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Rick Baker Knows Best

By: Allison P Davis

I.

Thomas Van Buskirk, 64, is a small-time chiropractor in Oakland, California. In 2004, he discovered he had a severely blocked carotid artery. He needed surgery to remove the blockage and he needed it soon.

Despite his own involvement in the healthcare industry, Van Buskirk was self-employed and, like 25 percent of self-employed Americans, he lacked health insurance. He was facing an \$85,000 fee for his surgery at his hospital in Oakland. Without it, the blockage in the carotid artery, the artery that provides oxygenated blood to the neck and head, left him susceptible to stroke.

Without the money readily available, he was running out of options. After some research, Van Buskirk chose to take a risk: He would have his surgery outside of the U.S. He began making plans to travel to India where the procedure would only cost \$12,000, including travel expenses. But before he finalized his plans, Van Buskirk made one last call, to a Vancouver, Canada-based medical broker named Rick Baker. "I told him 'No, do not board that plane,'" Baker said.

A week later, Baker had arranged for Van Buskirk to receive treatment at the Oklahoma Heart Hospital Oklahoma City for \$15,400 — an 80 percent savings compared to the original \$85,000 he had been quoted in Oakland. By going through Baker and his network of American hospitals, Van Buskirk was given a discount most patients aren't aware of. After a routine consultation with heart surgeons, Van Buskirk had his surgery and was back in Oakland four days later. "It was the nicest, most state of the art hospital I'd ever been to," Van Buskirk said.

Even after the passing of the health care bill and the promise of health care for all, the battle over affordable care continues. In 2008, the U.S. spent over \$2.3 trillion on

healthcare, 60 percent of which went to hospital care and physician/clinical services. In recent years, the number of uninsured patients has risen, swelling to 46 million in 2008. It is projected to reach 52 million by the end of 2010.

The result has been a growing number of patients who can't afford treatment. As a medical broker, Baker acts as a one-man HMO to uninsured patients. He has contracts with 22 hospitals in 13 states, a network that allows him to negotiate the same kind of write-downs that larger insurers get. Since 2003, Baker has brokered surgeries for over 500 clients from Canada and the U.S.

Most of Baker's clients are middle class or upper middle class citizens who have money, but for reasons beyond their control can't get insurance coverage. Often they are self-employed or have pre-existing conditions that do not qualify them for full coverage. When a patient like Van Buskirk calls, Baker will call the doctors in his network—all private hospitals sprinkled through out the North and Midwest—and negotiate a price, usually 50 to 85 percent less than the standard rate for an uninsured patient. Baker takes anywhere from 10 to 40 percent of the fee as his cut, he said, a figure he rarely reveals to the hospitals he works with.

The ability to deliver cut-rate surgical prices has given Baker a cult-like following. "He's a miracle," said Robin Clinker from Austin, Texas. "My son never would have gotten his jaw surgery without him." Dr. Keith Smith, an anesthesiologist at the Surgery Center of Oklahoma in Oklahoma City refers to Baker as a "messiah."

"He deserves a medal for what he's doing," Smith said.

Baker maintains that he's found his calling, "I get to save lives everyday—how cool is that?" he asks. But others aren't quite as sure. Some healthcare management experts worry that Baker is motivated by profit rather than philanthropy. Dr. Sandra Dratler, a faculty member in the healthcare management program at University of California, Berkeley she has also worked as a senior healthcare manager for over two decades said,

“There is no way he is doing this without marking up the prices. It feels a little exploitive.”

II.

Before establishing himself as a medical broker, Baker spent years bouncing from business to business. After receiving a degree from Faculty of Commerce at the University of British Columbia, he had stints at Merrill Lynch and Procter & Gamble. Eventually, he founded his own charter yacht company in Vancouver, where he planned boat tours for clients, including Christopher Reeves.

In 2002, Baker accompanied his wife Lori Ann, a trauma nurse, on a teaching sabbatical in rural British Columbia. While there, Baker overheard a doctor gripe that his patient, an 85-year-old with kidney stones, was on a 12-week waiting list just to get a consult with an urologist. To Baker, the moment felt like an epiphany. “I thought to myself, ‘I’m not a doctor and not a politician, but I know I can do better than that,’” he recalled.

Back in Vancouver, Baker sold his yacht charter business, bought an office and began recruiting patients and doctors to work with him. He called his new business Timely Medical, Inc. The patients were easier to find; Healthcare may be free but it takes a long time to receive surgery or specialty procedures—almost 100,000 Canadians are currently waiting for surgery.

Baker first started appealing to private surgeons in Vancouver, but met resistance from doctors who questioned the ethics of allowing patients to “line-jump” past public healthcare patients. So Baker looked to the US. He arranged a trip to meet with hospital directors in Michigan, New York and Minnesota. All were states close to the Canadian border—in case anything went wrong in the surgery, the patients could be transported back easily.

In 2003, Baker spent two weeks lobbying hospital directors to join his network trying to convince them that taking low paying patients is better than having empty hospital beds.

“There are tons of people on a waiting list for surgical procedures in Canada. There is no chance on earth that you would get this business without my involvement. If you have an available room and no patient, you’re already paying the nurses; you’re already paying the doctors and the custodians. It’s dollars and sense. Even if you only make a thousand dollars from me, that’s a thousand dollars you wouldn’t have,” said Baker.

His spiel was met with limited success. The Mayo Clinic in Rochester, MN turned him down, as did a slew of smaller hospitals, including Buffalo General in downtown Buffalo, New York and the Northern Michigan Regional Health Center in the tiny town of Patawsky.

Baker’s luck changed in 2004, when he received a call from Smith, an anesthesiologist and the founder of the physician-owned Surgery Center of Oklahoma. After reading an interview with Baker in Money magazine, Smith admired his business model and offered to work with his clients. “I told him, ‘I can beat those prices, you oughta come down and talk to me,’” Smith said. He set up a dinner with 15 other surgeons, all willing to listen to Baker’s business pitch.

Baker first negotiated within the pricing structure of each hospital to figure out how low the prices could get, said Dr. Blake Curd, of South Dakota’s Orthopedic Institute, of the general process each hospital goes through. Dr. Curd first met Baker when they were both advocating for healthcare on the Hill, and works with him now. The doctors took a look at the fixed costs to provide a service, and how much to pay the staff while maintaining a profit margin. Based on that, they figured out how much to discount a surgery.

Even with deep discounts on surgery, several other doctors agreed to work with Baker. “Once I was established in Oklahoma, other people heard about us and it all kind of fell into place,” Baker said.

Smith believes the situation is positive for everyone. He is in the business of saving lives, he said and this is another way to make that possible. "Its just more business, its win-win," said Smith.

These days, that business is growing. About 40 percent of Baker's clients are American; the rest are Canadian. From this increase in American patients, Baker was able to start a second business focusing in U.S. clients, North American Surgical. According to Baker, he receives an average of twenty phone calls a month from new patients needing surgery.

One of these patients was Jim McNerney. A sports agent from Kentucky who has suffered from a degenerative hip disease since he was a teenager, McNerney needed a hip replacement at age 35. The procedure costs roughly \$65,000, and his insurance refused to cover it on the grounds that it was a pre-existing condition. McNerney contacted Baker in March of 2009, and ended up getting surgery for \$15,000 at a private hospital in Nebraska. "I was able to stop along the way to take a photo in front of Mt. Rushmore," McNerney said.

McNerney now plans to seek Baker's help in brokering two other surgeries—a second hip replacement on his other hip and corrective heart surgery. "My wife was skeptical about how Baker got these surgeries so cheap," McNerney admitted. "But at the end of the day, I got the surgery I couldn't get, so what does it matter?"

III.

To some it does. Guy Golembiewski is the vice-president of Northern Michigan Hospital, a public hospital that had previously turned down a partnership with Baker in 2003.

However, Northern Michigan reports an increase in the amount of charity-care since the recession began in 2007. "It's increased four-fold over the past three years,"

Goliembiewski said. "If a patient comes in and needs something, we give them anything if we can afford to provide it, we're a hospital." Golembiewski said his hospital would be interested in working with a business like Baker's given the middle man was ethically sound. "It largely depends on his motivations," he said "Is it more commercially

motivated and or more altruistic? How much of a percentage is he taking? How much is the hospital making? ”

- Even though hospital prices are high, there is little room to cut prices for patients — the overhead costs of running one are too high. Much of a hospital’s “profit” is immediately eaten up in regulatory costs— hospitals are usually waiting weeks if not months for insurance companies to pay claims — and basic services to keep the hospital running. These fixed costs including keeping the lights on, paying the staff and covering equipment. Goliembiewski acknowledges that hospitals cannot take part in cost cutting; right now it takes too much to make a hospital run. In short, patients are expected to pay more.

The average cost of a procedure in the US is only about one third of what a hospital charges and only uninsured patients are charged full price, insured patients usually pay a fraction of the costs, with their insurance plans picking up the rest. Baker has built his businesses on these inflated pricing structures. Baker realizes this; as he told the Toronto Star, “If the U.S. adopts our system, where else can I send my dying Canadians?”

For Baker, physician owned hospitals like the ones Smith and Curd operate are the answer to where he can send his clients. These private hospitals exist in cities without competition from enormous general hospitals—they are only allowed in 37 states and there are over 200 nationally. They can perform surgeries that neighboring general hospitals often lack the resources to do. Low costs due to smaller staff sizes and higher profit allow them to expand and incorporate more state-of-the-art technologies and an almost luxury environment.

According to Molly Sandvig of the lobbying group the Association of Physician Owned Hospitals, the nursing ratio in the average hospital is 8:1, while the average at a private hospital is 3:1 or sometimes 1:1 in specialty cases. According to Sandvig, this leads to higher patient satisfaction ratings on consumer websites and an ability to churn out more surgeries. For example, Smith’s facility can perform over 30 tonsillectomies in a day.

But, not everyone thinks the physician owned hospitals are as great as they seem. While there are consumer reports available for the hospitals they are patient submitted. Unlike

- general hospitals which accept Medicare and therefore must have publicly accessible and clear clinical definitions of patient satisfaction, private hospitals do not—it is the difference between an online report stating “the staff was accommodating” versus “I survived my procedure.” The questions vary by type of hospital.

In 2007, the high profile death of a patient at a hospital in West Texas called attention to the ability of these hospitals to handle emergency situations. Following complications from surgery suffering respiratory arrest, the specialty hospital was not able to treat the patient’s emergency symptoms and instead sent him to a local community hospital, where he later died. In fact, a 2008 report by the Department of Health and Human Services revealed that specialty hospital staff is not always equipped to handle emergencies, as in the West Texas case. Only 30 percent of the hospitals have a doctor available at all times, the rest of the time it is staffed by nurses. Critics like Rep. Pete Stark (D-CA) and U.S. Sen. Max Baucus (D-MT) say that specialty hospitals are motivated by profit and focus on higher-cost technologies and surgeries, but rarely provide the same basic services as a general hospital.

As Dratler notes, given that the hospital is already operating and the staff is already paid, adding a patient to a vacant surgery slot is essentially free money. Supplies for the patient are cheap. That means that anything the hospital receives above the cost of supplies and staffing is pure profit. “That’s why these doctors agree: It’s greed, greed, greed,” she said.

Many private hospitals, like Smith’s, pride themselves on their practice of pricing transparency. The hospitals post all of their prices online; clients know exactly what they are paying.

However, less is known about Baker, the middleman. His clients and the doctors who work with him have no idea how much of a profit he makes. "Maybe he adds 10 percent of the total on for a profit? I don't know, you'll have to ask him," said Smith. A doctor, who wishes to remain unattributed, reported ending ties with Baker when he found out how much he charged as a finder's fee.

In the end, middlemen like Baker may not be necessary said Dratler. According to Dratler, any uninsured person can call a hospital finance office and negotiate for lower prices; most people just don't know the option is available. Hospital pricing is a complex and frustrating system, she said; if the procedure is necessary or important to someone, they are going to pay it no questions asked. Overall, she said, it's a problem of a lack of patient empowerment.

"Anybody can get a discount if they have the initiative," Curd agrees. "We would give anybody the same answer we give Rick."

IV.

In the sublevel conference room of the Sutton Place Hotel in Vancouver, Baker paced back and forth across a small, temporary stage. In early October, Baker had invited libertarian think tank leaders, reporters and D.C. wonks to his hometown to a "Canadian Healthcare Field Trip" — an opportunity for Baker to reinforce his opinions of socialized medicine and promote his new business. As he made his way from one end to the other, he cast a diminutive shadow across an enormous triptych advertising his latest endeavor, his second medical brokerage company, North American Surgery, Inc., his American brokerage firm. The cardboard monster featured a bespectacled, balding man in a doctor's coat who seemed to lean off of the triptych saying, "You're paying how much for your surgery?"

Stepping out into the hall later, Baker shoved his free hand in the pocket of his rumpled suit and extracted a cell phone. Baker was expecting a call from a Fox and Friends

producer and was trying to locate a Los Angeles Times reporter who was missing from the morning's activities.

Earlier that day, Baker had spent the better part of two hours presenting the pitfalls of Canadian healthcare for American libertarians who fear that "Obamacare" will be a version of socialized healthcare. Baker is an engaging speaker, and a natural storyteller; his voice rising to mock "those academics in their ivy-covered, liberal towers at Harvard" and can just as quickly sink low when he recalls the "eight-year old darling who couldn't afford her necessary cochlear implant."

Afterward, Baker presented some of his clients, all of whom praised Baker for his work. One patient started to cry as she described how her weight had prevented her from getting her surgery in Canada. At once, Baker came alive, clapping her on the back and shuffling her off the stage as he told the story of her first meeting with the doctor who would eventually perform her surgery. "He said, 'Well she's a skinny lady in Oklahoma!'" Baker laughed as he helped his client quickly to her seat. "You'll have plenty of time to interview Cheryl and myself later this afternoon." With that, he finished his presentation to a sprinkle of applause as the reporters in the audience lined up to nab interview spots.

Baker has been making the press rounds recently. Since his name appeared in a *Wall Street Journal* article in 2006, Baker had become one of American healthcare's most vocal critics. He appeared on *20/20* and made regular appearances on the Hill lobbying against the health care bill. His influence grew last summer, when he appeared in ads for Conservatives for Patients Rights deriding the public option in "Obamacare" with stories of patients languishing on medical waitlists in Canada. Baker routinely repeats this phrase: "The Canada Health Act is responsible for more pain, more suffering, and more death than any other piece of domestic legislation in Canadian history."

The horror stories Baker espouses certainly add to the current frenzy over fears of what many think will be Obama's socialized healthcare system, but he often neglects to discuss what is positive about his own Canadian healthcare system. When his wife Lori Ann was

diagnosed with breast cancer, she was taken care of by the public health care system without a problem, he reported.

However, these stories are not where Baker has made his greatest impact with American politicians or media. His recent fame has come from client sob stories, vast statements and quote-ready sayings like: “If [hospitals] would just lower costs, that would solve 90 percent of the problems with healthcare in America. It’s just too expensive. That’s what I keep telling people, we need to cut that fat.” Nobody would argue with Baker that the prices are too high, but, at this conference, nobody is asking how his model truly works, either.

Still, a few critics maintain that it can’t. “If all the hospitals followed [Baker’s] model, they’d all be bankrupt because they couldn’t cover their costs,” argues Dratler. “Somebody needs to pay.”

Now that the health care bill has passed, Baker’s credo of cutting the fat may not be relevant. However, in terms of the media, he will still find a platform. He appeals to a certain sect of the country that still believes Obama’s healthcare bill is one step away from “socialized healthcare.” In an email to another South Dakota doctor and members of the libertarian press, Baker shared his sound-byte-ready views. “He promised to “drain the swamp” in D.C., Baker wrote of Obama, The swamp stinks more than ever.”

“Either way, Timely Medical and North American Surgical won’t be affected anytime soon.”

At dinner later that night with the clients, doctors and reporters who had previously joined him in the conference room, Baker sits next to his wife, who gently chides her husband when he constantly checks his phone during the meal. Just as the salad plates are being cleared, the Fox producers call and Baker is gone, leaving his clients to fend for themselves.