



Rapid Health Care Reform Efforts Necessitate Reassessment of Existing Policy

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WHEN I COMMENT IN *METRODOCTORS* ON HEALTH CARE POLICY—I attempt to do so from a well studied and pragmatic viewpoint, bringing concerns and perspectives expressed from economic experts at Hopkins, Mass Gen, MIT, Carlson School, a variety of editorialists from *Wall Street Journal/New York Times/the Economist*, and many others in medical economics who have particular insight into such systems—likely more than most physicians or medical society staff who must handle many issues related to the practice of medicine to the best of their ability. I also attempt to ascertain available economic facts—as accurate as I can find them, which is very difficult given the agendas and spin of many stakeholders. Of course, I recognize physicians are stakeholders, and I try to understand how facts may or may not realistically support systems of patient autonomy, and our professional responsibility to them—and allow or hinder both private and employed models of practice to remain economically sustainable—without forcing physician direct rationing of care, or manipulation into unwanted consolidative structures. Be assured, sifting that analysis is exceedingly challenging.

At the MMA meeting, our well studied Mayo colleagues (touted in national policy) critiqued several possible approaches to addressing health care insurance/payment reform—I wasn't sure I took away complete support of the managed care system as is current MMA policy from this honest critique—but rather a consideration of several options with leaning toward the Federal Employee Insurance model. In fact, take home points between presentations from the current AMA President on HR 3200, and Mayo experts did not appear 100 percent congruent—and although each point of view had merits (both economic and political)—each did appear to have some room for the realities of available options, compromise, and new ways of thinking. Did I agree with each of them on everything? Not necessarily—but I did see the need for policy flexibility.

I personally do not see financial world “constructs” today in the same manner relative to years past given recent events—and likely those of you reading don't either. Reassessing the current payment/insurance solution set policy devised in 2004 for the MMA in times of rapid national and state financial flux seems to me not only to be a good idea—but rather a necessity. Such analysis for the MMA requires a broad based, non biased, democratically appointed, policy interested, physician based group to do so. I suggest member selection may be best based upon independent trustee districts.

Without reservation, I respect the efforts of the current MMA Health Care Reform Oversight Task Force charged with following issues on the current implementation of 2008 MN Health Care Reform. Literally juggling a myriad of policy issues, I honestly ask if committee members can realistically take stock of the literal mass of health economic information available. I appreciate the level of commitment by individuals on that committee to meet their charge, however, I can nary keep pace with health reform econ assessment while reading about two hours per day and having a prior background. Expecting in-depth expertise on medical economic options given the scope of the current charge would, in my view, simply not be a realistic expectation. As Ben Whitten, incoming MMA President commented in his acceptance address, “fulfilling everything that is expected of us as physicians by everyone is all but impossible”—so I suggest we place dedicated resources on issues which are particularly complex and important. I also recommend avoiding potential selection bias; staffing of the committee should be democratically entrusted to trustee district, with an effort to select physicians who have balanced interest and experience in economic policy.



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While Minnesota currently enjoys popular face time in the media for “low cost high quality health care” and a “model for the nation” via Mayo system status—we, in the land of managed care, should not be complacent in the fact we also do not have a sustainable effective model of health care coverage. Even Mayo cannot accept more Medicare and appears to deliver expensive health care for those with insurance (the standard cost shift), GMAC may remain severely curtailed by un-allotment almost assuring significant deficits in the health care access fund from the newly uninsured moving to MNCare within two years (likely impacting calls for increased demands on the provider tax, which few other states have), and we suffer from lack of transparency from insurance/health care corporations which have substantial profits/large executive pay and have failed to pass on legislative payment increases to providers for many years. United Health Care, one of the country’s most profitable and criticized health corporations is based here. We all know physicians and practice behavior are not blameless in cost, but physicians and other providers are not the only cost culprits of the entire system, and it is not clear to me that managed care is the only “great solution” to a complex system.

Though Minnesota is far from managed care nirvana—we’re better than many states—but we propose ways to cut reimbursements by potentially bundling services which appear attractive to those seeking budget reductions. Can some such proposals work?—*Maybe*. Should other options be able to be considered in policy?—*Absolutely*. The “nation” may be following Minnesota like we have “the answer”—but where exactly is Minnesota going? That has yet to be carefully and thoughtfully determined without disenfranchising patients, physician appropriate decisions, or practice types.

For transparency and practicality, I do not consider it onerous for a dedicated member committee of the MMA to examine past years’ payment model policy in times of landmark financial upheaval—which has potential (particularly on short or emergent legislative notice) to tie our collective hands into supporting managed care in policy. From extensive reading of both domestic and international payment systems—I suggest this is neither wise nor innovative.

At the MMA meeting, outgoing Board Chair Mike Ainsle presented a number of thoughtful outcomes on the way he could see health care going—some perhaps easier for the physician/patient relationship than others in his perspective—and some more administratively or overhead cost challenging. There was no “one way” support—but he did provide pros and cons for us all to consider for those options. Keeping patients at the top, as he pointed out, is the priority – and I agree. I also strongly support examining policy options which ensure Minnesota Patients’ and Physicians’ interests are not unduly undermined by only adherence to “systems” which have potential to: divert dollars to profits, underpay physicians by nontransparent means (having done so historically), disenfranchise the patient/physician relationship by incenting rationing, or “force” de facto practice consolidations. Will they necessarily? No. But they have in the past and we need to be honest about it.

Exploring options “outside of the traditional insurance plan/access box,” and transparently disseminating the pros and cons of such systems should be the priority. As economists and prior trial systems have recognized: 1) so-called corporate practice/physician rationing of medicine may be the unintended outcome of well intended systems; 2) national policy makers have indicated Minnesota reform policy supported provider accountable care organizations (ACO’s), which split capitated fees effectively runs counter to current state laws; and 3) “fee bidding” as in current reform law may not allow physician choice of contracting in (gatekeeper) “hospital systems” or “medical homes,” depending upon structure. I’m not suggesting some of these ideas cannot work in some way and that they cannot be placed upon us by national reform—I do suggest *physician* independent assessment and understanding of the economic implications of such systems is crucial as MMA policy moves forward.

Most importantly, I do not believe we, the members of the MMA, wish to necessarily have a society policy which is inflexible from a political standpoint. Secondly, I do believe it is our physician responsibility to work to understand what policy and proposed bills actually “say” in their text regarding our profession—versus relying on others to tell us what they mean. I appreciate the hard work dedicated members of the state and component societies put forth in serving all of our members on very demanding issues—but in the end, as part of our impossible task—I think we all need to read more on the facts of health care economics. ♦

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