Miller-Meeks also has a radical plan to phase out the employer deduction for health coverage. Her plan would undermine our current health care system of employer-based health insurance as we know it. As insurance and drug companies continue to jack up prices, it would force all Americans to fend for themselves with insurance companies on the open market.

**Miller-Meeks Claimed We Should Phase Out Employer Coverage Incrementally.** “We should phase out employer coverage incrementally while providing tax deductions for higher income and tax credits (pre-fund) for lower income and those with chronic pre-existing diseases. Funding such individual health plans accessed by debit cards would empower individuals, regulate the insurance industry and provide choice. We could maintain the innovative strengths of our current system, using the government to insure coverage of the needy, transparency of prices and prevention of fraud.” [Iowa City Press Citizen, 7/8/09]

*Please see primary source, “20090708 Iowa City Press Citizen”*

**Miller-Meeks Said The Government Could Gradually Phase Out The Employer Deduction.** “The problem with that, Miller-Meeks admits, is that each state has different coverage requirements. So she proposes ending that practice and requiring coverage just for the three things she believes people fear most. Miller-Meeks said the government also could gradually phase out employer deduction but offer individuals the same deduction so they could choose their best means of care.” [The Hawk Eye (Burlington, Iowa), 9/6/09]

*Please see primary source, “20090806 The Hawk Eye”*

**The Tax Exclusion For Employer-Sponsored Health Insurance Lowered The After-Tax Cost Of Health Insurance For Most Americans.** “Q. How does the tax exclusion for employer-sponsored health insurance work? A. The exclusion lowers the after-tax cost of health insurance for most Americans. Employer-paid premiums for health insurance are exempt from federal income and payroll taxes. Additionally, the portion of premiums employees pay is typically excluded from taxable income. The exclusion of premiums lowers most workers’ tax bills and thus reduces their after-tax cost of coverage. This tax subsidy partly explains why most American families have health insurance coverage through employers. Other factors play a role though, notably the economies of group coverage.” [Tax Policy Center, Accessed 8/17/20]

**Employer Sponsored Insurance Was The Dominant Form Of Insurance For The Non-Elderly Population In The U.S.** “ESI is the dominant form of insurance for the non-elderly population in the U.S. More than sixty percent of non-elderly individuals receive their insurance through their own employer or that of a family member. By contrast, only six percent purchase insurance privately through the non-group market. The remainder of the population is either insured by the government (19 percent) or uninsured (17 percent).” [National Bureau of Economic Research, 8/17/20]

**Becker’s Hospital Review HEADLINE: “14 Pharma Companies Post Q3 Profits Over $1B.”** [Becker’s Hospital Review, 11/12/18]


**In The Years Between 2000 And 2018, 35 Big Drug Companies Received A Combined Revenue Of $11.5 Trillion, With A Gross Profit Of $8.6 Trillion.** “Big pharmaceutical companies appear to be more profitable than large companies in most other industries, according to a new study. Researchers writing in the Journal of the American Medical Association (JAMA) investigated the financial balances of pharma companies dealing in the business of developing, manufacturing, marketing and selling drugs. Their calculations found that in the years between 2000 and 2018, 35 big drug companies received a combined revenue of $11.5 trillion, with a gross profit of $8.6 trillion.” [Newsweek, 3/4/20]
2020: Drug Prices Had Increased At An Average Of 5 Percent. “Three days into the new year, drugmakers have already increased the list prices on hundreds of medications, with experts predicting more hikes in the weeks to come. So far in 2020, prices on 411 drugs have increased an average of 5%, according to GoodRx, which tracks the cost of more than 3,500 drugs. Of the drugs that have seen rising prices, 407 were brand-name products and four were generic.” [CBS, 1/3/20]
I will begin by being contentious: To provide medical care to everyone, health care must be rationed.

This is an indisputable economic reality. The question then becomes: Who should ration health care, a government bureaucrat or yourself?

Americans have access to the best and newest technology, rapid adoption of innovation and minimal delays in obtaining state-of-the-art treatment. Yet awash in this abundance, some are economically prohibited or declined coverage for health insurance.

Misguided "code blue" reform is required for economic recovery and to bolster global business competitiveness. Rather than a shotgun wedding, what is truly urgent is careful deliberation before costly modifications force America to lose access to what most of the world envies.

I propose greater intellectual discourse and dissolution of myths and denial by all invested groups.

Public competition myth

It is a myth that a public option would reduce costs by providing competition. Already the competition in health care is aligned to bring value to the government, employer or insurance company.

True competition works and is exemplified by laser vision correction. The price started high, then bargain providers joined and ultimately the price settled where most patients deemed reasonable. Pay more for better service or perceived quality or less if price is paramount.

True competition is not granted by a public option. Insurance companies must have significant cash reserves, advertise and market their product. Other government agencies bear this cost permitting the public option to lower premiums, while the taxpayer subsidizes the hidden costs.

Premiums also would be higher by mandating increased benefits (already proposed) and the departure of individuals to a lower cost alternative. As premiums rise when participants decline, small businesses would drop coverage and further stress premiums. The private health insurance marketplace would collapse because of unfair, subsidized competition. Meanwhile, costs will continue to increase.

Increased costs
Cost increases are inevitable without deterring use. Numerous valid, controlled, non-partisan studies reveal that over-utilization is the norm when the consumer bears little or no cost. Thus, the rationale for co-pays and deductibles.

If lack of coverage were responsible for increased costs, why is the Medicare system reaching insolvency faster than predicted? Although there is a monthly premium, there is no restriction on the numbers of visits or services obtained. Nor do greedy providers alone account for increased cost. Cataract surgery reimbursement in 1986 was $2,400 per eye, and in 2008, $584 per eye -- despite a better procedure, faster visual recovery and no hospitalization. Because the numbers of seniors accessing care has grown tremendously, there is no governmental cost savings.

Limiting cataract surgery to one eye has been entertained here and abroad. In 2006, the National Institute for Clinical Excellence in England refused payment for vision-saving eye injections unless one eye was blind. After three years, this ruling was overturned.

This is not mentioned to incite fear, only to promote honest discourse. Lancet Oncology published a study last year that the five-year cancer survival rates were higher in the U.S., and the Joint Canada/U.S. Survey of Health indicates that Americans have greater access to preventive health screening and have higher treatment rates for chronic illness.

Although the single-payer countries (socialized medicine) provide access for all individuals to basic care, it was revealed in a paper in 2007 in "Forum for Health Economics and Policy" that the poor under socialized medicine seem to be less healthy relative to the non-poor than their American counterparts. There is a trade-off of specialist care for basic care for everyone -- for example, rationing by waiting.

I am not suggesting that patients defer necessary or critical treatment, but I do suggest that "gray-area" care -- such as the examples of second-eye cataract surgery or vision-saving injections -- could be decided by patients themselves.

The Agency for Health Care Policy could be helpful in providing current research and cost-benefit analysis. Benefit/value includes convenience, reduced waiting time, traveling distance and discomfort not merely the resolution of disease. That would help identify absolutely frivolous care versus necessary treatment and would leave the ill-defined "gray area" to be decided by well-informed patients.

Designing a better system

Can we then design a system that provides everyone, regardless of citizenship or familial relationship, with accessible, affordable and portable health insurance while maintaining our innovative edge and encouraging healthy lifestyles?

No person should be concerned that they may go bankrupt when faced with a catastrophic illness. But neither should someone pursuing alternative therapies such as acupuncture, meditation or herbs have to resort to lobbying their government to have this type of care researched and validated before it can be incorporated into a public option.

Costs of health care are tied to insurance. If we used auto insurance for each oil change and tire rotation, our premiums would be drastically higher. The state only mandates minimal coverage, and we choose the amount of the deductible. It is purchased nationally with a nationwide risk pool modified by location of the vehicle and the driver's history.

Health insurance prices would be lowered by:

* Eliminating mandated benefits;
* Purchasing tailored health insurance policies from numerous companies; and

* Varying deductibles.

Health care economists indicate a policy covering 100 percent of catastrophic after deductibles, including preventative and immunizations, could cost as little as $200 per month for a family.

We should phase out employer coverage incrementally while providing tax deductions for higher income and tax credits (pre-fund) for lower income and those with chronic pre-existing diseases. Funding such individual health plans accessed by debit cards would empower individuals, regulate the insurance industry and provide choice. We could maintain the innovative strengths of our current system, using the government to insure coverage of the needy, transparency of prices and prevention of fraud.

This is a simplistic sketch at best for a topic that deserves much more intellectual dialogue. Lively discourse will create an industry combining the best of single-payer systems without derailing the profound advances achieved through our current system.

Mariannette Miller-Meeks is an ophthalmologist from Ottumwa and a former Republican candidate for Iowa's Second District of the U.S. Congress.
Physicians mixed on health reform bills
The Hawk Eye (Burlington, Iowa)

September 6, 2009 Sunday

By CHRISTINIA CRIPPES
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"I will use those dietary regimens which will benefit my patients according to my greatest ability and judgment, and I will do no harm or injustice to them.

"Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption ...

"So long as I maintain this Oath faithfully and without corruption, may it be granted to me to partake of life fully and the practice of my art, gaining the respect of all men for all time. However, should I transgress this Oath and violate it, may the opposite be my fate," reads the conclusion of the Hippocratic Oath.

With that reverential vow to their profession's duties, graduates leave the college campus and enter the medical arena.

Pledging to care for others means doctors and nurses keep their doors open for the sick and the hurt, even if the resources aren't available to pay for the treatment.

It is with that pledge in mind that doctors are weighing the health care reform discussion taking place in living rooms, restaurants and in Congress.

There's little doubt medical professionals believe reform is needed. It's the method to reach that goal that varies dramatically.

Michael Maharry, a Muscatine doctor who operates a family practice in Iowa City, supports the largely Democratic legislation for the simple reason that he believes people have a moral right to health care in the United States.

"It's not about reimbursement ... It's about taking care of our citizens as a nation," Maharry said, adding the legislation will be great news for family doctors like himself.
"That is part of the 80 percent that I believe is bipartisan about the bill ... is that there needs to be more emphasis on primary care, more people need to have a medical home and they need to encourage more young doctors to go into the field of primary care."

He said the paradox is ultimately people will become healthier, and he'll have fewer patients.

"The goal is, it should be, to improve the health of the nation, not just to give everybody health insurance," Maharry said.

Mariannette Miller-Meeks, a nonpracticing ophthalmologist in Ottumwa, agrees with the ideal of health care for all, but says the proposed legislation doesn't do accomplish that task. Besides, she said it's too expensive.

Last year, Miller-Meeks, a Republican, sought to unseat Dave Loebsack from his 2nd District congressional seat.

"We can't afford to give everybody a Cadillac in health care," she said. "The amount of tax on the middle income person would be tremendous ... to provide everybody the same level of health care that we have right now.

"Instead of saying we have a financing problem in health care, we say our system is broke."

She added that if that level of care was provided to everyone, it would have to be rationed.

Medicare for all?

To begin tackling the myriad problems of the current health care system, Miller-Meeks proposes changing Medicare reimbursement, something finds support with Maharry and much of Iowa's federal delegation.

 Blocking that, though, are the more populous states have more representatives in Congress who support status quo. Compounding the problem, the Medicare fund is running out of money.

Miller-Meeks blames the bankruptcy on overuse, saying those who get care for free are prone to use it unnecessarily like patients with mild sore throats who'd otherwise would gargle with salt water.

Maharry, however, sees the good in Medicare.

"Medicare is run more efficiently, and people cannot deny that fact, that are against a public option. It costs less to run Medicare than Blue Cross-Blue Shield," he said. "That's what the savings would be under a health care option from the government."

For him, the public option essentially would offer Medicare to everyone.

"If you talk with people on Medicare, they're happy with Medicare, so giving that option to people under 65 doesn't seem to me to be a scary thing," Maharry said. "Medicare does not care if you have cancer or diabetes or are about to die; they will insure you. Private health insurance will not do that."

He doesn't dispute the notion the government program could become more efficient.

"People that are for the free market yet don't want the public option is sort of stifling the free market," Maharry said. "Let that choice compete with you guys (insurance companies) who haven't been successful at controlling costs the last 40 years."

Miller-Meeks, however, says that's a false argument. She said insurance companies have to worry about a bottom line, whereas the government can increase taxes.
"Just like Fannie Mae and Freddie Mac, it's a government-sponsored entity," Miller-Meeks said. "If Medicare is underfunded, in order to provide the current level of benefits that we provide to seniors, then how much taxation do people want to pay for that?"

Other options

Instead, Miller-Meeks would rather allow insurance companies to compete across state lines, with fewer mandates.

"We know that if you had a policy that allowed people to purchase across state lines from any company and it included a varying deductible like your auto insurance and it included the things that people are most frightened about ... the policy could be offered at an extremely low cost," Miller-Meeks said.

She said the biggest fears people have in coverage are immunization, prevention, and catastrophic events. Miller-Meeks said those could be covered and the government could fund an account for low-income people so it would still be subsidized.

"If people are paying for it out of their debit account, they'll utilize those resources in a great manner," Miller-Meeks said.

The problem with that, Miller-Meeks admits, is that each state has different coverage requirements. So she proposes ending that practice and requiring coverage just for the three things she believes people fear most.

Miller-Meeks said the government also could gradually phase out employer deduction but offer individuals the same deduction so they could choose their best means of care.

For example, she said Lasik eye surgery is not covered by insurance but that through competition it has become more widely available and less expensive.

Maharry would still rather lean on the government than trust the private industry.

Insurance concerns

"Private health insurance, if they wanted to cover everybody, they could right now," Maharry said. "They discriminate against people that have health conditions. They will not cover people you if you have diabetes ... The health reform will change that."

Miller-Meeks agreed, saying that health insurance companies made a "good-faith effort" by going to the administration and offering not to exempt preexisting conditions and to cover everyone.

She's unsure how often or egregious private health insurance companies drop coverage for sick people.

Earlier this year, however, executives from just three health insurance companies testified before the House Energy and Commerce Committee that during a five-year period they rescinded -- or dropped coverage on -- nearly 20,000 policies, acknowledging that the figure "significantly" undercounts the total.

They further reported they saved more than $300 million as a result of their rescissions during the same period.

At the conclusion of the testimony, one executive said the practice would continue to be necessary until there is comprehensive health reform.

Miller-Meeks said the law could be amended to provide an option for people to have guaranteed renewability in their plans for a nominal fee.
Maharry doesn't see it in those terms, saying the system definitely is not OK the way it is, despite claims to the contrary at town hall meetings.

"That's not really being emphasized, either, that insurance companies have been allowed to get away with this for so long, to pick and choose who they want to cover. You shouldn't have to. Our country should take care of our citizens."