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July/August 2008 Volume 6, Number 4

Going Green, Part 2

Why Hospitals Are Making the Investment

by Lisa Jaffe Hubbell

According to Anna Gilmore Hall, Executive Director of Healthcare Without Harm, the future economic survival of healthcare organizations could depend on their ability to go "green." The June issue of *Nightingale's* examined some of the ways hospitals are saving money by adopting environmentally responsible practices. This issue offers more examples of the cost savings that are being achieved around the country.

Going green can start with the simple practice of recycling. Recycling not only saves money on waste, it earns money in most markets. Cardboard, batteries, aluminum – they all bring in money. Just educating employees about waste can reap huge benefits. Go through the "red bag" waste at most hospitals, and chances are pizza boxes and newspapers have

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New Physician Recruitment Rules

Stark II, Phase III Regulations Go Into Effect

by Steve Raphael

Hospital executives should reexamine their written policies addressing physician recruitment to ensure they are in compliance with Phase III of the Stark II regulations that took effect this past December.

That's the message from Atlanta healthcare attorneys H. Carol Saul and Kimberly Ruark of Epstein, Becker & Green, two of the nation's top experts on physician recruitment rules. The pair shared their thoughts about the impact of the Stark change with hospital executives and attorneys during a recent teleconference, "Physician Recruitment Rules," sponsored by The Beard Group.

Phase III final rules tightened some physician recruiting rules and loosened others initially

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Carl Marks Adds Healthcare Unit

Boutique Consultant Aims at Turnaround Market

by Lisa Jaffe Hubbell

New York boutique consulting firm Carl Marks & Co. added a new healthcare business unit in June, hoping to create a largely independent unit that can work in the mid-sized healthcare market. It is a part of the market that doesn't have a lot of attention, says David Rock, Managing Partner of the Carl Marks Healthcare Partners unit. "Cap Gemini used to do a lot of mid-market work, but mostly it's just other boutique firms now." Rock says he won't be competing against the bigger groups because he doesn't seek the huge clients they go after.

Rather the new unit will focus on community and other hospitals up to 500 beds. They'll do due diligence for banks and investment groups looking to invest in healthcare, or help

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Going Green, *from page 1*

been included in waste that costs multiple times the rate of regular waste to dispose of.

Virginia Mason Hospital in Seattle is a good example of how recycling programs are reaping big benefits. Stephen Grose, the hospital's Administrative Director in charge of overseeing environmental and recycling efforts, says that they have a full recycling campaign for public areas, office areas, and procedure and exam rooms. The result has been a 30% reduction in waste. "We pay $10 per ton tipping charges," he explains. "Every time they hook up to a dumpster, it is $180. We are at about $167 per ton of waste overall. And recycling is free." For 2007 – the campaign started in March of that year – they reduced waste by 225 tons.

Aside from recycling, Virginia Mason has begun composting in its kitchens – about 750 pounds per day – removed Styrofoam from kitchens, and gone to fully compostable products (including corn-based drink lids). The composting means they don't have to use water to run the disposals, which saves about $200 per day. The hospital also encourages people to use dishes rather than disposable plates. And although healthcare is a single-use industry, Virginia Mason found ways to change, spending $30-$50 each for reusable containers for sterilized items that used to be wrapped in sterile surgical wrap. While they spent $300,000 on the reusable containers, over time it will pay for itself in reduced costs and waste.

Broward Health in south Florida was able to reduce red bag waste by 50% over three years just by educating staff, says Patricia O'Rourke, Corporate Safety Coordinator. O'Rourke says she still looks through the occasional red bag. Recycling has led to further savings, says Joe Rogers, Senior Vice President of Broward Health. The hospital recycles 880,000 pounds of paper per year, saving 4 cents a pound in waste costs. Given that costs of waste disposal have doubled in the last eight years – and are likely to continue to rise – any waste that isn't created is a further savings.

Other money-saving tips: make double-side printing and copying the default setting for all computers, printers, and copiers. One-sided printing or copying can always be specified when needed. Compact fluorescent bulbs are a no-brainer. Grose says that Virginia Mason has saved about $300,000 per year in electric costs after spending about $2 million on changes.

While going green has improved Virginia Mason's bottom line, Grose points out there are other benefits. Seattle is known as a green community, and some of the impetus for greening Virginia Mason hospital and clinics has come from employees. Indeed, Grose thinks that listening to them about being greener has helped with employee retention. "They want to work for an organization that cares."

There are marketing benefits also. Being green is chic, says O'Rourke. If you're the only green hospital in the area, you get a certain brand recognition, she says. Grose agrees. "The odd ones out are the ones not doing this," he says. "Whatever you do, don't do nothing. Do something. Think long term, medium term, and think tomorrow. I end every meeting by asking what can be done the next day. Things snowball when you do that. The operating room wasn't even on my radar until a radiology technician came in with an aluminum canister one of the drugs came in and wanted to know if it could be recycled."

For healthcare companies interested in going green, there's plenty of help available, says Grose. "While healthcare is a competitive industry, the people who work in supply chains and engineering are not competitive. We network actively and are very willing to share ideas."

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Physician Recruitment, *from page 1*

promulgated in Stark Phase I and Phase II regulations. The rule changes apply to any sized practice, whether a solo practitioner, a group of 10, or a group of 100 physicians.

The final rules broaden the geographic areas where physicians can be recruited and relax restrictions on recruited physicians where the arrangement is through an existing group. The changes should make it easier for hospitals to recruit doctors to practice in underserved and rural areas, as well as alleviate shortages in key specialties.

"Before Stark II, Phase III, it was unclear if employment agreements could impose restrictive covenants upon doctors," Saul said. "Without fully summarizing the tortured rule-making process that followed the enactment of Stark laws, suffice it to say that it often left the provider community with more questions than answers. With the completion of the final rules, some of the ambiguities have been cleared up."

"This is not an exception that allows in-house legal departments, or outside counsel, to simply prepare documents for their management teams and let them run with them through negotiations. There needs to be written policies and continual legal involvement and compliance monitoring of the entire process," Saul continued.

The prior regulations, issued by the Centers for Medicare and Medicaid Services (CMS) in 2004, changed the recruitment exception dramatically. "Suddenly groups were wary of recruiting because they couldn't have noncompetes for recruited physicians, and everyone was scrambling to restructure existing arrangements, revise recruiting policies, and rework agreements," Ruark said. Phase III of Stark II addresses some of these concerns by making the following changes:

- The recruitment exception is now available to hospitals, federally qualified health centers, and rural health clinics;
- Alternative methods for defining the "geographic area served by the hospital" are now permitted, particularly with more options for rural hospitals; and
- Additional categories of physicians are now exempt from the relocation requirement.

Regarding location, Ruark said the final rules clarify the hospital's service area, allowing a physician to move his or her practice 25 miles to a point inside the geographic service area. "The previous definition was written so narrowly that a hospital in this situation would not qualify for the recruitment exception at all."

CMS also said that, regardless of a hospital's location, the service area is to be set at the time the recruitment documents are executed. According to Ruark, "CMS acknowledged that the hospital's service area may be different for different recruits, based on a number of factors, such as age and demographic of patients in the hospital service area. CMS also said a service area for a multiple hospital system is determined by the location of each hospital within the system."

Saul added that the relocating physician must join the hospital's medical staff and can have had no prior staff privileges of any level at the recruiting hospital (including courtesy privileges). "Stark II, Phase III exempts from the relocation requirement those physicians who, for two years immediately prior to the recruitment arrangement, were employed on a full-time basis in the state or federal prisons systems, the defense or veteran affairs departments, as well as facilities of the Indian Health Service – assuming the physician did not maintain a separate private practice in addition to such full-time employment," she said.

Today an existing practice can retain payments for direct recruiting expenses, such as a headhunter fee, travel expenses, and

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Research Report

Who's Who in Inverness Medical Innovations, Inc. and Matria Healthcare, Inc.

by Francoise C. Arsenault

Inverness Medical Innovations, Inc. (Inverness) is a leading global developer, manufacturer, and marketer of advanced consumer and professional medical diagnostic products. The company, which is headquartered in Waltham, Massachusetts, supplies consumer pregnancy and fertility/ovulation tests and rapid point-of-care diagnostic products, including tests for infectious diseases, cancers, drugs of abuse, and serum cholesterol levels. The company's consumer diagnostics include the First Check brand of drug testing products. The company's latest areas of focus include the application of patented technologies to products in consumer and professional diagnostics, principally in the fields of cardiology, women's health, and infectious diseases.

Inverness also manufactures and markets a wide variety of consumer vitamins and nutritional supplements, including StressTabs vitamins and Posture-D calcium supplements. The Inverness Medical Nutritionals Group makes private-label vitamin supplements. Inverness has approximately 10,500 employees and revenues of approximately $840 million in 2007.

Matria Healthcare, headquartered in Marietta, Georgia, is a leading provider of health enhancement and high-risk pregnancy management programs and services to approximately 1,000 employers and managed-care groups across the United States. The company provides its programs and services through its Health Enhancement and Women's and Children's Health divisions. The mission of Matria Healthcare is to assist employers, health plans, and the government's healthcare programs in transforming the healthcare system from within by developing better educated, motivated, and self-enabled consumers.

Matria Healthcare manages major chronic diseases and episodic conditions including diabetes, congestive heart failure, coronary artery disease, asthma, chronic obstructive pulmonary disease, high-risk obstetrics, cancer, musculoskeletal and chronic pain, depression, obesity, and other conditions. The company delivers programs that address wellness, healthy living, productivity improvement, and navigation of the healthcare system, and provides case management of acute and catastrophic conditions. Matria Healthcare operates through nearly 50 offices around the United States. In 2007, Matria Healthcare had revenues of approximately $350 million.

Inverness entered into an agreement and plan of merger to acquire Matria Healthcare on January 27, 2008, for approximately $900 million in cash, stock, and assumed debt. The terms of the final acquisition, which was completed on May 9, 2008, provided for a purchase price of approximately $143.9 million and approximately 1.8 million shares of preferred stock. In addition, existing options to purchase Matria Healthcare stock were assumed by Inverness and converted into options to purchase approximately 1.5 million shares of Inverness common stock. As a result of the merger, Matria Healthcare's common stock no longer trades on the NASDAQ stock market. Pursuant to the merger, each outstanding share of Matria Healthcare common stock not owned by Matria Healthcare or its affiliates and not subject to appraisal rights has been automatically converted into the right to receive $6.50 in cash, without interest, and a portion of a share of Inverness preferred stock. The shares of preferred stock began trading on the American Stock Exchange as of the opening of the market on May 9, 2008.

Within 90 days of the close of the acquisition, Inverness intends to consolidate Matria Healthcare with the recently acquired Alere Medical and ParadigmHealth businesses. In late May, Inverness announced that private equity investors were interested in buying a half interest in the new joint venture of Matria, Alere Medical, and ParadigmHealth. The investors would pay Inverness $600 million for the interest, and the joint venture would borrow another $600 million to turn over to the company.

Transaction Professionals

Ron Zwanziger is the Chairman of the Board, Chief Executive Officer, and President of Inverness. **David Scott** is the Chief Scientific Officer. **Ellen Chiniara** is the General Counsel and Assistant Secretary. **Paul T. Hempel** is Senior Vice President, Leadership Development & Special Counsel. **Jon Russell** is Vice President, Finance. **David Teitel** is the Chief Financial Officer.

Parker H. Petit is the Chairman of the Board and Chief Executive Officer of Matria Healthcare, Inc. **Thomas D. Underwood** is the President and Chief Operating Officer. **Jeffrey L. Hinton, Sr.** is Senior Vice President and Chief Financial Officer. **Roberta L. McCaw** is Senior Vice President, General Counsel, and Secretary. **Thornton A. Kuntz, Jr.** is Senior Vice President and Chief Administrative Officer.

The law firm of **Goodwin Proctor LLP** served as the outside legal advisor to Inverness on the acquisition. **Scott F. Duggan**, a partner in the firm's Boston office, directed the work on the acquisition.

Troutman Sanders LLP acted as the legal advisor to Matria Healthcare for the acquisition. **James L. Smith, III,** and **David W. Ghegan**, partners in the firm's Atlanta office, directed the work on the transaction.

SunTrust Robinson Humphrey, Inc. provided Matria Healthcare with financial advisory services and rendered an opinion on the fairness of the transaction to the Matria Healthcare Board of Directors.

The Maren Group, LLC also served as the financial advisor to Matria Healthcare in connection with the identification of potential purchasers for the company. **Sean McDevitt**, a Managing Director and founding principal of The Maren Group, led the team.

Covington Associates LLC served as a financial advisor to Inverness on the acquisition. **Chris Covington**, the founder and a Managing Director, and **Tom Cibotti**, a Managing Director, directed the work on the engagement.

UBS Investment Bank also served as a financial advisor to Inverness on the purchase of Matria Healthcare.

Dewey & LeBoeuf LLP served as the legal advisor to UBS Investment Bank. **Denise A. Cerasani**, a partner in the firm's New York office, directed the work.

D.F. King & Co., Inc. acted as the information agent and communications consultant to Matria Healthcare.

Going Green, *from page 2*

"This wasn't true a decade ago," he continues, "those who tried to go green were few and far between. There wasn't a lot of information about what to do, what worked, and what didn't."

Now, the list of organizations that can help is long. Among the best, says Hall: Healthcare Without Harm (www.noharm.org); the Green Guide for Healthcare (www.gghc.org) which focuses on green building; and the Luminary Project, which publishes stories from nurses about environmental projects that work. There are entire conferences devoted to the topic, like the annual CleanMed conference (www.cleanmed.org).

More architects, designers, and builders are also incorporating green into their practices. Therefore, any healthcare organization planning to build or remodel can find expertise and see examples of green design in action. There are plenty of real-life examples to emulate. Hall notes that Kaiser Permanente, Boulder Community Hospital, Children's Hospital in Seattle, and St. Mary's Hospital in Green Bay, WI, are among the hospitals that have gone green.

But bear in mind, that going green can be more modest than a structural redesign and there's always something new to try. LED lighting technology is growing, changing, and getting cheaper. There are also increasing opportunities for hospitals to become energy producers. Grose says Virginia Mason is looking at using waste heat, solar power, and wind turbines to generate power. ¤

Physician Recruitment, *from page 2*

meals, "otherwise people could think that the hospital is giving money to an existing practice as a means to induce the practice to refer its patients," Saul said.

Whereas the previous Stark rules limited the costs to be allocated to a recruited physician, Stark II, Phase III opened up income guarantees to apply to any type of guarantee, such as net income and gross revenue, Ruark said.

Hospitals recruiting physicians to join an existing practice located in underserved or rural areas now have more flexibility for expense allocations. CMS eased the rule for recruiting into an existing practice while allowing some practice restrictions, such as moonlighting and requiring a physician to treat the poor, Ruark said. Any of the reasonable restrictive covenants imposed on a recruited physician must also comply with appropriate state law, including kick back statutes.

Hospitals and physicians seeking exceptions to any of the changes can seek an advisory opinion from CMS. Advisory opinions are binding only on CMS and not on the Department of Justice or the Office of the Inspector General. An opinion may be rescinded and the material submitted may be retained by the government and used for any purpose, Saul said.

"Hospitals with written policies should review those policies, but that alone is not enough," Saul said. "They must evaluate their medical staff development plan as well." She recommended that hospitals take a close look at the new regulations to see if they can offer more options to recruit new physicians. "Take the time to sit down and work through these changes as they apply to your individual situation." And, when structuring new arrangements, remember that Stark is only one law to be considered, she added. ¤

Carl Marks, *from page 1*

smaller hospitals determine if merging with a larger entity is in their best interest. If they do work for larger businesses, it will be on a departmental level, like operating theater operations or emergency department throughput.

One hot topic Rock expects to work a lot on is one-day stay operations. "We help organizations understand one-day stay areas, help with next steps and implementation of plans." Another area Rock says they'll work relates to the increasing trend for group medical practices to merge into larger units of 60-100 or more physicians. "In the Northeast, hospitals are struggling to understand the impact of those groups on their organizations," he says. "There are many different reactions, including some hospitals purchasing smaller practices to keep them out of larger groups. Their fear is that large group practices will have significant leverage and may start ancillary services that compete with their facility."

Carl Marks has worked in turnarounds for middle-market companies for over 80 years. But over time, the firm was doing more investment and advisory work in healthcare. "The company wanted to take advantage of this growing market and formalize the work they do in healthcare," says Rock, who along with Co-Managing Partner Martin Payson came to the firm with years of experience in healthcare consulting and management.

There will likely be overlap with some of the other units, he says. "I can tap into the expertise in finance or turnarounds outside of this unit. But those groups don't have the depth of experience in healthcare, and it's often a more complex industry than others." Having a separate unit will enable Rock to differentiate with prospective consultants. "At some points we intersect, but we are mostly independent and separate," Rock adds.

There are already signs of success in the unit. Consultants have been working with a 250-bed community hospital in the Northeast that has been struggling operationally. "We replaced some senior executives, restructured their strategy, looked at the community they served and their competition and were able to set them on a whole new direction," Rock says.

A generalized example of what they did might involve looking at a hospital's area demographics. That study could show that an aging population has more need of an orthopedic program and joint replacement specialty than does a pediatric hospitalist program or a new obstetrics facility.

Another success story involves a hospital and a large supply-chain engagement. "They had two other consultancies in before us, and they did identify some cost savings," Rock says. "But the hospital felt there was still money on the table. We went in and looked at the pricing of products the other consultants didn't study and we looked at how they moved products internally. They had too much of some supplies, not enough of others. They had too much space for supplies that could have been used for other things."

In the end, the Carl Marks team found a potential $20 million in savings. In the last six months, policies and procedures have been put in place and contracts negotiated that led to half of those savings. Over the next few months, the hospital's management expects to do the rest. "That's pure profit," Rock says.

Although some think that an economic downturn isn't the time to engage consultants, Rock points out that getting started on the aforementioned project enabled them to renegotiate contracts and lock in prices before fuel surcharges and increased prices for just about any petroleum-based product were really felt. "Our timing was great," he says.

While most of the group's work will be in the Northeast and Midwest, Rock has a lot of relationships from former positions in healthcare in the west; and it's possible that for the right job, the group will work outside of those two markets. Indeed, Rock worked for some time in Montreal and New Zealand, and if the right opportunity arose, he says he'd take a job outside the country.

Rock, Payson, and the 30 consultants in the unit will be based in Carl Marks's New York City offices. ¤

Special Report

Full Service Healthcare Consulting Firms – 2008

Firm	Senior Professionals and Locations	
Bain & Company Boston, MA Tel. (617) 572-2000 www.bain.com	Charles Farkas, Boston, MA	Preston Henske, New York, NY
Booz Allen Hamilton McLean, VA Tel. (703) 902-5000 www.boozallen.com	Gil Irwin, New York, NY Gerald Adolph, New York, NY David Knott, New York, NY	Gary Ahlquist, Chicago, IL Reginald Van Lee, McLean, VA DeAnne Aguirre, San Francisco, CA
Boston Consulting Group Boston, MA Tel. (617) 973-1200 www.bcg.com	Alastair Flanagan, London, UK Philippe Guy, Paris, France Peter Lawyer, Minneapolis, MN Mark Lubkeman, Los Angeles, CA Dave Matheson, Boston, MA	Amyn Merchant, New York, NY Marty Silverstein, Boston, MA Peter Tollman, Boston, MA Kim Wagoner, New York, NY John Wong, Hong Kong, China
The Coker Group Alpharetta, GA Tel. (800) 345-5829 www.cokergroup.com	J. Max Reiboldt, Alpharetta, GA Kay B. Stanley, Alpharetta, GA Keith Solinsky, Alpharetta, GA Crystal S. Reeves, Alpharetta, GA	Craig W. Hunter, Alpharetta, GA Jeffery Daigrepont, Alpharetta, GA Rick Langosch, Alpharetta, GA
ECG Management Consultants Seattle, WA Tel. (206) 689-2200 www.ecgmc.com	Andrew S. Macdonald, Seattle, WA James W. Lord, St. Louis, MO Daniel J. Merlino, Seattle, WA Gary K. Edmiston, San Diego, CA	Edward T. Baloun, Seattle, WA Gita B. Budd, Washington, DC Jay K. Levine, Boston, MA
FTI Healthcare Brentwood, TN Tel. (877) 515-5345 www.ftihealthcare.com	John A. Siedlecki, Brentwood, TN Tom Singleton, Brentwood, TN James Braley, Brentwood, TN Martin Cohen, Washington, DC	Robert Gamble, Philadelphia, PA Jeff Brown, Atlanta, GA Steven Nathan, Brentwood, TN
Health Strategies & Solutions Philadelphia, PA Tel. (215) 636-3500 www.hss-inc.com	Alan Zuckerman, Philadelphia, PA Hugo Finarelli, Philadelphia, PA	Keith Pryor, Philadelphia, PA Craig Holm, Philadelphia, PA
Hooper Cornell Healthcare Boise, ID Tel. (208) 344-2527 www.hoopercornell.com	Kenneth E. Hooper, Boise, ID Peter J. Butler, Boise, ID Dennis R. Reinstein, Boise, ID Keith A. Pinkerton, Boise, ID	Amy Bailey-Mucker, Boise, ID Katherine M. Jones, Boise, ID Sarah Spry, Boise, ID
Huron Consulting Group Chicago, IL Tel. (866) 229-8700 www.huronconsultinggroup.com	John F. Tiscornia, Seattle, WA Mukesh Gangwal, Chicago, IL George Whetsell, Orlando, FL Janice James, Dallas, TX	Gordon Mountford, Los Angeles, CA Ramona Lacy, Ft. Lauderdale, FL Curt Whelan, Dallas, TX David M. Shade, Chicago, IL
Medical Development Specialists El Segundo, CA Tel. (310) 531-8228 www.medicaldevelopmentspecialists.com	Phil Dalton, El Segundo, CA Eric P. Themm, El Segundo, CA Dan Vincent, El Segundo, CA	Kenneth E. Avery, El Segundo, CA Christine Ortale, El Segundo, CA
Partners Healthcare Consulting Minneapolis, MN Tel. (952) 582-8900 www.partnershc.com	Arthur W. Saunders, Minneapolis, MN Jeanne M. Chapdelaine, Minneapolis, MN	Perry R. Hanson, Minneapolis, MN Davis D. Fansler, Minneapolis, MN
Research & Planning Consultants, LP Austin, TX Tel. (512) 371-8000 www.rpcconsulting.com	Ronald T. Luke, Austin, TX	Eben G. Fetters, Austin, TX

Worth Reading

Health Care and Insurance – Distortions in the Financing of Medical Expenditures

Author: George Ross Fisher, M.D.

Publisher: Beard Books

Softcover: 218 pages

List price: $34.95

Healthcare insurance is deeply and inevitably intertwined with healthcare. The way health insurance is paid determines to a large extent the way the healthcare system is structured and health services are delivered. Health insurance is shaped by government regulations and programs, particularly the giant programs of Medicare and Medicaid, more than actual health needs and concerns of individuals and the desires of doctors and other healthcare workers in providing and administering healthcare. Doctor Fisher, as have others before and since this timely book was first published in 1980, sees through personal experiences and keen analysis how the contradictions and irrationalities in the healthcare system are reflected in health insurance. This author's particular contribution is to analyze the fundamentals of how and why health insurance works the way it does.

Fisher not only analyzes the numbers about what is really going on in the insurance payment for health care, he explains the thinking, the social psychology and values, and the economic principles accounting for the health insurance industry's practices. There's a network of such practices that cannot be justified financially. Nor can they be justified on the ground that they are effective even if they make no sense financially. However innocuous or apropos a wide variety of fundamental financial structures and practices may have seemed in the beginning days of the large government healthcare programs, their counterproductive effects have grown to seriously affect healthcare.

Fisher is not alone in recognizing the senseless, bewildering nature of the healthcare system. But unlike most other authors seeking solutions to its problems, he realizes that changes in insurance coverage for healthcare would lead to changes in healthcare services and the costs of healthcare. He recognizes that there is barely any likelihood that changes could come to health insurance without changes in the healthcare industry that leaders in it would agree to. But in widening the scope of factors involved in the ongoing and worsening troubles of health care, Fisher increases the possibilities that something positive can be done.

Health insurance along with healthcare have gone awry because of two improper premises guiding them. The first is that "modern health care is such a fundamental right of all citizens that it ought to be subsidized by income tax concessions." Fisher is not saying that all citizens do not deserve healthcare. But they ought to be able to afford most basic services, including things like medication and eyeglasses. And citizens ought to be able to have medical care they cannot individually afford, such as costly surgery or long-term intensive care, provided for them by government programs, private plans, health insurance, or some combination of these.

Thus, Fisher proposes bringing healthcare into the reach of nearly all citizens in ways other than considering it as an incontestable right to be guaranteed by the government in league with private organizations no matter what the cost. Paradoxically, considering healthcare a right takes good healthcare away from a large part of the population. In going too far in trying to offer this right to all citizens, the government has ended up denying many adequate and timely coverage.

The second premise is "the insurance mechanism is an appropriate way to finance the entire health system." The health insurance industry's devising coverage for virtually every conceivable health condition, possibility, and requirement has resulted in a confusing plethora of insurance policies and the high cost of health insurance. In one analysis, Fisher shows how this premise that insurance is the most desirable way to finance the entire health system has led to much higher costs for elementary health needs, and incredibly high costs for surgery and other specialized health costs and hospital stays. One contrarian position Fishers takes is that, by paying directly for basic health services, consumers would come out ahead in lower insurance premiums and stronger assurances regarding the truly costly healthcare. The book is filled with such revealing analyses pertinent to the problems in the healthcare system.

The author's critical analyses and ideas for healthcare are indispensable for anyone – private citizen, policymaker, healthcare worker – aspiring to play any part in reforming the healthcare system. The author comments that only the public can resolve the deep-seated and continuing problems of the system and, to do this, the public must understand how health insurance policies and payments contribute to irrelevant and harmful healthcare practices.

Fisher says, "This book was written to stimulate public awareness of a problem which, apparently, only the public can resolve." The author succeeds estimably in fulfilling this aim. His accomplishment is to place the interrelated contradictions and irrationalities, the financial mismanagement and myopia, etc., in the health insurance field on a par with those of the field of healthcare. In widening the view on the sources of the problem, Fisher opens up new avenues for solutions to them. With *Health Care and Insurance*, one sees that the problems with healthcare cannot be reduced by altering healthcare organizations and services alone. Reforms have to be made to health insurance in conjunction with any changes in the healthcare field.

George Ross Fisher has written extensively about healthcare financing for the New England Journal of Medicine and many other publications.

Special Report

Outstanding Hospital Lawyers – 2008

Lawyer	Firm	Outstanding Achievements
William H. Boling	Epstein Becker & Green Atlanta, GA Tel. (404) 869-5334 bboling@ebglaw.com	Served as general counsel to MCG Health, the clinical delivery system for the Medical College of Georgia for five years after its inception. Extensive civil trial experience in Georgia and federal courts and regulatory bodies, with emphasis on healthcare litigation and special investigations. Clients include major hospitals, academic medical centers, other health providers.
James P. (Jim) Connelly	Foley & Lardner Milwaukee, WI Tel. (414) 297-5653 jconnelly@foley.com	Lead counsel and strategist in development of Aurora Health Care System, a non-profit health system with an extensive teaching and clinical relationship with the University of Wisconsin Medical School and annual revenues in excess of $3 billion. Has also served as general counsel to American Medical Group Association and special counsel to American Medical Association.
James Dutro	Latham & Watkins LLP San Francisco, CA Tel. (415) 395-8142 james.dutro@lw.com	Clients include Adventist Health, Catholic Healthcare West, John Muir Health, Hawaii Pacific Health, Lucile Packard Children's Hospital, and Stanford Hospital and Clinics. Represented John Muir Health in issuance of more than $500 million in tax-exempt bonds. Represented Stanford Hospital and Clinics in connection with its investment in Pacific Partners Management Services.
Sherry A. Fabina-Abney	Ice Miller Indianapolis, IN Tel. (317) 236-2446 sherry.fabina-abney@icemiller.com	Provides legal counsel to hospitals and their medical staff leaders in addressing quality, behavioral, and employment concerns related to physicians and other credentialed practitioners. Has defended hospitals in federal court challenges brought by physicians who have been summarily suspended or are subject to corrective action. Represents hospitals in contract disputes with physicians.
Christopher M. Jedrey	McDermott Will & Emery LLP Boston, MA Tel: (617) 535.4405 cjedrey@mwe.com	Advised many healthcare transactions including: establishment of Atrius Health, a system of five nonprofit group practices with approximately 600,000 patients; formation of Beth Israel Deaconess Medical Center's Cardiovascular Institute; merger of Partners HealthCare System's seven faculty practice foundations into Brigham and Women's Physicians Organization.
Sheree Kanner	Hogan & Hartson Washington, DC Tel. (202) 637-2898 srkanner@hhlaw.com	Serves as counsel to the AHA on Medicare and Medicaid matters; counsels major cancer hospital in retaining PPS-exempt status; counsels one of the nation's largest hospital chains on complex Medicare reimbursement issues; represented large teaching hospital in False Claims Act case in federal court; assisted state hospital associations in efforts to gain CMS approval of Medicaid provider taxes.
Holley Thames Lutz	Sonnenschein Nath & Rosenthal Washington, DC Tel. (202) 408-6836 hlutz@sonnenschein.com	Recent accomplishments include extensive counseling for Miami Children's Hospital related to clinical research activities and reimbursement matters; identifying areas of regulatory scrutiny for Baptist Health South Florida and acting as compliance counsel; extensive counseling on Medicaid upper payment limit programs and working with regulators to develop a compliance program.
Ann McCullough	Faegre & Benson Denver, CO Tel. (303) 607-3500 AMcCullough@faegre.com	Drafted and negotiated variety of healthcare contracts, joint ventures, and acquisitions involving compliance with physician self-referral and anti-kickback safe harbor laws; advised healthcare organizations regarding medical staff credentialing, peer review, antitrust, and other provider relationship matters; advised nonprofit healthcare organizations regarding IRS constraints.
Maureen Demarest Murray	Smith Moore LLP Greensboro, NC Tel. (336) 378-5258 maureen.murray@smithmoorelaw.com	Represents healthcare providers in medical staff and peer review matters, malpractice actions, reimbursement appeals, fraud and abuse investigations, and business disputes. Counsels hospitals, long-term care facilities, home health agencies, medical technology companies, and physician groups on corporate compliance, EMTALA, credentialing, HIPAA, patient care, and other matters.
M. Daria Niewenhous	Mintz, Levin, Cohn, Ferris, Glovsky & Popeo Boston, MA Tel. (617) 348-4865 DNiewenhous@mintz.com	Serves as vice president of legal services at a tertiary care teaching hospital. Orchestrated and spearheaded a transaction preserving 52 FTEs, with annual projected savings of $1.8 million. Has led many recent capital projects, including a new medical/surgical inpatient building and new technologies. Successfully prevented facility from locating a satellite in a client's backyard.
Sara Kay Wheeler	King & Spalding Atlanta, GA Tel. (404) 572-4685 skwheeler@kslaw.com	Represented hospital systems, physician groups, and suppliers in OIG and DOJ investigations; represented hospital systems and other healthcare providers in variety of Medicaid and other investigations and audits initiated at the state level; advised major hospital system regarding internal investigation of hospital-physician relationships and subsequent voluntary disclosure to the OIG.
Robert Wild	Garfunkel, Wild & Travis, P.C. Great Neck, NY Tel. (516) 393-2222 rwild@gwtlaw.com	Repesents dozens of hospitals on such matters as merger of two New York City hospitals; merger of three upstate hospitals into an integrated healthcare system; affiliation between pediatric neurology department of two hospitals; claim against an actuary in relation to a hospital's pension fund. Addressed issues before commission on hospital closings in New York.

In Focus

Boston Scientific

Founded in 1979, Boston Scientific's mission is to improve the quality of patient care and the productivity of healthcare delivery through the development and advocacy of less-invasive medical devices and procedures. The company has more than 25,000 employees and 26 manufacturing, distribution, and technology centers.

The company's products – more than 13,000 of them – are primarily designed to provide alternatives to major surgery and potentially traumatic procedures. The products include guide wires, catheters, stents, imaging systems, defibrillation leads, forceps, needles, and pelvic floor repair kits. Boston Scientific went public in 1992 and in 2007 had revenues of $8.3 billion.

New technology is the linchpin of Boston Scientific. The company spent $680 million in research and development and secured 4,016 patents in 2005. At the end of that year, another 7,800 patents were pending. That rate of innovation and investment is at the top of the heap among Boston Scientific's peers and is spread across the entire company. There are currently more than 140 pre-clinical studies at the company, and more than 40,000 patients enrolled in pre- and post approval clinical trials.

Boston Scientific has four core business groups:

- Cardiovascular is dedicated to treating medical conditions that include cardiovascular, peripheral vascular and neurovascular diseases, cardiac arrhythmias, neurological disorders, neuro- and aortic aneurysms, and acute myocardial infarction.
- Endosurgery includes endoscopy and urology/gynecology. The group's products are used to help patients with malignant and benign tumors, gastrointestinal cancers, incontinence, abscesses, end-stage renal disease, benign prostatic hyperplasia, gallstones and urinary stone disease, as well as uterine fibroids and menorrhagia.
- Neuromodulation offers solutions for pain management by developing devices that use neurostimulation to mask chronic pain signals with electrical impulses.
- Cardiac rhythm management develops implantable devices to treat cardiac arrhythmias, heart failure, sudden cardiac death, and heart disease.

Recent news from Boston Scientific includes the sale of non-strategic investments to Saints Capital for more than $100 million. The net after-tax cash proceeds will be used to pay down debt. In May, the Food and Drug Administration approved a new family of Boston Scientific pacemakers, ALTRUA, that delivers enhanced therapies while maintaining its small size and battery longevity. It is the first Boston Scientific-branded pacemaker to treat bradycardia, a condition in which the heart beats too slowly. Less positive was the news that Boston Scientific lost a patent infringement case brought by Medtronic that could cost them $250 million. The company will present a number of defenses not considered by the jury in late July. If successful, the court will set aside the jury verdict.

While second quarter financial results were not released at press time, first quarter 2008 results included just over $2 billion in revenues, down $40 million from the year before. Neuromodulation sales were up 40%, and endosurgery posted a 9% revenue increase. CRM products increased $26 million to $565 million compared to the first quarter of 2007. Net income was $322 million, or 21 cents per share. In June, the company announced it received a revised rating of stable – up from negative – from Fitch Ratings. This was in part due to the progress of its drug-eluting stent and cardiac rhythm management business, as well as the pay down of $1.7 billion in debt over 12 months.

Key personnel:

- **James R. Tobin** was named President and Chief Executive Officer in 1999, and his tenure was extended indefinitely in June of this year. He was previously President and CEO of Biogen, and spent 22 years with Baxter International, rising from financial analyst to president and CEO.
- **Donald S. Baim**, MD is Executive Vice President, Chief Medical and Scientific Officer, a position he has held for two years. Baim is responsible for all clinical affairs, including pre-clinical and clinical studies; medical affairs, including education programs and physician relationships; and safety. Prior to joining Boston Scientific, he was a professor at Harvard Medical School and senior physician at Brigham and Women's Hospital specializing in interventional cardiology.
- **Brian R. Burns** is Senior Vice President of Quality. He joined the company eight years ago as quality director. In his current position, Burns instituted a corporate quality system for all operational areas, resulting in a 20 percent reduction in complaints. He also upgraded Boston Scientific's quality systems to support evolving business needs such as combination products, and improve complaint handling, operational metrics, supplier quality, clinical quality, and global quality systems training. Previously, Burns was General Manager at Allegiance Healthcare, a manufacturer of instant hot and cold packs.
- **Jim Gilbert** is Executive Vice President, Strategy and Business Development, for which he oversees marketing, electronic marketing, health economics, and reimbursement. He also has responsibility for directing and supporting corporate strategy. Prior to this role, he was President of the Cardiovascular Group at the company.
- **Sam R. Leno** serves as Executive Vice President of Finance and Information Systems and Chief Financial Officer, a position he has held since 2007. He came to Boston Scientific from Zimmer Holdings, where he was also in charge of finances at the executive level.
- **Timothy Pratt** was brought in last May as Executive Vice President and General Counsel to oversee the worldwide legal functions at Boston Scientific. Pratt came from Shook, Hardy & Bacon, a firm he joined in 1977, where he concentrated in defense of pharmaceutical and medical device litigation.
- **Kenneth J. Pucel** is Executive Vice President of Operations where he is in charge of manufacturing plants in the United States and Ireland. He joined the company in 1989, holding various positions in the Cardiovascular Group. He is also a member of the company's Cardiovascular Council, Operating Committee, and Executive Committee. ¤

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