

Good for Patients, Good for America

The Patient Protection and Affordable Care Act (aka ObamaCare) neither protects patients, nor does it lead to affordable care. The two fundamental problems that drive up the cost of health care in the United States are the lack of true competition in the health insurance industry and the isolation of physicians and patients from the true costs of health care. Rather than addressing these problems, ObamaCare aggravates them by limiting choices of insurance, increasing regulation, and centralizing decision making. It is the wrong prescription for health care reform in America. A majority of Americans, particularly physicians, recognize this and thus oppose the new health care law and support its repeal.

Docs 4 Patient Care is an organization of physicians dedicated to the preservation of the doctor-patient relationship. What follows is our prescription for health care reform in the United States. Our primary concern is the health and well-being of our patients. An additional concern is the health and well-being of our country –physically and financially. Accompanying each of the following eight recommendations is a rationale. These recommendations are intended to serve as a framework on which responsible legislation can be constructed.

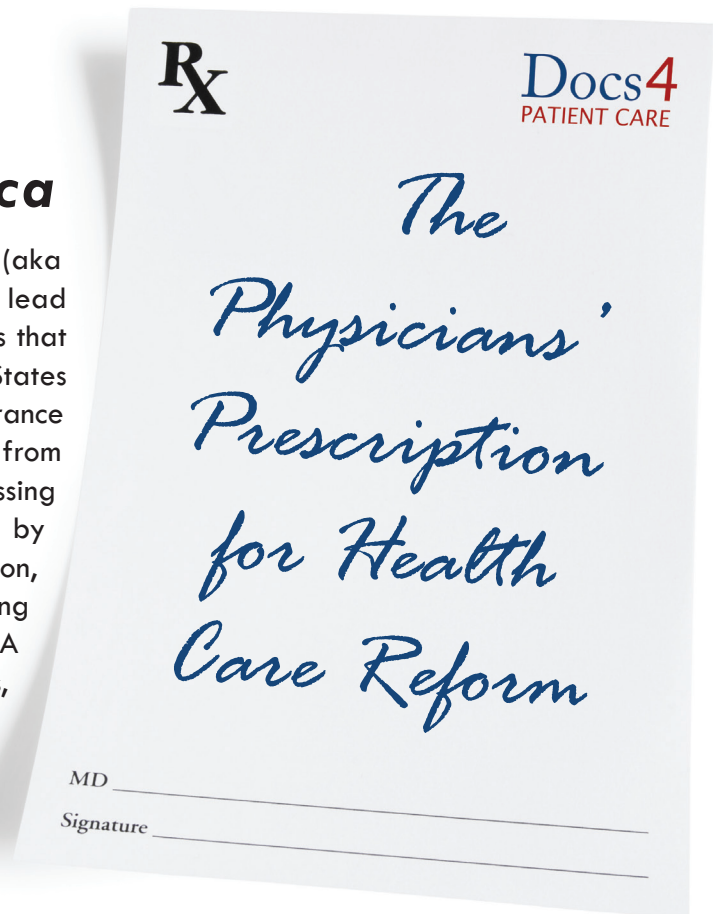
1. Increase competition by allowing individuals to purchase health insurance across state lines.

In state capitols across the country, powerful lobbying groups have successfully added various mandates to legally allowed health insurance policies in each state. There are several thousand such mandates, averaging 45 per state. Each mandate adds to the cost of the health insurance coverage, and collectively they dramatically increase the cost of coverage. These mandated regulations are enforced by insurance regulators in each state, and the interstate sale of health insurance is prohibited.

A national competitive health insurance market must be established. In a national free market, insurance providers would list the coverage provided and the associated cost. Individuals and families can and should choose the specific coverage they need, rather than be compelled to purchase coverage that they do not find desirable or necessary. They should be able to obtain insurance coverage from any provider in any state. Market forces would eliminate providers who provide poor service, just as it does in other sectors of the economy.

2. Equalize the tax treatment of money spent for health insurance by employers and individuals.

The most significant expansion of employer-sponsored health insurance plans occurred in response to wage controls imposed by the government during World War II. The War Labor Board declared that fringe benefits, such as health insurance, did not count as wages. Employers responded by offering health insurance



as a benefit to attract higher quality employees. The marriage between employment and health insurance was further cemented in 1954 when the Internal Revenue Service decreed that premiums paid by employers for employee health insurance were exempt from income taxation. These conditions result in an unnecessary union between employer and health insurance coverage, and they encourage employees to demand, and thus employers to provide, much more expensive coverage than individuals would otherwise purchase themselves. This drives up the cost of insurance coverage. Furthermore, these conditions are unfair to the self-employed, who do not receive the same tax benefits.

Private ownership of health insurance policies would make health insurance portable and more affordable, and would make tax treatment of health insurance premiums more equitable. If employers need to attract better employees, they should offer higher wages.

3. Encourage the Health Savings Account qualified High Deductible Health Plan (HSA qualified HDHP) model as the basic structural health insurance model across the entire spectrum of health insurance options by broadening allowable use.

The purpose of insurance is for the protection from asset loss as a result of unpredictable, uncontrollable occurrences. The evolution of employer- sponsored health plans during World War II, followed by the provision that health insurance was subject to collective bargaining eventually led to a departure from the original purpose of health insurance to the notion that health insurance would cover any and all health-related expenditures. When health care consumers are insulated from the actual cost of care, they tend to over-utilize services, ultimately leading to the rapid escalation of health care costs.

By broadening their allowable use, HSA qualified HDHP's will become a preferred choice of health plan. By putting the decision-making control and responsibility for basic health care costs back into the hands of the consumer (the patient), HSA qualified HDHP's will make the patient a better and wiser consumer of health care, will control costs, and will ultimately lead to improved quality of care through increased competition.

4. Promote transparency in medical costs.

In order to be informed consumers, the cost of health care services must be made readily available to patients prior to the time of service. This includes doctors, hospitals, pharmacies and outpatient facilities. These costs should be readily available to health care consumers on the internet, and in providers' facilities.

5. Encourage medical liability reform.

ObamaCare does nothing to substantially address the medical malpractice crisis, and, in fact, it punishes states that already have tort reform in place by excluding them from grants to study the issue. Meanwhile, the malpractice crisis continues. Frivolous law suits and resultant defensive medical practices cost the consumer billions of dollars every year. A recent study by the Cato Institute notes that in 2002, the medical liability system provided benefits of \$30.0 billion, but cost \$113.7 billion, imposing a cost on society of \$80.7 billion, to say nothing of the additional hidden costs of defensive medicine. The Congressional Budget Office estimates (some might argue very conservatively) that tort reform similar to that which already exists in some states would reduce the federal deficit by \$54 billion over the next 10 years.

No national prescription for health care reform should be without medical liability reform as a prominent component. The solution to this problem must respect each state's right to address this problem at the state level. However, given that the liability crisis increases the cost of medical care, we recommend that the federal government incentivize states to have meaningful tort reform in place by increasing federal health care-related subsidies to the states that have meaningful reform enacted. Components of meaningful tort reform could include several or all of the following:

1. A cap on awards for non-economic damages of \$250,000.

2. A cap on awards for punitive damages of \$500,000 or two times the award for economic damages, whichever is greater.
3. Modifications of the “collateral source” rule to allow evidence of income from other sources to be introduced at trials or to require that such income be subtracted from jury awards.
4. A statute of limitations – one year for adults and three years for children from the date of discovery of an injury.
5. A fair share rule, under which a defendant would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury.
6. Specialty panels to determine if claims are potentially meritorious.
7. Specialty courts to hear meritorious claims and award damages.
8. Loser pays legal fees.
9. No-fault insurance.

6. Transform Medicare into a defined contribution program.

When Medicare was introduced in 1965, the federal government became a de facto health insurance provider for its senior citizens. By taking on a role that it is unqualified to fulfill, it has taken on costs which are far above those that were originally projected. These costs are bankrupting our country. Furthermore, the federal government establishes reimbursement rates for health care providers under Medicare, and the private health insurance industry establishes reimbursements based on these rates. This artificial price fixing does not allow free market forces to work within the health care system and results in an upward pressure on health care costs.

The United States should honor its commitment to provide health care coverage to its seniors. However, with \$38 trillion in unfunded obligations and projections from the Medicare trustees of bankruptcy by 2018, the current Medicare program is unsustainable. ObamaCare only aggravates these circumstances by withdrawing more than \$500 billion from Medicare (which are then used to fund new entitlements under ObamaCare). Those cost “savings” will come largely from decreased reimbursement to health care providers, which will lead to an increasing number of providers who are unwilling to treat Medicare patients and will opt out of the program. Our senior citizens deserve better.

We support the creation of a new Medicare program for future retirees in which the federal government provides a payment to assist individuals to purchase and maintain health insurance. Payments to individuals would be adjusted by income level, inflation and other appropriate factors. Participating health insurance providers would be required to provide insurance to all comers, thus assuring that all patients will be covered. In this fashion, patients would be empowered to choose the health coverage that best suits their needs, rather than being provided with a one-size-fits-all program.

Until Medicare as we know it is phased out and the transition to private health insurance is accomplished, physician compensation under Medicare part B will continue to be problematic. In 1998, the sustainable growth rate (SGR) formula for physician reimbursement was established. The SGR was based on GDP, which over time has risen more slowly than actual health care practice costs. As a result, physician reimbursements under Medicare have fallen behind costs, making it untenable for many physicians to continue to see Medicare patients. We recommend that the SGR be abandoned. In its place, we recommend that Medicare standardize reimbursements to physicians, eliminate geographical variations in reimbursements, and allow physicians to bill Medicare patients for the balance of the cost of care not covered by Medicare.

7. Restructure Medicaid to assist low-income families to purchase health insurance.

Under ObamaCare, an additional 18 million Americans will be “insured” by simply increasing the eligibility for the Medicaid program, thus placing them on Medicaid. However, the inherent flaws in Medicaid were not addressed. Physicians nationwide are refusing to see Medicaid patients due to payment levels from the Medicaid program that

are insufficient to cover the physician's cost to provide the service. This results in difficulty for Medicaid recipients to locate providers willing to accept Medicaid. Medicaid is a leading item on most states' budgets. States, already facing serious budget deficits, are unable to absorb the additional Medicaid expenditures resulting from the dramatic expansion of the Medicaid roles. Medicaid as it now exists is a disaster for physicians, patients and states alike.

We support the elimination of Medicaid as it now exists. We support the proposal to remove the federal share of Medicaid payments to the states, and to replace it with allotments to the states determined by the state's per capita low-income population. The states should not function as health insurance providers, but should be encouraged to investigate other private options for providing health care to low-income citizens. We encourage states to subsidize low-income citizens based on their income to allow them to purchase private health insurance, and individuals should be strongly incentivized to purchase HSA/HDHPs. This approach would accomplish the following:

1. Save the states money by extricating them from being health insurance providers.
2. Increase availability of providers.
3. Improve reimbursement for health care providers.
4. Increase quality of care.
5. Incentivize patients to be prudent health care consumers.

8. Encourage pooling.

States should be encouraged to set up mechanisms such as high-risk pools that allow individuals with pre-existing conditions to obtain health insurance with state assistance. Protections for those with preexisting conditions who maintain continuous coverage should be extended in order to reward responsible behavior and minimize the number of patients requiring high-risk pools in the future.

Group purchasing arrangements based on membership in organizations such as professional and small business associations and religious groups should be promoted. Participation in these groups should be allowed across state lines.

Summary

The recently passed ObamaCare takes the control of health care decisions out of the hands of patients and places it into a dramatically expanded federal bureaucracy. This top-down, centralized control of health care has everything to do with power, but nothing to do with health care.

We believe in the capacity of our patients to make the right decisions, and we support the rights of our patients to make their own health care decisions. That is why we oppose ObamaCare and support its repeal.

The physicians at Docs 4 Patient Care present a prescription for health care reform that addresses the root causes of the problems that have developed in our health care system over the last 50 years. These reforms relieve the federal government of its role as a health insurance provider, prevent the intrusion of the government in the health care free market, and place patients in control of their own health care decisions.

ObamaCare is the wrong prescription for health care reform. Let's get it right this time.

