

President's Message



Think Nationally—the Choice is Coming

RONNELL A. HANSEN, M.D.

THE CURRENT FEDERAL HEALTH CARE REFORM PLAN (Democrat) is potentially onerous for American taxpayers, health-care providers, and our patients. End game: Initially private insurance would exist; however, medicine would be administered as a utility, with regulation of many aspects. A Federal Government (FG) run, single-payer system (Canada, Britain) may be an ultimate extension. Is this end “bad” for medicine? Let’s dig deeper...

Phase 1—Mandated: Employers must offer coverage, or individuals must buy it. A FG run Medicare-like plan will compete with private insurance, using comparative/cost-effectiveness research to impose practice guidelines and to limit coverage of “expensive” drugs and devices as in the UK. Private insurance will likely face new regulations: requirement to insure all applicants, and prohibition on pricing premiums on risk basis (community rating). FG subsidies will assist “middle earners” to purchase insurance, and FG subsidizes/manages a national system of electronic medical records. Result: Unprecedented FG control over one-sixth of the U.S. economy, *and* over personal and private medical decisions for Americans.

Employer mandate: Required to “pay or play,” those failing “meaningful coverage” pay a penalty (% of payroll), into a national fund providing insurance for non-covered workers. Interpretation: A disguised employment tax, as judged by Princeton University professor Uwe Reinhardt (Dean of health-care economists), with potential cost of 1.6 million jobs over the first five years.

Individual mandate: A similar disguised tax. Worst case for these precedents: the first falling domino leading to greater FG control of the U.S. health care system.

Recent history: The Massachusetts *failed* plan: more expensive than expected, \$1.1 B in 2008 and \$1.3 B 2009, now broke and understaffed for primary care. Gov. Deval Patrick will keep this “reform” with money from safety-net providers (SNP) including public hospitals and community clinics. While those lacking insurance are reduced, surveys show substantial problems with access to care. New insurance provides improved access for some, however many low-income (previously receiving free care) now face co-payments, premiums and deductibles blocking them from needed care. SNP cuts reduce resources for remaining uninsured, and those relying on SNP for services in short supply in the private sector (ED, mental health, primary care). Result: modest improvement in access for some, and for others, much poorer access.

Summary: FG defines criteria for “qualifying insurance” and mandate requires purchase of specific services (heavily) regulated by the FG. At minimum, deductible levels and lifetime caps are specified, and minimum benefits will likely be defined. Result: promised “if you are happy with your current insurance, you can keep it” will be untrue. Millions satisfied with current coverage will likely have to purchase FG sanctioned insurance, even if more expensive or covering unwanted benefits.

Phase 2. New FG universal-health-care Medicare-like program competes with private insurance. Subsidized by taxpayers, it has inherent advantage in the marketplace (potentially artificially low premiums or extra benefits), with Treasury to cover shortfalls. Result: Consumers unduly attracted to lower-cost, higher-benefit FG program. Why negative? This program’s market presence allows imposition of low reimbursement rates on physicians, providers, and hospitals—ala

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Medicare/Medicaid/MNCare—considerably below private insurance. Providers historically recoup “lost income” by raising prices on private insurance patients. Private insured pay an estimated \$89 billion annually due to this “cost-shifting” from underpaying government programs. If FG public option provides (likely) similar underpayment, an additional \$36.4 billion annually could be cost-shifted. Result: Private (appropriately paying) insurance raises premiums, appearing even less competitive than the FG “taxpayer-subsidized public plan,” and an estimated 118.5 million Americans (two out of every three with insurance) shift to the FG program. Summary: Death spiral for appropriately paying private insurance.

Many advocates of the “public option” have past supported a FG run single-payer system, now presuming the public option would squeeze out private insurance with end result of single payer. President Obama: “it may be that we end up transitioning to such a system.”

FG cost research will define procedures/technologies as “most effective” (laudable) *but*, more ominously, cost-effective. Yes—there is unneeded U.S. health-care system cost, but better understanding and improvement is unlikely the cost research goal. The more likely result may be restrictions on *practice* of medicine. Other countries use such research as basis for rationing. Great Britain: Cancer drugs “too expensive.” The U.K.: Price tags a citizen's life—about \$44,305 (£30,000) per year, a baseline, with sometime approved treatments costing as much as \$70,887 (£48,000) per year of extended life—approved only if extending life by at least three months, used for illnesses affecting fewer than 7,000 patients per year.

Undermining free market forces: New insurance regulations—driving up costs, limiting consumer choice (leaked proposal: a choice of four standardized insurance plans); middle-class family subsidies (family of four earning up to \$83,000 per year under one proposal); FG preemption of private investment and research into health IT. Estimated cost to taxpayers: at least \$1.5 trillion over the next 10 years.

Competition: Patients' Choice Act (PCA–Republican), eliminates employer tax breaks for providing health-insurance benefits, instead provides annual tax credit of \$2,300 individual and \$5,700 family to offset cost of health insurance. Low-incomes receive subsidy to buy into private insurance plans. In common with FG plan: Exchanges (for comparison-shopping only), and investment in prevention of chronic diseases (i.e. heart disease and diabetes—some of the largest costs—as prevention is considered cheaper than treatment with some overall population statistic cost caveats). To counter, Max Baucus (D., Mont.), leading policy overhaul, has said eliminating tax incentives for benefits “would destroy the employer-based health care system we have today.” PCA addresses tax code, employer roles, chronic care, HSA shortcomings, health plan competition, affordability, health IT, risk selection, Medicare solvency, litigation, payment reform—but is far from perfect. Long-term care, federal health care benefits as minimum for all Americans (expensive), failure of integrating Medicare with health plan market, guaranteed issue regulation on health plans, and insurance exchange (not politically accountable, just comparison shopping) are all potential criticisms. End Game: Government control versus pulling popular tax subsidies which provide constituent “cheap” health care. Yes, the playing field is complex and far from level. ♦

New Members

EMMS welcomes these new members to the Society.

Active

Curtis A. Boehm, M.D.
Park Nicollet Clinic–Prairie Center
Internal Medicine

Dennis J. Callahan, M.D.
Allina Medical Clinic Coon Rapids
Orthopaedic Surgery

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Metropolitan Obstetrics & Gynecology, P.A.
Obstetrics & Gynecology

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University of MN–Otolaryngology
Department
Otolaryngology

Loree K. Kalliainen, M.D., FACS
Regions Hospital
Hand Plastic Surgery

C. Scott Kammer, M.D.
Allina Medical Clinic Forest Lake
Family Medicine

Stephen J. Kolar, M.D.
HealthEast Care System
Internal Medicine

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Highland Family Physicians
Family Medicine

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Midwest Spine Institute, LLC
Orthopaedic Surgery

Carl K. Sakamoto, M.D.
Shriners Hospital for Children
Anesthesiology

Todd A. Stivland, M.D.
Bluestone Physician Services
Family Medicine

Stephen B. Sundberg, M.D.
Gillette Children's Specialty Healthcare
Orthopaedic Surgery

Andrew D. Thomas, M.D.
Summit Orthopedics, Ltd.–Hand Clinic
Hand Surgery (ORS)

Daren J. Wickum, M.D.
Summit Orthopedics, Ltd.–Gallery Office
Orthopaedic Surgery ♦

In Memoriam

KENNETH O. NIMLOS, M.D. died March 14 at the age of 86. Dr. Nimlos attended the University of Minnesota Medical School and worked first in general practice. Later, in the 1970s, he became a board certified Psychiatrist and taught family practice and psychiatry at the U of MN as an associate clinical professor. Dr. Nimlos traveled extensively, having visited 26 countries, participated in many outdoor activities, and was a gourmet food and wine enthusiast. His motto was, “work hard, be responsible, do your best, and always remember you are just an ordinary human being.” Dr. Nimlos joined EMMS in 1950. ♦