A COMMON SENSE PRESCRIPTION FOR HEALTH CARE

by

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TimothyMiles.com

If not me, who... if not now, when?

Please visit my site and sign the petition which will be forwarded on to Senators and Representatives. I encourage you to forward a copy of this to them yourself right now as well with your endorsement.

Contact your Senator

Contact your Representative

"When men yield up the privilege of thinking, the last shadow of liberty quits the horizon."
Thomas Paine

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A Prescription for Health Care

To effectively reform health care in America, one must consider three primary players, the citizens (consumers), the medical community (suppliers) and the manufacturers (pharmaceutical and equipment manufacturers) while being under controlled by none. This appears impossible for Congress since they sold out long ago to their favorite lobbyist so it's up to us, the citizens to do it for them. As long as one realizes that nothing is free and that health insurance is a way to effectively stabilize the cost of health care over a lifetime as opposed to somehow magically making it cost less than it really does, one can develop rational solutions whereby we all can share the risk of needing an inordinate amount of care. After all, in the end, that is exactly what health insurance does.

This objective has been accomplished in the past, through charities where churches or other groups voluntarily helped the less fortunate. By purchasing health insurance, you are accomplishing the same thing but instead of the church or some other charity overseeing the distribution of donated cash and services, the insurance company receives voluntary "donations" in the form of premiums and then pays for an agreed upon amount of health care for those that require it.

Likewise governments have assumed this roll as well but with their bloated and corrupt inefficiencies, both the product and the value suffer greatly. Still, one only has to apply reason, a commodity in short supply in Washington these days, to develop a solution.

What is presented here may not be a perfect solution but it will solve most, if not all, of the problems currently plaguing America's medical delivery systems. It will provide care to everyone in an equitable way while saving us all a lot of money in the process. Additionally, it will allow you to have the level and quality of care you desire from the doctor of your choice. If you agree and support this proposal, please go to my website at TimothyMiles.com and sign my petition and forward this plan on to your friends to do the same. You can make a difference. **Together we can be heard.**

1. PROBLEM – EXCESSIVE HEALTH CARE COSTS

1.1 CAUSES

- **Defensive Medicine requires unnecessary testing**
- **Excessive malpractice insurance rates due to punitive damages in litigation**
- **Lack of supply of physicians**

1.2 COST REDUCTION SOLUTIONS

- **Eliminate all punitive damages from medical malpractice suits**
- **Establish peer-lay review panels to award actual damages in malpractice claims**
- **Increase the supply of MD's and Nurse Practitioners**

Eliminate all punitive damages from medical malpractice suits

Life, at times, is painful and unfair and there isn't much we can do about it. With that in mind, there is no reason that you and I should be required to pay for the suffering of a unique few while others who suffer (even more) get nothing. Think for a moment, does a parent who loses a child as a result of poor care from a physician suffer any more than a parent who loses a child to terminal cancer? What about a parent whose child dies at the hands of a pedophile or dies in an accident where litigation is out of the question? Who compensates those parents for their pain and suffering?

There is a direct correlation between the cost of medical malpractice insurance and the cost of care. As is always the case in a free market, all costs incurred by a physician are passed on to his patients. As medical malpractice premiums increase, so does the cost of an office visit and in turn our insurance premiums.

It's not just the cost of awards either. An Arkansas Study of Malpractice Insurance Companies reveals the "Defense and Cost Containment Expense" can amount to more than 77% of the amount paid out in settlements. In fact, studies show that close to 80% of all malpractice suits are settled in favor of the defendant. This is a clear indication of just how pervasive frivolous lawsuits are in driving up the cost of health care in America today.

What does this mean to you and I? It's simple... as long as people and attorneys think of malpractice insurance as a potential lottery ticket, there will be frivolous law suits and as long as we as a society think the answer to the pain of life is money, there will be lawyers looking for the deep pockets in society to sue. In the end, it's always going to be the consumer who ends up footing the bill for this corrupt practice of enriching a few at the expense of many.

Establish peer-lay review panels to award actual damages in malpractice claims

To further reduce the cost of malpractice insurance premiums while continuing to provide justice to the victims of medical malpractice, people will be able to file claims with review panels consisting of members of the medical community as well as qualified laypersons who can judge the validity of each claim and award actual damages for actual costs plus the loss of earnings into the future. If a claimant is not satisfied with the outcome, they could still sue with the added stipulation that the prevailing party will be granted reimbursement of their legal expenses by the losing party.

Enact Consumer Protection Disclosure Law

Consumers of medical care need to be protected against doctors whose work is substandard. Currently it is too difficult to determine if a doctor you are considering is highly capable or incompetent. While it is incumbent upon medical associations and state boards to create remedial and punitive actions in the case of doctors who display negligence or poor ability, it seems necessary that the Federal Government enact disclosure regulations whereby a consumer can readily obtain information regarding successful malpractice awards or regulatory actions taken against a doctor online as well as from the doctor's office through a simple request.

With the facts, a free market rapidly adjusts to a substandard product and the same could be said about a substandard doctor. With disclosure, the incidence of valid malpractice claims will be reduced further without additional governmental controls.

SAVINGS

The CBO estimates that the savings to government of reducing punitive damages to $500,000 will amount to about $56 Billion over the next decade. Eliminating them entirely will add significantly to these savings and the figures don't even reflect the savings to the average American's insurance rates.

If a doctor's malpractice insurance was reduced from $100,000 a year to $50,000 a year through this reform and if he saw an average of 4,200 patients a year, he could reduce the cost of his office visits by $12 without giving up any personal income. Add on the savings enjoyed by the elimination of defensive treatment practices and the savings will be considerable.

Increase the supply of MD's and Nurse Practitioners

As in any industry, one significant way to reduce costs of a product or service is to increase the supply. Given the fact that the income of doctors in the US is about twice that of other developed nations, it's surprising that, as of 2002, the US was 31st in the world in doctors per capita at 2.3 doctors per 1000 population.

When you also consider that the US only graduates about 17,000 doctors from medical school each year to fill some 25,000 residency positions, the remainder of which are filled by doctors from other countries, it's obvious that we suffer from a lack of supply. Given free market dynamics, one might actually think that the medical community is intentionally keeping the income of doctors elevated by working to keep the total number of doctors low.

By comparison, Russia has 4.25 doctors per 1000 population, Germany 3.4 and the Czech Republic 3.5 per 1000. At the same time competition for admission into the 130 accredited medical schools in the US is fierce while the process of accreditation of a new medical school is long, several years under the best of circumstances.

In a free market, supply and demand dictates cost so it's not difficult to see how the medical community has conspired to maintain the elite status of the profession by limiting the members it allows. This is the only way specialists can earn up to $400,000 a year and primary care physicians can earn close to $200,000. Providing medical care to the citizenry is an honored profession but it shouldn't be treated as an exclusive club only available to those at the top of the class who can pass muster and pay the price.

To increase the doctor patient ratio from 2.3 per 1,00 to 3.3 per thousand requires an additional 300,000 doctors to be added to into the system. If we double the number of graduating physicians to 34,000 per year, it would take over 17 years to increase the number of US graduated physicians to bring the ratio to 3.3 per 1,000 population. Obviously, there's no time to waste. The cost to establish a new medical school comes to around $120 million before it can begin accepting students and collecting tuition. A commitment of $14.4 Billion to establish 120 new medical schools could increase the number of doctors entering practice by 100%. Over time, this added supply of doctors would significantly reduce the cost of care while increasing its quality as doctors begin to have to compete for patients.

A side benefit of more doctors and the competition it would create is that we would see the average wait time to see the doctor will stop creeping up as it has for the past decade and start to turn around. No one should have to wait more than 20 minutes past the appointment time (the national average) to see a doctor. (some wait times actually exceed an hour)

An equal push to increase the number of nurse practitioners to provide primary care will further reduce the cost of care and accordingly the cost of medical insurance premiums. The agreed upon reimbursement for an office visit and for procedures directly impacts on the cost of health insurance premiums. If the US today had 4 doctors per 1000 instead of 2, the added competition would reduce the cost of an office visit today by at least 20% and would result in an equivalent savings in insurance premiums.

Note: While the US government should underwrite the construction of these new medical schools, it should endeavor to “rent” or “sell” the name of the medical school to commercial or benefactor interests in order to recover much of the cost. The practice of naming a medical school after a major benefactor is a time honored tradition. The only difference is, in the past, the university waited for the benefactor to donate before beginning construction. Here, the government will facilitate construction and then begin the process of selling the naming of the school while the school is proceeding through the construction and accreditation process.

SAVINGS:

While it's impossible to predict the total effect of a higher ratio of Doctors to the population, free market basics support our conclusion that significant savings will result over the next decade as the supply of new doctors increases toward 100%. Additionally, insurance companies will be able to more effectively negotiate with providers to offer their insured more savings and in the end, America will be much the better for it. We estimate the savings over the next decade to be in excess of $100 Billion.

2. PROBLEM: HIGH HEALTH INSURANCE PREMIUMS

2.1 CAUSES:

- **Lack of Competition**
- **Inequity between employer based and individual programs**

2.2 SOLUTIONS:

- **Remove state restrictions to the sale of health care insurance**
- **Include employer paid health insurance in taxable benefits.**

Remove state restrictions on the sale of health insurance

The best way to reduce health insurance premiums is to remove the near monopolies enjoyed by health insurance companies as a result of placing severe and unique restrictions on selling health care in individual states.

Different states place different requirements and mandates on insurance companies. They are (1) mandated health benefits, which require insurers to cover particular treatments or particular services; (2) “any willing provider” laws, which restrict insurers’ ability to exclude hospitals and doctors from their networks; (3) community rating laws, which require insurers to limit premium differences across individuals; and (4) guaranteed issue laws, which require insurers to sell insurance to all potential customers regardless of health or pre-existing conditions. By eliminating these conditions and allowing insurance providers to offer a wide variety of policies, with full disclosure, in a free market, it is estimated that individual health care insurance premiums could be reduced by as much as $2,000 a year for similar coverage.

Additionally, consumers would be able to choose between inexpensive catastrophic coverage and so called “Cadillac” plans plus everything in between based upon their own unique financial and healthcare needs.

Create Equality Between Employer Paid and Individually Purchased Health Insurance
It's essential to level the playing field between the self employed and businesses when it comes to access to coverage. While it might have made sense when employer provided healthcare was initiated, it no longer makes sense than an employer can deduct the cost of health insurance it purchases on behalf of it's employees yet the employee can receive that benefit tax free.

While every employer has the right to provide its employees with whatever benefits they and the employee decide, employer provided health benefits should be both taxable and portable. When the employee is called to be accountable for the actual value of the benefits provided, just as if it was cash, it allows for a more rational negotiation for the type and cost of insurance being provided. Additionally, when an employee leaves an employer there is no reason why their health insurance should be put at risk.

This also opens the possibility that an employee could opt for a tax deductible medical savings plan in lieu of traditional health insurance.

SAVINGS: Individual savings of up to $2,000 per year in health insurance premiums.

3. PROBLEM: LACK OF UNIVERSAL COVERAGE

3.1 CAUSE

Poorly planned and executed methods
With hospital emergency rooms required to provide treatment to anyone, the problem is not universal coverage, it's poorly and inefficiently delivered coverage. Emergency rooms are very expensive to operate as urgent care providers and are not well situated to provide basic services to a large population.

3.2 SOLUTION:

Community Healthcare Clinics

- Scholarship Programs
- Tax Breaks
- Universal Coverage
- Sliding Scale Fees
- Additional Benefits
- The Clinic Care Insurance Policy
- Insurance Covering Pre-existing Conditions
- High Risk Pools

The Community Healthcare Clinics

The key to is to encourage the development of privately operated Community Clinics where quality care can be delivered in the most cost efficient way possible. It would, in effect, be a second tier of healthcare that would not be equal to the premium care provided by private physician's offices but

would still exceed all existing minimum acceptable standards. The primary difference between "clinic care" and care provided by a private physician could be:

- **Longer waiting room time and more spartan waiting rooms**
- **Longer lead time to get an appointment and to receive certain treatments**
- **Services provided by what ever doctor is available rather than making appointments with specific doctors. Clinics would have the choice of assigning a specific doctor to treat unique care situations.**
- **Shorter time allocated per office visit than provided by private physicians.**
- **Greater utilization of Nurse Practitioners for primary care.**

These would be privately run clinics and would be staffed by physicians in two unique ways.

Scholarship program – As part of it's program to increase the number of MD's the Federal Government would offer grants and loans to qualifying students entering medical school in return for a commitment to serve in Community Clinics for 1 year for each year of scholarships. Doctors would also be able to serve their residency in these clinics where and when proper oversight can be created.

Doctors serving in these clinics, and not in residency, would earn a salary basically equivalent to the pay of a Captain in the Army. In return, clinics would assume full responsibility for providing care to medicaid and medicare patients at a rate that is discounted from the current reimbursement rate provided to private physicians.

Tax Breaks – Physicians in private practice would be encouraged to dedicate anywhere from 1 day a week to one day a month to serving in the Community Clinic in return for a nominal fee of 75% of the pay of Doctors serving under the Scholarship program. This income would be paid on a tax-free basis and reported on a new form "1099 Md." Additionally, any doctor participating in this program would be granted a charitable tax deduction equal to the amount of compensation paid on the "1099 Md."

Universal Coverage – The Community Clinic would become the primary care facility for any and all non-emergency patients who are US Citizens or legal residents and do not have a regular physician, regardless of their ability to pay. This service would replace the current system wherein emergency rooms are required to provide urgent care to all walk-ins. Emergency rooms would instead use the intake triage as the opportunity to refer non-emergency cases to the community clinics for treatment.

Sliding Scale Fees - All visitors to the clinic, including undocumented aliens, would be offered care at the Community Clinic at a standard rate for that Clinic. The standard rate would be determined by each clinic and be such that it could provide care and generate a reasonable profit for the clinic owners. Payment would be required, in advance, to prevent undocumented aliens from receiving free health care.

Any citizen or legal resident with a social security card who wishes to obtain care through the Community Clinic, without insurance, and on a sliding scale basis, would be required to register with the Clinic System and provide proof of income in the form of their tax returns annually. This un-insured treatment would be charged in accordance with the patient's ability to pay based upon their registration. Additionally, any patients who qualify for Medicaid or other state or federal programs yet are not enrolled, would be counseled and helped to apply.

Private insurance companies would be encouraged to offer special "clinic care" policies that would provide this second tier coverage at a greatly reduced rate compared with preferred coverage offering a much broader choice of private doctors and generally a premium variety of healthcare.

Additional Benefits – Doctors currently providing medicare and medicaid services to patients, would be prohibited from dropping existing patients but would be allowed, should they choose, to stop taking new patients. By significantly reducing medicare and medicaid underpayments from private doctors, these doctors in turn, would be encouraged (and compelled by competition), to further lower their rates since they no longer would have to increase their normal fees to offset losses incurred by treating medicaid and medicare patients.

This same financial dynamic would apply to hospitals whose emergency room losses due to un-reimbursed care requires higher fee structures throughout the rest of the hospital.

"Clinic Care" Insurance Policies - Similar to many current statewide practices, Clinic Care insurance would be available to all citizens and permanent tax paying residents on a sliding fee scale basis and would be offered competitively by any private insurance company wanting to compete for the business. Qualifying low income individuals would have their premiums subsidized through tax credits or direct subsidy. A modest but not insignificant co-pay would be required to discourage excessive use of the system. States already offering subsidized health insurance would be encouraged to incorporate their programs with the Clinic Care Insurance providers. Additionally, Clinic Care insurance would be available to undocumented aliens at an unsubsidized rate determined by the various insurance providers.

Subsidies to qualifying individuals would also be factored based upon a percentage of the premium set by the provider. Sliding scale rates would be determined by income but allowed as a percentage of the entire premium. In other words, a qualifying individual might be entitled to a 80% subsidy of their insurance premium based upon their income. Then, their actual net costs would be determined by the amount of the total insurance premium, which would necessarily be affected by the insurance company's underwriting procedure. In this way, it's entirely likely two people earning the same low salary might have entirely different insurance rates because one was a smoker and the other a non-smoker. All subsidies would be reviewed annually and adjusted accordingly.

Pre-existing conditions – All citizens and permanent residents would be encouraged to purchase health insurance beginning at age 21 or when they cease to be covered by their parent's health insurance policy. People choosing not to purchase health care insurance until later, would necessarily pay a higher premium when they do sign up. The actual amount of premiums would be determined by the Clinic Care Insurance providers on a competitive basis.

Health insurance companies will be prohibited from dropping an insured due to excessive claims so long as those claims are not deemed unreasonable by independent review board (non-governmental) and so long as the insured remains current on their premiums in accordance with the terms of the policy.

Additionally, health insurance companies will no longer be allowed to isolate certain customers from the rest of the general population of insured thereby creating unreasonable rate increases upon people needing a greater amount of care.

High risk pool

Companies offering Clinic Care insurance policies will jointly participate in a "high risk" insurance pool (or pools) to provide clinic care insurance to high risk individuals and individuals with pre-existing conditions that could otherwise make them uninsurable. While the pool itself would not be subsidized, individuals would be eligible for subsidies on a sliding scale basis in a fashion similar to

non-high risk policy holders. Simply put, it is neither rational nor reasonable that everyone should pay the same for healthcare when everyone utilizes it in a different way yet it is appropriate that all citizens be able to afford health care and health insurance. It is also reasonable, in a free market, that health insurance premiums necessarily reflect lifestyle activities that can materially affect one's anticipated need for significant health care.

Individuals choosing to purchase healthcare insurance only after the emergence of a pre-existing condition, will be able to obtain “clinic care” level insurance but not necessarily premium care offered in the free market by private health insurance companies. While clinic care insurance will be available even in the event of a pre-existing condition, the premiums will be necessarily higher to reflect the additional expense to the insurance company or to the high risk pool. Likewise, sliding fee scale subsidies for individuals electing to only obtain insurance after the emergence of a pre-existing condition, will be penalized resulting in significantly higher rates and co-pays in accordance with the nature of the pre-existing condition. As a result, if a person decides not to get health insurance until he really needs it, he is going to be able to get it but it is going to cost him more in accordance with his condition at the time.

Simply put, every accommodation will be made to encourage people to opt for cradle to grave coverage but in the end it is the individual's responsibility to obtain coverage and the burden resulting from a failure to do so, should first fall on the individual.

Accommodations will be made as the clinic care program is rolled out for individuals who are currently unable to obtain health insurance as a result of a pre-existing condition. High risk insured with pre-existing conditions coming into the system initially will be entitled to the same subsidies as insured without pre-existing conditions. Accordingly, the additional premium required initially will be considerably lower than those who do not purchase health care at the roll-out but wait until the system is fully integrated and then apply with a pre-existing condition. We would suggest a 6 month grace period.

There are currently 34 states offering high risk pools to their residents. Many are at no cost to the state. It is recommended that the Clinic Care providers look to assimilate the new high risk pool with these and expand it to the other 16 states. This can be left to the states and the insurance companies to coordinate.

SAVINGS/COST - The Community Clinic program would provide a net savings to both the government and private insurance companies when factoring in the following variables:

- Reduced Medicaid and Medicare reimbursement rates to Clinic Care facilities
- Lower hospital rates as a result of reduced deficits in hospital emergency rooms
- Lower insurance rates as doctors lower their normal fees due to competition and a reduction in Medicaid and Medicare patients
- Institution of clinic care fees and clinic care insurance for undocumented aliens reducing government subsidies currently in place.

While the pre-existing conditions feature would require subsidization of premiums to some affected lower income families, it would allow the insured to remain financially stable, albeit not abundant, as opposed to creating a greater liability on the system through financial ruination.

With the Clinic Care system in place we will have successfully expanding the availability of more rational health care to all sectors of society while providing subsidies, where necessary and appropriate, in a far more cost effective manner. This, in turn will significantly reduce the cost of health care in

every segment of society.

NOTE: It should be noted, to assure fair pricing in Clinic Care insurance, methods will be developed to provide consumers with adequate and easy to understand comparisons of varius Clinic Care policies to assure rigorous competition.

4. PROBLEM: MEDICAID AND MEDICARE FRAUD

4.1 CAUSE

Inadequate enforcement

Currently, healthcare fraud within Medicaid and Medicare is costing Americans about $60 Billion a year. That's $200 a year for every man woman and child in America and that's just what we know about. It could be higher.

Why all the fraud? It's simply human nature. When you have a government running an industry that has a budget of $676 Billion a year (19%) of the US Government's budget and , it's natural that people will attempt to defraud the system. The ineptness of governmental oversight is legion so it's easier for fraud to occur than against private insurers. Still, they too are victims of fraud, just not at the same rate.

When the US Government launched its Health Care Fraud Strike Force in 2007, the number of people charged has only increased by 2% indicating that either the government is more concerned about recovery than it is punishment or they are being generally ineffective.

In 2008, the FBI budgeted a total of just over $1 Billion and the equivalent of 4,779 Full time employees to all White Collar Crimes and Cybercrimes, including Mortgage fraud and Medicaid and Medicare fraud plus insurance fraud in general. Considering current advancements of computerized metrics and algorithms that could be used to detect possible crime, it appears that the FBI is understaffed when it comes to halting Medicaid and Medicare fraud.

After an increased push in 2007 and 2008 to disrupt criminal enterprises engaging in White Collar Crime, in 2009 the FBI reported a decline from 211 to only 160 disruptions. Major corporate crime cases successfully investigated also declined last year under the current Administration.

4.2 SOLUTION

Increased law enforcement efforts

While the overall size of the US government has grown dramatically in the past year to record levels, the size and staffing of the FBI has not kept pace. The total number of Full Time Equivalent employees assigned to Criminal Enterprises/ Federal Crimes was actually reduced from 11,934 in 2008 to only 10,596 in 2009. Additionally, the FBI now specifies Mortgage fraud as a separate crime type while Medicaid and Medicare fraud still are grouped with all other White Collar Crimes.

By increasing the FBI staff through an expanded Medicaid and Medicare Fraud Task Force, we could begin to reduce this massive outflow of of tax payer dollars and actually create a net positive return on our investment. With $1 Billion allocated to expand the Task Force, adding bounties for whistle-blowers, harsher penalties to offenders and aggressive “no mercy” collection policies shown toward the offender we could cut that $60 Billion by 65% to around $21 Billion. The added benefit here is that we can vastly improve healthcare in the American prison system while reducing costs by putting these doctors who scam Medicare and Medicaid to work in prison infirmaries for about $.29 an hour.