Health Care Reform and Universal Health Care for All (Single Payer)

The U.S. Health Care System gradually evolved sector by sector, hospital by hospital, doctor by doctor. What these players are doing is, technically speaking, perfectly legal. Participants in the marketplace respond to the incentives and opportunities a market allows or will put up with. We, the patients, are stuck in the middle, and responsible for our U.S. $3.5 trillion medical bill.

Fee schedules and national price negotiations:

Many countries (Japan, Germany, etc.) set national fee schedules for some combination of medical encounters or supplies and medicines. Those fees are negotiated by some combination of doctors, hospitals, governments, and academics; they can't be gamed or changed. Medicare in the U.S. already does this. Japan and Germany have hundreds of private insurers. The Netherlands government sets caps for some basic medicines and hospital services under their set package of essential benefits.

Single payer:

This is when a single authority usually the government, dispenses most of the money paid to health care providers. Used in Canada, Australia, Taiwan, Denmark, Great Britain, as well as other countries. The U.S. existing Medicare program is a single payer health care system.

Universal Health Care for All (Choice Option?): Private insurance companies would be required by law to offer the mandated package of benefits (could have additional benefits), prices for insurance are fixed, and every American would have to be on the plan. The federal government would be the single payer. There would be strong cost controls with elective treatments not covered as an example.

One option to gain Conservative support would be to allow extremely rich ($$$??? And above) to opt-out of the Universal Health Care program similar to Germany. The rich insurance plans would have to be extremely high with a portion still helping support the Universal Health Care program. This extremely rich segment of the population could then get on the only private insurance plan covering whatever each individual private insurance company comes up with. Some hospitals may then offer special facilities or doctors but should not be able to skip ahead of a patient that already has a scheduled appointment with a specific doctor or surgeon.

Another option is let anyone opt-out of Universal Health Care as long as they are still paying for it. They could then get private insurance. Private insurance that covers the same treatment as Universal Health Care could only happen at private hospitals or centers/offices that the law would not permit patients under the Universal Health Care program to go. The law would also state that these private hospitals or centers/offices accepting private insurance cannot be paid by the Universal Health Care program.

This single system is much easier to administer, with one set of forms to fill out, one book of rules, and one price list. As an economic principle, a unified system is a powerful force for cost control. Since the single payer health care system (Universal) is the only buyer of medical services, it has enormous market clout in negotiating fair reasonable fees with doctors, hospitals, drug, and medical device companies, and so on.

Court cases: Sick people in other countries, invoking their right to health care, have gone to court to force the National Health Care Agency to provide a particular drug or procedure or prosthetic device that is not covered. The judges have routinely sided with the National Health Care Agency. The courts have concluded that the national system- or its rationing body- can set the rules for prescriptions and treatment, if everybody has equal access to the care that is provided.

The U.S. is already covering about 30% of the population in different forms of universal health care if you are a senior, a soldier, a veteran, a Native American, a member of Congress, a renal-failure victim, or if you are scratching by on an income below the designated rate of poverty.

Universal Health Care Cost: The cost of health care could shoot upward toward unthinkable levels if everybody had the right to the full range of testing, treatment, surgery, and medication afforded by state-of-the-art medicine. To offer all possible treatment to every patient would lead any health care system rapidly toward bankruptcy. For this reason, other developed nations have framed the right to universal health care in terms of a floor and a ceiling. There is some floor level of care- the basic package of benefits- to which everybody has access. Generally, this includes standard diagnostics and treatment for disease, some level of preventive care, and access, either for free or a small fee, to an approved list of drugs. Then generally a ceiling beyond which the system will not go. Some expensive drugs, some advanced surgical interventions, cosmetic surgery, elective treatment, and so on will generally not be covered by the health care system. Some effective but expensive procedures will not be covered for a patient who has only a brief time left to live.

Issues and Solutions for health care in the U.S.

1. **Issue:** Insurers first priority are no longer the patient/members, but instead their shareholders and investors.

   Solution: Under a single payer system, insurers and the medical industry would focus more on patients/members.

2. **Issue:** For-profit insurers executives are compensated for how well they perform the financial function and are compensated well.

   Solution: Insurers executives could still be compensated well under a single payer health care system but most likely not to the degree they are now.

3. **Issue:** Insurers medical loss ratio (health care) has gone from 95% for “Blue” in 1993 to 64% in 2010 (Texas Blues) because of the increase of marketing, lobbying, administration, and the paying out of dividends. Medicare was using 98% of its funding for health care and only 2% for administration costs.

   Solution: Universal Health care for all (single payer) would allow marketing, lobbying, and administration costs of insurers to decrease.

4. **Issue:** Hospitals charge whatever amount they want, and insurers will pay as they don’t want to lose the big clients (hospitals) and can just pass the cost onto the patients/public by increasing premiums, co-payments, or deductibles.

Solution: Universal Health care for all (single payer) and health care reform would help set reasonable prices by region for health care while still allowing for hospitals, centers, doctors to make a profit.

5. **Issue:** Consultants and firms run around hospitals to improve revenue, improve compensation, and get a piece of the pie. Billing, collection companies, and contractors do things like claims and preapproval even though jobs like these don't exist in health care in Europe.

   Solution: Universal Health care for all (single payer) and health care reform would eliminate this thus bringing U.S. health care cost down.

6. **Issue:** Most hospitals are nonprofit institutions and cannot legally show a "profit". They end up going to Wall Street for bond issues to build new wings, so the bankers are involved with health care issues, too.

   Solution: City ordinance that mandates review of charitable performance in conjunction with approval for new hospital construction. This provides a stick for cities to use and demand more of its high-end health providers (hospitals). San Francisco was able to negotiate with a major hospital $1.1 billion to contribute to the city so the hospital could hang onto its tax-exempt status.

7. **Issue:** If hospitals or doctors don't make what they want from government programs (fixed amount depending on diagnosis) or big insurers then they use leverage an insist smaller insurers and people with no insurance pay more.

   Solution: Health care reform, universal health care (prices for insurance are fixed), and government negotiated prices (regional price arrangements with hospitals and doctors' associations) would fix this issue.

8. **Issue:** Some hospitals and medical centers no longer pay physicians a fixed salary; instead, they compensate in proportion to the Relative Value Units (RVUs) of the care they dispensed. Some tie salaries to physicians RVUs or sometimes offer "productivity bonuses" based on them. Physicians make sure to check the right boxes so they can up code to make more profit.

   Solution: Universal Health care for all (single payer) and health care reform would help prevent upcoding when patients don't need certain extra treatment that is not needed or as efficient. This will bring down the cost of the U.S. health care.

9. **Issue:** Hospitals and medical centers sometimes charge "Facility Fees" which no other type of business does.

   Solution: Health care reform should not allow "Facility Fees" to be charged to patients and Universal Health care for all (single payer) should not pay these fees.

10. **Issue:** New machines are purchased not based on medical necessity or even utility but according to financial gain. (Health Care Industry thinks that More or New treatment is always better. Default to the most expensive)

    Solution: Universal Health care for all (single payer) and health care reform would eliminate hospitals and medical centers from purchasing more or new machines that are not truly needed or to be able to

charge insurers and patients extra. Japan has seen more less expensive MRI machines all over the country which has brought down the cost of health care.

11. **Issue:** Patients are stuck with private room (single supplement) charges even if they didn't have a contagious disease or were vulnerable to infection.

    Solution: Universal Health care for all (single payer) and health care reform must eliminate these extra charges unless the patient truly has a contagious disease or was vulnerable to infection.

12. **Issue:** Medicare pays hospitals a bonus for performing well on patient surveys. Hospitals will give extra tests not needed if a patient requests to make them happy. This leads to higher health care costs.

    Solution: Universal Health care for all (single payer) and health care reform must eliminate extra testing that is not truly needed for an issue the patient came into a hospital, medical center, or doctor's office for in the first place.

13. **Issue:** Research has shown that many hospitals are providing nowhere near the amount of charity care and community benefit that would justify the value of their "Tax Exemption". A survey of the forms conducted by the California Nurses Association concluded that 196 hospitals received "$3.3 billion state and federal tax exemptions and spent only $1.4 billion on charity care- a gap of #1.9 billion." Three-quarters of the hospitals got more dollars in tax breaks than they spent on benefiting the communities they serve.

    Solutions: Under Universal Health care for all (single payer) and health care reform this would not be an issue as all Americans would be covered.

14. **Issue:** Pathologists, anesthesiologists, radiologists, and ER physicians (PARE) have created LLC companies and have become corporate contractors. Patients go to in-network hospitals but then get charged for out of network fees because of these PARE specialists (contractors).

    Solution: Close the loophole of centers buying in as investors and not participating in any insurance networks so they can charge facility fees that are not constrained by insurers. This could save patients tens of thousands of dollars.

15. **Issue:** Doctors/Specialists are billing for supervising multiple rooms/offices at one time.

    Solution: Do not allow doctors/specialists who never saw a patient, never had any interaction with the patient, to bill a service under themselves. Do not allow a doctor/specialist to bill for supervising in more than "X" number of rooms at once.

16. **Issue:** Doctors and hospitals who use more expensive drugs earn far more. Prices of drugs/treatment rise over time rather than fall.

    Solution: Universal Health care for all (single payer) and health care reform must require doctors, hospitals, and medical centers to only prescribe the least expensive drug(s) that the patient needs under federal government negotiated prices.

17. **Issue:** Drug companies are abusing the so-called "Accelerated Approval" (AA) measures for financial advantage rather than using it to address true health emergencies. These sponsors of drugs and biologics view the AA process as the easiest to get their products onto the market and with much less research expenditure. These drug companies make empty promises to do follow-up studies to make sure products approved through these proxy targets actually yielded long-term improvement for patients. There are no punishments for failing to carry out the subsequent research. Nor is there any mechanism to revoke FDA approval or take drugs off the market if scientific studies by academics proved them to be without benefit.

    Solution: The FDA should require drug companies to perform research after their drug goes through the "Accelerated Approval" (AA) process. Drugs must be taken off the market if scientific studies by academics proved them to be without benefit.

    The FDA should require pharmaceutical companies to determine if their product is more effective than the dozens of other treatments for a particular condition that are already on the market for new drugs/treatments. They should also include consideration of "price or measure of cost-effectiveness" metric that virtually all other countries now use as they consider admitting new drugs or old drugs requesting a new patent. (Cost, Cost-Effectiveness, and Comparative Utility)

18. **Issue:** Drug companies modify their drugs delivery right before their patent ends. Since generics must be identical in dosage and form to the brand-name drug for a pharmacist to substitute, each move/change succeeds in delaying competition from generics for years.

    Solution: The FDA should require all drugs to have at least a minimum number of subjects and days/years study for research on the drug.

19. **Issue:** Drug companies take out weak patents which generic brands will challenge. The drug companies use "Hatch Wasman" when those challenges come in which sets off a mandatory 30-month halt in the FDA's consideration for the generic entrant while the main drug company could still be making billions.

    Solution: Allow Medicare or new Government Universal Health Care (prices for insurance are fixed) to bargain for a national price.

20. **Issue:** Patients cannot have their co-payments waived for drugs. Drug companies have figured out they can increase their price of a drug and then send the patients "co-pay assistance", "donations", or "rebates" so the patient can afford their share then have the insurers cover the rest.

    Solution: Don't allow drug companies to use any "co-pay assistance", "donations", or "rebates" for patients so they can then charge an extremely high amount per dose and to the insurer. Don't allow drug companies to earmark their donation to non-profits such as Patient Access Network (PAN) for certain diseases that their drugs treat. This is a loophole to get donations, rebates, co-pay assistance to Medicare patients since it is not coming directly from the drug company but rather PAN or other similar groups.

21. **Issue:** According to antitrust law and under contractual gag clauses, insurers cannot compare prices they pay for medicine. Instead, insurers use "Pharmacy Benefit Manager" (PBM) and hospitals us "Group Purchasing Organization" (GPO) as a middleman to negotiate drug purchases with pharmacies. The

items that end up on the formularies of covered drugs and devices aren't always the ones patients need most or those that work best, but rather the ones on which the PBM has wrangled the best deal, with the best negotiated profit margin for the PBM.

Solution: Eliminate "Pharmacy Benefit Managers" (PBM) and "Group Purchasing Organization (GPO) by having universal health care (prices for insurance are fixed) and having the federal government negotiate drug prices.

22. **Issue:** Medical device such as "hip implant" prices are extremely expensive because they go through a chain which includes joint implant manufacturers, joint brokers, joint distributors, joint device salespeople, and the purchasers at the hospital or surgery center.
    Solution: Universal health care for all (single payer), health care reform must eliminate this chain. The federal government negotiated prices must limit price(s) which would mean the people in the chain would have to negotiate between themselves how much they each would get from the federal government negotiated prices. Prices must not be allowed to go over the federal government negotiated prices to try and force the patients to pay even more.

23. **Issue:** Medical Devices- Most applications for medical devices are now Class 2 in the 510(k) program which gains speedy approval, only averaging 20-hours FDA evaluation, only about 8% chance applications would be scrutinized by outside reviewers, 10% chance they contained clinical data. This is shocking since most drugs can be stopped in an instant if problems emerge and many devices are permanently implanted in the body. Manufacturers only need to prove their devices are "substantially equivalent" which is vaguely defined. Devices in Class 1 or 2 don't have to prove they are "safe and effective". Doctors and Manufacturers are only asked to voluntarily report problems with devices which means tracking and patient safety not very good. This program allows companies to continue to sell their devices and not have to inform patients using the device even if they are recalled because of proven harmful.

    Solution: Medical Devices- Need stricter more defined language for Class 2 devices which should really be considered Class 3. All device/patient problems must be reported by doctors and manufacturers. Devices need to be taken off the market if recalled, patients informed, and manufacturers cover any additional medical bills the patient needs for device issues related to recalls or problems. This should be like the auto industry.

24. **Issue:** Medical Devices- Some companies are making their own judgements about their products being "substantially equivalent" to others on the market that have gone through FDA approval, so they decide not to inform the FDA or go through approval. If the FDA finds out about this, they tend to only inform the medical device companies that they should have sought FDA clearance and receive no punishment at all.

    Solution: Medical Devices- Have strict laws if companies skip FDA clearance that they will either receive a mandatory very fine ($Millions) or can only get clearance if they go through Class 3.

25. **Issue:** Medical Devices- Companies, middlemen, and Physician-Owned Distributers (PODs) mark up the prices of medical devices and sell them to hospitals, surgery centers, and surgeons who they have relationships with or are employees. This means prices go up over time rather than down or better quality or less expensive medical devices are not being used or patients informed about.

Solution: Medical Devices- Don't allow hospitals, surgery centers, or surgeons to have personal choice in which medical device they will use of inform patients about. Government should decide base on safety, quality, and price or patients should have entire list of all medical devices with rankings on safety, quality, price, and where to find more information such as research. Hospitals, surgery centers, and surgeons must be required to inform and request consent before using any medical device fairly new (timeframe?) to the market. Government needs to decide on what the timeframe is to be considered fairly new (timeframe?) to the market.

Medical Devices- Is there a current excise tax?

26. **Issue:** Medical Devices & Drugs- Companies will stop making older products or raise older product prices to match or be extremely close to their new product prices. This means there is no real free choice. Patients are stuck and they're stuck buying American.

    Solution: Medical Devices & Drugs- Universal health care (prices for insurance are fixed) coverage and the government being the only player for basic health care can negotiate better prices if companies try to raise prices even for older products. Make it law that any company that wants to stop selling a medical device or drug must give other companies the option to purchase the patent/rights to manufacture and sell the product at fair price.

27. **Issue:** Testing, Medical Equipment, and Ancillary Services has become to hospitals and clinics what booze is to restaurants: high-profit-margin items that can be billed for nearly any amount.

    Solution: Testing, Medical Equipment, and Ancillary Services should only be used or performed if absolutely needed. Universal health care (prices for insurance are fixed) should not cover these unless medically required to treat or diagnose and patients must be informed if not covered that they will have to pay out of pocket and what that price will be before used or performed.

28. **Issue:** Pathology has become big business with medical centers own labs or hospitals sending off samples to commercial companies that are charging extreme prices.

    Solution: Pathology prices- The government negotiating prices under universal health care (prices for insurance are fixed) would have a single more accurate price. No patient could ever be billed more that the government negotiated price.

29. **Issue:** Some ambulance (ground and air) refuse to contract with any insurers because they consider their negotiated rates too low and charge incredibly high rates/prices.

    Solution: Health care Reform must make these ambulance companies negotiate under the universal health care program.

30. **Issue:** Home evaluation companies take advantage of Medicare Advantage plans and others by trying to uncover any new illness or tease out a new complaint from the patient which then pushes up "risk scores" or "burden of illness". This increases the fees for the home evaluation company. This is leading to too much treatment and extracting billions in dubious billing.

    Solution: Only allow home evaluation companies to perform care if prescribed by primary doctor and following new guidelines under universal health care reform.

31. **Issue:** Hospitals, Clinics, Centers, Doctor offices make it almost impossible to get an itemized bill. If an itemized bill is sent or given to the patient, then it is missing numerous items although the price is there. These itemized bills tend to be in medical language and coding that no ordinary patient could ever understand.

    Some hospitals will require patients to jump through all kinds of hoops to gain an itemized bill. First a patient will have to complete a patient privacy authorization form that can only be sent by fax. Then the request for an itemized bill has to be in writing and sent only by ground mail. Then the hospital will mail a letter explaining there is a fee to receive a copy of the itemized bill. This letter will explain that the request has to be sent by mail and that the fee has to be paid by paper check. After months of forms and delays a patient will finally receive an itemized bill.

    Solution: Pass law that patients can have access to an itemized bill(s) in a required 5-10 business days (Acceptable??) that is in plain language so anyone can understand it. Make it mandatory these medical building have costs price lists online with an easy search function. This should be created by the federal government once under universal health care (prices for insurance are fixed) with government negotiated prices.

32. **Issue:** Some hospitals, doctors, and surgeons have learned to up-code by giving treatment that makes them more money even if it is not the simplest or more cost-effective solution for the patient and their bank account.

    Solution: Federal government under universal health care must set limitations to prevent as much as possible the up coding for profit issues.

33. **Issue:** Insurers require precertification before treatment of patient. This precertification is normally contracted out to a middleman which adds to the cost of insurance plans and health care.

    Solution: Federal government must set precertification standards and guidelines for universal health care (prices for insurance are fixed). This will save doctors or office time and allow more human contact (Patient/Doctor) time.

34. **Issue:** Medication- Prices for certain treatments have skyrocketed over the years despite few significant advances in treatment or as technologies have aged rather than fall. Some patients have had to quite their medication treatment with unrealistic costs.

    Solution: Universal health care (prices for insurance are fixed) with federal government price negotiations would help keep prices more predictable for patients and affordable.

35. **Issue:** Companies focus on developing and selling ever-costlier treatments and supplies rather than cures.

    Solution: Universal health care (prices for insurance are fixed) with federal government negotiated prices may help influence companies to start focusing more on cures rather than lifetime treatments that make them large profits.

36. **Issue:** Pharmacy Benefit Managers, Pharmacies, Drug Companies, and Insurers all have a vested interest in keeping their cost a secret and then charge patients or premium costs whatever they decide or to whatever the local market will bear.

    Solution: Universal health care (prices for insurance are fixed) with federal government negotiated prices will bring these prices down to fair market value while allowing companies to make a profit but not an outrages profit.

37. **Issue:** Doctors and medical groups have stopped bills that would make it mandatory to inform patients whether every person who was giving them care would be in-network or not.

    Solution: Universal health care (prices for insurance are fixed) would mean everyone no matter where they go for treatment would be in-network. This must be included in health care reform and universal health care across the country.

38. **Issue:** Hospitals in certain areas/regions have consolidated which has driven out competition and raised prices. Doctors are pressured by their hospitals to refer patients for testing and surgery in consolidated areas with overpriced treatment.
    Solution: Universal health care (prices for insurance are fixed) with government negotiated prices would prevent these sky-high monopoly prices that negatively affect our health care costs and patients.

39. **Issue:** There are different electronic medical record systems/databases used within the medical field which allows hospitals to direct/default tests and surgeries to their own company's labs and surgery centers with overpriced treatment.

    Solution: Under Universal health care (prices for insurance are fixed) the federal government must create or contract out a single company that manages electronic medical records or make it law that all the different companies that make electronic medical record software talk to each other with ease. This would help prevent overpriced treatments that negatively affect our health care costs and patients.

40. **Issue:** Some hospitals are taking advantage of Medicare's remote hospital 25-bed or less "swing bed" rates by filling their beds with non-urgent problems and even flying patients to these hospitals. Patients, insurers, including Medicare are left paying these massive bills.

    Solution: Add restrictions to transporting (ground or air) patients to these smaller hospitals. The restriction should also require patients that must be transported to another facility to be the closest one that can provide the treatment no matter the company owner. Price would not be as large of a factor if universal health care (prices for insurance are fixed) was in place with federal government negotiated prices.

41. **Issue:** Some hospitals are permitting Freestanding ERs which are often owned by entrepreneurial physicians. Arriving patients are checked on by a doctor who then sends the patient to the nearest real emergency department connected to a hospital with facilities like operating rooms and a cardiac laboratory. The results are risks in delaying treatment and receiving bills for two separate high-level ER visits and a charge for emergency transport. Medicare and Medicaid do not allow this practice since government insurers insist that to qualify as an ER and bill ER rates, an emergency room must be physically connected to a hospital.

Solution: Under universal health care (prices for insurance are fixed) this practice could no longer happen saving patients from financial ruin.

42. **Issue:** Big hospitals hold enormous leverage in setting the terms of insurance contracts, because insurers need them in their networks. Local doctor offices can no longer give certain drugs in their offices to their own patients because the insurers contracts require that those types of procedures be done in a "hospital", even though the hospital charges multiples times that amount to the patient compared to their primary care doctor.

    Solution: Universal health care with government negotiated prices would prevent these sky-high monopoly prices that negatively affect our health care costs and patients.

43. **Issue:** Hospitals, medical centers, and doctors have turned over patient accounts to billing services and collection and credit rating agencies. In 2014, 52 percent of overdue debt on credit reports was due to medical bills and one in five Americans had medical debt on their credit record, impacting their ability to get a mortgage or buy a car.

    Solution: Health care reform, universal health care (prices for insurance are fixed), and government negotiated prices will extremely shrink this percentage.

44. **Issue:** Providers have found ways to maximize revenue by gaming the rules such categorizing procedures as "diagnostic" instead of as a "screening" procedure to make more money.

    Solution: Health care reform, universal health care (prices for insurance are fixed), and government negotiated prices must make one specific type of procedure the same price whether it is diagnostic or screening.

45. **Issue:** Under the current system insurers hyperlocal networks include no doctors out of state. In some areas even in-state networks are so narrow that patients are unable to secure an appointment and are forced to pay for out-of-network care themselves, particularly if they need a specialist.

    Solution: Health care reform, universal health care (prices for insurance are fixed), and government negotiated prices will allow patients to go anywhere and see anyone in the U.S. and keep prices in-network. There wouldn't by any out-of-network prices in the U.S. Universal health care may only cover certain health/medical care. Certain patient voluntary treatments the government does not decide to cover under the universal health care plan would be out of pocket or under a private supplemental insurance plan.

46. **Issue:** Finance departments at hospitals and centers along with doctor office finance people have negotiated with insurance carriers that are protected by "gag clause". Hospitals and centers have even encouraged or even forced separation of the finance departments and doctors which leaves the doctors and patients not knowing the cost of care until a bill shows up at the patient's house.

    Many hospitals (many nonprofits) will file lawsuits if patients don't pay bills marked up 2 to 23 times what Medicare would pay for the same service. The nonprofits hospitals even enjoy huge tax benefits because they claim to the IRS that they provide charitable care to the community. Yet in some cases, they were filing lawsuits without providing discounts or payment plans. Even when these medical facilities did offer payment plans, they were often for the full bill.

Approximately one in five Americans have medical debt in collections, and one third of the population is in debt due to medical expenses.

Solution: Health care reform (mandatory price transparency before treatment), universal health care (prices for insurance are fixed), and government negotiated prices will fix these issues. The primary doctor for a procedure or a hospitalization must be responsible for getting fees in advance from any ancillary doctors. Australia considers it every doctor's professional obligation to obtain informed financial consent as well as medical consent from patients.

This does not suggest that a quoted price be mandatory or made available if a person is shot in the chest and brought into the ER/ED. Sixty percent of medical care is shoppable, representing a large opportunity for transparent fair prices before treatment even happens.

Example if the restaurant industry was like the health care industry: When you go to a restaurant and ask for a menu, you might be alarmed if the waiter or waitress were to respond by asking, "Who's your employer?" If you then learned that the prices on your menu were much higher than those on menus given to other customers, you'd conclude it's a dysfunctional market. Yet this is exactly what happens when you need medical care in our status quo system today.

It's ironic that the federal government already has a mandatory disclosure rule for the real out-of-pocket costs people incur at a vulnerable time in their lives. But it's not a rule for health care- it's for funeral homes. The Funeral Rule, enacted by the Federal Trade commission in 1984, requires funeral providers to offer itemized pricing information to consumers before they purchase any services. The rationale is that consumers in a distressing situation should have honest pricing information, a rule that should also apply to the living, not just the dead. Patients and their families are also vulnerable when they seek medical care. But American health care is so crazy that if you are alive, you are susceptible to being taken advantage of. Ironically, once you're dead, federal law protects you.

47. **Issue:** Medical malpractice has grown into a lucrative industry because our medical system is terrible at responding to unhappy customers.

    Solution: Health care reform must offer limited warranties and guarantees on certain predictable services. Example would be any complications after an operation and the center/hospital will take care of the problem at no additional charge. This would be like the auto industries recall program.

48. **Issue:** Some physicians own medical care facilities and refer patients to them for further care to make more profit off the patient.

    Solution: Universal health care (prices for insurance are fixed), health care reform, and government negotiated prices would not prevent this conflict of interest in referral but patients would be charged the same price no matter where they go and have the option to go anywhere they are willing to travel and wait or schedule an appointment.

49. **Issue:** Health care has taken a backseat to generating as much revenue as possible.

Solution: Health care reform and universal health care (prices for insurance are fixed) must focus on cost-effective, patient-centered, evidence-based care.

50. **Issue:** Hospitals can keep patients up to three day (2 midnights) on observation status which make them a larger profit rather than fully admitting the patient.

    Solution: Require hospitals to officially admit (inpatient) all patients and not allow patients to be under "observation". Another option is to still allow hospitals to have "observation" status for patients that are there for 6-hours or less per week. This would save some patients thousands of dollars as their insurers would have to cover the amount.

51. **Issue:** There's an epidemic of drive-by doctoring on helpless inpatients. These medical personnel turn up whether you need or want them, with the intent of charging for their services. These drive-by doctoring are billed at exorbitant rates.

    Solution: Health care reform and universal health care (prices for insurance are fixed) that has government negotiated prices would help prevent exorbitant rates and only cover basic health/medical care. This drive-by doctoring and charging would not be covered under the universal health care or health care reform. This would then be a free service for patients or hospitals, centers, doctors and such would have to inform and get consent from competent patients what the extra drive-by service is for and what it will cost (itemized bill) before the service(s) even happen.

52. **Issue:** Health care is the only industry consumers don't know the price they will be charged until after the service/product. It is also the only industry that multiple consumers can go into the same building or business (hospital), be given the same exact service/product, but then all be charged completely different prices depending on insurer (private vs government), paying cash, or no insurance.

    Solution: Health care reform must make it mandatory hospitals, centers, medical offices give up-front estimates of charges (itemized bill) before treatment or care and get consent from competent patients. Nationwide master price lists must also be posted online. These itemized bills and "chargemasters" must be in a standard nationwide universal easy-to-understand format anyone can understand.

53. **Issue:** There is no industrywide or legal standard about when medical accounts should be considered seriously delinquent.

    Solution: Health Care Reform must include: At the very minimum make is 6-months before a patient is considered delinquent with their medical bill(s), given how long it takes for insurers to process their portion of the payment. No bill should be sent to collection while the patient is disputing its legitimacy.

54. **Issue:** The private sector (Non-VA hospitals) focus or tend to only give care oriented toward profitable expensive medications and surgeries for obesity and type 2 diabetes as just a couple of examples. The VA focuses on weight management programs for the exact same patients as the VA system has standards and is transparent.

    Solution: Universal health care (prices for insurance are fixed) must have set caps, standards, and processes for treatment, care, and medicines.

55. **Issue:** Health insurance provider directories and formularies are inaccurate and can change from one month to the next. A patient may purchase their medication with only a $20 co-payment one month and then be demanded to cover 20 percent of the same medications $1,500 cost the next month.

    Solution: Health care reform, universal health care, and government negotiated prices must set fair standards and prices from insurance companies.

56. **Issue:** Tests and ancillary services normally associated with procedures may be billed as out of network even if the procedure is listed as covered under a plan.

    Solution: Universal health care (prices for insurance are fixed), health care reform, and government negotiated prices would prevent any out-of-network charges decreasing the cost of health care for patients overall.

57. **Issue:** During an "emergency" a patient may have no other choice but to use a facility or a provider outside the network for treatment.

    Solution: Universal health care (prices for insurance are fixed), health care reform, and government negotiated prices would prevent any out-of-network charges decreasing the cost of health care for patients overall.

58. **Issue:** The unbundling of every medical encounter has inflated medical bills.

    Solution: Universal health care (prices for insurance are fixed) and health care reform must wrap all aspects of treatment into bundles and not just for patients in the hospital. The level of payment will cover the hospital, all the doctors, physical therapy, and any rehabilitation. Each party will bill separately and if the charges come in below the bundled price the hospital gets to keep some of the difference. It is penalized if they come in above it (they cover the difference).

    At NYU Langone Medical Center, for example, the cost and standard practices involved in hip replacement surgery radically changed with the financial incentives. When not paid for each service, the hospital decided that patients required only $742 of inpatient rehabilitation compared with $6,228 before the program; it also decided that if patients were extremely obese they should not be offered the surgery unless they lost weight, because surgery was unlikely to help or be much more complicated otherwise.

    Maryland's independent Health Services Cost Review Commission has set bundled rates for hospitalization; all insurers, including Medicare, pay the same rate for the same procedure on every patient. (To undertake such experiments, states need only to get a waiver from the Centers for Medicare and Medicaid Services). Then Maryland assigned hospitals a "global payment" based on the number of patients in their system. They will have to use the money wisely and well to benefit patient health rather than profit by doing more visits and procedures. Patients and insurers will still see bills based on the services provided to them, which will be used to determine co-pays. If the volume of procedures decreases, leading to less calculated revenue than the global payment benchmark, the hospital will get to keep a portion of the savings.

59. **Issue:** Hospitals charge "facility fees" and some doctor offices rebrand themselves as hospitals for profit to increase their prices of treatment.

Solution: Health care reform, universal health care (prices for insurance are fixed), and government negotiated prices should not all these fees or higher prices.

60. **Issue:** People have to pay for a doctor visit just to get their long-term medicine prescriptions such as birth control, asthma inhalers, or thyroid medication renewed.

    Solution: Health care reform and universal health care (prices for insurance are fixed) should allow pharmacists to dispense these long-term medicines without doctor visits to get renewals.

61. **Issue:** Drug approval and patent process- The FDA maintains the so-called Orange Book, a list of all the patents that protect approved drugs, currently compiled regardless of the clinical importance of the innovation. All patents in the Orange Book must be expired or litigated before a competitor can start production of a generic. Drug companies frequently file frivolous lawsuits that claim patent infringement solely to be rewarded with that automatic extension of patent protection for thirty months, while the case is adjudicated or settled.

    Solution: The U.S. Patent and Trademark Office could restrict the patents available to drugs that do not offer true novelty or benefits. The FDA could distinguish between patented products of high and low value to patients. For example, a drug that represents a genuine medical breakthrough could be rewarded with a prolonged period of market exclusivity, while a replica drug or a modification that merely offers greater convenience, such as a once-a-day formulation, could be granted shorter periods. Drugs judged to offer no significant benefit to patients (a chewable birth control?) could receive no market protection at all.

62. **Issue:** Drug company efficacy studies have only to compare new drugs with a placebo or nothing, instead of similar products already on the market. Crowded markets create a lose-lose situation for doctors and patients, who are forced to choose among half a dozen pricey drugs that have never been properly compared with one another to see which one is most effective.

    Solution: The FDA must revamp its policies about the types of studies it requires drug companies to perform before a drug is approved for use. The FDA must start accepting the results of scientific studies from other countries and be more collaborative in deliberating with foreign counterparts like the European Medicines Agency, which approves drugs for use throughout the European Union. The enhanced cooperation would result in faster approvals and greater availability of some useful but not terribly profitable drugs. This should all happen under health care reform.

63. **Issue:** A drug companies may decide to cease production of a medication which could create a monopoly or a near-monopoly to other companies. Prices could then soar and be a public safety issue.

    Solution: Health care reform must require drug companies to gain government approval to cease production of individual medications. The government must activate its “march-in rights,” which allow it to assign certain patent licenses to a new company to make the drug because of a threat to public safety.

64. **Issue:** Pharmaceutical companies have massive prices in the U.S. only and then have corporate relocations overseas or use tax loopholes to legally avoid U.S. taxes.

Solution: Health care reform must allow the federal government under universal health care (prices for insurance are fixed) to negotiate with drug companies. Drug companies must justify yearly price increases for long-used drugs and get preapproval.

65. **Issue:** Drug and Medical Device companies charge exorbitant prices.

    Solution: Health care reform must make drug and medical device companies estimate a price point from the very start of the FDA application process. Include price as part of the debates at the FDA and in the broader medical community from the very beginning, even if it can't be considered as a factor for approval.

    The U.S. must create a national body like the United Kingdom's National Institute for Health and Care Excellence (NICE) that is tasked with assessing the value of new drugs and treatment. Are they cost-effective compared with other options already available and at what cost are they worth buying? The British National Health Service uses those judgments to negotiate for lower prices. Many countries perform similar cost-benefit analyses, whether or not they run a national health system.

66. **Issue:** Screening events around communities has skyrocketed and the scientific consensus is that many of the new high-tech screening techniques being promoted to healthy patients are not much more useful than snake oil. There is no "normal" for such tests and treatment brings new risks and dangers along with un-needed costs to health care.

    Solution: Published guidelines on testing/screening from both the U.S. Preventive Services Task force and Choosing Wisely must be added as law in health care reform. Universal health care (prices for insurance are fixed) should have set standards for testing/screening under the basic health care coverage. Medical treatment that is not covered under the universal health care (medical treatment covered under private supplementary insurance) can allow from testing/screening for only those set of medical conditions.

67. **Issue:** Medical information (electric and hard copy) are held captive in disparate doctors' offices and hospitals. That isolation translates into pointless expense, higher administration costs, because patients frequently have tests repeated. It means worse care because doctors don't have previous test results for comparison.

    Solution: A universal, national program supported by taxpayer money. All that information could be placed on a chip card to carry in a wallet, which could be scanned by each new provider. The information could be stored in a national data collection system akin to a credit agency like Equifax. This public agency would keep records of all your medical encounters in a secure and searchable form, they could be made available to providers of your choosing. The database could also act as a national early warning system if people using a new drug or device were having unexpected serious side effects or benefits.

    The U.S. could copy France's Carte Vitale- the "Vital Care," or the "Card of Life"- contains the patient's entire medical record, how much the doctor billed for each visit, how much was paid by insurance and by the patient. This card can be used at drug store pharmacies and private supplemental insurance for treatments not covered under the universal health care program. The card is put into a small reader and with a single keystroke, all billing information like how much the patient owed, how much the patient paid the doctor as a co-pay, how much each of the insurance plans (universal and private

supplemental) should pay back to the doctor and the patient. Insurance plans must pay within three days. No doctor, hospital, medical center, drugstore would have to pay a "denial management" company to collect what is owed by the health insurance industry. The expensive layer of administrative and clerical workers and paper handlers found today in the U.S. would not have to exist anymore. The lack of administrative and clerical workers would then allow for more doctors, nurses, and dietitians per patient.

68. **Issue:** The public has to call or look online to receive in-network treatment. It takes time to figure out who and when to schedule an appointment, prices are never given up front, figure out if treatment is covered with insurers, filling out form after form when visiting providers, mailbox filled with paper statements for months afterward.

    Solution: Health care reform must create a government website with a one-stop shopping and payment system. These sorts of interlocking online arrangements could become standard features of every contract between insurers, drug and device companies, or medical providers. The government could mandate adoption or offer financial incentives to participate such as Medicare bonus payments to doctors and hospitals. Thanks to digital technology you can price, book, and pay for a hotel, flight, car rental on your computer. Why can't we do the same for an X-ray down the block or a doctor's appointment?

69. **Issue:** Some doctors will recommend surgery for treatment even if other less invasive, lower cost, and just as effective alternate treatments are out there such as exercise, healthy diet, or medication.

    Solution: Health care reform and universal health care (prices for insurance are fixed) must require doctors to use less invasive, lower cost, and just as effective alternate treatment(s) first before moving onto surgery or other high invasive and high cost treatments.

70. **Issue:** In a study conducted by the University of Iowa, researchers called 101 hospitals and asked them what they would charge for the same type of heart bypass operation. The range of prices for the exact same heart bypass operation was from $44,000 to $448,000 with the average price of $151,271. In France, the same exact type of heart bypass operation was only $15,000. Another study found that medical treatment markups to be up to 23 times higher than what was paid by Medicare for the exact same service. Hospitals will say the "We have to make up the cost of taking care of the uninsured", "That's to compensate for charity care", or "Don't worry, people are not expected to pay those prices". The data did not support their assertion.

    Insurers fight for a bigger discount every time they renew a contract with a hospital. Then hospitals go around and inflate their prices. These higher hospital bills are then passed to the public in the form of higher insurance premiums.

    Solution: Health care reform must create an independent Health Services Cost Review Commission to make a standard price on all treatments, medication, medical devices. Locality rates could increase the base standard price as an option in health care reform like federal employee salaries.

71. **Issue:** Current U.S. health care includes the repricing industry, dedicated to negotiating bills among three or four parties after care is delivered. There is countless consultants, vendors, and well-paid middlemen. One study found that for every ten doctors, the average U.S. hospital has seven nonclinical

full-time-equivalent (FTE) staff working on billing and insurance functions. This all adds up to the U.S. sky-high health care prices.

Solution: Health care reform, universal health care (prices for insurance are fixed), and federal government negotiated prices would eliminate this issue and lower the cost of health care in the U.S. like other countries.

72. **Issue:** Medical air flights have extremely inflated prices for anyone not covered by Medicare or Medicaid. Some of these flights are not even needed as they are non-emergencies and ground travel would suffice. Some of these medical air flight companies deliver gifts to emergency room staffers, built helipads for the hospital and installed activation buttons so doctors or nurses can rapidly summon a helicopter for a hospital-to-hospital transport. They even pay paramedics, nurses, and doctors to become advisers, with informal agreements to promote the company to first responders and other medical professionals. Many of these companies hide their prices (True & Pre-Billed) from consumers until the bill show up in the mail. This leads to higher health insurance premiums.

    Solution: Health care reform, universal health care (prices for insurance are fixed), and federal government negotiated prices will help this issue. The federal government will determine what situation would allow for air flight and cover a negotiated price (maybe per mile in a straight line?). Distance would work better than time as air companies might abuse this. Require medical air flight companies to inform patients about prices before a flight is even scheduled or approved. A database must be created that would name the person who made the decision to summon the air ambulance company, so that hidden conflicts of interest could be revealed. The database must also track and publicly report each companies' charges per flight. Make medical air flight complaints information available for the public online.

73. **Issue:** Some hospitals and doctors surgery rate (higher cost) vs other treatments are performed even if out of accordance with best practices. One example is a doctor with a 95% C-section rate vs natural birth for his patients even if it is not in the mother or baby's best interest. The same can be said for other surgery's and higher cost treatments when other less costly and just as efficient treatments are out there.

    Solution: Health care reform and universal health care (prices for insurance are fixed) must make doctors and hospitals track patterns of treatment and if the procedure was appropriate or not.

    An independent committee would confidentially inform doctors and surgeons (individual data) of their individual surgery or high cost treatments fell outside the boundary of what is considered appropriate. This feedback must show them how they compare to their peers to help these doctors and surgeons improve on which treatments they should be using/giving their patients. The goal is to let outliers know that they are outliers and help guide them toward best practices. The goal is improvement and create a culture of accountability.

    Not preferred- These doctors and surgeons outside the boundary of what is considered appropriate for treatments must be monitored every six months. If no change in practice or appropriate rates, then they must be penalized by the federal government under universal health care (prices for insurance are fixed).

74. **Issue:** One in 16 surgical patients prescribed opioids become long-term users. Furthermore, 70-80% of opioids prescribed after surgery are not used and 45% of patients are over-prescribed opioids at the time of hospital discharge compared to their inpatient opioid use. Despite the new knowledge about over-prescribing after surgery, there is a lack of procedure-specific guidelines about what providers should be prescribing. Some poor patients have bought heroin to manage their surgical pain because it cost less than their copay.

    Solution: Health care reform and universal health care (prices for insurance are fixed) must have procedure-specific opioid guidelines. A good source is the Center for Opioid Research and Education found at solve the crisis.org. Opioid prescription must be used sparingly and focused only on patients with terminal cancer, burns, and major surgery. Universal health care must make over-the-counter medicines like pain killers and nonsteroidal anti-inflammatory drugs free or almost 100% covered to limit the number of opioids used and fight the crisis in the U.S.

75. **Issue:** The number of medications prescribed to patients has doubled over the past decade even though the incidence of disease has not doubled in the same amount of time. Most of the doubling represents pills that could be avoided with lifestyle changes or more judicious prescribing. This has led to higher insurance premiums.

    Solution: Health care reform and universal health care (prices for insurance are fixed) must make doctors and hospitals track patterns of treatment and if the medication and amount of medication was appropriate or not.

    An independent committee would confidentially inform doctors and surgeons (individual data) of their individual patient medication prescriptions fell outside the boundary of what is considered appropriate. This feedback must show them how they compare to their peers to help these doctors and surgeons improve on which medication and the amount they should be prescribing their patients. The goal is to let outliers know that they are outliers and help guide them toward best practices. The goal is improvement and create a culture of accountability.

    Not preferred- These doctors and surgeons outside the boundary of what is considered appropriate for prescribing medication and the amount must be monitored every six months. If no change in practice or appropriate rates, then they must be penalized by the federal government under universal health care system.

76. **Issue:** Insurance brokers get kickbacks for selling health insurance and pharmacy benefit manager plans to employers. The brokers convince an employer to buy an over-priced plan or a great value plan. They can convince an employer to switch insurance carriers, stick with their current carrier, go to the mat for a better price, or bypass health insurance and simply self-insure. Brokers have a lot of power. Employers grow to trust them. Insurance companies use cash to control the brokers such as bonuses, overrides, persistency bonuses, or contingent income. This pushes the brokers to get employers into plans that were way too expensive for them. If brokers don't do what the insurance companies want, then they black-balled them from their entire business.

    The financial crisis of 2008 was in part because people were buying and selling products they didn't understand. Retirement plans were buying collateralized debt obligations (CDOs) even though no one had any idea what assets they contained. The market was too complicated for anyone to deconstruct.

Employers have similar problems understanding the health insurance products they purchase. They designed to be complicated, so employers won't try to figure out where their money is going.

The similarities to the subprime mortgage crisis are striking. Back then, mortgage brokers were paid bonuses for putting people into subprime mortgages they couldn't afford. Both mortgage brokers and health insurance brokers were selling their clients products they didn't understand. The main difference was that after the global recession, the government cleaned up the mortgage broker business. The health insurance broker business, on the other hand, has never faced the needed clean up or reform.

One of the reasons employee wages have been stagnant in recent years is because of the expense of health insurance. Fixing this issue would help employers to get better rates which would save billions across the country every year. This saved funding could then go toward wage increases.

Solution: Health care reform must make it mandatory the health insurance broker business is fully transparent by showing the public and employers how brokers, insurance companies, pharmacy benefit managers, and providers are being paid. All brokers must sign a code of conduct and have a standard disclosure form that show all the different ways they are being paid to show anyone they are doing business with. The federal government should have a website that has voluntary employer insurance plans from both insurance companies and employers to the public can have an idea on rates. Health care reform should make it illegal for any type of gag clause in insurance or broker contracts/deals.

77. **Issue:** Pharmacy Benefit Managers (PBMs) are extremely overcharging employers. Employers, directly or through their health insurance company, hire a PBM to manage the pharmacy benefits for their employees. "The Spread" is the difference between what the PBM pays a pharmacy for a medication and what they invoice an employer or health plan for that same medication. PBMs are making 5 to 20 times more than what they pay a pharmacy for the medication. Sometimes the patient's copay covers the entire cost of the medication, thus the PBM is charging the employer for the medication but paying the pharmacy nothing. PBMs send extremely complicated itemized bills that don't have the price they paid the pharmacy or "The Spread". The PBMs have gone to great lengths to keep the real prices secret, using a fog of fees, rebates, and discounts that make a true value too complicated for anyone to determine. Pharmacists are also gagged under their PBM contracts to not disclose what they are paid by the PBM. Pharmacists can however help patients find less expensive options.

    Health insurance companies that cover the same employers are in cahoots with the PBMs. In fact, many times they are co-owned. Health insurance companies direct their business to their own PBMs, which increases their margins.

    Solution: Health care reform must make it mandatory the PBMs give all their clients a standard simple to understand itemized bill that includes what the PBM paid the pharmacy and what "The Spread" is for each item. Health care reform and universal health care (prices for insurance are fixed) must set a reasonable flat fee for PBMs of $2.75-4 administrative fee per prescription above the price paid by the PBM that will more than cover their management costs and yield a healthy profit. PBMs must show full transparency in rebates and discounts to employers and the public. This would save health care billions every year. PBM contracts with gage orders must be outlawed. Congress and health care reform must repeal the 1987 Safe Harbor Law that exempts GPOs and PBMs from antikickback laws. This reform will end price distortion.

78. **Issue:** PBMs try to get individual patients signed up for mail order medication programs. But once the patients get on the mail order, it's hard to get off. Suddenly, they are getting stockpiles of medications they don't want or need because the PBM is getting their doctor to sign a refill request even though they never asked for one. When a doctor's office receives a refill request, they often just sign it.

    Solution: Health care reform must make it illegal for PBMs to order refills without patient consent every single time. PBMs must also make it extremely easy for patients to opt out of the program with multiple options such as just a click of a button on a website or calling an 1-800 number. A mail order must never be a requirement under universal health care (prices for insurance are fixed) or allowed under health care reform.

79. **Issue:** Most hospitals and medical centers today acquire devices, supplies, and medications through Group Purchasing Organizations (GPOs) rather than directly from a manufacturer. GPOs ask manufacturers to pay them pay-to-play fees for product placement in their catalogs. GPOs can invite a manufacturer to pay a premium fee to become a sole supplier, allowing a manufacturer to essentially purchase market share, rendering hospitals and patients dependent on a single manufacturer's supply chain. GPOs are like PBMs in how they operate in a fog of transactions, making value difficult for any buyer to ascertain. In the case of GPOs, hospitals may simply pass on high costs to patients in the form of a hospital bill.

    In 1972, Congress enacted the Anti-Kickback Statue as part of the Social Security act amendments. Designed to protect patients and federal health programs from obvious conflicts of interest, it banned kickbacks, bribes, or rebates for furnishing products or services. But in 1987, after intense lobbying by the industry, group purchasers were granted an exception to the antikickback law, known as a safe harbor exemption. It's the same exemption that allows PBMs to receive kickbacks from the pharma companies they guy from. This has allowed GPOs to come up with creative strategies to increase their profits but cost patients and health care overall.

    In 2018 alone, manufacturers and pharma companies paid GPOs billions of dollars in pay-to-pay fees. Manufacturers and pharma companies then built those expenses into the price of the products they sold to hospitals. As GPOs grow and gain more market share, they are in a stronger position to demand that manufacturers and pharmaceutical companies pay whatever fee the market will allow them to charge. GPO kickbacks inflate health care costs by billions every year and these inflated costs ultimately fall upon patients and taxpayers (Medicare, Medicaid, VA).

    Solution: Congress and health care reform must repeal the 1987 Safe Harbor Law that exempts GPOs and PBMs from antikickback laws. This reform will end price distortion.

    Hospitals should avoid GPOs that use sole supplier contracting and pay-to-play games that give manufacturers market dominance. Hospitals should also avoid GPOs that prevent them from purchasing outside their catalog.

80. **Issue:** Insurance companies hire thousands of adjusters and investigators to go through submitted claims looking for reasons to deny payment. In other developed countries, insurers are required to pay every claim.

    Solution: Health care reform must not allow insurance companies to deny payment if treatment falls under universal health care. Once a doctor submits a bill under universal health care then insurance

companies must not be able to deny that bill. Health insurance companies could deny payment under private supplemental insurance for treatment that does not fall under the universal health care plan.

81. **Issue:** The U.S. is the only country where when a person leaves their job, they also lose their health insurance.

    Solution: The coverage of universal health care must continue if a job ends (unemployment benefit) under health care reform. The federal government must pay the premium until the unlucky employee can get back to work or is retired.

82. **Issue:** Life Expectancy at Birth is not a good indicator of a nation's health status.

    Solution: An option for health care reform could require the federal government or an independent committee to gauge the U.S. health status by using the Disability-Adjusted Life Expectancy (DALE) or Health-Adjusted Life Expectancy (HALE) along with Quality-Adjusted Life Year (QALY) and Disability-Adjusted Life Year (DALY). These could help the U.S. decide which medical treatments, drugs, medical devices are worth spending money on, and which ones don't provide a significant return for the money spent.

83. **Issue:** Medical centers are being bought into as investors and are not participating in any insurance networks so they can charge facility fees that are not constrained by insurers.

    Solution: Health care reform must close this loophole and force medical centers to take Universal health care for all (single payer) insurance. This could save tens of thousands of dollars per patient and lower the cost of health care in the U.S.

84. **Issue:** Doctors/Specialists can bill for their service (higher pay/cost) who never saw the patient, never had any interaction with the patient, but their staff treated the patient.

    Solution: Health care reform must not allow doctors/specialists who never saw a patient, never had any interaction with the patient, to bill a service under themselves. Do not allow a doctor/specialist to bill for supervising in more than "X" number of rooms at once.

85. **Issue:** Currently drug companies can have new drugs enter the market even if it is not as effective as other similar drugs on the market. The price of these potential less effective drugs could cost just as much or even more than the more effective drugs on the market.

    Solution: The FDA should require pharmaceutical companies to determine if their product is more effective than the dozens of other treatments for a particular condition that are already on the market for new drugs/treatments. They should also include consideration of "price or measure of cost-effectiveness" metric that virtually all other countries now use as they consider admitting new drugs or old drugs requesting a new patent. (Cost, Cost-Effectiveness, and Comparative Utility)

86. **Issue:** Drug companies are using the Accelerated Approval (AA) process so they can spend less time and funding on research and get drugs into the market even if they have little to no benefit for patients.

    Solution: The FDA should require drug companies to perform research after their drug goes through the "Accelerated Approval" (AA) process. Drugs must be taken off the market if scientific studies by

academics proved them to be without benefit. The FDA should require all drugs to have at least a minimum number of subjects and days/years study for research on the drug.

87. **Issue:** Currently Medicare cannot bargain for a national price.

    Solution: Allow Universal health care for all (single payer) to bargain for a national/regional price.

88. **Issue:** Drug companies have found loopholes to increase the prices of their drugs to insurers.

    Solution: Health care reform must eliminate these loopholes to bring the cost of health care in the U.S. down. Don't allow drug companies to use any "co-pay assistance", "donations", or "rebates" for patients so they can then charge an extremely high amount per dose and to the insurer. Don't allow drug companies to earmark their donation to non-profits such as Patient Access Network (PAN) for certain diseases that their drugs treat. This is a loophole to get donations, rebates, co-pay assistance to Medicare patients since it is not coming directly from the drug company but rather PAN or other similar groups.

89. **Issue:** "Pharmacy Benefit Managers" (PBM) and "Group Purchasing Organization" (GPO) are middle people that are not needed in health care and have led to some of the extremely high prices of health care in the U.S.

    Solution: Eliminate "Pharmacy Benefit Managers" (PBM) and "Group Purchasing Organization" (GPO) by having universal health care for all (single payer) and having the federal government negotiate drug price and discounts with manufacturers, distributors, and other vendors.

90. **Issue:** The medical device industry is getting almost all their new devices classed as class 2 products. These means no research or studies are needed which has allowed defective and dangerous products out into the market and be placed inside human bodies. The outcome has been pain to even death for some patients depending on which medical device along with lawsuits.

    Solution: Medical Devices- Need stricter more defined language for Class 2 devices which should really be considered Class 3. All device/patient problems must be reported by doctors and manufacturers. Devices need to be taken off the market if recalled, patients informed, and manufacturers cover any additional medical bills the patient needs for device issues related to recalls or problems. This should be like the auto industry.

91. **Issue:** The U.S. sees the most health care related malpractice lawsuits compared to any other country.

    Solution: Health care reform and universal health care for all (single payer) will help to almost eliminate this like other countries. Place limits on noneconomic damages in malpractice lawsuits to dissuade patients from bringing frivolous suits in the hope of a huge payout. In California, patients can sue for the costs of past and future medical care as well as income lost because of injuries or poor medical outcomes.

    Malpractice lawsuits are typically long, drawn-out affairs that end in settlement, it makes sense to have a system of judge-directed arbitration or dispute resolution at the state level. This will help patients with serious injuries as the result of malpractice or defective medical products often wait years for a payment even as their day-to-day medical expenses mount.

92. **Issue:** Health care debt has led to patients having their paychecks garnished, sent to collection agencies, not enough money for food or rent, lose their house, and not afford medication.

    Solution: The federal government and hospitals could work together to gain low-interest loans from banks where the hospital backs the debt for patients who cannot pay in full. So, if the patient's defaults, it falls on the hospital, not the patient. Health care reform must also allow patients to get on a payment plan and not pay in full.

93. **Issue:** There is zero price transparency with hospitals, medical centers, and some doctor's offices in the U.S. Patients are unable to shop around for reasonable prices and are limited to certain in-network locations, doctors, and specialists. This is very inefficient and is not like any other industry in the U.S. or health care industry in any other developed country.

    Solution: Price transparency- States could follow Florida by passing a law that requires hospitals to not only show the Chargemaster prices/Sticker prices but also the discounted prices they have accepted. We need to see prices, so patients and health plans can determine which facilities are operating in a way that's efficient, and which are just trying to maximize their profit.

Other Solutions to Research:

1. Medical Devices- Is there a current excise tax? Should there be?
2. If this health care reform, universal health care, and federal government negotiated prices happen could every hospital file to be a non-profit and get tax exemptions?

These "issues" and "solutions" were identified in three books (See References).

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