

*Healthcare Reform
White Paper*



OCH

Ozarks Community Hospital

Preface

We are a for-profit organization but we provide care to a higher percentage of governmental and uninsured patients than most of the charitable healthcare organizations in southwest Missouri—patients typically served by nonprofit or tax-supported providers. We have searched for other similarly organized systems still functioning today and we have found none. For-profit physician-owned hospitals operating as safety-net providers for governmental and uninsured patients simply do not exist. Our organization is unique in many ways but its uniqueness provides the opportunity to test (and possibly rebut) some of the assumptions often made about this country’s healthcare system and the path reform should take. In that sense, Ozarks Community Hospital could be considered a demonstration project for healthcare reform. We are providing this “white paper” presenting our perspective on healthcare reform to contribute to the national debate.

This OCH White Paper on Healthcare Reform is presented in three main parts—our rationale for reform now, our unique perspective on healthcare and our reform recommendations. If the reader has no particular interest in our rationale for reform or our story but is primarily interested in the reform proposal itself, the final section can stand on its own. With the anticipation of reaching a general audience, certain healthcare industry concepts are explained in a manner that will no doubt irritate readers inside the industry. We placed some inside a text box to make them easier to skip!

This OCH White Paper was written by Paul Taylor, CEO.

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RATIONALE FOR REFORM NOW

During the long history of the mostly failed attempts to reform healthcare in this country, physicians have consistently lobbied against universal healthcare coverage. Today, having seen their individual autonomy eroded and their sacred relationship with patients compromised, physicians are increasingly likely to favor any reform that will allow them to concentrate more on patient care and less on the often hopeless task of navigating a sane course through the dysfunctional current system.

During the 1930's, according to legend, Frances Perkins, the woman who served as Franklin Roosevelt's Secretary of Labor, was the intellectual force behind the minimum wage, work-hour limitations and the Social Security Act—and would have added universal healthcare to the list had it not been for intense lobbying against the idea by physician groups, including a plea by Eleanor Roosevelt's personal physician. In the 1960's, Lyndon Johnson's "Great Society" created both the Medicare and Medicaid programs but might have gone further and created a true national healthcare program had it not been for political maneuvering by the American Medical Association and grass roots opposition promoted by physicians. Physician opposition to universal healthcare seemed to be waning during the 1990's, and reform seemed inevitable when Bill and Hillary Clinton first pushed it forward, but the momentum for reform died when the insurance and business lobbies mounted an effective campaign against it.

At this moment in our country's history, the stars do seem aligned behind the possibility of comprehensive healthcare reform. There is support by physicians for some sort of a national healthcare reform for the first time in our history. We elected a charismatic President on an agenda of change. Healthcare reform is at or near the top of his list. His party controls both houses of Congress. The business community is reeling from the high cost of healthcare. Employers are either reducing or eliminating the benefit to their employees. If the employer maintains the benefit for its employees in this country, it becomes difficult to compete with employers abroad. There are almost 50 million uninsured: an impressive lobby. We are trying to recover from the worst credit crisis since the Great Depression and everyone is looking for some kind of stimulus. The healthcare sector of the economy would be a good place to spend it.

For too long now it seems that this country has been ready for universal healthcare but we keep waiting for the right moment, waiting for our leadership to act. They have been more indecisive than Hamlet: "If it be now, tis not to come; if it be not to come, it will be now; if it be not now, yet it will come: the readiness is all." We were ready in the 1930's. We were ready in the 1960's. We were ready in the 1990's. We are ready now. It is time to act.

HEALTHCARE: AN ESSENTIAL SERVICE

Healthcare should be considered an essential public service. The fundamental goal of living should be to live well. It is difficult to live well without being well, without having good health. Few would argue with that simple statement, but there is little objective evidence that we believe it in this country. We have laws requiring connections to highly regulated utility services in order to ensure public health, safety and welfare. We have laws requiring automobile owners to maintain liability insurance coverage and to provide proof of it on demand in order to protect the public from reckless, irresponsible drivers. We have laws forcing employers to cover employees with workers compensation insurance in order to protect workers from irresponsible employers and to provide benefits for those injured on the job. There is no similar mandate extending the essential service of affordable healthcare to all people striving to live well in this country.

Compare healthcare service to other public services. Assume a man lives in a dwelling in Springfield, Missouri. The man's dwelling must be connected to public utilities: water, sewer, trash and power. It is the law. Unless he convinces the government he qualifies for some sort of exemption or exception, he not only has to make the connection to the public utilities, he has to pay for the service. If he does not pay, the service will be disconnected. If his dwelling remains disconnected from the service, he could be evicted and the property condemned. He cannot simply say: "I do not want public water or sewer. I will take care of such service needs in my own way. I will collect rain water, compost my waste and burn wood for power." If we let him do so, his private actions could have negative consequences for the rest of us.

Public health, safety and welfare concerns trump individual liberties every day in every town in America. Mature, rational adults understand the necessity of laws ensuring public health, safety and welfare. Since we have laws compelling individuals

to connect exclusively to the public service instead of choosing a private option, we regulate those who provide the public service. In some cases, the service is provided by a publically owned entity; in other cases, it is a private service provider. If it is a private service provider, there is typically a franchise agreement between the government and private provider of services, and the agreement regulates to manner in which the service is provided as well as the cost of the service.

Some might argue that utility service is different than healthcare service. For example, it is possible for a man to live his entire life and never use a healthcare service. That is true. A man might also be so good at collecting rain water, composting waste and burning wood for power that he could live in town his entire life without causing any harm to his neighbors. Following that same logic would lead to the conclusion that no law or regulation is necessary. Live and let live and trust that the actions of our fellow man will never cause harm to us or others.

The old cliché is that there is safety in numbers. There is also harm in numbers. There are a lot of people in Springfield and we all know a few we would not trust to dispose of their own waste. What if everyone in this country drank “found” water, disposed of their waste in their own way and burned wood for power? It is a scary thought. How many would die before the numbers worked in our favor and we could live and let live because there were so few left alive?

There are almost 50 million uninsured in this country. There is harm in that number. Why? It is easier to see the threat to public health and safety in allowing complete freedom in the matter of waste disposal. Why should it cause harm to me or others if the guy next door does not have health insurance? It is bankrupting the country. That statement is not a cliché. Over half of all the personal bankruptcies filed in this country are caused, at least in part, by medical bills. The rising cost of healthcare is making American companies struggle to be competitive and driving jobs overseas. The cost of providing healthcare for their employees and retirees was one of the leading causes of the recent bankruptcies filed by automakers GM and Chrysler. If the guy next door does not have healthcare coverage, it makes healthcare coverage more expensive for everyone else. When almost 50 million guys next door lack healthcare coverage, the entire system breaks down. To complete the parallel, that is a lot of rancid water, raw sewage and smog. There can be safety in numbers—but only if everyone has to play by the

same rules. If everyone has to pay their fair share of the cost of providing clean water, proper waste disposal and safe power, we all benefit—not only in promoting public health and safety but in reducing the cost of an essential service. If everyone paid their share of the cost of providing healthcare to all, the cost to each of us would drop significantly.

A Parable of Comprehensive Reform

As City Attorney for a small town many years ago, I was part of a reform effort aimed at improving the trash service. There were four or five trash hauling services licensed to operate in a city of about 10,000. Each hauler billed and collected from the residents under direct contracts. It was difficult for the city to monitor the service. There were no regulated, fixed routes. Trash trucks were rumbling all over the city six days a week. Some residents were hauling their trash outside the city limits and dumping it in abandoned mine pits. Some haulers who were being paid to dispose of trash properly used unregulated dump sites. It was a mess. It was also expensive. Rising landfill costs and the price of fuel were driving fees up. The Missouri Department of Natural Resources was also putting pressure on us to reduce the amount of trash going into the landfill and to do a better job of monitoring trash disposal. The city did not have the funds to do anything on its own.

We decided to adopt a single hauler contract for the entire city and put it out for competitive bid. We hoped economies of scale and more efficient management of trash collection would allow a single hauler to collect and dispose of trash at a lower rate than five competing haulers. We expected better bids if the city paid a single hauler instead of each hauler collecting from residents. We would require all residents to use the city service and pay for it on the water bill. We had a series of town hall meetings. Some were angry and confused. Some claimed they never had any trash. Some had their own versions of appropriate disposal. Some objected it was a free country and no one had the right to tell them what to do with their trash. While acknowledging there were real problems, some advocated for tighter regulation of the haulers within the existing system. Some haulers objected the city was depriving them of their livelihood. [A state law required the city to provide ample advance notice to haulers if the city intended to do what we proposed.] The bids came in so low that we were able to add a curbside recycling service—the first of its kind in any city in the area—and the rates were *still* much less than residents had been paying. Given the heated debates during the town hall meetings, city staff prepared to deal with a mob of angry residents—but there were no serious complaints.

The moral of the story is that comprehensive reform is often not only the better option—it is unexpectedly the *easier* path to reform.

A HEALTHCARE REFORM DEMONSTRATION PROJECT

HISTORY

Ozarks Community Hospital (“OCH”) is a health care system headquartered in Springfield, Missouri, serving patients in Southwest Missouri and Northwest Arkansas. “Ozarks Community Hospital” is the current business name of SGOH Acquisition, Inc., a private, for-profit corporation owned by a small group of local physicians. The “SGOH” is an acronym for “Springfield General Osteopathic Hospital,” the corporation which built and occupied the north Springfield facility in November 1967. Springfield General was a nonprofit corporation that had been operating an osteopathic hospital at various locations in Springfield since the 1930s.

Faced with mounting financial pressures as Medicare transitioned hospital reimbursement, from the cost-based system in place from 1965 to 1987, to the current system based on fee-for-service schedules, Springfield General filed for Chapter 11 bankruptcy protection in 1991. SGOH Acquisition, Inc. acquired the assets of Springfield General in 1992, assuming all of the debts of the nonprofit, and began doing business as Doctors Hospital of Springfield. The corporation was owned by 11 physicians, all of whom were active in the hospital and most of whom were general practice osteopathic physicians. The hospital operated at a modest profit from 1992 through 1994.

In 1995, threatened by increasing managed care exclusivity in the Springfield market and suffering from changes in Medicaid reimbursement, particularly with regard to mental health patients, SGOH entered into a partnership with Columbia HCA, a large national healthcare organization which owned the hospital in south Springfield then doing business as Community Hospital. SGOH was a 10% partner with Columbia. The hospital in north Springfield did business as Columbia North and the old Community hospital did business as Columbia South. Acting on its own initiative, Columbia decided to close the north hospital in June 1997. Almost immediately, SGOH initiated a series of negotiations with the intent to dissolve the partnership and, if possible, get back the north hospital assets with the intent to reopen it.

The Springfield, Missouri healthcare market, then as now, is dominated by two large nonprofit systems: Cox and St. John’s. Both are billion dollar systems with large medical towers and multiple facilities spread across southwest Missouri. Cox is an independent organization and St. John’s is part of the still larger Mercy system. The two systems effectively control more than 95% of the healthcare market in a tightly integrated duopoly. All of the major commercial insurance companies in the market have exclusive contracts with one system or the other. The only patients with freedom of choice are those covered by traditional Medicare or Medicaid. Virtually all the physicians are employed by the two systems and do not cross lines. The compensation arrangements between the systems and the physicians are essentially identical: pay is based on net collections less overhead costs imposed by the system. As a result, the system-employed physicians are acutely aware of the payment source of their patients.

Neither Doctors Hospital nor Community hospital had the clout to break the duopoly and contract independently with a commercial insurance company—nor did Columbia despite its national presence. Consequently, the negotiations to dissolve the Columbia partnership with SGOH and reopen the north hospital involved both Cox and St. John’s and ultimately hinged on Cox’s willingness to put a clause in the contract that would allow SGOH to participate in Cox’s managed care contracts—provided SGOH proved able to reopen the facility and keep it open. As history unfolded, the ability of the SGOH organization to participate in the Cox managed care provider network with access to private payer sources became more and more problematic.

Today, the SGOH hospital and *some* of its physicians are included in *some* of the Cox network payer contracts. *Most* of the SGOH-employed physicians are entirely excluded from the Cox network payer contracts. The hospital and *all* its employed physicians are entirely excluded from the St. John’s network payer contracts. When SGOH is allowed to compete head-to-head with the big systems in the market and patients have free choice, SGOH does quite well. In this market, the patient pool with free choice is exclusively governmental. Some would argue that the competitive success SGOH has achieved in that pool is less because it out-performed the other systems and more because the big systems do not covet governmental patients. If true, it is less an endorsement of SGOH and more an indictment of the healthcare system.

There is, however, another factor in the success SGOH has experienced despite the power and exclusivity of the duopoly. Few hospitals and physician systems recognize it, but the governmental payers behave more rationally than their commercial brethren and **that rationality can be a competitive advantage for health systems** that understand it.

In the fall of 1998, Columbia ultimately agreed to dissolve the partnership selling the assets to the Cox health system which began operating Columbia South as Cox Walnut Lawn. The SGOH group of physicians had to decide between cashing out completely or taking the north hospital assets with no certainty the hospital would ever reopen. With 7 of the original 11 physician shareholders deciding to move forward, SGOH re-acquired the hospital, expanded the ownership group to 20 physicians and began work necessary to reopen the hospital.

The hospital had traditionally provided care mostly for the distinct north Springfield population as well as regional rural patients whose family physicians were more likely to be osteopathic. The hospital's patients were predominantly covered by Medicare and Medicaid. The State of Missouri's Certificate of Need law then in effect would not allow a new hospital to open unless it could prove there was need. Previous patients of the hospital responded with a letter-writing campaign in support of the application to open. The CON application emphasized both the osteopathic nature of the organization and the underserved patient population in north Springfield.

The Certificate of Need was granted on June 28, 1999. The organization then began hiring staff and making the renovations necessary to reopen the facility. The construction process proved to be a challenge. When it closed, the facility lost its "grandfather" status as an operational hospital and had to meet current design and construction standards for buildings and hospitals before it could reopen. The State of Missouri was more stringent on the application of current codes than had been anticipated. For example, the older patient wings had seven foot hallways. The current code required eight foot halls. The hospital had been functioning quite safely in 1997 with seven foot halls in the patient wings, but the halls now had to be every bit of eight feet. It is surprisingly expensive to "move" a long wall just one foot.

The facility was re-designed to house all of the patient services in the newer sections of the building. It had been operating as a 100,000 square foot, 110-bed hospital and it was reduced to a 49,000 square foot hospital with 45 beds. The reduction in beds was obviously done partly out of necessity, but it was also based on the trend in healthcare to reduce lengths of stay in patient beds and provide more care on an outpatient basis.

The building had also been allowed to deteriorate significantly and required substantial repair. Maintenance personnel became construction workers. Registered nurses became painters. By the time the facility opened, all of the employees had a great deal of "sweat equity" invested in the project.

A working capital loan in the amount of \$3 million had been secured by borrowing against the hospital real estate. The organization was unable to obtain any other financing or assistance from public or private sources. The working capital was almost completely depleted before the facility opened.

Doctors Hospital of Springfield reopened on January 1, 2000, with approximately 50 employees and an active staff of about a dozen physicians. Many of the physician owners had practices that committed their time elsewhere. In fact, some were employed at other hospitals. For the most part, the physician owners continued to practice as they had while the facility was closed. As a result, utilization of hospital services was driven by patient choice—and the only patients who had freedom of choice in the healthcare referral regions were those covered by Medicare and Medicaid.

After spending \$3 million on start-up, the hospital lost another \$3.5 million dollars in the first year of operations—a serious problem for a business that did not have any cash reserves or ability to obtain new financing. The small, locally-owned bank that made the original loan increased the loan by half a million, but that was it. While the hospital was steadily building momentum, increasing patient volume, services and active staff, the initial operational debt proved too much to overcome, and the organization filed for Chapter 11 bankruptcy relief in August 2002. The bankruptcy did not discharge any debt or discount any claims. Certain long term liabilities were restructured, and all unsecured creditors were paid 100% of claims over a three-year period.

With the financial condition of the organization stabilized, management focused on expanding services. When the hospital first resumed operations, it was using less than half the available square footage of the facility for patient care. Some of the old hospital space was remodeled to house hospital-based physician clinics. Since there was no money for outside contractors, the construction work was performed by the hospital's employees. The entire facility was soon in use and bulging at the seams.

Soon after we opened, we were invited to community meetings about the problem Medicaid patients were having getting access to care. Most of the physicians in Springfield were employed by the big systems. The physicians' compensation arrangements were based on their net patient revenue collections less overhead. As a result, few physicians were willing to see Medicaid patients because the fee for service was shockingly low: about one-third of what most commercial insurances were paying. The solution being tossed about during these meetings was a federally qualified health clinic (FQHC) because it could receive grants from the government and would be cost reimbursed for treating Medicaid patients similar to a rural health clinic. While the meetings continued and without any governmental assistance, we opened a unique kind of clinic: one that would *only* accept Medicaid patients. The clinic was designed this way because it was not unusual for an independent practice to accept Medicaid patients in the beginning in order to build patient volume and then cut back on the number of Medicaid patients as the practice grew with better paying patients.

Dr. Lewis McKay, one of the physician owners, relocated his existing practice in north Springfield to the hospital in order to serve as Medical Director of the clinic. Dr. McKay coordinates care of the patients with several other providers. Our Medicaid clinic was treating over 100 patients per day by the time the FQHC opened—25,000 visits each year focused on primary and preventive care, chronic disease management and wellness education. There is no doubt that our clinic has made a substantial reduction in the number of ER visits by Medicaid patients.

Our physician compensation arrangements are structured to pay the same fee for service regardless of the payer source of the patient. That fact alone is responsible for many of the differences between our organization and other health systems in our region. Since treating a Medicaid patient pays the same as treating any other patient, physicians become "payment blind" when accepting patients into their practice. The organization as a whole had a Medicaid patient mix of almost 45% by the end of 2004.

In some respects, it worked too well. With so many Medicaid patients, specialists began refusing to take referrals from our physicians. Most of the specialists are employed by the other health systems and they are not free to work at our hospital. We did not have the means or the patient referral volume to recruit and retain our own full time specialists. To help solve the problem, we built a specialty care clinic within the hospital to provide space for a number of employed

part time specialists. One such specialist was Dr. Ed Roeder, an orthopedic surgeon who filed litigation to contest a covenant not to compete. He prevailed in the litigation and established a part time hospital practice principally seeing Medicaid and Medicare patients, while also maintaining a separate private practice in south Springfield focused on commercial insurance patients, because the Cox network would not allow him to see commercial insurance patients in our facilities.

In 2004, Dr. William Campbell, one of the physician owners, was in the process of moving his practice in Nixa, Missouri, where he had practiced for 20 years, to a new building on Highway 14 in Nixa. He and the hospital decided to create a hospital clinic in the new facility. The clinic was to be modeled after the clinic in the hospital under the medical direction of Dr. McKay. Several other physicians with existing practices in the area suddenly decided to move in to the new facility as well. Six general practice primary care physicians employed with the Cox health system left employment and moved into the facility during the year it was being built. Some of the physicians were allowed to stay in the Cox provider network with exclusive third-party payer contracts. Some were not, even though they had been included in that network for years. Patients who had been seeing those physicians for decades had to choose between finding a new doctor or paying out-of-network copays that were as much as 100% of the cost of the service. Those who were excluded from the commercial insurance network had to start over building a practice seeing only governmental and uninsured patients. Before the dust settled in 2005, there was a new hospital clinic serving much of Christian County with more than a dozen full time providers, half a dozen specialists on a part time basis, a hospital-based urgent care clinic, radiology department, lab and rehabilitative services.

In 2006, continuing to fill a need to provide care for Medicare and Medicaid patients, the hospital opened rural health clinics in Rogersville (Webster County) and Mt. Vernon (Lawrence County). The hospital also opened a clinic in Webb City (Jasper County) when the mobile rural health clinic serving the local Medicaid population closed.

Unfortunately, legislative reductions in Medicaid, begun in 2005, with the impact worsening in 2006, took a financial toll on the hospital. The number of uninsured patients seeking treatment in the hospital ER rose from 25% in 2004, ultimately reaching 75% in the fall of 2006. The hospital, profitable from 2003 to 2005, lost over \$2.5 million in 2006.

Case Study: *Effect of Medicaid Cuts*

Before the Missouri Medicaid program was “reformed” in 2005 during Governor Matt Blunt’s administration by reducing the number of covered beneficiaries state-wide and entirely eliminating certain benefits such as physical therapy and wound care, over forty percent of our patients were covered by Medicaid. Following these Medicaid reforms, the percentage of our patients covered by Medicaid declined dramatically and we saw a corresponding increase in the percentage of uninsured patients. Our hospital had positive net earnings in 2005 in the amount of \$1.5 million (all of which was earned early in the year before the cuts took effect). By the end of 2006, we had lost over \$2.5 million. Unlike the other health systems in town, we have no large foundations or cash reserves. That kind of loss should have been a death sentence.

In response, our employed physicians voluntarily accepted a 10% reduction in compensation and benefits. The hospital froze salaries, terminated some employees and reduced expenses not related to patient care. There is an excellent study available¹ documenting the impact making it clear all health systems were affected, but our hospital might as well have been the poster child. Because of the high percentage of Medicaid patients we treat, we felt the cuts more acutely than most systems. Had our dedicated physicians and staff not been willing to make sacrifices, the hospital would not have remained open. The patients eliminated from the Medicaid program still received care though in most cases no one paid for that care. In effect, the Missouri legislature had imposed a “tax” on Missouri hospitals, physicians and other providers to pay for that care. We read the self-congratulatory remarks made by the politicians responsible for Medicaid reform in Missouri and the resulting healthier balances in the state budget, and we cannot forget whose pockets were emptied while providing medically necessary care to our patients.

Along with our patients, we learned firsthand how the mauling of Medicaid made a mess of much needed services. The unintended consequence of politically motivated tinkering is often more likely to produce the opposite of the effect intended. For example, rehabilitative services such as physical therapy and wound care were eliminated as a Medicaid covered service to save money. We believe dollars saved by eliminating rehabilitative services were eclipsed by the increased dollars spent on more expensive orthopedic and neurological services—not to mention the fact that patients were less likely to resume normal physical activities without rehab and more likely to stay on pain management medications.

The delivery of healthcare is a complicated organism. Moving money away from isolated components of that total delivery system is not likely to reduce the total cost of care. It is, in fact, more likely to increase the total cost, and, worse, the care delivered will not only be less efficiently delivered, it will be less effectively delivered. The State of Missouri saved the State money by eliminating people from the program—by passing the cost onto providers of care—but it no doubt cost the State money through its ad hoc elimination of certain services.

This “unintended” consequence illustrates another benefit of a single payer system built on Medicare. Medicare’s extensive database is best-equipped to monitor the flow of dollars and patient utilization, allowing the system to control over-utilization and “engineer” the delivery of services in an efficient, rational manner—provided that politically motivated tinkering is kept to a minimum.

With the influx of uninsured patients stemming from the Medicaid cuts, and recognizing that the organizational focus on providing care to governmental patients and the uninsured would be better situated within a non-profit entity that could benefit from tax exemptions, grants and donations, the physician ownership group transferred the hospital to a start-up nonprofit corporation. Ozarks Community Hospital, Inc. took over management of the organization effective January 1, 2008. Since it proved impossible to obtain third-party financing, the physician owners agreed to finance the acquisition of the assets by the nonprofit through a long-term installment payment arrangement. Under the terms of the agreement, the nonprofit would not begin making payments until approval of the Form 1023 application for tax exemption by the IRS. Furthermore, no donations or nonprofit grants would be accepted until IRS approval.

Also at the beginning of 2008, Ozarks Community Hospital accepted the task of reopening a hospital facility in Gravette, Arkansas, that had been closed since 2005. The hospital had been closed pursuant to a “suspended license” rule in Arkansas that would allow it to reopen without loss of its “grandfather” status under applicable building and hospital construction codes. However, the suspended license was in jeopardy from a bank foreclosure only weeks away from happening. If it lost that suspended license status, it would have become economically impractical for the facility to open as a hospital.

The town of Gravette had been devastated by the closure of the hospital. It was not only one of the largest employers in town but it provided needed access to critical care: getting to the nearest other hospitals required a forty-five minute drive on two-lane roads—or a trip in a helicopter. Following limited renovation and repair to building and equipment, the hospital was ready to open for business in early March, 2008.

The project proved to be an unbearable strain on the fledgling nonprofit. Unforeseen delays in obtaining permission to operate as a Medicare cost reimbursed critical access hospital caused irreparable financial damage. Consequently, it defaulted on the transaction agreement with SGOH Acquisition, Inc. and ceased operations on June 30, 2008. SGOH resumed operational control on July 1, 2008, deciding to do business as “Ozarks Community Hospital” in order to lessen confusion with patients and to reduce the cost of transition. The nonprofit corporation filed for Chapter 11 bankruptcy relief and SGOH agreed to pay all of the debts owed by the nonprofit.

In 2008, OCH opened new hospital based clinics in Bolivar, Missouri; on Primrose Avenue in south Springfield; and on Kearney Street in north Springfield. It opened an outpatient rehabilitative service department on South National in Springfield. The hospital in Gravette has remained open and is continuing to grow, adding services and staff. As this narrative is written in June 2009, SGOH Acquisition, Inc. is doing business as “Ozarks Community Hospital” in Missouri and as “Ozarks Community Hospital of Gravette” in Arkansas.

Both the Gravette and Springfield hospitals reopened after being closed for two-and-a-half years. Both hospitals began with about 50 employees. In a little over a year in Gravette, the number of employees doubled and so has gross patient revenue. The Gravette hospital is already once again one of the largest employers in the city. Beginning January 1, 2010, the hospital in Gravette is adding a ten-bed inpatient geriatric mental health unit similar to the unit in the Springfield hospital.

When the organization resumed business in Springfield, on January 1, 2000, it had 50 full-time employees. Annual gross revenue in 2000 was \$7 million. In 2009, the organization has over 700 employees. Annual revenue in 2008 surpassed \$100 million and is on pace to exceed \$120 million in 2009.

It would be unrealistic to predict that kind of growth in Gravette—it is located in a much smaller population area—but it will be fascinating to study the parallel development. Though the strain of getting the closed facility reopened—and keeping it open—came at great cost to the organization, the community of Gravette once again is home to its own, thriving hospital.

The organization accomplished that growth and development without any tax exemptions, subsidies, grants or governmental assistance. There have been no concessions such as those provided to prospective large employers by city, county or state agencies that offer incentives to spur economic development. There are no corporate or individual investors with deep pockets. It is true there have been three Chapter 11 bankruptcies filed by three different organizations trying to make a go of it at the hospital in north Springfield, but none of the creditors were discharged or paid less than 100% in any of the bankruptcies. **Despite financial limitations, the organization survived and, in some measure, thrived, operating in the equivalent of a single payer system with overall compensation no better than Medicare.**

PRIMARY CARE FOCUS

Our goal has always been to develop a strong base of primary care physicians—family practice, geriatric, pediatric, internal medicine, emergency and urgent care—around a small hospital associated with a few specialists.

Primary care physicians are called that because patients do not need a referral from another physician in order to make an appointment. Primary care physicians are typically engaged in family practice, pediatrics and internal medicine. Some specialists like obstetricians and orthopedic surgeons are considered primary care physicians because patients often know when they need an obstetrician or orthopedic surgeon and make an appointment without being referred. A physician who accepts patients referred by a primary care physician is therefore providing “secondary” or specialty care.

We believe strongly that this nation’s health care system must be refocused around generalists like primary care providers in order to bring rationality and stability to a necessary service that now spirals out of control as it is continually co-opted by special interest groups. Patients would trust the advice of their general practice doctor—if they could just find one and keep one. Patients need the advice of their general practice doctor, the one who has known them for years, if they are to avoid being “processed” by the industrialized, mass-produced, automated medicine being forced on us by big government and big business. Healthcare does not become more efficient or more affordable when patients are channeled directly into medical towers by virtue of contracts brokered by big business (whether nonprofit or for profit) or big government.

Our perspective finds validation in the work being done by the Dartmouth Atlas Project² which has accumulated and analyzed Medicare data for more than 20 years to demonstrate regional variation in healthcare. The Dartmouth Atlas Project, referring to the article published in the *New England Journal of Medicine* by its research group, summarized their analysis by stating: “Many experts have blamed the growth in spending on advances in medical technology. But the differences in growth rates across regions show that advancing technology is only part of the explanation. Patients in high-cost regions have access to the same technology as those in low-cost regions, and those in low-cost regions are not deprived of needed care. On the contrary, the

researchers note that care is often better in low-cost areas” [emphasis added; www.dartmouthatlas.org].

A well-trained general practitioner situated in a healthcare environment that is patient-centered instead of tower and technology centered is more likely to make referral decisions based on the needs of the patient instead of the economic needs of the system. This statement from the research group’s article in the *New England Journal of Medicine*, Volume 360:849-852, February 26, 2009, No.9, summarizes their findings comparing referral tendencies of physicians in high-cost regions with physicians in low-cost regions: “researchers found that physicians in high- and low-spending regions were about equally likely to recommend specific clinical interventions when the supporting evidence was strong. Those in higher-spending regions, however, were much more likely than those in lower-spending regions to recommend discretionary services, such as referral to a subspecialist for typical gastroesophageal reflux or stable angina or, in another vignette, hospital admission for an 85-year-old patient with an exacerbation of end-stage congestive heart failure. And they were three times as likely to admit the latter patient directly to an intensive care unit and 30% less likely to discuss palliative care with the patient and family. Differences in the propensity to intervene in such gray areas of decision making were highly correlated with regional differences in per capita spending.”

The Dartmouth Atlas Project authored a “white paper” of its own addressed to President Obama titled: “An Agenda for Change.” One of their recommendations to President Obama and Congress is that: “The nation does not need to expand its supply of physicians; it already has enough active physicians and trainees in the pipeline to take care of the needs of America’s citizens well into the future. Congress should resist efforts to remove limits on the number of graduate medical training posts funded by Medicare. Instead, Medicare should promote the training of primary care physicians and preferentially fund post-graduate training programs that teach coordinated, community-based care in treating chronic illness” [emphasis added; p. iii].

Our claim to be a low cost provider of healthcare is backed up by data obtained from the Dartmouth Atlas Project. A principal focus of the Dartmouth Atlas Project has been to accumulate data concerning the cost of care during the last two years of life. The data was collected from Medicare payments to hospitals over the last 20 years and adjusted for inflation. Many commentators on healthcare reform have

opined that the reason we spend more on healthcare in this country is the amount spent during the last two years of life. When that “fact” is voiced, it often prompts outrage from those who fear that the only solution to the problem is to ration healthcare for the elderly. As the data collected by the Dartmouth Atlas Project suggests, there must be another way to reduce the cost of care during the last two years of life, because there are health systems—like ours—that are doing so now. The following table shows the data for a number of selected hospitals in southwestern Missouri. The last row is the average for the U.S.

Hospital	Deaths	Cost/Death	Days	Diem
Citizens	823	20,913	19.7	1,060
Skaggs	1,118	19,941	17.4	1,145
St. John's	4,022	19,737	19.1	1,033
Cox	4,632	19,498	19.5	1,000
Doctors Hospital	583	15,833	20.1	787
United States		25,860	23.6	1,096

Medicare has been paying our hospital an average of \$15,833 for each patient during the last two years of the patient’s life—more than \$10,000 *less* than the national average. The other hospitals in our market average around \$20,000. This result is true even though patients spend a little more time in our hospital than the others in our market. The rationalizations many experts would give to explain this result (and, no doubt, many physicians and administrators at other hospitals) are likewise raised and refuted in the Dartmouth Atlas Project materials.

One of the rationalizations would be that the patients at other hospitals are *sicker* than at our hospital. There is this from the Dartmouth Atlas Project white paper: “This geographic variation in spending is unwarranted. Patients who live in areas where Medicare spends more per capita are neither sicker than those who live in regions where Medicare spends less, nor do they prefer more care. Perhaps most surprising, they show no evidence of better health outcomes.”

There is an objective basis for drilling down into the “we spend more because our patients are sicker” argument. Medicare reimbursement to hospitals is based on a fixed fee for a diagnosis related group (DRG). If the diagnosis is simple pneumonia, Medicare pays every hospital the same fee regardless of the patient’s length of stay or the amount of charges claimed by the hospital. Uniform coding guidelines in use by all hospitals ensure that comparable “sicknesses” are assigned to the same

DRG in every hospital. When comparisons of cost are made across the same DRG, the “sicker” rationalization disappears. The following data is from 2007 Medicare payments to hospitals in our market based on the DRG. ALOS means “average length of stay” counted as days in a hospital bed:

Hospital	Cases	ALOS	Charges	DRG \$
DRG 79 Resp infection & inflammation age >17				
Cox	124	7.66	21,758	
St John's	118	6.48	21,782	
Skaggs	54	6.67	23,776	
Citizens	38	9.71	28,368	
Doctors Hospital	55	6.45	13,734	8,196
DRG 89 Simple pneumonia & pleurisy age >17				
Cox	330	5.26	14,863	
St John's	336	5.26	15,072	
Skaggs	107	4.05	15,566	
Citizens	101	5.13	13,381	
Doctors Hospital	95	5.94	12,462	5,228
DRG 127 Heart failure & shock				
Cox	334	5.21	15,691	
St John's	339	5.13	13,488	
Skaggs	192	3.22	13,608	
Citizens	72	4.61	12,412	
Doctors Hospital	45	5.56	10,761	5,402
DRG 296 Nutritional metabolic disorder age >17				
Cox	139	4.97	14,260	
St John's	146	4.78	12,804	
Skaggs	63	3.43	12,223	
Citizens	52	3.77	10,092	
Doctors Hospital	28	5.25	11,135	4,292
DRG 320 Kidney/urinary tract infection age >17				
Cox	111	3.97	11,281	
St John's	116	6.09	17,292	
Skaggs	23	4.00	11,940	
Citizens	25	3.96	9,120	
Doctors Hospital	38	4.84	8,615	4,516

We charged much less than the other two hospitals in Springfield for treating the same illness, and, with one exception, less than the other hospitals nearest to Springfield. Though DRG payments are not directly related to the amount of charges, these charges are reported annually to Medicare, added to the national database and used to set the DRG payment schedule.

This hospital charge data does not reflect another significant difference between the cost of care at our hospital versus most large health systems. Patients treated at the mega-mart will be seen by anywhere from 5 to 10 specialists. Patients admitted to our hospital will be treated by 1 or 2 physicians. Thus, Medicare pays 4 to 10 times as much for physician care at the mega-mart. Again, some might argue that the patient will receive better quality care at the mega-mart with all its technology and subspecialists. The Dartmouth Atlas Project analysis suggests that the opposite is true. Some of it is common sense. If the admitting diagnosis would be within the appropriate level of care at either our hospital or one of the mega systems, the patient may very well receive better care at OCH. Too many cooks spoil the broth and too many subspecialists flogging the patient (sometimes at cross purposes) can spoil a healthy recovery.

We can make healthcare better and more affordable if we empower general practice physicians and give them the freedom and means to care for patients independently using their judgment, experience and intelligence—augmented (only when necessary) by the positive aspects offered by technology, specialists and medical towers.

There is an excellent piece in *The New Yorker*, online edition, June 1, 2009, coming at this debate from the opposite side of the cost spectrum from OCH: “Annals of Medicine: The Cost Conundrum / What a Texas town can teach us about health care” by Atul Gawande³. McAllen, Texas is one of the most expensive healthcare markets in the country. Medicare is spending \$15,000 per beneficiary, almost twice the national average in McAllen. Mr. Gawande went there to find out why. He investigated the usual culprits the experts blame.

1) *People are sicker in McAllen.* Some of the people he interviewed certainly thought so, but the data told a different story. People from a nearby Texas county were just as unhealthy as the people in McAllen but the per capita Medicare expenditure was about half: “An unhealthy population couldn’t possibly be the reason that McAllen’s health-care costs are so high” (p.1). The “sicker” rationale is so embedded in the genetic code of healthcare providers today that no amount of data will convince them it is not true. The Dartmouth analysis has come under attack since it recently gained nationwide attention (partly as a result of Mr. Gawande’s article). It has become part of the American consumer creed: more is better; the higher the cost, the greater the quality. As we have shown, using DRG data, it is possible to compare

costs based on a single diagnosis thereby eliminating the “sicker” argument. We expect the results we found would be repeated across the country. Costs have more to do with the culture of the health system than the relative health of patients

2) *McAllen is providing better quality care.* Again, the rationale seemed true. There was anecdotal and “visual” evidence supporting that claim. The array of medical towers and technology was impressive, but the data told a different story: “there’s no evidence that the treatments and technologies available at McAllen are better than those found elsewhere in the country” (p.2). It is the *utilization* (or, more precisely, the *over utilization*) of technology—not the cost of the technology itself—that is really driving up the cost of care.

3) *Legal malpractice claims are driving up costs.* Mr. Gawande interviewed a number of McAllen physicians: “McAllen is legal hell,” the cardiologist agreed. Doctors order unnecessary tests just to protect themselves, he said... That explanation puzzled me. Several years ago, Texas passed a tough malpractice law that capped pain-and-suffering awards at two hundred and fifty thousand dollars. Didn’t lawsuits go down? “Practically to zero,” the cardiologist admitted. (p.2)

The fact is that the actual economic cost of malpractice litigation has little bearing on today’s high cost of healthcare. However, we would depart somewhat from Mr. Gawande’s conclusion. There is more to this than the objective data, because many physicians still feel the threat of litigation as a very real thing. Despite the impact of tort reform in many jurisdictions, physicians still practice defensive medicine. Where a culture of high utilization of diagnostic technology exists, physicians (and hospital executives) make decisions based on the perceived “community standard of care.” Frankly, though, the “standard of care” rationale is often so intermingled with the financial incentive behind utilization that it is impossible to separate the two. It is now often used as a palatable rationalization—an “excuse”—for ordering tests and performing procedures when the real motive is financial.

4) *Over-utilization.* Finally, one of the physicians got at the real culprit:

“Come on,” the general surgeon finally said. “We all know these arguments are bullshit. There is overutilization here, pure and simple.” Doctors, he said, were racking up charges with extra tests, services, and procedures. (p.2)

Organizations with a large number of primary care providers are typically networked with specialists and a large hospital so as to integrate care within a single system. Primary care providers in these systems are often compelled by economic considerations to refer patients exclusively to the hospital that employs them and the specialists affiliated with that system. The industry refers to that arrangement as *integrated* care. There are positive aspects of an integrated system. Referrals are more efficient and communication between providers should be better. If the integrated system is patient centered, it can be an arrangement that produces high-quality care at low-cost.

Mr. Gawande offered the Mayo Clinic as an example of such an integrated system: *The core tenet of the Mayo Clinic is “The needs of the patient come first”—not the convenience of the doctors, not their revenues... I asked Cortese how the Mayo Clinic made this possible. “It’s not easy,” he said. But decades ago Mayo recognized that the first thing it needed to do was eliminate the financial barriers. It pooled all the money the doctors and the hospital system received and began paying everyone a salary, so that the doctors’ goal in patient care couldn’t be increasing their income.* (p.6)

However, an integrated system can also be an arrangement capable of producing low-quality, high-cost care. Referrals to other service providers are made because the other service provider is inside the integrated system—not because it is the best fit for the patient or because the integrated provider is the best choice based on quality. Many integrated systems are prone to high utilization rates—particularly as to certain services that pay very well.

One would expect a hospital with as many general practice physicians as we employ to be functioning as an integrated system. Our system operates contrary to those expectations. Our primary care providers refer as much care outside our system as they do within it. There are several reasons for it.

1) Our physician contracts do not include a covenant not to compete or exclusive practice provisions. We do not threaten our physicians with loss of employment, as some integrated systems do, for failing to keep patient referrals inside the system. If the system’s physician contracts include a covenant not to compete, physicians are more susceptible to pressure—overt or implied—to be a compliant soldier. Due to the covenant, termination of employment would necessitate relocation—uprooting family and starting all over building a new practice. Neither are our employed physicians required to

perform services exclusively within the organization. Many employed physicians, including some of the owners, maintain second practice locations outside the organization. The lack of exclusivity creates a more independent referral pattern, less focused on a single system.

2) Integrated systems are more likely to exercise control over commercial insurance payers through managed care networks. The system’s control over physician access to private insurance patients is a stronger pressure on physician decision-making than employment contracts with no-compete covenants. The current dysfunctional state of healthcare in this country has trained a generation of primary care physicians to believe that it is impossible to make a decent living unless their practice has a healthy percentage of commercial insurance patients. Our organization has no control over and limited access to commercial managed care contracting. We claim no credit for that circumstance, but we will claim credit for making a virtue of necessity. Since physicians are paid the same fee for service regardless of the amount we actually collect for the service, they are not susceptible to pressure exerted by the systems that control access to commercial insurance patients.

3) It is also true that we do not offer many of the specialty services provided by the larger systems in our market. Our physicians *have* to look outside our system for those services. We believe that is a good thing. Despite the example of a few organizations like the Mayo Clinic, which is an anomaly in that it depends on patient referrals from all over the country instead of a distinct regional referral market, systems which develop control over all specialty services within their market are more likely to develop a system-focused referral culture than a patient-centered one.

4) Referrals to specialists by our physicians are also affected by the fact that some area specialists simply will not accept our patients no matter how often we call. The reasons are both political and economic. The political reasons are complicated and unique to our history and our market—and unlikely to offer lessons to others. The economic reasons should be obvious. Most of our patients do not have what the specialists would consider a good payer source.

5) The primary care providers in this organization simply make fewer referrals to specialists. Some of that practice habit is a result of the composition of the original physician ownership group. They were mostly general practice osteopathic physicians more likely than a newer generation of medical doctors to

treat the whole patient on their own. Their practice culture is different than in a large system dominated by specialists who consider primary care providers as mere “gatekeepers” whose main purpose is to feed referrals to the specialists. Once that culture takes root, it shapes the hospital system and the specialists who practice in it. Despite the fact that some of our physicians have an ownership interest in the hospital, they will refer patients to another system for services we provide if the other service is a better fit for that patient. They can’t help themselves.

We employ a large number of physicians relative to the size of our hospital. There are more than 50 employed providers admitting or referring patients. Our physicians care for almost 3000 patients in long term care beds. Despite those numbers, the bed capacity of the hospital in Springfield is limited to 21 medical and 10 psychiatric. The average census in Springfield is 14 and 9. A third of the medical patient census is admitted from patients seen in the ER instead of being referred by one of our providers.

Our hospital patient volume may not look like much based on the number of physicians we employ, but it works for us and for our patients. Our organization has managed to sustain the hospital and support a large physician clinic—on average reimbursement no better than Medicare—while our primary care physicians make as many referrals to the specialists and hospital services of the other systems as they do within ours. The result is a low-cost approach to care that focuses on the needs of our patients.

PHYSICIAN OWNERSHIP

Since we reopened, the physician ownership group has never received a distribution of profit—despite significant personal risk and obligation on debt incurred by the hospital. The physician owners are employed and paid a fee for service. Those fees are set in accordance with the Medicare physician fee schedules. There is no income incentive tied to ownership. Furthermore, we have never managed the hospital in such a way that would maximize its profitability in preference to our patient care mission. In our view, there is very little real difference between a for-profit hospital that makes no shareholder dividend distributions and a nonprofit hospital—except that all the nonprofits in our market are highly “profitable” billion-dollar health systems.

CMS regulations regarding physician-owned hospitals require written disclosure of the ownership interest to all patients. According to the government, the required notice is intended to promote

transparency and to assist the patients in making informed decisions regarding their care. These governmental regulations are responding to the rise of physician-owned surgery centers, imaging centers and specialty hospitals owned by specialists. The media has been inundated with claims from mega health systems to the effect that physician ownership of healthcare organizations increase over-utilization and result in “cherry picking” by the physicians, leaving the worse paying patients and uneconomic services to the other healthcare providers. Those who claim that physician ownership results in such abuses have obviously never visited our hospital.

We are one of the only physician-owned, general acute care hospitals in the country. Most physician-owned hospitals are specialty hospitals providing a limited menu of services and are typically owned by specialists like orthopedic and neurological surgeons. Our hospital is owned by a group of mostly primary care physicians. Primary care physicians often have starkly different concerns and opinions about healthcare than hospitals and specialists.

Primary care physicians tend to have long-term relationships with patients and earn most of their income through office visits. They create revenue for hospitals and specialists through their referrals. They currently earn significantly less than specialists. Not long ago, the general practice, primary care physician reigned supreme in the healthcare system. They delivered babies, performed surgeries and dominated hospital policy. They cared for patients as often by doing nothing—letting nature take its course—as by doing something. They still remember those days.

Specialists tend to have short-term relationships with patients and earn more of their income through procedures. They make money for hospitals through the procedures they do. They currently earn significantly more than primary care physicians. They used to depend entirely on primary care physicians for patient referrals. Now, through managed care networks and integrated hospital systems, specialists and hospitals may depend less on referrals from primary care physicians and simply rely on the system to deliver patients to them. In some cases, recognizing the revenue they create for hospitals, specialists have focused on different mechanisms to capture some of that “facility” revenue—either in cooperation with or competition against hospitals.

Physicians, regardless of primary or specialty care, have a significantly different perspective on healthcare reform than hospitals. Physicians believe

that healthcare legislative changes have been more responsive to large hospital systems and there is some validity to their belief. The hospital lobby has been effective in getting legislation aimed at controlling or even eliminating competition from specialists over facility revenue from procedures. Hospitals deal with the constant pressure of providing services to patients while having little meaningful control over the physicians and patients who utilize hospital resources and virtually no control over how much the hospital will be paid for that utilization.

Few healthcare reform advocates have the advantage of our uniquely blended perspective on the needs, expectations, pressures and obligations of primary care physicians, specialists and hospitals. Lacking that perspective, some would-be reformers focus on form over substance. The current lobbying and legislative efforts aimed at curtailing or eliminating physician ownership of hospitals are diverting attention away from the real problem: a dysfunctional national healthcare system that treats an essential public service more like a private commodity to be managed and brokered for profit.

It would be disingenuous to suggest that all employed physicians do not feel some pressure to refer patients within their own system—some of that is not only natural but preferable for continuity of patient care. However, it is not the form of the organization or the ownership of assets that determines whether a system will be focused on patients or profits. If we suddenly became a nonprofit organization (as we tried to be in the first half of 2008), our culture of patient care and referrals would not change one iota.

Those concerned about the supposed dangers of physician referrals within physician-owned systems would do well to consider the plight of the physician employed by a large, nonprofit health system who has to make referrals within his own system both because his job may depend on it and because the system has created an exclusionary network of providers and contracts with payers that punishes patients if they are referred outside the system. If such a physician were to make referrals outside his system at the risk of losing his job, he would also do so knowing that he would have to relocate his family.

From our perspective, it is difficult to believe that physician ownership of a hospital is a stronger influence on patient referrals than the yoke and whip of the money master. We refer to it as the “money hat” versus the “physician hat.” The real issue is which hat the physician more often wears in decision-making. If our physicians can keep the

“physician hat” on more often than not given their ownership interest and our system’s habitually strained financial circumstances, hat selection cannot be as simple as ownership and employment contracts.

EMERGENCY SERVICES

When our hospital reopened, we established a policy of treating patients who came to the ER by taking them immediately back to an exam room and not discussing insurance or payment until after the patient was discharged from the treatment area. We decided to skip the EMTALA [see box below] emergency medical treatment exam and simply treat all patients as though they had an emergency medical condition. Upon discharge from treatment, we asked uninsured patients to pay something on the bill. No one should be surprised to hear that few did. Despite that fact, the hospital continued to follow its open door policy. Patient visits in the ER increased from 15 per day in 2001 to 60 per day in 2004. By the end of 2004, three-fourths of the patients seeking treatment in the hospital emergency department were Medicaid (50%) and uninsured (25%).

Though the numbers were becoming alarming from the standpoint of financial viability, we continued to do so. It was a way to give back to the community that helped us obtain the Certificate of Need. Our hospital ER had become a significant resource for north Springfield—particularly as the only other hospital in north Springfield, a few miles away, was being phased out of operation by the Cox health system. It was the original Cox hospital but had become Cox North when Cox built a medical tower on the south side of Springfield. The south side was where all the economic development action was taking place in Springfield.

Our decision to stick with our open door policy in the ER also made a statement about the organization. The hospital was physician owned, but it was not, as some physician-owned hospitals are accused of doing, “cherry-picking” the best paying patients and the best paying services. These physician owners had a practice history of providing care for the underserved Medicaid and uninsured patients in the area.

Unfortunately, no good deed goes unpunished. After “reforms” to Missouri Medicaid in 2005, uninsured ER volume grew until it reached 75% in late summer of 2006. In October of 2006, we decided we could no longer sustain the open door policy and we began conducting the emergency medical screening exam before taking patients into the ER.

EMTALA

We already have a law mandating universal healthcare coverage in this country. EMTALA is that law: anyone with an emergency medical condition will receive treatment in a hospital. EMTALA is an acronym for the Emergency Medical Treatment and Active Labor Act (42 U.S.C. § 1395dd) passed in 1986 as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA). It requires hospitals and ambulance services to provide care to anyone needing emergency treatment regardless of citizenship, legal status or ability to pay. It was enacted following several high profile instances like one in which a woman in labor bled to death outside a hospital emergency room entrance because the hospital refused to admit and treat patients without insurance or the ability to pay. EMTALA applies to any hospital that receives money from Medicare or Medicaid—in other words, virtually every hospital in the country. Patients needing emergency treatment can be discharged only under their own informed consent or when their condition requires transfer to a hospital better equipped to administer the treatment. Once the patient's condition is stable, the hospital can ask about payment and discharge the patient.

Under EMTALA, hospitals must conduct an emergency medical screening examination to determine whether the law applies to that patient—unless the hospital opts to do as we did and treat all patients as though they have an emergency medical condition, treating immediately without regard for the patient's ability to pay. It is extremely unusual for a hospital to do so. Most hospitals perform the screening exam, and if there are more patients with emergencies than the hospital ER has the capacity to treat immediately, the hospital then prioritizes treatment under a separate kind of analysis known as triage. If the patient does not have an emergency, the hospital initiates the registration process *before* treatment and asks the patient the “insurance” question. If the patient is uninsured, the hospital then follows its internal policy regarding whether it will treat without first receiving payment. Given the risk of guessing wrong about an emergency medical condition, most hospitals err on the side of caution and treat patients with any serious condition. Most people know the law—and for those that do not, hospitals are required to post notices that people have the right to be treated in emergencies regardless of ability to pay. As a result, many people now seek treatment in emergency rooms because they find it difficult to get access to care if they either have no insurance coverage or have a poor paying coverage like Medicaid.

EMTALA has no reimbursement provisions. Hospitals are required to guarantee the service but there is no guarantee of payment. This asymmetry has had a profound ripple effect on our national healthcare system. It created a culture of entitlement. It is our position that healthcare is an essential service, but even if we did not believe it, there is a law proving it. The law says we are entitled to it regardless of whether we pay for it. We have conditioned people to see healthcare fundamentally in that light. Is it any wonder so many people feel conflicted about paying their medical bills and that so many are filing bankruptcy? As a private attorney many years ago, I counseled clients on personal bankruptcies. Though they seldom thought about why they felt that way, people with large medical bills were much more likely to feel justified in filing bankruptcy. They felt they had been saddled with a debt that was somehow really not fair. The next ripple from this asymmetry is the insurance quagmire. People have a feeling they are entitled to coverage but, often for reasons they have little real ability to control, there are increasing millions who do not. With that fuzzy sense of entitlement and a concrete realization that the healthcare system is indecipherable, people give up the quest for coverage much more readily.

Hospital emergency rooms are not very efficient places to treat people, but it is our country's current version of universal healthcare. Those who are opposed to universal healthcare should have sufficient courage of their conviction to propose the elimination of EMTALA. Those who advocate reliance on total free market reform must consider if they are willing to let people die on hospital parking lots. If not, then they should acknowledge that we already have a universal healthcare system and focus on how to pay for it and manage it in the most efficient manner possible.

In some ways it was a good thing we began screening patients. The ER is not a good place to treat patients for a non-emergency. A hospital ER is an expensive place to treat a cold or a chronic condition like diabetes, and because the ER is not set up to provide continuing care for patients, it does not provide the most efficient care. Once the patient is stable enough to be discharged, the ER does not provide follow-up the way a primary care physician would.

In some ways, though, it was a bad thing. We have no way of knowing if those patients who are now choosing to leave the ER without being treated are finding a medical home. The cost of treating the uninsured in the ER is a burden to the hospitals providing it; however, there is a more serious problem arising from the increasing numbers of uninsured patients being treated in the ER: the lack of follow-up care by primary care physicians once the uninsured patient is discharged from the ER.

The law mandates that the uninsured patient will receive treatment for the acute, life-threatening problem; however, most uninsured patients seeking care in hospitals really need continuing care by a primary care physician. The law does not require that continuing care be provided in such circumstances and few hospitals try to get patients into continuing care without regard for the patient's ability to pay.

When we treat an uninsured patient in our ER, patients who do not have a doctor are referred to our follow-up clinic. When the patient shows up at the follow-up clinic, we do ask for payment at the time of service (by definition, these are not emergencies, so we have no legal obligation to treat without payment); but, we see the patient regardless of payment. Unfortunately, a high percentage of these patients do not show up for the follow-up visit. When they want to access care again, they simply go back to an ER. There is much more work that needs to be done in getting patients who seek care for non-emergency and chronic conditions in hospital emergency rooms. These patients must be educated and motivated to establish care in a primary care clinic setting; otherwise, no amount of increased capacity will really solve the problem.

COLLECTION PRACTICES

As a for-profit organization, we adopted collection policies and discounts for the uninsured that should shame many charitable systems. We have never sued a patient to collect money due for medical services. Charitable nonprofit hospitals routinely do so. We may send a past due patient account to a collection

agency, but we do not allow the collection agency to threaten the patient with a negative report to a credit bureau. Other nonprofit hospitals routinely do so. We provide an across-the-board forty percent discount for the uninsured based on our belief that those without coverage should never have to pay more than Medicare pays. We allow uninsured patients to pay what they can without having to beg for charity or fill out complicated forms "proving" they deserve charity. We trust our neighbors.

In some healthcare systems, the uninsured are actually compelled to pay more than the government pays hospitals for the same service—often more than *twice* what Medicare pays. Some hospitals offered the excuse that Medicare prohibited them from giving discounts to the uninsured but that rationale has always been a self-serving distortion of Medicare regulations. In recent years, faced with an epidemic of class-action lawsuits, bad press and governmental persuasion, some hospitals have begun offering better discounts to the uninsured, but the rates typically remain higher than Medicare.

The healthcare system in this country has been programmed to treat uninsured patients either like pitiful charity cases or contemptible deadbeats. We refuse to do so. It is not the uninsured patients who are contemptible—it is the system. Most people want to pay their fair share of the cost of health care, but no one really knows what their fair share is. More than half of the individual bankruptcies filed in this country are the result of medical bills. That fact alone should make it obvious the current system is broken. Some politicians and those who parrot them love to point at supposed deadbeats, Medicaid bums and mythical families who drive expensive cars and lounge in hot tubs but "refuse" to buy healthcare insurance. We are not saying such things do not ever happen and that such people do not exist, but, please, let us look around with our eyes fully open. *We* are the uninsured. *They* are our family, friends and neighbors. There are almost fifty million uninsured. Should we design a system to protect us from the few thousand who abuse the system or for the benefit of the millions who have been abused *by* the system?

EXCLUSION FROM INSURANCE NETWORKS

Most hospitals rely on the income they make taking care of patients with better paying commercial insurance to subsidize the cost of providing services for their patients who have no insurance or governmental benefits. Our organization can not do so. The physicians and hospital services we provide are either in-network or out-of-network depending

not on the desire and need of our patients and providers but on the whim (and profit motive) of billion dollar charitable health systems and commercial insurance companies. It is frankly too complicated to explain all the ins and outs of our participation and nonparticipation in commercial insurance networks, and, if we did spend the time explaining it all, few would believe us. Imagine what our commercial insurance patients must think when we inform them, even though their primary care physician and the specialist they need to see are located next to each other in our building, and both are listed in-network, the commercial insurance patient must go to another office miles away from our campus in order to be seen by that same specialist because a charitable health system in our market controls the insurance network.

The situation became even more complicated with the advent of Medicare Advantage and its poorly communicated network affiliations. There is also the threat (or promise) of Medicaid managed care in our market. Unless someone changes the rules that govern relationships between third-party payers and healthcare providers, given our small size relative to the other hospitals in the area, we do not anticipate that our exclusionary status will improve.

Traditional Medicare and Medicaid contain “any willing provider” regulations that allow patients the right to access our hospital and our physicians. The increasing prevalence of Medicare and Medicaid managed care products in this market further restricts patient access to our system. With managed care, comes steerage to the in-network providers, and we are typically excluded.

Although we were often the only “willing provider” when the patient was covered by traditional Medicare or Medicaid, our patients, accustomed to going to our physicians and our hospital, discover to their surprise upon being converted to the managed care version that our physicians and our hospital are no longer in network. We cannot convey the shock and outrage felt by many of our long time traditional Medicare patients when we explained to them that, because they enrolled in a Medicare Advantage plan, they can no longer see their physician or come to our hospital. Our hospital is in network with certain Medicare Advantage plans but it can be complicated even then. For example, a Medicare Advantage patient might be in-network at our inpatient medical service but out-of-network at our inpatient mental health service. If a single payer system eliminated this sort of tom foolery, it would be a blessing to us all.

HEALTHCARE REFORM RECOMMENDATIONS

The healthcare reform proposal presented here in a bare-bones outline is complicated. We apologize for that, but we believe that the healthcare system will suffer more harm from half-way measures and shortcuts attempting reform than from doing nothing—and we have already said that doing nothing will bankrupt the country in a decade. The moment for a complete overhaul of the system is now. If we fail in this attempt, we may not survive to make another. Please bear with us. Even this truncated “bullet list” is a longer discussion than many will care to read.

Universal Coverage of Basic Benefits

Every U.S. citizen would have basic benefit coverage for ER visits, primary care, major medical and certain drugs (pretty much the services now covered by Medicare) under a program called “Americare.” There have been a number of names used to describe what would essentially be an expansion of the existing Medicare program, but we like this one best.

Why choose the Medicare program as the single standard? Medicare has the largest database and the most comprehensive system coordinating healthcare between patients, hospitals, physicians and other care givers. There simply is nothing else like it. If it did not already exist, we would have to invent it. Despite its shortcomings, it is or at least *can be* a rational system. Even without legislative intervention, it seems obvious that we are evolving into a single payer system because almost every commercial insurance company has adopted the Medicare payment methodology in their contracts with service providers. What do we mean by that? Not too many years ago, many insurance companies would have said in their contracts with hospitals that they would pay a certain percentage of what the hospital charged for the service: say 70% of billed charges. Today, most insurances simply say they will pay 130% of what Medicare would pay for the same service, and Medicare establishes what it pays according to a complicated fee-for-service schedule.

Most people in this country understand the Medicare program well enough from the consumer side. Few would object to a “Medicare for all” plan if we could suggest a rational way to pay for it. We refer to the “Medicare for all” coverage as a basic benefit package because there will be room for discretionary

add-ons that can be purchased by consumers through private insurance companies or under direct contracts with healthcare providers. The basic benefit package concept also provides for future contraction or expansion of the basic package by Congressional mandate (or the Federal Health Board discussed below). If, for example, the country is in a flush economic condition or if technological innovations significantly reduce the cost of certain services, the basic package might be expanded. On the other hand, if economic or other factors necessitate it, the basic benefit package might be reduced. For example, would the basic package include dental or vision coverage?

NOT GOVERNMENT-RUN HEALTHCARE!

Just because they say it with conviction does not make it true. Universal healthcare is not government-run healthcare. If our reform recommendations were adopted, the government would have no more presence in our hospital, and no more control over the way we run it, than the government does now. Ownership and control of the care giver does not change in a single payer system. To those who worry the single payer system would give the single payer (the government) too much control, we offer the following common sense rebuttal from a health system that already essentially operates under a single payer system since 80% of our revenue comes from the government. The payers already exercise control over healthcare. Based on the way the payers behave now, we would rather be “controlled” by Medicare than any of the private insurances. The money we get from commercial payers is often a nuisance and almost more trouble than it is worth to collect. Insurance companies have more complicated rules and practices governing the way we must provide services to our patients—and they change the rules, without notice, overnight. They make us beg for permission to provide services (a little thing called “precertification”). No sane person likes the morass of excluded providers and ever-changing networks invented by insurance. Getting an insurance company to pay a claim timely is harder than winning the powerball lottery. If the Wall Street collapse and the trillion dollar bailout taught us anything, it taught us greed is not good and greed dominates private insurance. The other thing it taught us is that billion dollar insurance companies and politicians always take care of each other. If politicians “reform” healthcare by “tougher regulation” of their billion-dollar insurance friends, laugh them out of office.

There is an “inconvenient truth” about universal healthcare coverage in this country: we already have it; it just does not work very well. If a patient has an emergency medical condition and seeks treatment in a hospital, the patient will be treated regardless of ability to pay—everyone is covered by this policy benefit. Since we already have a universal healthcare system, we really should stop debating whether to create one and focus our attention instead on how to pay for it fairly and efficiently. Currently, those who do not have insurance are more likely to wait until they are seriously ill before seeking treatment. Consequently, when they do seek treatment in the ER, it costs more to take care of them. The old cliché still applies though translated into economic terms: a penny of prevention is worth a dollar of cure. Still others, knowing that hospitals are reluctant to deny treatment in the ER, will seek care for minor ailments or non-emergency chronic conditions, because they have no insurance and no family physician. Hospital emergency rooms are not only expensive places to provide such care, they are not efficient places to provide such care, because follow-up is problematic and there is little continuity.

Emphasis on Primary Care

No reform of healthcare will be meaningful over the long term without an increased emphasis on the primary care relationship between physician and patient and a related increased reliance on generalists over specialists. While there may be a number of ways to accomplish this change, it will no doubt require enhanced compensation for primary care physicians and decreased compensation to hospitals and subspecialists. The best means of accomplishing this goal would be by bundling payments for services. CMS has already begun this transformation but it has to go much further.

As we discussed earlier, it is in this regard in particular we believe OCH may serve as a demonstration project for this aspect of reform. OCH helped physicians become payer blind by basing compensation on the Medicare fee for service regardless of payer. The result was a system with one of the highest percentages of Medicaid patients in the State of Missouri. The single payer system will ensure that all healthcare providers will be payer source blind. That is only the starting point. In order to curb over utilization prompted by provider hunger for profit, Americare should bundle payments for services provided by hospitals and specialists. For example, Medicare compensation pays hospitals a set fee for each inpatient admission based on the

patient’s diagnosis regardless of how long the patient stays in the hospital or how much it charges for services related to the diagnosis (the DRG payment). The treating physicians, on the other hand, are paid for each patient visit they make while the patient is in the hospital—and the physicians are the ones who decide when to discharge the patient. If Americare bundled the compensation for hospital and physician services into one *global* DRG, financial incentives of hospital and treating physicians would be aligned: everyone should be motivated to provide efficient care and keep the length of stay as short as possible. [To keep hospitals from cutting those stays too short and dumping a still-sick patient on other providers, Medicare has already created a “take back” rule that recovers part of the DRG if the hospital does so.] This principal of bundling compensation should be extended over time until it covers virtually all hospital-based services.

Primary care providers should be paid on a per capita basis for certain services and fee for service for the rest. Everyone will be required to establish care with a primary care physician (PCP). Most payers already require patients to do so. The PCP will be paid so much per month for every patient in order to cover the cost of maintaining mandated electronic medical records, the cost of providing preventive care on a regular basis and the cost of providing appropriate continuing treatment of chronic illnesses. Each diagnosed chronic illness would increase the capitated fee by a certain amount. The PCP capitated fee would be supplemented by “pay for quality” performance bonus. Unanticipated patient visits to the PCP due to acute illness or injury would be paid on a fee-for-service basis. The incidence of patient-driven over-utilization of this service would be managed in two ways: 1) by the “healthy” co-pay required and 2) by the increased premium cost for the insurance covering the co-pay assessed by the system against the patient if the frequency of visits was determined to be the result of inappropriate decision-making and/or noncompliant unhealthy behaviors on the part of the patient.

Admissions to the hospital, including access of ancillary services like lab and radiology, would require a referral from the patient’s PCP. That requirement is in broad use across all payer sources and it has proven merit. The only exception to the PCP referral is in the case of a true emergency. All hospitals will still be required to perform an emergency medical screening exam. If a patient seeks treatment in the emergency room for a non-emergency, the patient will be referred back to the patient’s PCP.

For the last forty years in this country, we have been obsessed with building bigger and better medical towers and packing them with more and more specialists. We now have compelling evidence that patient outcomes may actually be *worse* in some regions where tower-based medicine drives cost of care higher. It is time to take a different path. We believe there is a better, healthier, saner approach to healthcare. Create strong, long-lived relationships between patients and general practice physicians, and let those generalists provide and control care as much as possible. In a certain light, it may look like we are simply proposing a softer, gentler way to ration services to make healthcare more affordable and more efficient—and that may be true. Though it requires an emphasis on and trust in the *art* of medicine over science and technology, it is certainly not a rejection or repudiation of the advances and advantages of science and technology. The point is we are in danger of creating a system in which the technology drives the care instead of the care driving the technology.

Implementation

Full implementation of the program would be phased in over a period of four years to reduce the impact on healthcare providers and insurance companies.

The economy is already stressed. We do not want to add to it by creating a scenario in which a dozen billion-dollar insurance companies petition for bailout money because they can no longer make billion-dollar profits providing health insurance. Likewise, billion-dollar hospital systems with marble edifices built on higher-dollar commercial insurance rates and the heavy utilization of expensive specialty care will need time to adapt to Medicare payment rates and an increased reliance on primary care.

Governance

Governance of Medicare and recommendations to Congress regarding future amendments to the program would be made by a non-political regulatory entity. Tom Daschle argued for a Federal Health Board much like the Federal Reserve Board.

Remember Daschle? He was the guy who was supposed to be President Obama's Secretary of Health until we found out that he liked to skimp on paying his taxes. This feature was recommended by

Tom Daschle in his book, *Critical: What We Can Do About the Health-care Crisis*. The idea is a sound one. Politicians tend to make a mess of healthcare. Once created, a Federal Health Board would be able to tweak the system when and where needed without meddling from politicians. Of course, at the end of the day, as with the Federal Reserve, the President and Congress would have the ultimate authority. The Federal Health Board would have to make good decisions (just as we depend on the Federal Reserve to make good decisions). We need decisions like the one to transition hospitals during 1983-1987 from Medicare cost reimbursement to DRG prospective payment. It resulted in the closure of hospitals all over the country but it saved Medicare from collapse. We do not need decisions like the Missouri legislative "reform" of Medicaid in selecting certain necessary services to be eliminated without understanding the impact on the entire healthcare delivery system.

Claims Processing

Private, for-profit insurance companies would be hired to do claims processing under Medicare. The insurance lobby will furiously oppose Medicare, and it will be politically necessary to offer something to lessen the pain of lost profits. A reduction in profit-taking by private insurance has to happen no matter which healthcare reform program ultimately prevails. The country simply can not afford to pay for healthcare while putting billions of dollars every year in the pockets of the "middle men."

There will still be an opportunity for insurance company profits with Medicare, but the return will be more rational. It will be based more on the efficiency, quality and innovativeness with which insurance companies provide legitimate services in claims processing and less on Wall Street tactics. Government employees do not actually handle claims processing and payment for the Medicare program. Medicare contracts with private companies to perform claims processing and payment. The money comes from the federal government but claims processing is performed by these private fiscal intermediaries. Those who argue that the government is incapable of doing anything efficiently should be pleased to learn that the work is already being done by the private sector. Though the claims have to be processed and paid promptly according to Medicare regulations, there is still a profit incentive for the fiscal intermediary to do so efficiently. The fact is, though few advocates for "free market" reform of

healthcare like to hear it, the government is significantly more efficient than the commercial insurance industry when it comes to paying for healthcare. For every dollar paid by the consumer for healthcare, Medicare spends about 2 cents for administration. Commercial insurances spend on average more than 20 cents. Why? Are the commercial insurance companies less efficient? No—the difference is mostly the profit margin. Those profits could pay for a lot more care.

Cost Savings

There would be huge cost savings with a single payer system. Anyone who has studied the debate over healthcare reform should already know the numbers and it is not important to repeat them here. The savings are literally billions of dollars.

There is at least one economic advantage of “universal” healthcare coverage that no one can legitimately deny: spreading the risk of loss over the entire population will decrease the unit cost of coverage. Yes, it costs more to cover more people, but the cost being paid by those already paying for coverage will go down. Why? Because there are people being “covered” and receiving healthcare who do not pay for it or who pay less than the care costs. There are almost 50 million uninsured people in this country. A high percentage of the uninsured are young, healthy adults. They are less likely to have health insurance because they are working at lower paying jobs at the beginning of their work careers, but also because they are less likely to worry about getting sick. The more healthy people the system has paying for healthcare, the less healthcare will cost per person. We need to get all those healthy young people paying for coverage now when they are not likely to need it, not only so we can afford to cover all of us older, sicker people but also so we can afford to cover those same healthy young people later when they get old and sick.

Even those who are opposed to a single payer system will, if they are being honest, admit that it would be more efficient on the claims processing side. At OCH, we have about 25-30 employees on any given day hard at work in our billing office. It typically takes three or four of them to process all of our Medicare and Medicaid claims. Those governmental claims produce 75% of our revenue. All the other employees in the billing office work like crazy trying to get the remaining 25% from the hundreds of commercial insurance companies and the thousands of patients paying claims. We typically get paid by

the government in less than 30 days from the date of service. It takes 90 days or more to get payments from insurance companies and the uninsured patients. Commercial insurance companies routinely deny claims simply because that is how they do business. They make us work hard to get paid. The slower they pay, the more claims they deny, the more profit they make. Commercial insurance payments to healthcare providers look good on paper. For us, it would appear that, on average, commercial insurances pay 30% more than the government. In reality, those paper promises do not pay our bills. Healthcare organizations are businesses much like other businesses. Cash flow struggles consume resources and create inefficiencies. We would rather be paid less but paid more promptly—and with fewer shell games. Some complain about the complexity of Medicare regulations, but it is far easier to become knowledgeable and efficient in dealing with one set of rules than the idiosyncratic and intentionally muddled process by which hundreds of different commercial insurance companies process claims. If healthcare reform does nothing else, it could save us all billions without going to a single payer system simply by requiring all payers to process claims *exactly* the same way. We keep hearing that there are regulations standardizing claims processing, but it seems to be another one of those things that only looks good on paper. The claims processing multiple payer system in this country is an awful mess.

How Financed

The basic benefit coverage would be financed for the elderly through Medicare, for the poor through an expanded Medicaid program, for the employed through mandated coverage paid equally by the employer and employee, for the unemployed through unemployment benefits, and for the self-employed through a mandatory premium. Anyone “falling through the cracks” would be assessed the premium on their federal income tax return. It would not be a “pay or play” plan. Everyone would be expected to play and pay.

We do not have the resources of the CBO to assess the impact on the federal budget, but our version of healthcare reform would not place a heavy burden on government. Everyone would pay, including millions who are not paying now. The cost of covering each state’s Medicaid beneficiaries would be financed as it is now but that cost would be less as a result of these reforms. For those consumed with concern that there will be too many deadbeats who get their health

insurance paid for by those who work hard and strive to get ahead, there will be a tax for the cost of the premium assessed against anyone who failed to pay. The tax assessment would perhaps go unpaid for those who earn no income and who do not qualify for Medicaid, but it would alleviate the concern about those who have the money and simply refuse to pay. It would even be possible to specify that the unpaid premium assessment would accumulate year-to-year and be non-dischargeable in bankruptcy.

Universal Co-pay

Patients would be responsible for a 30% co-pay for all services covered in the basic benefit package, but there would be no deductibles and no lifetime limits. The 30% co-pay liability would be covered through a mandatory, purchased secondary insurance providing everyone an opportunity to shop around, take advantage of discounts offered for maintaining healthy lifestyles and allow those with sufficient financial strength self-funding options. Consistent with some of the legislation now pending, patients could buy policies from all insurance companies licensed in the nation. The secondary insurance market would be regulated in part by the Federal Health Board. As a fail safe, there could be a guaranteed secondary insurance policy offered to all residents of each state by the franchised fiscal intermediary, at rates established by regulatory control.

This provision of our proposal is critically necessary in order to hold down the cost of universal coverage, but it does more than that: increased patient responsibility promotes good health. There is no doubt a “healthy” co-pay reduces over-utilization and encourages patients to rely less on the service provider and more on themselves to maintain good health. There has to be an individual cost associated with healthcare and a meaningful incentive to decrease those costs. However, there would be no deductibles. Deductibles are nightmarishly inefficient. Simply put, they are more trouble than they are worth. The “universal co-pay” would be easier to process and easily understood. The 30% co-pay would significantly decrease the government’s outlay. For those who could demonstrate the financial strength to “self-fund” the co-pay, there would be waivers of the mandatory purchase of a policy. The government would encourage the use of Health Savings Accounts (“HSA”) to satisfy the mandatory co-pay coverage requirement. Employers could provide secondary insurance coverage but would not be required to do so. Employers could allow

employees to purchase it through cafeteria plans. Anyone who failed to pay any co-pay liability timely would be required to purchase a secondary insurance policy from the government regulated fiscal intermediary plan.

Medicaid programs would provide secondary insurance coverage through state-defined benefit programs on a sliding scale for the poor, for the disabled, for children of the working poor, etc. but no state program could completely eliminate the requirement that patients would bear some financial responsibility for utilizing the healthcare system—which could be accomplished for the very poor by establishing a funded HSA and providing that the beneficiary would be allowed to benefit from money not spent by using it for other defined benefits (like education, child care, internet access), thereby creating an incentive to avoid over-utilization of healthcare services.

Secondary insurance plans could also offer expanded benefits (here will be the debate about dental and vision—whether to include some coverage as a basic benefit—as well as the right to access services or providers not included in the basic benefit system).

Malpractice

Comprehensive medical malpractice tort reform has to be part of the overhaul of the healthcare system. Malpractice litigation is expensive and inefficient. Malpractice litigation must accept at least some of the blame for making the practice of medicine technology driven instead of being directed by the wisdom and experience of a general practice physician with a unique insight into a particular patient. Patients deserve compensation for damages caused by negligence. We need a system designed to identify careless, reckless or incompetent providers. A medical tort claim process modeled on the workers’ compensation system would provide the necessary mechanism in a more efficient, rational manner than the current winner-take-all contest.

We want physicians to be comfortable advising a patient to forego procedures that have more to do with protecting the physician from malpractice claims than in taking proper care of the patient. We cannot return control of medicine to the generalist if the generalist gets sued for not referring the patient to a specialist even when the better course for the patient was to remain in the care of the generalist.

Any Willing Provider

Our reformed healthcare system would include an “any willing provider” rule within the basic benefit system, but expanded benefit packages would permit provider networks, and the Federal Health Board would have jurisdiction over restraint of trade complaints and abuses accomplished through the market power of big systems. Open competition among providers on a level playing field is the best way to ensure that patients consistently receive the highest possible quality service at the lowest possible cost. It is not only the best way, it is the American way.

Everyone can go to the doctor and hospital they want. Monopolistic tactics and exclusive, coercive provider networks have left patients unable to “vote with their feet” when service does not meet expectations. When the mega system controls patients’ access to care, there is little incentive to provide quality care or to contain costs. Utilization follows services that offer the provider good reimbursement while needed services with relatively low reimbursement become scarce. The patient has no real choice but to accept the in-network provider regardless of quality. However, the “any willing provider” rule would not have to extend beyond the basic benefit package. For example, medical spa, cosmetic dental or plastic surgery services could be offered to those willing to pay separate premiums for the coverage through an exclusive “managed care” network of providers.

Elimination of Provider Tax-Exempt Status

The reform legislation would phase out the tax-exemption of nonprofit health systems (including all state and local ad valorem taxes) unless the services were provided completely free of charge by the charitable organization. Under a uniform system such as the one we propose, there is no legitimate rationale to give one tax treatment to a for-profit organization and another to the non-profit. The system will be designed to pay a sustaining fee for service. There should be a level playing field for all providers.

Charitable organizations with additional funding derived from donations and tax exemptions would be able to outspend for-profit organizations, thereby increasing the likelihood of a tower and technology race to get bigger and better than the competition. The result drives up costs for everyone. The system has to be able to control spending by controlling compensation. If the system has determined that a

proliferation of a certain type of new technology is driving up costs without a corresponding improvement in outcomes, it will limit the increase of that technology by suppressing compensation. A provider organization that gets non-system funding for that technology could do an end-run around the system’s containment strategy. There would be other benefits of elimination of the tax-exemption. Many large hospital systems would begin paying millions of dollars in taxes increasing both local community coffers and, on the national scene, contributing to the revenues needed to pay for the expanded healthcare system.

Eliminate Tax Deduction of All Premiums

Reform would also eliminate the “before tax” treatment of employment related insurance coverage. Everyone will be paying the cost of the premium in one manner or another, so it would be only fair for everyone to get the same tax treatment.

A number of current reform proposals would do the same and use the additional tax revenues to offset the cost of expanded coverage.

Separate Premium for Long Term Care

We also propose imposition of a separate “premium” for long-term nursing care of the elderly and disabled, thereby eliminating the Medicaid long-term care benefit and making it part of the Social Security program, emphasizing the provision of care in the home instead of institutions.

Politicians love to complain about the amount of money being spent on providing “welfare” to Medicaid “bums” but a large percentage of the Medicaid dollar is actually spent on long-term care. Few politicians will publicly complain about the cost of the Medicaid nursing home benefit because it hits too close to home for many of their constituents. This simple reallocation of the benefit and a direct “premium” (i.e., tax) to pay for the service would make the issue transparent. We would see both the cost and the source of payment.

CONCLUDING REMARKS

The obligation to ensure the basic necessities of human life is a fundamental principle of human society. It does not depend on the “kindness of strangers” but on something deeper and more sacred. We have to ask ourselves. What do we believe? Do we believe that life, liberty and the pursuit of happiness are fundamental human rights? If so, then the creation of a healthcare delivery system designed to ensure that people have an opportunity to lead healthy, happy lives is not charity. It is an obligation imposed on each one of us simply by living in a human society.

Independence and self-reliance are important values—particularly in our culture. Modern technology allows us to think that we are more independent than ever, but, modern technology also makes it easy for us to forget how thin that veneer of technological civilization is—unless we happen to live in the wrong part of New Orleans when the hurricane hits. In the past, when it was an obvious fact of daily existence that we all had to depend on one another in order to survive, people took for

granted the need to help others and, as a result, they found it easier to expect help from others. In this day and age, it is easy to deceive ourselves into believing that we are really managing on our own, and so, we expect others to do the same. We need a healthcare system based not on an individual entitlement to “charity” care but on the mutual obligation of all parties. Each person has a responsibility to bear his own load so that he does not encumber others, but when someone stumbles on the road under their burden, those near who stand firm must reach out a steadying hand. Healthcare is not an entitlement, but it is an obligation our society must honor.

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