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Compromising the Doctor–Patient Relationship: The Impact of the House Health Care Bill

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On July 16, the American Medical Association (AMA) voiced its support for H.R. 3200, the America's Affordable Health Choices Act of 2009. Letters of support from the American College of Surgeons, the American Academy of Family Practitioners, the American College of Physicians, and a number of specialty organizations soon followed, prompting President Obama to state that "the docs are on board" with his health care reform plan.

It is becoming increasing clear, however, that a sizeable segment of the medical profession does not agree with the AMA's decision, and many feel that H.R. 3200 "will ultimately limit patient choice, will put the government between the doctor and the patient, interfering with patient care decisions, and because of its tremendous cost—immediately and in the future—will be a burden to all Americans."[1]

Doctors Want Health Care Reform. Physicians understand better than the President and Congress about the burden of the large number of uninsured Americans and the high levels of uncompensated care. Physicians provided an estimated $22.4 billion of uncompensated care to the uninsured in 2008.[2] Unlike hospitals, physicians are generally not subsidized for this care.

Essentially all physicians want to see the American health care system become as good as it can be, and most are willing to make sacrifices to achieve that goal. However, at least a dozen state, local, and specialty societies—representing more than 45,000 physicians—have already expressed opposition to the current House reform proposal, and others remain undecided pending further discussion of key issues.

Concerns with the Current Proposal. Physician groups have cited a number of serious concerns with H.R. 3200. The most troublesome issues for physicians are the inclusion of a government-administered public plan to compete with private insurance plans and the methodology that will be used to reimburse physician services in both the public plan and Medicare.

The Public Plan Option. The House health reform bill includes a public plan that will be administered by the federal government and "compete" with private insurance plans. However, premiums in the public plan will be at least 10 percent lower and more likely 20–25 percent lower, on average, than premiums in private plans.[3] The Congressional Budget Office initially estimated that enrollment in the public plan will be as low as 8–9 million people but admitted that variability in the numbers is likely to be considerable.

In fact, the Lewin Group, a non-partisan health care consulting firm, more recently estimated that when fully implemented, the number of enrollees in

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the public plan is likely to be 103.4 million, and an estimated 88.1 million of these enrollees would be shifted out of their current employer-based coverage.[4] Between Medicare, Medicaid, SCHIP, and a large enrollment of Americans in the new public plan, the government could control the health care of well over 200 million Americans.[5]

This would move American health care closer to President Obama's once-stated preference for a single-payer system. According to the legislation, physician participation in the public plan would be "voluntary." However, as physicians know from the managed care experience, non-participation in a plan of that size would not be a practical option for most physicians.

Physician Payment Methods. More troubling is the congressional plan to replace the current doctor payment system with the Medicare Economic Index (MEI), which attempts to estimate inflation in the costs of providing medical services. However, the MEI was implemented in the Medicare system in the 1970s, did not reduce Medicare spending, and was abandoned.[6] There is no reason to believe it will be any more effective this time around.

According to recent Lewin Group analysis, if the public plan would use Medicare payment levels plus 5 percent, as planned, some physicians would "win" but many physicians would "lose." Physician income declines would be determined by the degree of enrollment in the public plan in different areas of the country and the impact of Medicare payment on physician income in different areas of the country. In Maine, for example, where Medicare physician payments are 63 percent of the private payment to physicians, the per capita income loss would be substantial. According to AMA survey data, faced with significant income cuts, many physicians would be forced to make significant changes that could affect their practice, such as deferring the purchase of new medical equipment and not investing in information technology.[7]

The Doctor–Patient Relationship. Even more important, however, is the effect the current legislation would have on the privacy of medicine, an institution that the AMA has sustained since the organization was founded in 1847.

Physicians understand the potential value of clinical care guidelines and even comparative effectiveness research as tools that can add to the fund of knowledge to help inform patients and physicians. But the ultimate decision regarding what is appropriate in an individual clinical situation should not be mandated or coerced by MedPAC, a health care czar, or any other "independent" entity.

1. Press release, "Neurosurgeons Oppose Limiting Patient Access and Government Interference in Medical Care: House Health Care Reform Bill Jeopardizes Future of American Medicine," American Association of Neurological Surgeons, at *http://www.aans.org/legislative/aans/Health percent20Reform percent20Press percent20Release.pdf* (July 21, 2009).
2. Jack Hadley, John Holahan, Teresa Coughlin, and Dawn Miller, "Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs," *Health Affairs*, Vol. 27, No. 5 (2008), w399–w415, at *http://content.healthaffairs.org/cgi/reprint/27/5/w399* (July 22, 2009).
3. See Douglas W. Elmendorf, director of the Congressional Budget Office, letter to Honorable Charles B. Rangel, Chairman Committee on Ways and Means, U.S. House of Representatives, July 17, 2009, at *http://www.cbo.gov/ftpdocs/104xx/doc10464/hr3200.pdf* (July 22, 2009); John Sheils, "Impact of the House Health Reform Bill," testimony before the Committee on Energy and Commerce, U.S. House of Representatives, June 25, 2009 (updated July 6, 2009), at *http://www.lewin.com/content/publications/June25TestimonyUpdateJul09.pdf* (July 22, 2009).
4. Memorandum to Stuart Butler Ph.D., , Vice President, Domestic and Economic Policy Studies, The Heritage Foundation from John Shiels and Randy Haught, Analysis of the July 15 draft of The American Affordable Health Choices Act of 2009, Revised July 23, 2009, p. 5.
5. This assumes current Medicare enrollment of 44.8 million, Medicaid/SCHIP enrollment of 70 million following the proposed expansion, and 122.9 million in the public plan. See Elmendorf, letter to Rangel.
6. John S. O'Shea, "The Urgent Need to Reform Medicare's Physician Payment System," Heritage Foundation *Backgrounder* No. 1986, December 5, 2006, p. 2, at *http://www.heritage.org/Research/HealthCare/bg1986.cfm.*
7. American Medical Association, "2006 AMA Member Connect Physician Survey: Physicians' Reactions to the Projected Medicare Payment Cuts," at *http://www.ama-assn.org/ama1/x-ama/upload/mm/468/medicarepaymentmc.pdf* (July 23, 2009).

Although there is concern among the general public about the costs of health care, polls consistently show that the vast majority of Americans are satisfied with their individual health care arrangement and the quality of care they receive.[8] The President has said, repeatedly, that if you like the doctor you have, you can keep your doctor. However, this legislation compromises the relationship you have with your doctor.

By increasing government involvement in the doctor–patient relationship, the current legislation contradicts President Obama's promise to build on what is good in the system.

Misplaced Value Incentives. For decades the government has tried to control spending in Medicare by deciding what benefits patients should receive and setting the price for more than 7,000 individual services. Obviously these efforts have been entirely unsuccessful. Congress has so far failed to recognize that cost, as well as quality of care in the health care system, is driven by decisions made by individual patients and their doctors. To contain costs, the incentive structure needs to be shifted to the individual level.

Doctors should be able to privately contract with patients and set their own prices. If some patients wish to spend out-of-pocket for a physician who provides quality, efficient care, they should be allowed to do so. This will provide incentives at the individual doctor–patient level. Patients will demand cost and quality transparency, and physicians will be more conscious of where they stand in terms of outcomes and efficiency and be incentivized to continually improve. This is more likely to lead to individual value-based decisions than federal price setting and global spending targets.

All Doctors Are Not on Board. Physicians understand the need to undertake serious reform of the American health care system. There are a number of ailments that need to be attended to before the system can be as healthy as it could be. Although the AMA and several other physician organizations feel that H.R. 3200 is the right prescription, a growing number of physicians believe that this hastily prepared treatment plan is likely to make matters worse.

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8. ABC News/Kaiser Family Foundation/USA Today, "Health Care in America 2006 Survey," October 2006, at *http://www.kff.org/kaiserpolls/upload/7572.pdf* (July 23, 2009).