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Obamacare: Impact on Doctors

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No class of American professionals will be more negatively impacted by the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act than physicians. Third-party payment arrangements already compromise the independence and integrity of the medical profession; Obamacare will reinforce the worst of these features.

Specifically, physicians will be subject to more government regulation and oversight, and will be increasingly dependent on unreliable government reimbursement for medical services. Doctors, already under tremendous pressure, will only see their jobs become more difficult.

Medicaid Expansion and Payment. Under the new law, an estimated 18 million of the 34 million who would gain coverage over the next 10 years would be enrolled in Medicaid,[1] a welfare program jointly administered and funded by the federal government and the states.

Physician payments in the major entitlement programs, Medicare and Medicaid, are already well below the prevailing rates in the private sector. On average, physicians in Medicare are paid 81 percent of private payment; physicians in Medicaid are paid 56 percent of private payment.[2] Medicare payment has resulted in sporadic access problems for Medicare patients, and the lower Medicaid payments have already contributed to serious access problems for low-income persons and worsened hospital emergency room overcrowding. In a recent survey conducted by Opinion Research Corporation, 67 percent of primary care physicians said that under current conditions new Medicaid enrollees would not be able to find a "suitable primary care physician" in their area.[3]

Obamacare does not substantially change the general pattern of the government's systems of physician payment but instead expands their reach and adds new regulatory restrictions. For example, beginning in 2010, the new law, with few exceptions, will prohibit physicians from referring Medicare patients to hospitals in which they have ownership.

In 2011, Medicare primary care physicians and general surgeons practicing in "shortage" areas will receive a 10 percent bonus payment. And primary care physicians participating in Medicaid will get no less than 100 percent of the Medicare payment rates for their services for 2013 and 2014, with the federal taxpayer making up the difference between Medicaid funding and the higher Medicare payment rates. But there is a catch: There is no provision for continued federal taxpayer funding beyond these two years, so states will have to either increase their own Medicaid expenditures substantially or cut back their Medicaid physician payments.

The Sustainable Growth Rate Formula. Medicare physician payment is annually updated on the

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basis of the Sustainable Growth Rate (SGR) formula, which ties annual physician payment increases to the performance of the general economy. But every year, Congress passes the so-called "doc fix," which overrules the SGR formula and keeps Medicare payments from falling to artificially low rates.

Under the SGR, without congressional intervention, the initial Medicare pay cut would amount to 21.3 percent. The impact is not hard to fathom. For example, the Fairfield County Medical Association in Connecticut reported that, if such cuts were to actually take effect, 41 percent of county doctors would stop taking new Medicare patients, and nearly one out of four doctors would drop Medicare altogether.[4]

The new law provides no SGR fix. Moreover, Congress has shown no inclination to fix the broken SGR formula without adding to the federal deficit rather than embracing fiscal discipline and embarking upon a genuine reform of the Medicare program.

More Bureaucracy. On top of existing payment rules, regulations, and guidelines, the new law creates numerous new federal agencies, boards, and commissions. There are three that have direct relevance to physicians and the practice of medicine:

1. Under section 6301, Obamacare creates a "nonprofit" Patient-Centered Outcomes Research Institute. It will be financed through a trust fund, with initial funding starting at $10 million this year and reaching $150 million annually in fiscal year 2013, with additional revenues from insurance fees. In effect, the institute will be examining clinical effectiveness of medical treatments, procedures, drugs, and medical devices. Much will depend upon how the findings and recommendations will be implemented and any financial incentives, penalties, or regulatory requirements.
2. Under section 3403, there will be an Independent Payment Advisory Board in 2012, with 15 members appointed by the President and confirmed by the Senate. The board would aim to reduce the per capita growth rate in Medicare spending in accordance with specified targets (based initially on measures of inflation and eventually GDP growth) and make recommendations for slowing growth in non-federal health programs. The board's recommendations would go into effect unless Congress enacts an alternative proposal. An unprecedented cap on Medicare spending, the process would doubtless reduce Medicare physician payment.
3. Under section 3002, the law extends the Physician Quality Reporting Initiative. While it provides incentives for the quality of care delivered to Medicare beneficiaries, the program is nonetheless burdened with time-consuming compliance and reporting requirements.

Doctor Dissatisfaction. Notwithstanding the American Medical Association's high-profile endorsement of the massive Senate health bill, now the law of the land, recent polling underscores deep physician discontent.

For example, according to a recent survey of physicians conducted by Athena Health and Sermo, 79 percent of physicians are less optimistic about the future of medicine, 66 percent indicated that they would consider dropping out of government health programs, and 53 percent would consider opting out of insurance altogether.[5]

1. Richard S. Foster, "Estimated Financial Effects of 'The Patient Protection and Affordable Care Act,' as Amended," U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, April 22, 2010, p. 3.
2. For a discussion of Medicare and Medicaid rates within the context of a proposed "public plan," see Greg D'Angelo, "A New Public Plan: How Congressional Details Will Impact Doctors and Patients," Heritage Foundation *WebMemo* No. 2482, June 12, 2009, at *http://www.heritage.org/Research/Reports/2009/06/A-New-Public-Health-Plan-How-Congressional-Details-Will-Impact-Doctors-and-Patients*.
3. See United Health, "Coverage for Consumers, Savings for States: Options for Modernizing Medicaid," April 2010, at *http://www.unitedhealthgroup.com/hrm/UNH_WorkingPaper3.pdf* (May 11, 2010).
4. Press release, "Medicare Cuts Will Impact Patient Care and Increase Health Care Costs," Fairfield County Medical Association, April 6, 2010.
5. Daniel Palestrant, M.D., "Why Physicians Oppose the Health Care Reform Bill," *Sermo*, April 8, 2010.

More ominously, with America already facing a shortage of physicians, particularly in geriatrics and primary care, many physicians also say they would leave the profession. Based on earlier polling and surveys of physician sentiment, none of this should be surprising. The new law does not address physicians' most pressing concerns, such as tort reform, and it worsens the already painful problems with third-party payment and government red tape.

Scrap It and Start Over. A key goal of health care reform should be the restoration of the traditional doctor–patient relationship. In such a relationship, physicians would be the key decision-makers in the delivery of care, and patients would be the key decision-makers in the financing of care. This cannot be achieved unless and until patients control health care dollars and decisions and third-party insurance executives are directly accountable to those who pay the health care bills.

Obamacare does none of these things but instead entrenches the worst parts of today's third-party payment system. Obviously, Congress needs to start over from scratch.

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