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EDITORIAL

Is a Seismic Shift Coming in Health Reform?

A shift may be occurring as politicians and health policy experts consider moving away from a single-payer system similar to those in the United Kingdom, Canada, and France to a universal coverage system such as in the Netherlands and Switzerland. A universal coverage system in the United States would include government subsidies and consumer-driven features that allow patients and private insurers to pay for care at hospitals and from physicians.

Democratic and Republican politicians, including some of the candidates for president, believe a single-payer system is unpopular. It is often labeled as socialized medicine. But these same politicians recognize that most Americans want universal coverage.

One clue to this possible shift took place earlier this month when federal Health and Human Services Secretary Michael O. Leavitt met with health officials in the Netherlands and Switzerland. Health policy experts had urged Leavitt to visit these countries to see if the health systems there might serve as models for reforming the U.S. health system, Leavitt said.

In the Netherlands and Switzerland, all citizens must buy health insurance or pay a penalty. Employers are exempt from government mandates, and private insurers, hospitals, and physicians pay for or provide care. These provisions may be acceptable compromises for Democratic and Republican presidential candidates. The Netherlands model may work best for the United States because it represents a shift away from an employer-based system to an individually focused system that also subsidizes care for the poor and those who are chronically and critically ill. This approach also does not conflict with the Bush Administration's proposal to let individuals buy insurance with tax-free dollars.

Two proposals by Democrats borrow heavily from the Dutch and Swiss systems. So does Mitt Romney's Massachusetts plan; Arnold Schwarzenegger's California plan; and the Healthy Americans Act of 2007 (S.334), a bipartisan proposal from Sen. Ron Wyden, D-Oregon, and Sen. Robert Bennett, R-Utah.

The act would require Americans to buy a basic health insurance policy for themselves and would reduce health care costs by putting individuals into large private insurance pools, and create incentives for more preventive care. In the Netherlands, all citizens must buy insurance on the private market, and health insurers are free to charge any price. Citizens can get insurance through an employer, but the employer does not have to offer it. Those who have chronic illnesses would get a government subsidized "risk-adjusted equalization payment."

No matter what transpires, physicians will be central fixtures in making reform work. We welcome your comments by phone, e-mail, or fax about which type of reform system is most workable.

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Practices May Need to Realign

Health care markets across the country are experiencing a rising demand for cardiovascular services while the pool of cardiologists is shrinking. This environment creates a heavy burden for practicing cardiologists who manage the pressure of high patient demand daily.

"Cardiologists have to pursue strategies that will help them alleviate the pressure of growing patient demand over the long term," says John Goodman, president and CEO of John Goodman & Associates, Inc., a cardiovascular program consulting firm in Las Vegas, Nev. Goodman is the co-author of *Cardiovascular Megatrends: The 21st Century* (John Goodman & Associates, Inc., 2001). "As our population is aging and more cardiovascular disease is emerging, the challenge for cardiologists is to leverage their time such that they can care for large numbers of needy patients in a timely fashion."

An Unmet Demand

The problem of unmet cardiology demand will continue to grow over the next two decades. "Unmet demand for cardiology services is evidenced in long wait times for appointments and a higher acuity of patients by the time they are actually treated," Goodman says. "Although the overall mortality rate from cardiovascular death has improved to some degree, as the population grows and ages over the next 15 years there is a real chance that unmet cardiology demand will constitute a major crisis."

Today, cardiac care is a $500 billion industry. "That revenue is divided among hospitals, physicians, technology firms, insurance companies and intermediaries, pharmaceutical companies, and others," Goodman explains. "Cardiologists have to proactively manage their own role in this industry in order to best serve their patients while ensuring their financial success. They cannot let the growing demand for cardiology services lie fallow. If they do, unnecessary patient deaths will occur, and the competition will eventually take over the best portion of the market."

To meet the rising patient demand, cardiologists in small- to medium-sized group practices should consider making a strategic shift in how they deliver care by aligning with other partners, such as another group or groups of cardiologists, or with a hospital, Goodman advises. "Cardiologists have to consider the optimal strategic alignment that will help them acquire the personnel and technology resources they need to maximize the number of patients they can serve," he says.

Two Main Strategies

One such strategic change might involve merging with other practices to form large groups that can provide cardiology and cardiology-related services. "This strategy allows cardiologists to take advantage of economies of scale," Goodman comments. "By pooling capital resources and patient volumes, cardiologists can purchase new technologies and justify the addition of physician extenders to the practice, thereby maximizing the number of patients they can treat. They also can share coverage, meaning that their personal time would not be overly drained by the pressures of high patient demand."

An alternative involves aligning with hospitals. "In many markets, hospitals and cardiologists are working more closely together," Goodman notes. "In fact, in many instances, hospitals are starting to employ cardiologists, who then have access to technologies and support staff that enable them to meet market demand more easily."

By aligning with other medical groups or hospitals, cardiologists can acquire all the latest technology, effectively screen patients in a timely manner, and then quickly determine the best and most effective treatment option for each patient, Goodman explains.

Furthermore, such an alignment enables cardiologists to take a more comprehensive approach to care, one that not only optimizes and coordinates care for the patient but also enables cardiologists to leverage market opportunities. "For example, one of the biggest markets for cardiologists and vascular specialists today in the United States is the female market," Goodman offers. "Cardiologists are now starting to consider developing the type of centers that will meet the needs of female cardiology patients. We are now kicking off new heart and vascular centers for women

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"As our population is aging and more cardiovascular disease is emerging, the challenge for cardiologists is to leverage their time such that they can care for large numbers of needy patients in a timely fashion," says consultant John Goodman.

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that will also include endocrinology, obstetrics-gynecology, and plastic surgery services. These centers will serve as efficient, one-stop shops for a patient population that up until now has been largely ignored."

Under certain circumstances, cardiologists, endovascular surgeons, and interventional radiologists may align to provide comprehensive care covering the total circulatory system, Goodman adds.

The current health care environment is driving physicians in many specialties to consider such strategic alignments. "At one time, many physicians and hospitals tried to integrate, but ultimately most hospitals divested themselves of the physician groups they acquired," notes Goodman. "But both physicians and hospitals have learned from those experiences, and are now much more likely to structure relationships successfully."

Take Steps Toward Realignment

Before choosing a new practice strategy, a cardiologist first should define his or her priorities. Decide if it's more desirable to work in a small practice or a large one. Evaluate the advantages and disadvantages of working for a hospital. Next, a cardiologist should discuss his or her goals with an accountant, a lawyer, and a consulting firm before broaching the subject of strategic alignment with any outside party, says consultant John Goodman, president and CEO of John Goodman & Associates, Inc., in Las Vegas, Nev.

"Hospitals have a team of lawyers and accountants and consultants," Goodman points out. "This gives them a real advantage when negotiating with physicians, unless the physicians also have advocates who can level the playing field. If hospitals have the advantage, they can negotiate an arrangement that is less than optimal from the perspective of the physicians. So, my advice to cardiologists is to align your own team first. Obtaining good counsel can help cardiologists determine the optimal strategy from a clinical and financial standpoint."

Once they have the advice in hand, cardiologists can approach a strategic partner to present a compelling case for the practice. "For example, cardiologists can walk into a meeting with hospital executives and say, 'We perform 2,500 cardiac catheterizations, 750 angioplasties, and 300 open heart surgeries a year. We want to grow this business but we want your help. Here are four options for how we can achieve this business growth. Our team is prepared to discuss this with you, but if you are not interested we will approach another hospital.'"

—DJN

Benefits for Physicians

In addition, in the current environment, the benefits of integration are more likely to outweigh the downsides. "With our annual national health care budget over $2 trillion, Congress is looking to cut payments to physicians, particularly cardiologists, because cardiology has been a high-cost specialty and one-third of the population has some level of cardiovascular disease," Goodman counsels. "Integration with a hospital can help cardiologists mitigate the effects of reimbursement declines."

Hospital employment can help cardiologists avoid the restrictions that government regulations are placing on them, he says. "Many of the restrictions placed by Stark regulations, Medicare fraud and abuse regulations, and others are not necessarily applicable to employed physicians," Goodman comments, adding that the number of restrictions on cardiologists and other physicians is rising.

"While Stark III legislation was recently passed, Stark II.5 fee reductions have been deferred to a later date for implementation, and may eventually substantially reduce revenue earned from physician ancillary services," Goodman says. "But if cardiologists are working for a hospital, remuneration can be designed legally in such a way so that they do not have to take a significant income loss."

Regardless of ancillary revenue limitations, cardiologists will still pursue ancillary service development as a way to provide efficient and high-quality patient care, even if the return on investment is delayed. "Cardiologists are expanding ancillary services with the full knowledge that there will be reimbursement cutbacks at some point," Goodman says. "The new 64-slice CT scanners, new MRIs, and other new technologies cannot be overlooked as patients must have access to that care."

The fact that cardiologists need to invest in ancillary services to remain competitive is yet another force driving them toward alignment. "New technologies are quite expensive," Goodman acknowledges. "Most cardiologists cannot afford to offer these services unless they are aligned with a large single-specialty group or with a hospital, giving them greater access to capital for investment and greater patient volumes to maximize technology use."

Easier recruiting from the smaller pool of cardiology physicians is another benefit of larger practices. "A larger group simply has more to offer: a stronger organizational structure, better on-call schedules, guaranteed income, established referral relationships, a greater range of sub-specialization possibilities, and the ability to participate in research studies, which is profes-

sionally and intellectually appealing," Goodman says.

While these factors clearly appeal to new physicians, older physicians are recognizing the benefits of larger practice settings, which previously may have been unappealing. "The average age of the practicing cardiologist in the United States is 53 years, the oldest it has ever been," Goodman explains. "Most older cardiologists do not want to stop practicing completely, but without flexible practice options, they simply retire, a huge loss to society.

"In contrast, if cardiologists are part of a merged practice, they can slow down, limiting their professional obligations while still being an asset to the group," he continues. "For example, they can choose to evaluate outpatients four days a week. They can still earn some level of income, stay current in medicine, serve patients, and maintain pride in their status as practicing cardiologists. Furthermore, given the cardiologist shortage, other cardiologists as well as hospitals are more willing to accommodate a doctor's lifestyle choices, particularly an experienced cardiologist."

Taking A Longer View

Given the time pressures cardiologists face, it can be hard for them to step back and take a longer view of the future. "Cardiologists often find it hard to consider major changes in practice patterns because they are so steeped in the pressures of today," Goodman acknowledges. "They must set aside time to consider their future, or else opportunities to enhance practice success will be completely overlooked."

Strategic alignment options under consideration should be assessed for their flexibility and how they will affect the cardiologist's quality of life, ability to treat more patients, personal income, and potential retirement plans.

"Given shrinking reimbursements, increasing overhead, and growing patient demand, the pressures of the current health care environment can seem overwhelming," says Goodman. "Cardiologists must proactively consider the best approach for expanding their practices to meet patient demand. Those cardiologists who are flexible and can consider new opportunities for medical practice are the most likely to have a successful, profitable, and personally satisfying career."

—Reported and written by Deborah J. Neveleff, in North Potomac, Md. More information on physician practice strategies is available on our Web site (see page 16).

Consultant Says Preserve the Human Touch

Practicing as part of a larger organization should not mean the loss of the human touch, says consultant John Goodman, president and CEO of John Goodman & Associates, Inc., in Las Vegas, Nev. Maintaining personal relationships with patients is absolutely essential in today's environment, when technology has replaced personal relationships in many areas of medicine.

"Patients don't want their cardiologists to function in an impersonal mode," Goodman asserts. "Personal service is critical; cardiologists should be efficient, but in a caring way.

"In cardiology, it is very easy to slip into a pattern of dealing only with physiological issues," he explains. "But if cardiologists lose track of the whole person, they will eventually lose patients." Of course, balancing a personal touch with the time pressures of medical practice is difficult, and a cardiologist's success at striking this balance will depend heavily on one's personality. "This is an art, one that all cardiologists should try to develop," he says. "Even cardiologists who are overwhelmingly busy still need to take a few minutes to build personal relationships with patients."

While the right technology and the right support staff can enhance cardiologists' efficiency, physicians cannot use these resources to replace their own effective interaction with patients. Employing physician extenders, for example, enables cardiologists to focus their time on the high-level clinical problems for which they have been trained.

"But the secret is to utilize the extenders properly," Goodman cautions. "If the cardiologist uses the extender to see all the non-complex patients, these patients may look for another cardiology practice. Why? In primary care settings, patients may be satisfied with extender care. But in cardiology care, patients want to see a specialist, not an extender. The better strategy is to use the extender to gather initial information and then pass the patient to the cardiologist.

"The cardiologist can quickly review the history, verify the information with the patient, and then determine the next step in the diagnostic process," Goodman continues. "At this point, the extender can re-enter the process to facilitate these next steps. In this way, the cardiologist's time with the patient can be reduced by 70% to 80%. But, while the cardiologist is with the patient, he or she should take a few minutes to chat with the patient and build a relationship so that the patient, justifiably, feels as if the physician has personal interest."

—DJN

The Benefits of a Captive Insurer

By David B. Mandell, JD, MBA, and Claudio A. DeVellis, JD, CPA

Physicians are often interested in captive insurance companies (CICs) because they provide a way to protect one's assets if they are established and maintained properly. Many advisers believe there is no better way for successful physician practice owners to create such a flexible and efficient planning tool as a captive insurer.

Successful physicians typically face significant financial risks. As a result, they often are interested in asset protection and in building tax-favored wealth over the long-term. Of course, many want to find practice buy-out and estate planning opportunities as well. All of these factors make a CIC an attractive and important financial-planning and risk-management tool. What's more, the interest level in a CIC is likely to be even more pronounced among high-liability and high-income specialists such as allergists, oncologists, pulmonologists, rheumatologists, and others.

The disadvantage is that establishing and running a captive insurer is costly. But if it is managed well, the returns a CIC provides will more than offset the costs.

A CIC is a fully licensed insurance company domiciled either in one of the states that has special legislation for small captive companies or in an offshore jurisdiction that has similar legislation enabling such captives.

Whenever a CIC is established offshore, it is critical that the CIC complies with all U.S. tax rules and must be handled by captive managers, tax attorneys, or CPAs experienced in these matters.

Physicians can use the CIC to supplement existing insurance policies. Such excess protection gives the physicians the security of knowing that the practice and its owners will not be wiped out by a lawsuit award in excess of traditional coverage limits.

Managing Risk

For any CIC, the general rules are simple. It must be established with a real insurance purpose, it must serve as a facility for transferring risk and protecting assets, and the transaction must make economic sense. Beyond these general rules, there is much flexibility in how the insurer can benefit its owner.

First, the physicians can use the CIC to supplement existing insurance policies. Such excess protection gives the physicians the security of knowing that the practice and its owners will not be wiped out by a lawsuit award in excess of traditional coverage limits. Medical professionals are concerned about all types of lawsuits, including medical malpractice, employment liability, and other practice risks. For these risks, a CIC provides significant protection. Further, the CIC may allow the physician-owners to reduce existing insurance because the CIC policy can provide additional coverage, if needed.

Also, using one's own CIC affords the physicians some flexibility in using customized policies that are not easy to get from large third party insurers. For example, many physicians would like a liability policy that would pay legal fees and allow a wide choice of attorneys, but would not be available to pay creditors or claimants, which are sometimes called Shallow Pockets policies. This strategy prevents the client from appearing as a deep pocket, meaning a prime lawsuit target. Avoiding this appearance is a necessary asset protection strategy today.

In addition, the CIC has the flexibility to add coverage for liabilities excluded by traditional general liability policies, such as wrongful termination, harassment, or even violations of the Americans with Disabilities Act of 1990. Given that the awards in these areas can be over $1 million per case, physicians should recognize that a CIC would offer significant benefits in just such a case.

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Case Study

Here's an example of how Justin Smith, MD, and Harry Jones, MD, used a CIC to their advantages. Each physician owns a successful practice and surgery center. Smith believes he is paying too much for his group's medical malpractice and commercial liability insurance policies. After meeting an attorney and actuary who specialize in CICs, Smith formed a CIC to issue policies that cover the least significant (under $100,000 per occurrence) but most common medical malpractice and commercial liability claims. Doing so significantly reduced his existing insurance premiums because he then had much higher deductibles for his third party insurance policies.

Smith believed he could reduce the amount of premiums he was paying to commercial insurers, implement successful risk management programs, reduce the claims of the surgery center, and reduce his overall payments too. Ultimately, he hoped that the CIC would help him increase the surgery center's profitability. While a significant portion of the $1.5 million in total premium payments was paid out to cover claims, after five years of operations, there was still over $1 million in his CIC reserves. Smith also had a trust for his family owned by the CIC, so that he could build wealth created by the CIC outside of his taxable estate.

Jones had a different approach. He established a CIC to insure lesser risks that were not covered under commercial insurance. These risks included Medicare fraud defense, litigation expenses under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and a malpractice defense policy (which is available only to pay for the practice's legal fees, but not to pay claimants). After five years, Jones' CIC had not paid any claims. As a result, the premiums were still being used to grow the CIC's reserves and could be used to pay future claims.

Jones also was considering bringing on younger partners into his practice and planned to use the CIC as part of an exit strategy for his practice. Under this strategy, each new partner would be responsible for paying some of Jones' buyout from both the practice and from the CIC.

For Smith and Jones, the CICs offered different solutions to problems that would be difficult to solve otherwise. In addition, CICs are a better alternative than what many physicians do, which is set aside funds in separate accounts for unforeseen risks. In a litigious society, many physicians have been self-insuring against potential losses by saving money in a separate bank or other account and using it to pay any expenses that arise such as an unusual liability. Such accounts are also known as the proverbial rainy day funds. While a rainy day fund may be a wise move, a physician would be better off using a CIC to insure against some risks because once the CIC premiums are paid, the funds enjoy the highest levels of asset protection and can be structured to grow outside of one's taxable estate. They also can be structured as part of a practice exit strategy and have some income tax advantages as well. Rainy day funds do not offer all of these benefits.

Pitfalls to Avoid

For any CIC to achieve all of the risk management, asset protection, and estate, practice, and tax benefits that are possible, it must be structured and maintained properly. As a result, it is critical to use professionals (particularly attorneys and insurance managers) who have expertise establishing CICs. While using such experts and having a valid CIC structure may be more expensive than using some of the cheaper alternatives touted on the Internet, it is critically important to be 100% compliant with CIC rules and regulations to ensure that the physicians get all the potential benefits.

Thus, as might be expected, the professionals most experienced in these matters charge significant fees for both forming and maintaining a CIC. Establishing a CIC typically totals about $100,000, and maintaining a CIC costs about $50,000 per year. These fees are significant, but often are fully tax-deductible. Keep in mind that the CIC's potential risk management, tax, practice, estate planning, and asset protection benefits often make it an attractive option for physicians.

—More information on physician practice strategies is available on our Web site (see page 16).

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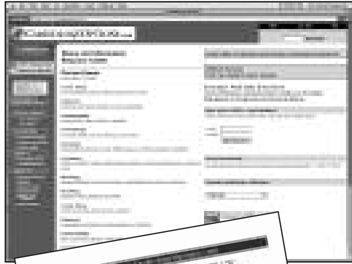

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