



Should Physicians Support America's Affordable Health Choices Act of 2009?

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BELOW IS AN EXCERPT FROM TESTIMONY provided to Congresswoman Betty McCollum at a recent event she hosted at the Minnesota State Capital. Dr. Hansen represented the concerns he has gathered from physicians in the metro area over many months as it relates to the national health care reform efforts.

AMA supports H.R. 3200, "America's Affordable Health Choices Act of 2009" —but there is far from uniform agreement amongst health care providers and health care economists on whether this was the right choice to make.

What many who currently practice medicine and care for patients fear is that the proposed federal health care reform will effectively result in an expansion of public programs which enlarges the chronically under-reimbursed Medicaid-type system and moves enrollees on private plans into a federal Medicare-style public plan. Both of these options offer little comfort to the health care system as truly transformative health care reforms.

What's wrong with the way providers are reimbursed by government programs? From a federal perspective, Medicare rates were set on a flawed formula developed many years ago. Raises in payments brought forth at the national level typically do not even cover the rate of inflation. From a Minnesota state perspective, increases in payments by the legislature to Minnesota health plans for state programs over each biennium has occurred nine times, although an actual payment increase was passed onto providers only once. Where is the transparency on where the money is going? Perhaps these areas are where we should begin true reform.

Given what most Americans expect for their health care, there is another fundamental question which deserves consideration. Is it wise to expand the number of people in health plans with government set reimbursement rates, yet expect the current level of quality, availability, and innovation from the system? While the "health care system" appears to be the focus of a number of cost saving initiatives—as many economists also suggest, I'm not so certain overall quality is really the biggest question for our health care system—but cost and access in that system are the correct questions.

On net, H.R. 3200 adds substantially to future budget deficits—even according to the Congressional Budget Office's Director, Doug Elmendorf. He states that reform bills fail to include the two leading strategies to reduce costs: 1) Medicare payment reform; and 2) tax code reform. Can the value index proposal leverage against the political forces in Washington which created the inequities to begin with? Perhaps—but if widely applied through a federal insurance program which may "compete" with private plans, driving appropriately paying private insurance to very low levels or, in the end, eliminating it completely—does this leave us with a financially viable and sustainable health care system of current quality and availability?

Past attempts to manage increasing health care costs through either corporate and/or government rationing of supply (access), have been shown to not work well. In past reforms, transferring the "gatekeeper" function initially used by HMO corporations to health care providers effectively resulted in the bankrupting of clinics which were unwilling to ration care to their patients. Such mechanisms interfere and run counter to the obligation of provider decision making in the best interests of their patients.



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Though “Accountable Care Organizations” sound effective in concept, ACO’s in the most basic sense capitate providers on a fixed budget. Under such systems, small independent “at risk” providers will face the same dilemma as failed powerful insurance corporations: cost, quality, or access—you can have any two, but not all three.

I suspect American taxpayers likely fear the hundreds of billions of new debt introduced by the federal program—and they should, as in the future, it will burden fewer and fewer workers to pay for it. Calculations estimate, that in the next 10 years, the number of workers per Medicare beneficiary will drop from 3.7 to 2.9. Thoughtful and realistic assessment of any reform proposal must break down to basic mathematics of the economy.

As outlined, mandated insurance is interesting and attempts to address the laudable concept of improved access to care, but the economic repercussions of such a proposal are potentially onerous (refer to the financial difficulties of the Mass. Plan and the more open rationing by Oregon). Required to “pay or play,” those businesses or individuals failing “meaningful coverage” pay a penalty (a percent of payroll near 8 percent), into a national fund providing insurance for non-covered workers. Economist’s interpretation: A disguised employment tax, as judged by Princeton University professor Uwe Reinhardt, with potential cost of 1.6 million jobs over the first five years. Interestingly, H.R. 3200 may in fact suppress appropriately paying private individual coverage by preventing any new policies from being written after the public option becomes law. The legislation may also limit health savings accounts (HSAs)—a more “market-based” option allowing consumers direct control of their health care spending. Thus, in the final analysis, Federally backed insurance, a public option “managed care” plan (likely underpaying), would not really compete on a level playing field with private plans—most of which are only other “managed care” corporations which also have failed to control costs.

As a consequence of White House negotiations, I suspect all private pay patients will likely be impacted by the new deals aimed at cost reduction with the pharmaceutical industry and the hospital association. Most of what these interests agreed to was to take lower Medicare reimbursement rates. Due to the “cost-shift” we are now familiar with—the unpaid “cost” of lower reimbursement rates to providers are then effectively passed on to these private payers—either individuals out of pocket, or seen as higher insurance premiums by private insurance holders.

Efforts to reduce ineffective or duplicative care, primarily posed by electronic medical records (EMR) and medical homes, are admirable; however, will the massive amounts of EMR data and the construct of the medical home be used primarily for effective patient care and efficient cost reduction, or will the data and constraint allow undue scrutiny (and financial penalty) of physician “resource utilization” (money used) for patient care?

As informed policy people, we must understand individual patients are not population statistics (the data frequently invoked for such reforms), and there appears to be a frequent assumption of authenticity of such clinic statistics in policy formation. Such statistics are really only robust when derived from very large populations, “smoothing” the bell curve and lessening the financial impact of outlier events on insurance corporations. Insurance risk is actuarially sound when calculated across large groups of typically 25,000—50,000 at minimum, not your average practice, nor an individual physician.

Ultimately, the worries of many health care providers are: 1) the primary driver of “reform” will be financial penalty to “non-compliant” physicians, with continued unsustainable decrease in reimbursements, and 2) the continued evolution of a “reform solution” which incentivizes physicians to restrict care (save premium dollars) from “bundled services” pricing, bid down by competing large clinics/corporate providers to unsustainable levels for independent/small practices.

If poorly structured, bundled services may translate into “comprehensive care” for an episode, and splitting of capitated (bid down) fees among all providers (including the hospital)—and in some cases covering up to 90 days of patient complications. In such a system, the true price transparency and market forces remain suppressed and hidden from the users of health care. ♦

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