening in health care takes place in the hospital or doctor’s office. Many of the most innovative practices are taking place elsewhere. I visited with a variety of different organizations and groups that are trying new and innovative ways of providing care. These included high-tech biomedical companies in Houston and a

small union clinic in Evadale.

Affordability: The number one health care concern for most people is cost. Health care spending in the United States has grown at an average rate of 10% per year over the past four decades - far outpacing inflation. Sixteen percent of America’s economy is spent on health care today and it will rise to 20% by 2016.

Since the new millennium began, health insurance premiums have increased 87 % for the average American family. That’s five times faster than consumer prices have grown and four times faster than wages have grown.

The cost of supplies, medications and procedures are increasing beyond the ability of many to pay. Hospitals must contend with emergency rooms filled with non-emergency cases and an increasing number of illegal immigrants.

In some facilities I visited, the number of non-emergency patients (patients who should be treated at a clinic or in a doctor’s office) was as high as 50%. Many of these patients do not have insurance and are simply unable to pay their bills. Several smaller hospitals in east Texas indicated that these bad debt cases can amount to nearly 12-14% of revenue.

As one hospital leader pointed out, “There is no other industry in America today where it is expected that such a high percentage of the bills go unpaid.”

These losses have to be made up somewhere. So costs are shifted, where they can be, to those who



have insurance. Procedures and treatments that should only cost several hundred dollars cost several thousand.

Government: For all the good it does, there is no one factor that contributes more to the cost and frustration in health care than the government.

The federal government is the single largest buyer of health care in America. Therefore, it has the most influence over how the system operates. Medicare and Medicaid are simply not efficient, often paying twice as much for equipment while paying only half what's needed for doctors. Medicare often pays twice as much in different regions of the country with no improvement in the quality of care.

Despite these rising expenditures, hospitals, and rural hospitals in particular, are losing money on each Medicare patient they treat. For instance, hospitals in east Texas currently receive only \$0.43 in reimbursement for every dollar spent on Medicare patients. This situation impacts rural hospitals more dramatically where 50-60% of the patients are on government health programs. Consequently, fewer and fewer doctors will accept Medicare and Medicaid patients.

Innovation: Old problems need new solutions and that requires innovation. We have to think of new ways to expand coverage, increase efficiency and maintain quality in the services we already deliver. At the same time, we must invest in biotechnology and life science research to create new products and cures faster and lower costs.

Unfortunately, our ability to continue to produce many of these miraculous innovations is threatened without a continued commitment to funding basic biomedical research. To begin with, we must develop a more unified and coordinated approach between government and private sector research and development in health care. We must do more to move new medications to market and help the FDA retain high-level and well trained staff. And we must continue to provide substantial funding for research at the National Institutes of Health.

Workers need to be able to see doctors after their workday. Families need clinics open on weekends. Wait times need to be reduced so that individuals can get the treatment they need without spending an entire day waiting for a test. We need more choices in health care so that we can visit facilities close to home.

The Evadale Model: Some employers are not waiting for change. They have found innovative solutions to provide their employees access to care. In Evadale, TX, I saw how Mead Westvaco and the United Steelworkers Union work together to provide inexpensive health care to mill employees. When health care costs began rising, Mead Westvaco contributed the money it was paying in employee health benefits to the Steelworker's to run a clinic that would provide medical services directly to its 3,000 union employees. Today, the clinic handles nearly 9,000 medical visits annually. Even more amazing, the clinic's medical premiums have not increased in seven years - all while providing a complement of services, including pharmacy and x-ray. By negotiating services directly with



providers, the clinic avoids the higher costs of dealing with multiple insurance providers and slow government reimbursements.

Workforce: With the looming retirement of baby boomers, our country is facing a demographic shift like we have never experienced. The simple truth is we do not have enough skilled health care professionals to provide the care our population is going to need. The problem is even worse for our rural communities that have a difficult time attracting new professionals from larger cities.

Alarming, many fear that our best and brightest are being deterred from entering the medical profession. I heard repeatedly that low-reimbursements, from both government and private insurance, are driving many doctors out of business and deterring many of our most promising students from entering the medical profession. No other specialty is more emblematic of this problem than OB/GYN. During a town hall in The Woodlands, an obstetrician described how the total reimbursement for global OB service (pre-natal care and delivery) was only \$1700 per patient.

We are going to have to provide more incentives for younger individuals to enter

into the health care field. Our rural communities are going to need more resources to train workers and keep them in the community in which they live.

Online Poll Results

The level of frustration in health care was vividly illustrated in an online poll I conducted, in which 5,291 people participated. Those who voted split almost evenly between supporting a European-style national health care system, or a system with no government involvement at all. Clearly people are so frustrated that they are willing to try anything new, so long as it is a change from what is occurring today.

What Direction Do You Want to See Health Care Headed in America?

5,291 opinions

- 51%** Keep government out of health care. Lower income taxes so families can afford to purchase their own health care insurance.
- 48%** A national health care system (similar to programs in Canada and Europe) operated by the federal government.
- 1%** Require every adult above the poverty level to carry basic health care insurance.
- <1%** Require every company to provide health care insurance for their workers, shared with workers at a 50/50 cost.



The IDEAS

While I heard a great deal about what is wrong with health care today, I also heard a tremendous number of good, common sense ideas for how we can begin to turn things around now. Taken from comments at the town halls, tours, listening sessions and e-mails, I have identified the following ideas as steps government, insurance, and health providers can begin taking now to improve health care in America. Here are some of those ideas.

The Patient

1. Create a “worker backpack” to allow individuals and families the option of receiving federal tax breaks to buy health care insurance independently from their employer. These policies can follow a family for a lifetime.
2. Create a “Consumer Report for Health Care” to provide consumers up-to-date and online information about medical pricing, including the costs of medicines at area pharmacies, exams, tests and treatments at physician’s offices and clinics, hospital charges, surgical outcomes, and infection rates. Require health care providers that receive federal funds to participate.
3. Hearing loss affects 75% of the elderly, but treatment is expensive (\$1,400 or more) and generally not covered by Medicare or private insurance. Congress should enact a \$500 tax credit to help families afford hearing aids for themselves and family members.
4. Provide incentives to insurers, and require government health programs to cover experimental treatments for terminally ill patients.
5. Establish a medication pool for children with cancer or chronic diseases. Many of these medications are unaffordable even for those with insurance.

Prevention

6. Prevention, prevention, prevention. The entire health care system – government, business, insurance and consumers – needs to be reassessed to focus more dollars on preventive care, from pre-natal to end-of-life.
7. Encourage companies to require pregnant mothers to attend pre-natal classes and get pre-natal check-ups.
8. Require health care insurers to provide discounts for individuals who demonstrate healthy choices, such as regular exercise, diet, smoking cessation and other preventive measures.
9. Create a national initiative to lower the costs of preventive tests, such as colonoscopies and CT scans.



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10. Provide free immunizations for flu and pneumonia to Americans over 65 years of age.
11. Congress should develop tax credits for a broad range of wellness and preventive care.
12. Require that a portion of the earned income child credit be used for children's health care.
19. Remove restrictions on Medicare reimbursement for hospital-based nursing school programs in rural areas.
20. Require all individuals, including those residing illegally in the country, to pay for a portion of their medical care.

Medical Professionals

13. To end "cost-shifting," ensure Medicare and Medicaid reimbursements reflect the true cost of medical care, and adjust these rates annually for inflation.
14. Eliminate disparities in reimbursement between rural and urban health care facilities.
15. Require a co-pay for individuals who use emergency rooms for non-emergency visits.
16. Provide incentives for after-hours outpatient clinics for non-emergency care located near emergency rooms to reduce congestion in ERs.
17. Establish reasonable national medical liability limits for emergency physicians and medical personnel providing unreimbursed "charity care" in ERs.
18. Forgive student loans for doctors, nurses and skilled health care professionals who practice for a period of time in a community or county health care clinic.
21. Small practitioners often have difficulty obtaining a sufficient supply of immunizations. Steps must be taken to ensure that these providers have adequate supplies of these medications to meet the needs of their patients.
22. Reassess federal reimbursement for inpatient mental health treatment. The government has overreacted to the fraud of the 1980's, leaving hospitals without staff, facilities or sufficient security to treat mentally ill patients in their ERs.
23. To help rural hospitals afford Electronic Medical Records systems, tailor the Veterans Administration's VISTA open source record system for use in rural hospitals.
24. Expand pharmaceutical patient assistance programs into emergency rooms for non-scheduled/non-controlled substances, so that hospitals can provide low-income and uninsured patients help with medications.
25. If a patient is initially admitted into an ER for emergency care, do not require the hospital to



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- treat unrelated non-emergency conditions.
26. Reimburse physicians that assign care managers who successfully keep patients healthier by following their treatment regimen between office visits.
33. Re-assess the federal Health Insurance Portability and Accountability Act privacy provisions. While these are well-intended protections, they often hinder a physician's ability to discuss important medical matters with immediate family members.

Government and Medicare

27. Expand "gainsharing" among health care providers to deliver better quality care more efficiently and at lower cost. Adopt "pay for performance" measures.
28. Medicare and Medicaid should provide preventive dental care.
29. Decrease delays in payments made to hospitals, physicians and medical providers from Medicare and private insurers.
30. Provide flexibility in serving the "near eligible" (those not eligible for Medicaid, but too poor to afford health insurance) within government assistance programs, especially for parents working multiple jobs while completing nursing school or pursuing a health care profession.
31. Mandate more uniform standards of eligibility across all government-sponsored health care assistance programs.
32. Government health care programs should consider the total impact of new regulation. For instance, before Medicare considers issuing a new regulation, first assess existing regulations to determine if there is a conflict or if it is necessary.
34. Medicare and Medicaid should reward beneficiaries who make positive lifestyle changes, such as smoking cessation, alcohol treatment and weight loss surgery.

Insurance

35. Allow health insurance to be purchased across state lines.
36. Create a \$200 insurance deduction for policy holders who create and maintain a comprehensive and up-to-date family medical history.
37. To reduce unnecessary delays between medical offices and insurers, the second attempt to resolve a pre-approval request or resolve a post-treatment payment dispute should be conducted by a medical professional on both ends of the communication. Delaying sound treatment and appropriate payment decisions hurts patients and drives up the cost of health care.
38. The lifetime cap on health care insurance is especially punitive to patients with rare or costly diseases, as well as families whose young children are diagnosed at an early age



with severe illnesses. The lifetime cap should be increased to reflect the high cost of U.S. health care, adjusted annually to reflect health care inflation, and/or reset when a child reaches 18 years of age.

39. Standardize insurance forms and policies to promote increased transparency and easier comparison of plans.
40. Private insurers should cover preventive care measures when indicated by family history or medical examination. This coverage should be outside of the individual's deductible so that a person won't have to spend their savings to stay healthy.
41. Allow small businesses to join together to purchase health insurance across state lines without expensive federal health care mandates.
42. Expand the use and contribution limits for Health Savings Accounts.

Veterans

43. Allow the Veterans Administration to contract with local providers in rural communities so that veterans can receive care closer to home.
44. Increase the income threshold so more veterans have access to Veterans Administration medical services.

Cost and Efficiency

45. Create a national standard for electronic medical records, and expand the use of telemedicine.
46. Standardize the language used on medical billing and insurance claims for transparency and efficiency.
47. Rather than waste expensive but unused prescriptions, allow hospitals, nursing homes and other medical facilities to dispense, in-house, unused medications that are still sealed or can be verified as safe, such as blister packs.

Innovation

48. Increase medical research at the National Institutes of Health 7% each year.
49. Improve retention of expert and high level staff at the Food and Drug Administration to accelerate assessments of pharmaceutical and biotechnology submittals.
50. To foster biotechnology, allow companies with 50% venture capital to be eligible for the Small Business Innovation Research Program.

