ObamaCare: Embattled Doctors & Patients

The Obama administration finally finagled reticent Democrats into passing "healthcare reform," despite the fact that a majority of Americans were against the Democrats' bill. And the Democratic Party, as a whole, will likely face retribution by the public during elections in November, but the retaliation will probably not be for the reasons you might think.

Though many Americans are against the "reform" because it represents the fulfillment of the final steps of full-blown socialism in America, in truth, a large majority of people express support for some socialistic features of the plan, such as those that effectively abolish insurance — forbidding insurers from "discriminating" against people with "pre-existing conditions" or setting a maximum lifetime insurance payout.

Some even argue that "healthcare reform" as recently enacted in the Patient Protection and Affordable Care Act (PPACA) is not really socialized medicine. Indeed, it does not seize ownership of the healthcare sector.

However, it does violate the principles of insurance. Insurance defined is a voluntary sharing of catastrophic risks, with premiums based on risk and level of potential benefit (see "ObamaCare's Health Insurance Reform"). Healthcare reform is based on the fundamental axiom of socialism: "From each according to his abilities, to each according to his needs."

Socialism has been called "the war of all against all." It is exactly that in medicine, where the carnage, waste, and enmity of war is most appalling.

This should be abundantly evident to everyone. A number of states have already experimented with requiring guaranteed issue of insurance and community rating of insureds' risk, rather than individual assessments of risk, with consistent results: huge premium increases, pricing almost everyone out of the market, as in New York and New Jersey. Low-risk people see the new, high insurance premiums as a rip-off and refuse to buy. After all, with guaranteed issue of insurance, they can always buy in without penalty when they get sick. So premiums rise even more. Enter the Democrats' individual mandate, requiring everyone to buy insurance.

Under the mandate, we are promised that our insurance will be "affordable," but it is the government that will define the term and there is nothing in the healthcare bill that will reduce the cost of care — except perhaps by denying some people care. And your "fair share" of the "affordable" premiums *will* be collected by the government. Based on reports you will constantly have to file, the IRS will determine

how much tax credit or subsidy you are entitled to. This will go directly to the insurer. If your income increases, your subsidy will decrease stepwise, which for some people could mean the equivalent of a marginal tax of 100 percent or more. Many may find that if they work harder, they will just be lining the pockets of insurance executives, not bringing home more money.

Now everyone gets punished by government for the improvidence of some — and the penalties the citizens will pay will extend beyond the monetary realm into their physical well-being.

Day-to-day Effects on Patients

Supposedly, under PPACA, everyone will pay into a great collective insurance pool — which at least for now will be owned by a cartel of government-approved and -regulated private insurers — then everyone will get healthcare: the right care to the right patients at the right time in the right place from the right providers, as available.

We have heard that expression many times from the giant managed-care cartels, and the results will not be any better with government-controlled care.

The battles that are already happening, thanks to our partly socialized system of Medicare and Medicaid, will be greatly intensified. Already approximately 28 percent of doctors no longer take new Medicare patients; 50 percent of doctors don't take new Medicaid patients. The opt-out rates are higher for specialists, such as internists, gastroenterologists, gynecologists, and psychiatrists. The doctors' reasons for their decision to opt out of the programs is not just the below-market rates that physicians must accept for their services, but the intrusive regulations. As the *New York Times* states, "Reimbursement rates are too low and paperwork too much of a hassle." The Mayo Clinic, which received praise from President Barack Obama for providing cost-effective, high-quality care, stopped accepting Medicare payments at its Glendale, Arizona, branch (Medicare patients must pay cash for continuing care) because, according to Bloomberg.com, the Mayo Clinic lost $840 million on Medicare last year. People who thought they were being given a free ticket to medical care will be very angry when they learn they are actually being forced to buy a very expensive ticket for a place in an ever-growing line.

Adding to the lines, everyone will have prepaid for a "fair share" of care and will be entitled to certain things, like "preventative" care without even a copayment. In Sweden, clinics have barred the doors at a certain hour and posted police inside to quell any disruptions. Do we think that Americans are inclined to be more patient and polite than Swedes when sick or in pain?

To counteract doctor opt-out, Massachusetts proposed to force physicians who participate in an existing health plan to participate in an "affordable" plan for small businesses that would tie their payment to Medicare rates. The Massachusetts health plan is the model for the national plan. That state is feeling the pressure to force doctor participation because its waiting lines are almost twice the national average, according to Dr. Richard Reece, author of *Obama, Doctors, and Healthcare Reform,* on KevinMD.com. But such a plan will merely exacerbate a growing shortage of doctors and lengthen lines even more, as bright potential medical students choose other career paths rather than work for a pittance. Already, there is "a shortage of doctors, estimated at 50,000 but headed towards 150,000 by 2020," says Dr. Reece. So much for a new "right" to healthcare.

Also, once people navigate the waiting lines, there still won't be equal care for all — or, as proponents of Obama's healthcare reform chant, "fair healthcare."

One thing most people have in common is that they really resent being forced to pay for other people's

care, especially for people who don't take care of themselves. And the very people who advocated for "reform" are the most resentful of all. For example, one woman wrote a letter to the editor expressing her outrage that "we all" were paying for emergency visits for the man she saw at the grocery store, who was paying $63 for a carton of cigarettes.

Guess what. Smokers and others who can be made pariahs may be punished by higher taxes and premiums, and possibly by diminished access to care or other benefits. Some states, including Georgia, have already experimented with threats to cut off welfare benefits for noncompliance with health directives, for example, a 100-percent vaccination rate. At the same time, those with politically favored conditions, such as HIV/AIDS, will get priority in funding.

In a related vein, one focus of reform will be to "reduce disparities." There is only one way to do that: give less care to patients who are now getting "too much" and give more to those who are now getting "too little." The section on "requirements for financial and administrative transactions" reads that "the standards and associated operating rules adopted by the Secretary shall, to the extent feasible and appropriate, enable determination of an individual's eligibility and financial responsibility for specific services prior to or at the point of care." (Sec. 1104 (b)(4)(A)(i)) The concept of "eligibility," which occurs many times in the bill, implies the existence of "ineligibility."

Congress has attempted to delegate the responsibility for the hard decisions about who gets what coverage to more than 100 new executive agencies, who will be insulated from political pressures. But we can't expect them to be any nicer than NICE (the National Institute for Clinical Excellence) in Britain, which often decides not to allow new cancer drugs and other costly innovations. People like Obama's poster patient for reform named Natoma are more likely to be dead than singing the praises of the new system. The stream of hard-luck stories will increase — but they are much less likely to be broadcast by the media.

Day-to-day Effects on Doctors

Patients will not be the only embattled ones. Doctors' and facilities' fights to collect payments will only intensify. Tighter government price controls, greatly enhanced reporting requirements, and more scrutiny are guaranteed. (Private insurers are increasingly tying their fees to Medicare's, so a change in Medicare may affect most of a physician's practice.) There is vast new funding for auditors, bounty hunters, and law enforcers to "find" instances of "waste, fraud, and abuse," which now include providing "unnecessary" services or ones that don't meet bureaucratically approved "best practices." Even if doctors do collect payment for a service, there is the risk that it can be "recovered" (taken) by electronic funds transfer from their bank account at a later time. Each recovery of discovered "waste, fraud, and abuse" could also be attached to $50,000 in civil monetary penalties, or a prison sentence. (Mothers, do you still want your children to be doctors?)

Doctors will spend increasing amounts of time fighting with or defending themselves against insurance clerks and government enforcers. They will constantly be deluged with more compliance requirements and documentation demands. They will be at odds with their patients because doctors will pay financial penalties for providing "too much" or "deviant" care.

Physicians' "resource use" will be tracked. Proposed legislation would reduce Medicare payment by five percent for physicians whose resource use is at or above the 90th percentile of national utilization rates. Reformers envision that more and more physicians will be in "accountable care organizations," which divvy up lump-sum payments among various providers, meaning doctors will be fighting with

each other for their share of the collective payment pot.

And of course, as small businessmen, they will face increasing costs for employee benefits, as premiums increase and more "comprehensive" benefits are required for government-approved coverage. Those who have chosen low-cost, high-deductible plans will have to change into high-cost plans to avoid penalties — and their preferred plan is likely to become unavailable.

Doctors *can* get rewarded with paltry Medicare or Medicaid fee increases of a percentage point or two if they install interoperable electronic health records, collect megabytes of data, and show compliance with government criteria. The "stimulus" bill will help pay for the new electronic systems, which may cost $50,000 per physician — if, and only if, the doctor continues to make "meaningful use" of it. But the doctor is on his own for ongoing maintenance and technical support of the system.

According to some surveys, as many as half of currently practicing physicians may quit rather than accept Obama's reform. Arizona's Governor posted a photograph on her webpage of a sign on Dr. Joseph Scherzer's door. A Phoenix dermatologist, Scherzer's sign says: "If you voted for Obamacare, be aware that these doors will close before it goes into effect." Dr. Jack Cassell of Mount Dora, Florida, also has a sign: "If you voted for Obama, seek urological care elsewhere." He goes on to state that "changes to your health care begin right now, not in four years."

Explaining the Design

Clearly, this reform was not created with the intention of increasing the availability of lower-cost, high-quality medical care to masses of Americans. So what are the designers of this plan trying to achieve?

The goals of the longtime advocates of reform are spelled out plainly in professional journals, such as *JAMA*, the *New England Journal of Medicine*, and *Annals of Internal Medicine*, but not mentioned by politicians. The idea is for the elite planners to gain control of the medical dollar, and use it to engineer a new system, one that places the good of the state above that of individual patients. They talk about prevention and emphasis on wellness — as opposed to our current "disease orientation" — and it sounds pretty good, until you ask what it means.

In practice, it means healthy taxpayers and voters will be getting lectures on smoking, diet, and exercise. After all, if government is going to take control of the medical dollar, government is also going to attempt to make sure that you live your life in a way that decreases the risk of sickness! There will be frequent vaccinations, blood pressure checks, and glucose measurements. We'll be rewarding "primary care providers" and "medical homes" by diverting resources from specialists and sophisticated treatment facilities. All at the expense of the care of the sick.

Yet, there is no evidence that any government anywhere in the world has managed to make its population healthier through government mandates and coercion.

Prevention is really an inexpensive, do-it-yourself task. You do not need a doctor to tell you to eat your vegetables. Nor do you need insurance to pay for it. Nor will it make sick people well.

Medical care makes the biggest difference in the first "golden hour" after trauma, or in acute heart attack, stroke, or serious infection. That's when you need a level 1 trauma center fully staffed with specialists, a cardiac catheterization lab, an operating room on standby, a heliport and helicopters, and instant access to magnetic resonance imaging (MRI) and computerized tomography (CT). The main thing reformers say about those things is that we have too many, they cost a lot, and often people die anyway. As David Leonhardt wrote in the *New York Times*, "Reforms should focus on showing that less

care can have better outcomes than more extensive or expensive care." The main task of people carrying out the reform is "figuring out how we can say no."

The reformed system is really upside down and backward. It pays for things people could better afford to buy for themselves, such as check-ups, care for minor illnesses, or immunizations, and skimps on life-saving care that people really need and want. Meanwhile, it makes patients dependent on government-approved entities for the medical care, and physicians dependent on the same for their livelihood.

We already have a preview of what this dependency means. Seniors have almost no choice when it comes to health insurance. While they can forgo Medicare Part B and be self-insured, they can only get out of Medicare Part A, which covers hospitalization, if they forfeit all Social Security benefits and give back any they have already received.

Why would seniors want to pay for care they can get "for free"? The reason is that hospitals must follow Medicare rules for Medicare patients, such as payment by the diagnosis, rather than by the care provided. Quicker, sicker discharges are one result of implementing the DRG (diagnosis related group or prospective payment system) decades ago. As Baby Boomers retire (10,000 more qualify for Medicare every day), more and more restrictions will apply.

So why would government not be glad that some seniors elect to pay their own way instead of burdening the system? Government apparently doesn't like competition, especially if it makes its own programs look shabby. When proponents of a "single payer" system warn of a two-tier system that might be "unfair," there does not seem to be any doubt about which system — public or private — would be superior and preferred.

The Association of American Physicians and Surgeons is the first medical association to challenge the constitutionality of this mandate. Many states have filed separate challenges. And we need to win!

PPACA is war on medicine and on Americans in general, and will cause or worsen all kinds of conflict. Taxpayers vs. the IRS; subscribers vs. their insurance company; doctors vs. insurers, government agents, and even patients; patients in one entitled victim group vs. those who are not among the favored ones; trauma centers vs. community health centers; specialists vs. primary care; medical facilities vs. schools, highways, and other uses of tax money; the young vs. the old; the strong vs. the weak. The only winners in this war, if any, are the power elite, who will have the power to micromanage the lives of Americans.

Photo: AP Images

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