

# THE NEW HEALTH LAW: BAD FOR DOCTORS, AWFUL FOR PATIENTS

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## EXECUTIVE SUMMARY

While much has been said about the Patient Protection and Affordable Care Act (PPACA), lengthy debates have failed to adequately address the impact that the 2,800 pages will have on doctors, patients, and the practice of medicine. This Galen Institute white paper does just that. This paper examines in detail how the government already hinders physicians' abilities to provide good care for their patients and how these harmful trends will only worsen under PPACA.

Medicare's physician reimbursement regimen is fraught with underpayments and perverse incentives. During the health care debate, supporters of PPACA praised Medicare's ability to exploit its size to obtain lower fees with providers. While it is true that Medicare can bludgeon down physician fees, this is not one of the program's greatest strengths, but actually one of its greatest weaknesses. These underpayments are ultimately shifted to patients in the form of shorter visits, less doctor face time, quick hospital discharges, and compromised care. Rather than reforming the government's flawed reimbursement regimen, PPACA merely expands its scope to more people.

Health care is currently one of the most regulated industries in the country. Doctors already devote a significant amount of their day to detailed documentation, paperwork, and signatures. This takes away from potential time doctors can spend at the bedside with their patients. These requirements are likely to increase under the health overhaul law. New regulations will place unaccountable bureaucrats in Washington, D.C., between physicians and patients and grant these regulators unprecedented control over medical decisions. While this will no doubt be frustrating for doctors, it will be the patient facing limited access and choice.

PPACA will strip away physician autonomy, drown doctors in bureaucracy, and drain job satisfaction. As the profession deteriorates, older doctors will retire while younger doctors will look to switch careers. Many students considering a career in medicine will pursue other opportunities. The supply of providers will dwindle as demand for services reaches an all-time high. Ultimately, the consequences of health overhaul law will be passed along to patients through restricted access, long wait for appointments, and rationed care.

The Patient Protection and Affordable Care Act is indeed bad for doctors, but it is always the patient that suffers the most.



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## **THE NEW HEALTH LAW: BAD FOR DOCTORS, AWFUL FOR PATIENTS**

Despite multiple speeches, town hall meetings, radio addresses, and Democratic majorities in both the House and Senate, President Obama's radical health care agenda has failed to garner widespread support. The president often claims this is because the public does not understand the contents of the package. Yet the problem for the administration is that people understand it all too well.

The president was unmoved by public opposition and a historic Republican Senate victory in Massachusetts; ultimately, he and the Democratic leadership in Congress passed The Patient Protection and Affordable Care Act (PPACA)<sup>1</sup> via reconciliation along party lines without even a single Republican vote. To accomplish this, they employed a myriad of budgetary gimmicks, smoke and mirrors, and sweetheart deals – definitely not the type of political showmanship reserved for C-SPAN, as President Obama had previously promised.<sup>2</sup>

The health care overhaul rolls the dice with the world's premier health care system and approximately one-sixth of the economy. Of course there is room for improvement, but why start from scratch? A better approach would have been to build off current strengths and target the shortcomings.

While the 2,800 pages of mandates, red tape, spending, and regulations will not control spiraling costs, it will change health care as we know it. Approximately 90% of Americans have health insurance in this country,<sup>3</sup> and of those, 84% rate their coverage as good or excellent.<sup>4</sup>

The deleterious effects of this legislation will be felt the most by physicians and their patients. It is brutal for physicians, and the detriment transcends dollars and cents. New regulations will place unaccountable regulators in Washington, D.C., between physicians and patients and will grant these bureaucrats unprecedented control in the medical decision-making process. It will strip away physician autonomy, drown doctors in bureaucracy, and drain job satisfaction. As physicians are required to do more, they will likely be paid less.

As medicine deteriorates as a profession, older doctors will retire while younger doctors will try to switch careers. The composition of those still practicing will be a stark contrast from those currently in the field: the best educated, the brightest, the best trained, and the most dedicated.

The supply of providers will decrease at a time when the demand for services will be at an all-time high. Ultimately, the consequences of the health overhaul law will be passed along to patients through restricted access, long waits for appointments, and compromised quality of care. PPACA is indeed bad for physicians; however, it will always be the patient that suffers the most.

## LESS TIME WITH PATIENTS

Medicare's physician reimbursement regimen is characterized by underpayments and perverse incentives. The brunt of Medicare's declining reimbursements is shifted to patients in the form of decreased access to physicians and inferior care. Rather than trying to reform this flawed reimbursement system, which jeopardizes patient safety, PPACA expands its scope to more people.

During the health care debate, supporters of reform sought the expansion of government in health care, in part, based on their praise of Medicare's ability to control costs by exploiting its mammoth size to obtain lower fees with providers. Despite a lengthy and thorough debate, this faulty argument went largely unchallenged.

Ignoring the fact Medicare has trillions of dollars in unfunded liabilities,<sup>5</sup> and Medicare's own nonpartisan Office of the Actuary concluded that health care reform will increase health care costs,<sup>6</sup> not decrease them, the idea that the government can or will be the trendsetter in curbing rising health care costs lacks credence. It is true that the government can bludgeon down provider fees in certain areas with the inevitable corollary being reduced doctor-patient face time and shorter hospital stays. However, this is no panacea and has significant ramifications on the patient-doctor relationship and quality of care.

This "bargaining" ability is not Medicare's greatest strength, but actually one of its greatest weaknesses. Medicare, with its sheer size, can indeed "negotiate" reimbursements in a take it or leave it manner, but this does not benefit patients.

## UNDERPAYMENTS

Medicare reimburses hospitals and doctors, on average, 71% and 81%, respectively, of private rates.<sup>7</sup> Medicaid reimburses doctors even less, on average 56% of private rates.<sup>8</sup> The federal government's payments to health care professionals are so low that on average, overall, hospitals lose money caring for Medicare and Medicaid patients. In 2008, hospitals received only 91 cents from the government for every dollar spent on a Medicare patient. That same year hospitals received only 89 cents for every dollar spent on Medicaid patients. According to data compiled by the American Hospital Association, on average, Centers for Medicare and Medicaid Services (CMS) payments are less than hospital costs and the amount of underpayment has increased over time. In 2000, Medicare and Medicaid's underpayments amounted to \$3.8 billion. By 2008 they had increased to \$32 billion.<sup>9</sup> At first glimpse, this is the doctor's problem and not that of the patient. Unfortunately for the nation's infirmed, this is not the case. Ultimately, these consequences are passed along to the patient.

From an economics point of view, Medicare's below-market reimbursements create cost-shifting onto private payers where hospitals raise private payer fees to compensate for lower payments from government programs. In a 2006 *Health Affairs* study, researchers focused on this phenomenon by studying data from California private hospitals. The authors discovered a statistically significant inverse relationship between

Medicare fee changes and private payer fee changes. The research revealed that a 1% decrease in average Medicare price correlated with a .17% increase in private payer price, and that a 1% decrease in the Medicaid rate was associated with a .04% increase. From 1997 to 2001, Medicare and Medicaid cost-shifting accounted for 12.3% of increases in private payer prices.<sup>10</sup>

From a clinical perspective, Medicare's underpayments result in diminished access and compromised quality care. The most widely cited effect is the difficulty that Medicare and Medicaid patients encounter trying to find a physician. This problem is increasing. The American Academy of Family Physicians discovered 13% of doctors surveyed did not partake in Medicare in 2009, up significantly from 6% in 2004. According to the American Osteopathic Association, 15% of members don't take Medicare and 19% don't take new patients with Medicare. In New York state, approximately 1,100 physicians have stopped participating in Medicare.<sup>11</sup> According to a 2009 *New York Times* article, at New York Presbyterian Hospital, only 37 of the 93 affiliated internists accept Medicare.<sup>12</sup> Even fewer doctors are taking Medicaid, with its lower reimbursements and administrative burden. A Center for Health System Change survey discovered that in 2004–2005, 35.3% of solo practitioners and two doctor practices were not accepting new Medicaid patients compared to 29% in 1996–1997. The survey also showed that over this same period, small group practices accepting no new Medicaid patients had increased from 16.2% to 24%.<sup>13</sup> This translates into access problems for patients. According to a 2008 Medicare Payment Advisory Commission report, 30% of beneficiaries seeking a new primary care physician had problems obtaining one.<sup>14</sup>

Finding a physician is a serious problem for patients with government health care plans, however, Medicare's harmful influence on access to physicians is more broad and complicated. In the outpatient setting, low reimbursements force doctors to see more and more patients to stay in business. The nonpartisan Congressional Budget Office (CBO) agrees. It wrote in 2006 that, "Considerable evidence suggests that a reduction in payment rates leads physicians to increase the volume and intensity of services they perform."<sup>15</sup> This leads to shorter visits and less doctor-patient face time. It forces doctors to race through medical appointments so they can fit as many into the daily schedule as possible. It compels doctors to frantically bounce from exam room to exam room like a wayward pinball, practically having one foot out the door even before stepping into the exam room.

The time constraints of the medical appointment are frustrating for both clinicians and patients. Patients get upset when they don't get to spend the time that they would like with their physician. They are less likely to get questions answered and be educated appropriately. They can often be left feeling that their physician just doesn't care. While this is usually not the case, it is an inevitable consequence of the rationing Medicare already places on the health care system.

These shorter visits are not only frustrating, but both common sense and the published literature suggest they are dangerous. University of California at Davis researchers examined the effect of visit length by recording 294 primary care appointments and

discovered that patient satisfaction increased with visit length. Multiple studies have confirmed this, and other research has indicated that patient satisfaction can improve outcomes.<sup>16</sup> *British Medical Journal* research studied consultation length and linked shorter medical visits with the inability of patients to understand and cope with illness.<sup>17</sup> Research from the New England Medical Center has also associated shorter office visits with decreased patient participation in the decision-making process, which could be detrimental to quality.<sup>18</sup>

For doctors, this is equally troubling. Doctors enter medicine to heal the sick, establish rapport, and advocate for their patients. Perhaps this used to be possible, but sadly it's becoming less and less common under Medicare's reimbursement regimen. It's demoralizing for physicians who want to be there for their patients, who want to give their patients all the time they want, who want to make sure patients have all their questions answered, and want to make sure patients know how to best care for themselves. However, working in a reimbursement system that rewards quantity at the expense of quality, it is difficult to make a living doing so. The situation can become even more upsetting for physicians when patients publicly display their discontent or take it out on the physician. This is especially difficult since many physicians would echo their patients' concerns about time constraints, but unfortunately no one asked them. Physicians have little control over the situation, other than, of course, to move on to the next patient.

In the inpatient setting, Medicare's reimbursement system similarly hinders the practice of good medicine. It indeed decreases patient-doctor face time, but its main impact is pushing toward early and quick hospital discharges. Medicare pays hospitals based on diagnosis related groups (DRGs), a fixed payment depending on disease. Thus, in general, the longer patients stay in the hospital, the more money hospitals lose. This puts tremendous pressure on hospitals to discharge patients. Physicians responsible for writing discharge orders feel this pressure from social workers, case coordinators, nurses, department chiefs, and even hospital administrators. The planning for discharges in some hospitals begins as early as the day of admission. This places unnecessary stress on physicians and can serve as a point of contention with patients who know their bodies the best and may not believe they are ready to go home. It also puts physicians in a particularly tough spot when they themselves are not convinced that the patient is stable enough to leave, but superiors want the patient discharged.

Just as in the outpatient environment, the quality of inpatient medicine suffers because of Medicare's underpayments. Inevitably, some patients get pushed out prematurely and some of these patients come right back. It's not good care. Readmissions are dissatisfying for physicians. These premature discharges also unnecessarily expose doctors to malpractice risks. And of course Medicare administrators want it both ways. Their reimbursement rates force hospitals to rush patients out the door, but if that patient comes back, Medicare looks to punish the hospital.

In hospitals, Medicare's underpayments also translate into less ancillary staff, such as transporters and nurses. Thus, critical tests necessary to guide life-saving medical

intervention decisions can take longer. In teaching hospitals, this also means there is a greater reliance on medical residents.

Ultimately, the excess work hospitals must do merely to survive in a climate dominated by Medicare and its underpayments puts significant unnecessary strain on the system and promotes medical errors. Medicare's ability to get itself a good "deal," is anything but for patients.

## FALLING BEHIND INFLATION

It should also be noted that Medicare's physician reimbursement regimen nationally has not kept up with inflation. Over time, as medical overhead expenses and staffing costs increase and doctor reimbursements simultaneously decrease, this forces physicians to see more and more patients to maintain the same income. If these current trends continue, then the aforementioned access problems will worsen — resulting in scarcer resources, even shorter visits, and declining care.

Former CBO Director Douglas Holtz-Eakin warned in 2004 that current physician reimbursement systems would "hold updates below inflation through 2014."<sup>19</sup> In 2007, the CBO studied increases in Medicare spending per beneficiary between 1997 and 2005. It determined it increased 34.5% over this period, which resulted from increases in volume and intensity of physician services, as opposed to Medicare reimbursement changes. In fact, the CBO concluded that "after medical price inflation, as measured by the MEI, is taken into account, Medicare's payment rates for such services actually declined slightly during that period."<sup>20</sup> Parenthetically, the sustainable growth rate (SGR), employed by Medicare to determine physician reimbursement, has only worsened these trends and the patient access problems they create.

Medicaid reimbursements from 2003 to 2008 have on average not kept up with inflation either, according to the Urban Institute. In the fields studied, Medicaid physician reimbursements increased 15.1% between 2003 and 2008. This amounted to an annual average increase of 2.6%. The problem for physicians is that over this time period, the Consumer Price Index (CPI) rose by 20.3%, or 3.4% annually, and the CPI's Medical Care Services increased by 28.1%, or at an annual average rate of 4.6%. Thus, on average during this five year period, in real dollars, Medicaid physician reimbursements decreased annually by 1% compared to inflation, and by 2% compared to medical inflation. In New York and Minnesota, average Medicaid fees for all services failed to increase even in nominal terms. In 25 other states, Medicaid reimbursements rose less than inflation.

Primary care Medicaid reimbursements fared the best of all the medical specialties. Fees in this specialty grew at approximately the rate of inflation (20%). The reimbursements for obstetrics and other services (hospital visits, surgery, radiology, psychotherapy, and laboratory tests) grew at significantly lower rates, 8.8% and 8.7%, respectively. The Urban Institute researchers concluded "the data show that Medicaid fees have fallen in real terms over the past fifteen years."<sup>21</sup>

Only the government could have the ingenuity to attempt to solve access and quality of care problems secondary to underpayments by further lowering those payments. It remains to be seen if the strategy will work, but it is certainly not very enticing for physicians trying to provide for their families.

## PERVERSE INCENTIVES

As if Medicare's declining reimbursements was not a big enough deterrent to lengthier, more satisfying higher-quality visits, Medicare's reimbursement system actually outright punishes doctors for spending more time with patients. As the length of visit increases, Medicare reimburses physicians marginally less. For example, in the D.C. metro area, Medicare reimburses physicians \$47.53 for a ten-minute follow up visit (CPT 99212), but only \$154.76 for a comparable 40-minute visit (CPT 99215). Financially, doctors are better off taking care of four established patients in a 40-minute block as opposed to seeing one patient for 40 minutes. This puts additional pressure on physicians to see more patients in less time, with job satisfaction and quality of care suffering as a result.

These perverse incentives span the country from Fifth Avenue to Ghiradelli Square. In Manhattan, physicians receive \$48.92 for a ten-minute follow-up visit, compared to \$158.86 for a 40-minute follow-up appointment. In San Francisco, doctors receive \$51.82 for a ten-minute established visit versus \$165.52 for a 40-minute visit. As a result of this paradox, on average nationally, doctors lose approximately 17% of potential Medicare reimbursements by seeing fewer established patients in more time in an outpatient environment.

In initial visits, the time constraints of medicine are even more pronounced. In these encounters, doctors must not only explore the history of present illness, but typically elicit a thorough account of past medical history, past surgical history, medications, allergies, family history, and social history. In the first visit, patients want to get to know their new doctor, and physicians should get to know their patients. Patients usually have questions. Sometimes they have paperwork. This all takes time. These new patient visits can be quite detailed and complicated depending on the complexity of the patient. Patients often present with multiple complicated comorbidities. Physicians simply do not have enough time to adequately address all these issues. Shockingly, Medicare reimbursement rates for these more time-consuming new patient evaluations exhibit similar perverse incentives (CPT 99201 and 99204).<sup>22</sup>

Medicare and federal regulators want doctors to educate patients. They would like physicians to include patients in the decision-making process. They urge doctors to talk about lifestyle modifications such as the benefits of exercise and healthy eating. They direct physicians to provide counseling on smoking cessation. Medicare wants physicians to perform these tasks, but it won't pay doctors to do them. In fact, Medicare financially punishes doctors for doing this by marginally lowering already low reimbursements. It's just another example of Medicare exploiting its size and clout to squeeze money out of the system. This approach has serious consequences for patient care.

## THE SUSTAINABLE GROWTH RATE

Physician reimbursements are determined by the Sustainable Growth Rate (SGR). The 1997 Balanced Budget Act established the SGR to control health care costs. The SGR sets target annual and cumulative spending levels and then adjusts reimbursement rates to bridge the gap between actual expenditures and the target. The SGR encompasses three parts: spending targets, the growth rate, and annual updates to physician payments. The SGR includes changes in prices of physician goods and services, Medicare enrollment, real GDP per capita, and regulation that could influence Medicare spending. The SGR then compares actual spending to the spending target and adjusts physician payments accordingly. The adjustments attempt to bring spending to targets over a few years. Thus, when actual spending exceeds the target, the update will reduce the spending increase (a negative update) and if spending is lower than the target, then the update will be positive.

Since 2002, expenditures have exceeded target spending every year, and thus the SGR has repeatedly called for decreases in physician reimbursements. In 2002, the SGR calculated a 4.8% reduction in physician payments. That year the cut was implemented. Every year since, Congress has stopped the negative update. The Consolidated Appropriation Resolution of 2003 replaced a 4.4% decrease in physician payments with a 1.6% increase. The Medicare Modernization Act replaced additional decreases in 2004 and 2005 with increases of 1.5% both years. The Deficit Reduction Act froze 2006 payment rates at 2005 levels, avoiding a 4.4% reduction.<sup>23</sup> From 2007 to 2009, the same trend of pending pay cuts continued, with Congress ultimately intervening each time.<sup>24</sup>

Doctors largely hoped that sweeping health care reform efforts would end this once and for all, especially with a prospective 21% pay cut looming for physicians. Ultimately, however, a permanent fix proved too costly for PPACA supporters looking to artificially lower its projected cost.

The SGR places physicians at the mercy of Congress. If Congress fails to correct the update, then physicians caring for Medicare patients would receive a significant pay cut. The SGR is an unpredictable reimbursement calculator and this unpredictability jeopardizes access for Medicare patients — many of whom are already struggling to find a physician. While precedent indicates that Congress will prevent the physician pay cuts, there are no guarantees. For doctors hoping to make a living, the SGR is just one more reason to do without Medicare.

While the public, media, and physicians were distracted with the SGR, this past year Medicare actually changed a regulation resulting in a substantial physician pay cut, which for some could have an impact comparable to the SGR. Until recently, consulting physicians utilized a different set of billing codes than referring physicians to bill for their work. These consultation codes typically paid more money. In 2009, Medicare paid \$124.79 for a moderate complexity office consult, but only paid \$91.97 for a new office visit, and \$61.31 for an established office visit at the same level.<sup>25</sup>

Beginning January 1, 2010, CMS stopped recognizing Current Procedural Terminology (CPT) consultation codes (99241–99255) for both outpatient and inpatient specialty consultations. Instead, consultant doctors now have to use the corresponding lower paying evaluation and management office visit codes (99201–99205 for new and 99211–99215 for established) and inpatient visit codes (99221–99223).<sup>26</sup>

While CMS acknowledged the change would decrease pay for specialists, it claimed the reduction would be minimal and not more than 3% of revenue for any given provider.<sup>27</sup>

In April 2010, the American Medical Association (AMA) conducted a survey to quantify the impact of this change. The survey of 7,781 respondents (with approximately 5,500 completing most questions) seems to indicate an effect significantly more substantial than federal regulators predicted. Eighty-three percent of physicians reported that as a result of the change, their total revenue stream has decreased and 52% said their total revenue would decrease by over 10%. As a result of the change, physicians have again been forced to reconsider treating Medicare patients. Twenty percent polled decreased their number of new Medicare patients, 5% stopped accepting new Medicare patients, and 11% are now spending less time with Medicare patients. Thirty-four percent of physicians have eliminated staff, 39% have delayed purchasing new equipment, and 19% have stopped sending written reports to the primary care physician.<sup>28</sup> While the ramifications of this coding change on care coordination and the new ambiguity it has created for specialist documentation are beyond the scope of this paper, the additional pay cut will only worsen access problems for Medicare patients looking for a specialist.

## EXPANDING THE SYSTEM

Rather than trying to reform the government's faulty physician payment system, the health care overhaul expands its purview. PPACA enrolls more people into Medicaid by increasing the threshold to 133% of the poverty level (\$29,327 for a family of four). Additionally, as businesses find it cheaper to pay the fine, as opposed to offering private insurance, and as private insurance companies find it increasingly difficult to survive in a regulatory community where they must offer more and charge less, no doubt more and more people will find themselves on the government dole utilizing this payment scheme. Inevitably, the government market share will increase in the health care sector. As costs soar and promised savings from preventive medicine and electronic health records fail to materialize, the government will need some way to control costs. Section 3403 of the law establishes an Independent Payment Advisory Board designed to do just that. Steep physician pay cuts, as well as more regulations designed to get physicians to do more for less, such as the abolishment of consultation codes, will likely be forthcoming. This will only accelerate the trend toward hospital discharge one day post surgery and further undercut the patient-doctor relationship. When the government squeezes money out of health care, it is not shortchanging the industry, it is shortchanging the patient.

During the prolonged health care debate, President Obama made some less-than-flattering remarks about physicians, including:

*Right now doctors a lot of times are forced to make decisions based on the fee payment schedule that's out there. So if they're looking – and you come in and you've got a bad sore throat, or your child has a bad sore throat or has repeated sore throats, the doctor may look at the reimbursement system and say to himself, you know what, I make a lot more money if I take this kid's tonsils out. Now that may be the right thing to do, but I'd rather have that doctor making those decisions just based on whether you really need your kid's tonsils out or whether it might make more sense just to change – maybe they have allergies, maybe they have something else that would make a difference.<sup>29</sup>*

The president made a similar implication about surgeons motivated by money to perform unnecessary amputations at his Portsmouth, New Hampshire, town hall meeting. However, he was off on the actual Medicare reimbursement by almost a factor of one hundred.<sup>30</sup>

Look for a return to this mantra down the line as the government will try to characterize doctors as greedy to garner support for physician pay cuts.

The health care reform legislation does not abolish the SGR and does little to make Medicare and Medicaid reimbursements competitive with private rates. The legislation does increase Medicaid rates for primary care physicians to Medicare levels for 2013 and 2014. However, Medicare rates are still significantly less than private insurance reimbursement rates. More importantly, federal taxpayers are only paying for this increased reimbursement for two years. Thus, in 2015, cash-strapped states will have to pay the difference or the reimbursement rates will return to their original levels, which is the more likely alternative. Without guaranteed permanence, it is unlikely that this provision will have much impact on access for Medicaid patients. It is highly unlikely that physicians currently not accepting Medicaid patients will spend the capital to hire and train new staff to learn Medicaid's complicated rules and regulations for the likely possibility of only participating in it for two years. The 10% Medicare bonus payment to primary care physicians and general surgeons in shortage areas is also unlikely to significantly impact access for Medicare patients struggling to find a doctor. Medicare reimbursements will still on average be lower than private rates and Medicare access problems are not limited to shortage areas.

## MORE REGULATIONS

The health care sector is already one of the most regulated industries in the country. While these regulations may be made with the best intentions, in practice they often jeopardize patient care and lessen the time doctors can spend with their patients. Unfortunately, health care reform will not decrease these regulations. Instead, the legislation will increase red tape. It creates approximately 159 new committees, agencies, programs, and bureaucracies<sup>31</sup> with vast, new sweeping powers and the potential to place bureaucrats in between doctors and their patients. This will drown doctors in bureaucracy and further hamstring their ability to provide the best treatment for their patients. A few of the more alarming phrases in the 2,800 pages include the

Patient-Centered Outcomes Research, the Value Based Payment Modifier, and the quality reporting initiatives.

## PATIENT-CENTERED OUTCOMES RESEARCH

Section 6301 of PPACA establishes the Patient-Centered Outcomes Research Institute (PCORI), an organization that will identify research priorities and conduct research comparing the efficacy of medical and surgical interventions. PCORI will disseminate this research to health care providers and patients. The legislation creates a Board of Governors to run PCORI and a trust fund to financially support it.<sup>32</sup>

Supporters of PCORI believe this research could educate patients and help them make better medical decisions. This organization indeed *could* foster patient education and benefit patients and doctors. In fact, researchers creating hypotheses, conducting research, challenging perceived norms, and publishing in peer-reviewed journals is modern medicine at its finest. The potential harm from PCORI depends how the research is used. It could easily quell medical innovation by centralizing care.

The fear is that officials seeking to control costs would use this research to restrict access to more costly medical interventions as done by Britain's National Institute for Health and Clinical Excellence (NICE). As the government puts more people into the U.S. health care system and promised savings fail to materialize, there will be tremendous pressure on elected officials to slow spiraling costs.

In a 2008 report exploring ways to reduce health care costs, the CBO wrote that comparative effectiveness research (CER) "would gradually generate modest changes in medical practice as providers responded to evidence on the effectiveness of alternative treatments, the net effect of which would be to reduce total spending on health care in the United States by an estimated \$8 billion over the 2010–2019 period (or by less than one-tenth of 1 percent)."<sup>33</sup> Thus CER would generate some savings, but not nearly enough to support the \$2.4-trillion health care industry. In an earlier report, the CBO wrote that for CER to significantly decrease spending, the government would probably need "additional legislative authority to allow the program to consider relative benefits and costs in a more extensive way and to modify the financial incentives facing doctors and enrollees accordingly."<sup>34</sup>

President Obama has promised that comparative effectiveness research won't lead to rationing. Yet his recess appointment of Dr. Donald Berwick to head CMS and implement this system, without even a confirmation hearing, definitely raises eyebrows. Dr. Berwick has expressed lavish praise for NICE and its restrictions on care. In a 2009 interview with *Biotechnology Health Care*, he said NICE has "developed very good and very disciplined, scientifically grounded, policy-connected models for the evaluation of medical treatments from which we ought to learn."<sup>35</sup>

PCORI could easily become America's version of NICE. The potential danger from PCORI depends how the research is used. Thus, it's concerning that the person implementing it and determining its influence, supports NICE and its approach.

NICE employs a complicated mathematical formula to limit care based on a “quality adjusted life year.” In general, Britain won’t spend more than \$22,000 to prolong life by six months. This figure has stayed relatively constant and does not take into account medical or overall inflation. Under NICE, desperate patients requiring badly needed cancer drugs encounter an incredibly difficult time obtaining these expensive life-prolonging medicines.<sup>36</sup> NICE recently rejected Vidaza for bone marrow malignancies, Tyverb for breast cancer, and the multi-cancer drug Avastin. Sutent, a treatment for advanced renal cancer, was only approved after doctors publicly rallied on its behalf.<sup>37</sup>

NICE rations other types of medicines as well. In 2007, NICE limited the use of two medications for macular degeneration. It completely blocked Macugen, while the drug Lucentis was approved, but restricted to approximately 20% of patients with macular degeneration. Even then it was limited to use in only one eye.

NICE has limited the commonly used Alzheimer’s drug, Aricept, in the early stages of the illness. NICE has maintained its ruling that early stage treatment is not “cost effective,” despite pleas from doctors that treatment should begin as early as possible to slow disease progression. NICE has also imposed limitations on fertility treatment, back surgery, and steroid injections.<sup>38</sup> When NICE recently rejected the drug Avastin in combination with chemotherapy for metastatic colorectal cancer, NICE Chief Executive Andrew Dillon said, “We are disappointed not to be able to recommend bevacizumab as well but we have to be confident that the benefits justify the considerable cost of this drug.”<sup>39</sup> In this system, access to medication is not decided by patient desires or the professional opinion of doctors, but rather by government decree. The government bases its decisions largely on cost.

These government-mandated restrictions lead to poor patient care. For example, the United States boasts a five-year survival rate for breast cancer and prostate cancer, significantly higher than that of England. In the United States, the survival rates for breast cancer and prostate cancer are 83.9% and 91.9%, respectively, compared to 69.7% and 51.1% for England.<sup>40</sup>

NICE has indeed managed to suppress costs. Yet its methodology that ignores choice and individual predilection would warrant concern from most Americans, however, not from Dr. Donald Berwick. In fact, he has also said, “The decision is not whether or not we will ration care — the decision is whether we will ration with our eyes open.”<sup>41</sup> One could easily conclude that the Patient-Centered Outcomes Research Institute would be the perfect medium to open the eyes of rationers.

Republicans and Democrats would both agree that health costs are spiraling out of control. Ultimately, there are only two ways to lower costs. One approach empowers and incentivizes patients to be smarter health care consumers. This entails solutions such as expanding health savings accounts, creating a national market for health insurance, and leveling the tax playing field. These could bend the cost curve down and strengthen the patient-doctor relationship. The administration shunned this approach. Instead it opted to empower bureaucrats. PCORI could easily lay the foundation for

bureaucrats implementing rigid formulas and making tough medical decisions for patients. This focuses on the best interest of society overall as opposed to that of the individual patient.

It would be very tempting for federal regulators to exploit comparative effectiveness research to ration care. This could be implemented by financially punishing physicians prescribing these “less effective” interventions with lower reimbursements or refusing to pay for them outright. If prepared to go down this route, the government could apply tremendous pressure on physicians to coerce them to practice to its liking. A recent *Health Affairs* paper by Dr. Steven Pearson and Dr. Peter Bach advocates for such a reimbursement regimen where reimbursements would be tied to the comparative clinical effectiveness of a product.<sup>42</sup> This would be a stark deviation from Medicare’s current “reasonable and necessary” benchmark. It would stifle medical innovation and limit patient choice.

This would be allowed under PPACA. The legislation explicitly says it should “not be construed as preventing the Secretary from using evidence or findings from such comparative clinical effectiveness research in determining coverage, reimbursement, or incentive program.”<sup>43</sup>

PCORI will recommend treatment regimens for the standard patient. These recommendations, coupled with reimbursement changes, could easily pave the way for government dictating to patients the medicines, tests, procedures, and medical interventions that they can and cannot have, irrespective of willingness to pay and individual preferences. This one-size-fits-all approach could replace the professional judgment of the physician actually examining and talking to the patient with rules set by regulators and bureaucrats in Washington. While this could indeed control rising costs, such an approach would not “bend the cost curve” as the president has promised, but arbitrarily flatten it by government fiat.

A one-size-fits-all model for health care does not benefit patients. Patients are individuals, not programmed robots. Despite similarity in name, Tim, Timmy, Timothy, and Timberly are all very different. A hypothetical patient, Tim may respond quickly and positively to Bactrim, a cheap and common treatment for urinary tract infections (UTI). In fact, most people respond this way. However, not everybody responds this way. Tim’s hypothetical cousin Timberly might take the same dose of the same drug (Bactrim) for the same illness (UTI) and get Stevens Johnson Syndrome, a very serious and potentially fatal adverse drug reaction. The problem is that not everybody is the same. In medical school, future physicians are taught the saying “Patients do not always read the book.” It emphasizes that patients have different manifestations of the same illness and respond differently to the same therapies. It’s just not possible for a regimented health care algorithm to account for the innumerable vagaries and complexities of the human body. CER ignores these crucial differences.

While it is impossible to know when a patient might act differently from the standard patient, physicians need flexibility to use their years of education, training, and

experience to make professional judgments and provide good care for outliers as well. A treatment algorithm could hinder a doctor's ability to provide care and will put patients at risk.

Not to mention patients approach their doctor with various cultural, religious, and life experiences, which translate into a wide range of personal treatment preferences. When presenting with a common complaint like back pain, some patients want the most invasive procedures available despite potentially significant side effects, while others prefer more conservative treatment. Is a patient suffering from back pain wrong to prefer over-the-counter aspirin and rehabilitation? Is another patient with back pain wrong to want a riskier laminectomy? Who knows best? Perhaps they both do. Physicians should work with patients to determine the best treatment course. A regimented approach to care will likely ignore these individual preferences.

The average patient may indeed respond one way to a specific treatment, but not everyone will respond like the average patient. Some may respond better and some may respond worse. The government should nurture this individualism. These important medical decisions, with implications sometimes as complex as life and death, should not be made by a complicated mathematical formula or inflexible methodology with no account or concern for the individual situation. These decisions should be made in private discussions between patient and doctor where they can discuss options and work together towards ensuring each patient receives the treatment that he or she needs. The government should not further wedge itself between the doctor and patient. Instead it should work towards helping doctors treat the actual patient as opposed to merely the "average" patient.

Mandating the same treatment regimens and algorithms for every patient seems to violate basic individual rights and freedoms. It also contradicts current medical trends towards more individualized and personalized care. Unfortunately, this is Dr. Berwick's vision of medicine and he will have great power to implement PCORI accordingly.

## AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS

Section 1311 entitled "Affordable Choices of Health Benefit Plans" calls for states to establish exchanges by January 1, 2014 for customers to purchase "qualified health plans." This regulation grants the Secretary of Health and Human Services (HHS) significant control over insurance companies. The HHS Secretary will establish criteria to certify health insurance plans as "qualified health plans" and a ratings system to rate different plans. The terminology is crucial, as the exchange is limited to "qualified health plans," and explicitly states "An Exchange may not make available any health plan that is not a qualified health plan."<sup>44</sup>

This gives the federal government broad new control over the insurance industry. Most likely exchanges will become the new marketplace for health insurance policies and health insurance companies most likely will need to participate to stay in business. While the effect of exchanges on insurance companies has received significant coverage

in the media, their influence on physicians' abilities to practice medicine has received little attention.

Section 1311 gives the federal government vast new control over physician practices as well. It calls for a payment system that rewards and incentivizes, amongst other things, "quality reporting ... chronic disease management, medication and care compliance initiatives ... use of best clinical practices, evidence based medicine, and health information technology." The regulation subsequently gives the Secretary of HHS the authority to develop guidelines to address these matters. Starting on January 1, 2015, a qualified health plan can contract with a provider "only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require."<sup>45</sup>

Depending on the guidelines, this regulation gives the federal government broad control over the activities of physicians accepting any health insurance plan offered through the insurance exchange. Most likely all insurance companies will need to compete in the exchange. These companies will only be able to do so if they force their providers to practice by the guidelines. This regulation is an unprecedented move by the federal government. It expands government control over physician judgments, and to not just those physicians accepting Medicare and Medicaid, but possibly any physician accepting any third party payer.

Of course, quality care is a good thing, but it should not be determined by HHS Secretary Kathleen Sebelius. Who knows best for patients? Do doctors who have dedicated approximately ten years to medical education and training and are actually seeing, talking with, and examining the patient know best? Or do political appointees at HHS know best? This regulation seems to be based on the notion that the latter does. This undercuts the rigorous training physicians must complete to practice.

Section 1311 gives the government broad power to force physicians to practice one way and avoid other ways. In essence, physicians who practice the way the government wants will be paid more, while those who don't will be punished. This part of the statute will coerce physicians not to practice medicine the way they were taught, but the way the government tells them. It will also force doctors to ignore individual patient preferences and cultures. Patients will rightfully be upset. Physicians will have to treat the "average patient" rather than the patient sitting in the exam room chair. This regimented treatment approach will lead to standardized care. Ultimately, this will restrict access and limit patient choice.

For doctors, this will be very demoralizing and frustrating, especially since they will be witnessing the adverse consequences from this bad medicine first hand. They will also have to pick up the pieces. Physicians will be on the ground having to tell patients that they cannot have the care they need and have been getting, even though the physicians may want to prescribe it. Doctors will also be the ones having to care for patients deteriorating clinically because "best clinical practices" were not best for them.

Physicians will have little alternative but to comply with this regulation. The third party payer system has become ingrained in the medical community. Physicians' only option to avoid this loss of autonomy would be to opt out of the third party payer system entirely. While possible, this would require a significant amount of time and energy to accomplish. Not to mention, if enough providers did this, regulators could potentially outlaw this. President Clinton's health care reform legislation would have made this illegal.

Perhaps the greatest irony of this regulation is it could hurt those the most that need the most help: the sickest, poorest, uninsured, drug abusers, and noncompliant patients. If the government implements rigid guidelines and ties doctors' salaries to these parameters, then doctors will have incentives to see patients that are responsible and compliant. Doctors could lose out financially when patients do not take care of themselves or don't follow treatment instructions. This could deter physicians from wanting to care for these patients.

While comparative effective research from the Patient-Centered Outcomes Research Institute *could* easily be used to force physicians to practice a certain way and prevent patients from receiving the care they want, Section 1311 of the law already lays this groundwork with or without comparative effectiveness research.

And that's just one section of the 2,800-plus page law!

## VALUE-BASED PAYMENT MODIFIER

Section 3007 of PPACA establishes the Value-Based Payment Modifier. This will adjust physician reimbursements based on quality of care as defined by the Secretary of HHS and cost compared to other physicians. Essentially this will establish an arbitrary cut-off for acceptable physician costs and those physicians above this threshold will be punished. This will penalize physicians who fail to practice a certain way or spend too much relative to their peers.<sup>46</sup> This will disincentivize physicians across-the-board.

This is unprecedented. The threat of fiscal punishment will further push physicians to practice standardized care and put tremendous pressure on physicians to not order tests, consults, or medicines that their patients may need. Ultimately, this will result in compromised care and further limit patient access.

Doctors will want to practice medicine as they see fit, but it will be difficult for them to do so with possible recrimination looming over their heads. This limitation on ability to practice will be personally very frustrating for physicians wanting to help their patients. It could also create tension between patients and physicians, as well, if patients start to get upset when physicians are reluctant to recommend appropriate interventions. These restrictions are a double-edged sword. PPACA does not protect doctors from lawsuits. Thus, the government will punish doctors for doing too much, but if a physician does not do everything and the patient experiences a bad outcome, then the doctor is still susceptible to lawsuits.

In hospitals, this regulation will likely lead to new administrators and business people looking over physicians' shoulders at every move. Currently, doctor documentation is scoured exhaustively, but as far as the actual physician orders, per se, in my experience the hospital administrators tend to focus only on decisions to admit and decisions to discharge. The Value-Based Payment Modifier will likely change this. It will lead to an onslaught of compliance and oversight in cash-strapped hospitals like never before. To avoid falling in the top tier, which will trigger the penalty, every physician decision will be placed rigorously under the microscope. Physicians will have to explain and defend every CT scan order, every MRI order, every test, every procedure, every consult to multiple nursing supervisors and business administrators. This will be incredibly draining for physicians wanting to provide the best care for their patients. Furthermore, the implementation and enforcement of these compliance measures designed to save money will ironically be quite costly. It will also waste valuable physician time and energy. Doctors will have to spend even more of their day in front of executives as opposed to with patients.

The Value-Based Modifier will likely have other unintended consequences. The formula is to include adjustments for risk and geography. Depending on how these adjustments are implemented, it could easily wind up jeopardizing access to care for the sickest patients most desperate to see a physician. Sick patients could lower a provider's rating substantially in two ways. They will reduce quality and likely raise a physician's costs because they will require more tests, consults, and procedures for their more complex issues. Physicians wary of this new payment adjustment could indubitably become reluctant to treat these sick and complicated patients. Those patients with reputations for being noncompliant could easily harm a doctor's quality rank and encounter similar access problems. Like Section 1311, the Value-Based Payment Modifier could wind up hurting those that need the most help.

Physicians and their patients certainly won't be the ones enjoying the "value" from the Value-Based Physician Modifier.

## PHYSICIAN QUALITY REPORTING SYSTEM

While the Value-Based Payment Modifier and the Patient-Centered Outcomes Research Institute will grant federal bureaucrats unprecedented control over patient and doctor decision-making, the "Improvements to the Physician Quality Reporting System" has the potential to take already onerous medical documentation requirements to all new levels. Physicians currently devote a significant amount of their day to detailed documentation, exhaustive paperwork, and frequent signatures. These requirements will likely increase extensively under this regulation.

PPACA's changes to the Physician Quality Reporting System require physicians to regularly submit information on "quality" care administered and "if the eligible professional does not satisfactorily submit data on quality measures for covered professional services for the quality reporting for the year," providers will face a penalty. In 2015, physicians will receive 98.5% of reimbursements "for such services" for failure

to comply, and starting in 2016 and in each subsequent year, noncompliant physicians will receive 98% of reimbursements “for such services.”<sup>47</sup>

These rules will likely culminate in a tremendous amount of additional work and hassle for physicians. They will likely lead to more stringent documentation requirements. Physicians will need to complete more complicated paperwork and confusing government forms. These requirements will likely prove time-consuming for physicians and for their staffs. In addition to having a significant opportunity cost, these “quality” reporting requirements will likely be costly to implement as well. Physicians could have to purchase expensive software and hire new staff to comply, thereby increasing the cost of care. These regulations could also open the floodgates to a flurry of new lawsuits.

These regulations will serve as one more thing for physicians to focus on other than their patients. They will compel physicians to spend more of their day sitting in front of a computer or sitting at a desk in front of a chart and less time with their patients actually administering quality care. For doctors this will be very demoralizing. Physicians enter medicine to provide quality care, not quality documentation.

In 2015, these reporting demands will offer physicians two choices: they can receive less pay for the same work, or the same pay for more work. Those doctors sticking with the Medicare system will likely have no choice but to comply with these requirements as physicians simply cannot afford any more reductions to Medicare’s already low reimbursement rates; however, these unpaid mandates could easily be the final straw for some with Medicare. Doctors already have a host of reasons not to accept Medicare patients and this will be one more to add to the list. Ultimately, this could easily endanger access for Medicare patients struggling to find a doctor.

Everyone wants quality care and wants their doctor to provide high-quality care. The question is: Who should determine the definition of quality and how to provide it? PPACA is based on the premise that President Obama and his bureaucrats know best. Hence, they should define quality for the American people. If you love waiting in line at the DMV, appreciate the efficiency of the United States Postal Service, like traveling on Amtrak, thought FEMA did a good job with Katrina, and were impressed by the government’s handling of AIG, then perhaps you, too, may share this view. But I respectfully imagine many would share my skepticism.

## HARM THE DOCTOR- PATIENT RELATIONSHIP

The Patient Protection and Affordable Care Act certainly does not protect the doctor-patient relationship. This relationship is about to change drastically.

New regulations and red tape will force physicians to spend more time in back rooms doing paperwork and less time at the bedside with patients. Reductions in reimbursements will compel doctors to see more patients in less time. Doctors’ daily schedules are already full and patient visits are already very short. It remains to be seen how these encounters can be made any shorter, but no doubt they will. Inevitably,

worsening time constraints of medical practice will significantly strain patients' relationships with their physicians. Time pressures will further push patient-doctor interactions away from a patient participatory discussion with emphasis on patient comprehension and compliance, to a more paternalistic physician-dominated approach. Physicians will also have less time to educate, counsel, answer questions, and offer explanations to their patients. As a result, patients will be less likely to understand their diseases and how best to treat them. This will understandably be frustrating for patients and even more so when they feel rushed and don't get their questions answered.

While worsening time constraints will harm the patient-doctor relationship, the mountain of new regulatory requirements in the health overhaul law could kill this relationship. Supporters of PPACA contend a more centralized approach to medicine could better coordinate care and better serve patients. This theory is based on the faulty premise that federal regulators know better than doctors.

Regulations such as the Patient-Centered Outcomes Research Institute and the Value-Based Payment Modifier will impinge on physician autonomy and could prevent patients from getting the care they need. Medical decisions and treatment courses will become standardized. Bureaucrats in Washington will be put between patients and their doctor. These regulators, with little medical background and most likely no knowledge or compassion for the individual situation, will have unprecedented control over health care decisions.

This will be frustrating for both patients and doctors. Patients could encounter difficulty obtaining the care they have been accustomed to and want. Patients will feel helpless. This will be very upsetting for them. They will likely blame the doctors and could possibly take this anger out on physicians as well.

Physicians will not be able to practice medicine as they have for years and as they would like. They will be unable to order the tests, consults, and medicine that patients need. This will be very frustrating for physicians who will want to give patients the care they desperately are pleading for, but will have little alternatives or flexibility against rigid regulators in an increasingly more powerful Washington. Physicians will feel hapless. Their ability to help and advocate for their patients will be limited. Job satisfaction will decrease significantly.

## EXACERBATE THE PHYSICIAN SHORTAGE

A severe physician shortage exists in this country. There simply are not enough doctors or doctors in training. In 2005, the Council on Graduate Medical Education issued a report on the status of the physician work force. It concluded that even though the absolute number of doctors will expand between 2000 and 2020, the demand for physicians will grow at a relatively faster rate than the supply of physicians. Thus, the number of physicians per 100,000 Americans will decrease.<sup>48</sup> In November 2008, the Association of American Medical Colleges (AAMC) also examined this issue and predicted a national shortage of 124,000 full-time equivalent physicians by 2025.<sup>49</sup>

While these deficiencies may be most significant in both number and newsworthiness in the field of primary care, the dearth of doctors actually encompasses most medical and surgical subspecialties.

Unfortunately, the Patient Protection and Affordable Care Act will only exacerbate this harmful trend. After the passage of the legislation, the AAMC readdressed the supply of physicians and reached a similar conclusion.<sup>50</sup>

PPACA will affect the physician shortage in two ways. It offers insurance to the uninsured without significantly increasing the number of providers. The 1997 Balanced Budget Act (BBA) capped funding for medical residencies. This has limited the number of new physicians, since all physicians must complete a residency to practice medicine. By increasing demand for care without a comparable increase in the supply of doctors to treat the additional infusion of patients, this will add to the current physician shortage. Although the magnitude of this effect could be less than anticipated, as the Emergency Medical Treatment and Active Labor Act already guarantees emergency medical care to all regardless of ability to pay.

The federal government's decision to cap residency funding in the 1997 BBA deserves at least part of the blame for the current physician shortage. It was a short-sighted decision based primarily on lowering costs as opposed to the best interest of patients. It is likely that PPACA's National Health Care Workforce Commission designed to study the health care workforce and make recommendations to Congress and the executive branch will exhibit similar faulty priorities.

## DECREASE PHYSICIAN SUPPLY

The health care overhaul law will mainly worsen the physician shortage by inevitably decreasing physician supply. The onslaught of increased bureaucracy, additional paperwork, more oversight, and less autonomy will likely drain job satisfaction and could push some doctors to retire or switch careers. Some might postulate that the time doctors must invest before they can actually practice medicine would make their supply quite inelastic. The published literature, although limited in this area, suggests otherwise. Doctors, like any other employee, can and will, only tolerate so much.

A study in the *Journal of Law & Economics* reinforced this by showing that practice climate does indeed influence the physician work force. Helland et al. studied doctor work schedules in relation to malpractice risk. They determined that doctors work 1.7 hours less per week when the risk of medical liability increases a mere ten percent. This effect was most pronounced for older physicians and those physicians who own their practice.<sup>51</sup> Malpractice and regulations are certainly different issues per se. Yet just as the fear of malpractice drains job satisfaction and lowers take home pay, so too do costly, time-consuming regulations. Thus it seems reasonable to conclude they would similarly deter physicians from working.

Physicians agree. In September 2009, an *Investor's Business Daily*/TIPP poll of 1,376 practicing doctors randomly chosen throughout the country revealed that 65% of

doctors opposed the Obama administration's health care agenda, and that 45% of practicing physicians would consider leaving their practice or retiring early if it passed. Applied to the entire physician population, this translates to 360,000 doctors who might stop practicing medicine.<sup>52</sup> A more recent survey of 1,195 doctors conducted by Medicus, a national physician search firm, reached a similar conclusion. This poll showed that almost one third of physicians and 46% of primary care physicians would want to leave medicine if health care reform passed.<sup>53</sup> Obviously, not every doctor who said they would quit will, but when faced with more hassle and red tape, many will seriously entertain this option.

Older doctors will retire early. This most likely won't be a feasible option for younger physicians with families to support and loans to repay but many could pursue opportunities outside of clinical medicine, such as jobs with consulting firms, corporate America, finance, or even in politics. Those who continue to practice might opt out of the third party system (although if enough doctors did this, it would be tempting for federal regulators to outlaw this). In all fairness, many doctors will stick with medicine. Some will want to continue practicing while others will find it easiest to continue working, just with less effort and lower morale. The upfront investment to practice medicine and subsequent barriers to exit the profession could keep the number of physicians practicing artificially high, but this certainly won't serve patients' best interests. Obviously this would result in poor patient care.

## DETER YOUNG PEOPLE FROM PURSUING MEDICINE

PPACA will also dissuade young people interested in medicine from pursuing it. This will likely comprise health care reform's main influence on the physician shortage. A career in medicine requires a tremendous investment in both time and money. After four years of undergraduate studies, future doctors must complete four years of medical school. Upon graduation from medical school, young doctors must then complete an intense residency training program before they can practice independently. Depending on the specialty, residencies range from three to six years. After residency, most doctors also then complete a fellowship. Fellowships are typically an additional two to three years of training. By the time doctors start their career, most are in their mid-30s and have accumulated an average of \$150,000 in education-related debt.<sup>54</sup> Some physicians accrue even more.

Residency is not only mentally challenging, but physically and psychologically demanding as well. It's rigorous training consisting of regular 30 hour shifts and 80 hour plus work weeks. When residents work these lengthy shifts on a floor block, they typically only get four days off per month. Throughout this training marathon, residents receive an hourly compensation, which hovers just above minimum wage. This salary lacks any correlation with responsibility, skill set, or education.

Medical training is not just a job for young physicians. It's their lives. It requires major sacrifices to become a physician. Doctors should be rewarded for giving up so much for

this noble calling. They certainly should not be discouraged or punished, which is exactly what the health care reform law will do.

PPACA will deter bright young minds from entering medicine altogether. The composition of those who do decide to pursue medicine will probably deteriorate. It will likely be a stark deviation from the status quo of the brightest, best educated, best trained, and most dedicated.

Fewer new physicians coupled with an exodus of those already in practice will create an access nightmare for patients desperately seeking care. While it will be a nuisance for doctors having to change practice style or switch careers, ultimately the patient always suffers the most. New patients will not be able to find a physician and with time, despite President Obama's "if you like your doctor" promise, many patients content with their health care and content with their doctor will encounter a similar fate. This will inevitably lead to restricted access, long waits for appointments, and rationed care.

## MASSACHUSETTS

The negative effects of this likely paradigm are currently being seen on a smaller scale in the Bay state. In 2006, Massachusetts passed its universal coverage health care reform legislation. The law, considered a model for national reform, required everyone to obtain insurance. The hope was this expansion in coverage would improve and expand the uninsured's access to health care services and lower the number of expensive emergency room visits. The exact opposite happened. According to data from the Division of Health Care Finance and Policy, only 60% of family medicine doctors in the state are taking new patients. This is a big reduction from 70% in 2007. And only 44% of internal medicine practices are accepting new patients. In 2005, 66% were taking new patients.<sup>55</sup> These problems are magnified by the fact that current Massachusetts physicians are having an increasingly difficult time attracting new physicians to join their practices. According to the Massachusetts Medical Society's *2009 Physician Workforce Study*, 54% of practicing physicians noted the time to recruit new physicians has risen over the past three years. In 13 specialties, it takes practicing physicians over one year to recruit a new physician. For internal medicine, family medicine, orthopedics, and neurosurgery practices, it takes 13.8 months, 15.5 months, 17.6 months, and 24.8 months, respectively, to recruit new physicians.<sup>56</sup>

As doctors in Massachusetts have stopped accepting new patients, patients have encountered an increasingly difficult time finding desired and needed care. Between 2007 and 2008, residents reporting problems obtaining care increased from 16% to 24%,<sup>57</sup> and as access has deteriorated, patients have been forced to rely on costly, overcrowded emergency rooms for medical treatment. In the state, emergency room visits have increased by 9% from 2004 to 2008.<sup>58</sup>

It remains to be seen how the federal government will deal with this imminent fiasco on the national level. Obviously the administration can't make doctors practice nor can it make people attend medical school. The likely solution will be a combination of

rationing and an increased reliance on midlevel providers such as nurse practitioners and physician assistants.

## SOLUTIONS

While the majority of physicians oppose PPACA, the majority do support health care reform, just not President Obama's radical prescription. Our country boasts the world's premier health care system. But there is certainly room for improvement. Rather than rolling the dice and starting from scratch as the recently passed health care overhaul law will do, a reform proposal should build off the successes of the current system and try to target its shortcomings. Such an approach could make it easier for doctors to provide high-quality care while simultaneously guaranteeing that patients receive the care that they need and also work towards lowering costs.

1. **Repeal:** The recent health care reform legislation that passed via reconciliation along party lines should be repealed. The 2,800 pages of regulations, red tape, bureaucracy, and new mandates will place unaccountable bureaucrats in Washington between patients and their doctor. It will grant them unprecedented control over health care decisions. Furthermore, this legislation will not control ballooning costs and ultimately will lead to restricted access, increased waiting time, and rationed care. While the statute is a regulator's dream, it will soon be a nightmare for patients and doctors. It should be repealed.
2. **Replace:** During the prolonged health care debate, many supporters of reform claimed that opponents of their health reform plan lacked any serious ideas of their own to improve the health care system and were merely the "party of no." This, however, was not the case. Opponents of PPACA indeed had a platform for health care reform. Serious reform proposals do exist that could work towards improving patient care and lowering costs by maintaining the successes of the current system, but also targeting its failures.
  - a. **Tort Reform:** Our nation's malpractice system is out of control. Large, unpredictable jury payouts encourage frivolous lawsuits. This increases medical malpractice premiums and can at times force doctors in high-risk fields to retire or relocate. As a result, patients pay inflated prices and have problems acquiring care. The threat of lawsuits also compels physicians to order oftentimes unnecessary tests, procedures, and specialty consults, simply to prevent lawsuits. This common practice, known as defensive medicine, wastes between 100 and 200 billion dollars annually. Tort reform could curb these problems and allow physicians to practice good medicine for the best interest of patients, as opposed to the best interests of the trial bar. Not only was comprehensive tort reform not included in the legislation, but new regulations will likely expose doctors to the possibility of more lawsuits.
  - b. **Lower costs:** Health care costs have been growing exponentially. The Heritage Foundation research explores the background of these rising costs. Solutions that

empower patients and expand choice such as creating a real national market for health insurance would be a great way to start combating these trends.<sup>59</sup>

- c. **Deregulate:** The health care industry is one of the most overly regulated industries in the country. Although these regulations are likely made with the best intentions, in the trenches, they often take physicians away from patients, increase costs, and foster poor quality care. Rather than expanding and creating new regulations, the impact of the regulations already on the books should be examined, and those causing more harm than good should be nullified.
  
- d. **Abolish the SGR:** Every year since 2002 the SGR has called for a reduction in doctor reimbursement rates, and in all but one of those years Congress has intervened to preclude the cuts. As the cost of business increases with inflation, it is unfathomable that physicians should receive less and less reimbursement each year. They should not be placed at the mercy of Congress every year either. It's an unpredictable reimbursement system that jeopardizes access for Medicare patients. It should be abolished and replaced with a more predictable payment system. This would benefit both physicians and patients.
  
- e. **Protect the Practice of Medicine:** Congress should pass legislation making it illegal for politicians or regulators to punish or criminalize physicians opting out of the third party payer system. As doctors are being browbeaten by the bureaucracy and price controls of PPACA, they need a guarantee from the government that they will always have this option. A failure to offer this to doctors, will exacerbate the aforementioned impact on the physician shortage and its subsequent effects on access to care.

## CONCLUSION

PPACA's detriment to physicians is extensive. It will drown doctors in red tape and bureaucracy. It will limit physician autonomy and their ability to help and advocate for their patients. Job satisfaction will be drained and the patient-doctor relationship ruined. As federal regulators require physicians to do more, they will actually get paid less. As the situation worsens, older doctors will retire and younger doctors will look to switch careers. This will come at a time when the demand for physician services will be higher than ever. Ultimately the consequences of the Patient Protection and Affordable Care Act will translate into restricted access and inferior quality of care. No matter how you look at it, this legislation is terrible for physicians; however, it is always the patient that suffers the most.

## ABOUT THE AUTHOR

Jason D. Fodeman, M.D., is an Internal Medicine Resident at the University of Connecticut and a Visiting Fellow at the Galen Institute. He previously completed a graduate health policy fellowship at The Heritage Foundation where he studied the etiology of rising health care costs. His research was featured online in the *Wall Street Journal*. He has written multiple op-eds on health care that have been featured in *National Review Online*, *Washington Times*, and the *Daily Caller*. He has also discussed health care policy on *FOX & Friends*. He was recently appointed to serve on the Connecticut Medical Inefficiency Committee.

He is also the author of the critically acclaimed book *How to Destroy a Village: What the Clintons Taught a Seventeen Year Old*. The book received national media coverage and peaked at 33 on Amazon (out of 1.5 million books ranked).

He is a Phi Beta Kappa graduate of Johns Hopkins University and was one of two economics majors in his class to be recognized by the department on graduation day, receiving the Federal Reserve Bank of Richmond, Baltimore Branch 2005 Excellence Award for Outstanding Achievement in the Study of Economics.

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## ENDNOTES

<sup>1</sup> The Patient Protection and Affordable Care Act (Public Law 111–148) was signed into law on March 23, 2010. It was amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111–152), which was enacted on March 30, 2010. In this paper, for convenience, the final legislation will be referred to as the Patient Protection and Affordable Care Act (PPACA).

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<sup>4</sup> Dana Blanton, “FOX News Poll: Uncertainty on Health Care Reform,” *FOX News*, July 23, 2009, at <http://www.foxnews.com/politics/2009/07/23/fox-news-poll-uncertainty-health-care-reform/> (October 18, 2010).

<sup>5</sup> Pamela Villarreal, “Social Security and Medicare Projections: 2009,” *National Center for Policy Analysis*, June 11, 2009, at <http://www.ncpa.org/pdfs/ba662.pdf> (September 24, 2010).

<sup>6</sup> Associated Press, "Gov't: Spending to Rise Under Obama's Health Care Overhaul," *FOX News*, September 9, 2010, at <http://www.foxnews.com/politics/2010/09/09/spending-rise-obamas-health-overhaul/> (September 24, 2010).

<sup>7</sup> "The End of Private Health Insurance," *The Wall Street Journal*, April 13, 2009, at <http://online.wsj.com/article/SB123958544583612437.html> (September 24, 2010).

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