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The Hartford Hearing: Is United Listening?

ELAINE C. JONES, MD
PRESIDENT, RHODE ISLAND MEDICAL SOCIETY

UNITED STATES SENATORS Sheldon Whitehouse (D-RI) and Richard Blumenthal (D-CT) treated us all to a fascinating and valuable piece of political theater with their January 22 oversight hearing on what some are now calling “the United fiasco” – that’s the decision by the UnitedHealthcare Group



to disrupt hundreds of thousands of patient-doctor relationships in a dozen states by dropping thousands of doctors from their Medicare Advantage networks on short notice, without consultation and without divulging anything of the insurer’s rationale or game plan.

The hearing in Hartford was a welcome diversion as we continue to wait for the Second Circuit to rule on the injunction that is currently postponing the fate of hundreds of physicians in Hartford and Fairfield Counties who received termination notices from United in October. By the way, the Rhode Island Medical Society and all of the other 49 state medical societies, in addition to the District of Columbia and the AMA itself, are represented among the *amici* whose brief urges the Second Circuit judges to uphold the injunction. We should hear soon.

Meanwhile, we all owe a great debt of gratitude to Raymond Welch, MD, the eminent dermatologist who has practiced in Providence for almost thirty

years and who is without question a credit to our profession as well as a very nice guy. He took a day off from his practice right after a heavy snowstorm to travel to the Hartford state house on Wednesday, January 22. There he acquitted himself with dignity, clarity, humor and passion.

During the hearing, the interplay between the two Rhode Islanders, Dr. Welch and Senator Whitehouse, was particularly entertaining. At one point Dr. Welch made the point that insurance companies do not care for patients, only physicians do. Senator Whitehouse interjected, “In Rhode Island I have never seen an ambulance rush a patient to an insurance office.”

As was to be expected, the UnitedHealthcare Group refused to send a spokesperson to the hearing, thus thumbing their corporate nose at public opinion, the people’s elected representatives, and the hearing process – and squandering an opportunity to make a public case for their actions, assuming they could do so. Stephanie Kanwit, Esq., counsel to the health insurance industry’s trade association (which calls itself America’s Health Insurance Plans, or AHIP), had the thankless job of defending the industry’s point of view in general, if not UnitedHealthcare’s conduct specifically. In doing so, Ms.

Kanwit predictably cited three things in the abstract: the popularity of Medicare Advantage plans; the impact of the ACA’s gradual reduction in the government’s payments to Medicare Advantage plans, compared with traditional fee-for-service Medicare, from +14 percent to +1 percent by 2017; and the industry’s response to these phased-in funding reductions by developing “high value provider networks.” The implication was that United’s massive terminations

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this fall were but a necessary step toward consolidating “high value provider networks” in the affected markets.

Skeptical discussion of “high value networks” inspired another quip from Senator Whitehouse in support of Dr. Welch’s testimony regarding the unreliability of the provider directories United makes available to subscribers who might try to find a new doctor. Dr. Welch observed that he found physicians listed there as if they were available to accept new patients, whereas in fact some of those listed had long since left the state, retired or died. Dr. Welch

even found himself listed there – with an obsolete identification number and at a street address that has not been valid for a decade. Remarked Senator Whitehouse, “You would think that a ‘high value provider network’ would pick up on the deadness of a doctor.”

Late in the proceedings things took a new turn after Senator Whitehouse revisited one of the themes of the hearing, which was the theory, accepted by many, that United’s dumping of doctors

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was a proxy for dumping panels of patients who suffer from costly conditions. Viewing United’s action in this light, Senator Whitehouse characterized it as “cherry picking” and another example of “privatizing profits and socializing costs” – particularly since many patients would elect to stay with their doctors by switching their coverage from Medicare Advantage to traditional fee-for-service Medicare, which has the broadest, most inclusive network of all. This theory must be valid, Senator Whitehouse observed, since no one has even attempted to rebut it.

Indeed, it hadn’t been rebutted, and this was by no means the first time the theory had been cited in the course of the proceedings. The hearing was almost over when Attorney Kanwit of AHIP finally responded to Senator Whitehouse’s charge. She asserted that

because the government’s per capita payments to Medicare Advantage plans are risk-adjusted, plans have “no incentive to cherry-pick.”

It is true that since 2004 Medicare has modulated its payments to Medicare Advantage plans based on patients’ health status. The plans receive a higher, risk-adjusted capitation rate for a patient with diabetes or heart disease than for an otherwise similar patient without such conditions. Before 2004, the incentive for plans was simply to enroll low-cost patients; and indeed, that is what happened. One study concluded that before risk-adjustment, the government was overpaying Medicare Advantage plans by \$1,800 per person on average, compared with what these relatively healthy patients would have cost under fee-for-service Medicare.

Risk-adjustment was therefore introduced in 2004 in order to correct for these overpayments by recognizing the overall lower risks of the Medicare Advantage population. But – *mirabile dictu!* – once risk adjustment was implemented, enrollment and usage patterns shifted, and Medicare Advantage spending actually increased to a differential of \$3,000 per capita over traditional Medicare. It seems that somehow even enrollees with higher “risk scores”

tended to be significantly below the average cost in their “risk category,” and so the Medicare Advantage plans prospered even more. A study published by the National Bureau of Economic Research concluded sadly that “the Medicare Advantage program both increased total Medicare spending and transferred Medicare resources from the relatively sick to the relatively healthy, and that risk-adjustment was not able to address either of these problems.”

In summing up what he learned from the hearing, Senator Whitehouse decried the human cost of what he called “Medicare gamesmanship.” Senator Blumenthal said it was a case of “bait and switch” when United sold one product in bad faith and delivered another of lesser value. Both said better consumer protections are needed. We’ll see how the Senators follow through. ❖

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Simplicity Isn't Always a Virtue

JOSEPH H. FRIEDMAN, MD
joseph_friedman@brown.edu

IN THE FIELD OF NEUROdegenerative disorders, like Alzheimer's, Parkinson's and related diseases, there are two types of research. The more important is focused on finding the causes, which will, hopefully, result in treatments that prevent, halt progression and possibly restore function.



The other type aims to treat symptoms, such as movement, cognitive and behavioral problems that occur in all of these disorders. My own work has been in the latter realm and, while I think I have contributed to better management of some of these conditions, I am quite disappointed in both myself and my colleagues for failing to accomplish more. Over the last few years I've come to believe that much of our research vision has been limited by our inability to break out of old models and become more creative. We continue to repeat our old mistakes.

A cardinal principle of research, especially clinical research, is the KISS principle: Keep It Simple, Stupid. I fully believe in it. However, it applies to designing clinical protocols. It does not apply to interpreting results or creating hypotheses. I have come to believe that much of clinical medicine has, for want of more creativity, come to cling to the KISS principle in developing new treatments. Keep it simple, or simply

mimic something that works. Striking out in new directions is difficult for many reasons, if not impossible, for simple lack of funds if the funder is the marketplace.

I believe that Parkinson's disease has been like the La Brea tar pit for neuroscientists. It is the first neurological

disorder for which a designed, rational therapy was instituted and found to be effective. Drugs that depleted catecholamines, a small family of chemicals in the brain, were used experimentally to treat people with schizophrenia. When these patients developed features of Parkinson's disease, which luckily was reversible, the brains of people who had died with PD were examined and were found to be deficient in catecholamines, but particularly dopamine. A gigantic simplification then was hypothesized. Increase the dopamine and perhaps people would become more normal.

Assuming that increasing dopamine in a brain that was deficient in dopamine would work similarly to giving insulin to a body that was deficient in insulin was extraordinarily naïve. After all, insulin works in the bloodstream and dopamine works in the tiny space between two brain cells called a synapse. Insulin simply has to get into the blood. Dopamine has to get into a highly targeted region. And, making the

challenge more difficult, dopamine itself can't get into the brain at all because it is blocked by the blood-brain barrier. So a drug that does enter the brain and which brain cells can break down to make dopamine, L-Dopa, was given. One of my mentors, who was in training at the time L-Dopa was developed, thought that the notion that L-Dopa would be taken up by cells damaged by PD, then converted to dopamine and secreted in a normal fashion, was like expecting a car, out

We, in the clinical neurosciences, need to follow the path laid out decades ago by oncologists, and use multiple therapies simultaneously.

of gas, to start up again if gasoline was poured over it. Luckily he was wrong and L-Dopa remains our best treatment 50 years later.

The problem, as I see it, is that generations of scientists have come to believe that other brain disorders are like PD and that the symptoms of disorders such as Alzheimer's, Parkinson's and related disorders may be treatable with a single drug, a "magic bullet." In PD we have the "dopamine deficit." In Alzheimer's disease it is the "cholinergic (acetylcholine) deficit." In schizophrenia there is a "dopamine excess" hypothesis. Unfortunately, even Parkinson's disease isn't like Parkinson's disease anymore. Despite learning that

improving these presumably cardinal deficits or excesses may provide some benefit, these improvements are, unfortunately, severely short of satisfying for most patients. Since almost all new medications are developed by drug companies, because of the enormous cost required they are rarely innovative, and almost always based on the notion of a single problem, to be addressed with a single drug. Unfortunately, even in PD, where dopamine replacement produces a clinically significant benefit, the results are limited and, neurologists have come to realize that most of the changes in the brain do not involve dopamine at all. Alzheimer's disease is much more than a simple memory problem. Few

neurological disorders are "simple" in the sense that only one type of brain cell or one region in the brain is affected. Even in disorders in which we know the cause, a single gene abnormality, the extent of the pathological process is wide. Expecting to improve symptoms by focusing on a single chemical in the brain is destined to failure.

We, in the clinical neurosciences, need to follow the path laid out decades ago by oncologists, and use multiple therapies simultaneously. These trials will be costly and will only happen when government funds the trials or multiple pharmaceutical companies band together and patients step up to the plate and volunteer. ❖

Author

Joseph H. Friedman, MD, is Editor-in-chief of the *Rhode Island Medical Journal*, Professor and the Chief of the Division of Movement Disorders, Department of Neurology at the Alpert Medical School of Brown University, and chief of Butler Hospital's Movement Disorders Program.

Disclosures

Lectures: Teva, General Electric, UCB Consulting: Teva, Addex Pharm, UCB, Lundbeck

Research: MJFox, NIH: EMD Serono, Teva, Acadia, Schering Plough

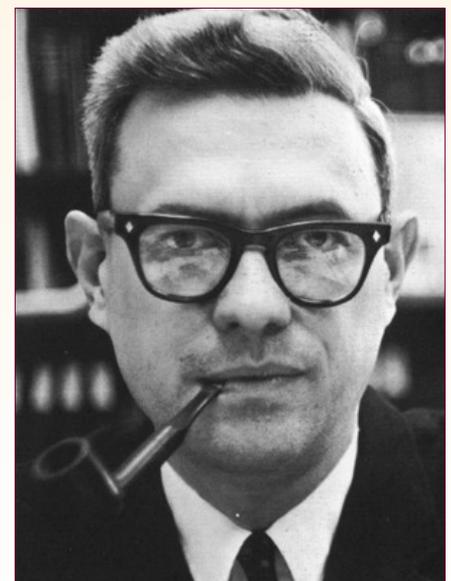
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Dr. Aronson in 2007 receiving Doctor of Medical Science (DMS) at Brown in 2007.



Stan Aronson, MD, in the early years in the 1950s at Downstate Medical Center in NYC.

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STANLEY M. ARONSON, MD
smamd@cox.net

THE GREEK TITAN, Atlas, sired a daughter named Calypso, a sea nymph. Calypso, and her beguiling music, enticed Odysseus to delay his voyage (his odyssey) to home and Penelope, his wife. And for seven years Odysseus dallied on the isle of Ogygia, allegedly missing Penelope yet utterly en-



tranced by Calypso and her music. Zeus finally declared that this sabbatical was counterproductive and Odysseus, the lone survivor of his fabled crew, went back to sea to reunite with Penelope.

The name, Calypso, from a Greek root meaning to hide, to make secret, also came to define a form of Caribbean music. And then, with the prefix, *apo-*, the Greek word, apocalypse, meaning an uncovering, a revelation. The apostle, John (6 – c.100 CE), voyaged to the Mediterranean island of Patmos to write what is now the terminal chapter of the New Testament, a book called Revelation (or The Apocalypse) which tells, in vivid metaphors, the ultimate battle between good and evil.

Two millennia ago, an apocalypse had been a revelation, neutral in its content. But the Book of Revelation changed the import of an apocalypse: it now defined a sequence of catastrophes, an eschatological view of the ultimate confrontation between the forces of divine and deadly. And the cosmic destruction that ensued

was an overt expression of heavenly displeasure.

In many ancient tales, an isolated male with impeccable moral credentials lives in a deeply corrupt society. And so, when the apocalyptic event arrives, only he and his family are spared while the rest of humanity perishes. The Baby-

lonian Epic of Gilgamesh, and its hero Utnapishtim, and the tale of Noah and his ark are early examples of apocalyptic tales. And so, the word apocalypse began life as defining a disclosure; but gradually it came to define a terrible catastrophe prompting a need for revelatory explanation.

'Another mechanism for the swift eradication of humanity is a global pandemic caused by some exotic virus originating in a primitive village in southern Madagascar.'

The revelations of St. John, in many ways, were the continuation of the prophetic responses within the Hebrew books of Jeremiah, Ezekiel and Isaiah: solitary voices predicting an apocalyptic future for an unrepentant people.

Isolated fictional works portraying worldly disaster appeared during the

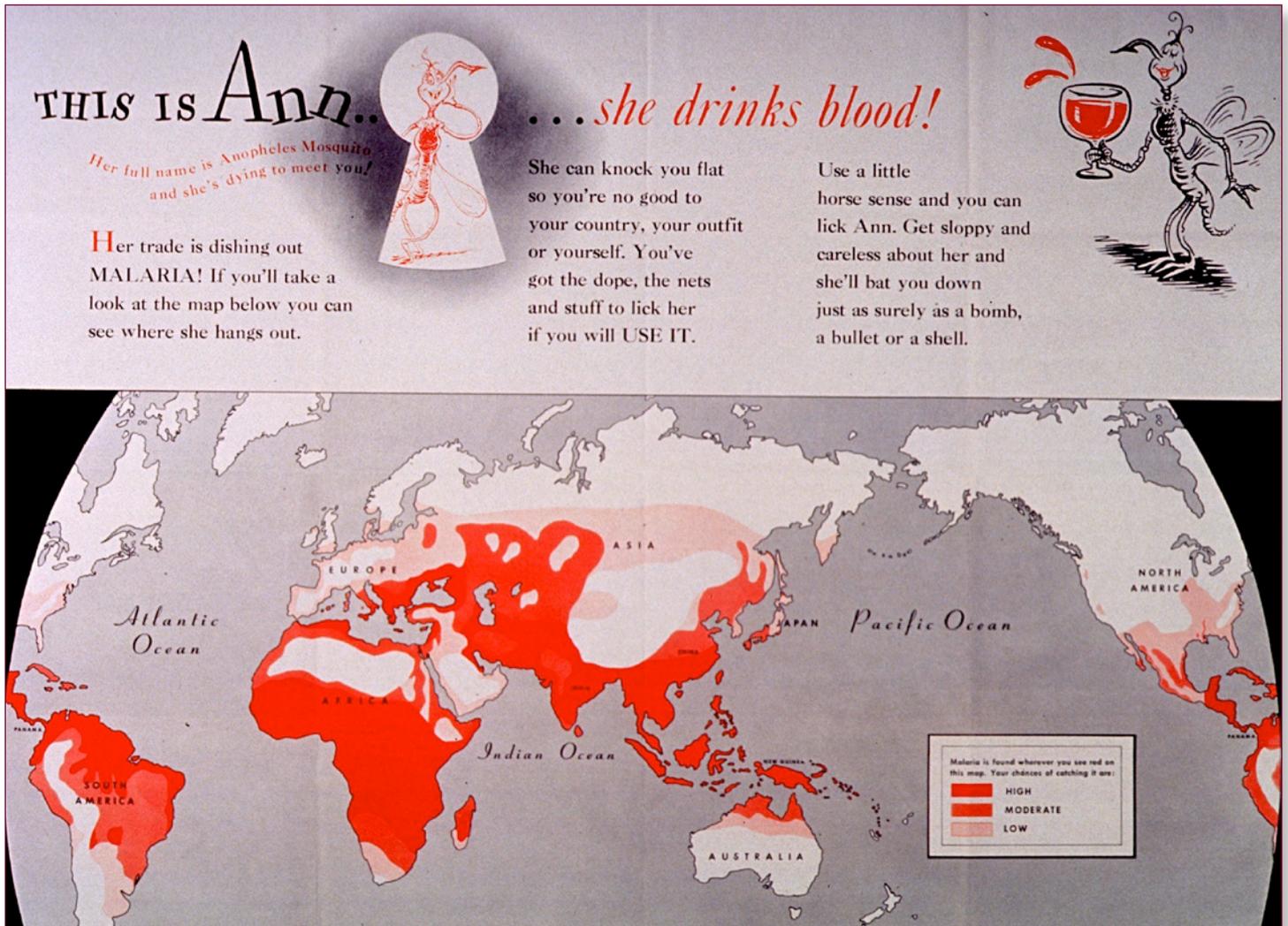
19th and early 20th Centuries, particularly in the writings of Mary Shelley, Edgar Allan Poe and H. G. Wells. But the genre of apocalyptic and post-apocalyptic fiction emerged in the 20th Century only when there had been widespread apprehension of nuclear warfare and global annihilation.

The post-nuclear apocalyptic works portray, at the least, a hero and a faithful heroine undergoing an existential series of disasters, often leaving them as survivors in a world bereft of humans.

Writers of such eschatological accounts have a broad menu of destructive agents to initiate their fictional apocalypse. Nuclear warfare resulting in widespread atmospheric contamination, for example, may kill off the populace – while providentially exempting the hero/heroine from such radiologic poisoning.

Another mechanism for the swift eradication of humanity is a global pandemic caused by some exotic virus originating in a primitive village in southern Madagascar. In this variant of the apocalyptic tale, the hero may also be afflicted; but somehow he survives to contemplate a world now dominated by anthropoid creatures suddenly learning to converse in English.

Yet other themes for the apocalyptic genre include extraterrestrial invasions, genetic defects contaminating billions and ultimately, the revolt of the machines, sometimes with endearing names such as HAL, taking control of



This poster was used in 1943 by the War Department in an Army orientation course, warning U.S. soldiers of the dangers of malaria and the pathogenicity of the Anopheles mosquito.

the world; adverse climate change; or ecological disarray caused by depletion of essential natural resources. The underlying message is best expressed in a movie advertisement: "Danger is real. Fear is a choice."

Speculation on a global apocalypse fuels such expressions as Sunday sermons, summer movies and even university commencement speeches. And whether the medium for an apocalyptic vision is the printed page, comics, radio, television or the cinema, the subtext is always twofold: first, the inevitability of human extinction; and second, except for the hero/heroine, the powerlessness of humanity to forestall the inevitable.

But amongst all of these ultimately tragic books, tales and movies, one film stands out as offering a human intervention capable of halting the disaster. In 1951, a movie appeared entitled, "The Day the Earth Stood Still." Humanity is on the brink of total extinction by alien robots. But if the heroine, played by Patricia Neal, would but remember the phrase that would nullify the robot's action, the world would then be saved. The critical words were "*Klaatu barada nikto.*" At the last moment, Neal says these fateful words, and the world is saved.

Again, for your preservation, please rehearse the comforting words of salvation: "*Klaatu barada nikto.*" ❖

Author

Stanley M. Aronson, MD, is Editor emeritus of the *Rhode Island Medical Journal* and dean emeritus of the Warren Alpert Medical School of Brown University.

Disclosures

The author has no financial interests to disclose.

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