SJR-15 SUBCOMMITTEE meeting. Jan. 24, 2008 Paul J. Byorth M.D.
Room 137 State Capitol
Re; SJR-15 (SB-417), SB-312

Presiding:
Sen. Dan Weinberg, Senate public Health comm..
Rep. Dan Dutton, House Business and Labor comm..

1) Issues regarding the label "economic credentialing".

I think that the "Orwellian" term should be changed as it is intrinsically deceptive. The label does not address any form of credential although implies at a glance that it does. Ultimately this bill is about prevention of restriction of trade, exclusion of physicians from malpractice insurance, protectionism, economic discrimination and further propagation of the current broken system.

2) The current definition is ambiguous.

"Economic credentialing" means the denial of a physician's application for staff membership or clinical privileges to practice medicine in a hospital on criteria other than the individuals training, current competence, experience, ability, personal character, and judgment (i.e. anything other than real credentials). I would like to see the definition of "other than". The effective current definition is that a hospital would like to be able to deny privileges based on any perception of financial competition.

3) The root of this issue is control over health care dollars.

*Hospitals are asking the legislature to be allowed to compete with doctors in every way (employed doctors, ancillary services etc.), but do not want doctors to be able to compete with them. Economic credentialing has only one driving force and it is to remove competition*. We are arguing about tangential issues. The primary problem is how to pay for health care. The current social premise is that all people should receive health care, regardless of their ability to pay. The problem created by this premise is that we have an extraordinary ability to treat medical problems which has a dollar cost associated with it. There are definable benefits to that health care delivered. BUT, there is no one willing to define (due to concern about litigation?) what is cost effective, or what we as a city, county, state, or country are willing to PAY for these services.

4) Health care has been taken for granted by our communities.

Historically health care has been provided to members of our communities by physicians and hospitals whenever (day or night, 365 days/year, 24 hours/day) a need was present. The current perception (due to EMTALA) is that health care is a RIGHT! Now there is a demand for care, not necessarily emergent, 24 hours/7 days a week. Hospitals and physicians have continued to try and meet this unreasonable expectation at their own expense. Hospitals have met this expectation at a great expense. Staff must be present, or

on call 24 hours a day to meet the need but there is no guarantee of any compensation for these services to pay staff. Physicians must cover “emergency rooms” without any compensation for being on call, and infrequently are compensated for services rendered. Hospitals and physicians have carried the burden of providing and financing health care for our communities. Hospitals have argued that if specialty hospitals are allowed to exist that there would be an exodus of physicians away from hospitals and that they would not have anyone to cover emergency call. How could you blame physicians for moving their practices to a facility that valued their services? Specialty hospitals would provide the services available by their practitioners, without a loss of services to the community. Physicians have dedicated their lives to caring for patients and will continue to care for patients because of their compassion and not because they are compelled to by hospital administration.

5) Cost shifting has become an expected way of life for hospitals.

The only way for an institution to stay open is to charge a premium fee for all services to all PAYING “customers”. The current consumption of healthcare in our nation costs us approx. $7,000.00 for every man, woman and child. The median income in Montana 2004-2006 was one of the lowest in the nation at $37,821.00. In cost shifting they have been responsible for making healthcare unaffordable to the average Montanan. Hospitals have been expected to provide services to all patients regardless of their ability to pay, or their insurance company’s willingness to pay a reasonable fee for services. Medicare, Medicaid, Chip, and many commercial insurers pay only a fraction of the cost to provide the services. This system has created a DE FACTO TAX on all of those not covered or protected by a government entitlement program. Someone has to pay the bill! If the legislature is to presume that hospitals should be entitled to this “tax” revenue then maybe they should oversee the expenditure of this revenue to ensure its’ appropriate use.

6) Doing business with people who pay their bills is GOOD business.

Physician entities including imaging centers, laboratories, surgicenters, and specialty hospitals have been accused of “Cherry-picking”. The current cry of the hospital lobby is that without the legislative protection of this ENTITLEMENT that they would no longer be able to cost shift and be able to continue to provide services. Previous lobbying by hospitals has guaranteed that many procedures can only be done in hospitals and not outpatient settings. Outpatient fees are almost universally dramatically less than hospital fees for the same services. All physician ancillary services serve the same population as hospitals, have the same payer mix, and will continue to care for OUR patients. Why would you not “shop around” for the best, and least expensive place to have your services provided (thus avoiding the cost shifting premium)?

7) What about physicians?

Physicians have spent many years preparing for practice, and many have substantial debt (avg. $100,000.00 student loan burden) upon arriving in a community to practice medicine. The vast majority of physicians routinely work 50-80 hours per week NOT

including time spent on call. So called staff privileges require that "police call" be covered by each specialty so that all services are available 24/7-365 days per year. This call schedule means that physicians may have anywhere from 40 to 120 call days per year (in some small communities call may even be more frequent). That equates to 960 to 2,880 hours of uncompensated work hours per physician per year! This has been charity almost to an excess. Communities that provide services that are required to be available 24/7 days per week must PAY firemen, police, and other workers. Physicians have no means of cost shifting other than working more hours, becoming more efficient, or having an additional source of income. The primary driving force for physicians to establish ancillary services has been a need for efficiency. Better technology, convenience, efficiency, and improvements in cost have been the result of these physician led entities.

8) What is a conflict of interest?

Federal Stark legislation has been pushed by the hospital lobby. The premise being that physicians cannot be trusted to own or have a financial interest in "a designated health service" to which they may refer a patient for auxiliary services. In name, this is to PREVENT the over-utilization of services which MAY increase cost, and the creation of a captive referral source which limits competition by other providers. Hospitals are asking for further legislation to allow them to expressedly do that which they believe physicians are doing. Physicians have always been held to a higher standard regardless of the issue, and I sincerely doubt that if one cannot trust physicians that one could trust a businessman/ hospital administrator. Employed physicians are much more likely COMPELLED to refer to their employers services. What would lead you to believe that a hospital with employed physicians has not created a captive referral system, and without competition would decrease cost and utilization? All that physicians are asking is to play on a level playing field. ***Once again, the hospitals are asking to be able to compete with everything doctors provide (even being doctors), while they are asking the legislature to not allow us to compete with them.***

9) Let's talk about community benefit.

Physicians and physician owned ancillary services have provided medical services to the community that is convenient, cost effective and SUPERIOR to many hospital services. These auxiliary services provide charity care, care to Medicare/Medicaid recipients, and create efficiency where hospitals have not been successful or willing. In addition to that, as opposed to "non-profit" organizations, these private entities pay personal property taxes, property taxes, and ALL profit is taxed. Recent news articles have presented for debate the Attorney Generals' evaluation of the "benefit to the community" of the "non-profit" hospitals. Our surgicenter has performed as well or better than these entities in addition to paying tax. Our Surgicenter performed 7553 cases in2007, 25% were Medicare/Medicaid, charity care totaled 4% of our net revenue, uncompensated care/bad debt was 6% of our net revenue, and $100,840.00 was paid in taxes. Overall 11.5% of our total profits directly benefited our community. All profits distributed to physicians were then taxed. This clearly refutes any argument to the contrary. Physicians CHOOSE to

provide charity care and have not had to be compelled as is apparent with many “non-profit” entities.

In summary;
SB-312 would simply prevent hospitals from eliminating physicians from their communities, holding them subject to administrative whim, and eliminating efficient competitors.

SB-417 is nothing other than an attempt by the hospitals/ hospital lobby to institutionalize their inefficiencies, poor fiscal record, and maintain the broken status quo. This bill as written effectively enforces the current method of cost shifting as a legislative mandate/ second tax on all people who pay for healthcare services. This is not the answer to our healthcare crisis; it only propagates a social problem.