

Perspectives on the Patient Protection and Affordable Care Act (PPACA)

The Bulletin presents here a perceptive and perhaps provocative opinion piece by Karen S. Sibert, M.D., which originally appeared in “CSA Online First” on the CSA website, as well as responses from Joseph Andresen, M.D., and Steven Goldfien, M.D., CSA Past President, both of which also appeared on the website.

Shall We Toast the End of Obamacare?

By Karen S. Sibert, M.D.

The Supreme Court announced last year that it will hear a challenge to the constitutionality of the 2010 health care reform act, known as “Obamacare.” Before we pop open the champagne, we should take a moment to consider what this may mean for California physicians and for anesthesiologists in particular. “Whatever Court Rules, Major Changes in Health Care Likely to Last,” claims a recent *New York Times* headline. Should we believe that forecast?

The court is allowing a remarkable five and a half hours for argument, as opposed to the one hour that it traditionally permits, because of the complexity of the questions it will decide. The first and arguably most important question is whether or not Congress has the constitutional power to require people to purchase health insurance or face a penalty: the “individual mandate.” This twist on taxation clearly infuriates many people. Whereas taxes support public services, this provision would pressure all of us to buy a product that not everyone wants.

Another key question is whether or not the rest of the law—the Patient Protection and Affordable Care Act (PPACA)—will stand if the individual mandate is struck down. The law forbids insurers to turn away any applicant or charge more for pre-existing conditions, assuming that new revenue from healthy patients would balance out the costs. Without the individual mandate in place, anyone could wait to buy health insurance until an accident happens or disease strikes, and insurance companies wouldn’t survive.

Uninsured patients are everyone’s problem. We all pay—directly or indirectly—when they turn up in our emergency rooms and we have to provide anesthesia for them. There’s a certain appeal to insisting that everyone pay something into the health care system that will be responsible for scooping them up from the freeway after a car wreck. Certainly here in Los Angeles we have our share of personal trainers and aspiring actors who have smartphones and cars but won’t spend the money to buy health insurance.

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So let's consider possible consequences of the Supreme Court's decisions. If young, healthy people don't have to buy health insurance, we're back to the starting gate in terms of figuring out how to pay for trauma care. Here in California, changes in state law have already been made to align with the provisions of PPACA, and would be unaffected by the law's repeal. The withdrawal of some proposed insurance rate hikes has saved consumers millions, though I'm willing to bet that doctors have absorbed more of that hit than the insurance companies, as fee-for-service reimbursements continue to shrink.

If the entire law is repealed, many physicians hope to see a return to happier days for the private practice of medicine. I doubt that's realistic. Too many changes have already taken place: the absorption of small practices into large groups, and consolidation of hospital systems. Medical staffs are no longer composed of physicians only, but may include nurse practitioners and other mid-level providers who can provide cheaper care. The drive to have fewer anesthesiologists supervising more cases is only going to escalate.

For anesthesiologists, it would be wonderful to see the repeal of PPACA's Section 2706. This is the innocent-sounding provision that prohibits discrimination by insurance companies against health care providers as long as they are acting within the scope of their licenses. This "nondiscrimination" clause has opened the door for non-physicians to open clinics without physician oversight and bill insurers directly for anesthesia nerve blocks, epidurals and other complex pain management procedures. Putting a stop to that would truly be a service to public safety.

But the repeal of PPACA doesn't answer the question of what we are going to do with our unaffordable health care system. As the recession drags on, more people are joining the ranks of the long-term unemployed, and their COBRA coverage is running out. America isn't going to let the bodies of uninsured people pile up in the streets, so we will continue admitting them to hospitals. Without some motivation to alter the status quo, we will continue to "do everything possible" even for terminally ill patients, and waste billions in the process.

At some level, I think most of us realize how unsustainable the current system has become. My 89-year-old father who lives in South Carolina is as conservative as anyone. His idea of a nice Saturday afternoon is to take a walk around the statehouse grounds to see the monument to Sen. Strom Thurmond and the Confederate flag. But when we were discussing health care, he said, quite seriously, "You know, when your mother and I lived in Canada for a

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couple of years, the government paid all our medical bills. We had good doctors and it worked fine. Why doesn't the U.S. just do the same thing?"

I winced. "Dad," I said. "Would it be OK if we wait to do that until I have the last child through college?" He agreed. But in the long run I fear that if the Supreme Court rules against Obamacare, we may be moving that much closer to a single-payer system as the only way out of our current dilemma. I hope I'm wrong.

Celebrate Repeal? Seriously?

By Joseph Andresen, M.D.

As a physician and anesthesiologist for the past 27 years, I offer my own perspective on PPACA.

First, as a physician: Mary was brought to the operating room immediately after admission from the emergency department. She had a high fever, racing heart rate, and low blood pressure. An infection had spread throughout her body and bloodstream. In the pre-op area, before her emergency surgery, I asked Mary why she had not come to the hospital sooner. She tearfully replied, "I have no medical insurance. I came to the hospital only when I knew my life was in danger."

Secondly, as a father: When my daughter was 3 years of age, she had a catastrophic neurosurgical emergency. We didn't know if she would survive. She underwent several operations and thankfully recovered. I am happy to say that 19 years later she is a college student and enjoys good health. However, to this day, she has not been eligible for health insurance and currently relies on a high-risk-pool state program that costs hundreds of dollars a month.

Finally, as a patient: Fifteen years ago, as a father with a young daughter and son, I was diagnosed with cancer. I'm alive today because of the excellent physicians who took care of me and because of medical insurance that covered my care. But ten years passed before I could again qualify for an individual health insurance policy.

Mary is among the growing numbers of both working and unemployed Americans without health insurance. My daughter and I are among those penalized for pre-existing conditions.

Nor are these the only problems with our current health care system. Consider:

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- An estimated 40,000 lives are lost annually due to delayed treatment or lack of medical care.
- Medical bills are now the leading cause of bankruptcy, home foreclosures, and financial ruin.
- And as a nation, we find ourselves paying too much for health care—and in many cases getting too little.
- We currently spend more than twice as much on health care as our industrialized counterparts yet rank much lower in many major measures of health and longevity.

PPACA addresses such issues. It offers significant protections for patients: no pre-existing-condition exclusions, no lifetime caps, policy portability, and a requirement of a basic foundation of coverage in all policies. In addition, its benefits include:

- 32 million more Americans will have access to health insurance.
- Medicare services will include free preventive services and closure of the “donut hole” in the Part D drug program.
- New benefits are provided, such as coverage for adult children until age 26.
- Medical decisions remain in the hands of patients and their physicians.
- State-run health insurance exchanges will offer a competitive market of coverage options beginning in 2014.
- Small-business tax credits for employee health insurance coverage are immediately available.
- Medicare gains firmer financial footing for an additional ten years with a reduction in the federal deficit of \$143 billion.

Not that the PPACA health reform law is perfect. It has significant shortcomings. And the challenges to successful implementation are many. First and foremost are the political obstacles. Then there are legal obstacles: Twenty state attorneys general have filed lawsuits challenging the requirement that individuals must buy health insurance coverage (known as the “individual mandate”).

There are significant monopolies in the insurance market that will be hard to overcome. Will there be enough competition to lower health insurance premiums? The public option that was excluded from the final bill was an attempt to create a necessary competing nonprofit insurance alternative, as in most other industrialized nations.

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Expensive duplication of hospital services in many urban areas needs to be addressed. There must be a true competitive marketplace for pharmaceuticals. Only in these ways will we be able to save health care dollars without sacrificing quality in our health care services.

Perhaps the biggest challenge is whether adequate funding will be available to cover the costs of providing care. The new health care law will use Medicaid to expand coverage significantly. But Medicaid (Medi-Cal in California) is a state program that is severely underfunded. Patients have difficulty in finding a physician and subsequently use costly emergency rooms to seek treatment, often as a last resort. Doctors limit or close their practices due to low reimbursement. Hospitals are forced to reduce services due to lost revenue. The federal government will assume responsibility for funding all new Medicaid-eligible enrollees at higher Medicare levels, and hopefully this will prevent state governments from raiding federal dollars earmarked for these health services. However, it is clear that physicians and hospitals will face severe financial challenges ahead, and there is reason to fear that these groups will be the victims of budgetary cost containment in future years.

Despite the challenges, going back to the old ways is not an option. The more the public learns of the protections and benefits of this law, the more difficult it will be to return to the time when insurance companies wrote many of the rules.

Health care by its very nature is an emotional topic. Your relationship with your doctor is personal, private, and one that requires the utmost trust at times when we are most vulnerable. No one wants intrusion into this relationship—not from the government, insurance companies, or bureaucrats. Yet we do rely on our government for such things as the safety of the water we drink, the food we eat, the medications prescribed to us; for police and fire protection; for safe airline travel. And if you're a senior citizen, Medicare and Social Security benefits assuredly are welcome. The provision of adequate and universally available health insurance is a reasonable extension of government protections and benefits.

Over my years as a physician, it has been a privilege to enter into each of my patient's lives and provide them with care and comfort, often at a time of crisis and vulnerability. Medicine is and continues to be a noble profession, unparalleled by any other. We are a nation of unbounded dreams and accomplishments. I do believe that we can preserve the best that American medicine has to offer while strengthening and making it accessible for all Americans. Quality medical care for all will only be available if the highest priority is given to adequately fund patient care services. Without it, health

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care reform will become only an empty promise. PPACA is a first step in this direction. Its repeal would be no cause for celebration.

Toast the End of Obamacare? I Will!

By Steven Goldfien, M.D., CSA Past President

It may be premature to toast the end of Obamacare but we certainly should be delighted that the Supreme Court may give us that chance. Such a turn could redeem physicians for the enormous political blunder they committed by supporting the Patient Protection and Affordable Care Act (PPACA) in the first place, and thereby give them a rare second chance to do health care reform the right way. Of much greater importance to both our profession and our country is the opportunity this case gives the justices to limit or even reverse the long-time expansion of federal power based on the commerce clause. The nearly tragic irony here is that by working to mitigate the defects of Obamacare instead of supporting its outright repeal, doctors, including the ASA, are making exactly the same mistake they made two years ago. Instead of relying on others, in this case the Supreme Court rather than the Congress, to derail this huge expansion of federal power, they should be working as hard as possible in the court of public opinion to rid themselves of this terrible law. Few get a second chance and no one gets three.

The list of specific reasons to repeal Obamacare is too long for full discussion in this forum but three general objections deserve comment. First, it won't work as claimed; second, it will allow the federal government to control health care quality, depriving the medical profession of its traditional role and damaging the doctor-patient relationship; and third, it will do irrevocable harm to the country.

Obamacare will not decrease health care costs (<http://spectator.org/archives/2011/07/06/obamacare-tragedy-primed-to-fu>). Medicare's own actuary (<http://economics21.org/commentary/cms-medicare-actuary-disavows-medicare-trustees-report>) has said that the financial savings of Obamacare are illusory, based on unwarranted assumptions such as enforcing Sustainable Growth Rate cuts to physician income. In fact, the vast majority of the projected \$15 trillion in savings from the president's plan comes from reducing payments to doctors and hospitals below those of Medicaid, levels too low for them to remain in business. The death of the CLASS Act—a new entitlement program designed to subsidize long-term care for beneficiaries (<http://news.heartland.org/newspaper-article/2011/11/29/>

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class-act-exposes-obamacare-accounting-tricks-democrats-oppose-repeal)—reinforced this view as the Obama administration itself was forced to admit to flagrantly double-counting revenues to deceive the public on the true costs of the new law.

Obamacare provides subsidies to buy individual health insurance on government exchanges for those earning up to \$95,000. Original Congressional Budget Office estimates were that 19 million people would avail themselves of this discount at taxpayer expense. But the small penalty employers will have to pay for switching (dumping) their employees into government programs means that it will be cheaper for business to abandon employer-provided private insurance altogether. “Competitive dumping” will follow as businesses struggle to compete by taking advantage of lower labor costs. Recent estimates are that some 78 million individuals could take advantage of these government subsidies, adding some \$6 trillion more to the cost of Obamacare in the first six years alone. In 1965 Medicare was forecast to cost \$12 billion by 1990. The actual cost was \$110 billion. No federal health care program has ever come in on budget and Obamacare will be no exception.

Obamacare will not stabilize the private insurance market. As written, the insurance changes are designed (and intended) to disadvantage the private insurance market in favor of a single government payer. Federal regulators can now dictate to insurers what they must cover at the same time that they also have veto power over premium increases. This financial squeeze, coupled with the loss of market share from employers dumping employees into government plans, will spell the end of the private market. Big-government advocates will get their single-payer system, the productive members of the public will get the tax bill and doctors will lose the ability to cost-shift. About the only thing advocates will still cite as a benefit of PPACA are the few insurance reforms such as the elimination of pre-existing conditions that, while important, are untenable without the individual mandate. These changes are indeed desirable but already enjoy widespread bipartisan support and will be a top priority for whoever leads the next round of reform if Obamacare is repealed.

This titanic shift of people into government plans means that Obamacare is simply a stop along the road to single-payer: Medicare for all, including doctors, who will all suffer the 33 percent problem now unique to anesthesiologists. The only consolation is that once the private insurance market disappears so will the 33 percent problem.

The quality of medical care is the responsibility of physicians and central to our ethical obligations to our patients. This is what distinguishes us from other health care providers. The advent of the Value Based Purchasing Program at

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the Centers for Medicare and Medicaid Services (CMS) signaled the intention of the federal government to arrogate that responsibility to itself. Over the last several years, culminating with Obamacare, Congress has passed sweeping health care legislation intended to provide CMS the requisite *authority* to develop and implement a program to define and control quality. Once these sundry programs of performance measures, comparative effectiveness research, and accountable care organizations are in place; the Independent Payment Advisory Board is functioning; and health care data is computerized via electronic health records, the day of physician-led health care is ended.

The most important point of all is one many doctors fail to fully appreciate, to wit, the damage to our country from a federal takeover of the entire health care system is a far greater issue than any benefit or harm it will do to physicians. Working to make Obamacare tolerable for physicians ignores the fact that its final implementation will give the federal government so much control over our wealth and our lives as private citizens that it will become even more difficult, if not impossible, to turn back from our rapid descent into the bankrupt abyss of failed European-style socialism. The medical profession of 1965 understood and exemplified American exceptionalism. Doctors were great because the system they worked in fostered greatness. The fact that the medical profession is now more the tool of its government overseers than an independent voice supporting the right of physicians to practice freely may be in great part the explanation for the decline in its social position and its current status of political nonentity.

As America goes, so goes the medical profession. To save the latter we must first rescue the former. Accepting a government takeover of the health care system and then working out the final details through compromise is not an option; it's socialized medicine that's unacceptable, not the details of its implementation. The demise of Obamacare is an essential step back down the path to freedom, self-reliance and limited central government. If it's the Supreme Court that lowers the guillotine, so be it. I for one will break out the bubbly, while recognizing that far more needs to be done.

