REPEAL AND REPLACE, PART 2:

Health Care Reform Act of 2012: Standardization of Procedural and Medical Care Related Costs
https://docs.google.com/document/d/1iSymML641RVjHfUCx-xQH5iFDIU7eaijbC2MbWBsLqg/edit?pli=1

Purpose: This concerns the exploitation of health care costs by health insurance companies for profit, companies who are dictating the cost of care that hospitals must charge patients. This legislation is piloting standards for Medicare and Medicaid costs, to prevent the government from being overcharged for services that taxpayers fund for the general welfare. Costs that could better be served creating a program to cover those that are uninsured at state levels, which did not occur with any of the legislation passed under Obama health reform.

While a legitimate funding mechanism was proposed for health care for the uninsured, in order to maintain the solvency and guarantee of retirement for aging Americans through Social Security Reforms proposed August of 2010 as repeal legislation: https://docs.google.com/document/d/1jK6-kGCB_Dbb5K98YSS9o9kSNBwLJsSb7XQ5GQSvTks/edit?authkey=CIS_je8I&authkey=CIS_je8I premiums have continued to rise due to increased and stagnant unemployment holding at 8% for three years, with the expectation of higher tax increases, all with the accessibility of care not improving by the Obamacare/Unaffordable Care Act. Inflation and government shutdown pending September 30th 2012, makes this the 5th shutdown the Obama Administration faces for failure to restrict spending to Constitutional levels which makes getting care in this economy that much harder, especially for those unemployed.

The consensus is the only two provisions remaining from the dead legislation and mountain of dysfunctional legislation package known as "Obamacare" are requiring insurance companies to keep children on parents' insurance until 26yrs. of age and non-exclusion of pre-existing conditions. While these are great, these two provisions are not enough to keep H.R. 4872 as a means of reconciling the entire health care industry by a federal government buyout. Health insurance companies should 'insure' and the federal government should regulate and govern the market, not violate the Commerce Clause by requiring purchase of insurance or medical services, devices, products, or care that is inappropriate, unused, or misappropriated and unaccounted for tax increases.

For the past 20 years health care costs have risen at twice the inflation rate http://www.halsaservices.org/uploads/20%20Most%20Common%20Ways%20Hospitals%20Overcharge%20Patients.pdf and given that inflation robs the dollar of $.67 of its value before the consumer gets it (for what is borrowed against its value), it is an understatement to say that health care costs, along with borrowing to pay for military operations have given us a substantial deficit problem since 2006, and without proper reforms and legislation that creates jobs rather than destroys them like Obamcare did, it will take us 5yrs. to reverse this deficit to 2006 levels and at most 7-8yrs. to pay it off, adhering to a $2.5 trillion annual revenue http://lnk.ms/Wb6nV and $1.7 trillion annual deficit reduction payment with new revenue created from job creation.

With that said, the Tea Party supports the Republican initiatives to adhere to this budget, budget balancing, with consideration and concession of government spending in accordance

to Constitutional priorities. Diplomacy spending on food stamps has increased 100% since Obama took office, which has further compounded the amount of time left to reverse this deficit and prevent government shutdown, little time to reform federal programs past their sunset that are bloated for their inefficiency with their strain on the overall budget. This all equals less money is actually making it to the poor and those needing health care; hence the stark example being no one has health insurance that is uninsured despite passage of this Obamacare package legislation.

REQUIREMENTS OF HOSPITAL AND INSURANCE REFORMS:

- **One issue is a monthly premium under $100 that includes a hospital supplemental plan: http://www.halsaservices.org/uploads/20%20Most%20Common%20Ways%20Hospitals%20Overcharge%20Patients.pdf**

Hospitals and insurance companies have played a highly elaborate game of ping-pong when it comes to overcharging for services and supplies in order to write-off indigent care to profit off of the health care industry. Private practice doctors are at the mercy of whether or not Medicare, Medicaid, or insurance pays in order to see their patients rather than their Oath.

- **Require hospitals detail a service contract and what care costs in writing.**

-The delivery of each good and service
-The method of pricing each good and service
-The reasonable value of each good and service

- **Hospitals will be required to upgrade their records to be accessible to be viewed by the I.R.S. and government health related agencies. As a provision of the current legislation, a standard interface was considered to standardize forms, track supplies and costs, and prevent waste, fraud, and abuse. This is particularly so when it comes to hospitals being targeted for identity fraud. http://www.baycitizen.org/blogs/quality-of-life/hospitals-pay-23-million-settlement/**

Hospitals are overcharging to attain 800% profit http://hospitalbillingformula.blogspot.com/ which is why Tort Reform is so important to limit lawsuits and to bring gougers to court, to hold them to accountable to consumers.

FOR CONSUMERS TO REPORT SUSPECTED GOUGING AND FRAUD OF GOVERNMENT TAX DOLLARS:
1) REQUESTED AN ITEMIZED BILL: I received a list of shorthand descriptions of services that I couldn't understand. For example: a $403.68 charge for "IV SUPPLIES". What were the IV Supplies? The needle? The tubing? The gauze? The piece of tape that kept it all in place on my arm? I called to find out. I was referred to three people, but nobody in the hospital billing department could tell me.

2) DETERMINED FINANCIAL RESPONSIBILITY OF MY INSURANCE COMPANY: Blue Cross assured me that they paid out their maximum reimbursement amounts to the hospital for the services I received, and would not be paying any more. They sent me an Explanation Of Benefits form (EOB) and went over it with me to my satisfaction. They said that they were able to negotiate a lower rate with the hospital on my behalf, and covered costs that exceeded my

deductable. They suggested that I contact the hospital to see if they would lower my costs, since the hospital determines their own charges.

3) FOUND A PATIENT ADVOCATE: I went online to find people who have gone through this before and discovered a number of Patient Advocacy groups. A couple of them are: Hospital Victims.org (http://www.hospitalvictims.org/) and The Southwest Medical Review and Recovery. (http://www.southwestmedreview.com/) Southwest Medical Review has over 20 years of hospital billing experience under their belt, and left the industry when they realized that they could help people with their knowledge of billing systems. I found them to be very patient and extraordinarily knowledgeable.

4) REVIEWED BILL FOR CORRECT CODING: I sent my itemized bill to my patient advocate for review. A billing code is assigned to each item being charged. This is what is read by the insurance companies to determine how much the hospital will be paid. I learned that up to 90% of all hospital bills are coded incorrectly. My patient advocate told me that there is supposed to be transparency in the billing system – and that there are definitive coding guidelines that apply to each hospital. However, this hospital administers their own coding system – making it impossible to determine exactly what is being charged. Despite this, my patient advocate was able to figure out three incorrect codes in my bill, resulting in over $300 of erroneous charges. They forwarded me the proper verbiage from the most recent coding manual. I went back to the billing department at the hospital and had them amend my bill. The billing specialist apologized for her oversight and resubmitted my bill with the proper coding. I can only wonder how many more codes were erroneous, had they been using a transparent billing system.

5) REQUESTED ALL BILLING AND DOCTOR RECORDS FROM HOSPITAL – PARTICULARLY THE UB-04 FORM: It is the patient's right, under the Health Insurance Portability and Accountability Act, (HIPAA) to receive a copy of all medical and billing records from the hospital. The UB-04 form is used to determine the cost of services. The billing department at the hospital first told me that they would look into releasing my UB-04 form. After repeated requests, I was told that it was not their policy to release this form to the patient. This is typical. Know your rights as a patient. Every hospital has a HIPAA officer on the premises. I called theirs. She said she would look into it for me. I didn't hear back. She didn't return my messages. I then contacted the California Office of HIPPA Implementation. They agreed to contact the HIPPA officer at the hospital. A day later, the HIPPA officer called me to get my address and let me know that my UB-04 form was being sent to me. Release of my U-04 form took me a full year.

·The sections of the HIPAA legislation that the state officer referred to were two federal 45 CFR codes: The Designated Record set was under code 164.501 and the Right of Access was 164.524 (a)(1)

6) DESPITE REMAINING IN GOOD STANDING WITH THE HOSPITAL, I WAS SENT TO COLLECTIONS: I kept meticulously close contact with the billing department, who insured me that I was in good standing with them. Every month, when I received a new bill, I called them and assured them that I wanted to settle the balance, and that I was investigating charges that were in question. Each month, I told them that is was my priority to remain in good standing with them. I even paid them $50 in good faith. But when I went out of town, and didn't get my mail for a week, I was sent to collections. This was also during the time that I was being told that they were "looking into sending out" my UB-04 form. My challenge here was to

keep the perspective that it wasn't personal. Even though I was on a first name basis with many people in the billing department at that point, the overall billing system didn't know or care about who I was. I needed to be reminded of this – because I was assured that I was kept in good standing with them.

7) KEPT COLLECTIONS DEPARTMENT FROM PURSUING FURTHER PAYMENT: Diligent effort through close communication and refusal to pay any overcharges for my services kept them at bay. I assured them that I would keep them posted to each and every new bit of information that I received – and kept them in the loop every step of the way. I kept telling them that it was my utmost interest to settle the bill – but that I would only be paying fair and reasonable charges, as determined by industry standards.

8) DETERMINED THE COST OF SERVICES: With the codes on the UB-04 form, my patient advocate taught me how to figure out the cost of services. There is an industry standard for determining cost of services. It is simply what Medicare would reimburse for each line item. The reason why they use Medicare as the guideline is because Medicare reimburses between 92 cents and $1.12 on the dollar. So, for example, if Medicare would reimburse a hospital $1.00 for a box of tissues, it is understood that the cost of the box of tissues is between 92 cents and $1.12. My patient advocate and I went over, code by code, the line items on my UB-04 form. They showed me how to track down, on the internet, the reimbursement amount for each charge. Remember the $403.68 charge for "IV SUPPLIES" on my itemized bill? Well, it turns out that Medicare doesn't reimburse that cost code – those supplies are not billable. Those supplies are included in numerous other services – like the cost for the antibiotic, the cost for administering the IV, etc. After the reimbursement for each line item was determined on my UB-04 form, I had a total – as calculated by industry standards. The total cost of services being billed to me for my emergency room visit came to a little less than $400!

9) CALCULATED FAIR AND REASONABLE CHARGES: There is an industry standard for calculating fair and reasonable charges. Fair and reasonable charges ensures the hospital receive a profit on their cost. Here is the formula: The amount that Medicare would reimburse the hospital + 25% to 50%. So, in my case, we know that the cost of services were – and we'll round it up - $400. Add to that, 50%, which is $200 - and the industry standard, for fair and reasonable charges for the services that I received, was $600.

10) OFFERED A SETTLEMENT: Between what my insurance company and I had paid, the hospital had already received $905 at this point – already recouping a 125% profit – as determined by industry standards. I went back to the hospital and insisted that I settle with them, not the collections agency. They complied. I chose to offer an additional 100% profit, giving them a 225% profit on cost of services, to ensure that the hospital does well. They denied it. Instead, they offered me an application for financial assistance.

The silver lining is that I somehow qualified for an 80% discount on my bill. They offered me a settlement of $348. I took it. This does not get them off the hook for their enormous over charges, but it does allow me to settle with them what I considered to be fair and reasonable.

"We can charge anything we want", I was told by Crystal Crowe, Financial Supervisor at the hospital. Cedars-Sinai Medical Center netted in excess of 190 million dollars in 2007 - which I applaud. I feel secure knowing that there is a reputable, well funded hospital nearby. I just want to pay fair and reasonable charges for the services I receive from them.

I know that there is much talk of overhauling the health care system – but until it is changed, this is what we have to encounter. Here's hoping that this information can help other people navigating through the existing system.

USE A MEDICAL COST REDUCTION ADVOCATE
http://www.medicalcostadvocate.com/blog/?tag=overcharging-for-health-care

- **Ambulance transport costs are a huge burden to those in desperate need of care, and ironically, these workers are the last to get paid out of the scheme though they are first responders. Sometimes their pay is withheld if government insurance has not paid, sometimes as much as two weeks. Even if it is the government, pay can not be withheld, wages are given for work done. PAY YOUR TRANSPORT BILLS ON TIME.**
- **The UnAffordable Care Act does not standardize the cost of all common medical procedures in the U.S. to make insurance competitive or affordable. It only covers certain routine screenings and forces people to do cost comparison on their own. http://www.changehealthcare.com/downloads/hcti/HCTI%202012%20March.pdf**

  - Type 2 diabetes screening - Adults with high blood pressure
  - Mammography - Breast cancer screening for women 50+
  - Pap smear testing - Cervical cancer risk assessment for women ages 21+
  - Preventive colonoscopy - Colorectal cancer screening for adults 50+
  - Lipid screenings - Men 35+; women 45+; younger adults at risk

- **The Unaffordable Health Care Act should be renamed: "NO REFORM FOR MEDICARE, EXCEPT TO TAKE $500 BILLION FROM THE ELDERLY TO PAY FOR ABLE-BODIED 30-60 YEAR OLDS TO GET SCREENINGS" this perhaps should be the most compelling reason that we should have standardized costs of procedures. Though this may vary from hospital to hospital, each hospital is required to make a cost procedure available for download online and one copy at the hospital, whatever they charge. If hospitals do not comply, they will be subject to I.R.S. investigation, civil lawsuits, and fines for every 30 days this information is not available or up-to-date.**

http://informthepundits.wordpress.com/2011/06/22/the-affordable-care-act-obamacare-not-so-affordable/

THIS REFORM LEGISLATION WILL BE UPDATED TO INCLUDE WHAT BASIC ITEMS SHOULD BE COVERED UNDER COST PROCEDURES OR CARE PROVIDED, SO THAT HOSPITALS CAN ASSURE THAT THEY ARE IN COMPLIANCE, THOUGH HOSPITALS MAY BEGIN DRAFTING THESE MATERIALS NOW, THEY MUST HAVE THEM AVAILABLE TO THE PUBLIC AT THEIR FACILITY AND ONLINE BY 1/1/13, OR THEY WILL BE REPORTED FOR TAX FRAUD.

STATES UP FOR AUDIT:

1) TEXAS HAS THE WORST RANKED HEALTH CARE, EXCEPT FOR MATERNITY
http://www.huffingtonpost.com/2012/07/05/texas-health-care_n_1652066.html?utm_hp_ref=business&icid=maing-grid7%7Cmain5%7Cdl1%7Csec3_lnk3%26pLid%3D176216

THE TEXAS TRIBUNE

State Audit Exposes More Problems at Cancer Institute

- by **Becca Aaronson**
- January 28, 2013
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Enlargegraphic by: Todd Wiseman

- **REFERENCE MATERIAL**

CPRIT Audit
PDF (797.6 KB)download

A state audit has revealed that transparency problems at the Cancer Prevention and Research Institute of Texas extend beyond the improper review of an $11 million commercialization grant that sparked criminal and civil investigations.

State auditors found business and professional relationships between CPRIT's management, CPRIT's commercialization review council, and donors who contributed to the CPRIT Foundation, a non-profit association that supplements the salaries of CPRIT's executive director and chief scientific officer. They also found three grants that were approved without proper review — the executive director recommended the applications receive grants, but the peer review council did not — for a total of approximately $56.3 million. CPRIT also broke a state constitutional requirement by allowing grantees to report matching funds spent on other projects, rather than the CPRIT-funded research project, according to the audit.

"Weaknesses in CPRIT's processes reduce its ability to properly award and effectively monitor its grants," the State Auditor's Office report concludes. The report recommends that CPRIT address deficiencies in: making award decisions, evaluating grant applications, verifying compliance with matching fund requirements, processing payments to grantees, monitoring grantees' expenditures, assessing and measuring research progress and managing contract agreements with grantees.

"The Legislature should consider clarifying statutory requirements to strengthen the independence and professional judgment of CPRIT's grant decisions and governance structure," the report states.

The 2007 voter-approved constitutional amendment that created CPRIT authorized the state to purchase bonds to fund $3 billion in cancer research grants over 10 years.

After it was discovered that CPRIT awarded an $11 million commercialization grant to Peloton Therapeutics without proper review, the Travis County district attorney's office and the Texas attorney general opened criminal and civil investigations into the agency. Gov. Rick Perry, Lt. Gov. David Dewhurst and House Speaker Joe Straus have called for a moratorium on new CPRIT grants. And the 2014-15 biennium budgets proposed by both the House and Senate slashed all funding for the institute.

CPRIT officials agreed with the state's findings, and said in the report that the organization has already begun implementing a process to fully vet all grant applications for conflicts of interest, which includes comparing all grant applications to a list of CPRIT Foundation donors. They've also adopted administrative rules and revised policies to comply with some of the recommendations.

Read the full report to see detailed information on the state's recommendations and CPRIT's response.

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2) ILLINOIS - CHICAGO'S SACRED HEART HOSPITAL "CBS THIS MORNING" aired 7/7/12 for being unsafe and infection rates.

3) JACKSON, MISSISSIPPI - FRAUD AND OVERBILLING
http://www.huffingtonpost.com/2012/07/14/meera-sachdeva-guilty-health-care-fraud_n_1673219.html?ncid=edlinkusaolp00000003

INITIATIVES http://www.tfah.org/report/104/

A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years

JANUARY 2013

Trust for America's Health (TFAH) released *A Healthier America 2013: Strategies to Move from Sick Care to Health Care in Four Years, which* provides high-impact recommendations to prioritize prevention and improve the health of Americans.

The *Healthier America* report outlines top policy approaches to respond to studies that show 1) more than half of Americans are living with one or more serious, chronic diseases, a majority of which could have been prevented, and 2) that today's children could be on track to be the first in U.S. history to live shorter, less healthy lives than their parents.

"America's health faces two possible futures," said Gail Christopher, DN, President of the Board of TFAH and Vice President – Program Strategy of the W.K. Kellogg Foundation. "We can continue on the current path, resigning millions of Americans to health problems that could have been avoided or we invest in giving all Americans the opportunity to be healthier while saving billions in health care costs. We owe it to our children to take the smarter way."

The *Healthier America* report stresses the importance of taking innovative approaches and building partnerships with a wide range of sectors in order to be effective. Some recommendations include:

- Advance the nation's public health system by adopting a set of foundational capabilities, restructuring federal public health programs and ensuring sufficient, sustained funding to meet these defined foundational capabilities;
- Ensure insurance providers reimburse for effective prevention approaches both inside and outside the doctor's office;
- Integrate community-based strategies into new health care models, such as by expanding Accountable Care Organizations into Accountable Care Communities;
- Work with nonprofit hospitals to identify the most effective ways they can expand support for prevention through community benefit programs;
- Maintain the Prevention and Public Health Fund and expand the Community Transformation Grant program so all Americans can benefit;
- Implement all of the recommendations for each of the 17 federal agency partners in the National Prevention Strategy; and
- Encourage all employers, including federal, state and local governments, to provide effective, evidence-based workplace wellness programs.

"Prevention delivers real value as a cost-effective way to keep Americans healthy and improve their

quality of life," said Jeffrey Levi, PhD, executive director of TFAH. "Everyone wins when we prevent disease rather than treating people after they get sick. Health care costs go down, our local neighborhoods are healthier and provide more economic opportunity, and people live longer, healthier, happier lives."

A Healthier America also features more than 15 case studies from across the country that show the report's recommendations in action, such as:

- The first-of-its-kind Accountable Care Community (ACC) launched by the Austen BioInnovation Institute in Akron, Ohio, which brings together more than 70 partners to coordinate health care inside and outside the doctor's office for patients with type 2 diabetes. By improving care and making healthier choices easier in people's daily lives, the ACC reduced the average cost per month of care for individuals with type 2 diabetes by more than 10 percent per month within 18 months of starting the program – an estimated savings of $3,185 per person per year;
- The Community Asthma Initiative (CAI), implemented by Boston Children's Hospital, has provided support to improve the health of children with moderate to severe asthma in at-risk Boston neighborhoods. The CAI has led to a return of $1.46 to insurers/society for every $1 invested; an 80 percent reduction in percentage of patients with one or more asthma-related hospital admission; and a 60 percent reduction in the percentage of patients with asthma-related emergency department visits; and
- The Healthy Environments Collaborate (HEC) in North Carolina is an innovative partnership across four state agencies – Health and Human Services, Transportation, Environment and Natural Resources and Commerce. The partnership focuses on creating win-win policies and programs that improve health while also meeting other priority goals, such as improved transportation, increased commerce and stable housing programs.

In addition, the report includes recommendations for a series of 10 key public health issues: reversing the obesity epidemic; preventing tobacco use and exposure; encouraging healthy aging; improving the health of low-income and minority communities; strengthening healthy women, healthy babies; reducing environmental health threats; enhancing injury prevention; preventing and controlling infectious diseases; prioritizing health emergencies and bioterrorism preparedness; and fixing food safety.

The report was supported by grants from the Robert Wood Johnson Foundation, the W.K. Kellogg Foundation and The Kresge Foundation and is available on TFAH's website at www.healthyamericans.org.

How Prevention Works in Communities:

Alabama

Jefferson County: Tobacco
Jefferson County: Obesity

California

First African Methodist Episocopal Church
Los Angeles County
San Diego
San Diego: A Built Environment that Encourages Health

Delaware

Nemours & the Delware Valley

Florida

Corporate Network Services, Washington, D.C. & Florida
Manatee County

Indiana

INshape Indiana

Kentucky

Boyd and Greenup Counties
UNITE (Unlawful Narcotics Investigations, Treatment & Education)

Maryland

Baltimore
Breaking the Link between Unhealthy Housing & Unhealthy Children

Massachusetts

BCBS of Mass. Global Payment Plan
Boston Children's Hospital
Boston Dudley Greenhouse
Boston Tobacco Free Environments

Michigan

Muskegon Community Health Project

Minnesota

The Statewide Health Improvement Plan

Mississippi

Hernando: A Small Town Remakes Itself
Hernando: A Model for Active Living

Montana

A Menu Approach to Public Health in Billings

Nebraska

Nebraska's Integrated Health Plan
Omaha

New York

New York City

North Carolina

Mecklenburg County
Pitt County
The State's Healthy Environments Collaboration

Ohio

Akron--the first Accountable Care Community
Austen BioInnovation Institute in Akron

Oklahoma

Explorer Pipeline, Tulsa

Oregon

Oregon Medicaid Global Budget

Pennsylvania

Healthy Armstrong

South Carolina

Spartanburg

Tennessee

Dyersburg County
Nashville

Texas

Austin
Healthy Schools, Workplaces and Communities
San Antonio

Utah

Salt Lake City

Vermont

Vermont Global Budget (page 2)

Washington

Seattle and King County

West Virginia

Chief Health Strategiests Transforming Communities

Wisconsin

Dane County
La Crosse Area Family YMCA
Workplace Wellness in La Crosse

Prevention and the Faith Community

Adventists In Step for Life
First African Methodist Episocopal Church
Jewish Community Centers: Discover: CATCH Early Childhood Program
National Baptist Convention: H.O.P.E. Initiative

Prevention and the Business Community

Corporate Network Services, Washington, D.C. & Florida
Creative Craftsman
Explorer Pipeline, Tulsa, Oklahoma

Prevention and Insurers

BCBS of Mass. Global Payment Plan
Blue Cross and Blue Shield Association: Creating Health Communities
Kaiser Permanente and Total Health

2013 HEALTH REFORM AS APPLIED TO MENTAL HEALTH ISSUES:

MENTAL HEALTH -- THE CASE FOR DIGITAL BRAIN SCANS AND BLOOD TESTS BEFORE PRESCRIBING MEDICATION OR TREATING THE MENTALLY ILL

MEN AND WOMEN'S BRAINS WORK DIFFERENTLY: MEN ARE MORE PRONE TO VIOLENCE, BECAUSE THEIR BRAIN IS MOST ACTIVE IN PRIMAL RESPONSE AREAS OF THE BRAIN. WOMEN ARE MORE VULNERABLE TO STRESS AND HORMONAL PROBLEMS THAT MAY BE MIMICKING MENTAL ILLNESS OR CONTRIBUTING TO A MISDIAGNOSIS OF MENTAL ILLNESSES.

STUDIES ON THE FEMALE BRAIN HAVE YIELDED A NEW ERA OF TREATING THE MENTALLY ILL
http://www.doctoroz.com/videos/unleashing-power-female-brain

SPECT, which looks at blood flow and activity patterns can help us discern between high-risk mentally ill patients in assessing risk of harm to oneself and others and can help us individualize any prescribing or treatment recommended. SPECT technology can seriously reduce the costs and risks of treatment associated with those who may be mentally ill.

OTHER TESTS:
CAT, MRI, PET, fMRI

THE ROLE OF BRAIN SCANS FOR THOSE WITH BIPOLAR DISORDER
http://www.sevencounties.org/poc/view_doc.php?type=doc&id=11207&cn=4

STATES THAT WILL HAVE TO ADOPT OR INCORPORATE TESTING INTO A TREATMENT PLAN TO RECEIVE FEDERAL FUNDS FOR SERVICES THE STATE PROVIDES:

ARIZONA

COLORADO

CONNECTICUT

COUNTY-BY-COUNTY OR RURAL HEALTH ISSUES:

GEORGIA

http://www.countyhealthrankings.org/app/georgia/2013/rankings/outcomes/overall/by-rank