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Health Wonk Review Review: PPACA 2.0, 3.0, and 4.0?

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Health-care bloggers spent this edition of Health Wonk Review delving into a number of the issues that PPACA attempted to address, along with the new problems it has created. The blogosphere has its work cut out.

Jaan Sidorov of the Disease Management Care Blog hosted this fortnight's HWR. Jaan's work is worth checking out, if you're interested in delving into the weeds of health policy research. He has a nice piece out this week on correcting the misleading record on the relationship between illnesses and bankruptcies.

Maggie Mahar, in part 2 of her rebuttal to Michael Tanner's lengthy critique of Obamacare, takes on the individual mandate. She cites a paper by a third-year Seton Hall law student that argues that the Uniform Militia Act of 1792, enacted under President Washington, serves as precedent for the mandate. That law "made militia service compulsory for every white, able-bodied male citizen between 18 and 45." Bradley Latino, the Seton Hall scholar, argues that the 1792 act is "indistinguishable" from the Obamacare individual mandate in terms of the Fifth Amendment. However, as Latino points out later in his blog post, there may be other constitutional issues for which this defense won't suffice. But that's no matter to Mahar: "I would argue that leaving 32 million Americans uninsured 'threatens' our economy and our society, just as surely as an attack from abroad." It's a good thing that Mahar's comparison is currently imaginary.

So far, I've been disappointed in Mahar's response to the Cato paper. Her arguments haven't lived up to her abilities, and she hasn't covered the most substantive topics. Hopefully she'll get there.

Our old friend Austin Frakt at the Incidental Economist has reposted his piece defending the individual mandate in Massachusetts. "The mandate is working," says Frakt. "The results seen in the state imply that little gaming should be expected nationally." Michael Cannon wrote two excellent pieces on this topic, in rebuttal, last month. In particular, Cannon challenges the statistic that only 2.6% of Massachusetts residents are now uninsured. Cannon cites a separate study, that he coauthored, that show that at least another 2.5% of state residents appear to be *concealing* their lack of insurance so as to avoid the fine, doubling the number of uninsured. As the 2.6% number assumes that nobody is gaming the system by hiding their lack of insurance,

claiming that 97.3% of state residents are insured is at best "an upper-bound estimate." I would love to see Austin take a look at the Yelowitz/Cannon paper and share his thoughts.

Those who believe that PPACA will actually bring down health costs often point to its pilot programs that encourage doctors and hospitals to reorganize in smarter, more efficient ways, like in Accountable Care Organizations (ACOs). After reviewing the relevant studies, Bran Flansbaum of the Hospitalist Leader pours some cold water on these hopes. "Invariably though, as the group [of studies] tumbles the weeds, so many obstacles, stumbling blocks, and intangibles begin to crop up, that before you know it, you are not discussing ACO's but wholesale payment, delivery, provider, and patient reform. In short PPACA 2.0, 3.0, and 4.0. Think I am kidding? Just ask a group of hospitalists."

Brad Wright, of Wright on Health, pointed out that reducing inappropriate use of emergency rooms was a key justification for PPACA. The President said, in his September 2009 speech to Congress, "those of us with health insurance are also paying a hidden and growing tax for those without it—about $1,000 per year that pays for somebody else's emergency room and charitable care." But Wright says, "there's just one problem: it doesn't work that way. Opponents of health reform who suggested…that universal coverage would lead to long waiting lines were somewhat correct. It isn't likely that the change will be very noticeable at your physician's office, but it is very likely in the ER waiting room…Waiting to be seen in the ER is no picnic, but for many people it is a more easily understood process than trying to get a referral to a specialist from their primary care physician—assuming that they even have one."

Timothy Jost points out in the *Health Affairs Blog* what readers of this blog already know: that the temporary high-risk pools set up by PPACA are significantly underfunded and, in that sense, doomed to fail.

Bob Vineyard of InsureBlog checks out Obamacare's new website, Healthcare.gov. Vineyard writes that the site asks you a large number of intrusive questions: "The site will not let you progress until you answer every question. At first the questions seem non-threatening but gradually become more personal…I will let you decide if you really want to share this much information with big brother." If you do move forward with Healthcare.gov, you'll find at the end of the rainbow a pot of coal: "When you click on a carrier link you are offered a very brief description of plans that are readily available in the market either direct from health insurance companies or through an insurance broker. The difference here is, if you want rates you have to come back in October. There are no rates available at this time on the government site. So you have given the government all this personal information only to find there are no answers. I don't know about you, but this just makes me feel used."

Julie Ferguson of Workers' Comp Insider writes that, given that insurers pay for employees' health costs in our odd system, employers are incentivized to discriminate against hiring the unhealthy—and indeed it could be argued that they have a responsibility to their existing stakeholders to do so. She also points out that this is yet another reason that more and more insurers will eat the federal fine and dump their employee insurance plans into the new, subsidized exchanges.

An anonymous Canadian pre-med who edits the Notwithstanding Blog writes about a *New York Times op-ed* about the decline in pediatric subspecialists. He wonders whether this is being caused by the expansion of Medicaid and S-CHIP into this population, given that Medicaid and S-CHIP drastically underpay physicians. Dean Schraufnagel, president of the American Thoracic Society, confirms his suspicion.

Richard Fogoros (a.k.a. "Dr. Rich") of the excellent Covert Rationing Blog, has penned a four part series on "Why Big Health Insurance Supported Obamacare," including audio podcasts. He points out that insurers will become heavily subsidized by all the new customers that Obamacare forces up on them. He notes that, as that system breaks down, insurers are likely to be either abolished or regulated as utilities (more than they already are).

The always-excellent John Goodman points out that the vast majority of innovation in health-care delivery in the United States is taking place in the most free-market portion of the population: those who pay out of pocket for their health care. Walk-in clinics, telephone and e-mail consultations, mail-order pharmaceuticals, Wal-mart's $4-a-month price for generic drugs, and concierge doctors are all coming out of the out-of-pocket system. Procedures that are not reimbursed by insurance, such as LASIK and cosmetic surgery, have enjoyed improved technology and lower prices for the same reason.

David Williams of the Health Business Blog discusses walk-in clinics in more detail, in the context of the reported decrease in doctor visits and the corresponding big jump in "MinuteClinic" volumes – those clinics you've seen at pharmacies like CVS to take care of minor issues and checkups. "It's hard to get people out of their established…relationship with their own doctor," Williams points out, but over time these things are changing, because wait times for appointments are increasing, and co-pays and deductibles are going up. To me, this is an interesting development, one that echoes comments by Kaiser Family Foundation President Drew Altman, that conservatives are "winning" because the cost-saving measures they seek are being adopted out of necessity, rather than choice, as the cost of traditional health insurance continues to increase.

Roy Poses, at Health Care Renewal, points out that the CEOs of non-profit hospitals make *beacoup d'argent*. Those who are ideologically opposed to for-profit institutions should be aware that non-profits know how to make money too: the only difference is that they put those profits in their bank accounts instead of distributing them to their shareholders.

Rich Elmore, at Healthcare Technology News, delves into the ins and outs of comparative effectiveness research. CER is supposed to run large clinical trials to see if some drugs or treatments outperform others, and adjust Medicare and Medicaid reimbursement accordingly. While many conservatives see this as a foot-in-the-door for drug price controls, I actually welcome it: well-conducted comparative effectiveness studies will improve the practice of medicine. Elmore, for his part, points out that executing on comparative effective research is a lot harder than it looks. Taking the example of rotator cuff surgery, "only limited conclusions can be reached—certainly not sufficient for the thousands of patients making decisions."

And, as we get to the end of a long HWRR, one idea for improving the training of medical students in end-of-life care would be to require them to attend geriatrics clerkships. Chris Langston of Health Agenda looks at a Canadian study that suggests there may be something to this idea. But: "The study also showed that attitude toward older people became more negative across the board." Why is that? "The patients are too big a share of practice to give up, yet the comprehensive, person-centered care that complex older people need is exactly what the health care system," i.e., Medicare, "is not designed to do well."