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Minnesota on verge of deciding its future health care system; COACT and physician urge policymakers to choose wisely

Will it be single-payer or an HMO plan that further monopolizes health care?

Dr. Dick Peterson, MD, retired from internal medicine practice at Park Nicollet Clinic, and COACT Executive Director Don Pylkkanen co-authored this article for publication in Minnesota newspapers.

Amidst all our bad news, economists continue to report that health care costs are rising faster than the gross domestic product, which is unsustainable for families, farms, and businesses. (See other side.)

However, there's been little reporting on the good news that the Affordable Care Act (ACA-Obamacare) provides an opportunity beginning in 2017 for any state to improve its health care system with the law's State Innovation Waiver. Two Minnesota proposals are being readied for legislative consideration.

The Minnesota Department Human Services (DHS) proposed to change health care service to Minnesotans primarily through increased use of **Accountable Care Organizations (ACOs)**. ACOs are large physician-hospital groups voluntarily organized around cost-quality, carrot-stick incentives. Savings and risks are shared between payers and providers based on achieving selected cost and quality benchmarks.

The ACO concept was formulated about a decade ago on a premise that tightly integrated physician-hospital groups with dollar-incentivized benchmarks would produce significant cost savings without compromising quality. However, numerous pilot projects and studies indicate ACOs do not significantly reduce costs.

$51.3 billion is Minnesota's health care cost in 2016 and projected to reach $76.5 billion in 2022. However, a 2015 task force legislated to find ways to reduce cost did not document savings with ACOs. Single-payer was ignored; and the risks of monopolies, misuse, and physician burnout were not addressed.

The other option is the Minnesota Health Plan, proposed by COACT and other citizen groups. This %Medicare-for-all+ model has been well tested in the U.S., Canada, and elsewhere. It needs no %pilot+study. In this single-payer proposal, providers are paid directly for medical care, thus avoiding the intermediate overhead costs of multiple insurers.

All Minnesotans would be covered, have uninhibited choice of physicians, and not lose coverage with job losses or changes. There would be no deductibles, and no co-pays for primary care. The plan's volume purchasing of prescription drugs would reduce prices.

At a COACT-organized town meeting in Nisswa, Dr. Dick Peterson, MD (far right), clarifies to a Medicare recipient opposed to single-payer (standing far left) that Medicare is single-payer.

The independent **Lewin Group**, commissioned by Minnesota Growth and Justice, found it fiscally sound and projected a 10-year savings of $189.5 billion.

U.S. health care costs are 50 - 70 percent higher than the other twenty most advanced countries, while they have better longevity and disease-morbidity outcomes. This is because they had a moral commitment to cover everyone. They then determined the best economic model to achieve this goal: single-payer or tightly regulated insurance companies.

Dr. Arnold Relman, a former editor of the *New England Journal of Medicine*, made two relevant assertions in his book, *A Second Opinion*. First, he agreed with Nobel Laureate economist Kenneth Arrow's 1963 judgment that health care costs do not respond to market forces like most businesses. One obvious reason is that purchasers of health care do not shop for provider services on the basis of price.

Relman also warned of a coming %medical industrial complex+ that falsely presumes market forces keep costs at their optimal minimum. The recent national push for ACOs may be related to the recently reported increase in physician burnout. Both may be signs of this new medical-industrial complex.

Policymakers are advised that proposals be studied before legislative consideration. COACT is urging legislators this session to vote for an independent comparative study of the ACO and Minnesota Health Plan proposals to determine which one merits the waiver. In 2017, the legislature can begin legislation to direct the Minnesota Department of Human Services to apply to the feds for the waiver to allow enactment of what should be the cost-efficient Minnesota Health Plan rather than the costly ACOs.