The following pages are the body of my web site OurHealthReform.com.

Mark E. Green MD
OurHealthReform.com

Health Care Reform

No one can deny that the state of healthcare in America is atrocious. Most talk about change, but few really know what the problems truly are, and if they did know they may be disinclined to change them. Change, if properly done, appropriate change would strip many segments of the healthcare industry of massive and undeserved profit margins. It is my feeling that if a just and equitable system for healthcare delivery is ever to be enacted, it will require a grass roots push and a pledge from the average man or woman to vote out of office any elected official who votes against this reform.

I have been a physician for 22 years and I love my job. I work with patients I truly care for and for whom I want the best. I have a better than average income, although I work far more hours a week than my friends in other industries. I also have community recognition, a sense of purpose, a sense of job satisfaction and of job security, This is tempered, however, by the long hours mentioned above, by the declining role physicians play in health care delivery, by a sense of helplessness in dealing with the insurance and legal industries, by a profound sense of the unfairness of health care delivery and of the waste in the system, and by the increasing despair caused by the mounds of paperwork with which I am increasingly having to deal. I want to keep practicing general internal medicine, though it is becoming progressively more difficult to justify to my family or myself.

There is much discussion of the problems with healthcare and multiple plans outlined to confront the system and to mold it into one vision or another. In general, though, no one will attack it head on and do what needs to be done. Health care is expensive, though I believe there is currently enough money being spent to adequately fund a reformed system. A large part of this money is sequestered from patient care by being tied up in waste, inefficiencies, legal fees, defensive medicine, excessive drug and medical equipment costs, and especially in insurance industry and medical plan profit margins. The following are a few of the details that need to be addressed.

Each day I deal with scores of insurance companies, and with many times that in individual insurance plans. Each has its own rules, regulations and paperwork exchange that are independent of actual patient care. Each company is required to verify the credentials of each provider, carry out chart reviews and office surveys, operate patient wellness programs, operate pre-approval systems for procedures and medications, as well many other programs and are all dollar intensive. Simply marketing all of these plans must cost a staggering sum of money. Considering all of the separate insurance companies, each spending money as above, one can appreciate the built in and expensive redundancies that are contributing to the costly system that is health care. An easy way to eliminate a huge cost is to eliminate the multitude of insurers.

Private insurance companies offer us nothing. The only management they can effect is to simply deny procedures, drugs, treatments and/or services. They are beginning to try to modify patient behavior, though it is very late in the game. Private insurance is obtainable for the low risk and relatively healthy person. This is a profitable patient type

for an insurance company to underwrite. Care for the chronically ill, infirm, deficient, malformed, or cancer-ridden patient is left up to a patchwork of governmental and taxpayer based entities. All efforts to “reform” health care delivery simply by trying to buy private insurance for the “uninsurable” is simply guaranteeing a profit margin to insurance companies that contribute nothing to the real health of Americans.

No one begrudges a reasonable profit margin to any business. Unfortunately, greed seems to know no bounds. This greed ranges from practitioners who fraudulently bill for services, mobility stores who charge $5200 for a scooter that can be bought on the Internet for $2700, to pharmaceutical companies who minimally alter a drug at the end of its patent life only to charge full price as a “new medication”. It includes the massive salaries of upper management of most any insurance giant, the unquestioned legal fees charged by the ever-present healthcare lawyers, to home equipment suppliers who continue to bill for home oxygen well after the patient no longer has a need. The list is nearly endless. It is impossible to track this waste across so many thousands of insurance companies and plans, so many drugs and medical equipment suppliers, so many practitioners, and so many hospitals and other institutions. The best answer may be to manage and pay them all through one system.

There are a lot of people who are against a single payer system, though they generally have a vested interest in the current system staying as it is. They use terms like socialized medicine and point to the inadequacies of socialized systems in other countries. Socialized medicine would not work in America for many reasons and I do not advocate for one. The United States is fortunate, however, in that we already have an insurance system in place that functions well and grants universal health care coverage to its clients. What is Medicare except guaranteed health care for those 65 years and older and by a single payer? No one tells me how to treat my traditional Medicare patients. No one is constantly looking over my shoulder telling what to do. In fact, traditional Medicare insurance requirements are the least intrusive to my practice. Medicare is not considered a socialized system by the patients participating in it, nor by physicians in general. There is nothing magic about 65 years of age as a starting point. Since the system functions well already, it would be simple to expand it incrementally until all persons are covered. As new ages are incorporated, the money they are now paying for their current insurance would be paid into Medicare itself, but at reduced rates. Since there is currently a massive amount of money being paid into the insurance industry and since waste, redundant functions, and huge profit margins could be eliminated, Medicare could again be solvent and self-sustaining. Further details are available (on a following page). As stated above, the majority of people voicing an opposing opinion have a strong interest in the current system. As examples, consider insurance and medical plan executives, investors in those companies and plans, practitioners who make large salaries from the system as it is, stock brokers, investment lawyers, bankers, retirement plan advisors, and many other people, many who are simply fearful of change. Many politicians will voice strong opposition to this type of change. I am sure that some are well meaning, though under informed. Others are financially hooked to the current system and would loose money with change. Still others owe favors to important people and campaign contributors whom they cannot

afford to disappoint. I would encourage all people interested in health care reform to analyze opposing opinions to see if they are rooted in self-interest.

If we had a one payer of health care benefits, we could standardize coverage and extend it to all Americans, regardless of age, sex, race, disease, or disability. We could analyze the unified system for medical errors and waste, and we could eliminate the patchwork of coverage, and non-coverage, that exists now. Do we not deserve this as Americans?

One possible scenario is for Medicare to have an age sensitive baseline benefit plan and an optional Medicare sponsored supplement. This arrangement would allow the healthiest people to pay a lower premium, if they so choose, by opting out of the supplement. The drug formularies, that we have come to despise, could cease to exist. Medicare would simply pay a set amount for a given class of drugs. That price would be paid no matter what drug of that class was written. If the patient or physician desired a different drug of that class, the patient would simply pay the difference. The patient would steer the physician to the lowest cost drug unless they both were convinced that the different drug choice was justified. In any event, the general cost of medications should be coming down as there are an increasing number of generic drugs available. Often a patient and be treated effectively for many common disorders for 10-20 dollars a month. Most drug cost would decrease as the drug companies make an effort to capture part of the market. Certain classes of drugs could not be accommodated in this way for many reasons. An example would be cancer therapeutic medications.

All concerned want high quality healthcare, and a one party payer system would finally allow this to happen. Medical errors, waste, and inefficiencies are hard to track across the multitude of payers. A unified, single system would allow aggregate tracking across all providers, equipment suppliers, patient age groups, illness and treatments. The current system cannot hope to capture all of this data. The discovery of patterns or systems of errors could steer us to a safer delivery of health care and improve the educational process giving better-trained providers right out of training. Hopefully we could finally eliminate the need for the rampant, wasteful, unfair, and punitive insult that is now the malpractice litigation industry. It certainly is an industry and they certainly will oppose these changes to the current system.

There needs to be a big change in healthcare and I believe that all Americans need to be covered from cradle to grave. I challenge anyone to justify to me how the current patchwork of insurance plans and government programs with all of it gaps of coverage and paperwork can ever hope to be efficient enough to work for America.

Please E-Mail me with your thoughts, for or against!

Mark E Green, MD
MarkGreen@OurHealthReform.com

What Can We Do?

- Discuss HealthCare reform with your friends and warn them of the rhetoric used by the opposition; Socialized medicine, loss of choice, restriction on provider options, expensive, government control, etc.
- Contact your state and federal representatives and demand single-payer/universal coverage reforms.
- Challenge them to recount any benefit afforded by the for-profit health plans and/or insurance companies above Medicare plus a Supplement.
- Encourage the above representatives to view this web site and send comments back to you, and hopefully to me as well.
- Send letters to President Obama encouraging the above reform (I have sent letters requesting a meeting (you never know if you don't ask)).
- Help find a way to get me before any/all Congressional committees dealing with HealthCare reform.
- Write Letters-to-the Editor for the above HealthCare reform to your local newspapers.
- Be inventive and let me know.

Thanks,

Mark Green
www.OurHealthReform.com

Health Care Reform
What can we do to help launch Health Care Reform?

As noted above, we cannot expect our elected officials or the health care industry in general to effect meaningful reform. Talk to each other and write letters. This must be a true grass roots effort to make it happen. We do have the power of the vote. Do not underestimate its value. We are currently writing a Bill for healthcare reform, modeled on HR676, and when available will be published on this web site (OurHealthReform.com) and promoted elsewhere. When available and if you agree, help promote it though friends, local newspapers and clubs, and through correspondence with your elected officials.

Only wide spread “common citizen” support will drive this effort. If there is enough interest from others we can spread this concept to hundreds of thousands of voters, if not millions. As interest builds, this and other web sites can be built into effective communication tools. There should be no profit derived from these sites. I am sure there are thousands of people out there, perhaps retired and experienced in efforts such as this, who could really contribute to raising American health care delivery to the highest level. Certainly we can overcome our 37th in the world status.

Over the last 22 years I have put a lot of thought into the problems we have and also in how we might fix them. Not just by throwing dollar after dollar into a dysfunctional institution. There are ways we need to retrain our primary care physicians, to educate the public in general about their responsibility for themselves, to redirect our specialists, to reform some payments schedules, to streamline our medical information system, and to extricate ourselves from our legal quagmire, to name a few. Paramount is the main goal of ridding ourselves of the private health insurance parasite and thereby capturing all of the money available for healthcare and to **use** it for healthcare. I want to interact with persons of similar or of opposing interests to further refine these concepts. All opinions are welcome.

I want employees of the insurance industry to realize there will be opportunities to roll most everyone into the new system. For instance, claims processing will always be needed, nurses will be needed, home health will surely expand, and hospitals and other providers will need to be fairly paid and administered, simply to name a few. The real change will be for the upper financial echelon of the current system. They will loose as the private insurance market evaporates.

Please give this some dedicated thought. Talk to your friends, colleagues, union members, family and anyone else, not only to spread the concept, but to better refine our arguments. Our most important job is to talk to other persons to promote the concept of a Medicare based universal health care system. We need a bill written for introduction into the legislative system (see above) and then to push each legislator to pass it into law, uncorrupted. We can do this!

Mark Green

13Sept2008
MarkGreen@OurHealthReform.com

Health Care Reform

About Me:

I am an average person who happens to be very concerned about the state of health care delivery in the United States. So many politicians and other persons of interest spread so much misinformation about reform, the only way to make it happen is to mobilize average Americans. This is my first attempt to expose my ideas to criticism. This is not a professional web site and it is crude. It should, however, allow me to get some feedback on the potential to generate some controversy.

I am 55 years old, married to my wife Debbie for 30 years, and have four children. I am a medical doctor, and have my master's degree in Microbiology/Immunology. I practice general internal medicine in Maryville, Tennessee, at Blount Memorial Hospital where I am currently Chief Of Staff.

My hobbies include hiking in the Great Smokey Mountains, learning the guitar, and writing poems. I have a collection of various firearms, though I do not hunt. I ride my motorcycle (Dynaglide) daily and work out in the gym at least twice a week.

Mark Green MD
MarkGreen@OurhealthReform.com

Health Care Reform
A Very Long Road

Any meaningful attempt to reform health care and to direct as much money as possible to patient care, will meet with an unbelievable amount of resistance from the powers that be! Our elected officials are much more interested in being re-elected than effectively guiding this country. On their own, I have NO confidence that they will do anything except modify our existing private insurance based system, replete with its high profit margins, incalculable redundancies, unnecessary drug plans and drug restrictions. It is increasingly patched up by a confusing hodgepodge of governmental plans meant to cover those segments of the population that are not profitable in our “free enterprise “system. The rest of the patients that fail to fit into even the government entitlement plans, are cared for at financial loss by local hospitals and providers. All this allows private insurance companies to reap huge sums of money from the lowest risk patients. These huge sums of money are what could bring Medicare, as well as health care in general, back to solvency.

Partly in the defense of congress, this is a complex and entrenched system and unless one has experience on the inside of health care, it is hard to understand what needs to be done and what should be done. For those of us in health care, knowing what needs to be changed may actually make some resist reform, realizing that profit margins for us will change as well. For this reason, it is vitally important to expose as many people/voters as we can to the concepts of what needs to be, and can be done. Through education and prodding from average citizens, congress could enact meaningful reform of health care delivery, under threat of expulsion by the people, at the next election. They must feel enough prodding from the public to overcome the pressure they will feel from insurance companies, lobbyist, special interest groups, and from their own stock portfolios.

If this concept builds momentum, there will be an unbelievable amount of “smoke” blown by profiteers of the health care delivery machine. They will scream “Socialized Medicine” and will produce anecdotal instances of health care reform gone wrong. What they cannot refute is that Medicare works and that it is not delivered in a socialized manner. Sure there are changes that need to be made to Medicare, but these changes are in the depth of coverage and not in the mechanism of delivery itself. They also cannot argue that what we are doing now is not working.

This site is a work in progress. I welcome any input that will help lead to the long needed reform of the way we deliver health care in America. Opposing arguments will also help by educating me to the concepts of the average American or helping me better understand how to dissect and to counter the counterattacks that are bound to arise. All input welcome.

Mark Green
18July2008
MarkGreen@OurHealthReform.com

Health Care and the Legal Industry

It is hard to comprehend how much health care money is wasted each year due to the legal industry. From malpractice insurance payments and defensive medicine to the huge volume of medical records now generated simply to cover all possible angles of a potential lawsuit. Recently a patient of mine was in France and had the onset of a cardiac condition. She was treated for five days in a French hospital and discharged back to me. I received a full copy of the medical records by mail. The records were medically complete and detailed. Interestingly, there were fewer pages from her five day stay in the hospital than in one of our routine emergency visit charts. They seem more centered around medical information rather than on legal protection.

Malpractice decisions have in some cases increased the chance of a bad outcome. When the “clot busting drugs” first became available for use in stroke patients we had some leeway on a time frame in which to use them. There is a risk anytime these drugs are used though they are often the only chance one has to avoid certain paralysis. The current "legal" time window is three hours. At this point in time, if a stroke workup is completed at 3 hours and 15 minutes, the option to use this treatment will not be extended. We know if there is a bad outcome we will be sued due to being 15 minutes past the accepted time window. If we explain this to the stoke patient and if they would rather risk death than to be severely disabled, we could still be sued by the patient or the surviving family simply because they were under duress at the time of the stroke and therefore could not really give informed consent. In other words, we have very little option to treat this patient as they might want.

In the same pattern, When I was a medical resident, I saw a patient in an outlying Emergency Room suffered a bee sting caused respiratory failure and was brought in by ambulance. He was a lung cancer survivor by almost ten years, but still had a “Do Not Resuscitate” order on his medical record. He was unconscious and no family was available. I elected to put him on the ventilator anyway and within two hours he recovered enough to breath on his own. He was thankful. Never-the-less, for a solid year I worried about the possibility of a lawsuit for violating his written request. For if he had died in the process or within a year of the event, a gold-digging next of kin and a clever lawyer could have made a case against me. Interestingly, had I let him die by honoring his ten year old paperwork, I would have been fully protected legally, though not morally.

What we need is to establish free standing, 3-5 member arbitration panels that render binding judgments in the face of a bad outcome. Reasonable monetary damages could be awarded for ongoing care, treatments and support and would be based on similar judgments from across the entire medical system. Any practitioner mistakes could be tracked specifically and in aggregate to allow re-education or disciplinary action for the practitioner as needed and the data could be reviewed for system wide problems that also need correcting. This would eliminate the legal industry mantra that some lives are worth more than others, simply because they earn more money. The latter is the reason we

have life insurance policies available. In medical circles, the life of a homeless person is just as important as the life of a corporate executive.

The malpractice/legal industry has no place in medical care, though rational compensation is reasonable.

Mark Green
10Sept2008
MarkGreen@OurHealthReform.com

Rational Health Care Reform

The first step in health care reform is to make a Medicare sponsored “Medicare Supplement” available directly from Medicare for those current Medicare patients who want a supplement as part of their plan. A Medicare “Part D” drug benefit would be part of the standard offering. Then to dismantle all of the Medicare Advantage plans and roll their existing patients back into Medicare, as expanded above. Fees currently being paid into those plans would be scrutinized for fairness, adjusted as needed, and paid directly into this Enhanced Medicare. Standard fees would have to be reasonable for everyone, though there will need to be a declining “co-pay” schedule for those in lower economic classes. With this in mind, however, everyone needs to have to pay something to help them feel vested in the system and to help prevent over utilization. In the process we need to ensure we have the infrastructure in place to handle the increasing administrative load. This might be a way to utilize some of the existing claims processing capacity of the current private plans, allowing many of their employees to transition into Medicare based employment, as opposed to losing their jobs as the private market contracts.

The next step is to organize the second most expensive segment of society, one that is in large part supported by a huge and inefficient patchwork of governmental agencies and programs, as well as private insurance. All persons under age 18 and all pregnant women, though two years post partum, would be enrolled into the Enhance Medicare plan as expanded above. Each enrollee would have benefits specific for them, as opposed to being a member of a “family plan”. Monies currently utilized for the existing coverage could be consolidated and used to defer the cost of the new system. Establishment of a reasonable “resource based” premium assessed to all would further reduce costs. These monies would be collected from the parents or guardians, much as their current insurance premiums are at present, but at the lower rates allowed by a consolidated, profit free system. Again, time would be allowed for the consolidation of the infrastructure and funding required to run the system.

Once the two most expensive age groups above are fully incorporated, we could then incorporate the remaining, and more “profitable” age groups into this Enhanced Medicare plan. Perhaps starting at age 64 and working backward till all are incorporated. The speed of this enrollment would only be limited by the monies available and by the expansion of the required infrastructure. As each age group is enrolled, they would begin paying their health care premiums directly into Enhanced Medicare, as mentioned above.

One of the many downfalls of the current system is the inability of persons with heath risks to obtain insurance. Accordingly, premiums would be built on a much more rational consideration. A child born with a defect or an adult who develops leukemia have done nothing wrong and should not be penalized for the rest of their lives by doing without health insurance or by paying exorbitant rates for it. Accordingly, premiums would be established by age and would be independent of uncontrollable risks, as exampled above. We could elect to modify premiums upward in relation to controllable risks. Examples

would be smoking, excessive alcohol use, and obesity. We could also consider charging some amount extra to persons for medical noncompliance. Examples would be persons not controlling their blood sugars, blood pressures, or cholesterol. These extra amounts need not be excessive. It is likely that many patients could be steered toward improving their health simply by getting their premium statement each month showing their basic premium and optional supplement plus the extra assessments for their controllable risks that are not currently controlled, each itemized with the related extra charge. Those 65 and over could be assessed a flat rate modified as above for controllable risk factors. Correspondingly, we could consider reducing the premiums some amount for those people who successfully control their risks. Obviously, the monies need to be fully evaluated before the exact possibilities can be determined.

Provisions will have to be made for the collection of monies due to be paid to the Medicare system, such as premium and co-payments. Industries/corporations currently play a role in supplying health care and they still would in the new system, paying a per employee amount. Industry would benefit from controlled costs and protection from rampant heath care inflation. Payments for individual premiums would have to be collected from those individuals, separate from their employer's contribution. These payments could be deducted from payroll checks, as is currently done for persons who get their health insurance through work. For persons getting their support from the government, insurance premiums could be deducted directly from their checks as well. Self employed persons could pay monthly or have their premiums added to their income tax indebtedness. No matter what payment arrangements we try to make, there will always be people who show up needing health care, but who have sidestepped the system. These people will have to have care and a pool of monies will have to be made available.

Any laws that need to be changed to accommodate this reform can be passed through congress. There are, of course, many aspects and possibilities that need to be fleshed out as the current legal restrictions are revealed. It will be up to the American voter to force our elected officials to do what is right, and to enact any legislation that needs to be put in place.

Mark Green
24August2008
MarkGreen@OurHealthReform.com

Rational Health Care Reform: A Plan
Bullet Points

Step One:

- Start with the basic Medicare plan, as it exists today.
- Issue a unique ID number to each current enrollee. Not to use the current social security number.
- Eliminate the current yearly “deductible” payment.
- Maintain the current per visit co-payment, though adjust it for income/means, and build in a per individual/family maximum co-payment amount for any 4 week interval.
- Include drug coverage for common medications. Pay a fixed price for a given class of drugs, regardless of which drug in that class is prescribed.
- Construct a Medicare sponsored supplement plan and offer it to all traditional Medicare clients. Enrollees would pay an income adjusted monthly premium for this supplement, as they currently do, but less than they currently do.
- Re-evaluate Medicare’s computer and manpower infrastructure and enhance it as needed.
- Dissolve the Medicare “Advantage” Plans and re-enroll those clients into the Enhanced Medicare Plan as above.
- Take the monies currently ear-marked for the Medicare Advantage Plans and infuse them into the Enhanced Medicare Plan above.
- Re-evaluate the infrastructure and correct as needed.

Medicare would now be a decent and affordable insurance product for its clients.

Step Two:

- Enroll people 0 through 17 years old and pregnant women through two years post partum into this Enhanced Medicare Plan. A hodgepodge of private insurance plans and a multitude of governmental programs cover these groups.
- Examine the sources of monies currently used to pay for the health care for these population segments and, as appropriate, roll those monies into the new plan. This would include income adjusted premium payments from parents and guardians.
- Re-evaluate the infrastructure and enhance as needed.

The two extremes of age would now be covered.

Step Three:

- As seems feasible at each time, begin enrolling the rest of America in the Enhanced Medicare Plan, starting with the upper 5 year age block first and working backward, as infrastructure allows, till all Americans are covered.
- As each age group is enrolled, begin collection of income adjusted premium payments from them, much in the same way as they pay now.
- Periodically the infrastructure would have to be expanded aggressively.

Reformed in this way, universal coverage could be obtained, personal responsibility can be required, the expense could be incrementally accounted for, private health coverage could be phased out , and the taxpayer could be spared the total cost burden.

All Americans would now be covered by an insurance plan. Any care issues could be monitored. Tracking of fraud, abuse, waste, and medical errors would then be possible.

Mark Green
25Aug2008
MarkGreen@OurHealthReform.com

HealthCare Reform

Medicare Based Supplement Rationale

It is clear that the taxpayers of America cannot underwrite universal healthcare and that we must utilize premiums, co-payments and some private/corporate monies to fund the system. It is also clear that there are some persons who take excellent care of themselves and would not want to pay for full coverage. That should be their option, though basic medical coverage should be required of everyone.

With that understanding, there could not just be one plan for all. I would envision a system where each American would have full healthcare coverage with variable use of a drug benefit, depending on age and general health, and an option for one of a two tiered co-payment/premium structure. The number of options should be minimal to avoid the confusing array of plans currently offered by the “for profit” companies.

Having some options would give people the feeling of being in control and of not having to pay for more that they require. Medicare based options would, for the first time, make Medicare a complete product and a good platform on which to build a universal system.

Mark Green
1Sept2008
MarkGreen@OurHealthReform.com

Health Care Reform

Letters Sent to Newspaper Editors
And Others

Dear Editor,

I am a local physician with a strong interest in health care reform. As I have researched the movement it seems clear why the message is not being heard, as there are many people and organizations with the same interest. I feel we need to bring the message to the "common voter" and empower them to force the issue through the ballot box. Please consider publication of the enclosed letter to the editor.

Any constructive feedback would be appreciated.

Sincerely,

Mark Green MD
Maryville, TN 38703
MarkGreen@OurHealthReform.com
18Aug2008

Dear Editor,

Recently there has been news of changes in regional managed health care ownership. Most will consider this as general business information and will not consider it further. Many others will understand it for what it is, a further consolidation of the "for profit" insurance industry. This is an industry that will maintain their profit margin at the expense of actually delivering health care. In fact, the monies that are spent on patient care by this industry are universally termed the "medical loss ratio". If its not profit, it must be loss! If anyone denies profit is involved, consider the sums of money that are slated to change hands in the recent announcement.

There is no love lost between physicians and companies of this type, and it is not due to the decline in salaries. Rather, it is knowing that the number of mind numbing pre-authorizations for medications and procedures is only going to go up as is the endless stream of paperwork and chart reviews. The latter designed to maximize profit at the expense of patient confidentiality. The insurance industry has only two ways to maximize profit and thereby minimize the "medical loss ratio". These are by encouraging patients to be more healthy and/or by restricting each patient's medications and testing. We all want to be healthier, but we also want any medications and any testing that is deemed necessary.

The power of the health insurance industry has become nearly absolute. I have recently been contacted by a local health insurance company who wants me to set aside space in my small office for them to come in for 2-3 days and set up a copying machine to entirely copy nearly 100 charts. They will then take my patient's private information out of my office for review by persons I cannot observe at a site over which I have no control. They say this information is kept private, but considering they are doing this across the area, they must have hundreds of reviewers looking through this information. The law of averages demands that periodically charts will be read by reviewers that just happen to know the patient involved. Information such as HIV infection, breast augmentation, depression and marriage issues will be known to those reviewers. I would like to feel the average reviewer would keep this information secret, but I would hate to bet my health information on it. In contrast, other insurance companies will request 10-20 charts to be gathered and they review them in my office. I have no problem with this approach as patient privacy is less compromised.

I have developed a long list of local managed care abuses of power and could give many other examples. In respect to brevity, I close with the hope that America will soon realize that profit centered managed care is not the answer to our woefully inadequate health care system and that it only allows this industry to take money out of an overstressed system at the expense of patients' health and of providers' sanity.

Sincerely,
Mark Green MD
MarkGreen@OurHealthReform.com
16Aug2008

Dear Editor,

This is my second “Dear Editor” letter and I plan many more. They will continue to be sent to many newspapers across Tennessee as well as to selected broadcast journalists. As mentioned in my first cover letter, I am a local physician (Maryville, TN) with a strong interest in health care reform. The discussion of the problems with health care and the need for reform is not being heard by average Americans. Most efforts at change are directed at the legislators themselves, most of who are themselves, or have friends who are, vested in the current system. I feel we need to bring the message to the voters themselves and to help them to feel empowered to force the issue through the ballot box. Please consider publication of the enclosed letter to the editor. Newspapers are still the greatest disseminator of thought and your help is greatly needed.

Any help and/of constructive feedback would be appreciated.

Sincerely,

Mark Green MD
Maryville, TN 38703
865-977-7551
MarkGreen@OurHealthReform.com
24Aug2008

Dear Editor,

Only in America can local and national health insurance companies have such a disruptive hold on patients and providers. I have previously described the practice of one local health insurer coming into private medical offices only to copy patients' protected medical information and to remove it to places unknown to be "reviewed" by persons unknown. Other insures, instead, send the reviewers to the doctors' office to conduct these reviews in private. "For profit" health insurance companies are privileged and can invade patient privacy at will. They also commonly interfere with effective management of a patient's disease state by requiring medication and/or procedure "pre-approval". The following are a few of the insurance issues I have had in my office in the last week alone.

1. A 58 year old female patient of mine came to the emergency room on a Friday with crushing chest pain and shortness of breath that was relieved by nitroglycerin and who has family and personal risk factors for heart disease. She was admitted for a workup. While hospitalized she had intermittent recurrence of her chest pain and shortness of breathe several times. We reviewed her previous cardiac workup, obtained a gastroenterology consultation resulting in stomach endoscope, evaluated her for possible blood clots in her lungs then obtained an evaluation of her swallowing mechanism which revealed a swallowing problem which was allowing liquids to trickle into her lungs giving her spasm of her airways and giving her pain in her esophagus. This was leading to her symptoms. She was discharged the day the diagnosis was made, and on appropriate therapy. Now her insurance company states this should have been completed in 24 hours and are currently declining to pay past the 24 hour "approval". This work up progressed over the weekend, which is a time the insurance reviewers do not work and are not available to us. Consequently, we have "Monday morning quarterbacks" critiquing what we have done while they were off enjoying their weekend. I doubt they would have the same objections to her care if this had been their mother, sister or daughter. Currently her admission is "under review".

2. I have a 78 year old woman with a failure of her pituitary gland and she makes no cortisol at all. Cortisol is required by the body to function. Symptomatically she had failed other medications before we finally got her nicely controlled on her current drug. Her insurance company sent me a letter stating they would no longer pay for her medication unless she failed a trial of each of the generic drugs in turn. Since the medication is required for her to live, I am not sure how I would measure the "failure". I cannot get the medical director to call me. Hopefully, they will drop this demand.

3. On one day last week I received from a single local health care insurer separate requests for me to review patient medication records on 30 patients to see if I would change some of the medications to better suit the insurer. None of these requests were for quality of care issues, but simply to better suit their drug formulary. Considering the time it would take to process these requests by pulling the patient charts, reviewing the reasons that those patients are on those medications, deciding if it is or is not reasonable, contacting the patients to explain these changes and then contacting the patients' pharmacy with the changes, I wonder if the insurance companies think I have as much

time to fiddle with paperwork as they apparently have. Thirty requests times 10 minutes each comes to 5 hours of time required to adequately respond to their letters. I fully agree with any review related to quality of care, no matter what the time requirement. However, I fully resent any extra time I have to spend to enhance their profit margin.

Other instances could be described from this week alone though space is limited. The private for profit health insurance companies are holding back any hope of health care reform in America. We need the average private citizen to educate themselves and to become involved. We can then force our legislatures to directly address these issues or to be voted out of office.

Mark Green MD

MarkGreen@OurHealthReform.com
Maryville, Tennessee
23August2008

Single Payer Reform for Health Care Delivery

As a practicing physician for 19 years, I have long been perplexed and embarrassed by the method of health care delivery in the United States. Over the last five years I have become less perplexed, but more embarrassed. The reason we are stuck in this ridiculous system is simple. There is too much money moving around in the higher echelons of health care delivery for there to be any consideration of meaningful reform. Consider the influence enjoyed by insurance executives, pharmaceutical executives, health industry legal representatives, and medical equipment suppliers, among others, over our congressman and other elected officials. Many, if not most, of our politicians have much of their 401K monies and other savings tied up in the stock of this system as it stands. If not them, then their families, friends, or co-workers might suffer financially. It is clear that any shift to a single payer system would divest many medicine related companies of much of their income source. Can we have any hope that our legislators will forego their self-interest? Can we ever imagine that they might ignore the influence of the lobbyist? Is it conceivable they can ever construct a meaningful reform bill and move it to a vote without mindless compromises and diluting amendments? I have NO confidence that they will or that they can. The embarrassment of explaining to patients why I cannot give them a certain medication, or why it is taking days to get a test approved, or why they cannot have the surgeon of their choice is becoming harder to tolerate.

I have just read the OpEdNews article by Dustin Moore on single payer health care reform becoming more mainstreamed, and it is encouraging. There are, however, at least two concerns that come to mind in considering the popularization of this concept. One is the confusion over single payer systems verses socialized systems. Certainly socialized medicine utilizes a single payer, but a single payer system does not have to be socialized. Socialized systems own and manage the doctors, the clinics and the entire infrastructure. Traditional Medicare is an example of a single party payer but does not employ providers and is not socialized. It does not tell the providers how, where, or when to practice. The providers still practice in a free market environment and can see who they want and work when they want. The last thing we need is to have providers as employees of the health care system, working a "shift", and on a salary. Productivity would plummet; just as it would if you placed an assembly line on hourly pay. The second concern is that we are building some midlevel support for health care reform, hopefully a single payer, but are not having success in educating the people that can make it happen: **the voters**. The voters need to know the difference in the above systems and they need to know when the self-interested opposition confuses the issues in attempts to scare people away from the concept.

I encourage all interested persons to send letters to the local editors, engage anyone and everyone in dialog, and attempt to disseminate as much of this information as possible.

Mark Green
31August2008
MarkGreen@OurHealthReform.com

Comments on HR 676

http://www.guaranteedhealthcare.org/legislation/hr-676-conyers/united-states-national-health-insurance-act

A noble attempt and I am almost for it. I am 100% for a Medicare based single party payer delivering universal health coverage. There are many benefits available from this bill an they are listed elsewhere. I will focus on the problems.

1. You cannot establish a "global regional budget" and "cover all medical services" as envisioned. Utilization will skyrocket and then to stay under budget, payments would have to be reduced, becoming more unfair toward the end of each fiscal year.
2. Everyone needs to pay a monthly premium, scalable to income. Having a premium assigned will allow ownership of the plan and will supply a lever that can be used to prod individuals into a healthier lifestyle. For example, if someone continually fails to control certain risk, as with smoking or hypertension, they could be assessed a few dollars more each month. They would be reminded of their need to improve each time they received their premium statement. Small sums added would be sufficient to make people think.
3. Everyone needs a per incidence co-pay. It does not have to be much. I was working an outlying emergency room one night and a mother brought in her oldest child for "cold symptoms". She then signed the other 5 children in "just to be checked". Don't think for an instant that over utilization will not be a problem under HR 676 as written.
4. Drug costs could be controlled by paying a flat rate for a given class of drugs. If a different drug was desired we would still pay that set amount toward the new drug and the patient would pay the difference. Patients would pressure the providers for the least expensive options and the drug companies would feel to keep their drugs within an affordable range. Negotiating with the drug companies, as envisioned, would leave the system open to fraud and favoritism.
5. Tapping into the "top 5%" of income earners is not always tapping into people with disposable income. Many people live at the edge of their income as it is. All people need to pay a scalable fair share. We need to avoid building resentment for the system.
6. If you require all people to be covered under a universal plan and require all providers to accept the plan, you do not have to mandate anything to private insurance companies. There will not be a market for their product.
7. Too much of a "Mandate" will simply breed resentment. Better to make the product indispensable.

Mark Green
1Sept2008
MarkGreen@OurHealthReform.com

Comment Posted OpEdNews

No matter how you reform healthcare, there will have to be an information manager. Something has to be in place to track monies, utilization, outcomes, quality, fraud, and to just oversee the system. If we scrap all that we have, we still have to set up a new support structure. Medicare, with all its flaws, still represents an infrastructure that is currently tracking data on all persons 65 years and over, plus other groups of people, as with the disabled. Medicare should be perfected, see OurHealthReform.com, and then expanded as its capability builds. It would be scalable, fundable, and could be broadened in increments. This would not require a one step jump into an unproven program. I want a one party payer system supplying universal coverage that is not owned by, but rather managed be that payer. Government ownership of the providers would not be in our best interest, for productivity reasons. Remember, congresses' health plan is managed by the federal government and I dare say is not lacking in coverage.

Mark Green
1Sept2008

Healthcare Reform: Obama verses McCain

I have just read both versions of Healthcare Reform as presented by the Republicans and the Democrats. How either is considered reform escapes me. Reform implies a great change intended to improve the quality or performance of an item. Few of the current healthcare deficiencies would be improved by the current proposals. The problems with the current system that must be addressed include too many people with insufficient or no coverage, too high a cost for the products (drugs, procedures, etc.), too much manipulation of patient care by the insurers, too many healthcare dollars being divided up in board rooms and on Wall Street, and no way to track and control abuse by providers, suppliers, institutions, and especially of the health insurance industry itself. If these problems were corrected, it would still be only one half of the reform we need.

The other half of the needed reform is in the financial aspects. Our economy is hurting and most people already feel the crunch. As reported by Ross Perot at http://perotcharts.com/, 53% of our current Federal spending is non-discretionary. In other words, we have no choice but to e spend that percentage just to get by. That leaves approximately 37% to spend on everything else (defense, roads, etc) including healthcare reform. It is clear that what ever we do with healthcare has to be fundable. That does not mean we can just dump it on the taxpayers. We need to look at what we have in place, both in structure of the current system and how we fund the current system, and keep as much as is reasonable, too save money, and to reform the rest. It is the only way we can get a non-watered down version of Healthcare Reform that we can fund for years to come.

It is clear that a free market system only works if the product can be taken or left behind. Healthcare cannot adhere to that constraint. When you need it, you have little choice. The system we have in place is based in the free market and it clearly does not, and cannot, work. Now, what is offered by our "reform candidates"?

John McCain's plan is simply more of the same. He wants to expand insurance in the private sector, often at taxpayer expense. This also means further profits for those insurance companies who participate. Aren't they already bleeding us dry while restricting care in order to do so? His plan would deregulate the insurance market in a way that would allow a person to buy health insurance across state lines. The downside is that the current regulations are the only reasons some companies cover patients as thoroughly as they do. Removing these regulations may free them of that requirement. He also wants to move away from fee-for-service opting for a bundled payment approach. There is no surer way to get providers to work less hours and to see fewer patients. How many cars would be assembled on a line if a workers pay was bundled into one lump payment, giving them little or no incentive to work harder. Lastly, by making the cost of care visible to the patient, McCain feels they would shop for cheaper products and insurance. What a misperception. This is such a complicated business and the products and insurance plans are so confusing and incomprehensible that the average person will not be able to barter their cost downward by any amount.

The Obama plan at least makes a gesture in the right direction, but still relies heavily on the private insurance companies. He would set up a government backed public health insurance plan, somewhat on the Medicare system, and would let people with expensive coverage or no coverage to pick between the private or the public sectors. This would potentially expand the number of persons covered, but would be terribly expensive to the taxpayer. By allowing this voluntary shift, the healthy, low cost patient could stay in the private sector (with his premium profit margin going into the afore mentioned board rooms) while the high cost patient would wind up in the public sector where his premium deficit could be shouldered by the taxpayers. Further, people choosing not to participate in any plan would still wind up costing the taxpayers anytime they were sick and needed care. There are no funds of these folks anywhere. Obama is counting on letting the Bush tax breaks expire as partial financing for this plan, but with our current national economy and deficit, how much tax money can we really afford to commit?

I am very disappointed in each of these proposals. They seem to represent a gross misunderstanding of what is needed and/or of mindlessly compromising with those persons and industries that are opposed to healthcare reform. There are other plans available. Some can be instituted in the upper and lower age groups now, and then scaled to include all age groups as funding and infrastructure improve. This is a major reform for us, and knowing how slow congress is to repair its mistakes; I would rather get it right the first time.

Mark Green MD
14Sept2008
MarkGreen@OurHealthReform.com

Posted on Web Site 18April2009 with “Realm of Private Insurance”.

Step One:

Improve Medicare by getting rid of the for-profit supplements and then incorporating the supplement-type benefits into the new "enhanced" Medicare. Monies currently being paid into the private sector for the supplements would be paid into Medicare directly on a "means adjusted" basis. Medicare would now be, for the first time, a complete product. Lastly, dissolve the so-called Medicare Advantage plans and re-enroll those people into the Enhanced Medicare. Re-evaluate funding and infrastructure before proceeding to the next step.

Step Two:

Enroll people of ages 0-17 and pregnant women through two years post delivery into the new Enhanced Medicare. Roll all of the monies currently being spent on those people into the new plan. Re-evaluate funding and infrastructure before proceeding to the next step.

Step Three:

Starting with ages 60-64, offer the new Enhanced Medicare to all Americans. As they enroll, they will begin paying their means-adjusted premium into the new plan. As funding and infrastructure allow, offer the new plan in 5 year age spans, working backward through the age groups, until all are covered. After each age group is enrolled, re-evaluate monies and infrastructure before proceeding to the next age group.

We would soon have Universal HealthCare Coverage by a Single Payer, utilizing the Federal Government only to collect the monies (and channel them by mandate into the HealthCare System), but staffed and administered by the private sector in a not-for-profit manner.

Simplicity Personified!

Mark E Green MD
463 POB BMH
Maryville, TN 37804
MarkGreen@OurHealthReform.com