



A Citizen's Guide to Reforming Our Health Care System

Fred Bannister, M.D.

Lundquist Hills Publishing Company

What people are saying about *Health Security America*:

“This family practitioner shows unbelievable insight into the health care affordability problems in the country. He presents a good narrative on the evolution of medicine from the 1960s to the present. His solution is provocative and worth considering.”

David Pierpont, M.D.
Family Physician

“I found *Health Security America* a fascinating and a brilliant work. I watched the health care situation unfold over the same time frame as you have [the author]. I have arrived at the same conclusions. *Health Security America* is on the right track”

John Hughes
Pharmacist

“To me, it looks like a workable health care system. And with so many farmers without health insurance and those that are paying exorbitant premiums that continue to climb every year, we must try something different.”

Harold Kringle
Farmer

“Having been owner of a successful manufacturing company I know the out of control health care costs in the United States are driving our manufacturing over seas. Finally, someone with hands on patient care experience, Dr. Bannister, proposes a rational, workable, affordable approach to controlling our burgeoning health care costs. This proposal must get the attention it deserves from our politicians and health care providers, or else health care costs and the enormous social cost of the uninsured will drag the United States into an ever downward spiral heading us towards being a second class nation.”

Jim Torseth
Founder and former owner Press On, Inc
(three hundred employees)

"Finally, a plan written by a physician who knows why the current health care system doesn't work and who offers a citizen/consumer-driven solution. This plan will save employers billions, insure everybody and eliminate the stranglehold on our economy by providing additional revenue to address the problems in education, the environment, energy, disasters and security facing the nation today."

John Banks,
Retired educator

"Finally someone has a national health care solution for all citizens that actually reduces cost, insures high quality care, and gives citizens ownership of their health care system. Thank you, Dr. Bannister, for proposing a sensible solution to a health care system that has become an economic drain on our nation, bankrupting citizens, businesses, and putting health care out of reach for millions of citizens. I hope every citizen and legislator reads this book."

Jim Adams
Teacher

"In reading Health Security America, it is quite obvious that it gets to the root cause of the medical crisis in this country. All other 'so called' Washington fixes just put more dollars into supporting an already bad plan, causing it to get even worse. A *bipartisan* acceptance of the Health Security America plan could guarantee health care to all children and all elderly."

David Hamm, BS., MS

“Dr. Bannister provides a much needed look at America’s health crisis from the standpoint of an experienced physician. His discussion of his own experiences results in health care reform proposals that are imaginative as well as practical. A careful study of this book by our politicians and health care reformers is essential.”

Carrie Finn
Citizen

“They say the only two sure things in this life are death and taxes. Dr. Bannister’s Health Security America gives hope to the working person that we can also be assured of affordable health care. Through his plan, we can control our own destiny rather than be held hostage by astronomical premiums. This book is a must-read for every U.S. citizen!”

Aaron Kittelson
Package Car Driver
Union Member

“I totally agree in the concept of eliminating a health care system that is in the hands of insurance companies, special interest groups, etc., and returning it to the people. Common sense seems to have taken a back seat in our present health care system. Your personal examples really add to the understanding and relate to the problem and solutions.”

Mary Huset, RN

Health Security America: Fixing the health care crisis

A citizen's guide to reforming our health care system

F.M. Bannister, M.D.

Lundquist Hills Publishing
Chetek, Wisconsin

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**To each of the 46 million people who need health insurance—
especially the children.**

**Any profits from the publishing of this book will go to advancing a
health-secure America.**

The National Coalition on Health Care correctly describes the current United States health care system, saying, “Experts agree that our health care system is riddled with inefficiencies, excessive administrative expenses, inflated prices, poor management, inappropriate care, waste and fraud. These problems significantly increase the cost of medical care and health insurance for employers and workers.”¹

*Honorary Co-Chairs of the National Coalition on Health Care are former Presidents Gerald R. Ford, Jimmy Carter and George H.W. Bush*²

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PREFACE

The health care professions, despite their financial strength, their brilliance in developing new life-saving drugs and devices, and despite their continually repeated concerns for the well being of people, have failed miserably over the last 25 years to provide health care for all Americans. We rank 22nd in the lineup of 23 industrialized countries for providing life expectancy for dollars spent.¹ We leave 45 million of our people to fend for themselves with no health insurance. Over ten million of the uninsured are kids². Unfortunately, public health has taken a back seat to profit.

Pharmaceutical companies and their lobbyists were the major winners when the Medicare drug benefit program became law in December of 2003. The Asbury Press posted 10/7/05, “The government is barred from being involved in negotiating prices as the Department of Veteran Affairs does, which results in significantly reduced costs for veterans.”³ We are told drug companies need the money from these windfall profits to develop new drugs but these are not the facts. In his book *Overdosed America*, Harvard instructor and family practice physician John Abramson writes, “From 1991 to 1999, U.S. pharmaceutical companies did not develop more than their share of drugs based on a per capita basis compared with Western Europe and Japan.”⁴ In fact, Abramson goes on to state, the Food and Drug Administration

has concluded that only 13 percent of the drugs approved in the United States from 1995 to 2000 contain new active ingredients.⁵

Corporate America, with privileges granted by the people, works within corporate law to provide health care, but it has failed. Traditional corporate guidelines are dictated by legitimate profit motives, working through existing laws. While this combination has made America an industrial powerhouse, corporate America has failed in dealing with our current health care crisis. The business of health care is not the same as selling refrigerators or cars for profit; the health care system doesn't function very well with General Motors' or Westinghouse's corporate rules, and if it did, we would not have the health care crisis at this stage in our history. The present corporate rules have created an albatross of a situation, *legally* allowing two people with different insurance policies to be charged as much as 500 percent difference in fees for the same procedure (page 66). Corporate America's business rules have allowed companies to lose their health insurance by simply raising its premium 34 percent in one year. (Page 32) This is not illegal and, in fact, U.S. citizens through the corporate laws allow this. It is time for us to *wake up to this albatross* around our necks.

Are people who are suffering from these inequities angry? Yes they are, and if you happen to be lucky and not affected by the descriptions above, ask a friend who has. He won't be hard to find, and your ears will be burning! If one person is not convincing enough, make sure you go to your union hall or corporate boardroom and you will find total exasperation with our health delivery system. The very existence of companies like General Motors is threatened by our failed health care system.

Not everyone sees the problem. Not everyone in the health care professions will attempt change or even agree with me. It is too comfortable for some, who would rather leave well enough alone. At the very most, people who study health care reform work around the edges, on eliminating medical errors and adding

new computer technology. These areas are all worthy endeavors, but not enough to fix the mess we are in. Many physicians who are ensconced in large clinic practices and are content with their incomes don't want change. Some physicians don't want to worry about administration even if it would take very little of their time. Administrators with their huge salaries certainly don't want change. Patients who are lucky to have one of these all-encompassing health plans that are very expensive, but a benefit to them, without any personal input, are not going to raise any ruckus. It is not any part of their daily thought. The government would like something to happen before the debt overwhelms the country, as Medicare debt is threatening to do, but they are pulled from side to side by lobbyists and can't get much done to help fix the health care problem.

Citizens, it is time to take over your own health care system and create guidelines by common sense, not by lobbyist influence or drug and medical device company urgings. There is room for everyone to take responsibility to correct this health care crisis that we are all mired in. Don't let the people in power tell you that you won't understand. You will! Beware of the people in the profession who say that there will be fewer practicing doctors; there won't be. This book will provide a solution to this crisis, outlining a workable plan that hinges on citizen input. It is called Health Security America.

INTRODUCTION

The goal of this book is to provide an understandable roadmap to health security for every American. Health Security America, a health plan, is the summation of a five-year effort to put together a solution to our health care crisis that is *feasible, voluntary, affordable and effective*. My explanations rely on experience afforded me over the last 40 years of practicing medicine and in medical management. More than anything, Health Security America has to work in a format that is understandable and available to the entire country with a minimum of new laws or administrative rulings. I do not ask you to put faith in a plan that uses concepts never before tried or that are not easily understood. Health Security America is based on proven, successful concepts, rules and administration.

THE THREE MANDATES OF HEALTH SECURITY AMERICA

- ? Health insurance from birth to death for all Americans
- ? Free health insurance for Americans through their first 18 years
- ? Health Security America *will pay for itself—in fact it will not work unless it is self-funded*

Health Security America encompasses some “Single Payer” ideas and “Universal Health Care” ideas put forward by others. However, I ask for more *responsibility* on the part of all Americans who are capable mentally and physically of assuming it. Those who are not physically or mentally able to deal with their responsibility will be helped by the rest of us. I will explain in chapter 12 of the book how this will be accomplished.

The book addresses how Health Security America will work and in some cases how we got to our present crisis. I will use experiences in the journey to our health care crisis only where they demonstrate how Health Security America will require a change in present health law. It is not a detailed history book on health care in America.

Below, I summarize the health care crisis we are currently experiencing in the following indisputable statements; the summary is accurate and current enough that it will not need to be repeatedly identified in the book.

- ? 45 million people lack health insurance—*24 percent of them children.*¹
- ? Statistics in 2001 show the United States spending **\$5,000** for every citizen, with a life expectancy of 69.3 years.²
- ? Japan spent \$2,000 per citizen, with a life expectancy of 75 years.²
- ? Sweden spent \$2,200 per citizen, with a life expectancy of 73.2 years.²

The latest statistics available for 2003 reveal United States health care spending per citizen at \$5,671.³, yet I have found no

statistics demonstrating significant improvement in life expectancies since 2001 to justify this in comparison to Japan and Sweden costs per citizen. These statistics clearly demonstrate a broken health care system.

- ? Our present system stifles competition, eliminates patient choice of his or her physician, and keeps costs high.
- ? One half of all personal bankruptcies are triggered by costly illnesses, and yet, three out of four of these persons have health insurance policies.⁴
- ? Some estimates have concluded as many as 18,000 Americans die per year due to this crisis.⁵
- ? The crisis has been deemed by many to be ten times as important as the current Social Security discussions. It is still not in the forefront of congressional discussion, and my concern for this neglect is another reason for the book. My hope is that, as a result of your reading, the health crisis will be in the forefront soon.

If this book provides an understandable roadmap, it will have been a success. It is designed to be helpful to all political parties, citizens and businesses. My goal, at the very least, is for the roadmap to create bipartisan support for a bill encompassing the minimum three mandates of Health Security America. The first chapters in Part One will give my background as a practicing physician deeply involved in the business of medicine. It is necessary *to understand my experience to understand my conclusions.*

The next chapters in Part I will give you some knowledge of the institutions and guidelines that direct us in medical practice. You will see how these institutions and guidelines differ after the

advent of managed care plans and large clinics. There are many versions of managed health care plans from health maintenance organizations (HMOs), to point of service plans, preferred provider plans and several others. I will, for the purposes of the book, include them all under the cover of managed care plans.

Components of health care administration will become part of your vocabulary. You are going to have to understand non-compete contracts, peer review, usual and customary charges vs. set fees. Adding more to the list, there are open and closed staffs, patient choice, restrictive or closed physician panels, self-funded versus government-funded, single payer and universal health plans. They will all become a part of your vocabulary. It is necessary to understand these definitions, since the roadmap will spell out **eight rules** that, if followed and not adulterated *by special interest groups*, will make it possible for Health Security America to succeed. You will become familiar not only with some of the inner workings of our medical societies and large clinic boards, but also with medical administration strategies that have been costing U.S. citizens *100 percent more for our health care*⁶ than those of other industrialized countries. Costing more, but resulting in a poorer outcome, as gauged by life expectancy. *This does not have to be!*

Part II is a roadmap to a health-secure America. One might choose to think of Health Security America as a new business model for health care in America. Chapters six, seven and eight define a health-secure America, and outline a first and second step to realizing the three mandates in the Health Security America Health Plan. Part III deals with how the various parts of the health industry and its related entities will function and fare under this new plan. You could call this “What happens if we take this road?” Part IV ties up some loose ends, addressing some special questions.

Do I have answers? Yes, I have enough to put us on the proper track for a health-secure America. Do I have enough answers to get us off dead center and dealing effectively with the

issues of a complex industry understood by very few people in the American population? Yes. Some of you who are reading the book and are very involved in the health industry may disagree with some of my conclusions. If you do, please consider your affiliations in the industry, experience, background, training and who pays your salary and see if your disagreement relates to your position and might give you prejudice. If you are one of the 46 million without insurance, you will undoubtedly have a different view from that of a lobbyist or insurance company CEO. Review the eight rules and ask yourself which of the rules you oppose, and finding one, simply think through the rule. See how the problem that the rule corrects is obstructing the reduction of health care costs. The answers are there.

My own agenda is to help all Americans with a terrible crisis by using the information and experience accumulated over 40 years in the business and practice of medicine, as I watched (and participated in!) problems leading to the health care crisis now unfolding. In many cases, this knowledge has come after many years of watching these problems leading to our present-day health care crisis. I do not claim to be without sin while this happened, and I take as much blame as anyone for this crisis. My conclusions did not come after a three-month sabbatical or waking one morning with a startling solution. Let's begin.

PART I

BACKGROUND

CHAPTER 1

MY FIRST THIRTEEN YEARS IN THE PRACTICE OF MEDICINE

My real entry into the business of the medical profession began in 1963 on a preceptorship, which is part of the curriculum of the University of Wisconsin Medical School in the junior year. When I took the preceptorship in 1963 it was defined in the medical education curriculum at the University of Wisconsin as a three-month period allowing a student to leave the academic atmosphere and work with a practicing physician in whatever field of medicine he or she might be. The medical student still picks the site he or she goes to in Wisconsin. The purpose of the preceptorship is to learn about the *real* practice of medicine outside of the academic atmosphere of a university town and medical school. A student accompanies the physician preceptor doing their daily work, observes and sometimes participates in caring for patients. If one has one of the better preceptorships, he or she is a part of the preceptor's after-work life, allowing one to observe his life in the community. I had one of these preceptorships. When the preceptorship is over, a student knows exactly what to expect if he or she goes go into the preceptor's field of practice. I was 24 years old and completed my preceptorship in the quaint town of Westby, Wisconsin, which had a population of 2,097. My preceptorship fulfilled all the criteria defined in the University of Wisconsin Medical School curriculum, thanks to an unbelievable mentor in Dr. P.T. Bland.

Dr. Bland was part of a practice of two family doctors in their own clinic that they shared with a dentist. Their clinic was state-of-the-art for the time. At 24 years old, with medical school debt and still no real job, I had to take an interest in what lay ahead. Dr. Bland, in his early forties at the time, understood my needs and shared his life with me for three months in his very rural western Wisconsin town. There was medical teaching on literally hundreds of patients, but he also shared his methods of investing, running his practice and socializing with many of the same folks he cared for and invested with. It wasn't long before I got to know his front office employees, how items were billed, how much was received from whom, and how much was not received from others. This was the time before Medicare, and I can never remember a case he turned away. How the patient paid his or her bill was not part of any discrimination in treatment and, as I recall, wasn't noted on the chart. The relationship with his employees was such that they knew what he meant before he said it.

The mid-1960s was a period before pension mechanisms like the 401k and IRAs. P.T. Bland looked at the community, determined his investment opportunities, chose one and invested in it. I watched first hand his involvement in developing a bulk fertilizer plant for his community. I met, worked, and played with his medical partners and investment partners. I still remember pounding nails building the fertilizer plant! I can still feel the blisters! I knew when I left Westby, Wisconsin, that I wanted to live the same life P.T. Bland did. *And I have!*

Having made the decision for rural family practice, I had to find a suitable location. There were literally hundreds of opportunities at the time. However, I also needed to have a very broad internship first with lots of "see one, do one" teaching methods. In the busy, big city charity hospitals of this era, the volume of work was so overwhelming that you were taught by the person superior to you, and then basically told to do it yourself from then on. I found these teaching methods in Los Angeles

County Hospital—far from the ideal small town I had in mind—but it afforded the necessary training. There was virtually no lab test or diagnostic procedure that I would need on a daily basis in family practice that I had not done literally *hundreds* of times. This training was not a university or suburban hospital setting. Nor was it what I would call a “protected internship,” meaning that all of an intern’s decisions required supervisor approval. People lived or died on my decision alone.

I specifically remember treating “Becky,” 18 years old, who had used a coat hanger to try to abort her unwanted pregnancy. This was before *Roe vs. Wade* made abortions legal.* I had observed the treatment given by my resident (my superior by one year) many times. This was my case. This patient was in septic shock, a dire, very near-death condition with a 104-degree temperature and no blood pressure to speak of.

To this day, I can remember the dose of the antibiotics—penicillin and Chloromycetin—and the cortisone preparation Solucortef used in these cases. I remember the effort to ensure the intravenous solution continued to run while virtually never, initially at least, leaving her bedside—one human being trying to save the life of another. I succeeded with that one. Some women with the same problems did not survive, and those memories stay with me, too. Treating patients like these provided a rapid march to professional maturity for a young doctor, and gave me a lot of confidence. After the year of training, I felt ready for the next step—my own medical practice, my own business, and my new life as a member of a community. I felt very comfortable going to my present community of Chetek, Wisconsin, where I have been in medicine for 40 years.

MY OWN BUSINESS

* I remain ready to explain to anyone wanting to overturn *Roe vs. Wade* this experience in its gruesome, brutal detail.

When I came to Chetek, a western Wisconsin community of 1,800 citizens in 1965, there was a clinic owned by the community built with Sears Foundation help. I rented space in that clinic. The town size compared to that of Westby, Wisconsin, the site of my preceptorship. There was a full-time physician who was leaving the community for family reasons. And there also was a wonderful, skilled physician, Dr. Robert Adams, who had served the community for many decades. He was approaching ninety years of age but he still took blood pressures; mostly he read the *Wall Street Journal* in the solitude of his office. The clinic had room for four physicians but I was really the only full-time doctor there.

I continued with the employees of the exiting physician, but started with my own medical records and financial ledgers. We used big black ledger books all entered by hand. Today it is almost impossible to fathom running accounts that way. I hired and fired and determined the business strategy of my new business. My employees were responsive, smart, and effective. I depended on a wonderful woman who had several years of business school and could implement my decisions, do the bookkeeping and inform me of the finances. I had another great employee who organized patient records, kept the patients moving and did virtually everything in the office. I also had a lab technician/patient assistant and a receptionist, and all of them were *cross-trained*. This means they could do each other's jobs, whether it be taking a chest x-ray, extremity x-ray, doing a simple lab test including controls, bringing anxious patients back to the examining room or collecting money for a bill. This cross-training allowed for vacations and family illness to be a part of everyday life without being an inconvenience to the rest of the staff. I was very much in charge of whom we hired and evaluating whether or not they were effective. We had a few false starts but not many. I was part of the decision making at most all levels and I enjoyed being there. It was, after all, *my business*.

In the summer, my community had as many as 15,000 people in the vicinity enjoying our lake resorts, cabins and seasonal homes. During the rest of the year, there were between 5,000 and 6,000 potential patients. I lasted about one year before it became obvious that I could not keep up the 24/7 pace. I had a big obstetric practice until I got more partners to help. As it is now, it was a cause for lots of night work and lost sleep. I remember times of virtually physically collapsing on the couch at home after days without sleep. I simply turned on the answering service advising people to seek care in one of the surrounding towns. This was a very poor plan, risky to my patients, and defeated my business efforts. I did not like the self-defeating business practice of referring patients away from my practice.

To remedy the problem, I formulated a plan to bring new doctors to Chetek and determined how they would be paid. Vietnam was beginning to heat up and there was a very low number of family doctors available. I determined to keep these hard-to-find folks by equally sharing my income immediately upon their decision to work in Chetek. We all continued to share equal income until we sold out to the Midelfort Clinic, which I will describe later.

My newly hired colleagues were instant partners. They did not have to wait two or more years to become full partners. The two-year wait was the standard of this era. The instant partnership plan had some risk with it. One had to be very careful there would be no personality clashes or significant difference in the way one practiced medicine, but I was able to make it work. My plan allowed Chetek to have up to three or four doctors living and working in its one clinic after my first several years in practice. Virtually all of them have stayed in our area. We expanded to two other communities by 1978, and some had moved to these surrounding towns. We called ourselves the Chetek Medical Clinic, SC. Every employee had the same health insurance and benefits that the doctors had. I remained president of the

corporation for most of its existence. Everyone appeared to be happy. However, it was time to consider putting money aside for old age. Doctors and employees alike agreed that retirement investment was a need.

We were able to form a pension fund, and for several years I annually tripled our investments. Our investments were mostly real estate but included cattle herds in Montana. I seemed to have some understanding of money, finance, peoples' instincts, and what they wanted as an employee or partner without their having to voice it. It took a lot of time but the investing turned out to be my hobby as well. The clinic's Board of Directors—*all the physicians*—approved my ideas. It is important to note we ran the business aspects of our clinic and our pension fund without difficulty. Today, there are many financial advisors to administer the pension funds at very reasonable rates if you want to give up the fun of doing your own investing.

In 1978, our medical practice was into its thirteenth year. We enjoyed thirteen years of good monetary rewards for our work. Physicians' and employees' needs for retirement packages, health and disability insurance were met. Physicians were able to have time off for rest and relaxation, as well as continuing education. All of our physicians were involved in the community whether it was golfing on a local team, Mayor of Chetek, Scout Leader or running as a candidate for the school board. Physicians were content with their jobs. Keep in mind that we exercised cost control to allow all these benefits, and we were ever mindful that patient care was never compromised.

Up until a debilitating accident in 1978 required me to recover for a year, I still had one of the largest practices in the clinic. The accident occurred while I was on a horse auditing a cattle herd our clinic pension fund owned in Montana. Life was rewarding and very interesting. I still approved all the hiring and firing. The firing was an awful job but only occurred twice in 40

years. I took all my partners' thoughts into consideration, and decisions were really made by consensus, but my partners still gave me the unpleasant tasks to do—such as firing. Throughout many negotiations, I gained valuable experience over those thirteen years.

CHAPTER 2

THE NEXT TWENTY YEARS IN MY PRACTICE OF MEDICINE

Mistakes led us to the present health care crisis, and I will describe them below. Based on my knowledge and experience in the health care business, I firmly believe that, by undoing those mistakes, our current insurance premium costs can be lowered *up to 50 percent*. The national economy will improve by taking less health care cost out of our gross domestic product. Health care cost was fifteen percent of our GDP in 2003¹, as opposed to an average 8.6 percent of thirty OECD (Organization of European Cooperation and Development) countries. All of us can improve our quality of life when we work together to lower our health insurance premiums. Each person can determine the definition of quality in his or her life, but if we were on a par with Europe, based on the figures above, the 6.4 percent savings of gross national product would amount to billions of dollars. We could spend that money on everything from more recreational activities to building bigger and better schools, while at the same time using the money to reduce our national debt. This all could be done while we reach the same life expectancy of countries like Sweden, which spends half as much on health care per citizen. This certainly makes lowering our health care costs a worthwhile endeavor.

HEALTH SECURITY AMERICA

Let me say it again. Together, we can take the fear of no available, affordable health insurance coverage out of our daily life. We will do this with a new health care plan called Health Security America that will enable all Americans to participate. First, I have to show you what went wrong and then how we will fix it, using the Health Security America roadmap. Fixing the present health care system will allow all of us health care regardless of present age or health at a cost we can afford. No one will be refused and, for once, no child will be left behind.

Statements such as this from a family doctor in a small, rural U. S. town have to be associated with some explanation of why I think this. We made some mistakes in the twenty years following our 1978 sea change. We made a major change in how our practice was governed after we sold our medical practice of nine physicians to a large clinic, accepting their method of governing a much larger group of physicians.

MISTAKES

- ✍ **Underestimated administrative overhead**
- ✍ **Dropped local medical society peer review**
- ✍ **Closed ourselves off from talking with other practices**
- ✍ **Dropped patients not on our managed care plan if they had another plan**
- ✍ **Adopted closed physician panel rules for our managed care plan**
- ✍ **Sacrificed doctor-patient relationship to economizing measures**
- ✍ **Worked with such a small risk pool that premiums were not accurate**
- ✍ **Locked ourselves into a failed system with non-compete employee contracts**
- ✍ **Let managed care and big clinics own hospitals as "cost-saving" measures and profit centers**
- ✍ **Forced solo practices out of business**
- ✍ **Enforced closed staff policy**
- ✍ **Refused to find a better way after the failure of managed care**

The mistakes are revealing in showing what we need to do to fix the health care crisis. I use the word *we* to include many other U. S. medical practitioners. My clinic was not the only clinic making these mistakes. I am going to describe each one. I should state up front that none of these wrong decisions, now seen to be errors, were intended to hurt anyone, most especially patients. Those of us in the decision making area felt as though we were doing these things for the good of both our business *and* our patients. We believed it would lower premiums—not raise them. In hindsight we were wrong, of course. Despite our having made financial mistakes, only our patients can pass judgment on us as medical practitioners, since they know us personally. I think they will give most all the physicians I worked with over these next years an A+.

I am going to be critical of business actions in retrospect. Criticizing in hindsight is always easier than when you have to say yes or no at the adoption date of an action. Back in 1978, private health insurance premiums were going up. It was called a health care crisis then, too.

The late 1970s saw groups such as ours in our region selling out to larger clinics. Prior to selling out, our own practice had grown such that we had opened another clinic in our county seat, and we were in the process of establishing a clinic in Cameron, Wisconsin, a neighboring town with no doctor. Our job descriptions were no different than they were before the branching out. We added employees as doctors were added. Our same group of people handled all Medicare and other various regulations as we did business. By this time, we had a full partner in Dr. Jim Fogarty, an excellent general surgeon, for a total of nine physicians. We had a pension fund directed by our board of directors, that is, all the physicians, as well as our original employees who had implemented our business strategy and assisted with additional hiring and building the new clinic in Cameron. Our expansion did not require an explosion of new employees.

We had no need of *human resources personnel, investment consultants, medical directors, executive secretaries, administrative CEOs, extra vice presidents, or quality assurance personnel*. The physician board of directors handled the decisions and contracts, and our assistants whom we hired implemented the required paperwork, just as they had been doing for the previous thirteen years. The added workload did not overburden the doctors. I have to say that most of us enjoyed our meetings, planning to improve medicine and our business in the area. With three buildings in three towns, we nine doctors were not intimidated by managing our own business. We had reached our goals of a good income, good benefits, a good quality practice and time off with our families. We could have stayed with a practice in which we all kept a finger on the pulse of our business understanding how many dollars were coming in and how many dollars were going out, but we did not.

Instead, we started to feel threatened by what we perceived as the “evils of socialized medicine.” In retrospect, I can’t identify those evils very well. It seemed that all businessmen grabbed that quote if there were any suggestion that someone was going to get something for nothing from the government, or even if there were government involvement of any sort. It was a strong emotion rather than a reasoned opinion. As an example of that kind of reflexive distaste, in the mid-1970s, governmental agencies established regional planning councils, and we reacted. The planning councils’ purpose was to make sure there was no duplication of large equipment purchases or services in geographically close hospitals. Planning councils sound like common sense to me now, but at the time we resented the interference of the government in our business.

And during that era, more physicians used to be members of the American Medical Association (AMA). As a group, they worked hard to try to defeat Medicare, a perceived threat to independence. The AMA did not defeat the Medicare bill, though.

Ironically, Medicare became a source of satisfaction in its early days. We rather enjoyed our ability to submit our “usual and customary fees” for services and be paid by an organization that did not question them. Usual and customary fees are fees that each physician thinks due him for a service. The customary part refers to fees within the same range of what other doctors in the same area tend to charge. I do not recall anyone’s ever charging too little, so underpayment was never a problem. Nor does the buyer of the service ever have any influence on the amount. To anyone who has ever been in any kind of business, doesn’t this sound like a bonanza? It was a bonanza. The original opposition by the AMA and its members seemed foolish for the first couple of years, when we found that it helped the income of almost all doctors.

It was not until the establishment of Medicare’s *set fees* that we actually felt our independence threatened and worried that the government might control us more. We thought we might have more clout in the future and yet guarantee our own independence by uniting with a larger group of practitioners. We assumed that we would then be able to hire people to worry about the expected regulations that by 1978 were present or on the horizon (Medicare set fees being only one of them). We did not realize the drain that all these additional personnel would have on our incomes, and looked for a buyer.

The Midelfort Clinic of Eau Claire, Wisconsin, bought us out. We talked ourselves into the buyout rather easily, for we were compensated approximately \$100,000 per doctor, including interest and principal. That was a lot of money in 1978! We all felt pretty business-smart at the time, and yet we gave up things as simple as setting our own work hours, determining our own methods of practice, and yes, even whether we needed a fax machine and what kind we bought. (Years have gone by, but that was a real battle with the medical director who delayed its purchase) We failed to recognize that administering a large clinic would eat up resources and require much more in staffing; we felt

as though we could go on earning without consequence. In a sense, we lost our professional autonomy, and in fact, later generations of physicians often have no memory of ever having the autonomy that earlier generations once did. I can tell all new medical practitioners that they can have all these little things back again that convey a sense of ownership, self-esteem and which, by their absence, probably cause more everyday irritation in the practice of medicine than could be imagined. In a smaller practice, if something bothers a physician, then he or she can simply change it. But big-clinic practices change course with glacial inertia. Health Security America will point the way back to autonomy. Read on!

Back in 1978, we were impressed with ourselves after our merger, thinking that we would still maintain our independence and make all this extra money besides. We thought that by being bigger we had protections from all those new government regulations sure to come. We did not quite know what those new regulations might be but we were sure that some were coming. We were even verbally guaranteed our internal independence in the function of our practices, since we were located 45 miles from the larger clinic that purchased us. I had been instrumental in arranging that buy-out, but after serving on the board of directors for the first two years, I did not seek re-election to that post. It did not take long at all before it was obvious that our independence was gone and we had made a mistake.

We were family doctors joining a specialty group. A specialty group consists of physicians who have skills in a certain circumscribed field of medical practice. Examples of specialties are internist, orthopedist, radiologist, surgeon, and so on. Although family practice had been an official specialty since 1972, we felt dictated to by other specialists who did not acknowledge our equivalence. Nor did they have sufficient knowledge to do so. We also deeply resented not being given credit for helping to build the other specialists' practices by referring patients for more

intense examination when it was required—credit being defined as recognition of our family practice specialty as well as financial considerations. Prior to our merger, we had sent such patients to all four compass directions, depending on the relationships each physician had built with specialists he would occasionally need. Now, we were sending them to our new partners at Midelfort. To this day, that tension is not entirely resolved.

In addition to the stresses of fitting into a specialty practice, the Midelfort Clinic administration and board of directors set about managing our professional lives. They began determining our rules of practice, setting hours of work and time off, and determining who was allowed to do certain procedures. The most annoying problem to develop was their change in the formula determining how each of us was paid. It took less than six months for our salaries to drop. My original partners put me back on the board to get us out of that mess. To my chagrin, I never managed to untangle that Gordian knot.

On top of these changes in practice rules, we added a CEO, section chiefs, human resources personnel, a medical director, a managed care plan director, quality assurance personnel and other job descriptions, increasing the overhead of our health care business at an exponential rate. All that extra staffing cost lots of money; the salaries of many of those jobs now range from \$50,000 to \$450,000 in clinics around the country depending of course on the individual clinic and job involved. We never accounted for that type of cost structure when we contemplated our buy-out. I am going to label this *lack of cost recognition* of joining a large practice **mistake number 1**.

Dollar signs and ego had clouded our vision. Our group of nine doctors, all with a stake in the running of our practice, owning our own buildings and determining how we would put money aside for retirement, had given all of this up for a big group with a growing administration. We were unhappy, of course, with our loss of business autonomy, but at this point, these changes did not

affect our doctor- patient relationship, which we valued as a top priority, and our lifestyle did not greatly change.

From the big-clinic perspective, I served for eight years on the Midelfort Clinic Board of Directors—six of those years as their treasurer. By 1988, the group I helped lead numbered about 50 doctors of all specialties, including family practice. Millions of dollars passed through our hands. I could not have gotten any closer to the action of the times.

CHAPTER 3

PROFESSIONAL INSTITUTIONS AND GUIDELINES BEFORE AND AFTER THE ADVENT OF LARGE CLINICS AND MANAGED CARE PLANS

Prior to 1978, and only occasionally now, medical practice was guided by state and local medical societies. Here in northwestern Wisconsin, we call our local society the Tri-County Medical Society. When I started practice in 1965, and almost immediately after coming to Chetek, I went to our local medical society meeting. I still remember being admitted to the society after its credentials committee approved my own credentials. It seemed I had finally arrived.

Despite the frequently snowy weather in our part of Wisconsin, virtually every meeting was filled to capacity, and we would hear why this person or that person could not be at the meeting. I think we had about thirty members, and they came from as far as 80 miles away. Most of us took our turn as president, and we all felt that those meetings were important and made the effort to attend, even during periods of bad weather. It was important to keep in touch, because clinics during the early and middle years of my career were small, employing anywhere from one physician to six physicians and were independent of one another. The local medical society forum allowed physicians to meet other physicians in our three counties and socialize—usually at dinner and an

annual Christmas party—providing a vital professional network. It is easier to call up a doctor and ask for help or advice if one has met him or her.

I became acquainted with a physician about twenty years older than I, Dr. Jim Maser, and I will never forget the guidance he gave me—particularly in one incident about two years after I started practice. I was at one of the two hospitals where I had staff privileges and was delivering the fourteenth child of a heavyset woman. I was alone with the obstetric nurse and after the delivery, our patient started to bleed much more than normal. It was trouble. After having no success at stopping the bleeding, I asked the nurse to please call Dr. Maser. He came almost immediately, cigar clenched between his teeth, and recognized the problem. I will never forget that wonderful cigar smell and the relief I felt when he arrived. The two of us fixed up the new mother, and I thanked him profusely for helping me. He made absolutely nothing of it. It was a typical example of two physicians cementing a bond, doing a job helping people. One of my colleagues reminded me after we talked of this book; it was very common for one physician to show another physician how to do a procedure in years past. Dr. Maser also taught me how to do an adenoidectomy and tonsillectomy. Some years later, I in turn taught a general surgeon how to do the procedure, since it had not been covered in his training.

That tradition of teaching a competing colleague a procedure after he was out of his official training is virtually gone. I have a family practice physician friend whose son has also recently finished his training in family practice. My friend (the older physician) has been a University of Wisconsin preceptor for many years. He has won prestigious awards for his effectiveness in teaching. Years have gone by, but one of his former preceptees returned to the large clinic in which both the young physician and his father, my older physician friend, work. Colonoscopy is a procedure that family doctors do, but it does take some training. It was not a long time ago that the procedure was taught one on one.

The new doctor, my friend's son, asked the former preceptee who had been taught much by the older, award-winning preceptor to mentor him in this task. The former preceptee refused. In an active medical society, the refusal to help a colleague learn would not have been well received. The person who refused to help mentor a new doctor would have a tainted reputation.

This story and those of many others help explain why medical societies are useful and worth preserving. I got to know Dr. Maser through our local society. We saw each other at least ten or twelve times a year, socially. These meetings were places in which we talked of cases and problems in medicine. It was expected that the older physicians would show the younger all the tricks they had learned as well as teach them procedures they might not have learned in their training. The older members enjoyed hearing all the new thinking that we brought from our more recent training. Pleasant memories of camaraderie aside, the medical society also served a peer review function, and credentialed new physicians—and did these things with a firm hand.

Peer review is a process in which people all doing similar work look over each other's shoulders and make sure that everyone operates under generally understood guidelines. Most people understand that a policeman who beats a prone, handcuffed man is out of line and should be reprimanded. He has not followed his guidelines. Physicians also have guidelines, and when someone practices outside designated standard guidelines the group will inform the physician that he or she has breached the standard of care and ensure that the practice be stopped. The following case illustrates the process.

The physician in question had taken care of a severely injured tibia (the big long bone in the lower leg). It had been badly broken. He put a cast on it and sent the patient home with instructions to walk on it the next day. This was not appropriate for the injury, since it could have resulted in a non-healing situation,

and of course, the inability to walk. Another physician who was asked to see the patient a few days later brought the case forward. The medical society took care of the problem by meeting with the physician in question; and, on further investigation, found other problems. The individual lost his license because of peer review.

Medical society peer review actually has dwindled away to nothing in our area as the large clinics like Midelfort have taken on the responsibility themselves. This I consider **mistake number 2**. This has been in some cases a *disaster*. The following recent case is an example. NBC News has just presented stories showing how peer review, were it still functioning, might have reduced the number of prescription drug abuse cases that we see.¹

I am personally familiar with a situation involving a middle-aged man who is deeply religious, has excellent family support but has had difficulty keeping a job. Prior to losing his job when the company closed his section, he had an accident involving an orthopedic issue. X-rays, and an MRI, (a very sophisticated test) showed no evidence of injury. A family doctor, two orthopedic specialists and a neurologist found no evidence of concrete injury. That is quite a portfolio of negative findings. The patient has a Workman's Compensation claim pending, but still does part time manual labor of various sorts. He needs to prove to the compensation panel that indeed he does have pain, disability and need of compensation.

I learned of the medicines this man was taking, which included opiates (narcotics) by the hundred-tablet quantity. The reason the opiates were given was for phantom pain. This is pain with a total absence of physical or laboratory findings, and a really unusual finding in the type of bone injury this man had. I add, however, that while it is unusual, it is still possible. Unfortunately, the man has become totally dependent on the opiates and now even more powerful narcotics. His family's wellbeing is threatened, as is his quality of life and his very life itself. His case badly needs peer review, and it could be initiated by anyone who knows of it by

notifying the local medical society, but the usual way is by another physician who becomes acquainted with the situation. Has there been a family conference on this phantom pain? Has the patient been sent for a psychiatric consultation before resorting to such a level of narcotics for pain control? Do they know the threats these medicines will cause? Is there total honesty in applying for Workman's Compensation in relation to the risk of these medicines?

I personally called a clinic where I thought the patient's pain expert worked, but learned that he did not in fact work there. The doctor I talked with said they could not do peer review on this case, since the pain clinic physician was not part of their group, and he didn't want to become involved without some official status—meaning the legal cover of our medical society's now nonfunctioning peer review committee. In the past, the practitioner would have been asked to explain his decisions privately to a committee of his peers. He well might have rendered good care, but it would have been reviewed to make certain. This particular case received no peer review at all, because there was no longer an institution in place to do it.

Supposedly, a large clinic is able to police itself through its own peer review. Many times, however, there is no one else in a large group to do peer review, for instance, another specialist if he is the only one in the group of this type. (It is hard for an internist to know if a cardiac surgeon is doing a good job) I have seen it happen twice in my area in the last eight years. I have watched the peer review system work for forty years and observed what has worked and what has not. Our local medical society always worked best.

As the Midelfort Clinic grew, the large entity made practice changes, and peer review was absorbed into its responsibilities. Peer review is always attempted during the hiring phase as credentials and references are reviewed. After employment, if a problem occurs it is usually an inside physician lodging a

complaint. If it is not a gross problem such as drug addiction or alcoholism, then it happens rarely. And clinic meetings were so frequent that the medical societies became less and less relevant. The present CEO, Randy Linton², of the Midelfort Clinic does not belong to his local or state medical society. That is a perfect example of today's disconnect—a lack of interest and communication with members of one's local physician community outside of one's clinic. Finally, no decisions made by the medical societies could be of any import unless the large clinics also agreed. I consider that **mistake number 3**. More on this.

In our area these days, the local medical society has waned in relevance, and, in its weakness, done little to check bad trends in managed care. For example, there is the trend of clinics not providing patient care to people insured by an outside managed care organization unless paying out of pocket. All of us in larger clinics *initially* justified not seeing another managed care plan of another clinic's patients in an effort to build our own managed care patient list. We thought it was healthy competition. Now, I consider it **mistake number 4**, and it mirrors not being allowed on the panel of physicians of a competing clinic in the same community with its own managed care patient list. I consider that bad trend **mistake number 5**. Both of these rules originated under the banner of more affordable care for people.

The panel of physicians of a managed care plan is the list of physicians that a plan subscriber is allowed to see if he or she wants medical bills covered—usually only the physicians of the sponsoring clinic. These are called *closed panels* if the physicians on the panel are restricted only to those working for the sponsoring clinic. If one is an independent physician practicing in a town with a large clinic and the large clinic develops a managed care plan, they can exclude the independent physician from seeing any patient in their managed care plan, simply by not paying the bill. If the managed care plan would newly insure a company, an independent physician would be bound to lose many of his or her

patients. Closed panel rules are applied differently, depending on who seems to have the upper hand in the local area. (Upper hand defined as the clinic with largest practice and influence in the community) The individual physician does not have the final determination on which insurance panels he or she might serve, but the corporation, clinic or the combination of the two, depending on the region he practices does. Large clinic management originally thought that, by having a closed panel “exclusion,” it could better control costs, but they were wrong. Health care costs did not go down. This was simply all-out war to garner patients.

Medical societies remained quiet despite the fact that the out-of-control competition of managed care plans was disrupting ongoing care and destroying the doctor-patient relationship. It remained a quiet destruction, since we had no legal way to stop it. Medical societies, however, do have moral authority to stop it. Some of us were in the midst of this competition and even sanctioned what amounted to the enucleation of medical societies and a time-honored tradition of continuity of care. To some extent, we all share the blame. Fearful of losing their livelihoods, physicians played a negative role and, by their silence, still do. The discontinuity could easily be reversed if the medical society were to declare devices such as closed panels inappropriate practice, and that anyone engaging in closed panel policies would be sanctioned. The right to sanction was always in our authority, but in all honesty never used. I think it was due not only to physician acquiescence to the leadership of large clinics, but also due to the coercive power of the non-compete contracts now in every physician’s employee agreement. (More on this in Chapter 4, page 34)

The sanctity of the physician-patient relationship was broken. I would like to describe a little of what that sanctity is. Looking back at my extreme experience saving the life of the patient with an infected incomplete abortion, consider her or someone like her, and her feelings toward the person who has saved her life. There is

a tendency to trust a physician who has treated one well, more so than one who has not had the chance to help or demonstrate professional capability. If one were to remain her doctor and years later another health question were to arise, this patient would be likely to trust one's opinion and feel less anxiety about suggested care if she has had a previous good experience. A typical example: The same person might come in with a breast lump and one might advise surgery for diagnosis and recommend it be done soon. This person, having had a good experience with the physician in the past, would probably follow the instructions immediately. If she were seeing a new doctor, she might delay while she gave it consideration and, perhaps, deliberated a little too long in the case of a potential cancer. These effects are subtle but real. We have long known that trust is crucial many times, and many more times at least *very helpful* in patient care. But imagine now that the sanctity of the physician-patient relationship is interrupted. The interruption all too often occurs when their employers shift people from one panel of physicians to another. The employer's bottom line might demand it. These cost-cutting shifts happened repeatedly in my practice, and I know it is common with others. Economists give the sanctity of the physician-patient relationship short shrift. Is making a nomad of a patient ultimately a change for the better? Pass your own judgment on it. I consider breaking the doctor-patient bond **mistake number 6**.

The Tri-County Medical Society may have one meeting this year and there may be no more than five physicians present. Will younger doctors meet colleagues in the next clinic or nearby town? Probably not. Will there be anyone to see that the sanctity of the patient-physician relationship is maintained and not compromised by managed care plans or large clinics? Not in the least. Will peer review function as it should? Not at all. Local medical society influence is at an ebb *but it is still in the background and could regain its former functions if another health care system were to require and encourage it*. Health Security America will revive this

time-tested system of self-governance and professionalism contained in medical societies.

Health Security America will automatically guide physicians back into their medical societies. After all, every professional group has guidelines and standards, and those of the medical profession did not dissolve. The state and local medical societies will be called on again to implement their guidelines and standards described earlier when large clinics and managed care plans no longer are able to rule by intimidation through the non-compete clause and other rules described in Part Two.

In the next chapter, I will tell readers more about the hazards of closed staff policies, dealing with risk pools too small, allowing large clinics to pour wasteful amounts of money into their hospitals and the non-compete clause and its stranglehold on large-clinic physicians. And after that we will move on to solutions in *Part Two: Roadmap to a Health-Secure America*.

CHAPTER 4

MANAGED CARE PLANS AND THE BIG CLINIC ERA (1983 TO THE PRESENT)

It was about 1983 when the Midelfort Clinic had decided that they needed their own managed care plan. We referred to it then as a *health maintenance organization* (HMO), and the government seemed to be nudging us in that direction anyhow. By managing care, or otherwise being in charge of all a subscriber's health considerations, the thinking went, the government could save money, as could corporations and the populace in general. HMOs were supposed to improve a subscriber's health, since health care professionals would supervise and encourage wellness. It looked good to me back then, as it did to all the other members of the board of directors. It seemed like a good idea at the time.

Unfortunately, HMOs have backfired, as costs have risen completely out of control and that promised "better health," using increased life expectancy and per capita cost as a guide, has never materialized. Back then, people were complaining of rising insurance premiums, just as they are now, and companies were looking for a change. At our clinic, we tried to accommodate them, with managed care. A managed care plan is a system in which the patient pays a monthly premium and is guaranteed that virtually all of his health care, including hospital, medical and surgical care, is paid. Such care can include optometry and drugs, depending on the

individual plan. Managed care plans do not usually include dentistry or long-term care. The patient is sick. He makes an appointment with one of the listed doctors whom he is permitted to see, and the bills are paid, minus some deductibles, possibly. Our clinic started a managed care plan, but the first year, and for many years to come there were complications with this concept that we could never get a handle on. To mention a few:

- ? The conventional wisdom was that if the managed care plan had a large enough pool of patients, the actuaries could keep us out of financial trouble by setting the right premiums. But we never were large enough for the statistics to always work out and keep us financially safe. The premiums were never predictable enough or stable enough. I consider limiting ourselves to a small risk pool and exposing ourselves to that instability **mistake number 7**.
- ? It followed that it was hard to know how high to set the deductible in order to prevent overuse of services. If set too high, people would delay needed care.
- ? There were conflicts about which new procedures to cover. It seemed a continuing unnerving battle to serve the patient and be fair to all participants at the same time. We agonized about allowing liver transplants, determining exactly when they were not experimental and proven to be an appropriate standard of care. There are many examples like it, and the decisions can be problematic for families that have the need for some advanced procedures that they view as routine, thanks to media exposure, yet the practicing physician does not. Who pays? It is a continual conflict.

During this same time of struggling with insurance premium issues doctors had little experience with, the clinic got into some

financial trouble. We could not find a local bank or any of their correspondent banks (larger banks in bigger cities) to finance our ongoing building mortgage. The Midelfort Clinic had a long reputation of delivering good care and still does. There was also never any question that it was not fiscally sound. I was on the board at the time, and when the clinic administrator told us about the banking problem, I was concerned. We had paid all of our bills, yet turned off the banks, and it was my opinion that the open ended liabilities of the managed care plan were the cause of the banks' unwillingness to finance. An example of an open-ended liability might be the unpredictability of an expensive procedure; they might have been nervous about the possibility of having four times as many heart by-pass surgeries as predicted, because it would put our group in bad financial shape. Did we have the financial depth to withstand such an eventuality? I am sure that banks discussed it in their boardrooms, and most decided not to take the risk. At about this time all of the doctor partners were on notes for \$80,000 per person—not a reassuring situation. Luckily, I had an association with another company in a totally different field from medicine that had experience in financing big projects. I called one of the consultants who worked with us and he got our clinic financed.

Twenty years have passed, and still the managed care plan offered by my old clinic or its clinic-friendly insurance company is not performing as expected. In our town, I am familiar with the owner of a small business with ten employees. His company premium went up an insupportable 34.1 percent in 2005, and he was forced to cancel the policy¹². In making that decision, the employer went through terrible anguish. His employees understood that the premium increase took more than the entire profit from the company for the entire year. What a stark, simple and typical snapshot of our health care crisis' economic impact: an employer is saddled with the terrible decision of either setting his

employees adrift, uninsured, or sacrificing his annual profits and taking a loss on top of that.

And it is not just my former clinic's problem. Car manufacturers and unions are very aware of the economic impact of high insurance costs. GM readily quotes a sum of \$1,500 to \$2,000 per car for health insurance for its retirees and workers, and is wasting no time exporting jobs to Canada, to take advantage of its less expensive comprehensive health care system.

Administration kept growing. All the new people worked—but for substantial salaries. The average salary for a medical director recently ranged from \$250,000 to \$400,000 per year. To pay that kind of money, a doctor has to see a lot of sore throats on a revenue versus expense basis. Those of us on the board who questioned large executive salaries or administrative growth were always shown statistics comparing us to clinics of equal size. These statistics were used to justify more administration and higher salaries as most clinics of our size had about the same administration and paid like salaries. Yes, we all were making the same mistakes and it is still happening. Let's look at some more of those mistakes

NON-COMPETE CONTRACTS

In the early years of our managed care plan we were forced to sign a non-compete agreement, making **mistake number 8**. That means if a doctor goes to work for the Midelfort Clinic and then becomes disenchanted with the working arrangements, he or she can leave but must practice outside a 25-mile radius (in our case) for a period of two years if he or she plans to practice medicine. That a departing physician may not set up a practice in the same town is the common thread in all non-compete agreements. Included in our non-compete agreement contract was a clause allowing dismissal from the clinic for any cause that the board might decide. It did not have to be warranted or described.

These added teeth tended to reinforce the idea of keeping one's mouth shut. Do not object to the administration's decisions even if they seem terribly wrong—and that is the intimidation to which I referred earlier.

In our clinic, some of the subspecialties (an example of a subspecialist would be an internal medicine physician who only works on hearts, or cardiologist) fought the non-compete contract but we finally corralled them all. In fact, it was our only cardiologist at the time who held out from signing. He was a big revenue producer as well as being in a hard-to-recruit specialty, and he might have halted the adoption of non-compete clauses if he had been persistent, since the board was in turmoil over the issue for some time. But fate intervened, and he finally agreed to sign. It did not matter how bad the board governance became, physicians lost their power to leave the clinic and go into their own practice. The management's thinking was, "We gave you all the patients and they belong to the clinic." That is, to the corporation, not to the physician's practice. I have often wondered if patients ever considered themselves a patient of their doctor or that doctor's corporation. I am willing to bet that patients would be clear that they are not owned by a corporation.

So, how did non-compete clauses add teeth to management edicts? Uprooting a family after a number of years with kids established in school and family entrenched in the community is daunting. To build a new practice after five or ten years of having built a previous one is almost insurmountable. It takes more than a couple of years to build a practice and finally be called someone's doctor. With the non-compete clause, administration now had a doctor by the neck and increasingly concentrated the business decisions of the clinic in the hands of non-physician administration. The process sounds benign enough, but it has caused more than a little strife over the years. Administration became much more dictatorial, making unpopular decisions, which, in their defense, were efforts to lower costs. But in

retrospect, their failure to lower costs is painfully obvious— and non-compete clauses, along with closed physician panels and other poor policies, helped cement that utter failure.

MORE ON CLOSED PHYSICIAN PANELS

The battle to have all the specialties under one roof and in the employment of the clinic was imperative. We thought that kind of integration would lower the costs of our managed care plan and of course of health care, but to begin with, the reorganization caused great local upset. Specifically, I remember an ear, nose and throat specialist who was disallowed seeing patients from our managed care plan. He basically was forced out of business. He was not on the panel of physicians that our managed care patients were allowed to see, and we recruited our own person in this field, since we thought it would make the plan cheaper. It did not. The idea had been to control costs, but it also created a “mini-anti-trust” question—at least in my mind.

With a closed panel of physicians, even though a plan subscriber might know another physician he or she liked, if that physician was not on the panel, the subscriber could not see him or her unless he or she paid the bill out of pocket. And his or her employer, thinking only of getting a better deal, did not care at all if the subscriber had to change doctors. Aside from disrupting continuity of care that way, the closed-panel practice forced many individual practices out of business, and I consider that kind of competitive restraint **mistake number 9**.

Restraining competition was an accidental byproduct of the zeal to save money, but it happened and it is still happening, and of course, the paradoxical effect is to drive costs ever higher. It is my impression that clinic managed care plans are now part of most big insurers, rather than totally clinic owned. But expanding to a larger risk pool did not really help, since now the goal was to look for even more profit, of which we never saw much. We have all seen

the salaries of the big managed care plan CEOs and they many times go into the millions.

Another example: I had been taking care of a working family going on twenty years, including deliveries, injuries, and many other physical crises. I was close to them. I knew their health charts without virtually ever having to look at them. I felt I was their friend. My receptionist came back to my office and said, “‘Ray’ wants to see you.”

“Bring him back.”

“Ray” appeared, saying, “Doc, I can’t see you any more!”

I was stunned. “Is there something wrong, “Ray”?”

“My employer bought a different managed care plan than yours and your clinic will not allow me to use my insurance plan to pay for it.”

I was not on the other clinic’s panel. It was the Midelfort *Clinic’s* decision to disallow the use of “Ray’s” insurance plan. What was that about? I started to get the real-world education about some of the decisions that the clinic board had made, in this case, the closed panel. Managed care plans and larger clinics thought if they could corral all the patients in the area by force, they could control costs and keep up profits. In other words, to the patient, it meant that if he wanted to see his regular doctor, he would have to sign up with his managed care plan. “Ray” did not have that choice. His employer had bought another clinic’s product, and if he wanted to see me he was going to have to pay his bill out of pocket. Of course, this was not possible. Competition failed miserably. That is, “Ray’s” employer got a cheaper plan by ten dollars per month and with 100 employees saved money for his company, as any good CEO should. But it interfered in what I would call the sanctity of long term physician-patient relationship mentioned in the section of this book on medical societies. The large clinic administration’s hooking up a panel of physicians to an insurance plan and then selling it on a competitive basis hurts medicine’s physician-patient relationship. Is this significant? I

think so. What does your doctor think? Ask him or her. Ask yourself. Selling washing machines and cars might warrant those kinds of marketing techniques, and well they should, but neither the situation nor the result is the same in health care and in this case medical care was compromised. I will address quality of care further along in the book.

A good part of my practice was destroyed by fiat of an administrative decision. The internal clinic war created here was immense. I could not believe this was happening but it did. I was the first physician of our group to come to Chetek in 1965, so I naturally had the largest patient load from the two largest employers, the school system and the nursing home—hundreds of people. I lost patients not by being a bad doctor but to whomever it was who had the cheapest plan for the year. Believe me; I lost the battle trying to put an end to the closed panel concept. This was the first instance in which the Midelfort Clinic's decision not to be on the other clinic's panel was hurting me badly.

I made my concerns well known and had no trouble indicating what I thought were very poor administrative decisions. I minced no words at our clinic meetings; my own clinic was willing to sacrifice the practice of individual physicians in hopes of signing on more participants in its managed care plan. The other major area clinic's plan was willing to pay these bills but our own board said "Our doctors, our insurance plan." It was the first time that I ever was sold as a commodity. It is my opinion that the relationship of a physician to his or her patients can not be sold as a commodity without sacrificing the best medicine, but the attitude of administration was that it made no difference. Their goal was to end up with the most patients from our town being seen by our clinic, even if we had to sacrifice people and their health to do it. Trouble was brewing, and I knew that any support I had given the decision at an earlier time had been a mistake.

The trouble was totally unanticipated, but to be charitable, my colleagues and I had never experienced such a disruption

before then. People were no longer in control of which doctor they saw. With the advent of the managed care concept it was a new confusing deluge of paper and new regulations at every turn, associated with what was sometimes disjointed medical care, secondary to transferring records back and forth between clinics many times, depending on the premiums of the various plans. These records did not always appear at the new clinic when the patient did and we had to make decisions without record availability. It was not good medicine.

OPEN AND CLOSED STAFF HOSPITALS

Clinics now buy hospitals, and if they don't own them, they still exert a lot of influence in the running of them. In many cases the closed staff policy is invoked. Closed staff policy means that only if a physician works for a certain clinic is he or she allowed privileges to practice there. For example, St. Mary's Hospital and Methodist Hospital in Rochester, Minnesota, serve only the Mayo Clinic. To my knowledge, no physician outside the Mayo Clinic with a regular daily practice in Rochester is permitted to practice in those two hospitals. In other areas, sometimes, if the doctor is from another clinic, the clinic will let the outsider practice there but he or she will soon feel excluded, and will be put last on the surgery schedule—sort of a “second best” physician. One is not really wanted there competing with the owner of the hospital's physicians. It is a subtle ostracism, but evident nonetheless. Enforcing a closed staff policy is **mistake number 10**. There can be no free provider competition if such a policy is put in place. And some areas do not have limitless hospital facilities, thus provider competition is inhibited.

Hospitals are enormous real estate investments made to serve people. The investment to equip and train people to run hospitals is equally huge, and adds to the total cost of health care. Considering the enormity of the investment and the universality of need,

hospitals have to be considered *citizen assets*, no matter who is in control of day to day activities, be it a large clinic, foundation or religious order. None of us can afford to have two hospitals where one could serve the need. We can not permit duplications to exist if it is a wasteful service such as two orthopedic departments in a town that only needs one. They must not be profit centers. Citizens need to have more input into hospital financial decisions and services offered, and I consider the loss of such input and control **mistake number 11**. More about hospitals in Chapter 10.

CHAPTER 5

ADMINISTRATIVE TECHNOLOGY ALLOWS A NEW PRACTICE

The health care crisis had arrived, but it was not until the next round of my career that a solution appeared to me. I found it hard to work under the aforementioned exigencies of managed care. We had worked to build our practice, as always in our clinic, but then had it arbitrarily taken away by the changing of managed care plans.

I have related my experience with Ray. He was just one example of many patients who lost out to the bottom line. Moreover, the benefit to the bottom line is sometimes difficult to discern; some patients are passed around between plans for a change in premium as little as ten dollars a month. I was having a hard time maintaining the personal relationships that develop between doctor and patient, disrupted as they were by the managed care system, which promised no hope of change. Remember, I had helped start that managed care mess, but I could not understand the clinic administration's failure to correct a mistake and move on. It was impossible to convince the board to allow us to serve all the insurance companies that patients would offer us and stop sabotaging the doctor-patient relationship with its managed care policies. In other words, *get out of the insurance business!* In the clinic management's defense, they were afraid that if we discontinued our managed care plan and did not compete, our clinic would not survive. I disagreed; managed care plans were and

still are hurting patients. I consider that inflexibility to be **mistake number 12.**

No one in clinic management seemed to think that managed care was bad for the practice of medicine or the patient. And it was obvious that the board of directors of our clinic and I had different goals for medicine, so I resigned from the board after eight years. I stayed in the background from then on and went through another buyout/merger by the Mayo Clinic in 1992, retiring in 1998. At the age of 58, I was still fairly young, but felt there had to be something better in medicine.

For two years, to honor my non-compete agreement, I worked in Alaska and Wisconsin, relieving physicians for differing periods—usually a month. Doing that took up the slack of ten hours per day of new leisure time. I worked in Wrangell, Alaska, an island 1,000 miles south of Anchorage. The natural environment was awe-inspiring, and the experience a dream of many a medical student. I went fishing for salmon with a huge, scopeless .375 caliber rifle on my back. The Alaska brown bears were big and they wanted the fish too. The head of the Natural Resources Department in Wrangell gave the rifle to me to use after taking off the scope. She told me that I wouldn't need sights, since I would be in very close range if I needed to use it. But Alaska was not home, and its patients were not my longtime patients, so the personal reward was not as great as it might have been, despite my having chosen where to work. In fact, retirement was not all that much fun even with salmon and bear stories. I suspect that it was inevitable, but I finally decided to go into my own practice again after 35 years of being with a group.

Once I made that decision, I limited myself to a house call practice primarily of the homebound and elderly. That was when the answers about cost-savings and the administrative methods with which to realize them finally started to come. I had not had any experience with either applying for staff privileges (Not at least since my first solo practice in 1965) or working with

insurance or Medicare on the financial end. Other people had taken care of those things for me. I was only asked to sign an assignment of funds to the clinic and in all honesty it was just one more paper to go through. I was not sure how to go about getting set up to bill Medicare and other insurers, but a consultant gave me a several thousand-dollar estimate to do it for me. It was a high enough fee that “No” came out of my mouth almost immediately, surprising even me, it was so automatic. I did find a way around paying that exorbitant consultant’s fee, and launched my new practice.

I ran my house call practice for about three years, and when I finally convinced myself that I had worked enough and could give myself permission to retire again, I did. Taking care of patients in their homes was unique, and some things need to be said about it before moving on. HSA (Health Security America) may wish to expand this type of house call coverage. It will be up to our citizens to decide. There are many physicians who have retired early because of the administrative differences that I have described. It might be refreshing for those retirees to run their own house call practices and reap the many rewards, which include serving the public in a unique and humane way.

I will never forget some of my house call experiences, such as my care of “Shorty.” Shorty lived close to my home and was the patriarch of a large farm family. At 86, he was a popular person, known over our entire area. He was excited when he heard that I was making house calls. He remembered Dr. Adams, my predecessor, who, over forty years, made house calls virtually up until he died. People appreciated that service.

Shorty was still getting around but not easily; he had undergone knee surgery about one month prior to my seeing him for a cough and a cold. I went to his house and he was sitting in his La-Z-Boy enjoying the day, except for what seemed to be a respiratory infection. My exam revealed something more serious than a cold. After giving him some medication, I told him that I would see him the next week. When I got to working on his

records a few hours later, I found out his last chest x-ray report and physical findings of a month prior. They were not alarming at the time for someone 86 years old. I went back the next week and, seeing no improvement, gathered the family forces to see that he got another chest x-ray. Indeed he had a mass, probably cancer, in the lung.

The oncologist at Midelfort Clinic gave Shorty excellent care, but there came a time when nothing more could be done and it was important to make Shorty comfortable. He was insistent that this be done at home, so I visited him about once per week and whenever he called. I used the usual range of medications for making someone comfortable and also included what we in the profession call “tender loving care.”

That aspect of medicine was refreshing. There were times when we simply talked about the beautiful view out of his window, his parents, grandparents and the generation now living on the land where he had spent his whole life. Not only did Shorty feel better after my coming, but it was rewarding and renewing for me as well. The priest would visit about the same time that I would on Thursdays, and I got to know him too. I am not sure that all this individualized care can be repeated with every citizen who would like it, but it is a distinct possibility with HSA, and the section on governance will show how it could be considered.

About ten years earlier, before I retired, I had started my computer literacy education, including learning to type. I enjoyed learning about computers and doing so was no great effort. And once I was retired and running the housecall practice, I was able to easily establish my administrative routine with the computer. It did not take much work to circumvent that expensive consultant who offered to set me up, just a short, easy internet search to contact Medicare and obtain my own provider number and all the other numbers required in order to file claims. Physicians keep their diplomas, licenses, drug enforcement number and other

necessary data close at hand, along with references and resumes. Upon retiring, I also made sure that I received a letter from our clinic CEO, chief of staff of the hospital where I worked as well as the hospital administrator, informing everyone that I was a good physician. Having such letters is important in the credentialing process if new staff hospital privileges are applied for in the future. One should always obtain them when peoples' memories are clear.

Manually sending those materials to the state Medicare office cost some stamps as well as twenty-five dollars for some simple software to communicate by computer with the Medicare office for billing and payments. I provided Medicare numbers from my bank account, and within two weeks of billing, the money appeared in my checking account. In order to be able to fill out forms accurately, using the appropriate codes for procedures and diagnoses, I purchased the two books *Current Procedural Terminology* (CPT) and the *International Classifications of Diseases* (ICD), which describe the documentation required for procedures and diagnoses, respectively. Billing was not and is not “rocket science.”

It was clear, however, that to be paid for something, one had to document it, and a few common consumer electronic items served that purpose. I used a laptop and had an internet connection, phone and fax. That was my total cost to go into business. I had all the necessary administrative tools for my new practice. At about that time in 2000, most insurance companies were using standard forms compatible with standard-issue home office software but not all. In as much as I was serving primarily the elderly, it was not a big problem for me as Medicare was the primary insurance carrier.

Okay—what's the big deal here? I was running the business part of my medical practice with the new technology that was available and did not need a receptionist, medical records transcriptionist, a lab tech or most of all, a business manager. I did not need to pay quality assurance people to read my records, or a

medical director to tell me about items of which I should already be aware. I never had any qualms about sending my records to people requesting them for review or information nor were there any problems with quality.

Thanks to easily available technology, the system worked well. The Medicare and insurance rules were straightforward. Every month I received a letter from Medicare with updates that sometimes affected me and at other times did not. And it took about thirty minutes of my time every month to stay abreast of the Medicare rules. I did not consider the time excessive. Five years earlier, adopting this method of administration using computer technology would not have worked, since the technology was not available to the individual physician. Remember that my practice was house call-oriented. There were still some minimal inconveniences that could have been fixed by practicing out of an office with one or two other physicians.

Next, I am going to take each of the administrative tasks apart and tell you how they worked for me. Complying with the rules proved to be no trouble at all. I followed the rules demanded by Medicare, since my practice was mostly treating Medicare patients. The CPT and ICD books seemed clear enough to me. The new *Health Information Portability Accountability Act* (HIPAA), the first comprehensive federal protection for the privacy of personal health information, was thrown in, and again, all of the necessary information was available on the internet, allowing me to make my practice compliant without hiring more employees. Medicare rules were the most demanding of any insurance plan, but I had no major problem qualifying for payment.

The receptionist's job was covered by a paging system and answering machine service. No one was ever out of touch with me. I answered calls and always called back if it was not an emergency to keep interference with patient care at a minimum. And as a family doctor making house calls, the number of different procedure codes I needed numbered ten, 90 percent of the time. To

be paid for one's work, however, one had to be specific in keeping and submitting records. Here is how I managed those tasks. I made templates of the procedures using Microsoft Office, and inserted each patient's procedure into one of these templates. All the prompts of the necessary questions that needed to be asked and the physical that had to be done were erased, but only after the specific patient information had been inserted. It was only a short time before I had memorized those templates, making typing even easier. I was able to create records quickly and efficiently. Remember, Medicare did not ask for pages and pages of typing—they only asked for documentation of services performed.

Billing was streamlined and easy. After the first time I entered the patient information into the Medicare online billing form, it took less than one minute. And within fourteen days, Medicare deposited my money into my own account. I did make a few mistakes—usually typographical errors—but not often enough to be bothersome. And the available help line was easy to work with. Any mistake was resolved quickly.

My lab work was dropped off at a pick-up in our area for the hospital at which I maintained staff privileges. Supplies were delivered by UPS next day from any number of supply houses. I am trying to make the case here for the reduction of business managers and insurance clerks, whom most clinics hire in droves. And record keeping people surpass the insurance people in number. I have not even mentioned the numbers of administrative personnel, but have patience—I will.

I still go out occasionally and help the government with National Guard exams when requested, but even this is getting hard to fit in with expanding family responsibilities. I now sit typing this roadmap to health security as one last effort for my profession, hoping it will provide some value and insight into solving our health care crisis.

Experience and facts—not projections—have given us a real chance with Health Security America. And it is becoming clear just where the major portions of the predicted 50-percent savings in premiums will come from. I had practiced in the first thirteen years of my practice with an almost identical business model as *my house call practice 22 years later* and it worked extremely well. However, it was necessary to reapply the old model to a current medical office practice to be sure it still worked. I accomplished that with the help of Dr. Howard Thalacker, my colleague for 26 years, whom I had hired in 1972 with the approval of our clinic’s board of directors. I did a research paper on applying my business model to his practice.[?]

To begin, I took all of his billing codes for one month and applied the set Medicare fees to them. I added one other physician to the model but it could easily extend to eight or nine physicians. I reviewed all the overhead—the cost of buildings, insurance, employees, vacations—and applied it to the model. The biggest surprise was that Dr. Thalacker would make more money under Health Security America and would be his own boss besides. Ironically enough, though, Dr. Thalacker could not take advantage of the opportunity to be his own boss, should he want to leave his big clinic practice, because of the standard non-compete clause in his employee contract.

Non-compete contracts and other impediments to the streamlined practice of medicine have got to go. I will lay out the details in the sections on governance, or “roadmap,” of HSA, as well as in later chapters.

[?] “How We Practice Medicine” (Bannister 2003). Please see appendix for the full text.

PART II

ROADMAP TO A HEALTH-SECURE AMERICA

CHAPTER 6

WHAT IS A HEALTH-SECURE AMERICA?

All Americans want good health care for their families but spiraling insurance costs threaten to make our country a fearful and insecure place. The roadmap to a Health-Secure America in the following chapters spells out explicitly how we will achieve affordable health care for all Americans. The roadmap is based on a lifetime of experience with what is actually necessary and what is counter-productive in the quest for one of America's highest priorities – Health Security.

A Health-Secure America has three feasible, voluntary, and affordable objectives which we will call The Three Mandates.

THE THREE MANDATES OF HEALTH SECURITY AMERICA

- ? All Americans shall have health insurance from birth to death
- ? Americans shall have free health insurance through their first 18 years
- ? Health Security America **will pay for itself**-*in fact it will not work unless it is self-funded*

HEALTH SECURITY AMERICA

THE FIRST MANDATE

Every citizen will have available a high-quality health insurance plan regardless of his or her present physical health, financial capability, mental status or location in America. In other words, there will be no age, disability or other impediment to obtain this health insurance. The citizen will have coverage from birth to death. If he or she is mentally and physically capable, however, he or she will have to participate in the operation of Health Security America—this will be spelled out in later chapters—or it will not work. This means that the plan demands personal responsibility not only to help govern HSA, but to take care of his or her health and keep abreast of health issues.

THE SECOND MANDATE

Never again will there be ten million children without insurance through their first eighteen years. It is well known that health care for this age group is the least expensive. We all need to be parents for all of our kids and absorb their health care costs into the premium structure of Health Security America, our new health insurance plan for all Americans.

THE THIRD MANDATE

Health Security America will pay for itself—in fact it will not succeed unless it is self-funded. This means that Americans will have a responsibility to participate in order to ensure that the plan is affordable. Citizens and employers will be writing out checks for this plan just as for any other insurance they would buy, and the government will only give us the legislative tools to make this plan work—not the money. There is no question that, if we work together on this plan, we can save fifty percent on our health insurance premiums, perhaps even more. HSA's self-funded, self-

governed design, with, for instance, its ability to negotiate the very best prices from drug manufacturers, would bring the current health care lobby juggernaut to a halt. Imagine the drug companies, device manufacturers, and provider associations no longer having any more influence on our Congressmen than we do. This alone should provide incentive for our leaders to work with us and get this done, if for no other reason than to relieve our growing federal deficit.

The three mandates of Health Security America will not be accomplished if we do not act with a passion to remove frictions, restraints and barriers to competition, except in the building and equipping of hospitals, as addressed in Chapter 10. And we must follow the pruning by adding the newest computer technology to every medical professional's repertoire. This friction will include many things, such as non-compete clauses, closed panels, set fee schedules and simple electronic bill procedures etc. I have addressed and will address them again, but it will be a new start. HSA's three mandates continually guide the policy outlines that follow. To accomplish the three mandates, we need to take two steps—the first in Chapter 7 and the second in Chapter 8.

CHAPTER 7

THE FIRST STEP TO REALIZING THE THREE MANDATES

The current health care delivery system has failed the American citizen despite 25 years of its trying to make the managed care and the large clinic options work. The U.S. citizen will have to take over this responsibility. Health Security America will have its own quasi corporation and it will correct the mistakes that medicine has made in health care delivery. It will have a governance structure overseen by U.S. citizens, not a private board of directors. **Congress will set up the corporation to begin, but after that it will be hands off, unless specific help is asked for by the governance structure of Health Security America. Initially, Congress will authorize the start up funding (for office space, reserves, and initial salaries which will be paid back over ten years from premium revenue) for the corporation and authorize it to use any Medicare information, Social Security information, government sources and facts needed to implement HSA.** Initially, HSA will use the Medicare fee schedule, coverage, regulations and actuarial, audit, software and technical staffs, and use of any vendor contracts that the corporation may need. If there is need for another resource besides money to run the HSA corporation the first year, Congress will furnish it.

HSA will *initially* cover *everything* that Medicare covers, adding any procedures that might be necessary to furnish

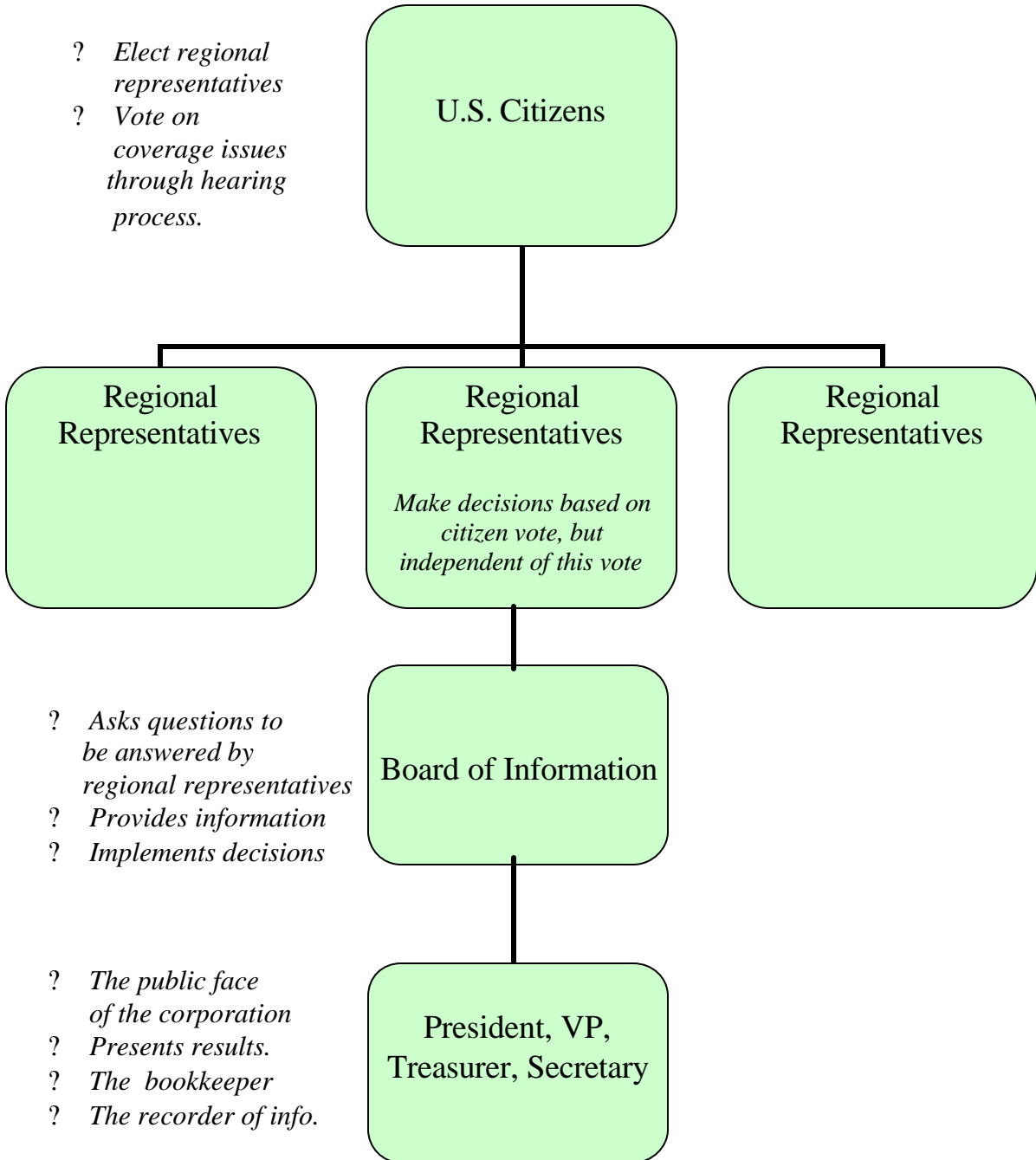
comprehensive health insurance coverage from birth to death for every American. Eventually, the new corporation itself will determine the premium and plan coverage. Every HSA recipient will be responsible to pay his or her premium, as required by the third mandate. (Medicare recipients who have money paid into Medicare from the past should expect this to apply to their premiums until past monies are used up). *Subscribers to HSA could well have their employer pay their premium as a benefit if this was mutually agreed upon.* Premiums and coverage will be dependent on 150 regional determinations and citizens' input via the hearing process. The plan, coverage and premiums will be the same throughout the U.S. This all will be addressed in detail.

The actuarial accuracy of HSA should be high, since it will be based on the entire U.S. population of 295 million people. It is going to take perhaps eighteen months to two years to get this plan up and running. In the initial few years of operation, Congress will be asked to stand by to fund any mistakes that are adverse to the premium. There could be normal actuarial error due to the plus or minus percentages attached to recognized actuarial numbers as the system gets going and the reserves might not be robust enough early in the life of HSA. Such funding errors, if any, will be made up the following year by adjusting the premiums of HSA. One of the mandates requires that HSA be self-funded and not add to the nation's budget deficit. This author hopes that the mandate be bipartisan, as well as all of HSA.

HEALTH SECURITY AMERICA

CORPORATE STRUCTURE

HSA Decision Tree The power emanates downward



HEALTH SECURITY AMERICA

There will be the usual officers: President, Vice President, Secretary, Treasurer, and a Board of Information, which will have definite functions but will not rule or dictate. It will implement, not decide, plans for care, medicines, salaries, premiums and coverage. The orders to implement plans on issues will come from the decision making body—the regional representatives.

REGIONAL REPRESENTATIVES

The regional representatives will be the decision making body of this corporation. The public in every state will elect them in a publicly financed campaign. There will be three regions in each state, and each region will elect one representative for a six-year term. After the first election they will draw straws to determine in which rotation they will serve, since there will be an election every two years. The United States would have 150 people in this body. The representatives would all work out of offices in their home districts. I am leaving to Congress to determine the fairest way allocate the three representatives in each state. It could be by population, area or combination of both.

CORPORATE JOB DESCRIPTIONS

President, Vice-President, Secretary and Treasurer

The President and Vice President will be the public face of this corporation, much as they are in private corporations. The Secretary and Treasurer will perform the same jobs as in any other corporation. The regional representatives elect these officers.

Board of Information

The Board of Information will have the special full-time task of sending to the 150 regions questions that they will need answered in order to proceed with the three mandates, change rules, premiums, coverage and other items. They will forward to the 150 regions all the information they have on a given topic. Included would be items such as effect on premium, effect on coverage, difficulty in implementation, possibly the ethical opinions of experts—and simply anything else that the board of information thinks people would need to know before making a decision. The board of information will be a source that will receive any information that other agencies of government or any source at their disposal can provide to the regions on a region's request. The model that will serve as a starting point is present-day Medicare coverage, Medicare fees and rules. HSA will inevitably modify some of those rules. As an example—and a controversial one, to test the system—a question before the regional representatives might be whether HSA would pay for aborting an unwanted pregnancy. First, the board will obtain the number of abortions done yearly in the U.S., as well as the professional fees, hospital fees and also the actuarial cost and effect on the premium. The process will include discussions of known objections from religious groups as well as discussions of arguments from abortion proponents.

All of the pros and cons of abortion have been debated for years in this country on a federal level, but this is simply the decision of whether this citizen-funded insurance program will cover this procedure; it will not be issued from a central government authority. And the abortion coverage question would come up early, since Medicare does not currently cover the procedure. It will be a decision that each individual will have to make before voting, asking him- or herself, “What is my responsibility to my neighbor and his responsibility to me on this

health issue?” And the responsibilities of making such an abortion coverage decision will run the gamut from ethical to financial. It is hard to “wear someone else’s moccasins” with ease, if one is not 15 years old, poor, unmarried, living in the inner city or a minority, and the decision may well be a difficult one. Citizens will cast their votes, and the regional representative will pass his or her vote back to the board. If 76 of the 150 representatives, a majority, vote in favor of coverage for abortion then nationwide coverage will be implemented by the board of information. I present more on the hearing process later in the chapter.

Regional Representatives

As part of their governing duties, regional representatives will have the task of holding hearings in their area on the topics that need to be decided, as forwarded to them by the board of information. Some further examples of issues that they might receive other than the abortion example would be:

- ✍ Do we start all new cases of hypertension (high blood pressure) out on generic drugs before going to branded drugs? (branded drugs are drugs with patents still in effect and are much more expensive)
- ✍ Do we pay for cosmetic breast surgery after breast cancer?
- ✍ What level of psychiatric care do we pay for?

The board will have the best available information on items such as these and will present them at the regional hearings. The information made available to the regional representatives will consist of items such as these:

- ✍ Cost changes to the premiums based on actuarial findings
- ✍ How many people are affected by the problem?
- ✍ Is there a downside by using generic as opposed to branded medicines?
- ✍ Are there social implications?
- ✍ Are there ethical concerns?

Every item of reasonable and accurate information will be posted in the media, including a web site, so people will have the opportunity to stay well informed and involved in the decision making.

The people who attend the regional hearings (or view pertinent material on the HSA web site) will always be balancing the coverage and the premium. The regional representatives, having followed the hearing process closely, will then vote on the issues, determining peoples' desires, including the effect on the premium and the tradeoff—*coverage*. The majority vote of the regional representatives will rule, and the results forwarded to the board of information for implementation. There will be complete transparency in the process. The implementation will be nationwide.

To reiterate, the regional representative will be answerable to his or her constituents—not to HSA or Congress. The regional representatives' vote will be the one passed on to the board of information. The votes of the people at the hearings are designed not to bind but to inform the representative of the peoples' desires on premiums and coverage. Any one regional representative can bring a resolution before the 150 members, and if a majority vote yes, the question will be brought before the board of information. They will accumulate all the information as previously described and forward it to the regional representatives for the hearing process. This is simply a check available in the system.

I am encouraging only one other check to be placed in the by-laws of the corporation at its inception. After its seventh year of operation there will be a vote of the people, all 295 million of them via the web site. Button one offers the choice: *Continue the decision process as we have for the last seven years?* The other button will offer: *The decision process will be by direct vote of the people on issues presented in the hearing process.* Such a vote, electronically secured, provides a vital check on a vital process.

The two checks included in HSA will prevent undue influence by interest groups. In our democratic society, interest groups sometimes have an overriding influence. Another function that I expect will be asked of the regional representatives by the board of information is to advise Congress on a related health issue not associated with the ordinary business of HSA, which would tend to be governance of HSA, coverage or premiums. The regional representatives will take the health issue question through the normal hearing process. An example: what cap should be placed on non-economic damages in medical malpractice lawsuits? These are the awards for pain and suffering, and punitive damages aiming to discipline the provider for negligence. I expect the populace to vote on the matter, but since HSA will be an insurance company, and not a legislative body, the voting will be advisory only. My guess is that Congress will hear the wishes of the people and will approve a damages cap. I also suggest that congressional representatives will want to vote accordingly on an issue such as this, or they will not remain in Congress. Although malpractice awards are important in protecting the health care consumer, capping awards is one of the crucial items needing to be visited to help reduce health care cost.

The 150 regional representatives *are* the governing body for HSA; I can not stress it enough. Regional representatives will also address items such as salaries after hearing from their constituents. I have great confidence that million dollar executive salaries will never be a part of HSA.

EXPECTED QUALIFICATIONS OF THE BOARD OF INFORMATION AND
REGIONAL REPRESENTATIVES

Qualification of the Board of Information

People on the board of information will come from active operating positions. (These are people now actively working in

their fields.) There will be four practicing physicians, and of these four, one will be a family doctor, one a surgeon, one either a pediatrician or internal medicine, and a psychiatrist. There will be three current hospital administrators, two practicing nurses and one pharmacist, three insurance actuaries and two insurance company CEOs. These people will be asked to leave their present posts and will have a full-time office in a central location that may or may not be Washington, D.C. The regional representatives will elect the board members, announcing the board's salaries before the election. The board members will have field assistants to research the information the board member will need to perform his or her function. The terms of the board will be six years and will be staggered, as are those of the regional representatives, on a two-year schedule. None of the board members will be permitted to enter into or maintain any consulting contracts with lobbying groups, drug companies or device manufacturers while on the board or for a period of three years after leaving their board position.

Qualifications of the Regional Representatives

I have great confidence that the citizens will vote for people in the health field that have the knowledge necessary to understand what is being discussed and pass on clarifications to constituents. The initial salaries of these people will have to be set by Congress, but once they are elected, the following year those salaries can be adjusted as with any other issue at hand.

THE HEARING PROCESS

The hearing process will be a busy one, with the representatives holding hearings virtually continually. There will be a schedule for deciding issues and a deadline by which citizen votes must be cast. The regional representative will have assistants to help with the process. The HSA web site will post all pertinent

hearing information and be interactive, permitting each HSA participant the opportunity to cast a vote online. The site will be secure and the participant will use his HSA number as his password to vote yea or nay on the issue at hand. There is no question that there will be an eventual decrease in public hearings as people become more involved with computer technology. It would save money to start with the computer, although I am not sure that our populace is quite ready to do it right now. Currently our eighth graders are able to manage the voting process on the internet, so I doubt that it will be long before all business can be tended to this way. On one's nineteenth birthday it will be a new responsibility to be involved with HSA. This is the date when one will start paying premiums.

CHAPTER 8

THE SECOND STEP IN REALIZING THE THREE MANDATES

The following eight rules will have to be in effect as by-laws of HSA or the plan will quickly fail. Here one can see the mistakes that I observed in my practice and management experience. Any provider (physicians, hospitals and others) who accepts payment from HSA will live by the following rules. I will dissect each rule after listing them, as follows:

- 1.** There can be no non-compete clauses in any physician's or any other provider's contract.
- 2.** Any hospital, clinic, or insurance company taking HSA fees may not have any association with a closed panel of physicians or other providers
- 3.** The initial fee schedules (set fees) and method of determining such fees will be the same as Medicare presently uses. The rules, procedures and diagnosis codes will be the same initially as Medicare. These rules, procedures and codes all may be adjusted later on by the regional representatives and citizens at their discretion, as discussed earlier.
- 4.** Regulations will be implemented allowing all citizens acceptance in the plan during the first year following its inception. (There will be open enrollment with no pre-existing conditions clauses) After the first year, those who

did not sign up initially will be subject to a six-month waiting period. The waiting period will help equalize the risk by preventing people from signing up only after they become ill. In essence, 295,000,000 people—our entire population—will be eligible for this program. HSA is a voluntary plan.

5. New HSA regulations will require participating hospitals to have an open staff policy. (Anyone licensed to perform medical procedures and credentialed to receive payments from HSA will be allowed on the hospital staff to perform his or her work)

6. Regulations will allow insurance companies to buy policies from HSA and resell them with a minimal mark-up. Insurance companies will be allowed to resell these policies with *added benefits* at whatever premium the market will permit. These added benefits could include international coverage, air ambulance from other countries back to the US etc. The financial risk to the added benefits would be born solely by the insurance company not HSA. The basic HSA policy must be available from this same insurance company with the low markup to be determined by the regional representatives. The basic policy is the coverage and premium determined by citizens through the HSA governance process to give us a health secure America and satisfies the three mandates of HSA.

7. After completing a procedure, a provider will electronically bill HSA and receive payment within two weeks.

8. Hospitals will have financial expenditures and services determined by citizens through the HSA governance process.

THE RULES DISSECTED

1. Non-Compete Clauses:

In today's medical practice, most clinics have non-compete clauses. To review, agreeing to such a clause means that if the physician chooses to leave a group practice and go into solo practice, he or she can not practice in the same community in competition with the clinic of prior employment. There is usually a time and distance limit from the employer's clinic.

HSA can not permit this clause in the contract of anyone taking payment from it, and the reason is simple. *Non-compete contracts prevent the physician from doing his or her own administration*, a change necessary to lowering the cost of his or her business up to 40 percent, as I discuss later in chapter 9. The lowering of administrative cost is core to making HSA work. If the non-compete clause is not removed, administrative costs will still be eating up a great portion of the provider's business income. Although the revenue will be determined *initially* by Medicare's set fees, the monies received from HSA will eventually total roughly 50 percent of the usual and customary fees. Some of the administrative cost saved will go to the provider, who is now by necessity doing the administration without the help of a large support staff. He or she will need to be able to compete and retain his or her old group of patients to maintain income and support his or her family. If the physician is unable to compete adequately in his or her place of residence, we will have increasingly fewer physicians and other needed providers. This new rule banning non-compete contracts will encourage more people to go into the medical profession and stay in it, and thereby provide us with more health care for the money.

Ultimately, the citizen-participants in the HSA governance process will determine fees. An added bonus of eliminating non-compete contracts will be to enable providers to migrate to areas

where there is a greater need for medical services, and still get compensated adequately for the work. Poorer areas should be much better served than they are today, and will be, under HSA. HSA will allow freer movement of providers and allow easier competition in communities, which will in turn foster better service.

2. Closed panels:

Closed panels are a way to keep other physicians from being a part of a given HMO or similarly managed health care model. The pool of patients in a given practice area is finite, and by disallowing payment from the insurance plans of a large set of potential patients, closed panels discourage choice of physicians, and effectively impose health care trusts. The resultant obstacle to competition among practitioners must not continue if HSA is to lower health care costs.

3. Fee Schedule:

The Medicare fee schedule (set fees) will be the initial schedule used, with its tested rules, procedures and diagnosis regimens. I say only initially, since the regional representatives and board of information, according to the prescribed process, will modify fees, as there is demand or reason to change. To start with, the Medicare schedule is a good model.

It should be noted that if a provider signs up to be a part of HSA, and a patient appears with HSA insurance, the providers will only be able to accept the fee from HSA. Fee schedules work using the procedure and diagnosis codes set by the CPT and ICD books, respectively. The books are published yearly by the American Medical Association, under contract to Medicare. The fee schedule is approximately 50 percent of the usual and customary fees; that is, fees set by the individual provider.

No new countrywide health care system like HSA could be held hostage to a usual and customary fee system. We do at present

hold the uninsured persons hostage to a usual and customary fee schedule, and it amounts to incredible discrimination. Why would two people having identical procedures pay a radically different fee? In some cases, one of them might pay a fee 100 percent and in some cases 500 percent more than the other must pay. If a patient is one of the unlucky who neither has insurance nor a small deductible insurance policy, he or she will be taken to court to pay the bill, if necessary, knowing that a neighbor probably paid substantially less through Medicare for a similar procedure. This kind of selective soaking is common, yet we do not blink an eye. I have found that, if people have adequate insurance and everything is paid for, they tend not to question the bill at all, even though it may come to an outrageous sum. This inequity has to change, and HSA will change it.

I am going to put a personal face on this concept. Amy and her husband Blaine are carpenters. They work together and do a fantastic job at their work. Amy injured her little finger with a chain saw and required amputation of the injured part at the first joint behind the nail. In forty years, I have done over 100 and probably more of this same procedure in my office treatment room. Her bill from the treating clinic, a very big, multi-office clinic in our area, dated July 18th, 2003, totaled \$5,444.36. There was a bill for \$1,675 for the surgeon, and the remainder was for one hour of anesthesia, although the clinic told her she did not have a general anesthesia, and other support charges. According to Amy, she was given gas and was sleeping during the procedure. She and Blaine spent three hours at the surgical center where she was sent (rather than the local treatment room in her local clinic). The remainder of the charges over the \$1,675 for the physician came to \$3,769.36. Amy was very clear and was not listened to when she demanded only local anesthesia for the amputation. She refused to pay her bill—and rightly so.

She is being taken to small claims court and has asked my help testifying as an expert witness. First I looked at the operative

note and the bills and told her that it had to be a mistake, and to try again to settle it with the clinic. She did, and they refused any reasonable settlement. As of this writing, the court date is being set for about four months from now. I will testify this should have been done in an office treatment room under local anesthesia. Her total bill for the procedure should have come to less than 1,200 dollars. She has another physician from our area as well who will be testifying, although his cost estimate is lower than mine is. And two physicians at our medical society meeting last month^{*} learned of the exorbitant bill. (I had cut the clinic name off the bill before showing the other physicians, since they work for or have worked for the treating clinic.) They said that they would have charged \$200 and \$500, including all support charges such as dressings and the use of the office treatment room. Needless to say, they were appalled at the charges.

I looked up the code in the Medicare billing book, and indeed it allotted \$674 for the total work done in an office treatment room. Is Amy being used because she does not have insurance? She is subject to whatever someone decides the usual and customary bill is. Others in the profession can also judge whether there was overtreatment besides the overcharging. I would say yes.

Is the problem that our health care system faces now becoming clearer? I am reasonably sure that this kind of overcharging is pervasive. I suggest that those interested look at the *Medical Advocates of America* web site. You too will be convinced that some people are being bilked. Their web site URL is <http://www.billadvocates.com/mission.htm>

Fixed fees (set fees) for everyone, by itself, will lower costs of the health care system and will force administrative reform. The set fee system is the only system that will function in the health care system of the future. This very simple rule will change premiums, coverage, salaries, and most of all the business models. Each of these items will be discussed in its own section.

^{*} September's 2005 meeting was our medical society's first meeting of the year.

4. All citizens will be accepted into the plan:

There will be no age, disability or other impediment to obtaining the HSA health insurance policy. The premiums will be free for all children through 18 years of age. It has been known for a long time that health care costs for the group younger than 19 years are very low and these costs will be absorbed by all of the rest of us. We simply must not allow our kids to go without health care. Moreover, there will no longer be exclusion because a person has lost his or her job or has moved to a different part of the country. There will no longer be increased premiums because one's spouse has diabetes or any other disease. Finally, we will have rid ourselves of the fear of living without a safety net—having no affordable health insurance. If you do not know what that fear feels like, ask a friend who has. He or she will give you a terrible story, and an all-too-common one. We have to try to get through this social logjam.

5. Open Staff:

This is a significant item when there is only one hospital in a given area. To keep the competition open and free there can be no private hospitals. If they do not accept HSA payments (remember, HSA is voluntary) and are not providers, then an exception would exist. There also could be some exceptions to this stipulation if a hospital was primarily research oriented. Open staff policy will be one of the very first items on the agenda of the state regions' hearing process

The Mayo Clinic hospitals, St. Mary's and Methodist, are not open to physicians who are not part of the Mayo Clinic system. It has a closed staff. To what extent will HSA make payments to a closed staff hospital, thus preventing open and free competition? If one is a physician and not part of the Mayo Clinic one can not practice at the two hospitals mentioned above and will have to go another hospital. This opens up a pandora's box of waste, excess

facilities and duplicated services. I wonder if our citizens will allow this sort of waste. The Mayo Clinic will have to present some good reasons for their closed staff policy to continue, but perhaps there are some, other than a marketing ploy or exclusion of physicians whom Mayo might not like. In communities with multiple hospitals that are not research oriented, the rule must stand that no physician licensed and credentialed with HSA to perform procedures can be excluded from its staff. Mayo Clinic physicians make a very good living at least partially dependent on revenue from patient care, not just revenue from research or foundation gifts. In view of the research, this sort of hybrid health care institution will have to be looked at closely and a judgment made by all citizens through the regional representatives and the hearing system. And there are other research centers that function as the Mayo Clinic does.

6. Insurance Companies will buy policies from HSA:

They will buy the basic policy given all citizens and will sell them for a very low markup, determined by the regional representatives and board of information decision mechanism. They will have no risk here of loss; the risk will be assumed by HSA, as addressed earlier. The insurance companies will add some of their own benefits, such as extensive plastic surgery coverage, international coverage, international air ambulance coverage, or any other benefit that they think will sell. They also, of course, will accept the risk as well as the profits from their own part of the policy. The basic HSA coverage will have the premiums paid to HSA by the insurance companies who have purchased the policies for resale.

The HSA health plan will need to have premiums paid by policyholders, and the money has to be collected. Insurance companies collect money better than most organizations, as anyone who has ever been late paying a premium can attest. We do not need to create a new bureaucracy to collect premiums. The set of

rules just laid down will accomplish this collection of premiums task

7. A provider after completing a procedure will electronically bill HSA and receive his payment within two weeks. The new billing system will work to eliminate accounts receivable and insurance battles, thus enabling a provider's office staffed with far fewer people.

8. Hospitals will be community assets no matter who is the controlling body for day to day operations. Hospitals will be subject to a regional planning agency run by citizens and approved through the HSA governance process. I describe hospital planning more thoroughly in Chapter 10.

Follow the eight rules that correct the mistakes that I have elucidated, and Americans will live free of fear—the fear of no affordable health insurance.

PART III

WHERE ARE ALL THESE PREMIUM
SAVINGS COMING FROM?

CHAPTER 9

PHYSICIANS AND CLINIC SERVICES

When people talk of health insurance premiums, they include physician bills and hospital costs. This is the traditional definition of “health insurance premiums.” I have suggested the idea of slashing our health insurance premiums by fifty percent. If your insurance premium is now \$1,000 per month, is it worth the battle to halve it to \$500 per month? I think that most people would agree. I also stated earlier that everyone will have a responsibility to see that we do it, and part of that responsibility entails learning how the system works. This chapter and the two following it will take our system apart and put it back together.

The last statistics available to me are from 2003 and taken from the *California Healthcare Foundation*, published on the internet and available to all.¹ I will not address the dental, nursing home or home care costs. I will address prescription drug costs, and, at this point in our health insurance history, coverage of those costs may or may not be included in the definition of health insurance as Americans understand the term. All of the decision making will be left to ordinary American citizens. Once this plan is put in place, if people don't like it, they can change it. They might think that the premiums are too high, and will have to think of ways to lower them. Health Security America starts us along this path of fiscal restraint. Everyone will have more responsibility put on him or her, including physicians and nurses, patients and

hospitals. I have laid out the form of governance describing how the Health Security America Plan can be accomplished in the last three chapters. Now I am going to show you how it will actually function. I will give you facts and figures, and as we move along, present difficulties that will have to be addressed. There will be no free lunch. These ideas that I set down here will map the road to health security for all Americans.

THE STATISTICS*

In 2003 Americans spent:

- ? \$556.6 *billion* on hospital care
- ? \$398.44 billion on physician and clinical services
- ? \$192.68 *billion on prescriptions*
- ? \$1146.72 billion total (*over one trillion dollars*)*

I am going to show you a practice in a large clinic setting and adapt it to a new paradigm of management under HSA. The new paradigm, if adopted, will save \$142.32 billion per year. Many of the numbers come from my 2003 research, titled “How We Practice Medicine.”(See Appendix A, page 113) My partner of many years, Dr. Howard Thalacker, who still practices with the Midelfort Clinic, a part of the Mayo Health System, provided me with the raw data from his own practice for 2003. This study was originally done for a presentation at the Tri-County Medical Society to demonstrate the waste in large clinic administration and how we could fix it. It can be found in Appendix A in its entirety. I am going to extract its results here in layman’s terms.

Dr. Thalacker goes to work every day and every two weeks receives a check representing his salary and a stub showing contributions made to his retirement funds and social security. He does not concern himself with billings, clinic rent, malpractice

* Administration costs for each category are included.

insurance rates, hiring or firing, utility bills, supplies or even if the heating system or air conditioning system is working. Another person does all the administrative and maintenance work for him. Someone else also dictates his work and meeting schedules. As for clinic policy, Dr. Thalacker determines none of them—a board of directors does. A staff of clinic corporate officers, medical directors and middle management administrative personnel presents the policies to him. And even if he does not agree with them, the senior management exercises considerable influence over his practice guidelines. As an example, Dr. Thalacker is no longer allowed to dispense free samples of drugs to needy patients, as has been done in the past.

As a result, both Dr. Thalacker and his patients suffer some distress, but he has dutifully followed these and other orders. He has no alternative, such as breaking with the clinic because of practice and policy differences and starting a new practice of his own, taking care of patients in what he sees as an appropriate way. Why is a typical family practitioner such as Dr. Thalacker so bound to the large clinic's way of doing business? The answer is contractual obligations. Although he is technically free to leave the practice at any time, he is a *de facto* captive, and his continued livelihood hinges on staying put. He has signed a non-compete agreement with the clinic stating that if he does leave, he must practice 25 miles from his present practice for a period of no less than two years. The penalty for disagreement is no job. It is accepted in the medical profession that if one leaves for two years, one's patients will find other doctors. If one chooses to stay in the same location, one's patient base will have drained away by the time the non-compete clause expires.

Dr. Thalacker has accepted the fact he will not be required to administer his practice despite the very little effort it would demand of him. Instead, he need only go to work every day and follow orders from his superiors. He goes to his job daily and his only concern is practicing medicine as best he can under the

administrative guidelines, receiving his check every two weeks. On the face of it, it may look like a fair trade-off, but the hidden cost is staggering. In fact, according to the Coalition for Wisconsin Health, administrators are “the most rapidly growing segment in the health care labor force. Between 1970 and 1996, the number of health administrators increased more than 20 fold while the number of physicians and other clinical personnel increased about 2 ½ fold.”² The money wasted using the current large clinic type of administration for a medical practice of two physicians in one office is \$289,640 per year (34.7 percent of total revenues) or almost one third of a million dollars. One of the strengths of HSA is that it will use the money saved from unnecessary middlemen to lower health care costs nationwide for *physicians and services* 34.7 percent. That amounts to 142.32 billion dollars out of 398.44 billion per year spent on physicians and services—an enormous savings.

Where did I come up with the administrative costs of a two-physician office functioning as part of a large clinic amounting to almost a third of a million dollars? How are we going to save this huge amount of money to reduce HSA premiums? I have to admit that I had to cajole my former partner with a grilled sockeye salmon lunch to admit his W-2 earnings of \$175,000 for 2003. That salary figure was crucial in demonstrating the method of savings. We are assuming a two physician medical practice, but this same method has worked for me in the past for all of thirteen years, with up to nine physicians in a practice using three buildings in three different communities.

The revenues of Dr. Thalacker’s practice as well as that of a partner, using the present usual and customary billing methods combined with Medicare and Medicaid payments, amounted to \$834,064 for one year. The expenses, if Dr. Thalacker and his partner were to administer their own medical practice, were determined by going out into the community and determining salaries, cost of buildings and equipment, insurance, utilities,

building taxes and other typical costs. The numbers are accurate and the sources reliable. Dr. Thalacker and his partner, with the help of a lead person[?], would have to administer their own two-physician medical practice, and it would include hiring, firing and cross-training of employees, deciding whether to buy or rent a building, making sure that the utilities are maintained and paid for, hiring a financial consultant to run the clinic's retirement fund and, in essence, do just as any other business on main street Chetek, Wisconsin, does.

This stands in stark contrast to the way it is presently done for him, with a large clinic's managed practice administrative employees doing all of the aforementioned tasks. The total cost of running this two-man medical practice would be \$194,424. If Dr. Thalacker and his partner each drew a salary of \$175,000 and the expenses totaled \$194,420, they would be left with \$289,640 of surplus—again, a windfall of almost one third of a million dollars for two doctors. ($\$834,064 - 175,000 - 175,000 - 194,424 = \$289,640$)

There is a place for skepticism, here. Why would the two doctors now administering their own clinic give back this surplus \$289,640? This is the major strength of HSA. They will not give it back, because, under HSA, they will not receive that money in the first place. HSA will start paying Dr. Thalacker and his partner only the Medicare set fees for all the procedures. This will cause about a 28-percent reduction in revenues for the two doctors. Remember, initially, the Medicare set fee schedule will be the HSA fee schedule and can be changed at the will of citizens via the governance methods described in Part Two of this book. The physicians will still make a good living—most probably better than they are now with the large clinic doing all the administration. Their revenues under HSA would total \$595,760, from which they would take \$194,420 in expenses, leaving each of them with a

[?] A lead person helps implement the decisions the doctors have made about their practice, as well as doing the same day to day activities as the other employees do, using the same cross training techniques keeping her or him current in these tasks.

\$200,670 salary. This is more than the \$175,000 they are now receiving, so the incentive to work as a physician remains intact, with the added incentive to manage one's own practice.

Veteran physicians will remember what it once was to be in charge of one's professional life, and newer physicians who have always labored for large clinics will be pleasantly surprised under HSA. If they were to set out on their own under the new system, no one would try to dictate to Dr. Thalacker and his partner whom to hire or how many. Certainly there will always be differences between medical offices; some doctors would choose to do things such as giving their own injections rather than hire someone to do this. Some doctors will choose to dictate notes into their computers and send the file to India at the end of the day and have it returned the next morning ready to be put in an electronic file or printed out, depending on the needs of the practice. I have chosen not to include dollar savings for this type of detail, since details will vary from office to office, and each physician will have to make his or her own decisions. And all of these decisions easily fall within the realm of expertise of a new physician. If he or she feels they are not, then someone will have to take on those duties for a cut of the profit. But most essentially, it is the physician's choice and responsibility; no remote CEO or accountant pulls the strings.

The new paradigm of clinic practice is the same one I was a part of for thirteen years, ending in 1978. Its methods are tried and have proved effective. There is nothing to indicate that the same format will not work again. As I said, this paradigm won't be new for the older physicians reading this, but it will be for the new physicians. Newly graduated physicians are going to have to look out for their own business, taking some extra time to learn, if the topic is a new one. When one's vital interests are at stake, running a business is not that hard, and common sense is all they will really need.

The newly trained physician has to find a place to practice medicine. It takes physicians about eighteen months to ferret out a

pleasant location in which to work and raise a family, and usually is concurrent with the last 18 months of his or her training. Indeed, there will be locations like the Chetek I encountered in 1965, where an established physician may want to add another partner. If the two parties can come to an agreement, they will be able to work together. There will be no non-compete agreements signed, since prohibition of non-compete clauses is one of eight inviolable rules of Health Security America. This same new physician might decide that he or she wants to be the absolute decisionmaker and start up a fresh practice, building his patient base over time. Starting up solo will be no problem, since he or she will be on staff at the local hospital unhandicapped by an exclusive closed staff policy—again one of the eight core rules of HSA. The new physician will have to find a building, hire employees, buy supplies and equipment, and find start-up funds to work with. Although medical practice start-up is essentially no different than that of any other business, most banks are exceptionally eager for the physician's patronage, since his or her chance of success is high, and the risk to the lender is thought to be low.

Dr. Thalacker and his partner will have to change the way their practice is administered, and will have to negotiate with owners of his clinic building in order to rent space. If renting falls through, they will simply find their own building. HSA legislation will give them the authority to do so, rendering the non-compete contract *unenforceable* for anyone accepting HSA payments. One of the eight rules states that physicians who accept HSA payments for work done will not be allowed to have a non-compete agreement with an employer. Clinics accepting HSA payments will not be able to make non-compete agreements with employees. Neutralizing the non-compete catch-22 will enable Dr. Thalacker and his partner to leave the large clinic practice and administer their own. And what is more, I am sure they will want to leave, since the large clinic administration costs will further shrink their

new revenue stream, already 28 percent less than what it is right now.

At first glance, the paradigm shift seems drastic, but really is not. The real estate consists of a special-use building (this means only one type of use for the building allows the building to have significant value—in this case a medical building), and the owners will either sell it to a group of doctors or rent them space in it, since there is no other feasible use for the building. Not without extensive remodeling, that is, and of course this is not typically a cost-effective use of resources in a town of 2,000 people. There will be no waste. I suppose that administrators will have to look for work, but so do the employees at General Motors who are losing their jobs, thanks to high health care costs.

Another welcome change will be the reinfusion of vigor into the medical societies described in Chapter 3. Long atrophied, medical societies will resume the functions that large clinics long ago seized (or left derelict): practice guidelines, peer review, credentialing, ethics, and many other functions.

Health Security America legislation will open the gates for all this to happen immediately on its passage through Congress. Is saving 142 billion dollars a year worth the change to physicians' lives? I think so. I am not worried about physicians handling the change; they will do fine. Their education is broad enough for them to be able to make the segue with minimal upset. I know that citizens governing HSA will ensure that the savings will go a long way toward helping the ten million uninsured American children to secure coverage.

CHAPTER 10

THE HOSPITAL

I don't claim to have hands-on experience with hospitals as I do with physicians, clinics, patient's responsibility and prescriptions. I needed to tour some hospitals and cajole a hospital administrator, a friend of mine, to "fess up." While I will keep his name a secret, I will tell you about him and his hospital and the two associated hospital-owned clinics that he runs. The facts and figures are real, and the area is within a day's driving distance of my community, Chetek, Wisconsin. "Jim" is a good friend of mine, and has, within fifteen years of earning his MBA, become one of the top hospital administrators in the region. The hospital and its associated clinics gross 90 million dollars per year. During my interview, I asked early on what he could save in expenses, and he replied that the savings would easily total fifteen percent. His answer surprised me, since my knowledge of the business of hospitals is restricted. And while I am sure that the hospital administrators reading this paragraph are sitting bolt upright, wondering when the heat will be on them, my guess is that they will ultimately be relieved to have a different operating paradigm.

In Part Two, I listed some of the rules to free up competition and thus constrain costs for physicians and clinics. But the new paradigm for hospitals under Health Security America will be in many ways *exactly the opposite*, since competition among

hospitals long ago ran amok. Competition among hospitals created a medical arms race of first-class proportions. The arms race metaphor refers to hospitals in close proximity to each other competing with each other for patients to create revenue. It also refers to the cold war, when the USSR and the U.S. needlessly spent billions on weapons after either side could have destroyed the world with one tenth of what already was available.

Much that I am going to describe was given to me by Jim, but not all. Anyone active in his or her community probably wonders about the same questions as I have, watching television, listening to the radio, and getting huge packages of junk mail from hospitals with a yen for profits. The rest of the “arms race” is a bit subtler, but real nonetheless.

The week of September 4th, 2005, I received a beautiful, high gloss, multi-page publication from Froedtert Hospital in Milwaukee, Wisconsin. It had imposing pictures of its leaders in administration and medicine. After reading it, one could not imagine not getting the best of the best from this hospital (it is in fact a wonderful place with a good reputation, and I am sure the care is above reproach). But my thoughts centered on the cost of the glossy publication, and why they would send it to me, when I live and work six hours away from Froedtert, yet live only two and a half hours from the world-class Mayo Clinic in Rochester, Minnesota. This publication, Jim assured me, could cost three to five dollars per piece to send out. If it went to all doctors in the state, as seems likely, then multiply the cost by 15,000. If it went out to the greater public, then all bets are off; there are five million people in Wisconsin. Froedtert Hospital invested in the mass mailing of a costly, slick flyer to somehow encourage people to use its services. Some of the money Froedtert receives comes from Medicare fees and/or patient’s insurance. Given that, one can easily imagine the implications of such high-priced advertising in rising health care costs. These massive advertising campaigns should not and indeed can not continue.

On almost any night, television carries the battle of the hospitals, each one aiming to convince people to use their hospital rather than the competition just twenty blocks away. Many times, these costly ads showcase the local “arms race” by featuring a newer machine or more sophisticated technology than the competition can boast. Sometimes the carrot dangled before the potential consumer’s nose is a raft of amenities calculated to remind a patient of home—or even of a five-star hotel. For instance, my friend Jim’s hospital has 24-hour room service with a full menu, a waterfall in the atrium, pull-out beds for relatives in patient’s rooms and obstetric suites with cherrywood cabinets. The latest plans entail offering full valet service at the front door. Jim’s hospital takes Medicare fees and part of those fees would be used to pay for these frills. These kinds of hyper-competitive expenditures can not continue; we all pay, yet no one can afford them, ultimately. The benefits of such competition accrue in too few accounts. In Jim’s defense, patients have not complained that these services were unwarranted, but all of us can stand some straight talk.

The new operating paradigm for hospitals will be guided by the concept that hospitals are *community assets* to be run at the least possible cost necessary to provide the best care. There can be no question but that we will have to implement a system of regional, citizen-based decision-making in order to determine the services a given hospital will provide, constraining costs and minimizing duplication. Regional planning agencies will have to be set up to provide information to the regional representatives and board of information of HSA. (Yes, these are the same regional planning agencies that I opposed during my first thirteen years in practice. I was wrong.) This is a situation in which the regional representative will present the planning agencies’ conclusions about which hospitals might do certain care and others different care, depending on the area served. One example of that might be to allow only one of two hospitals situated close together to do

brain surgery and orthopedics, while the other might concentrate on pediatrics and psychiatry. Staffing and equipping two hospitals near each other to perform the same tasks—some of which are highly specialized—is cost-ineffective. We don't need competition in these situations. In fact, competition hurts, because patient volume has to be there for the hospital to be efficient and to furnish high quality care. It is vital to cut down on duplication. In Jim's case, a hospital twelve miles down the road offers the very same technical skills as Jim's, as far as diagnostic machines and procedures are concerned. It is probable that soon no one will be able to afford that kind of continual battle for updated equipment at hospitals just blocks or miles apart.

Jim discussed another problem with me—a typical problem that citizens will have to solve, under HSA. He described an instance of his hospital having an MRI and CAT scan with a clinic across the street proposing to acquire the same costly equipment, which is, frankly, absurd. The total capital costs could run into millions of health care dollars. The capital costs would come out of the pockets of the populace. We can no longer bear such waste. Regional health planning agencies in the past dealt with hospitals. Are we going to have them approve clinic purchases of this highly costly equipment? This interferes with the individual private clinics. Yet, if both of these health care facility owners don't keep their MRI and CAT scan machines tightly booked and busy, the costs will be out of line. Imagine what kind of decisions interested, responsible citizens would make, given the proposed usage and costs. If there were a true need, that sort of duplication most likely would be allowed, but not if the duplication amounted to nothing more than competitive acquisition.

I have not touched on all the different opportunities to squander money that hospitals have, but the examples above should give an idea. The aforementioned HSA governance, accomplished by interested citizens, will correct this potential waste of money before it even starts. The people will receive the

medical care that they need, but I guarantee that the waste will not continue, since no group of sane people would tolerate it as reasonable. If a hospital administrator or board member should disagree, I can only remind him or her that what is now in place is not working. If 45 million people lack health insurance and 24 percent of them are children, the situation absolutely must change, if we are to call ourselves civilized. Twenty-five years of this type of failing has to be corrected. We are approaching critical meltdown.

The new hospital paradigm that I have suggested will work, and the populace will insist on its working. No entrenched government bureaucracy will call the shots; it will be the citizens implementing their own guidelines through their own corporation. If a hospital takes HSA money, it will follow HSA rules—the people’s rules. And people will insist on getting what they pay for. Administrators will do as they ask; their job will depend on it. Fifteen percent of 555.6 billion is 83 billion. What could the American people do with a spare 83 billion dollars?

I received a copy of an article, “Exposing Hospital Costs” by Guy Bolton in the *Milwaukee Journal Sentinel*,¹ quoting prices for procedures done in Milwaukee, Wisconsin. Listed below are two procedures and their charges for patients not covered by Medicare insurance or managed care plans. In other words, their price list for employers self-insuring their employees’ health needs without purchased insurance, people with no insurance and other plans.

Implant of drug-coated stent with heart attack

Columbia St. Mary’s Hospital_____	\$25,909 guaranteed	<i>Cost difference</i>
St. Joseph’s Hospital_____	\$40,475 estimated	+56%
Froedtert Hospital_____	\$34,068 estimated	+31%

Heart bypass with insertion of cardiac catheter

Columbia St. Mary’s Hospital_____	\$47,597 guaranteed	<i>Cost difference</i>
St. Joseph’s Hospital_____	\$100,723 estimated	+112%
Froedtert Hospital_____	\$65,101 estimated	+37%

Treating heart disease is one of the biggest uses of the health care dollar with 22 million Americans affected (according to Center for Disease Control statistics, 2000)². The situation described is the difference in cost for one person. The reader can calculate the savings potential in just this one example of billings—it will be enormous. HSA, through its governance, will not tolerate these situations, and I predict that the fifteen-percent cost savings quoted me by my hospital administrator friend, Jim, is but scratching the surface.

HSA will require that whoever owns the hospital—whether it be a religious order, non-profit corporation or longtime foundation—provide information about all their operating expenses to HSA, and then HSA, in turn, will determine the money paid for hospital procedures. The hospital will act as a community asset and not as a profit center for a foundation or private company. HSA will have a beneficial moderating effect on those community assets by setting the conditions and the fees it will pay a hospital, and in some cases, if a hospital is noncompliant, withholding payment. So as a *community asset*, hospitals will be working together, not as individual entities. With hospitals working together, along with regional planning agencies determining which hospital is best suited to do certain procedures, with the objective of saving money without sacrificing quality, a new transparency will evolve, and it will save enormous sums of money. The motive will not be profit for the few, but for the many, by saving money and furnishing more efficient care of the highest quality, so that all people have access to affordable medical care, including the 45 million without coverage today. The HSA board of information will work with the regional health planning agencies on fact finding, in order to oversee the reduction of wasted resources—a key mission. The gathered information will be passed to the regional representatives and then the mechanism for governance will function as it should. These are some hospital-side savings that we can expect very early on in the life of HSA. I

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have no doubt that more savings will be vetted by patients and their representatives once they are given the authority.

CHAPTER 11

A GUIDE TO REDUCING PREMIUMS WITH PATIENTS' ASSISTANCE

Without citizen input into the governance and policymaking apparatus of Health Security America, it can not succeed. One of the three principal mandates of HSA requires self-funding by the participants—that is, for the recipients to pay a premium —so the patient has real incentive to protect his or her health and pocketbook. It is vital that participants in HSA be close to the process of decision making, not isolated by layers of unresponsive bureaucracy. And by identifying three regions in each state where policy will be made through the hearings process, I have made close citizen involvement and responsive policymaking possible.

Here is how close involvement and patient responsibility works. The board of information described earlier will present the regional representatives with a set of issues to be decided. The citizen, through the hearing process and web site, will have all the necessary information at hand. He or she may choose to participate by actually going to the hearings in his or her region or through the HSA web site. He or she will participate in the debate and ultimately make a decision on an issue, casting a vote either at the hearing or through a secure web site.

I will give you a very simple example. The board of information may want to know if new rooms built in hospitals and rates to be paid by HSA will be based on four patients to a room or

two patients to a room. The board will furnish information on both situations' effect on premiums, as determined by their actuaries. The actuarial studies will be based on the hospital infrastructure required for 295 million people and will be accurate. The board will present pros and cons as they see the issue. All the information will be forwarded to the regional representative, who will include it in the hearing process. The regional representative will vote on the issue as he or she sees fit, but also based on the hearing process that has transpired. Each citizen, I am sure, will look at the effect on the premiums and evaluate items such as privacy—with four to a room as opposed to two, more noise versus less noise—and other conditions before he or she votes. The 150 votes will be tallied and the issue decided. After the matter is decided, the board of information will implement the change to the premium.

Some cost-reduction measures will practically decide and implement themselves; I don't foresee waterfalls in the hospital atrium, valet service, television ads, multi-page, five-dollar brochures, round-the-clock room service, or any similar type of expensive perquisite lasting past the first regional meeting. Nor will hiding these costs under non-profit foundations' auspices keep such items going since all hospital finances will be open and in my opinion citizens will not allow these excesses. I am not advocating building spartan cinder block hospitals, just building to a reasonable standard. After all, hospital stays are getting shorter. Most gallbladder surgeries keep people in the hospital less than 36 hours, in contrast to the six to seven days spent hospitalized not too many years ago. I doubt that patients will be upset if the atrium is missing a waterfall, and the 24/7 room service might be cut to three times per day at the usual meal times.

One of the first items I see being presented for hearing is a proposal for the establishment of a planning agency in each region to determine the location of expensive diagnostic equipment such as MRI and CAT scan units. I doubt a clinic will be allowed to

have its own MRI or CAT scan unit if the hospital just ten blocks away has them. Hospitals do need them for emergent problems, and because hospital patients may be too sick to transport off-site for the test. In clinics, MRI and CAT scans are elective procedures and there is no reason that people could not make an appointment at the hospital for the tests. The cost of such medical equipment runs into the millions of dollars, and we must get maximum use out of it. We can not allow placement of such hardware unless we are sure that it will be used effectively, efficiently and with the utmost fiscal responsibility. If and only if existing units are working round the clock and more capacity is needed, perhaps purchase of additional units would be allowed. Of course, the aforementioned example is hypothetical, but optimizing placement and use of expensive medical hardware has to be addressed for the sake of cost control. Is this rationing or common sense? I have no doubt that critics will object to some cost controls such as these, but I trust that citizens will see past their objections and do what is reasonable.

In addition to optimizing use of expensive equipment, all kinds of contentious issues will arise to be decided, and there will be no choice but to grapple with them. Will HSA fund abortions? This book will not presume to answer that particular question, but as citizens we will have to decide. Presently, payment for abortion with government money is not allowed, but under HSA, the money—and the decision—will be decided by a simple vote of citizens through the hearing process.

I have given examples of questions that will have to be answered but I have not given the answers. The citizen will make the decisions. The decisions will be put in the pot and out will come a health plan, premium and insurance coverage. The aforementioned examples are fairly cut and dried, and most reasonable people will easily agree on what to do. However, if we are going to lower health care costs in a serious way, we will also have to take an active role in managing our own health.

Patients—citizens—will have to take charge of their health and take more responsibility than they have in the past. What follows are descriptions of actions crucial to HSA’s success—actions close to the core of premium reduction.

Shouldering the responsibility of our own health will be tough, but it will have to be dealt with and not avoided. I have seen numbers showing that 25 percent of all Medicare costs are due to diabetes and its complications of obesity, blindness, kidney failure, stroke and cardiac disease, among others. The complications of what are, arguably, poor lifestyle choices comprise a big part of over 1 trillion dollars of annual health care costs.

I am going to give examples of the type of decisions that citizens will need to make; I will not decide the ethics of any of the scenarios, but eventually citizens in control of their own health care will. The citizen should regard himself *as a neighbor trying to help a neighbor-but how much help?* What is the responsibility of your neighbor to you, the patient, through premium costs that he, too, must pay? Each citizen will have to weigh questions of standards of care, and decide who should take responsibility for his neighbor’s health, the neighbor or to what extent -the citizen patient. The answers to these questions will be made evident through premium or coverage adjustments. I have great confidence in how patients will need to resolve the upcoming examples of health plan decisions, but many more such decisions will come up as we fine-tune our new health care paradigm using the hearing process.

I can cite many cases that have come into my office over 40 years concerning the common problem of high blood pressure; the names are not real, but the stories are. “John” was a successful businessman in our community. He came to see me when he was in his early forties. John liked drinking beer and grilling ribs for his friends and was about 75 pounds overweight. His blood pressure read 150/95-100 on repeated samplings, and all of his laboratory examinations still were normal, except for a slight elevation in

cholesterol. That blood pressure was too high to expect long life without significant health problems such as stroke, heart attack, and other blood vessel diseases. I had instructed him adequately about the risks of stroke, heart disease and other potential problems. We discussed his lifestyle, and he understood the need to hold back on the beer and food. Over the next several visits, John clearly understood the instructions, including dietary instructions that I dispensed. But John just wanted some medicine and to move on. I gave him the generic drugs atenolol and Dyazide at the usual doses, but it did not do anything to lower his blood pressure. His weight did not change and John admitted to not being very good at his diet.

Now, here is a step that we took that will have to be broached and understood by all: I added an ace inhibitor, an expensive drug, which at the time was not generic at the usual doses. Its cost was—in the range of 40 or 50 dollars per month. John's insurance paid the bill, and we got the blood pressure back to normal, yet we still had a man with an overweight condition and a lifestyle that was going to lead to more health problems within another five to ten years. I told John as much, and before he took the very first pill, John knew that he had to take the responsibility for his own health or he would die; his father had died of a heart attack in his early forties. John knew what he had to do, yet he simply was not ready to take responsibility for his own health. He took the easy approach of expensive medicine.

I want the hearing process to recognize and discuss this philosophy of taking responsibility for one's health. We know that, with weight loss, that blood pressure of John's type drops very quickly—even with a loss of only five or ten pounds, although it could take more. And in today's climate of scarce health care resources, it presents a question that can no longer be ignored: is it John's neighbor's responsibility to pay? After all, he is paying through his premium increase for John to advance to newly patented drugs that might cost up to \$60 per month when John

failed to take even the smallest of steps (weight loss) to fix his blood pressure problem. My opinion is no—the neighbor should not have to pay, not without some serious questions asked. The line is drawn. We need individual responsibility in these kinds of cases. And in deciding standards, through the hearing process, a rule stating that, in the cases of blood pressure problems of this type, only generic drugs would be used until after a trial of at least weight reduction. The percentage of weight lost might be used as a cutoff. Such a rule is not rationing, but common sense. When John and others like him are told that we, his neighbors, will not help him through our increased premiums for branded new drugs *until he helps himself*—he will lose weight. Call this tough love. Fellow citizens will decide the ethics of such a rule, not the insurance company or the government.

The next example of a patient's going for the expensive surgical fix over the inexpensive lifestyle fix is frustrating, since it is common and there are no present guidelines to curb it. I have a friend who is 75 pounds overweight. His knees started hurting, and he was found to have degenerative arthritis of both knees. There is a 40 percent greater chance for an obese person to get knee degenerative arthritis than a normal weight person. He was told to lose weight and instructed how, and in fact his wife was a home economics teacher with all the cooking and diet answers he could desire. However, he did not follow instructions and his knees became very painful. He called me about a year ago to let me know that an orthopedic surgeon had volunteered to replace both knees with artificial knees at the same time. At that point, he had not even attempted to lose weight. The prospect of his having surgery frightened his wife, since he was putting himself at risk of having a complication (my friend has some controlled heart disease as well) with the surgery, and the lives of his family members would have been affected, too. In these situations, we know that if the patient loses weight and does gentle physical therapy—swimming, for

example—up to 30 or 40 percent of the time he or she will get adequate relief and will not need surgery. Again, my friend's demand is "*Fix my knees—the insurance will pay the bill!*" It will indeed, but the neighbor's premium will also reflect this expense.

My friend eventually did take the weight loss route, with swimming and physical therapy, and he did get relief without surgery—but it was due to his wife's concern, not the expense that would have been incurred. And the expense would have been considerable. In Minnesota the *average* charge for total knee replacement among Minneapolis/St. Paul metro hospitals was \$29,817 during the fourth quarter of 2004. Nationwide, the average physician charge for total knee replacement is \$1,419, according to the Medicare web site. The cost for my friend's insurance company based on the aforementioned fees is \$62,472. That cost does not reflect any percentage for complications, and there are some complications, including bloods clots, heart attacks, infection or anesthesia problems. The added costs of complications would have to be dealt with and are a statistical certainty. Every year, there are 270,000 knee replacements performed in U.S. hospitals. The cost amounts to \$8,433,720,000 per year being spent in this country on this procedure. Possibly as much as two or three billion dollars—a not insignificant sum—could be saved with increased personal responsibility, such as weight loss.

Policy on knee replacement protocol and many other items will be on the table for everyone to decide. Medical professionals, actuaries and other informed people will present the facts and figures of each contingency—and its effect on the premium. Then neighbors—all of us—will decide on what is best to do. I think that the consensus will be that it is most prudent to attempt weight loss before rushing to surgery. A time frame could be set by citizens during which weight loss must be attempted before surgery is authorized. I believe the savings will be in the billions. Is it rationing—or hard common sense? Is it ethical? The consumer gets to decide.

I am adding a caveat that we will start implementing HSA with new conditions —that is, with new diagnoses, not longstanding ones. By no means will we take away the medicines and care for people already disabled with their diseases. I will leave changes to the plan for presently afflicted people up to the hearing processes previously described. There is room for debate.

These two cases of lifestyle change versus expensive treatments highlight some of the key principals of HSA *governance*, and a mechanism whereby we begin to save up to 50 percent of present-day premiums. In the next chapters, I discuss those who can not afford the premium—those in poverty. For someone who can not afford to pay for insurance, how does HSA stack up next to *single payer plans* and *universal health coverage*?

PART IV

TYING UP LOOSE ENDS

CHAPTER 12

POVERTY, SINGLE PAYER AND UNIVERSAL HEALTH CARE PLANS

Let's not fool ourselves. We have poverty in the United States and we all have been re-schooled in it as we witness the aftermath of Hurricane Katrina. There is much to be done to ameliorate poverty and ease the burdens on the poorest amongst us, and while Health Security America aims to make health care more accessible and affordable to everyone, it is not the primary agency dealing with poverty.

The poor do need health care, however. I am asking Congress to pay the premiums for those unable to afford the HSA premium as determined by the government agencies now dealing with poverty issues. The same agencies that place people in Medicaid plans will now pay HSA premiums for those same people. I see no difference between the government paying for a health care plan premium and its furnishing heating oil for those impoverished during the winter months. We consider it a right not to freeze to death because we're broke and out of money and yet we have 10 million kids without health insurance and let 18,000 people die each year due to no health insurance.

I say no more; we can not abandon that populace. These same people under HSA will be in our healthcare mainstream and will not receive inferior care, as they and others sometimes claim. They will go to the same hospitals and see the same doctors as everyone else. And those doctors, hospitals and other providers

will be compensated the same for everyone that walks in the office or hospital. Low-income participants will no longer have to wait until their health reaches a critical state before seeking care, and not only is that the right, humane thing to do—it also means savings.

There has been a lot of buzz about single payer plans as a necessary remedy to what ails our health care system. One example of a single payer plan is Canada's National Health System. Single payer plans refer to one entity making payments to all health care providers. Health Security America certainly could be classified as a single payer plan *but only* if one chooses to participate. It is each citizen's responsibility to decide to participate. Each citizen will have to pay his HSA premium or his employer will do it for him to have coverage. If he or she elected to take a chance and not take the insurance, the patient would be billed just as HSA would be billed for those who have paid their premiums. The citizen will be subject to no difference in laws than if he or she bought any other service and did not pay for it. It would be expected that the provider would dun and collect the money. The citizen will have had the chance to buy the policy or seek help through the appropriate government agency you now deal with because you have no money. If one's financial circumstances fall within poverty definitions set by other government agencies the government will pay the premium dispatching the poverty issue at the first sign up. No one will be turned away for health care but everyone will have a responsibility to be aware of his or her life's circumstances whether it be financial, personal health issues or life style and act accordingly.

Universal health care plans are also being promoted as an answer to our health care crisis. Universal health care refers to the government funding care for everyone and administering it, and determining coverage. It is funded through your taxes. Everyone formulating a solution to our health care crisis uses one basic premise, which is that our present health care system is severely

broken and needs fixing. The central tenet of universal health care holds, as I do, that *health care is a right and not a privilege*. However, with this right, I believe comes a responsibility to be borne by each and every participant.

HSA assigns this individual responsibility an active role to a far greater degree than do existing universal health care plans. In HSA the citizen-participant will not be a bystander. The physician will administer his or her own clinic, the patient/citizen will be part of determining the premium and coverage. The low income citizen will have the responsibility to tell some one that he or she cannot pay the premium. Participants will be obligated to become involved, think things through and work to make sure that HSA provides excellent and efficient care. HSA will underscore accountability in a way existing universal health plans do not.

I have not seen a universal health plan that curbs administrative waste as **does** HSA. Government does have a duty to set up the quasi HSA Corporation outlined in the governance section and to determine the level of income below which the government will pick up the premium. In HSA, the government will only ultimately help to administer the insurance plan by providing information requested; it may be something as simple as asking the appropriate agency the number of people in each age group in the U.S.. If these government tasks get done, our nation will be better off in the area of health and finance. Imagine the extra time our senators and representatives will have if they do not need to be concerned with health care coverage, paying for it, improving it or Medicare going broke. An enormously important part of HSA is the new citizen involvement we will use to administer, govern and distribute health care. This makes it a superior plan because it makes all of us active players.

CHAPTER 13

SO WHAT!

During one of the financial excesses of Teddy Roosevelt's time, a philosopher stated that you can `haul people over hot coals' just so long before they will revolt with an unimaginable anger. These same people, quiet for a long time, will take charge of that which you thought you were the master. The health care situation in the country has brought us to that stage. The November 28, 2005, *Jim Lehrer News Hour* showed people marching in the streets over lack of health care insurance. A physician working daily had to declare bankruptcy over her and her family's health care bills. A professional entertainer with two master's degrees but chronic health problems could not find affordable health insurance and was being treated in a charity clinic. If someone is still not convinced that we have reached a tipping point, he or she could talk to one of the people with no insurance, or one of the 18,000 people dying this year after waiting too long to seek treatment, for want of health insurance.

There is Amy, charged 500% more than expected, to have an injured finger sewn up. How about the mom bringing her screaming, ear-infected, feverish five year old child in to the emergency room? She could not pay the bill at the clinic, and out of desperation, hopes that the ER will treat her child and give some relief, even if it is midnight and she delayed her visit hoping her five year old would get better without help. And General Motors

has just laid off 30,000 employees, blaming the high cost of their health insurance benefits.¹ Imagine, we are told, that every car coming off the line has a \$1,525 health care bill attached. Think about the small company that had a 34-percent premium increase in its health policy and had to cancel it for all its employees.

Does it give us no cause for reflection that we have 45 million people with no health insurance—ten million of whom are kids? Certainly, the multi-million dollar bonuses given to the CEOs of large health care companies must rankle anyone who has been refused access to his or her physician of many years not being on the insurance company's approved panel of physicians. That loss of continuity of care translates into someone else's bonus.

I want to show just one more item, and ask readers if it is not time for citizens of this country to step up and take charge. Statistics in 2001 show the United States spending \$5,000 for every citizen, with a life expectancy of 69.3 years². Japan spent \$2,000 per citizen, with a life expectancy of 75 years.² Enough said!

Health Security America has outlined how the U.S. citizen can take charge of health care to straighten out the problems listed above and keep things straightened out. Americans, all of you, it is time that you:

- ? *Demand health insurance from birth to death for all Americans*

- ? *Demand free health insurance for Americans through their first 18 years*

- ? *Demand that this plan pay for itself*

Health Security America has drawn up a roadmap. If we follow it, a *feasible, voluntary, affordable and effective* health insurance plan will follow from it, available for everyone.

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Don't let one item of the roadmap escape attention and begin with a non-profit corporation legislated by Congress, Health Security America, *Incorporated*.

Set up the corporate officers, board of information, and regional representatives together with the methods of election as described. Do not let citizen control be seized by other powerful interests whether they be physician or hospital associations, insurance companies, drug companies or any other large special interest group.

Make a part of the by-laws the eight rules that cannot be violated:

1. There can be no non-compete clauses in any physician's or any other provider's contract.
2. Any hospital, clinic, or insurance company may not have any association with a closed panel involving physicians or other providers to HSA if they will be taking HSA fees.
3. The initial fee schedule (set fees) and method of determining such fees will be the same as Medicare uses at this time. The rules, procedures, diagnosis codes will be the same initially as Medicare. This all may be adjusted by the regional representatives and citizens at their discretion as discussed earlier.
4. Regulations will be implemented allowing all citizens to be accepted into the plan during the first year following its inception. (Open enrollment—disabled or not—no questions asked) After the first year, there will be a six-month waiting period for those who did not sign up initially. This will help to prevent people from signing up only after they become ill. Although HSA is a voluntary plan, in essence, 295,000,000 people will be eligible for this program—our entire population.
5. New HSA regulations will require participating hospitals to have an open staff (Anyone licensed to perform medical procedures and

credentialed to receive payments from HSA will be allowed on the hospital staff to perform his or her work.)

6. Regulations will allow insurance companies to buy policies from HSA and resell them with a minimum markup. Insurance companies will be allowed to resell these policies with *added benefits* such as private room coverage or international coverage. Insurance companies can sell these added benefits at whatever premium the market will allow them. (The basic HSA policy must be available from this same insurance company with the low markup to be determined by the regional representatives.)

7. A provider after completing a procedure will electronically bill HSA and receive payment within two weeks.

8. Hospitals will have financial expenditures and services determined by citizens through the HSA governance process that will use regional planning agencies as advisors.

When Health Security America, Inc., is established, the really thorny problems will begin to be resolved.

- ? Physicians and clinics will adapt to the new rules and fee schedules (even though the fee schedules are lower than now).
- ? Patients will take responsibility for their own health using common sense or they may be left at the wayside. I refer to weight loss before surgery is contemplated, or weight loss before going to more expensive medicines when the personal responsibility that costs nothing has not been tried. The list is very long. Don't wait to get started on these tasks!
- ? Hospitals will be subject to transparent governance by the people through regional planning agencies. Frivolous

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expenditure will end immediately and hospitals will no longer compete with each other but work together for the common good.

Americans, there can be a health-secure America. Write your congressional representatives and encourage them to bring a bill forward enabling a Health Security America Health Plan. Contact them by mail or through their web site. Let's go to work with a **Health Security America Health Plan**—now!

Fred Bannister, M.D
Chetek, WI
January 1, 2006

NOTES

Forematter

1. <http://www.nchc.org/facts/cost.shtml>, viewed 8/14/2005
2. <http://www.nchc.org/about/honorary.shtml>, viewed 1/04/2006

Preface

1. *Overdosed America* by John Abramson, page 46-47
2. Himmelstein and Woodlander, Tabulations CPS. Graph
<http://www.wisconsinhealth.org/stats.html>, viewed 3/31/2005
3. Medicare “D” Underachievers, posted Asbury Press 10/07/2005
<http://www.app.com/apps/pbcs.dll/article?Date=20051007&Category=OPINION&ArtNO=...> , Viewed 10/14/2005
4. *Overdosed America* by John Abramson page 48
5. *Overdosed America* by John Abramson page 48

Introduction

1. Himmelstein and Woodlander, Tabulations CPS. Graph
<http://www.wisconsinhealth.org/stats.html>, viewed 3/31/2005
2. Life expectancy ratings and the cost per citizen are both out of a recent book by John Abramson, M.D., *Overdosed America*, pages 46-47. Abramson is a family practice physician and on the faculty of the Harvard School of Medicine.
3. *Snapshot Health Care Costs 101, 2005, page 4*. California Healthcare Foundation

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4. Article in the *Austin American*, Sunday, Feb. 6th, 2005 discussing personal bankruptcy from research by Dr. David Himmelstein on the Harvard faculty.
5. Quoted from Dr. Steven Weiss on Wisconsin Public Radio "Westside" April 15, 2005.
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Chapter 2

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GLOSSARY

Usual and customary fees are fees that each physician thinks due him for a service. The customary part refers to fees within the same range of what other doctors charge in your area.

Closed physician panel: is panel composed of group of physicians that a clinic or insurance plan might insist that a patient use if he carries the plan. If he sees someone outside of the plan he will have to pay his own bill.

Open physician panel: implies you can see any physician of your choice and have the doctor submit his bill to your health insurance plan and it will be paid. A physician may or may not have to follow a fee schedule of the plan.

Closed staff policy: refers to a hospital that only allows doctors of a certain group or business association practice there.

Current Procedural Terminology (CPT): A manual that describes the documentation codes required for medical procedures.

Health Information Portability Accountability Act (HIPAA): The first comprehensive federal protection for the privacy of personal health information, giving patients greater control of how health information is handled.

Health maintenance organization (HMO): is a managed care plan with a panel of physicians that are usually closed panels. Many times these are formed around a large clinic with all specialties involved.

International Classifications of Diseases (ICD): A manual that describes the documentation codes required for medical diagnoses.

Medicare set fees: are fees that set for a year at a time for each procedure done by a physician. It is the same for all physicians.

Non-compete clause: A clause in an employee contract that prohibits a physician going into practice for him- or herself in competition with the clinic for which he or she is presently working. There is usually a time limit and mile limit from the present employer's clinic.

Open staff policy: Refers to hospital that allows all doctors licensed to practice in the area to practice in that hospital.

Peer review: A process whereby medical professionals all doing similar work look over each other's shoulders, making sure everyone operates under generally understood guidelines.

Point of service plan (POS): A plan in which one uses one's doctor and the hospital where he or she works as a point of departure. The insurance company gives the best coverage for services given by the primary physician at his or her facilities. It is another form of managed care.

Preferred provider plan: A plan that has a specific panel of physicians whose services are fully covered. It is another form of managed care.

Single payer plan: a plan in which one entity makes payments to all health care providers.

Universal health care: A government plan funding care for everyone, while administering it and determining coverage—all funded through taxes. In this plan everything is determined by a large central bureaucracy.

APPENDIX A

HOW WE PRACTICE MEDICINE

Fred Bannister, M.D.

4/15/2003

The purpose of this study is to answer three questions:

- ? What is the effect on a physician's income when using only Medicare fees for all patient billing codes?
- ? What is the difference in a physician's income in an independent practice versus a large clinic practice?
- ? Is administrative cost the primary cause of income variation or is it the fee structure? Answering this question is an ongoing battle within clinics, government and third party payers.

The assumptions made in this study are the following:

- ? Medicare fees are approximately 50 percent of usual and customary fees.
- ? Large clinics collect about 70 percent of all billings based on usual and customary schedule. (Medicare caps, Welfare caps and uncollectible bills bring the 100 percent schedule to approximately a 70 percent reimbursement rate).

The conclusions of this study are twofold. Number one: Large clinic practices are *very wasteful of money in administration*. At the present time, the total cash collected in large clinic practices is approximately 40 percent more than seen in the study done below using only money collected from Medicare. Number two: If everyone was paid Medicare fees for services rendered, the doctor can adapt with an independent practice and do well. Each physician will have to judge this independently, since salaries paid by large groups are not general information.

The following methodology was used in this study:

A family doctor in a large clinic practice (Midelfort Clinic part of the Mayo Health System) gave the author all of the codes he billed for an average one month period. The revenues were then determined using the above assumptions. 2003 Medicare fees were used except when the code was not covered by Medicare. In these cases, the usual and customary fees were used as was the case in preventive medicine in 2003.

The expenses were documented from a community with a population of 2,000. This included studying salary structure, building costs, utilities and other related expenses. An independent practice using the newest of technology was studied. The doctor's net income was then calculated based on the above mentioned revenues and expenses. Taxes were not included in the study. [?]

The Study

Revenues:

Medicare Fees Based on Published 2003 schedule for Wisconsin
Distributed **11/2002** If no Medicare payment for code then Usual
and Customary Charge was used.

[?] This practice model was the one used for 13 years by the author with the addition of the newest computer technology model to make it work even better.

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Present Family Practice Physician in Chetek,
Wisconsin a town of 2000 (Dr Thalacker's practice),

Codes	Number Codes per Av. Month	Fees	Amount Received	Description of Service
99243	12	\$105.00	\$1,260.00	Office Consult
99396	10	\$184.00	\$1,840.00	Established. Preventive Medicine
99397	20	\$204.00	\$4,080.00	Established. Preventive Medicine
99387	1	\$223.00	\$223.00	New Preventive. Medicine
99203	3	\$83.42	\$250.26	Office visit
99213	200	\$45.88	\$9,176.00	Office visit
99214	3	\$71.73	\$215.19	Office visit
99212	10	\$32.63	\$326.30	Office visit
99312	30	\$48.64	\$1,459.20	Nursing Home visit
99223	10	\$138.13	\$1,381.30	Hospital Admit
99232	25	\$49.16	\$1,229.00	Hospital follow
55250	1	\$329.00	\$329.00	Vasectomy
20610	8	\$60.58	\$484.64	Bursa-joint Inject
81001	20	\$24.00	\$480.00	UA
85025	20	\$40.00	\$800.00	CBC
93000	20	\$23.13	\$462.60	ECGs
DOT	6	\$85.00	\$510.00	Transportation PE
Lab draw	120	\$14.00	\$1,680.00	Lab draw
71010	12	\$24.11	\$289.32	Chest x-ray
73120	25	\$24.20	\$605.00	Hand-forearm x-ray
Total Revenue One Month			\$27,080.81	
Total Revenue 11 Months			\$297,888.91	Vacation one month
Total Revenue Two Drs.			\$595,760.00	

Expenses:

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Based on Monthly Amounts Then Annualized

Receptionist \$11 per hr plus 30 percent Dr.Assistant/Med	\$2,288.00
Dr. Assist/Med Lab Tech \$15/hr plus 30 percent	\$3,200.00
Dr. Assistant/Med Lab Tech \$15/hr plus 30 percent	\$3,200.00
Monthly supplies	\$400.00
Malpractice (2 Fam Drs) \$8000/Dr.	\$1,333.32
Person/Employee Leader/Pt assist/vacations \$15/hr plus 30 percent	\$3,200.00
Building amortization 15 years /\$150,000	\$1,348.00
Utilities	\$600.00
Equip amortization 10 years \$15,000 x-ray	\$125.00
Lab \$16,000	\$133.00
Building insurance	\$200.00
Building taxes	\$175.00
Total for two Drs./Mo	\$16,202.32
Total expenses 12 months	\$194,424.00

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Net Profit:

W-2 for Family Doctor Based on Two Physician Office
In Northwest
Wisconsin

Revenue based on 11 months per person	\$595,760.00
Expenses based on 12 months for two Drs.	\$194,424.00
Net profit	\$401,336.00
W-2 per doctor	\$200,668.00

Let's take a look at present large clinic practice where not 50 percent of the usual and customary fees are collected but 70 percent. We will use the above practice model. Only you, the practicing physician will decide if this administrative excess will continue to take your money away. (I say this as only you know what your W-2 is.) As new physicians look at \$160,000 loans on graduation they will have to take charge of their practice. If they won't then people will have to go into medicine who will or there will be few doctors in the future. The continued dropping of family doctor income will get progressively worse as the government deals with our health crisis. There is not much sympathy for physician's compensation in the minds of the public.)

Formula for adapting to the 70-percent Collections rate is:
\$595,760 (revenue for two doctors at 50% of usual and customary) multiplied by 2 = \$1,191,520 then multiply this figure by 70% = \$834,064. This \$834,064 is the gross for two doctors under the present large clinic administration. Taking away the expenses of \$194,424 leaves you with \$639,640 net profit for two doctors.

The W-2 for each doctor will be **\$313,820** (\$639,640 divided by 2) per year. Doctor! What is your W-2?

ABOUT THE AUTHOR

Dr. Bannister is a medical doctor recently retired for a second time. His last active service was caring for the elderly in a house call practice. He began the independent practice in June of 1999 and worked at it for 3½ years.

In 2001 Dr. Bannister published *Med-Ops*—a dissertation on health care reform.¹

In 2003 Dr. Bannister published *How We Practice Medicine*.²

He started solo family practice in Chetek, Wisconsin on July 17, 1965. (It was also Medicare's inaugural year.) He continued his family practice there until April 30, 1997, when he retired for the first time.

During the first thirteen years of his practice, Bannister helped lead an enlarging group of physicians as president and as a member of the board of directors that in 1978 numbered nine physicians and thirteen employees, covering three communities.

In the late 1970s, it appeared that larger practices were the future in medicine, so he led his group into a merger with the Midelfort Clinic in nearby Eau Claire, Wisconsin. Midelfort Clinic had grown to over 100 physicians by the year 2000. Bannister served for eight years on its board of directors, resigning in 1988. He was treasurer for six of those years. During his tenure on the board of directors, the Midelfort Clinic HMO was formed, and Bannister became well versed in its operation. Midelfort Clinic HMO has since metamorphosed into the Valley Health Plan of Eau Claire, Wisconsin.

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In 1992, his group merged with the Mayo Clinic of Rochester, Minnesota, and today it remains part of the Mayo Health System.

In 1997, conflicts with the HMO, large clinic managed care and its interference with the practice of medicine prompted Bannister to retire after 33 years in the same location.

PROFESSIONAL ATTAINMENTS

1979: appointed to faculty rank of Assistant Clinical Professor in the Department of Family Practice, The Medical College of Wisconsin.

1970s through 2003: served as president and in other offices of his local medical society, the Tri-County Medical Society.

1975: received medical license in Montana

1972: first certification as Diplomat of the American Board of Family Practice.

1965: completed internship at the Los Angeles County Hospital, Los Angeles, California.

1965: received his medical license in California.

1965: received his medical license in Wisconsin.

1964: graduated from the University of Wisconsin Medical School, Madison, Wisconsin.

1961: graduated with Bachelor of Science Degree from the University of Wisconsin, Madison, Wisconsin

“I pretty much knew that when the company [a company with a 34.1% increase in its health insurance premium in one year] had to cancel its health insurance, we’d be out of luck. My husband is an over the road truck driver, and the company he works for has very limited benefits. Now, we basically don’t have health insurance.”

“There really needs to be a way everyone can buy health insurance at a reasonable price. If the people in the government had to live by the same rules as we do, there would be some big changes fast.”

Karen Madsen
Production Manager
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