

# TheHealthCareSuMMit

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## Guiding Principles to Protect and Improve the Health Status of All Americans Follow-up Report

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### Introduction:

The American health care delivery system is broken. Too many Americans have difficulty accessing services, and the quality of service continues to deteriorate.

Our system has become so broken that preventable health delivery system errors have risen to become the third leading cause of death in the United States – more than a quarter of a million deaths annually (almost 10 percent of all U.S. deaths) – according to researchers at the Johns Hopkins University School of Medicine based on data from the Centers for Disease Control and Prevention as published by the British Medical Journal. Only heart disease and cancer claim more lives.<sup>i</sup>

As American health care has become more deadly, it has also become extraordinarily inefficient. Not only is the cost of health insurance much too high, continuing to increase at a rate higher than inflation, but also less than half of the health insurance premium (45%) is actually spent to pay for health care services, necessary and unnecessary, a drop from 80 percent in the 1980s.

The majority of the health care premium (55%) is not spent on health care services. Rather, that money is redirected toward processing finances, litigation, compliance with regulations (that do not ensure safety, access, prevention of fraud or improvement of quality), state mandated benefits (that do not prevent, diagnose, treat or rehabilitate illnesses and injuries), and toward services never rendered (i.e. fraud).<sup>ii</sup>

When compared to the late 1970s and early 1980s, today there are more hospital delivery system errors (>14% versus <9%),<sup>iii</sup> and more hospital acquired infections (>6% versus <2%).<sup>iv</sup> In addition, physicians are spending less time with patients than they did in the 1990s, and there are more patient complaints about unexpected adverse treatment outcomes. Also, physicians and nurses are now complaining of “burn-out,” in part because of the added administrative distractions imposed by the increased insurance, regulatory and administrative burdens.

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The greatest root problem with the system is that health care consumers and their physicians have been removed from the health care decision making process. Patients and their doctors lack the power to effectively implement their chosen plan for the best individualized care. Instead, the insurance companies (private and public), the corporate owners of health care organizations and institutions, and the regulatory agencies are imposing the health care service decisions – not the consumer with his or her doctor.

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The guiding principles of the HealthCare Summit are to protect and improve the health status of all Americans. We believe that the best solutions offer choice and flexibility to health care consumers by integrating the strengths of the public and private sectors.

We recognize that the American health care financing and delivery system has made some positive gains since the HealthCare Summit's first report was issued in 2009. More Americans are insured and fewer are denied coverage because of pre-existing conditions. Also, for the first time there is a national minimum standard benefit plan which includes guaranteed issue regardless of age or pre-existing condition, evidence based chronic condition disease management programs, and wellness services. In addition, the federal government currently provides more funding for preventive services and public health population-based safety and preventive services.

But more reform is needed to curb costs, improve efficiency, and most importantly, save lives.

Our expert analysis concludes that effective reform must address and reduce skyrocketing medical care costs, and it must include transparency of medical information. It must also guarantee that all Americans have access to a "Medical Home," coordinated by their chosen primary care physician, and it must ensure that consumers and treating physicians regain their power as the primary health care service decision-makers.

We also specify key proposals for course of action that will have the most direct positive impact in swiftly achieving the most effective reform throughout our health care system.

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## **A Brief Review of the History of Federal Health Care Regulations:**

Congress has had an active role in regulating health care services for more than 200 years. The Office of Investigator General was established in 1778, and the Department of Health in 1791. It was not until 1906 that the next federal regulatory agency was created, the Food and Drug Administration.

In 1921, for the first time Congress funded services to encourage states to develop programs to serve lower income citizens (the Sheppard/Towner Act), and in 1946 Congress for the first time funded private hospital construction (the Hill/Burton Act).

Beginning in the 1970s Congress expanded its regulatory role significantly. In 1970, Congress created the Occupational Safety and Health Administration and in 1973, the Drug Enforcement Administration. Also, in 1973, Congress enacted Health Maintenance Organization regulations. In 1977, Congress created the Health Care Finance Administration (today called the Center for Medicare and Medicaid Services); and in 1986, Congress created the National Practitioner Data Bank. In 1987, Congress created nursing home regulations; in 1988, clinical laboratory regulations; and in 1989, physician practice regulations (Stark I), which were expanded in 1993 and 1999 (Stark II).

In 1990, Congress enacted the Americans With Disabilities Act, which further expanded federal health care service oversight. In 1996, patient/provider and provider/provider communication restrictions were enacted (the HIPPA Privacy regulations).

In addition to the regulatory expansion, beginning in the 1960s other congressional initiatives were enacted intended to expand access to health insurance, health care services, and improve service quality.

In 1965 Congress passed Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act. Over the next decade Congress created programs to expand services to other uninsured populations (Office of Economic Opportunity), to promote alternative delivery systems and insurance arrangements, such as Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), to fund hospital expansion, to fund health professional training programs, and to create a comprehensive health planning framework.

By the late 1970s, access improved for seniors and indigent citizens. Some service quality improved with the creation of regionalized tertiary centers. However, costs continued to rise at an alarming rate.

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By 1979, because of increasing health insurance costs, a “health care crisis” dominated political discourse. American companies were not competitive because of excessive employee health insurance costs. Middle class families had difficulty accessing services because they could not afford basic health insurance coverage.

Beginning in the 1980s, reacting to pressure to control costs, Congress eliminated the failed comprehensive health planning law and promoted additional health service delivery organizational structure changes intended to reduce costs. These initiatives encouraged (1) the development of comprehensive outpatient programs, (2) the expansion of medical group practices, (3) the collaboration between physicians and hospitals (Physician Hospital Organizations-PHOs), (4) the promotion of “managed care” programs, and (5) hospital ownership consolidation. However, costs continued to increase at a rate that exceeded inflation.

In 1997, Congress, responding to pressure to eliminate significant Medicaid enrollment requirement differences among states, created the Children’s Health Insurance Program to insure that children’s family income, not residence defined eligibility.

Two additional policies were implemented specifically to control the cost of government funded insurance programs. In 1984, the Diagnostic Related Group (DRG) payment system was created. In 1997, the sustainable growth rate formula was initiated. Both failed to reduce cost or slow increases. In 2016 the sustainable growth rate formula was repealed. The DRG payment system is still in effect today.

In 2010, the Affordable Care Acts were enacted. Congressional intent was to increase the quality and affordability of health insurance, to transform hospital and physician practices financially, technologically and clinically, and to improve service access and quality.

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## The HealthCare Summit<sup>v</sup>

The HealthCare Summit was founded in 2006 as a forum for experienced health care professionals to discuss and evaluate the cost effectiveness of the United States health care delivery system. The HealthCare Summit is an organization of the general public, non-governmental organizations, health insurance professionals, state government, and public service sector organizations. The membership is highly experienced in dealing with the costs and benefits of health care coverage, access to and quality of health care services.

HealthCare Summit participants believe the way to achieve significant reform is for all participants to accept their responsibility as providers, consumers, insurers and regulators of health care services and to embrace change that establishes measures to ensure a high quality, cost effective system that is financially viable, sustainable and fair. The public and private sectors must also address their responsibilities to provide a system that allows for consumer choice, and emphasizes wellness, prevention, education, and consumer empowerment.

The participants concluded that significant reform was needed in order to improve access to services, improve the quality of those services, and eliminate system waste which created significant financial burdens on users and payers. In 2009, the HealthCare Summit released a report entitled "Guiding Principles to Protect and Improve the Health Status of All Americans."

After release, the HealthCare Summit report and eight federal reform proposals received wide acclaim. Most of the HealthCare Summit federal reform proposals were endorsed by Congress and incorporated into the Patient Protection and Affordable Care Acts (ACA). This includes the Health Care and Education Reconciliation Act amendments, signed into law in 2010.

In 2016, the HealthCare Summit participants reconvened to discuss and evaluate the cost effectiveness, access to and quality of the United States health care delivery system since the enactment of the ACA, and the implementation of other recent Federal and State initiatives.

The 2009 original HealthCare Summit Guiding Principles of reform were:

- 1. Reform must address and reduce skyrocketing medical care costs.*
- 2. Reform must include transparency of medical information, including cost that will enable treatment choices.*

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3. *Reform must include public and private wellness promotion initiatives.*
4. *Reform must guarantee that all Americans have access to health care coverage, which includes health insurance and other alternatives, and must preserve or improve the current health insurance coverage or alternatives that provides benefits to 85% of Americans.*
5. *Reform must provide a source of coverage for the uninsurable populations of the United States.*

In 2016, after review of the current health care system the HealthCare Summit participants added the following two additional HealthCare Summit guiding principles of reform relating to access and quality:

6. *Reform must guarantee that all Americans have access to a “Medical Home,” coordinated by a primary care physician.*
7. *Reform must ensure that the consumers and treating physicians are the primary health care service decision-makers (not the insurance companies, the corporate owners of health care organizations and institutions, nor the regulatory agencies).*

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## **Guiding Principles – Discussion:**

### **1. Reform must address and reduce skyrocketing medical care costs.**

The key to the success of any health care reform plan is its ability to address the true underlying problem with our existing integrated public and private system – the cost of health care insurance. True accessibility to health care and private health insurance coverage is dependent upon whether or not it is affordable. Constraining skyrocketing costs is a critical aspect of health care reform.

Since the early 1970s, the cost of health insurance has continued to rise faster than annual inflation. Although the rate of increase slowed during the first years following the passage of the Affordable Care Acts (ACA), it is again increasing at a rate significantly above inflation.<sup>vi</sup>

The following areas are those where, if improved, the U.S. health care system could achieve lower costs, greater efficiency, enhance quality, and provide better access.

#### **A. Administrative Overhead, Regulatory Expenses, Benefit Mandates, Unnecessary Services, Fraud<sup>vii</sup>:**

As noted in the original HealthCare Summit report, research by the Office of Management and Budget showed that an average of 15% of health insurance premium is retained by insurance carriers to cover administrative expenses, including profit; and an additional 6% is spent by health care providers to comply with the regulatory and accreditation requirements. Research by the Kaiser Family Foundation and the Maryland Healthcare Commission documents that an additional 5% of the premium is used to pay for mandated benefits not proven effective, for non-essential personal life-style choices, and for non-patient care services. Pricewaterhouse Coopers research documents that an additional 10% of the premium goes to pay for litigation costs to process alleged malpractice complaints, including defensive medicine costs.

In addition, recent office surveys confirm that an additional 3% of the premium is spent by providers for administrative expenses related to processing claims and contracting with carriers and provider networks. The White Collar Crime Division of the FBI reports that 10% of premium is spent on fraudulent claims and services.

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The summit participants note that since the implementation of the Affordable Care Acts, these non-health service costs continue to increase. In addition, the newly created Accountable Care Organization's administrative costs add an additional 6% administrative overhead.

The total of the above expenses is 55%. Today only 45% of health insurance is spent on medical services, both necessary and unnecessary; including the regulations which ensure access, ensure safety, prevent fraud, improve quality; and the basic health service infrastructure.

Controlling these non-medical service costs could potentially reduce health insurance costs significantly.

## **B. Medical Malpractice – Tort<sup>viii</sup>:**

As noted in the original HealthCare Summit report, the amount health care providers must pay for medical liability insurance coverage is on the rise. This has directly impacted health care costs in this country. An additional costly side effect of rising medical malpractice insurance rates is the cost of defensive medicine (when doctors order more tests, prescribe more medication, and make more referrals than they believe are necessary to protect themselves from being accused of negligence). Since 1975, when medical malpractice insurance data was first separated from other types of liability insurance, medical malpractice cost increases have outpaced other tort areas, rising at an average of 11.7% a year. In 2004, medical malpractice costs totaled over \$28.7 billion, up from about \$26.5 billion the previous year. Medical liability costs and defensive medicine combined, currently account for 10% of medical care costs.

Extensive independent research documents that:

- Negligent and substandard acts occur by physicians, other health professionals and hospitals. However, negligent acts are far less common and more difficult to identify than originally thought. In the largest study of hospitalized patients (30,000 patients studied by the Harvard Law School), adverse events occurred in 3.7% of the patients. However, negligence occurred in only 1% of the patients, and physician, nurse or other hospital staff negligence occurred in only 0.3% of the patients (3 out of every 1,000 cases).
- The malpractice complaint process is inefficient, ineffective and unpredictable. It takes an average of 4.88 years to process injury claims in



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America (2006). Sixteen times as many patients suffer an adverse event from negligence as receive compensation using the tort system. For every dollar award paid to successful malpractice claimants, litigation and administrative overheads consume 60%. Only 40% of every dollar is paid to the patient and only 29% of the patient's share is used to pay for medical expenses.

- There is no association between compensation and the occurrence of an adverse event due to negligence or an adverse event of any type.
- The size of the settlement or jury award is based on the severity of the patient's disability, not the occurrence of an adverse event or an adverse event due to negligence.
- The malpractice complaint process has serious, unintended complications. Physicians order medically unnecessary procedures and tests believing that this will help in their defense. Some of these unnecessary procedures and tests cause the patient injury or illness. All of these procedures and tests add to the already high cost of health care.
- This fault based system relies upon public, adversarial proceedings to address patient claims. It introduces anxiety, distrust and second-guessing into the physician-patient relationship which should be one of trust, confidence, and patient involvement in the decision-making processes. Court actions for medical negligence take a considerable toll on the emotions and resources of both patient and provider.
- The tort system has not been successful in affecting meaningful improvement to the patient care process or accomplishing significant reduction in the incidence of patient injury. This is partly due to the random nature of medical malpractice litigation. It signals to health care providers that the likelihood of being sued for medical negligence is related to statistical chance rather than the quality of health care rendered.

In conclusion, the current malpractice complaint process using tort is expensive, lacks a nexus, is inefficient, and ineffective.

## **C. Service Delivery Inefficiencies and Quality Gaps<sup>ix</sup>**

As noted in the original HealthCare Summit report, service delivery inefficiencies lead to unnecessary use of expensive emergency department services, poor communication, delays of diagnosis and treatment, adverse

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drug events, redundant medical tests and medical errors – all of which increase morbidity, mortality, and cost.

It was noted that the National Center for Policy Analysis (NCPA.org) reports that the total cost of unnecessary emergency room visits and unnecessary physician office visits is just under \$31 billion annually, or about \$300 per American household per year. They also noted that “patient medical records are often handwritten and are usually maintained and stored separately by each physician, clinic or hospital used. Consequently, conditions affecting the patient may be unknown at the time of treatment. Because most patients see a number of physicians over time, care is fragmented, and doctors and other medical providers often must treat a patient with limited information. This lack of care coordination often leads to medical errors, adverse drug events and redundant medical tests.”

In addition, it was noted that according to research published in The Journal of the American Medical Association, during a 20-minute office visit, physicians spend less than one minute planning treatment (on average). In addition, more than two-thirds of the public (72%) think “insufficient time spent by doctors with patients” is one cause of preventable medical errors, and three-fourths (78%) think that the occurrence of medical errors could be reduced if physicians spent more time with patients.

Unfortunately, as reported in the New England Journal of Medicine, since the introduction of the electronic medical record, physician administrative efficiencies have not improved and the physician time spent with patients has not changed.

As reported in the British Medical Journal, the third most common cause of death in the United States is preventable medical errors caused by delivery system problems. Also, the CDC reports that hospital electronic medical record introduction and implementation has resulted in information errors which have caused significant patient harm.

## **2. Consumers must have transparency of medical information, including cost, which will enable treatment choices.<sup>x</sup>**

As noted in the original HealthCare Summit report, Americans are consistently using health care services more and more. This has a tremendous impact on health insurance premiums. In a report prepared by PricewaterhouseCoopers (on behalf of America’s Health Insurance Plans entitled *The Factors Fueling Rising Healthcare Costs 2006*), “higher utilization of services accounted for 43% of the increase, fueled by

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factors such as increased consumer demand, new and more intensive medical treatments and defensive medicine, as well as aging and unhealthy lifestyles.” Americans need to become more engaged as consumers. Informed shoppers are more efficient consumers, and efficient consumers spend less money.

Since the original HealthCare Summit report was released there is no evidence that transparency has improved.

### **3. Reform must include public and private wellness promotion initiatives.<sup>xi</sup>**

As noted in the original HealthCare Summit report, unhealthy behavioral and lifestyle choices contribute significantly to the cost of health care. Research shows behavior is a significant determinant of health status with as much as 50% of health care costs attributable to individual behaviors such as tobacco, alcohol, and drug use, poor diet, and a lack of exercise.

Increasing numbers of Americans are obese, often starting in childhood as a result of poor eating and exercise habits. According to the National Center for Health Statistics, 38% of adults (more than 75 million Americans) are obese, a 29% increase in the past decade. Research has also shown tobacco use is responsible for approximately 6% of total U.S. health care costs. These behaviors lead to many serious chronic health conditions such as cancer, diabetes, heart and cardiovascular disease. Consumers are seeking medical solutions for these lifestyle issues rather than correcting unhealthy behavior.

The American health care financing and delivery system has made some positive gains since 2010. Age appropriate preventive and wellness insurance coverage is now available and the federal government more fully funds public health services which are primarily population based preventive services, community based, and proven to be effective by scientific evidence.

### **4. Reform must provide programs for uninsured Americans, while preserving the current health insurance programs that provide benefits to 85% of Americans.<sup>xii</sup>**

As noted in the original HealthCare Summit report, in 2006, 85% of Americans had health insurance coverage, leaving 15% uninsured. Demographic information revealed that 19.4% of the uninsured in America had incomes between 100% and 200% of the federal poverty level (FPL). Therefore most of this segment of uninsured were eligible for Medicaid, but not enrolled. While mass enrollment may be challenging, attempts to identify and cover this population are extremely important. If coverage for all is the goal, then locating, enrolling, and funding for this population must be achieved.

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Other segments of uninsured included the Low Wage Workers (LWW) defined as working individuals earning between 60% and 250% of FPL and the “irresponsible uninsured” who have the access and income to purchase health care coverage, but did not. Thirty-nine percent (39%) of America’s uninsured had income levels above 200% of FPL, (\$40,000 for a family of four).

The largest percentage of the uninsured, 58.2%, were young adults ages 18 to 44. This population is arguably the healthiest segment of our society. Because this segment also spans all socio-economic categories, any meaningful reform must address this population.

The American health care financing system has made some positive gains since 2010.<sup>xiii</sup> More than 90% of Americans are now insured. Also, there is for the first time a national minimum standard benefit plan which includes guaranteed issue regardless of age or pre-existing condition; evidence based chronic condition disease management programs; and wellness services. Also, the Federal Government provides more funding opportunities for public health services, which are population-based and community-based.

## **5. Reform must provide a source of coverage for the uninsurable populations of the United States.<sup>xiv</sup>**

As noted in the original HealthCare Summit report, the uninsurable populations in the United States were persons who cannot qualify for health insurance because of a physical or medical condition. This group included (1) individuals who lost their coverage through reasons other than failure to pay their premium, (2) certain individuals who move from state to state and (3) individuals who have acquired disqualifying illnesses or injuries.

The American health care financing system has made some positive gains since 2010. Uninsurable populations currently have greater access to insurance through health exchanges and Medicaid.

## **6. Reform must guarantee that all Americans have access to a “Medical Home,” coordinated by a primary care physician.<sup>xv</sup>**

As noted above, health service delivery inefficiencies lead to unnecessary use of expensive emergency department services and urgent care centers, poor communication, delays of diagnosis and treatment, adverse drug events, redundant medical test and medical errors – all of which increase morbidity, mortality and cost.

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This inefficiency can be eliminated if every American had a “Medical Home.”

A “Medical Home” is defined as a consumer having access to a Primary Care Physician coordinator, selected by the consumer, who is the coordinating physician for all health system interfaces. That physician is patient-centered, is wholly accountable for a patient’s physical and mental health care needs (including prevention and wellness, acute care, and chronic care), directs a team that coordinates care across all elements of the broader health care system (including specialty care, hospitals, home health care, community services and supports), is accessible 24 hours a day/7 days a week, and is committed to quality and safety.

Today, a “Medical Home” is not available to millions of Americans. Consumers without a “Medical Home” access the system through emergency rooms, urgent care centers and pharmacies as their only available option – all non-comprehensive, expensive settings.

**7. Reform must ensure that the consumers and treating physicians are the primary health care service decision-makers (not the insurance companies, the corporate owners of health care organizations and institutions, nor the regulatory agencies).<sup>xvi</sup>**

Insured consumers can no longer choose their physician. Instead, the insurance company makes that decision for them by restricting the consumer’s choices to contracted providers within their networks. Today, except for regular Medicare, “no network” insurance plans are unavailable in most markets.

In addition, as a practical matter, the insurance company is making the consumer physician choice and treatment decisions, not the patient or the patient’s physician. Today, the physician’s consultation, treatment and medication decisions are determined by the insurance carrier’s contracting arrangements. Also, most diagnostic and treatment decisions require prior approval by the insurance carrier, often delaying the patient’s health care needs.

Furthermore, corporate owners of health care organizations and institutions are frequently making physician treatment decisions, not the treating physician. As a condition of many hospitals (or other health care institutional privilege and insurance contracts), providers must agree to adhere to certain practice guidelines which may conflict with specific patient needs or require medically unnecessary services or treatments for specific patients.

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## Reform Proposals:

- 1. Enact legislation to create more insurance company competition.** This would promote competitive pricing and improve efficiency. Therefore, reform should include enforcing current laws and creating new laws if necessary to promote competition and reduce insurance administrative service costs. The current average insurance retention of 15% of premium is excessive and could be reduced to 10% or less without compromising access or efficiency. Administrative services include (a) benefit plan creation, (b) enrollment, (c) premium collection, (d) provider credentialing and contracting, (e) claims adjudication, and (f) benefit plan coverage interpretation and benefit dispute resolution.
- 2. The federal government should create a “no-fault” dispute resolution process to adjudicate malpractice complaints to replace the current “tort” process.** The “no fault” process can be modeled after the Federal Vaccine Injury Compensation Program (FVIC) using a federal minimum standard whereby the court asks if the condition was avoidable and a result of the treatment. In addition, the federal government should enact legislation to require that administrative court processes, such as mediation or arbitration, precede any tort action in all alleged malpractice disputes.
- 3. The federal government should modify, simplify or eliminate laws, regulations and/or accreditation requirements which do not improve patient safety, quality, access, nor prevent fraud or abuse as determined by independent analysis based on objective risk/benefit criteria.** Examples include (a) eliminate the requirement that providers report a diagnosis (ICD10) to get paid for services rendered in that consumption of resources is not related to diagnosis; (b) eliminate the National Practitioner Data Bank in that tort does not identify negligence; (c) eliminate Stark regulations that don't prevent fraud; (d) apply HIPPA privacy regulations to research providers only, in that during the almost twenty years since enactment, there have been few non-research institution-related provider prosecution.
- 4. The federal government should retain those regulatory agencies which improve patient safety, patient access, service quality, or prevent fraud or embezzlement as determined by independent analysis based on objective risk/benefit criteria.**
- 5. Remove the federal and state legal obstacles to delivery system reform.** Federal legal obstacles are found in current antitrust laws, incentives which limit service prohibition, federal medical payment policies, privacy and security

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laws and anti-kickback laws (Stark II). State legal obstacles are found in current corporate practice of medicine laws, scope of practice limitation laws, and certificate of need laws.

- 6. Remove all mandated benefits (state and federal) for services that do not prevent, diagnose, treat or rehabilitate injuries and illnesses.**
- 7. The federal government should prosecute individuals and organizations that commit health service embezzlement and fraud.**
- 8. Re-structure the health care financing, delivery, regulatory and legal systems to support the creation of a “medical home” for all citizens** whereby the patient and their selected primary care doctor are the coordinators and decision makers of health care services.
- 9. Remove federal and state current obstructions to consumer provider choice.** An example of a current obstruction is the limitation of Medicaid insurance products to HMO products only.
- 10. Re-structure the health care financing, delivery, regulatory and legal systems to ensure that local health professionals have controlling authority** to determine the medically related management decisions and processes within medical groups, health care facilities, and other health care delivery organizations and systems.

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## Definitions:

**Cost sharing:** The share of costs covered by insurance that the consumer pays out of his or her own pocket. This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it does not include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and CHIP also includes premiums.

**DRG payment system:** DRG is short for Diagnostic Related Grouping, a system first implemented by the U.S. government in the 1980s for determining how much Medicare should reimburse hospitals for medical care. Hospitals are paid a fixed rate for inpatient services corresponding to the DRG group assigned to a given patient. The DRG payment system is also used by a few states and private health plans.

**Health Care Delivery System:** A health care delivery system supports the interaction of one or more people who seek advice, and/or treatment, for a physical or mental problem from others who have the knowledge to advise or treat that problem. The system can include as few as two individuals or an organization of people, institutions, and resources that deliver health care services to meet the health needs of individual or larger populations.

**In-Network:** In-network refers to providers or health care facilities that are part of a health plan contracted network.

**Managed Care:** A system of providing health care, such as a Health Maintenance Organization (HMO) or a Preferred Provider Organization (PPO), that is designed to control costs and improve quality through managed programs in which the physician accepts constraints on referral and treatment options and on the amount charged for medical care and the patient is limited in the choice of a physician.

**Mandated Benefits:** Insurance benefits required by law.

**Medical Home:** A “Medical Home” is defined as a consumer having access to a Primary Care Physician coordinator, selected by the consumer, who is the coordinating physician for all health system interfaces. That physician is patient-centered, is wholly accountable for a patient’s physical and mental health care needs (including prevention and wellness, acute care, and chronic care), directs a team that coordinates care across all elements of the broader health care system (including specialty care, hospitals, home health care, community services and supports), is accessible 24 hours a day/7 days a week, and is committed to quality and safety.



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**Medically Necessary:** Health care services or supplies needed to prevent, diagnose, treat, or rehabilitate illnesses or injuries.

**Out-of-Network:** An out-of-network provider is one which has not contracted with the insurance company.

**Physician-Hospital Organizations (PHOs):** A management service organization in which the partners are physicians and hospitals. The PHO organization contracts for physician and hospital services.

**Quality of Care:** Health care quality is the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes. Every American has his or her own definition of high-quality health care. For some people, that definition revolves around whether they can go to the doctor or hospital of their choice. For others, it means access to specific types of treatment. The Institute of Medicine defines quality health care as “safe, effective, patient-centered, timely, efficient and equitable.”

**Tort:** An action that wrongly causes harm to someone but that is not a crime and that is dealt with in a civil court.

**Transparency:** As used in science, engineering, business, the humanities and in other social contexts, transparency implies openness, communication, and accountability. Transparency is a lack of hidden agendas and conditions, accompanied by the availability of full information required for collaboration, cooperation, and collective decision making, including the disclosure of agreements, dealings, practices, and transactions for verification.

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<sup>i</sup> Martin Makary, et.al., Medical Error-the Third Leading Cause of Death in the US; BMJ, May 3, 2016, 353.

<sup>ii</sup> The Kaiser Family Foundation, Employer Health Benefits 2006; Office of Management and Budget 2006; TS Jost, EJ Emanuel, Legal Reforms Necessary to Promote Delivery System

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---

Innovation. JAMA 2008;299:2561-2563; Office of Management and Budget 2006; Kevin A. Schulman, et al, Reassessing ACOs and Health Care Reform, JAMA Vol 316 No 7, August 16, 2016; D. E. Wilson (Chair), Study of Mandated Health Insurance Services, Maryland Health Care Commission, January 15, 2004; Health Benefits, The Kaiser Family Foundation, July, 2004; Health Insurance Mandates in the States, Council for Affordable Health Insurance, July, 2004; California Health Policy Roundtable, Mandated Health Insurance Benefits; J Cubanski, H Schauffler, Tradeoffs Among Benefits, Coverage, and Costs?, Center for Health and Public Policy Studies, UC-Berkeley, July, 2002; VC. Bunce, JP Wieske, Health Insurance Mandates in the States 2008, Council for Affordable Health Insurance; White Collar Crime Division, Federal Bureau of Investigation, 2012; White Collar Crime Division, Federal Bureau of Investigation, 2005; Anand Parekh, G. William Hoagland, Medical Liability Reform in a New Political Environment, JAMA, February 15, 2017; Carol Peckham, Medscape Malpractice Report 2015, Why Most doctors Get Sued”, December 9, 2015; Leslie Kane, Medscape Malpractice Report, “Did they Deserve to Get Sued?”, July 24, 2013; Towers Perrin, US Tort Costs, 2005 Update, March 2006; PricewaterhouseCoopers for America’s Health Insurance Plans, The factors Fueling Rising Healthcare Costs 2006, February 2006; Associated Press Graphics. MD Liability.(sources: Medical Liability Monitor; AMA) March 2002; Studdert DM, Brennan TA. No-fault compensation for medical injuries: The prospect for error prevention. JAMA 2001: 286:217-23; Sage WM. Principles, pragmatism and medical injury: JAMA 2001:286:226-8; National Practitioner Data Bank Annual Report 1999, 2000, 2006; Studdert DM, Brennan TA, Thomas EJ. Beyond dead reckoning: measures of medical injury burden, malpractice litigation, and alternative compensation models from Utah and Colorado; Indiana Law Review 2000:33 no.4:1643-86; Oshel R. National Practitioner Data Bank Researcher, Policy Branch July 2000; Studdert DM, Thomas EJ, et al. Negligent Care and Malpractice Claiming Behavior in Utah and Colorado, Medical Care 2000: 38 no. 3:250-60; Kohn LT, Corrigan JM, Donaldson MS, et al, To Err Is Human, Building a Safer Health System. Committee on Quality of Health Care in America. Institute of Medicine, Nov 1999; Liang BA, Error in medicine: Legal Impediments to U.S. reform, J Health Polit Policy Law 1999: Feb 24(1) 27-58; Brennan TA, Sox C, Burstin H, Relation between negligent adverse events and the outcomes of medical malpractice litigation. NEJM 1996:335:1963-67; Todd JS. Reform of the healthcare system and professional liability. NEJM 1993:329:1733-35; Localio AR, Lawthers AG, Brennan TA, Relation between malpractice claims and adverse events due to negligence. Results of Harvard medical practice study III. NEJM: 1991: 325:245-51; Brennan TA, Leape LL, Laird N, et al, Incidence of adverse events and negligence in hospitalized patients. Results of Harvard medical practice study I. NEJM 1991:324:370-6; Leape LL, Brennan TA, Laird N, et al, The nature of adverse events in hospitalized patients. Results of Harvard medical practice study II. NEJM 1991:324:377-84; Hiatt HH, Barnes BA, Brennan TA, et al, A study of medical injury and medical malpractice: an overview. NEJM 1989:321:480-4; Mann JN, Lathrop C, Bannermann J. Economic impact of a botulism outbreak. Importance of the legal component in food-borne disease. JAMA 1982:249:1299-1301; Convenient Care and Telemedicine, Nation Center for Policy Analysis, Study #305; Overuse of Emergency Department among Insured Californians, California HealthCare foundation, October 2006; Bradley C. Strunk and Peter J. Cunningham, “Treading Water: Americans’ Access to Needed Medical Care, 1997-2001”, Center for Studying Health System Change, Tracking Report, Vol 1, March 2002; “Addressing the Problem of Low Acuity Non-emergent ER Visits”, Mercer Human Resources Consulting, January 2006; See Occupational Health Management, “Self-Care Can Save Millions in Health Costs: Unnecessary Visits to ED, other Coasts Avoided”, Occupational Health Management, November 2001; Robert K. Blendon et al, “Views of Practicing Physicians and the Public on Medical Errors.”, NEJM, Vol. 347, No. 24, December 12, 2002, pages 1,933-40; “Quality Matters: Care Coordination,” Commonwealth Fund, Vol. 24, May/June 2007; Ronald M. Epstein et al, Communicating Evidence for participatory

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---

Decision Making, JAMA, Vol.291, No. 19, May 19,2004; M. Tai-Seale et al, Time Allocation in Primary Care Visits, HSR Vol 42(5), Pages 1871-1894. summarized in Healthcare Economist, September 24, 2007; The state of Health Care Quality 2006, National Committee for Quality Assurance.

<sup>iii</sup> Daniel R. Levinson, Hospital Incident Reporting Systems Do Not Capture Most Patient Harm, Office of Inspector General, DHHS, January, 2012; David C. Classen, et al, Global Trigger Tool Shows that Adverse Events in Hospitals May be Ten times Greater Than Previously Measured, Health Affairs, April 2011; To Err Is Human, Building a Safer Health System, Institute of Medicine, November 1999; Ross Koppel, EMR Entry Error: Not So Benign, PSNet, April 2009; Stephanie Baum, EHRs May Turn Small Errors Into Big Ones, Practice Management, December 16, 2012; John T. James, A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care, Journal of Patient Safety, Vol. 9 Issue 3, September 2013; Tim Xu, et al, The Potential Hazards of Hospital Consolidation, JAMA, Vol 314 No 13, October 6, 2015; Jonathan B. Perlin, Health Information Technology Interoperability and Use for Better Care and Evidence, JAMA, Vol. 316 No 16, October 25, 2016.

<sup>iv</sup> CDC Hospital Acquired Infection Reports, 1970 through 1985; Hospital Associated Infections, CDC Reports, 2013-2015.

<sup>v</sup> Guiding Principles to Protect and Improve the Health Status of All Americans, The HealthCare Summit, Feb.2009; Federal Reform Proposals, The HealthCare Summit, Feb. 2009; Public Law 111-152 (Health Care and Education Reconciliation Act)-2010; Public Law 111-148 (Patient Protection and Affordable Care Act)-2010; CDC, National Center for Health Statistics, May 2016; Publications and multiple studies from the following: The Kaiser Family Foundation, Office of Management and Budget, Maryland Health Care Commission, The Kaiser Family Foundation, California Health Policy Roundtable, Center for Health and Public Policy Studies UC-Berkeley, Council for Affordable Health Insurance, White Collar Crime Division of the Federal Bureau of Investigation, Journal of the American Medical Association (JAMA), Towers Perrin, PricewaterhouseCoopers, Associated Press Graphics MD Liability, National Practitioner Data Bank, Indiana Law Review, Committee on Quality of Health Care in America, Institute of Medicine, J Health Political Policy Law, NEJM, Nation Center for Policy Analysis, California HealthCare Foundation, Center for Studying Health System Change, Mercer Human Resources Consulting, Occupational Health Management, Commonwealth Fund, National Committee for Quality Assurance, Mercer Management Journal, Centers for Disease Control and Prevention, Partnership for Prevention, National Association of County & City Health Officials, American Public Health Association, American College of Physician Executives (now known as the American Association for Physician Leadership), American Academy of Pediatrics, Health Affairs, The Flexner Report, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research; Public Law 89-97 (Titles XVIII – XX of the Social Security Act-HR 7260) and amendments; Financing of Health Care, 1979; British Medical Journal, May 3 2016; David C. Cassin, et. al., Global Trigger Tool Show that Adverse Events in Hospitals May be Ten Times Greater than Previously Measured, Health Affairs, 30, no 4, 2011; Lisa Rosenbaum, Transitional Chaos or Enduring Harm? The HER and the Disruption of Medicine, NEJM, October 22, 2015; Evan Schuman, CDC on HER errors: Enough's enough, CDC, July 8, 2014; John T. James, A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care, Journal of Patient Safety, Vol 9, September 2013, p 122-128.

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---

<sup>vi</sup> Congressional Budget Office Reports, 2014, 2015, 2016.

<sup>vii</sup> Administrative overhead references: The Kaiser Family Foundation, Employer Health Benefits 2006; Office of Management and Budget 2006; TS Jost, EJ Emanuel, Legal Reforms Necessary to Promote Delivery System Innovation. JAMA 2008:299:2561-2563.

Regulatory overhead reference: Office of Management and Budget 2006; Kevin A. Schulman, et al, Reassessing ACOs and Health Care Reform, JAMA Vol 316 No 7, August 16, 2016.

Mandated Benefits references: D. E. Wilson (Chair), Study of Mandated Health Insurance Services, Maryland Health Care Commission, January 15, 2004; Health Benefits, The Kaiser Family Foundation, July, 2004; Health Insurance Mandates in the States, Council for Affordable Health Insurance, July, 2004; J Cubanski, H Schaufner, California Health Policy Roundtable, Mandated Health Insurance Benefits; Tradeoffs Among Benefits, Coverage, and Costs?, Center for Health and Public Policy Studies, UC-Berkeley, July, 2002; VC. Bunce, JP Wieske, Health Insurance Mandates in the States 2008, Council for Affordable Health Insurance.

Fraud: White Collar Crime Division, Federal Bureau of Investigation, 2012; White Collar Crime Division, Federal Bureau of Investigation, 2005.

<sup>viii</sup> Medical Malpractice references: Anand Parekh, G. William Hoagland, Medical Liability Reform in a New Political Environment, JAMA, February 15, 2017; Carol Peckham, Medscape Malpractice Report 2015, Why Most doctors Get Sued”, December 9, 2015; Leslie Kane, Medscape Malpractice Report, “Did they Deserve to Get Sued?”, July 24, 2013; Towers Perrin, US Tort Costs, 2005 Update, March 2006; PricewaterhouseCoopers for America’s Health Insurance Plans, The factors Fueling Rising Healthcare Costs 2006, February 2006; Associated Press Graphics. MD Liability. (sources: Medical Liability Monitor; AMA) March 2002; Studdert DM, Brennan TA. No-fault compensation for medical injuries: The prospect for error prevention. JAMA 2001: 286:217-23; Sage WM. Principles, pragmatism and medical injury, JAMA 2001:286:226-8; National Practitioner Data Bank Annual Reports 1999, 2000, 2006; Studdert DM, Brennan TA, Thomas EJ. Beyond dead reckoning: measures of medical injury burden, malpractice litigation, and alternative compensation models from Utah and Colorado; Indiana Law Review 2000:33 no.4:1643-86; Oshel R. National Practitioner Data Bank Researcher, Policy Branch July 2000; Studdert DM, Thomas EJ, et al, Negligent care and malpractice claiming behavior in Utah and Colorado, Medical Care 2000: 38 no. 3:250-60; Kohn LT, Corrigan JM, Donaldson MS, et al, To Err Is Human, Building a Safer Health System. Committee on Quality of Health Care in America, Institute of Medicine, Nov 1999; Liang BA. Error in medicine: Legal Impediments to U.S. reform. J Health Polit Policy Law 1999: Feb 24(1) 27-58; Brennan TA, Sox C, Burstin H, Relation between negligent adverse events and the outcomes of medical malpractice litigation, NEJM 1996:335:1963-67; Todd JS, Reform of the healthcare system and professional liability. NEJM 1993:329:1733-35; Localio AR, Lawthers AG, Brennan TA, Relation between malpractice claims and adverse events due to negligence. Results of Harvard medical practice study III. NEJM: 1991: 325:245-51; Brennan TA, Leape LL, Laird N, et al, Incidence of adverse events and negligence in hospitalized patients. Results of Harvard medical practice study I. NEJM 1991:324:370-6; Leape LL, Brennan TA, Laird N, et al, The nature of adverse events in hospitalized patients. Results of Harvard medical practice study II. NEJM 1991:324:377-84; Hiatt HH, Barnes BA, Brennan TA, et al, A study of medical injury and medical malpractice: an overview. NEJM 1989:321:480-4; Mann JN, Lathrop C, Bannermann J. Economic impact of a botulism outbreak. Importance of the legal component in food-born disease. JAMA 1982:249:1299-1301.

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---

<sup>ix</sup> Service Delivery Inefficiencies and Quality Gaps References: Convenient Care and Telemedicine, Nation Center for Policy Analysis, Study #305; Overuse of Emergency Department among Insured Californians, California HealthCare foundation, October 2006; Bradley C. Strunk and Peter J. Cunningham, Treading Water: Americans' Access to Needed Medical Care, 1997-2001, Center for Studying Health System Change, Tracking Report, Vol 1, March 2002; Addressing the Problem of Low Acuity Non-emergent ER Visits, Mercer Human Resources Consulting, January 2006; Self-Care Can Save Millions in Health Costs: Unnecessary Visits to ED, other Coasts Avoided, Occupational Health Management, November 2001; Robert K. Blendon et al, Views of Practicing Physicians and the Public on Medical Errors, NEJM, Vol. 347, No. 24, December 12, 2002, pages 1,933-40; Quality Matters: Care Coordination, Commonwealth Fund, Vol. 24, May/June 2007; Ronald M. Epstein et al, Communicating Evidence for Participatory Decision Making, JAMA, Vol.291, No. 19, May 19,2004; M. Tai-Seale et al, Time Allocation in Primary Care Visits, HSR Vol 42(5), Pages 1871-1894. summarized in Healthcare Economist, September 24, 2007; The state of Health Care Quality 2006, National Committee for Quality Assurance.

<sup>x</sup> PricewaterhouseCoopers, The Factors Fueling Rising Healthcare Costs, 2006; Amol S. Navathe, et al, Physician Peer Comparisons as a Nonfinancial Strategy to Improve the Value of Care, JAMA Vol 316 No 17, November 1, 2016; J. Matthew Austin, et al, Fostering Transparency in Outcomes, Quality, Safety, and Costs, JAMA Vol 316 No 16, October 25, 2016.

<sup>xi</sup> Public and Private Wellness Promotion Initiatives References: Public Law 111-152 ("Health Care and Education Reconciliation Act")-2010; Public Law 111-148 ("Patient Protection and Affordable Care Act") -2010; Katherine M. Flegal, et al, Trends in Obesity Among Adults in the United States, 2005 to 2014, JAMA, Vol.315 No. 21, June 7, 2016; CDC, Centers for Disease Control and Prevention, Smoking and Tobacco Use, 2014; CDC, National Center for Health Statistics, May 2016 Mercer Management Journal 18; Centers for Disease Control and Prevention; Employee Benefit News, Employers tackle obesity, Centers for Disease Control and Prevention, January 2006, <http://www.cdc.gov/nccdphp/dnpa/obesity/trend/maps/>; Centers for Disease Control and Prevention, Morbidity and Mortality Weekly Report, July 8, 1994; Douglas B. Kamerow, MD, Designing a High-Quality Package of Preventive Services, December 2008, Partnership for Prevention; Real Health Reform Starts with Prevention, December 2008, Partnership for Prevention; NACHO Recommendations for a Public Health Component to Fiscal Stimulus Legislation, National Association of County & City Health Officials, December 2008; Joseph Dielerman et al, <http://healthyamericans.org/health-issues/wp-content/uploads/2015/02/Prevention-Fund-Background.pdf>, <https://www.cdc.gov/chronicdisease/>, US Spending on Personal Health Care and Public Health, 1996-2013, JAMA Vol. 316, No. 24, December 27, 2016.

<sup>xii</sup> Uninsured Americans References: MedScape Today – January 8, 2008 - Nations Health. 2007;37(8) ©2007 American Public Health Association; Public Law 111-152 ("Health Care and Education Reconciliation Act")-2010; Public Law 111-148 ("Patient Protection and Affordable Care Act") -2010; CDC, National Center for Health Statistics, May 2016

<sup>xiii</sup> Jessica C Barnett & Marina Vornovistsky, United States Census Bureau, Sept.13, 2016; Lewis E. Weeks, et al, Financing of Health Care, 1979; Katharine R. Levit, et al, Americans' health insurance coverage, 1980-91, Health Care Financing Review/Fall 1992, volume 14, Number 1;

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---

Jessica C Barnett, et al, Health Insurance Coverage in the United States:2015,US Census Bureau, September 13, 2016; CDC, National Center for Health Statistics, September, 2016.

<sup>xiv</sup> Uninsurable Populations References: CAHI, Merrill Mathews; June 16, 2008

<sup>xv</sup> Medical Home References: American Academy of Pediatrics, The Medical Home, Pediatrics, Vol 110, July 1, 2002; Agency for Healthcare Research and Quality (AHRQ), Features of the Medical Home; Department of Health and Human Services, Health Resources & Services Administration, What is a medical home? Why is it important?; National Committee for Quality Assurance, The Patient Centered Medical Home (PCMH); Kenneth Osgood, et al, The Impact of Pediatricians on Hospital Utilization, American Journal of Public Health, October, 1980; Laura S. Sessums, Medicare's Vision for Advanced Primary Care, JAMA Vol. 315 No. 24 June 28, 2016; Peter B. Angood, Caring and Compassion vs. Compensation, American Association for Physician Leadership, November/December 2016; John K Iglehart, The Expansion of Retail Clinics- Corporate Titans vs. Organized Medicine, NEJM, July 23,2015; Howard C. Koh, Improving Health and Health Care in the United States, JAMA Vol 316 No 16, October 25, 2016.

<sup>xvi</sup> Patient/Physician Decision-maker References: John R Graham, Hospital Ownership of Physicians Drives up Costs, JAMA Internal Medicine, November, 2015; Sue Porter, Unintended Consequences: Obstruction of Patient Choice, The Bioethics Program, May 19, 2013; Martin Makary, et al, The Potential Hazards of Hospital Consolidation, JAMA, Vol 314 No. 13, October 6, 2016; Noam Scheiber, Doctors Unionize to Resist the Medical Machine, New York Times, January 9, 2016; Mark B. McClellan, et al, Competencies and Tools to Shift Payments from Volume to Value, JAMA Vol. 316 No.16, October 25, 2016; AMA Wire, 3 changes CMS is making to put patients back at the center of care, February 23, 2016.