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“The Secretary Shall” How the Implementation of the Affordable Care Act Will Affect Doctors

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Introduction

Two years ago, President Barack Obama signed the Affordable Care Act (ACA), a law purportedly designed to increase access to health care and to “bend down” the health care cost curve. The last two years have seen a great debate over the impact and potential impact of that law, especially in the areas of coverage, affordability, and quality of care. Most of the discussion on this topic, though, remains in the speculative realm, as the law is not scheduled to be implemented until 2014, and certain aspects of the implementation will be ongoing until 2019. Furthermore, the law has been subjected to a series of political and legal challenges that have generated uncertainty about the law’s prospects within the health industry and at the state level, where much of the implementation is slated to take place.

Despite these uncertainties, the Department of Health and Human Services (HHS) has begun the long and arduous regulatory process involved in implementing any new law, and has already issued over 12,000 pages of regulations elaborating on the original 2,700-page law.¹ More pages are of course expected to follow, but the initial wave of implementing regulations has already given us an insight into how the new law will impact one of the most crucial actors in any health reform effort: doctors.

There are over 850,000 physicians in the United States, and they play a crucial role in the administration of health care as caregivers, patient counselors, administrators, and policymakers. There are eighteen physicians in the Congressional GOP Doctors Caucus alone. As research scientists, doctors are in the front lines of identifying diseases and potential cures. Moreover, they hold a special status in the minds of the public. According to a recent report in *National Journal*, even in this era of tremendous cynicism and distrust, the American people continue to place great faith in doctors, giving them high marks on ethical standards and trustworthiness.²

¹ Chris Jacobs, “Obamacare Creating Thousands of Jobs. For Bureaucrats.” Senate Joint Economic Committee, April 17, 2012.

² Margot Sanger-Katz, “Why Do We Trust Doctors?” *National Journal*, April 26, 2012, <http://www.nationaljournal.com/features/restoration-calls/why-do-we-trust-doctors--20120426>.

The attitude of the medical profession toward the ACA and the statements and actions of individual doctors as the law begins to be implemented will therefore bear great weight in the minds of the public.³

For this reason, it is worth examining how the health law will affect doctors and their participation in the system, paying special attention to the views and reactions of doctors themselves. A full summary of the new health law would take many more pages than available for this paper,⁴ but the broad strokes are as follows.

The Obama health law would:

- Cover 32 million additional Americans—16 million via Medicaid;
- Increase regulation of insurers, including coverage requirements for individuals and mandates on services;
- Create a mandate requiring individuals to purchase insurance; and
- Create new Health Insurance Exchanges in which individuals not covered by employer-sponsored insurance will purchase policies.

Funding for the \$800+ billion cost of the ACA will come mainly via new taxes and Medicare reductions. While this list gives a sense of what the law is trying to accomplish, it does not really convey the ways in which the law will actually operate, and particularly how the law would affect physicians. This is because the implementation process creates a great deal of discretion for appointed and career federal officials to determine the exact shape of the law's final requirements. The word "secretary" appears nearly 3,000 times in the 2,700 page bill, most frequently referring to regulatory implementation requirements that will have to be undertaken by the HHS Secretary (currently Kathleen Sebelius) and appointed or career staff. As former

³ Although the American Medical Association (AMA) publicly declared its support for the ACA, many individual doctors disagree, as this paper will demonstrate.

⁴ A full summary is available at <http://www.kff.org/healthreform/upload/8061.pdf>.

HHS Secretary Michael O. Leavitt said of the new law, “It puts more power than is prudent in the hands of one person, and it is not an answer to our national health-care crisis.”⁵

According to the Robert Wood Johnson Foundation initiative *Changes in Health Care Financing & Organization*, a representative list of “The Secretary shall...” requirements includes the requirements that the Secretary:

- Promulgate regulations defining the young adults who can now remain under their parents’ insurance policies;
- Develop standards for use by insurers in compiling and providing information for enrollees that accurately describe benefits and coverage;
- Develop reporting requirements, in consultation with quality experts, for use by insurers with respect to benefits and provider reimbursement structures that improve health outcomes, prevent readmissions, improve patient safety, and implement wellness and health promotion activities;
- Collect and make publicly available reports of insurers’ minimum loss ratios and adjust the ratios to avoid destabilization of the individual insurance market;
- Establish a process for an annual review of unreasonable increases in premiums for health insurance coverage; and
- Establish, in consultation with the states, a mechanism, including a website, through which individuals may identify affordable health insurance options within their state; and develop a standardized format for the presentation of coverage option information to individuals.⁶

Incredibly, the bill’s powers are not limited to the broad macroeconomic issues described above. They also regulate a wide range of medical areas in minute detail, extending their reach even to one of the most personal arenas: the dentist’s chair. Section 4102 of the ACA, for example, states: “The secretary shall develop oral healthcare components that shall include tooth-level surveillance.” As Secretary Leavitt describes it, the mandate for tooth-level surveillance would

⁵ Michael O. Leavitt, “Health reform’s central flaw: Too much power in one office,” *Washington Post*, February 18, 2011, <http://www.washingtonpost.com/wp-dyn/content/article/2011/02/17/AR2011021705824.html>.

⁶ “‘The Secretary Shall....’: The Challenge of Implementing Health Reform’s Affordability Provisions,” *Changes in Health Care Financing & Organization*, April 2010, <http://www.hcfo.org/publications/%E2%80%9C-secretary-shall%E2%80%A6%E2%80%9D-challenge-implementing-health-reform%E2%80%99s-affordability-provisions>.

require “a clinical examination in which an examiner looks at each dental surface, on each tooth in the mouth.”⁷

The above sample is only a tiny percentage of all of the areas in which HHS has discretion under the new law. This discretion leads to additional uncertainty, beyond the political uncertainty about whether the law will indeed be implemented. There is already considerable evidence that doctors are nervous how the ACA will affect their incomes, their access to technologies, and their ability to practice medicine. According to a survey by the Doctors Company, sixty percent of physicians felt that the health care law will have a negative impact on overall patient care. Only twenty-two percent were optimistic in this regard. Furthermore, fifty-one percent felt that the law would have a negative impact on their relationships with their patients.⁸ In addition, a survey by the Physicians Foundation found that fifty-seven percent of young doctors are pessimistic about the future of health care, and thirty-four percent of them attribute their gloominess to the ACA.⁹ These troublesome numbers raise questions about how and whether doctors will participate in the new system.

Nature of Physician Concerns

Perception affects reality, and so if doctors feel that the Affordable Care Act will harm them and their ability to interact with patients, that will be problematic for the doctors, the patients who trust and rely on them, and the system as a whole. But reality shapes reality as well, and the more important question than that of physician concerns is that of the reality of what the ACA will do. Doctors want to know which areas of the bill are most likely to affect them and which aspects of

⁷ Michael O. Leavitt, “Health reform’s central flaw: Too much power in one office.”

⁸ “The Future of Health Care: A National Survey of Physicians,” Survey by The Doctors Company, February 29, 2012, http://www.thedoctors.com/ecm/groups/public/@tdc/@web/documents/web_content/con_id_004676.pdf?utm_source=Newsletter&utm_medium=Email;utm_campaign=FHCP.

⁹ Anna Yukhananov, “Next generation of doctors sees gloomy future,” Reuters, April 11, 2012, <http://www.reuters.com/article/2012/04/11/us-usa-health-survey-idUSBRE83A0ZH20120411>.

their practices the new law will affect. The answers to these questions will determine whether the concerns demonstrated in opinion surveys will change as the law is implemented, or whether they will harden or even worsen in the months ahead. The answers to these questions, especially from analysts who share the physician perspective, will also provide insight into the next key issue: if doctor concerns are indeed justified, what will be their likely response to the implementation of the new health care law?

1. Reimbursement

Doctors, like most people, tend to be economically rational actors. There is of course a certain altruism involved in the decision to become a care-giving actor, but economic elements will always play a key role in the decision-making process. From the economic perspective, doctors' top concern raised by the Obama health care law is in the area of reimbursement rates. The reimbursement question usually centers on the Sustainable Growth Rate (SGR). The proposed cut in reimbursements would hit doctors hard, imposing initial cuts of over twenty percent.¹⁰

Without going into its long and complicated history, the SGR is an expected rate cut that the Centers for Medicare and Medicaid Services is by law supposed to impose on doctors in order to get Medicare spending under control. Because of the likelihood that doctors would balk if the SGR were to go into effect, Congress—which created the SGR in the first place—undoes the SGR every year so that doctors will not have to experience the cut. This annual legislative dance, known as the “doc fix,” gets more expensive and more difficult each year because the SGR is built into the budget baseline. Congress, in other words, counts on the SGR savings in its long-term budget prognostications while at the same time knowing that it will not realize those savings.

¹⁰ Robert Moffit, “Obamacare and its Impact on Doctors,” *Wall Street Journal*, June 19, 2010, <http://online.wsj.com/article/SB10001424052748704122904575315213525018390.html>. (Note: article originally appeared in *Physicians News Digest*).

This problem gets more difficult because the “doc fix” has to be paid for, which means that the savings must come from somewhere, and the Obama health law has reduced the number of options for finding additional budgetary savings. This means that the Obama health law has made fixing the SGR even more difficult than it has been in the past, something doctors recognize and do not appreciate.

Even President Obama’s top aides and advocates for his health care plan recognize that the reimbursement question is a serious issue for doctors. In a 2010 article for the *Annals of Internal Medicine* that touts the Obama health law and its impact on physicians, three administration architects of the plan, Nancy-Ann DeParle, Dr. Ezekiel Emanuel, and Dr. Robert Kocher, acknowledge the uphill battle the administration faces in selling its new law to the physician community: “The uncertainty surrounding the sustainable growth rate policy is a distraction and potentially a barrier for some physicians to embrace the Affordable Care Act.”¹¹

In addition to the “distraction” of the SGR, there is also the issue of the growing Medicaid rolls. While the Obama health law will cover an additional 32 million Americans, 16 million of those newly covered Americans will get their coverage through Medicaid, according to the Congressional Budget Office. Doctors are well aware that Medicaid reimbursement rates are lower than those they get from privately insured patients. In fact, according to Moffitt, “physicians in Medicaid are paid 56 percent of private payment.” This reduced reimbursement rate is the reason that Medicaid patients often have difficulty finding a doctor. Imposing these lower reimbursement rates on a growing number of patients will likely have the impact of exacerbating access issues in the future.¹²

¹¹ Robert Kocher, Ezekiel J. Emanuel, Nancy-Ann M. DeParle, “The Affordable Care Act and the Future of Clinical Medicine: The Opportunities and Challenges,” *Annals of Internal Medicine*, August 23, 2010, <http://www.annals.org/content/early/2010/08/23/0003-4819-153-8-201010190-00274.1.full>.

¹² Moffitt, “Obamacare and its Impact on Doctors.”

2. Practice of Medicine

Beyond economic issues, physicians worry that the new law will interfere with their practice of medicine, and in a variety of ways. To begin with, there is a generalized concern about decision making being taken from doctors and having medical decisions made instead by government officials. Doctors worry about the imposition of “uniformity of practice,” the establishment of strict guidelines that fail to permit individual doctors to make decisions based on their in-person interactions with patients. As Dr. Saul Greenfield writes in the *Wall Street Journal*, “every physician must, at some point in the patient-care process, make decisions and take responsibility for them. And unless the doctor does so, the outcomes will be compromised.”¹³ While the fear of practicing medicine by committee is a long-standing concern among doctors, there are a number of provisions in the new health law that bring the prospect of committee-based medicine much closer to reality.

The main concern on this front has been the IPAB, or the Independent Payment Advisory Board. This fifteen-person board, selected by the President and confirmed by the Senate, will be charged with trying to control Medicare spending by making payment and practice decisions. This approach, which will make government decisions that are in almost all cases not then subject to Congressional oversight, has many doctors extremely nervous. As Drs. Jason Fodeman and David Gratzner describe it, “This unelected body will have the unprecedented ability to single-handedly change the allocation of health care resources should Medicare spending exceed medical inflation—which, for the record, it consistently does. IPAB’s recommendations, incidentally, are beyond congressional reach unless overturned by a supermajority of Congress.”¹⁴

¹³ Saul Greenfield, “In Defense of Physician Autonomy,” *Wall Street Journal*, September 7, 2010.

¹⁴ Dr. Jason Fodeman and Dr. David Gratzner, “Obamacare: One year later. Stripping patients and doctors of authority over care,” *The Washington Times*, March 22, 2011, <http://www.washingtontimes.com/news/2011/mar/22/obamacare-one-year-later-98975456/print/>.

A related worry is in the area of comparative effectiveness research (CER). President Obama famously described his view of CER's potential in July 2009 when he said: "If there's a blue pill and a red pill, and the blue pill is half the price of the red pill and works just as well, why not pay half price for the thing that's going to make you well?" A host of commentators have explained that this description vastly oversimplifies an enormously complex endeavor. Still, the Obama administration remains committed to pursuing CER and dedicated over \$1.1 billion to this type of research in the 2009 stimulus bill. The concern with CER is that it could lead to hard and fast rules dictating the practice of medicine, thereby limiting doctors' ability to practice as they see fit. A similar concept, that of Least Costly Alternative (LCA), could have a similar impact, although thus far the courts have limited the ability of the Centers for Medicare and Medicaid Services (CMS) to employ LCA. Still, MedPAC—the Medicare Payment Advisory Commission—often looks at LCA as a means for cost controls, and the new law's cost will increase the need for cost controls. Such a policy would not only affect physician choice, but also perhaps limit access to newer technologies. As noted, the courts have thus far blocked this approach, but the potential for its employment remains another consideration for physicians in making decisions about their future.

Another common concern stems from the ACA's creation of Accountable Care Organizations (ACOs). ACOs aim to depart from the strict fee-for-service model that does drive up costs, and try to use the concept of bundling payments as a way of getting costs under control. It is a concept that has had bipartisan support in the past, and is seen by many as a promising path forward. Unfortunately, HHS's first attempt at writing this rule was so restrictive that it put medical institutions at risk of losing money if they participated and failed to gain the anticipated savings. This and other restrictions scared off medical institutions, and, according to *Politico's* Lester Feder, "the 10 medical groups participating in a Medicare pilot program that paved the way for the ACO program declared that none would participate if the rule were not substantially modified."¹⁵

¹⁵ J. Lester Feder, "Health Reform Rule Spooks Providers," *Politico*, May 24, 2011, <http://dyn.politico.com/printstory.cfm?uuid=5BF19DDC-13F3-41A1-9AAD-B5C0E8E1CC16>.

After this poor uptake, the administration then rewrote the rule in a way that increased participation to some degree. Still, many physicians remain understandably skeptical about participation because of the way in which HHS initially approached the issue, as well as the still-imperfect nature of the revised version. As Sarah Kliff reports in the *Washington Post*, even with the new rule, willing participants “report little change in how they deliver care: The ones who felt confident enough to participate were already delivering integrated care and, with the start-up costs of administering the program, are not certain they’ll see significant savings.”¹⁶

ACOs and the IPAB have received most of the attention when it comes to new institutions that will impact the practice of medicine, but they are far from the only ones. According to a report by Senators Tom Coburn and John Barrasso, both physicians, the \$10 billion Center for Medicare and Medicaid Innovation is another source of worry for doctors. The report, which cites a Congressional Research Service memo to Coburn, demonstrates that the legislation authorizing the center gives the HHS Secretary and the CMS administrator enormous power not only to experiment with new payment and delivery systems, but also to impose the results of the experiments without external checks on those results.

Coburn and Barrasso note that CRS found “no references in [the law] to any external reviews or checks on the CMS” in evaluating the results of their experiments. Not only will patients lack judicial and administrative review if they object to the center’s demonstration projects, but doctors will as well. According to Coburn and Barrasso, “health care providers are also legally prohibited from contesting the Secretary of Health and Human Services’ (HHS) use of new payment models.” The Center for Medicare and Medicaid Innovation appears to be one more way in which the healthcare law will interfere with the practice of medicine.¹⁷

¹⁶ Sarah Kliff, “Why the Business of Health Care Will Never Be the Same,” *The Washington Post*, March 25, 2012, http://www.washingtonpost.com/blogs/ezra-klein/post/health-reform-at-2-why-american-health-care-will-never-be-the-same/2012/03/22/gIQA7ssUVS_blog.html#pagebreak.

¹⁷ “Warning: Side Effects,” report by Senators Tom Coburn and John Barrasso, March 20, 2012, http://www.coburn.senate.gov/public/index.cfm?a=Files.Serve&File_id=98be1143-f556-469d-91af-4213946fcf2f.

Impact: How Doctors Will React

Interfering with the way that doctors practice can potentially have an even bigger impact than economic questions on doctor participation and satisfaction. If doctors cannot practice as they wish, it raises the question of whether they will practice. As Dr. Mark Siegel has noted, because of the anticipated changes in health care, “To stay in business under ObamaCare, doctors will have to adjust. Some will see fewer patients themselves and hire nurse practitioners to help carry the load; others will work part-time and supplement their income elsewhere. Many will join groups or become salaried employees of hospitals or clinics.” As problematic as these scenarios are, Siegel is most pessimistic about the fate of lone practitioners, whom he suggests “are going to become harder and harder to find, at least, ones who’ll take your insurance.” Many of them, he predicts, “will join the growing group of ‘boutique’ doctors who’ll only see patients who pay cash up front.” While the relatively small number of patients of those boutique doctors may be pleased with the service, large numbers of doctors opting out of insurance will only exacerbate the access challenge faced by everyone else.¹⁸

Another factor driving doctors to change their behavior is the increased complexity of practice under the new law. The ACA will introduce a much greater level of legal compliance responsibilities, increasing the difficulty and expense of maintaining a private practice. The drive to provide quality care for more patients, at less expense but with more paperwork, will make practice much more burdensome for all physicians, especially those in private practice. Decreased reimbursements for the same services will make private practices less financially viable. Not surprisingly, a recent survey of over 2,400 physicians found that nearly eighty percent believe the reform will “erode the viability of the private practice model,” with twenty-

¹⁸ Marc K. Siegel, “ObamaCare: Flight of the MDs,” *New York Post*, December 10, 2010, http://www.nypost.com/f/print/news/opinion/opedcolumnists/obamacare_flight_of_the_mds_2zWYU1R9DYG4K6dJ8oj8gP.

eight percent reporting they believed the private practice model was “a dinosaur soon to go extinct.”¹⁹

Signs of this trend are already visible. Recent reports by the consulting firm Accenture found that doctors are increasingly backing away from individual practices and are joining larger groups, particularly hospitals, which have both more leverage with insurers as well as more staff to handle the increasing paperwork burdens. As a result, the percentage of doctors owning their own practices is dropping, and expected to continue dropping, from almost half in 2005, to forty-three percent in 2009, and to a projected one-third in 2013.²⁰ This is exactly the kind of trend Senator-physicians Tom Coburn and John Barrasso warned against in March 2010, predicting that the Obama health law, as a result of its complexity and attempted cost-savings, “could accelerate the trend of physicians leaving private practice to work in a centralized hospital setting.”²¹

Leaving private practices is one problem, but at least the doctors would still be practicing. A further concern is whether certain doctors would practice at all under the bureaucratic constraints and rejiggered economics of the new law, or if enough would continue to practice to meet the increased demands of the new health law, especially since we are already facing a looming physician shortage. As the Association of American Medical Colleges has noted, by 2020 we will already need an additional 91,500 more than we are currently projected to have—45,000 from primary care and 46,500 surgeons and specialists.²² While of course the AAMC has an

¹⁹ “Health Reform and the Decline of Physician Private Practice,” The Physicians Foundation, Oct. 2010, <http://www.physiciansfoundation.org/uploadedFiles/Health%20Reform%20and%20the%20Decline%20of%20Physician%20Private%20Practice.pdf>.

²⁰ “Physician Employment Trends Will Force Payers, Hospitals and Vendors to Revise Business Strategies, According to Accenture Survey,” Accenture study, June 13, 2011, http://newsroom.accenture.com/article_display.cfm?article_id=5220.

²¹ Tom Coburn and John Barrasso, “Grim Diagnosis,” October 26, 2010, 5, http://barrasso.senate.gov/public_files/FinalGrim.pdf.

²² Association of American Medical Colleges Fact Sheet: “Physician Shortages to Worsen Without Increases in Residency Training,” https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf.

interest in promoting the idea of physician shortages, their study shows the mentality of many in the medical field. Reports by the American Academy of Family Physicians (AAFP) came to similar conclusions, foreseeing a shortage of nearly 40,000 family physicians by 2020.²³ Other predictions are even more dire, with estimates of the shortage reaching 200,000 within the next eight years.²⁴

In addition to the question of practicing, there is the question of how doctors will practice. Will they create new pathways for cures, or will strict guidelines stifle their creativity? Another motivation for doctors, which can result in financial reward as well as the altruistic satisfaction of advancing medicine, is the ability to help in the innovation process. Doctors serve at the intersection of research and practice, and provide valuable feedback and guidance to life science companies about both products and needs. Doctors have also been known to invent a variety of products as well, from off-label uses to glidescopes and new vascular catheters. Unfortunately, the alphabet soup of governmental or quasi-governmental groups and approaches created by the Obama health law—including ACOs, IPAB, LCA, and CER—increases the concerns of government interference with innovation. These restrictive initiatives could not only affect the development of medical technology, they could also deprive doctors themselves of the freedom needed to create new products.

²³ Janice Lloyd, "Doctor Shortage Looms as Primary Care Loses Its Pull," *USA Today*, August 18, 2009, http://www.usatoday.com/news/health/2009-08-17-doctor-gp-shortage_N.htm.

²⁴ Dennis Cauchon, "Medical Miscalculation Creates Doctor Shortage," *USA Today*, March 2, 2005, http://www.usatoday.com/news/health/2005-03-02-doctor-shortage_x.htm.

Conclusion

As the implementation of the Obama health law continues, the ways in which the Obama Department of Health and Human Services interprets the law will have far-reaching implications for the supply, practice structure, and flexibility of physicians for many years. As this paper shows, a significant number of physicians themselves are extremely concerned about these implications, and both perception and reality will shape how doctors practice medicine in the years to come. Many of these changes, while worrisome, are predictable, and government officials and health care administrators alike can make certain adjustments to prepare for the expected consequences. Many others, however, are less predictable, and it is unrealistic to expect officials to be able to react to them. The unknowables include the possibility that the supply of doctors cannot meet the demand, or that dedicated professionals may lose the incentive or flexibility to create new cures, or that talented individuals choose not to pursue medical training at all. If these outcomes occur, we may never know what the ultimate consequences might be, and who will be left waiting for the treatment or the cure that never comes.

About the Author:

Tevi Troy is a Senior Fellow at Hudson Institute, and a writer and consultant on health care and domestic policy, whose commentary has appeared in major media outlets including the *Washington Post*, *Wall Street Journal*, *Commentary*, *National Affairs*, *Politico*, *National Review*, and *The Weekly Standard*. He is also a frequent commentator on outlets such as CNN, Fox News, PBS' NewsHour, and the Bill Bennett Radio Show. Troy is the author of *Intellectuals and the American Presidency: Philosophers, Jesters, or Technicians* (Rowman & Littlefield).

In 2007, he was unanimously confirmed by the U.S. Senate as the Deputy Secretary of the U.S. Department of Health and Human Services. As Deputy Secretary, Troy was the chief operating officer of the largest civilian department in the federal government, with a budget of \$716 billion and over 67,000 employees. In that position, he oversaw all operations, including Medicare, Medicaid, public health, medical research, food and drug safety, welfare, child and family services, disease prevention, and mental health services. He served as the regulatory Policy Officer for HHS, overseeing the development and approval of all HHS regulations and significant guidance. In addition, he led a number of initiatives at HHS, including implementing the President's Management Agenda, combating bio-terrorism, and public health emergency preparedness. He also sponsored a series of key conferences on improving HHS' role with respect to innovation in the pharmaceutical, biomedical, and medical device industries. Troy has led U.S. government delegations to Asia, the Middle East, Europe, North America, and Africa.

Troy has held numerous other high-level positions, including Deputy Assistant and Acting Assistant to the President for Domestic Policy, Deputy Assistant Secretary for Policy at the Department of Labor, Policy Director for Senator John Ashcroft, and Domestic Policy Director for the House Policy Committee.

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