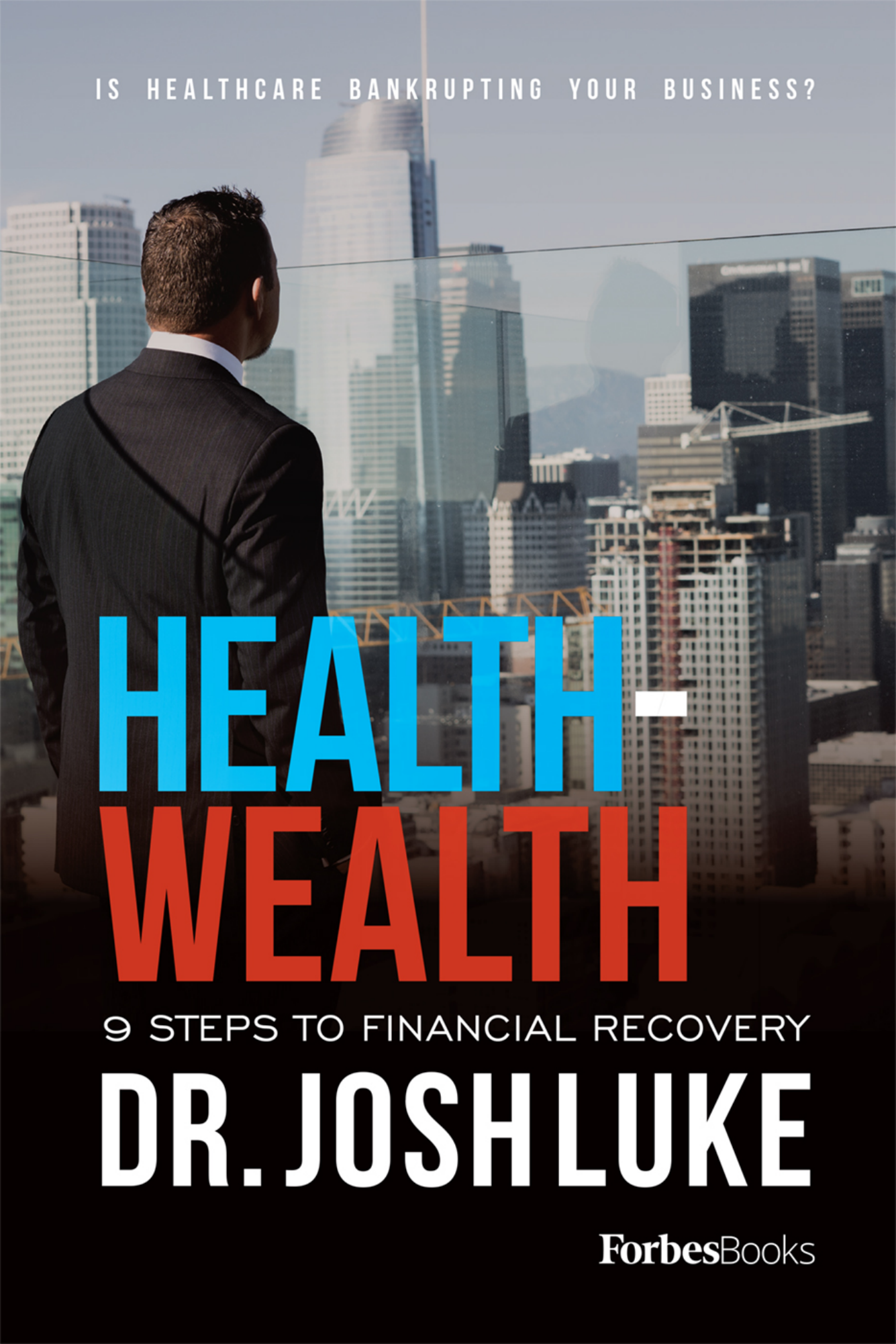
IS HEALTHCARE BANKRUPTING YOUR BUSINESS?
HEALTH-WEALTH
9 STEPS TO FINANCIAL RECOVERY
DR. JOSH LUKE
ForbesBooks

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TABLE OF CONTENTS

PART III —NINE STEPS TO CORPORATE HEALTH-WEALTH

PART I

HEALTHCARE IN AMERICA: CAPITALISM GONE WRONG

CHAPTER 1

THE AFFORDABILITY CRISIS

EAGER TO ATTACK the day on a Monday morning just three days before Thanksgiving 2004, I showed up for work a few minutes early to see if the hospital was entering the holiday week ahead of budget for the month. Six months earlier, just a few weeks after my thirty-second birthday in May 2004, I started in the role of Chief Executive Officer for Anaheim General Hospital.

My executive assistant, Cinthia, greeted me as usual, with a morning hello, and then inquired about my weekend. I loved holiday weeks as, although I was a workhorse always focused on measurable deliverables, I appreciated the slower pace of e-mails and calls during holiday weeks. They always provided some downtime. As I got settled into my cushy, leather executive chair, Cinthia walked in with an oversized manila envelope from corporate and handed it to me. As she turned and walked out, I stared in disbelief at the short but pointed handwritten note in the envelope.

It was a blank spreadsheet with a Post-It note on top. The Post-It simply said, "Great job increasing the total daily patient census. The boss wants to trim staff now. Fill out this list with forty names and their salary and return it by Friday. Thanks."

Silence. Disbelief. A pit in my stomach. Embarrassment. Despair. So many other emotions. How was this possible? We were growing in volume, and now we had to cut staff? And *forty* staff? Who would care for the patients?

At 8:31 a.m., the phone rang. It was my boss Mike, who reported to the corporate president. The conversation was short: "You're doing great, the hospital is way ahead of the projected turnaround plan, but the boss is testing you on this one. He is very happy with your performance to date. Keep it going. Get me that list by Friday."

Ten years in college, three degrees and a lot of hard work had led to what looked to be the opportunity of a lifetime. With three pre-elementary kids and a new mortgage, I was thrilled to be living in my hometown, pulling a six-digit salary with huge bonus potential, and on my way to a long career in hospital management. I had established a reputation in the healthcare space as a financial turnaround artist, having recently financially revived two nursing homes in a matter of months—not years, as was the norm—and six months earlier, I had been handed the microphone for the main stage: CEO.

On my way to a long career in hospital management, I had established a reputation in the healthcare space as a financial turnaround artist, having recently financially revived two nursing homes in a matter of months—not years, as was the norm.

But to date, I had done it my way: turning around facilities through communication, transparency, fiscal responsibility, and treating employees and patients with respect and appreciation. This is why you get into healthcare—to improve individuals' overall health. Until then, during my brief career in healthcare, I had never been put in a position where a financial decision forced upon me could potentially compromise patient care.

To date, I had done it my way: turning around facilities through communication, transparency, fiscal responsibility, and treating employees and patients with respect and appreciation. This is why you get into healthcare—to improve individuals' overall health.

I had pursued a career in healthcare with a personal goal of making a difference in the lives of seniors. These layoffs were far from what I had imagined. Some tough decisions lay ahead, and yes, just before the holiday season. As my dad said once I got my first CEO gig, "This is why you get paid the big bucks."

The cost of operating a business in America will continue to increase. There is no doubt. Inflation, unions, cost of living, interest rate fluctuations, real estate costs, and healthcare coverage—it's your job to manage these expenses. Your company is counting on you.

In most companies, the most significant year-over-year expense increase in recent years has been the cost of providing health coverage to employees. The annual increases insurers require of American companies, whether mom-and-pop or Fortune 500, have been staggering for several years.

In fact, hundreds of companies have gone out of business in recent years simply because they did not foresee how healthcare was bankrupting their company. The writing was on the wall and had been for years, but they ignored it—*The Big Short*, healthcare version. *The Big Short* was a 2015 film that documented how, from 2005–2007 almost every industry and every individual in America chose to keep their head in the sand and ignore the inevitable, as subprime lending statistics demonstrated that a nationally devastating crash of the entire financial and real estate sectors was not only probable but inevitable. In 2007–2008, the United States experienced this crisis, which proved financially catastrophic to many businesses and bankrupted many families.

In most companies, the most significant year-over-year expense increase in recent years has been the cost of providing health coverage to employees.

If only life had a rewind button. The next economic crisis and bankruptcy scare could be yours. You personally could be faced with that critical moment, where you are forced to decide between massive staff layoffs, filing for bankruptcy, going out of business, or laying off longtime, dedicated employees to cut costs. Are you prepared?

So let me be the first to ask you, as the keeper of your business: What are you going to do about it? The future success of your company is on your shoulders. Ever-increasing healthcare costs will bankrupt you if you allow it. Time is running out.

Your business's affordability crisis is America's affordability crisis. It's an American financial epidemic. It's no fault of yours that your company has inexplicably paid huge increases in recent years for health coverage, all while the insurer reduced the benefits afforded to you.

Well, there is one thing you can do. It's time for you to declare that your company has reached its "Health-Wealth tipping point."

In the hospital business, we have what we call "core staffing." This term simply refers to the bare minimum staff hospitals are legally required to have on hand at all times to care for patients. Hospitals go out of business when revenues no longer exceed the costs of core staffing on a consistent basis. That's capitalism 101.

So, what is your industry's "core staffing"? What's the phrase or term you use to describe that bare minimum of resources required to operate your company? At what point do your revenues no longer exceed your stripped-down, bare-minimum, can't-operate-without-these-items-in-place costs?

A critical next step as you begin your Health-Wealth journey is to identify your company's Health-Wealth opportunity. Once you identify your company's total, all-inclusive spending on healthcare in the prior fiscal year, there are three steps to identifying your Health-Wealth opportunity.

A. Project an increase of 6 percent a year for three years to identify your total spending amount on healthcare three years from now (X).

B. Subtract 20 percent from last year's annual spend to identify potential spending reduction (Y).

C. Health-Wealth opportunity = X – Y

or

Health-Wealth opportunity = (year 3 total) – (potential spending reduction from prior year)

Looking back now, I was clearly blindsided by this directive from my new boss shortly after becoming a CEO. As a young executive, I was confident and felt that my diverse career experiences to date had prepared for whatever would be thrown at me. Although I had rapid success in healthcare management in just a few short years, I fell into this career by accident. I'm just another Gen Xer from So Cal who grew up watching Bon Jovi and Michael Jackson on MTV, dreaming of hitting long balls for the Dodgers or dropping three pointers for the Showtime-era Lakers. Healthcare was the furthest thing from my mind as I went to college and then grad school.

So when I found myself sitting on a private jet in October 1998, flying to New York with the most famous baseball player in the world at the time, needless to say, I was content. Renowned baseball slugger Mark McGwire had just broken Major League Baseball's single-season home run record of sixty-one home runs in September 1998, and the global public relations firm I was working for was retained to handle his personal marketing efforts. I escorted Mark to interviews with *Time* magazine, who was considering him as a "Man of the Year" candidate, the Today Show, the Late Show with David Letterman, and the once-popular Rosie O'Donnell Show.

But then something unexpected happened. It was on the private jet back from New York that I found myself sharing with my wife for the first time that I was feeling unfulfilled in my career. After working with professional athletes in golf, basketball, baseball, football, and hockey for several years, I was losing my love for sports by working so closely with athletes, and I was now focused on raising a family.

My wife and I were living outside of California at the time, and my frequent calls home to Southern California to check on my aging grandmother's well-being often led to frustration. I was perplexed by how her caretakers at the hospital and in the nursing home had so little communication when she transferred from one facility to the other. I was even more shocked to find that when my grandma was transferred home from one of these facilities, the home-based caretakers seemed to have little instructional communication from the hospital or nursing home. This entire process made very little sense to me. I was beyond baffled; I was angry.

Anyone would be angry, right?

I made a career change and began learning the trade of healthcare administrator in a nursing home—a change that was inspired by my ailing grandmother. Just a few months after marketing NBA players and managing marketing efforts for a PGA Tour event, my focus had turned to caring for compromised seniors who lived within the walls of a nursing home.

It was baptism by fire—learning on the job came at me quickly. I also learned early on after the career change that margins were high for healthcare providers, doctors, and suppliers, because their costs were ultimately being passed on to patients and employers. There were integrity issues being exploited by business owners at every level of care. It was clear to me there was an absence of relevant checks and balances to keep spending under control.

In September 2017, Fierce Healthcare reported that the costs to employers to provide health insurance to its employees increased for

a sixth straight year.[1] Well, that's why I am writing this book. You are one of the lucky ones who still have time to address the issue of the inexplicable annual increase in healthcare costs your company has been incurring in recent years. The revolution begins today.

"Forget Taxes, Warren Buffett Says. The Real Problem Is Health Care," was a recent *New York Times* headline after the share-holders meeting for Berkshire Hathaway in May 2017. Famed American financial icon and company CEO Warren Buffet stated that, about fifty years ago, "health care was 5 percent of G.D.P., and now it's about 17 percent." Buffet went on to state that "medical costs are the tapeworm of American economic competitiveness."[2] This pretty much sums up the problem.

How did we get here?

In the 1980s, the fee-for-service (FFS) approach and a standardized fee schedule were created to pay doctors for each of the different services they provide, both in hospitals and in their offices. So other than office visits, if a physician wants to increase his or her income, then patients must be sick and institutionalized in hospitals, nursing homes, or other post-acute institutions.

So what exactly is "fee-for-service"? According to Wikipedia (January 2017), FFS is a payment model where services are unbundled and paid for separately. FFS is the dominant physician payment method in the United States. In healthcare, it gives an incentive for physicians to provide more treatments, because compensation is dependent on the quantity of care rather than the quality of care. Similarly, when patients are shielded from paying (cost sharing) by health insurance coverage, they are incentivized to

1 Paige Minemyer, Fierce Healthcare, September 20, 2017.

2 Andrew Ross Sorkin, "Forget Taxes, Warren Buffett Says. The Real Problem Is Health Care," *New York Times*, May 8, 2017, https://www.nytimes.com/2017/05/08/business/dealbook/09dealbook-sorkin-warren-buffett.html.

welcome any medical service that might do some good. Thus, some of these "just to be safe" tests and treatments, ordered when insurance shoulders the majority of the costs, would be refused by the patient if the patient was responsible for the additional costs or a significant portion thereof.

I have a shorter, simpler answer for you. FFS is exactly what the name says. Your doctor gets paid a fee for providing you a service. Likewise, the hospital is paid a fee for providing you a service. If you are healthy and never need to go to a doctor or hospital for their services, then they don't get paid. Thus, the goal of doctors and hospitals is to put a head in a bed, so they can get paid—and then order as many tests as they can, so they can get paid.

If you are healthy and never need to go to a doctor or hospital for their services, then they don't get paid. Thus, the goal of doctors and hospitals is to put a head in a bed, so they can get paid—and then order as many tests as they can, so they can get paid.

There are a number of problems with the FFS approach. The methodology, as described above, undoubtedly incentivizes and results in overutilization of services and delivery of expensive, unnecessary care. The FFS model financially incentivizes doctors to admit patients to hospitals and post-acute facilities and further rewards them financially for keeping patients in facilities for extended lengths of time. Not to mention the issue of primary care doctors taking care of their fellow physician buddies by referring often-unnecessary tests to them as specialists, which allows these specialists to bill for services as well.

While this is not the case for all physicians, of course, it is widely accepted and understood that this takes place in hospitals with a significant number of independent physicians who are not affiliated with or compensated by a larger group but rely strictly on the volume of patients seen daily for their income.

To be fair, it was not just doctors that were incentivized to institutionalize. Hospitals and post-acute facilities shared the same incentive. The FFS era drove the heads-in-beds strategy. That is how providers were reimbursed. This is also true for other inpatient providers, including nursing homes, long-term, acute-care hospital (LTACH), and acute rehab facilities have the same reimbursement methodology. The hospital or nursing home only benefits financially when a patient is admitted or receives care. Thus, the incentive is to find a reason—any reason—to admit a patient or order additional imaging or lab tests to identify potential concerns.

Are you looking forward to the day that you personally will be admitted to a convalescent home and told you will be living there for the remainder of your life? Most people chuckle when I make that statement. And that's fair. It's a laughable statement. Of course, no human being wants to be admitted to a skilled nursing facility (SNF). Perhaps some of our aging physicians should be reminded of this.

When you visit an emergency department, it is fair to assume that you are there to get evaluated by a medical doctor to see if care, medication, and treatment are necessary. But that assumption does not align with the reality of the business model of the hospital or the physician. Thus, the truth of the matter is that you are not there to be evaluated at all. By showing up to the emergency department, you are essentially volunteering to be a widget in a volume-based business model. For the past thirty years in America, we have referred to this as the FFS reimbursement model for doctors and hospitals.

Let's be clear about the business model. You are not in the emergency department to be assessed. You are in the emergency department so the doctor can identify a reason—in fact, any justification at all—to admit you to the hospital. Why? It's capitalism, and in American healthcare, a "head in a bed" is what drives profits for both hospitals and doctors. In the emergency room of American hospitals, you are a potential widget, and the doctors will run tests and order labs until they can identify a justification to convert you to a widget or, in more common terms, admit you to the hospital.

The key operational flaw in the FFS delivery model is that there is no required preauthorization for services. The term "managed care" emerged in the 1980s as a means to control this type of laissez-faire behavior by requiring the insurer to preauthorize any services ordered by a doctor or hospital. Without preauthorization, the doctor and provider do not get paid. There are many forms of managed care, but the one constant is a cost-control measure: written preauthorization from the insurer.

Without a required preauthorization, the delivery model was lawless, and much abuse took place. Fraud ran rampant in the healthcare sector as greedy hospital owners and physicians took advantage of an environment with no one at the helm. Thus, I have personally renamed the FFS era "the fee-for-service free-for-all."

In an era with explosive growth in the healthcare space, where there could not possibly have been enough oversight, the FFS era truly became a free-for-all, and it was lucrative for many. The problem was that the federal Medicare fund was disappearing at an alarming, unsustainable rate, and there was little evidence that this increase in spending was resulting in improved health or improved quality of care.

In FFS, there is a financial incentive for doctors and providers to order additional services—profit is based on quantity, not quality. It

results in overutilization of services and delivery of expensive, unnecessary care. It incentivizes doctors to admit patients to hospitals and post-acute facilities and further rewards them financially for keeping patients in facilities for extended lengths of time. Patients often simply pay a minimal copay regardless of the volume of tests, and in turn patients are also incentivized to welcome any medical service that might do some good. There are no checks and balances in FFS. A physician's order for care was the ultimate judge and jury; there was no preauthorization required for admission to these levels of care.

The FFS free-for-all was lucrative for all. One program in particular that utilized the FFS reimbursement model was Medicare. Medicare is the federal insurance program for Americans over the age of sixty-five. In recent years, approximately 22 percent of all Medicare patients admitted to an acute hospital are subsequently transferred to an institutionalized level of post-acute care (nursing home, LTACH, or acute rehab hospital). Although on the surface one would assume a doctor would only send a patient from the hospital to another institution as a last resort, that is not always the case. One reason for such a high volume of patients being transferred from hospitals to post-acute institutions instead of being discharged home is that their doctor is incentivized financially to keep them institutionalized.

Think about it. Let's provide a hypothetical example of a sixty-five-year-old male. The man calls his longtime family doctor, and this is what takes place:

> ***Patient calls doctor****: "Hey, Doc, I fell a week ago, and my hip is still hurting. Should I come see you or go straight to an orthopedic specialist?"*
>
> ***Family doctor responds****: "Come see me first. I will let you know if you need to see a specialist." (This is the first unnecessary step*

in the process, but now the primary care physician gets to bill the payer.)

***Patient visits family doctor at his office**. Family doctor examines patient and refers patient to the hospital for labs and imaging tests. Family doctor bills payer for office visit.*

***Patient goes to hospital for labs and imaging tests**. Hospital bills payer for services provided.*

***Hospital calls family doctor with results**. The doctor's fishing expedition (to find any possible issue with the patient) pays off, as he finds some minor swelling and a possible minor hairline fracture in one image, both of which would likely have healed on their own and never been a concern of the patient.*

***Family doctor refers patient to orthopedic specialist**. Orthopedic specialist says he only has office hours two days a week, so it's best to meet him at the hospital. Orthopedic specialist advises patient to go back to the hospital but to report to the emergency room and advise the nurse that the orthopedic specialist told him to come to the emergency department.*

***Patient goes to emergency department**. Patient reports to the nurse his minor hip discomfort from a week-old injury and that the orthopedic specialist advised him to go to the emergency department. Nurse calls orthopedic specialist, who orders additional x-rays and an MRI but does not have time to come to the hospital until twelve hours later, as he has other priorities. Hospital bills payer for emergency services, MRI, and x-ray.*

***Nurse calls orthopedic specialist**. Nurse advises orthopedic specialist that the images have been returned. Radiology doctor hired by*

the hospital documents that there is a possible hairline fracture but is unsure. Radiologist bills payer for reading images.

Orthopedic specialist orders the patient admitted to the hospital for observation and requests that the family doctor or assigned hospital primary care doctor perform the initial required history and physical upon admission*. Hospital doctor (hospitalist) does history and physical on patient, as the family doctor was unavailable to drive over to the hospital that night. Hospitalist is unable to find any pertinent information about the patient documented in the notes or chart, so hospitalist asks the emergency department nurse why the patient is there. Nurse reports, "He fell a week ago and has discomfort in his hip. There may be a hairline fracture. The orthopedic specialist thinks the patient may need hip surgery and wants to evaluate him as a precaution." The hospitalist, who thinks a different exam may be more effective than those images already taken, orders an additional image done and notices some lab results slightly out of range. The hospitalist then orders a consult by a cardiologist. The hospitalist bills the payer.*

Orthopedic specialist finally arrives at the hospital*. Orthopedic specialist examines the patient, who has been at the hospital for ten hours now, and does not see any need to keep the patient hospitalized any longer. He advises the patient to take Motrin but wants to hold off on discharging the patient until the cardiologist completes his consult. Orthopedic specialist bills the payer.*

Cardiologist completes consult*. Cardiologist consults patient, finds no reason for concern, and discharges the patient home after twelve hours in the hospital. The cardiologist and the hospital bill for services.*

All because the patient had a sore hip and needed Motrin. Which either doctor could have diagnosed without running any tests, and just feeling the affected area and doing some motion and stretch assessments. Do you wonder now why the Medicare fund is running dry and insurers require preauthorization for services? What if the patient had simply gone to the orthopedic specialist's office first? The result would have been identical, as each of those tests was unnecessary. This practice still continues today.

The Patient Protection and Affordable Care Act (PPACA), also known as Obamacare, had a triple aim: improved care, better health, and lower cost (efficiency). President Obama's goal to reduce costs may have ultimately come to fruition, had Obamacare survived. But that savings was not going to manifest in this decade, even if Hillary Clinton was elected and Obamacare survived. Why? There were too many iterations, innovations, transitions, transformations, implementations, technological mandates, and leadership changes to get it all right so quickly.

So whether it's under Obamacare or some version of the Trump administration's tweaks to the delivery model, healthcare costs were destined to continue to increase for businesses and families either way after the 2016 election. But what gives? When do American businesses reach a Health-Wealth tipping point where they can no longer allow health insurers to increase rates annually for the same or fewer services? Well, that may be up to you.

It has been shown that at current pricing and income levels, it is expected that the millennial generation in the United States will spend an average of 40 percent of their lifetime earnings on healthcare. This is not practical. In fact, it's frightening. But at present, this is what the numbers show. America's affordability crisis is not just a

crisis for your business but for your family as well. It's a healthcare affordability crisis on all levels—my family included.

In early 2011, the management company that owned the hospital I was running hired a new president who came in and made significant staffing cuts and sweeping leadership changes. Being one of the newer, younger executives, I was an easy target and found myself out of work for the first time since becoming a hospital CEO.

After six months of job-seeking, I received two job offers on the same day. My wife and I sat down with our children, discussed our options, and made the decision to leave California so I could manage a hospital in Las Vegas, Nevada. After less than a year in Nevada, though, we all missed Southern California and were anxious to move back. Once my employer caught wind of the fact that I was actively looking to return to Southern California, they abruptly ended my employment. Although I had been unemployed just a year earlier, I had been provided a severance package that covered our healthcare benefits the entire time between jobs, but this time around I was forced to decide whether to purchase health insurance for my family through COBRA.

Facing a move back to California and no job prospects, as my early departure was unanticipated, finances were tight. And when the COBRA invoice came in, the monthly premium was in excess of $1,300. Even though we had three children under the age of twelve at the time, this expense was hardly justifiable, even for your most precious assets—your children. We investigated other options, and even for the most basic benefit packages, we were looking at paying a minimum monthly premium in excess of $1,100—all while unemployed.

So in July 2012, my wife and I made one of the most difficult decisions of our lives: We decided to live without health insurance

for ourselves and our children. It pains me to this day even thinking back on that decision. It was my own personal affordability crisis. It's as if no one in America can escape it. I had been a hospital CEO for almost eight years, with a great salary, and my family could not afford basic healthcare insurance. That's the moment I realized the American delivery system was broken beyond repair.

The reason we are facing this affordability crisis is capitalism. Everyone is trying to make a buck. And to date, many have succeeded! And it's not about Obama or Trump, or a Democratic or Republican majority in Washington, DC. It is about finding an affordable model that meets everyone's needs: a seemingly impossible task.

America's healthcare delivery system is a capitalist's dream, an unstoppable machine with excessive margins for businesses at all levels. So long as American businesses and families are willing to pay, the system will continue to spiral out of control. I got into this business to serve senior citizens and make a difference in people's lives. But it became apparent within a few short years that my personal mission was at odds with the delivery model, as capitalism had interfered long before I arrived on the scene.

Our country's affordability crisis became my family's crisis when we went without healthcare benefits for more than six months in 2012, and it was quickly becoming my personal career crisis. The hurtful truth was this: As a hospital executive, I was now as much a part of the problem as anyone else working in healthcare. I had been labeled as an up-and-comer in the hospital space with the skill set to continue this culture of greed for years to come.

The mass layoff I was directed to conduct made for a tough holiday season for me in 2004, but not nearly as tough as it was for the forty individuals I had to lay off just weeks before the holidays. That round of layoffs was the first of many more I was directed to

oversee by hospital owners and operators in my ten years as a hospital CEO. It was never an easy task to fire someone when they knew business was improving. My job as CEO was to motivate employees and tell our story of success each day, so it was understandable when individuals being fired were in disbelief when they learned that the company was laying off forty employees, effective immediately. Balancing corporate greed without compromising patient care became more and more difficult with each year that passed. The effect of that greed is increased costs passed on to American businesses and families.

This culture of greed has bankrupted hundreds of once-thriving American businesses. It will bankrupt many more in coming years. Will your business be the next victim of this culture of greed? That may be up to you.