

# ASSAULT ON HEALTH FREEDOM

How The Health  
Care Bill Causes  
Government To  
Second Guess  
Private Health  
Care Decisions

By Jonathan W. Emord




The Patient Protection and Affordable Care Act of 2009 (PPACA) was conservatively estimated to add a whopping \$849 billion to the nation's already exploding debt and include provisions that further socialize America's health care system, thus expanding federal involvement and control over what medical care is offered and how it is administered to the American people. The overall effect is to eliminate innovation in medicine, standardize health care and expand bureaucratic control over physician-patient decision-making. In the end, if this bill becomes law it will reduce the quality of care and sacrifice innovation in medicine, including alternative medicine, in favor of a federally authorized one-size fits all approach to care.

At the same time, specific provisions in the bill will ensure that the pharmaceutical industry reaps enormous financial rewards at taxpayers' expense. In short, the Patient Protection and Affordable Care Act of 2009 should be renamed the Patient Neglect and Mediocre Care Act.

Consider its specific provisions and weep. Like Medicare Part D, this bill includes no provision that

permits the federal government to negotiate the price drug companies charge for prescription drugs made available through the prescription drug benefit. It also forbids the government from participating in negotiations between health plans it allows and drug manufacturers, thus freeing the two to adopt measures that increase costs without any check on the increases.



The Center for Medicare and Medicaid Services (CMS) currently presides over all care given, drugs dispensed to, and services provided to Americans aged 65 and older. CMS operates through contract insurance company carriers who administer the program. When a physician sees a Medicare beneficiary, the physician's charges are either assigned directly to Medicare for reimbursement at the rate Medicare prescribes or are charged directly at a government fixed price. When a physician provides a service or drug to a Medicare beneficiary, agents at the insurance carrier (acting as government agents for Medicare) second-guess the physician's actions. The physician may not legally bill a Medicare beneficiary for care that Medicare deems not medically reasonable and necessary, unless the physician opts out of Medicare entirely. Even then, the physician can be charged with Medicare abuse if the patient is given care that Medicare thinks is inappropriate. This system has been severely criticized by physicians and government observers alike because it essentially leads to a one-size-fits-all approach to the provision of health care to the nation's neediest population—senior citizens who depend on health care services more than any other population group. A physician who may think a therapy—not approved by Medicare—is necessary for the welfare of his or her patient cannot give that therapy to a Medicare beneficiary without risking rebuke from the carrier or, most significantly, an audit from Medicare. Medicare

audits, performed by the contract carriers, invariably find fault with a physician's record keeping, provision of care, or non-provision of care and can lead to demands from the government for reimbursement of funds paid. Indeed, often the audit will assess a fraction of a percentage of the physicians' files and will then extrapolate from errors found in that small group to the universe of that physician's Medicare patients. The results can be extraordinary. It is not at all uncommon for \$10,000 in fees said to be inappropriate to be extrapolated to over \$100,000 in money demanded for reimbursement. Even if care was appropriate but documentation confirming the propriety of the care is deemed remiss, Medicare will demand reimbursement. Failure to repay can lead to tax liens and blacklisting on a national database maintained by the federal government.

That awful system is effectively expanded to reach all health care in America under the PPACA. Under its provisions a 15-member Medicare Advisory Board is created and charged with evaluating health care in America to find ways to reduce the cost of medical services and improve the quality of care. If Congress does not act in response to the Medicare Advisory Board's proposals, they become law and bind caregivers.

PPACA creates a new government-run health insurance plan that competes with private health insurance. Because the government

will set rates competitively, they will undermine rates presently set in the private sector and thus draw away from those private plans, causing costs for people remaining in the private plans to increase. The government-run plan has another advantage that private insurers do not, under the bill the government health insurance plan can negotiate directly with hospitals and providers rates for service below those set by Medicare. PPACA creates "health exchanges" at the state level and permits states to unite and form regional exchanges. Thus, it authorizes the states to replicate insurance systems comparable to the federal public option.

An employer that fails to provide health insurance for every employee will be charged \$750 for each such employee. Employee sponsored plans have to meet certain coverage minimums to avoid penalty. The bill adds \$370 billion in new taxes to help offset its costs. The Joint Tax Committee lists the following tax increases affected by the bill:

1. A new 40% excise tax on health coverage in excess of \$8,500 (individuals) / \$23,000 (families). This amounts to a \$149 Billion tax increase. The bill penalizes health plans that provide the best benefits.
2. Additional .5% Medicare (Hospital Insurance) tax on wages in excess of \$200,000 (\$250,000 for joint filers). This amounts to a \$54 Billion tax increase. The bill penalizes wealthy individuals. >>

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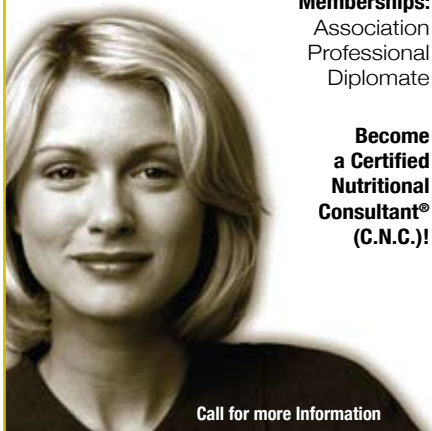
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3. An annual fee on manufacturers and importers of branded drugs. This amounts to a \$22 Billion tax increase.
4. An annual fee on manufacturers and importers of certain medical devices. This amounts to a \$19 Billion tax increase.

In addition, the bill cuts in half (to \$500,000) the amount of an executive's compensation that a health plan can deduct from its corporate income taxes. That constitutes a \$600 million tax increase. The bill also imposes a 5% excise tax on cosmetic surgery and similar procedures. That amounts to a \$6 Billion tax increase.

It is a cardinal rule that you do not raise taxes in a recession. The \$370 billion tax increase will likely increase unemployment and decrease productivity.

Overall, the bill will likely drive out of existence private plans that cannot compete with the public option. It will likely cause employers that cannot afford to provide health insurance to their employees to fire employees and rely on the money saved to pay for the new mandated coverage, thus increasing unemployment. It will increase federal control over the provision of medical care in the United States, promoting a one-size fits all regime everywhere that is comparable to the system now provided seniors under Medicare. It will reduce innovation in medicine and sacrifice quality care in order to reduce the costs of medical services.

The alternative to this highly paternalistic government mandated approach is a free market in health care that requires no taxes, no new massive national bureaucracy and maximizes patient choice.

Instead of this enormously costly government controlled health care system, we could provide freedom from federal income tax for all small to medium sized employers that provided private health care coverage as a benefit to their employees. We could also give individuals credits for reduced taxes equal to the amount they put into medical savings accounts. We could provide comparable tax incentives to hospitals for the provision of free or subsidized care to the indigent and the unemployed. With the success of private initiative in such an environment, we could phase out of existence Medicare.

If we choose to expand socialized medicine in America, we will afford politicians and bureaucrats control over the nature, degree, quality and quantity of care we receive. The present Medicare system fails precisely because the physician cares more about ensuring that Medicare carriers are satisfied than the patients are satisfied. The Health Care Bill would vastly expand this disincentive for quality care by making every patient-physician interaction one where a third invisible person is always in the room: the health care bureaucrat. Neither the economic health of the nation nor the health of the American citizen should be saddled with this horrendous new concoction from Washington. **HK**