# Nebraska Health Care Reform Task Force

*November 28, 2007*

*Advocating for Physicians and the Health of all Nebraskans*

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This Task Force was constituted by the president of the Nebraska Medical Association in response to a resolution of the House of Delegates passed in September 2006. It has deliberated the contents of the resolution and the charges therein and makes the following proposal to the Association Board of Directors.

PREAMBLE

The Nebraska Medical Association Health Reform Task Force posits that all Nebraskans should have good access to timely needed health care that emphasizes good health habits, wellness, and prevention, that health care in Nebraska must be of high quality, efficient, affordable and equitably accessible to all. It also posits that good health and access to needed health care are social goods that contribute to the well-being of the state and all its residents.

The Goal, Values, Principles and Recommendations that follow are based on these premises.

GOAL

"Health care plan outlining high quality, affordable and accessible health care coverage for all Nebraskans," while exploring the "feasibility of 'best practices' and 'practice guidelines' to the extent that they can help reduce unnecessary medical expense and engender reasonable expectations on the part of patients."

VALUES

- Access for all Nebraskans
- Quality care
- Individual choice and self-determination
- Individual accountability demanded of all participants
- Economic sustainability
- Shared responsibility of all Nebraskans

PRINCIPLES

- Universal portable insurance coverage
- Cost control
- Health care financing that promotes quality care, preventive care and wellness
- A pluralistic system that promotes competition based on value
- Coverage costs based on broad community rating
- Partnership with patients in medical decision-making
- A health care work force to meet the needs of all Nebraskans
- Public education about healthy living, evidence for optimal care, and wise choices through credible information

RECOMMENDATIONS

I) Assure universal health insurance coverage and fair sharing of costs by requiring all Nebraskans not covered by Medicare to have a basic health insurance benefit plan that includes preventive services, mental health care, dental care and long term care. This plan should be developed and reviewed periodically by a panel comprising generalist and specialist physicians, other health professionals and members of the public. The plan may be purchased either by employers or individually. Submission of evidence of insurance could be required when filing state tax returns, paying property taxes, enrolling children in schools, registering an automobile, obtaining a driver's license, or seeking health care.

*Rationale: The U.S. Census Bureau estimated that there were 194,000 uninsured Nebraskans in 2006, ~11.1% of the population [1], and these numbers have been increasing. Families USA has reported that 437,000 Nebraskans (28.2% of the <65 population) lacked health insurance sometime during 2006 and 2007. Of these, 262,000 (60%) were uninsured for more than six months [2]. The uninsured frequently fail to get needed care with the result that their conditions become worse and they incur higher costs and suffer poorer outcomes [3,4]. They frequently resort to Emergency Rooms (ER) for access to care, which also contributes to increased costs. The increased costs of delayed care and ER care are borne by those who are insured. Further, lack of timely access to needed care results in premature deaths and productivity losses estimated to exceed by many times the cost of the medical care needed [5]. There are only three ways to assure access for all Nebraskans to timely needed health care. Either government provides care, government provides tax funded insurance, or private insurance is made available and required. Combinations of these approaches are possible. In our pluralist economy and tax-averse political system, it is unlikely that state government will provide care to or be the insurer of the currently uninsured. To do so would provide incentive for many who are currently insured by employers or individually to drop insurance and opt for government care or government insurance. The state could expand Medicaid and SCHIP coverage but, to assure a sense of solidarity and shared responsibility, the Task Force recommends that all Nebraskans have access to comparable health care coverage. Furthermore, cost shifting from Medicaid results in higher insurance premiums [6], a state-imposed hidden tax on those who responsibly choose to be insured. The Task Force concluded that the only way to assure that costs are shared fairly is to require all Nebraskans to have private health insurance that provides an equal basic benefit for all. Some will doubt the ability to enforce a requirement but several methods are available [7]. Insurers should be permitted to offer richer coverage than the basic benefit plan, if they choose.*

II) Require all insurers, authorized by the State of Nebraska Department of Insurance to offer plans that satisfy the health insurance requirement, to guarantee issue and renewal of a basic health benefit plan at community rated premiums.

*Rationale: At the present time, persons with pre-existing conditions may be excluded from purchasing health insurance because insurers deny them coverage, will not insure costs arising from pre-existing conditions, or may drop them from coverage if they become ill. Further, even if healthy, premiums escalate with age to reach prohibitive levels for many middle income Nebraskans between 50 and 64. If all Nebraskans are able to purchase and renew health insurance at community rated premiums, it assures equitable sharing of costs and is likely to lower overall costs because timely preventive and chronic disease care are expected to diminish the need for more extensive and expensive care resulting from lack of timely access to needed care.*

III) Subsidize premium costs for low income persons utilizing current Medicaid funds. (Suggested guidelines: 100% premium subsidy for those below 200% of Federal Poverty Level; declining subsidy from 200%-300 or 400% FPL.)†

*Rationale: Many families and individuals cannot afford current high premiums of private health insurance. Family premiums in Nebraska can exceed 20% of Median Family Income and approximate 15% of the income of a family of four at 400% of FPL. To determine the appropriate level of subsidy will require a judgment of what is a reasonable expenditure for health insurance premiums. Some suggest that premium costs should not exceed 8-10% of household income.*

IV) Require insurers to offer plans that reward selection of a "medical home" to facilitate coordinated/integrated care.

*Rationale: This recommendation addresses quality of care and costs. It has demonstrated that continuity of care providing by longitudinal oversight and monitoring by one or a team of professionals results in better health care outcomes at lower cost [8]. In the absence of longitudinal continuing care, there may be*

*poor coordination with different providers caring for different aspects of a person's health with no one provider or team knowing exactly what is being recommended or prescribed for a patient. In the absence of a medical home, many resort to emergency rooms for their point of entry into the system, thereby resulting in poor care coordination and higher costs. Better coordinated care has also been found to diminish health disparities [8].*

V) Emphasize public health and disease prevention. Develop and implement education and counseling strategies in early childhood programs and schools; develop and promote education programs for the public and health professionals addressing:

- healthy lifestyles and disease prevention
- health and health care literacy

Promote and provide incentives for wellness programs in workplaces, schools and the community.

*Rationale: Enhanced public health efforts are essential to improve the health of Nebraskans and to reduce health care costs. Primary, secondary and tertiary prevention practices have been shown to diminish suffering, health care costs and to improve productivity. The U.S. and Nebraska face a pandemic of diseases related to lifestyle, notably diseases related to obesity but others as well. Poor health habits increase the risk of cardiovascular disease, diabetes, cancer, sexually transmitted diseases, especially HIV/AIDS, and others. Life style accounts for ~40% of premature deaths, 80% of them from smoking and obesity [9]. Obesity is estimated to account for 9% of U.S. health care costs [10] and $454 million in Nebraska in 2003 [11]. Improved health habits, disease prevention, and early detection of disease enhance the quality of life and decrease the costs of health care. Workplace health and wellness programs have demonstrated their value by decreasing health risk behaviors, improving health, decreasing costs, and increasing productivity [12–16]. It is estimated that in 2003 Nebraska expended $1.9 billion in health care costs and economic productivity was diminished by $6.1 billion because of preventable chronic diseases and their complications [17]. The same study estimates that, implementation of reasonable preventive measures could save $5.2 billion in health care costs and improve economic productivity by $17 billion in 2023.*

VI) Promote and educate the public about appropriate use of health care resources and choosing providers based on quality and value.

*Rationale: The public is bombarded with information suggesting that they need particular health care services, leading many to demand and expect care that may be of no benefit, and may carry risks. The public also lacks adequate information to make rational choices of health care providers to assure that they are getting the best care for the lowest reasonable cost. Information and transparency about the quality, cost and value of care should be made available to the public and communicated by well structured public education programs. It is important that these programs take cognizance of the culturally diverse populations of Nebraska.*

VII) Require provider reimbursement based on appropriate medically necessary services utilizing evidence-based, value-adjusted, nationally accepted clinical practice guidelines.

Nationally accepted evidence-based clinical practice guidelines should be subject to review by a panel of Nebraska professionals to assure local applicability.

*Rationale. This recommendation addresses quality of care and costs. One of the drivers of health care costs is the provision of care that does not contribute to health and well-being. The reasons for this include patient demand, uncertainty on the part of practitioners, opportunities for providers to increase income, and defensive medicine (the practice of ordering tests and consultations to avoid or diminish the possibility of malpractice suits). Furthermore, there is evidence that evidence-based interventions are frequently not provided when indicated [18, 19]. There is an extensive and growing array of evidence-based clinical practice guidelines that assure quality care and value-based outcomes [20]. Linking reimbursement to evidence-based preventive, diagnostic, or therapeutic interventions should have a positive effect on quality of care, outcomes and costs. There are occasions when it is appropriate to use or not use interventions prescribed by clinical guidelines—every patient is an individual different from other patients. Such deviations from guidelines may be reimbursed if they are individually justified.*

VIII) Limit out-of-pocket expenditures (premiums, deductibles and co-payments). (No OOP expenditures for those under 150% FPL, cap of 5% annual income OOP for those 150-250% FPL, sliding cap of 5-10% for those 250-300% FPL, cap of 10% OOP for those above 300% FPL.# This could apply to each year or be applied to rolling three year average.)

*Rationale: This recommendation also addresses quality of care and costs. It is well known that cost-sharing reduces health care utilization [21]. It is also well known that excessive cost-sharing reduces utilization of needed health care [22], especially preventive care [23]. Patients who feel as though they cannot afford prescribed care or monitoring frequently decrease drug dosages, skip medications and necessary monitoring for chronic conditions, and neglect useful screenings for conditions such as breast cancer, high blood pressure and diabetes. This results in greater incidence of preventable diseases and worsening of acute and chronic conditions with higher costs of care and subsequent poorer outcomes, including higher mortality. Health economists characterize the "underinsured" as individuals or families whose premium and out-of-pocket costs exceed 10% of income or 5% of income for those below 200% of poverty [24, 25]. Keeping cost sharing within affordable limits improves outcomes and decreases health care costs [26].*

IX) Support a secure and private statewide health information exchange to promote higher quality, safer and more cost efficient health care.

*Rationale: Individual patients are often provided care by different professionals, hospitals, long term care facilities, and other providers. Difficulty accessing patient health information or failure to communicate patient information between providers may result in lower quality of care, duplication of procedures, poor coordination of care, and higher costs. Ready access to patient health information at the point of care has the potential to improve quality of care and reduce unnecessary medical spending. It is essential that such records be secure and that they are available only to providers who are granted access by the patient. The Nebraska Health Information Initiative (NeHII), a collaboration of many health care stakeholders in the state, was established in 2005. Its goals include:*

- *Sharing timely and accurate patient health care information in a secure environment to improve patient care and*
- *Seamless, electronic medical system by which patients give physicians or other providers access to their health information.*

*It is a means for the state to meet the information needs of Nebraskans and Nebraska health care providers. (S. 1693, a bill that has been reported out of committee to the full United States Senate, will provide matching grants to states and other entities to develop such systems if enacted.)*

X) Establish educational loan forgiveness, scholarships and bonus payment programs, linked to service commitments, for providers who establish and maintain practices in underserved areas.

*Rationale: This recommendation is intended to improve access to timely, high quality care to Nebraskans. Many Nebraskans live in areas of health professional and health care service shortages. The Bureau of Health Professions [27] and the Nebraska Office of Rural Health [28] have designated large parts of the state as health professions shortage areas. These include primary care, dental care, pharmacy services, allied health and mental health, the last perhaps the most acute of the shortages. Nebraska has had low-interest loan and loan repayment programs to attract professionals to rural practice areas for nearly 30 years, yet great shortages persist. The Task Force concluded that greater incentives, linked to accountability, are needed to attract health professionals to locate in and practice in shortage areas. Incentives should be linked to commitments to serve for contracted periods of time in shortage areas.*

XI) Provide incentives for Nebraska educational institutions (public and private) to increase education of health professionals to address workforce shortages.

*Rationale: Nebraska is blessed with a substantial number of institutions that educate health professionals, physicians, nurses, dentists, physician assistants and mental health professionals. But, it also has a large number of health services shortage areas and some areas with shortages of specific professions. In addition to incentives for health professionals to locate in such areas (recommendation X.), incentives to select and educate professionals in ways appropriate to meet the needs of underserved areas should be provided for these institutions.*

XII) Strive to reduce medical costs associated with defensive medicine in collaboration with the legislature and the Nebraska Bar Association.

*Rationale: Defensive medicine is the ordering of tests, procedures, seeking consultation or avoiding interventions with the purpose of decreasing liability to malpractice suits rather than for the benefit of a patient. Such added services increase the cost of health care. It is difficult to quantify exactly how much of Nebraska medical practice is defensive or its costs; it has been estimated that 5-9% of national health care expenditures result*

*from the practice of defensive medicine [29, 30]. A survey of Pennsylvania physicians determined that 93% of physicians reported practicing defensive medicine [31]. Nebraska is relatively favored with respect to malpractice premium, award and settlement costs because of a limit on damages. However, Nebraska physicians relate many anecdotes of the practice of defensive medicine. There are several ways that the malpractice tort system might be modified so that defensive medicine is reduced by diminishing the threat of malpractice suits, thereby improving patient care.*

XIII) Collaborate with the Nebraska Hospital Association and others to promote patient safety by encouraging transparency and reporting of adverse events and nosocomial infections.

*Rationale: Medical errors and hospital acquired infections are important causes of injury, death and high costs in American health care. The Institute of Medicine (IOM) estimated that 44,000-98,000 Americans died because of medical errors in 1997 and that the cost of care for those injured by errors was $17-29 billion [32]. The Centers for Disease Control and Prevention estimated that in 2002 there were 1.7 million hospital acquired infections resulting in 99,000 deaths in the U.S. [33] It has been estimated that hospital acquired infections increased hospital costs more than $30 billion [34], a sum that does not include the cost of physicians or lost productivity. In 2003 there were 636 documented "medical misadventures" resulting in injury in Nebraska hospitals [35].*

XIV) Funding sources:

- premiums from employers and individuals
- existing state and federal Medicaid funds used to subsidize premiums and excess out-of-pocket expenses
- payroll tax of employers who do not provide health insurance
- penalty payments by those who do not voluntary enroll in the required plan
- if more funding is required, tobacco and alcohol or other taxes may be levied

*Rationale: Adequate and appropriate funding requires participation by both public and private sectors. The Task Force recommends utilization of funds, private and public, that are currently supporting health care for Nebraskans. The Task Force proposal will require a Medicaid waiver to utilize funds to subsidize premiums for low income persons. In 2004, total Nebraska expenditures for personal health care were $9.782 billion, $5599 per capita [36]. Of the total, Medicaid expended $1.387 billion, Medicare $1.691 billion and private payers $6.705 billion. Utilizing historic rates of cost growth, it is estimated that in 2007 total expenditures will be ~$12.2 billion, Medicaid expenditures ~$1.84 billion, Medicare expenditures ~$2.14 billion, per capita spending ~$6820.*

*Nebraskans are now paying for health care for the uninsured. The Nebraska Center for Rural Health Research computed that in 2003 $256.8 million uncompensated hospital costs of care for underinsured and uninsured patients were passed on to private insurers who in turn must pass these costs on to businesses and individuals who pay premiums. The Center further computed that hospitals also shifted $127.7 million of Medicaid underpayment of costs and $266.1million of Medicare under-payments, for a total of $650.6 million [6]. Again utilizing historic rates of cost growth, it is estimated that in 2007 this hidden tax has reached ~$940 million, approximately 7.7% of total health care costs in Nebraska. But, these represent cost shifting for hospital care only. If one assumes that physicians shift costs proportionate to those of hospitals, this would amount to ~$545 million in 2007 for a total cost shift of ~$1.485 billion, or ~12.2% of total personal health care costs of Nebraskans. This tax is borne by businesses, employees and individuals who responsibly buy insurance. Businesses that do not provide health insurance for employees and individuals who can afford but do not purchase health insurance are responsible for ~40% of this hidden tax.*

*The Task Force proposes that all businesses and individuals share in the costs of health care for Nebraskans. Businesses may purchase health insurance or pay a tax based on payroll expense. If individuals do not purchase insurance, they should pay a penalty that is sufficient to provide incentive for them to do so. Most believe that insuring all Nebraskans will result in lower costs by enhancing disease prevention and avoiding the higher costs that occur when uninsured and underinsured persons forego care and incur higher costs because their conditions become worse. In the event that costs increase in the short term, the Task Force recommends that a tax be levied on products and practices known to be detrimental to health.*

†FPL 2007 = $10,210 (1), $13,690 (2), $17,170 (3), $20,650 (4)

#est. NE health care costs 2007 (Economic Policy Institute) = 8-9% of 250% FPL

REFERENCES

1. U.S. Census Bureau. Income, Poverty, and Health Insurance Coverage in the United States: 2006. August 2007.

2. Families U.S.A. Wrong Direction: One out of three Americans are uninsured. Study of the Lewin Group. September 2007.

3. Institute of Medicine. Coverage Matters: Insurance and Health Care. Washington, National Academy Press, 2001.

4. Institute of Medicine. Care Without Coverage: Too Little, Too Late. Washington, National Academy Press, 2002.

5. Institute of Medicine. Hidden Costs, Value Lost: Uninsurance in America. Washington, National Academy Press, 2003.

6. Chen L-W, Shambaugh-Miller M, Zhang W, et al. The Cost of Uncompensated Health Care and the Expenditures of Self-Pay Hospital Inpatient Care in Nebraska. Nebraska Center for Rural Health Research, July 2005.

7. Blumberg LJ, Bovbjerg R, Holahan J. Enforcing Health Insurance Mandates. Blue Cross Blue Shield of Massachusetts Foundation, May 2006. Available at: http://www.roadmaptocoverage.org/pdfs/RoadMap_2_Mandates.pdf

8. Beal AC, Doty MM, Hernandez SE, Shea KK, Davis K. Closing the Divide: How Medical Homes Promote Equity in Health Care. Commonwealth Fund, June 2007.

9. Schroeder S. We Can Do Better — Improving the Health of the American People. N ENGL J MED 2007; 357:1221-1228.

10. Finkelstein EA, Fiebelkorn IC, Wang G. National Medical Spending Attributable to Overweight and Obesity: How much, and who's paying? Health Aff 2003; w3:219-226.

11. Finkelstein EA, Fiebelkorn, Wang G. State-Level Estimates of Annual Medical Expenditures Attributable to Obesity. Obesity Res 2004; 12:18-24.

12. Pelletier KR. A review and analysis of the clinical- and cost-effectiveness studies of comprehensive health promotion and disease management programs at the worksite: 1998-2000 update. Am J Health Promot. 2001; 16:107-116.

13. Ozminkowski RJ, Ling D, Goetzel RZ, et al. Long-term Impact of Johnson & Johnson's Health and Wellness Program on Health Care Utilization and expenditures. J Occup Environ Med 2002; 44:21-29.

14. Ozminkowski RJ, Ling D, Goetzel RZ, et al. Long-term Impact of Johnson & Johnson's Health and Wellness Program on employee Health Risks. J Occup Environ Med 2002; 44:417-424.

15. Mills PR, Kessler RC, Cooper J, Sullivan S. Impact of a Health Promotion Program on Employee Health Risks and Work Productivity. Am J Health Promot. 2007;22:45-53.

16. Wellness Council of America. A number of case studies of the effectiveness of wellness programs is available at: http://www.welcoa.org/freeresources/index.php?category=17

17. The Economic Burden of Chronic Disease on Nebraska. from DeVol R, Bedroussian A. An Unhealthy America: The economic burden of chronic disease, charting a new course to save lives and increase productivity and economic growth. The Milken Institute, October 2007.

18. McGlynn, Asch SM, Adams J, et al. The Quality of Health Care Delivered to Adults in the United States N ENGL J MED 2006; 354:1147-1156.

19. Mangione-Smith R, DeCristofaro AH, Setodji CM, et al. The Quality of Ambulatory Care Delivered to Children in the United States. N ENGL J MED 2007;357:1515-1523.

20. For examples of current clinical practice guidelines consult:
American College of Physicians Clinical Practice Guidelines. http://www.acponline.org/clinical/guidelines/#acg
Evidenced-based Medicine Resource Center.
http://www.ebmny.org/
Evidenced-based Decision Making.
http://www.evidencebased.net/ )

21. Manning WG, Newhouse JP, Duan N, Keeler EB, Leibowitz A, Marquis MS. Health insurance and the demand for medical care: evidence from a randomized experiment. Am Econ Rev 1987; 77:251-277.

22. Brook RH, Ware JE Jr, Rogers WH, et al. Does free care improve adults' health? Results from a randomized controlled trial. N Engl J Med 1983; 309:1426-1434.

23. Lurie N, Manning WG, Peterson C, Goldberg GA, Phelps CA, Lillard L. Preventive care: do we practice what we preach? Am J Public Health 1987; 77:801-804.

24. Farley P. Who are the Underinsured. Milbank Q. 1985; 63:476-503.

25. Commonwealth Fund Commission on a High Performance Health System. Why not the Best: Results from a National Scorecard on U.S. Health System Performance. The Commonwealth Fund, September 2006.

26. Choudhry NK, Avorn J, Antman EM, et al. Should Patients Receive Secondary Prevention Medications for Free After a Myocardial Infarction? An Economic Analysis. Health Aff 2007; 26:186-194.

27. Bureau of Health Professions, HRSA, U.S. Department of Health and Human Services. Professional Shortage Areas. Available at: http://bhpr.hrsa.gov/shortage/

28. Office of Rural Health, Nebraska Department of Health and Human Services. State and Federal Shortage Areas. Available at: http://www.hhs.state.ne.us/orh/SAmaps.htm

29. Office of Technology Assessment, U.S. Congress. Defensive Medicine and Medical Malpractice. Washington, 1994. Publication OTA-H-602.

30. Kessler D, McClellan M. Do Doctors Practice Defensive Medicine. Q. J. Econ 1996; 111:353-390.

31. Studdert DM, Mello MM, Sage WM, Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment. JAMA 2005; 293:2609-2617.

32. Institute of Medicine. To Err is Human: Building a Safer Health System. Washington, National Academy Press, 2001.

33. Klevens RM, Edwards JR, Richards, Jr CL, et al. Estimating Health Care-Associated Infections and deaths in U.S. Hospitals, 2002. Public Health Rep. 2007; 122:160-166.

34. McCaughey B. Unnecessary Deaths: The Human and Financial Costs of Hospital Infections. 2nd Edition, New York, Committee to Reduce Infection Deaths, 2006.

35. Nebraska Department of Health and Human Services. Nebraska Resident Misadventure Discharges, 1999-2003. February 2007.

36. Centers for Medicare and Medicaid Services (CMS). Nebraska Personal Health Care Expenditures, All Payers, 1980-2004. September 2007.

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