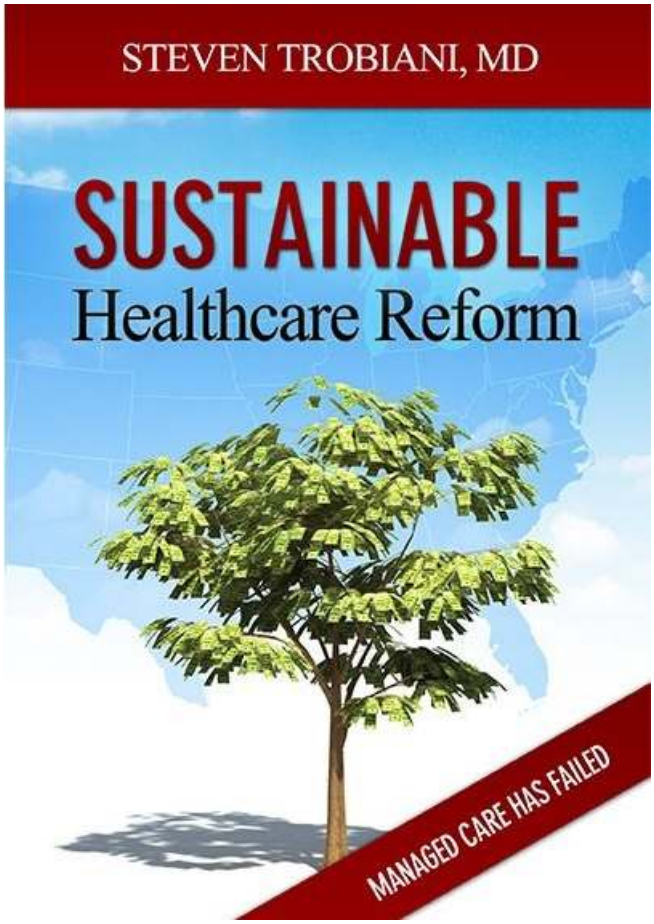

Sustainable Healthcare Reform:
Harnessing the Power of Capitalism to Fund our Social Needs

By

Steven Trobiani, M.D.

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Introduction

A Divisive Subject

On March 23, 2010 President Barak Obama signed into law The Patient Protection and Affordable Care Act providing health coverage for the uninsured while making sweeping changes to existing healthcare programs. If we were living in a democracy, this law would never have come to pass. Polls of American voters taken during the time in which the legislation was being debated showed overwhelming opposition to enactment of the legislation, with 85% opposed to passage of the bill.

We, however, do not live in a democracy. We live under a republic and, in a republic, our elected leaders are free to vote in accordance with their beliefs, and those beliefs may

not necessarily reflect the will of the populace that they represent. Depending on the point of view taken, this may be viewed as either a strength or a weakness in our system. Whichever it is, our system of government does offer one recourse. If the actions of our representatives are sufficiently unpopular, those representatives can be replaced by popular vote at the next election. This did happen in the 2010 mid-term elections in which the Democratic Party lost more seats in Congress than any party had in 70 years.

The healthcare debate in the United States is not, however, about the country's political process. Though congressional approval ratings are in the single digits and at an all time low, the population's disapproval is misdirected. As a republic, our political process is healthy as demonstrated by the 2010 mid-term elections. We can and do change the choices our political leaders make when those choices are not consistent with our wishes. Candidates and political pundits need not talk about changing our political process; that process is sound. The healthcare debate, instead, should be about the economic identity of our nation and we, as a country, are suffering from an identity crisis.

Our founding fathers in framing the United States Constitution established our form of government but did not set laws regulating the nature of the U.S. economy. They left us, the people, free to choose our path to economic success. They were wise to do so. Economies, unlike governments, need to adapt to changing times.

At its inception, the United States was largely an agrarian economy. Slavery was common as, morality aside, it was beneficial in an agrarian economy. Our founding fathers, even though philosophically conflicted over the ethics of slavery, maintained slaves on their plantations as a matter of economic necessity.

With the dawn of the Industrial Revolution in the 1800s, the economy shifted to a capitalist economy. The abolition of slavery in the industrialized North was consequently as much driven by economic policy as it was by a humanitarian one. It was simply cheaper to pay a man low wages for a day's work than it was to provide food, clothing and shelter to that man and his family as slaves. Following the Civil War, slavery was abolished in the agrarian South as well. With freedom no longer an issue, the attention of the masses turned to the concept of fairness in the wages being paid.

Labor movements characterized the social upheaval of the early 1900s, culminating in the elimination of the last remaining ruling monarchies in Europe and the establishment of Communism in Russia in 1917. Socialism, as a hybrid between capitalism and communism, evolved as the economic framework across most of Europe and throughout the United States to quell the political unrest associated with these labor movements.

However, socialism and capitalism mix about as well as oil and water.
At its core, capitalism is about the rights and efforts of individuals within a society. The role of government in a capitalist economy is to protect the rights of individuals and foster the ability of individuals to prosper in accordance with their efforts and abilities. The essence of socialism is collectivism. The rights of individuals are subordinated to the needs of society. Those who have more have an obligation to provide for those who have less. The role of government is to enforce that obligation.

These philosophies are incompatible and the effort to fuse them over the last century has crippled the progress of capitalism. It is the reason why Standard & Poor's has downgraded the credit ratings of the United States, France, Italy and Spain. It is the reason why Greece has become insolvent. It is the reason why the world today is

teetering on the brink of an economic meltdown as nation after nation spends more on social programs than it has the means to afford.

The conflict between capitalism and socialism is not, as the socialists within our government would have us believe, about business versus unions, employers versus employees. Collective bargaining, with or without unions, is a part of capitalism. Employers have no inherent right to impose artificially low wages on their employees. Doing so violates the right of each and every employee to prosper in accordance with his or her individual effort and ability, which is the basic premise of capitalism. Employees have the right to negotiate contracts with their employers and capitalism as an economic model ceases to perform at its best when that right is impeded.

Socialism is not about earned wages and benefits. Rather, it is about the redistribution of wealth from those whose efforts and abilities have allowed them to prosper to those who have not. It is about power acquired by pandering to a public unwilling to provide for itself. It is about the expansion of government to provide an ever enlarging array of products and services to a population that has not earned them. It is about interference with free market dynamics to essentially enslave one segment of the population to serve the needs of the rest.

Healthcare has been caught in the crossfire between capitalism and socialism since 1945. In framing the rhetoric for debates on the subject, socialists have focused on the concept of healthcare as a basic right. In fact, healthcare has so frequently been described as a basic right to citizens of developed countries that this characterization as a “right” is beginning to pass as an established fact. Some would almost have us believe that the framers of the United States constitution established healthcare in addition to life, liberty,

and the pursuit of happiness as one of the inalienable rights of U.S. citizens. Nothing could be further from the truth.

Basic rights are elemental. They are intrinsic to the human spirit. As such, basic rights carry three essential characteristics. First, a basic right cannot require a product or service to be provided by another human being as nothing intrinsic to the human spirit can be dependent on an extrinsic source. Second, a basic right cannot be taken from a citizen without just cause. Finally, a basic right cannot violate another basic right. Thus, because life is a basic right, we cannot be deprived of life without just cause. However, the need for food, clothing and shelter to sustain life does not endow us with the right to simply seize the food, clothing and shelter that we may need since doing so would violate the rights of those who possess the food, clothing and shelter we seized. In fact, no product or service provided by another human being can be validly characterized as a right as doing so would inevitably enslave the provider of the product or service and therefore deprive that human being of the basic right of liberty without just cause. Since healthcare cannot be provided to any individual without the services of other human beings, healthcare cannot be a right.

So, if healthcare is not a right, what is it? Most everyone would agree that there exists a basic need for healthcare. In meeting that need, healthcare qualifies as a **benefit**. So, in framing the healthcare debate in this country, it is not appropriate to insist that our citizens have a right to a government provided healthcare program to meet their needs but, rather, how do we best provide a benefit to our population. As with most benefits, there is no one-size-fits-all approach. As a result, the argument over how to best provide this particular benefit has been contentious.

Few issues have, in fact, stirred more heated argument or so firmly polarized proponents and opponents of socialism and capitalism as healthcare. It is not difficult to understand why. Healthcare is a topic that affects us all. At some point in time regardless of age, sex, race and financial status we all will encounter a need for healthcare. It is, consequently, along with food, shelter, and clothing, a universal need.

This universal need for healthcare has led to the development of programs to expand the access to healthcare. The first such movement occurred in the 1940s as the labor unions negotiated healthcare benefits for union members and their families as part of the payment due them from their employers and successfully lobbied the federal government to exempt those healthcare benefits from taxation. This eliminated the barrier to the access to healthcare for hundreds of thousands of Americans as employers across the country expanded healthcare coverage to employees irrespective of union membership.

This increase in access to healthcare produced a corresponding increase in the demand for services, fueling the growth of healthcare institutions in the United States. Hospitals, with the assistance of local and federal tax subsidies, were constructed so that few communities were without at least one local hospital by 1970. Medical schools flourished as did research largely funded through the National Institutes of Health. With the increase in medical education came a corresponding increase in specialization. While two thirds of physicians were in general practice in 1930, by 1970 two-thirds of physicians were in specialty practices.

The expansion of medical specialties and medical research served, in turn, to foster the need for the development and production of drugs to treat the conditions being more readily diagnosed. A myriad of pharmaceutical companies worldwide arose to fill that

need. Private institutions, not government, largely funded the research, development, production and distribution of pharmaceuticals. A complex relationship between private and public institutions consequently evolved. Medical schools needed information from the pharmaceutical companies to train emerging doctors on the drugs available to treat the conditions they were being taught to diagnose in their clinical training. Pharmaceutical companies needed the relationship with teaching institutions to embed their products in the treatment protocols being taught and thereby establish their markets.

The expansion in medical research, medical education, hospital construction, specialty practice and pharmaceuticals served to further increase the utilization of medical services and fan the flames of need that led to the initial expansion. This increase in both the utilization and complexity of care led to rapid increases in the cost of medical care, with the cost of healthcare nearly doubling between 1950 and 1960. This increase in cost fostered the development of health insurance companies in the same decade to provide employers with policies to insulate them from the unpredictable and rising healthcare costs of their employees.

Thus, healthcare in post-World War II America developed largely as an employer-based benefit. But this pattern of development, while serving the employed recipients of healthcare admirably, was not without its detractors. Virtually from the beginning, there existed forces which favored a public universal healthcare system over a private employer-funded healthcare system. Understanding the core values underlying the conflict between the supporters of employer-based healthcare and the supporters of government-run healthcare is critical to understanding what is truly at stake in the healthcare debate today. With healthcare representing 18% of the U.S. economy, this is

truly a debate over the economic and political identity of our country. The eventual outcome of this debate will determine whether we move forward as a capitalist nation or join our European predecessors as a socialist nation.

Chapter One

Medicare and Medicaid

As early as 1949, President Truman introduced legislation to create a universal healthcare program under a national health insurance board within the Federal Security Agency to be funded by a mandatory 1.5% payroll deduction from employees and a

matching contribution from employers.[1] While introduced annually to Congress throughout his second term in office, legislation enacting universal healthcare as a publicly funded benefit was never passed. Then, as now, it was viewed as a path to socialism and incompatible with the philosophical underpinnings of a nation dedicated to the principles of capitalism. There was also, at the time, little impetus for change.

Employer-based healthcare in 1949 was still relatively new and served the needs of the majority of our population satisfactorily. It could never, however, meet the needs of our entire population and, over time, the clamor for programs to do so grew louder. Three broad groups, in particular, pointed to the inadequacy of employer-based healthcare as the solitary model for healthcare in the United States. Those three groups are the unemployed or marginally employed existing at or below the poverty line, the disabled, and the retired population.

The first two of these three were the easiest to address. The turmoil of the 1960s led to the end of overt racial discrimination and an expansion of our collective social conscience. It was increasingly accepted that American society needed to atone for its previously repressive behavior, behavior which had held the African-American population in the bonds of slavery and then, upon freeing them, denied them an equal right to succeed as Americans. Catharsis required that we, as a society, facilitate advancement of minorities beyond the bonds of poverty. Affirmative action programs were enacted to accomplish this and it was only a natural extension of these policies to enact legislation that would assure the poor access to appropriate medical care. The addition of Title XIX to the Social Security Act in 1965 served that purpose by establishing Medicaid. The addition of the second group, the disabled who were poor

through no fault of their own and for whom society had a moral obligation to provide care, was never in question.

Medicaid was established as a program jointly funded by the federal government and the states, with state participation on a voluntary basis. Funding at the federal level was initially derived from the social security taxes collected and generally matched the funding provided at the state level. Because of the voluntary nature of state participation, the eligibility requirements and the services provided under Medicaid varied from state to state.

The third group, the retired population, was now easier to address. The increasingly pervasive opinion that a society has an obligation to provide all the needs of all its members made inevitable the decision to cover medical costs for the elderly following the decision to cover medical costs for the poor and disabled.

With a few exceptions, employer-based healthcare ceased when employment ceased. When few people lived into retirement, this was not a problem. However, the intensity and quality of healthcare services that followed the inception of employer-based healthcare led to longer life spans and served to underscore the inadequacy of employer-based healthcare as a solitary approach to meeting the healthcare needs of the nation. In 1900 the average lifespan was 47 years[2]. By 1965, the average lifespan was 70 years[2]. At the time of this writing the average lifespan is 79 years[3].

At the same time, the earnings of the average individual post-retirement are far lower than during their employed years while the need for healthcare and the cost of healthcare are at their greatest. Enactment of a publicly funded program similar to Social Security to provide for the medical needs of the elderly was, consequently, viewed as necessary by

1965 and led President Johnson to introduce and help pass legislation establishing Medicare as the healthcare program for the retired and disabled population.

The initial requirements for Medicare eligibility were set by age and disability. Then, as now, eligibility for Medicare began at age 65 for non-disabled adults. Disabled individuals were eligible for Medicare if entitled to Social Security disability benefits for the preceding 24 months. Permanent kidney failure also served as eligibility for Medicare after 1972.

In establishing the operational framework for Medicare, the federal government essentially borrowed the existing framework from the private insurers. Thus, payment for inpatient hospital care was separated from payment for out-patient services. Medicare Part A (also referred to as hospital insurance or HI) was established as mandatory coverage after age 65 and provides a 90 day benefit period for inpatient hospital care. Coverage includes a semi-private hospital room, operating room expenses, anesthesia, imaging studies, diagnostic labs, drugs administered while in the hospital, and blood transfusions with a 3 pint deductible. Those insured by Medicare are responsible for an initial deductible after which Medicare then pays 100% of the charges for the first 60 days of hospitalization. From days 61-90, those insured by Medicare are responsible for daily co pays. If the hospital stay exceeds 90 days there is a lifetime 60 day reserve to extend the benefit period.

Medicare Part A also provides limited payment for stay in a skilled nursing facility. To qualify, those insured by Medicare must first have spent at least 3 days in a hospital prior to transfer to a nursing home and admission to the nursing home must be for the same reason as admission to the hospital. If these conditions are met, Medicare then pays

100% for 20 days. From days 21-100, those insured by Medicare are responsible for a daily co-payment. Medicare pays no benefits beyond 100 days.

Medicare Part B (also known as supplemental medical insurance or SMI) is the framework for payment of out-patient services. This is optional for the Medicare insured and covers a wide range of services provided for illnesses that do not require hospitalization. These include doctor visits, physical therapy, x-rays and lab tests performed in the United States. Medicare Part B does not pay for prescription medication, dental care, podiatry, routine physicals, private nursing care, custodial care of any sort, and care received outside the United States.

Funding for Medicare Part A is provided by a 1.45% tax on employee wages with a matching employer contribution. Funding for Medicare Part B is from premiums charged by the federal government to those insured by Medicare.

The tax on employee wages was initially established as part of the nation's social security tax. Unlike Medicaid, however, all funding for Medicare was provided at the federal level. Consequently, the total Medicare tax paid was limited by the income limit for payment of the social security tax. With the passage of time, this funding mechanism proved problematic. Increases in expenditures related to increasing lifespan, medical inflation and increased utilization led to larger and larger portions of the funds earmarked for social security being used for Medicaid and Medicare expenses.

Largely to address this problem, Congress in 1977 created The Healthcare Financing Administration (HCFA) within the Health and Welfare Administration to administer both Medicare and Medicaid. With the creation of HCFA, funding of Medicare and Medicaid was separated from funding of Social Security. The creation of the Centers for Medicare

and Medicaid Services (CMS) further separated the administration of Medicare and Medicaid from the administration of Social Security. The income limits applied to the collection of Social Security taxes were therefore no longer imposed on the collection of Medicare and Medicaid taxes.

To illustrate, the social security tax is limited to 6.2% of the first $110,100 of earned income in 2012 with a matching contribution from the employer. Thus the maximum social security tax that could be collected per employee is $13,652.40 (12.4% of $110,100). The Medicare tax rate for 2012 is 1.45% of income with a matching contribution from the employer. If the same income limits applied to the Medicare tax as apply to the Social Security tax, the maximum Medicare tax that could be collected per employee would be 2.9% of $110,100 or $3,192.90. The total maximum combined Social Security and Medicare tax that could be collected on behalf of any employee regardless of income would be $16,845.30.

By separating the Medicare tax from the Social Security tax, the federal government was able to eliminate the taxable wage base limitation for the Medicare tax. Thus, an executive earning $1,000,000 would still pay $6,826.2 in Social Security tax but would now pay $14,500 in Medicare tax. His employer would match the $6,826.2 and $14,500 on behalf of this employee for a combined payment of $13,652.4 for Social Security and $29,000 for Medicare on behalf of this employee in 2012. The Social Security and Medicare taxes now collected on behalf of this employee total $42,652.40 rather than the $16,845.30 payable before the taxes were separated.

This separation of the Medicare tax from the Social Security tax has served to substantially increase the revenues paid into Medicare and Medicaid from payroll taxes

while simultaneously increasing the proportionate share of Medicare and Medicaid taxes paid by employees with higher earnings and their employers who match those tax payments. This shift in funding created a subtle but powerful, and increasingly pervasive, shift in attitudes in America. With the passage of three decades since the formation of HCFA, Americans have become more accepting of the single basic principle governing socialism---those who have more have an obligation to provide for those who have less and it is the role of government to redistribute wealth from those who have more to those who have less in order to enforce that obligation. This fundamental principle of socialism enabled President Obama with a democratic majority in the House of Representatives and a democratic majority in the Senate to take a risky gamble. In spite of the deepest recession since the Great Depression, in spite of massive government spending which would serve to double our national debt in only 4 years time, President Obama and a democratically controlled Congress pushed through and passed into law a massive expansion of healthcare entitlements under the Patient Protection and Affordable Care Act.

Chapter Two

The Patient Protection and Affordable Care Act

The Patient Protection and Affordable Care Act was signed into law by President Barak Obama on March 23, 2010. It has since been more commonly known as ObamaCare. No single piece of legislation in my memory has stirred as much controversy nor has any single piece of legislation been so poorly understood. In an effort to provide clarity, I will address the positive and negative aspects of the legislation separately.

Let us start with the positives.

1. The legislation eliminates the lifetime maximum benefit which could be paid under most health insurance plans.
2. The legislation eliminates the exclusion of coverage for pre-existing conditions.
3. The legislation provides insurance for the previously uninsured.
4. The legislation expands eligibility for coverage of children under family plans to age 26.

The elimination of lifetime maximum benefits payable under health insurance plans is laudable and a definitely valuable benefit. Most health insurance plans carried a lifetime maximum benefit of $2 million. Individuals with chronic illnesses and consequent high annual healthcare utilization who did not meet the criteria for social security disability and consequent eligibility for Medicare and/or Medicaid became essentially uninsurable once they exceeded their lifetime maximum benefit. Because of the Patient Protection and Affordable Care Act, these individuals can no longer be pushed into bankruptcy as a result of their illness or injury. Were I in this situation, I would be grateful for the new law. However, it did not require an overhaul of the entire healthcare system to accomplish this. Revising the rules for Medicare eligibility to allow for automatic inclusion of anyone who has exceeded their lifetime health insurance benefit limit would have produced the same outcome.

Eliminating the exclusion of insurance coverage for pre-existing conditions, while beneficial, has only limited impact. This issue was addressed earlier in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. HIPAA already prohibited insurers from denying coverage of claims for pre-existing conditions unless there was a lapse in insurance coverage which exceeded 90 days. The current legislation

therefore only benefits those individuals who have a pre-existing condition and have been without insurance coverage of any sort, including Medicaid, for more than 90 days.

The verdict remains out as to whether a new program to insure the uninsured is actually beneficial. It is estimated that there are 40 million uninsured Americans. These are individuals whose income disqualifies them from Medicaid eligibility and whose employers do not offer health insurance. Many of these are young, healthy adults who would rather pay for any healthcare that they need when they need it rather than pay for healthcare insurance that they are likely to never use. In short, they have made a conscious financial choice to be uninsured. The Patient Protection and Affordable Care Act has now stripped these individuals of the right to make that choice. As of January 1, 2014 they are required to purchase insurance or subject themselves to an annual tax of 1% of adjusted gross income or $95, whichever is greater. In 2015 the tax rises to 2% of adjusted gross income or $325, whichever is greater. In 2016 the tax peaks at 2.5% of adjusted gross income or $695, whichever is greater[1]. Furthermore, because this has been determined to be a tax by the U.S. Supreme Court, noncompliance with payment of the tax can now also result in the assessment of penalties of up to 25% of the tax owed as well as accumulated interest.

The final category under positive aspects of the legislation is the ability to retain "children" under a family policy to age 26. Like the pre-existing condition clause in the legislation, this is largely window dressing. Most health insurance plans already allow for continuation of coverage for any family member over the age of 18 who is enrolled as a full-time student. For students taking 6 years to conclude college, this would take them to the age of 24. The need to provide coverage under a parent's policy beyond this is either

an acknowledgement of anticipated continued economic stagnation which will provide no employment opportunities for these students upon graduation or an indefinite prolongation of adolescence in a society that has lost its sense of productivity and individual responsibility. Retention of "children" over the age of 18 on a parent's policy that are not enrolled as full-time students is clearly the latter.

We must now turn to what are the negative aspects of the Patient Protection and Affordable Care Act. Unfortunately for the state of our nation, the negatives far outweigh the positives.

1. The legislation expands eligibility for Medicaid.
2. The legislation imposes hefty new taxes.
3. The legislation will decrease the quality of care and the access to care.
4. The legislation will massively increase our national debt.
5. The legislation will lead to economic stagnation and decline.
6. As a sustainable mechanism for healthcare reform, the legislation has failed even before it has been fully implemented.
7. The legislation promotes the formation of healthcare cartels.
8. The legislation moves us further along the road to socialism.

1. Expansion of Medicaid

There are many in this country who would argue that the expansion of Medicaid eligibility represents a positive effect of the legislation. So why am I including this under the negative effects? The answer is complex. The Patient Protection and Affordable Care Act increases Medicaid eligibility to 138% of the poverty line. The poverty guidelines

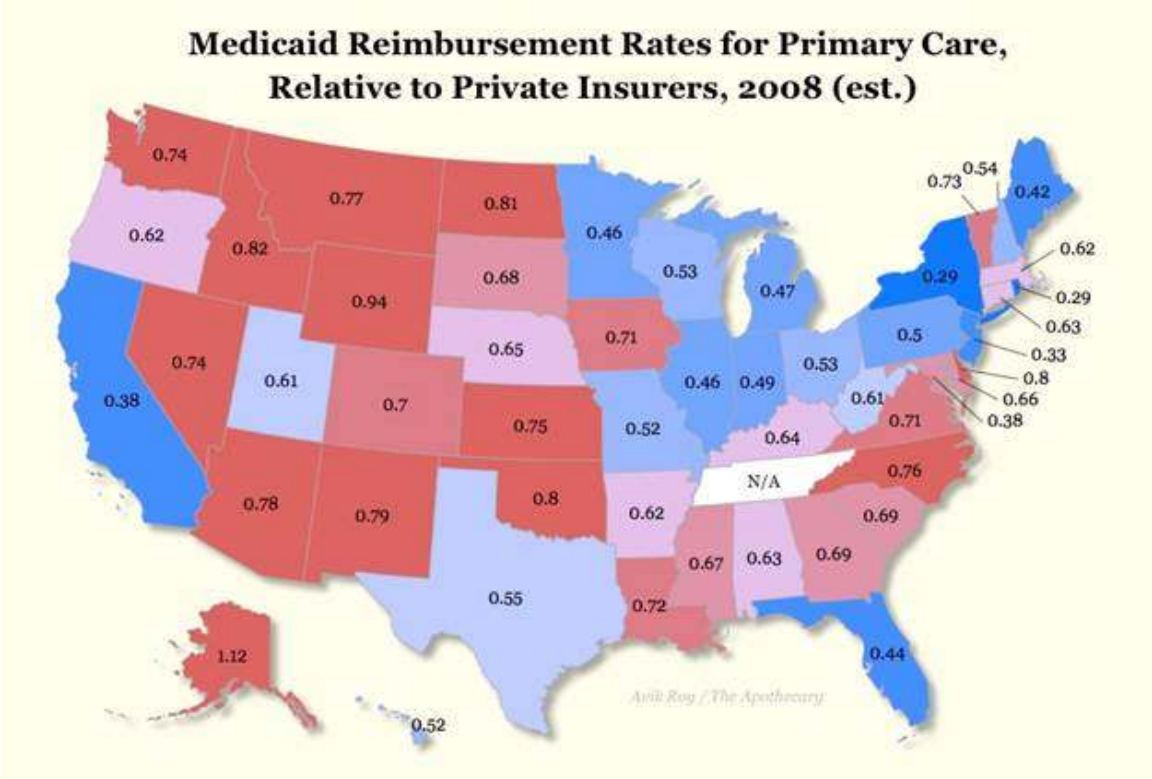
from the Department of Health and Human Services for the 48 contiguous states and the District of Columbia for 2012 are listed in the chart below.

2012 Poverty Guidelines for the 48 Contiguous States and the District of Columbia	
Persons in family/household	**Poverty guideline**
1	$11,170
2	15,130
3	19,090
4	23,050
5	27,010
6	30,970
7	34,930
8	38,890
For families/households with more than 8 persons, add $3,960 for each additional person.	

Thus, a family of four with household income at or below $31,809 (1.38 x 23,050) would be eligible for Medicaid. Now, I am not arguing that it is easy to support a family of four on $31,809, but I will argue that the eligibility determination for Medicaid is not really dependent upon this family's ability to live on $31,809. The poverty guidelines are based solely on income earned. The effect of other programs for the poor such as food stamps, energy assistance, aid to dependent children and housing subsidies are not considered. Because these are not considered, these programs do not alter the statistical picture of poverty in the United States but do nonetheless serve to elevate the standard of living for these families and individuals. According to the director of health and welfare studies at the Cato Institute, Michael Tanner, the United States currently spends $82,440 per year to support this poor family of four noted above. This perpetuates government dependency and creates an enormous disincentive to leave the roles of welfare and earn a living. The expansion

of eligibility for Medicaid under the Patient Protection and Affordable Care Act only adds to the problem.

Expanding Medicaid coverage, however, does more than just increase government dependency. It will also severely stress the healthcare system providing the care to Medicaid recipients. In those states in which Medicaid expansion will be the largest, the payment for services under Medicaid is the lowest. The following map shows the ratio of Medicaid payment relative to health insurance payment for each state. The Patient Protection and Affordable Care Act is projected to add another 16 million people to the Medicaid programs in these states. In California alone, another 1.6 million people are expected to enter the Medicaid roles. With reimbursement for services at only 38% of private health insurer reimbursement, the additional members are likely to overwhelm the physicians and hospitals whose profit margins are already lean and either render them insolvent or result in their refusal to provide care for this expanding population. California is not unique. Most states with large Medicaid populations pay less than 50% of private insurer rates as illustrated below.



I am currently practicing medicine in the state of Minnesota. CPT (Current Procedural Terminology) codes are used to classify the services for which we bill. The typical CPT code for a follow-up visit is 99213. The state of Minnesota currently pays 51.00 for a Medicaid patient seen for a follow up and billed under CPT code 99213. This is a 15 minute visit. I presently pay my receptionist $21/hour, my transcriptionist $23/hour and my billing staff $26/hour. Their combined salaries are $70/hour. As an employer, I am required to pay an additional 0.0765% of their salary for Social Security and Medicare raising the hourly rate by .0765 x 70 or $5.36 to $75.36/hour. Therefore, for each 15 minute appointment, my office staff costs me $18.84. For each 15 minute appointment, my office rent costs me $17.86. Health insurance for me and my 3 employees costs $3,003.41 with a $2,500 deductible. My health insurance cost for each 15 minute

appointment is therefore $5.36. My advertising expenses are $16,000 per year or $2.38 per 15 minute visit. My malpractice insurance is $12,000 per year or $1.79 per 15 minute visit. My expenses for staff salaries, rent, and health insurance, malpractice insurance and advertising are therefore $18.84 + $17.86 + $5.36 + $1.79 + $2.38 or $46.23. Were there no other expenses such as office supplies, postage, telephone, internet, continuing education, travel, legal fees, etc., my earnings per Medicaid appointment would be $51-$46.23 or $4.77. Holidays reduce the work year by 2 weeks. Therefore, if I spend the requisite 1 week per year in continuing education classes and take 2 weeks per year for vacation, I have 47 weeks per year in which to earn an income. If all I saw were Medicaid patients, I would earn $19.08/hour (4 x $4.77), $133.56/day, $667.80/week or $31,386.60 per year. However, these figures assume that every available appointment is filled and there are no cancellations or missed appointments. Assuming a more realistic appointment rate of 80% of capacity, my income drops to $25,109.28 for the year. Furthermore, my actual annual income would be far less as there are many more expenses involved in running a practice than the 5 items for which I have accounted.

As a consequence of the meager rates of payment for services under Medicaid, 31% of physicians in the U.S. are already refusing to accept new Medicaid patients[2]. This percentage is likely to increase sharply as the Medicaid population expands making it more difficult for the poor to receive the care they have been promised under the Patient Protection and Affordable Care Act.

The expansion of Medicaid eligibility will also serve to sharply strain the already strained budgets at the state level. States are being required to invest in technology to establish health insurance exchanges through which individuals can shop for health

insurance. These exchanges need to be sophisticated and will consequently be costly to develop and maintain. In addition, while the federal government is offering to initially cover 100% of the additional Medicaid spending consequent to increased enrollment, this is not permanent. Typically, the federal government pays only 50-57 % of the states' Medicaid expenses, with the wealthier states receiving the lesser percentage. On average, Medicaid expenditures accounted for 22% of each state's budget in 2008. Once the initial federal funding of the Medicaid expansion ceases, the added costs will substantially drive up the portion of the state budget dedicated to Medicaid. These additional funds can only come from either higher state taxes imposed on the populace or yet lower payments to physicians, hospitals and other healthcare professionals or a combination of both.

2. A Bevy of New Taxes

To fund this massive increase in entitlement spending, the Patient Protection and Affordable Care Act imposes a massive increase in federal taxes upon our population. Though these tax increases are advertised as a tax on millionaires who can afford to pay more of their "fair share", the actual fact is that they fall squarely on the middle class. The threshold for the increase in taxes is individuals earning $200,000 or more per year or couples earning $250,000 or more per year. Many of these are small business owners working 80-100 hours per week. Thus, a husband and wife working a small business together, each working 80 hours per week, earning a total of $250,000 per year is no different than a husband and wife each working 40 hour per week at two jobs, with each job paying $62,500 per year. In both cases, these individuals will be taxed substantially

more because they are ambitious and willing to work, but in neither instance are these individuals rich.

With the expiration of the Bush era tax cuts, these individuals will see their federal tax rate increase from 33% to 36%. Furthermore, this couple will see their Medicare tax increase by 0.9% from 2.9% to 3.8% on any income they earn in excess of $250,000 as a consequence of the Patient Protection and Affordable Care Act[3]. If these individuals also have dividend income, that income, previously taxed at 15%, will now also be taxed at 36% plus an additional 3.8% Medicare tax from the Patient Protection and Affordable Care Act creating a dividend tax of 39.8%[3]. Their long-term capital gains tax will also increase from 15% to 20% plus a 3.8% Medicare tax from the Patient Protection and Affordable Care Act changing their tax on long-term capital gains to 23.8%[3]. The truly rich, those earning $1,000,000 or more per year will pay only slightly more. They will have a maximum federal tax rate of 39.6%. With the addition of the 3.8% Medicare tax from the Patient Protection and Affordable Care Act, their dividend tax increases to 43.4%. Their long-term capital gains tax is the same 23.8%.

Pursuant to the U.S. Supreme Court ruling on The Patient Protection and Affordable Care Act, effective January 1, 2014 anyone not purchasing “qualifying” health insurance as defined by the Department of Health and Human Services will be subject to a federal tax. In 2014 that tax is the higher of 1% of adjusted gross income or a minimum of $95 for a household with one adult, $190 for a household with two adults, and $285 for a household with three or more adults[1]. Thus an individual supporting a wife and one adult child with an adjusted gross income of $50,000 would incur a tax of $500.

In 2015 the tax rises to the higher of 2% of adjusted gross income or $325 for a household with one adult, $650 for a household with two adults, and $975 for a household with three or more adults[1]. This same individual supporting a wife and one adult child with an adjusted gross income of $50,000 would now pay a tax of $1,000.

In 2016 the tax again rises to the higher of 2.5% of adjusted gross income or $695 for a household with one adult, $1,390 for a household with two adults, and $2,085 for a household with three or more adults[1]. This same individual supporting a wife and one adult child with an adjusted gross income of $50,000 would now pay not 2.5% of adjusted gross income ($1,250) but $2,085.

There are also taxes on employers who fail to offer health coverage for their employees. Effective January 1, 2014 any employer with 50 or more employees who does not offer "qualified" health insurance coverage for his/her employees and who has at least one employee who qualifies for a health tax credit, will face an annual non-deductible tax of $2,000 per full-time employee. If any employee actually receives health insurance coverage through the state's health insurance exchange, the tax for that employee increases to $3,000. If an employer requires a waiting period of 30-60 days before an employee is eligible for health insurance, there is a $400 tax per employee. If the waiting period exceeds 60 days the tax per employee increases to $600[4].

Effective January 1, 2014 the Patient Protection and Affordable Care Act also imposes an excise tax on health insurance companies. This is a complicated tax. Small insurers whose premiums collected are less than $25,000,000 per year are exempt from the tax as are companies whose third party administration fees are less than $5,000,000 per year.

The remaining companies are taxed according to their percentage of the market and their volume of business. Companies whose annual premiums are greater than $25,000,000 but less than $50,000,000 are taxed at 50% of their excise tax rate. Companies with over $50,000,000 in annual premiums are taxed at 100% of their excise tax rate. Companies with more than $5,000,000 but less than $10,000,000 in annual third party administration fees are taxed at 50% of their excise tax rate. Companies with more than $10,000,000 in annual third party administration fees are taxed at 100% of their excise tax rate[5].

The company's excise tax rate is determined by calculating the company's market share. Thus, a health insurer with a 10% market share with premiums exceeding $50,000,000 per year and third party administration fees exceeding $10,000,000 per year would pay 100% of 10% of the amount set for the excise tax on all insurers. That tax is currently $6,700,000,000. This company would thus be liable for 10% of $6,700,000,000 or $670,000,000 in tax.

The tax is calculated by the Secretary of Health and all insurers are required to report all necessary data by the date determined by the Secretary following the end of any calendar year. Failure to report will incur penalties of $10,000 plus $1,000 per day of delinquency up to the amount of the tax owed[5].

This excise tax on healthcare insurers will have substantial unintended consequences. First, it will likely result in the health insurer market consolidating in the hands of a few large key insurers, thereby restricting consumer choice. Small insurers lack the economies of scale that the large insurers posses and nonetheless will still need to outspend large insurers on advertising to gain name recognition. The profit margins of small insurers are therefore likely to be smaller than those of the large insurers and those

profits are at risk of be entirely erased by an excise tax imposed consequent to growth. For example, if an insurer with a 1.0% profit margin has grown its premium sales from $20,000,000 to 30,000,000, its profit is $300,000. If this company's market share is 0.0035% of the premium market, it would owe $117,250 in taxes, as its tax basis is 50% of sales, leaving an after tax profit of $182,750. However, this company's profit on $20,000,000 in sales the previous year when it was exempt from the tax at was $200,000. The increase in profit consequent to the increase in sales has been entirely lost along with a portion of the profit prior to the increase in sales. With less profit to fuel future growth, the company will need to further reduce its profit margin to cover the added expenses.

If the next year the company spends more to increase sales to $60,000,000 and their profit margin drops to 0.7%, the company's profit is $420,000. However, the company's market share is now 0.007% and its tax basis is 100% of sales. The company's tax is now $470,340, exceeding its profit for the year.

Faced with this dilemma, most small and mid-sized companies with lean profit margins will exit the market. Their exit may even be hastened by reductions in profit margins voluntarily taken by the large insurers in what amounts to government facilitated predatory pricing. These reductions will be applauded by the federal government as proof that the Patient Protection and Affordable Care Act is working to reduce healthcare cost. Once competition has been eliminated, however, the large insurers will increase their prices to recoup their losses, erasing the illusory savings attributed to the efficacy of the Patient Protection and Affordable Care Act and leaving us firmly in the grip of a healthcare cartel.

Secondly, the health insurers will pass the excise tax on to consumers in the form of increased premiums. This will serve to increase the cost of healthcare for all consumers. United Health Group, for example, had revenue of $102 billion in 2011. Raising its rates 10% more than the projected increase for the next calendar year, say from 7% to 17%, would raise the $10.2 billion necessary to cover the cost of the tax. That increase in premium effectively transfers the cost of the tax to all consumers of healthcare, producing an invisible tax levied by the federal government on all Americans who are now required by law to purchase these insurance policies.

Furthermore, the health insurance excise tax almost certainly guarantees double digit increases in health insurance rates on an annual basis. Higher rates produce higher revenue for the health insurers. Higher revenue for the health insurers produces greater tax revenue for the federal government ensuring a continued upward spiral in health insurance premium costs. I consequently predict that health insurance rates will triple over the next 10 years as a consequence of this provision of ObamaCare alone. Health insurance costs for a family of four using a preferred provider organization averaged $19,393 in 2011. For a middle class family with dual income totaling $100,000 per year, this represents 20% of pretax income. With the drag on the economy that ObamaCare is already creating, it is unlikely that there will be any substantial change in this family's earnings over the next 10 years, so that the increase in health insurance premiums will consume larger and larger portions of the family budget and eventually 60% of pretax income by 2021. The result will be the eventual destruction of the middle class as this form of wealth redistribution reduces all but the very rich to equal levels of poverty.

The Patient Protection and Affordable Care Act also imposes an excise tax on employer-sponsored comprehensive health insurance plans. This tax takes effect January 1, 2018. It is a 40% tax on "Cadillac" health insurance plans. A "Cadillac" plan is defined as insurance coverage which costs more than $10,200 per year for an individual or $27,500 per year for a family. In the case of employer-sponsored group health plans, the health insurer is responsible for paying the tax but the employer is responsible for providing the Secretary of Health with the proper data. Failure to do so in a timely and accurate manner will result in a penalty assessed against the employer equal to the excess cost of coverage over the allowed amount plus interest[6].

While this provision of the Patient Protection and Affordable Care Act was, no doubt, intended as an incentive for the insurer to contain the rising cost of healthcare premiums, I am not certain that the consequences will be to the liking of either the professionals providing healthcare or the population consuming healthcare. This pressure to contain premium cost or face a significant excise tax will result in the insurers offering fewer covered services and lower payment for those services. Healthcare rationing by 2018 will consequently be inevitable.

Effective January 1, 2010 The Patient Protection and Affordable Care Act also imposed an excise tax on pharmaceutical companies engaged in the development and production of new drugs[7]. This tax is complicated and convoluted. Orphan drugs used only for orphan conditions are exempt from the tax. Generic drugs are also excluded from the tax except for quasi-generic drugs approved under Section 505(b)(2) of the Federal Food Drug and Cosmetic Act.

The law does not establish reporting requirements for the pharmaceutical companies. Rather, the tax is determined by the Secretary of the Treasury from data provided by the Department of Health and Human Services, the Veterans' Administration, the Department of Defense and "any other source of information available to the Secretary of the Treasury". In essence, unlike any other tax levied, the Secretary of the Treasury determines the amount of the tax owed, not the accountants for the entity being taxed.

The amount of the tax owed is based upon the market share of brand name drugs held by each individual company and the percentage is tiered based on market share.

A company with $5 million in annual brand name sales or less pays	0%
A company with more than $5 million but not more than $125 million pays	10%
A company with more than $125 million but not more than $225 million pays	40%
A company with more than $225 million but not more than $400 million pays	75%
A company with more than $400 million pays	100%

These percentages are used to calculate the "sales taken into account". Thus, for a company with $300 million in brand name sales, the "sales taken into account" would be 75% of $300 million or $225 million.

The "sales taken into account" is now divided by to total sales of brand name drugs to determine the percentage tax owed by the company. If we assume the total brand name sales are $30 billion then the percentage owed by this company would be $225,000,000 divided by $30,000,000,000 or 0.75%. This is the company's "ratio".

To determine the tax owed by the company that ratio is applied to the "applicable amount". This amount is presently set to grow annually as follows:

2011	$2.5 billion
2012	$2.8 billion
2013	$2.8 billion
2014	$3 billion
2015	$3 billion
2016	$3 billion
2017	$4 billion
2018	$4.1 billion

Thus, in the case above, the company with $300 million in brand name sales would incur a tax of 0.0075 x $2,500,000,000 or $18,750,000, representing 6.25% of annual sales. Also, if this company's ratio remains the same, its tax will grow to 0.0075 x $4 billion or $30 million in 2017.

Unlike physician, hospital and medical equipment charges, the prices for brand name prescription medications are not set by federal or state governments and they are not set by private insurance companies. The pharmaceutical companies do have the ability to set the price for any new drug that they bring to market. Consequently, it is not likely that the pharmaceutical companies will simply absorb this new tax and reduce their profits. The tax will be factored into the price of each new drug. This tax is consequently inflationary in its impact. These increased pharmaceutical costs will be reflected in the insurance premiums paid by employers and individuals. These tax revenues from the pharmaceutical companies do, in other words, simply translate into an indirect tax levied on employers and consumers of healthcare through higher premiums and/or higher

prescription co-pays. Those who are receiving their healthcare through private programs will pay more in order to provide the pharmaceutical companies with revenue to pay the taxes to subsidize the public programs—billions of dollars more. As pharmaceutical costs for public programs will also rise, however, these taxes on pharmaceutical companies will additionally spur an increase in direct taxation on all workers to cover the increased cost of pharmaceuticals. The bottom line is that nothing has ever been made cheaper by taxing it more. This is not a valid funding vehicle for "Obamacare". It is a shell game, pure and simple.

While the taxes imposed on the pharmaceutical companies can, and most likely will, be passed on to consumers, the increased cost of new pharmaceuticals will make it harder for these companies to penetrate markets, recoup their investment in the development of their drugs and then generate a profit. Federal and state governments along with private insurers have been aggressive in their mandate for the use of generics over brand name drugs in virtually all circumstances. It is likely that they will further strengthen these mandates. These barriers to bringing a new drug to market only serve to further increase the cost of any new drug. If, ultimately, those barriers cannot be penetrated and the market for a new drug shrinks, this only further increases the cost of that new drug. These factors have already combined to slow the development of new, more effective and safer drugs. This will continue, resulting in stagnation in this extremely important arena of healthcare and a consequent decline in the standard of care relative to what we have come to expect in a country dedicated to innovation.

The Patient Protection and Affordable Care Act also provides for an excise tax on medical device manufacturers. This is a 2.3% excise tax to be paid by manufacturers to

the federal government on the sale of medical devices starting in January of 2014[8]. In a free market, these manufacturers would adjust the price of their products to reflect the tax. Healthcare in the United States, however, no longer operates in a free market. The same federal government imposing this excise tax on these manufacturers also sets the rate under Medicare that will be paid for their devices. The private health insurers do the same. Consequently, doctors and hospitals purchasing these medical devices are in no position to pay more for the products if they are unable to bill and receive more from the federal government or private insurers for the use of these products.

This tax consequently must be borne either by reducing the profits of the medical device manufacturers or by further reducing the already meager profits of doctors and hospitals operating within this system. If the device manufacturer is unable or unwilling to absorb the cost of this tax and the doctors and hospitals are likewise unwilling or unable, the device will fall into short supply as either production or orders are reduced. It is then that the patients in need of these devices will suffer. Items involved would include pacemakers, heart monitors, prosthetic devices for hip and knee replacements, hardware for spine surgery, stents for heart surgery and intrathecal pain pumps to name just a few. A number of device manufacturers have already warned that the tax would exceed their profits and drive them into insolvency.

Implementation of this tax on medical device manufacturers will have a chilling effect on research and development. These companies will become unwilling to invest in the development of new products if profit margins are too low to justify the investment. Such stagnation is also not in the best interest of healthcare consumers.

The Patient Protection and Affordable Care Act also penalizes individuals who have high medical expenses beyond those covered by their insurance plans. Current tax law allows expenses to be deducted if they exceed 7.5% of adjusted gross income. The Patient Protection and Affordable Care Act changes that threshold to 10%[9]. This will clearly serve to increase the taxes paid by the middle class.

The Patient Protection and Affordable Care Act also imposes a spending cap on Flexible Spending Accounts of $2,500 effective January 1, 2013[10]. Spending was previously uncapped. This provision will primarily impact working families with middle class incomes.

The Patient Protection and Affordable Care Act also eliminated the ability to purchase ove-the-counter medications with HSA funds effective January 1, 2011[11]. This has already served to increase the tax burden for working middle-income families.

The Patient Protection and Affordable Care Act also eliminates the tax deduction for employer-funded prescription drug coverage in coordination with Medicare Part D effective January 1, 2013[12]. This will increase prescription expenses for millions of seniors living on fixed-incomes.

The Patient Protection and Affordable Care Act also increased the penalty for early withdrawal of funds from an HSA for non-medical purposes from 10% to 20% effective January 1, 2011[13]. This provision particularly affected those individuals who lost employment as a consequence of the longest recession in American history and required these funds to meet expenses.

Effective January 1, 2013 The Patient Protection and Affordable Care Act amends Section 162 (m) of the Internal Revenue Code of 1986 to disallow deduction by a health

insurance company for any executive compensation in excess of $500,000 annually[14]. Put more plainly, any health insurer paying executives more than $500,000 per year in total compensation will now also have to pay corporate taxes on the amount in excess of $500,000 per employee. This provision of the Patient Protection and Affordable Care Act will serve to limit health insurance executive compensation and was no doubt intended as a pre-emptive measure to quell public outcry over health insurance executive excesses at a time when that public is being hit hard with measures to enforce healthcare rationing.

This measure is, however, more illusory than real. To explain, I will use United Health Group as an example. United Health Group is not a health insurer. It is a management corporation. The health insurance company within United Health Group is United Healthcare. Therefore, Stephen Hemsley, the CEO of United Health Group who was paid $48.8 million in 2011[15], will not see his income affected by this provision of the Patient Protection and Affordable Care Act. This provision will simply serve to limit the amount that United Health Group (upper management) is obligated to pay to its middle management executives staffing the positions in United Healthcare and thus increase the revenue flowing to upper management. In the event that upper management wishes to reward an individual at United Healthcare beyond the $500,000 allowed under the new law, all that is required is to create a position for that individual in the management group and compensate that position with bonuses or stock options generated outside of the health insurance company and therefore exempt from this provision of the law.

Other insurers are likely to emulate this structure in order to blunt the impact of this legislation. Those that fail to do so will operate at an extreme financial disadvantage and

will sooner or later be acquired by the larger entities that have done so, further consolidating the healthcare industry and facilitating the formation of a healthcare cartel. Excesses in executive compensation will continue within these management groups. United Health Group is only one such management company. Express Scripts is a pharmacy benefit management corporation that paid its CEO $51.1 million in 2011[15]. CVS Caremark is a pharmacy benefits manager that paid its CEO $68 million in 2011[15]. Omnicare, the largest dispenser of pharmaceuticals to nursing homes (another management company), paid its CEO $98.3 million in 2011[15]. These excesses are not addressed by the Patient Protection and Affordable Care Act nor are they likely to be addressed in the future. The federal government and these management companies share a common goal—the ability to maximize revenue while minimizing expense. Revenue comes in the form of premiums collected for both the federal government and these management corporations. Expenses are primarily healthcare delivery costs and these expenses are best controlled by consolidating power into the hands of a few management companies working in concert with the federal government to control price and competition.

Effective January 1, 2010 the Patient Protection and Affordable Care Act modified the taxes on non-profit health insurance companies such as the Blue Cross/Blue Shield organizations to eliminate the 20% reduction in unearned premium allowed under section 832(b)(4) unless 85% or more of premiums collected are spent on clinical services[16]. This requirement for a medical loss ratio of 85% in order to retain non-profit status and its attendant tax advantages has not served to restrain premium increases during the 2 years

in which it has been in effect. Premiums did instead rise by 9% in 2011. Figures are not yet available for 2012.

Effective January 1, 2010 the Patient Protection and Affordable Care Act imposed a 5% excise tax on elective cosmetic medical procedures[17]. This tax is paid by the individual undergoing the procedure and is collected by the individual performing the procedure as part of his/her charge and then paid by that practitioner to the federal government quarterly. If the tax is not collected by the practitioner, the tax is owed by the practitioner.

This is clearly a consumer tax which will serve to increase federal revenue and discourage cosmetic procedures.

Effective January 1, 2010 the Patient Protection and Affordable Care Act imposed an excise tax on charitable hospitals that failed to "conduct a community health needs assessment which takes into account input from persons who represent the broad interests of the community served by the hospital facility, including those with special knowledge of or expertise in public health" and then "adopted an implementation strategy to meet the community health needs identified through such assessment." Hospitals which fail to meet these requirements will incur a $50,000 fine per hospital per year[18]. This measure places institutions such as the various Catholic hospitals throughout the country at risk. If the community health need were to include the provision of abortion services as determined by members of the community outside the Catholic hospital system, the church would have to face the choice of weathering the fines, closing the hospital's doors, or violating its religious beliefs and allowing abortions to be performed at Catholic hospitals. This is a clear afront to religious freedom.

3. Erosion of the Quality and Access to Care

Closing the Catholic hospital system, as outlined above, would have an unmistakable impact on the access to care in the United States. These hospitals provide charitable services for millions of Americans across the country. This is, however, not the only threat to the access to care. The greater threat lies in the disappearance of medicine as a viable profession. To explain, we must first look at the overall structure of business in the United States.

The business structure of the United States can be largely divided into 3 groups—management, labor, and the professions. All corporations recognize sharp distinctions between these groups. Management exists to make the corporation more profitable and individuals are hired based upon their capacity to do so and then trained to further that ability. Largely, these individuals are rewarded in accordance with their success rate in achieving benchmarks of prosperity for their company.

Labor exists to perform the daily tasks that are needed to provide the product or service on which the corporation depends for its profits. For most corporations, labor is simply a necessary expense—an expense no different than the raw materials that a corporation must purchase in order to make its products. Just as it represents good management to pay as little as possible for quality raw materials, it is also good management to pay as little as possible for quality labor. This, not our tax structure, is what has been driving income inequality. For decades, the gap between executive and labor compensation has been widening into what has now become an enormous chasm. In 1980, the average CEO of an American company earned 42 times the average income of

American workers[19]. By 2009, the average CEO was earning 263 times the average compensation of American workers[20]. By 2011. the average CEO was earning 380 times the average compensation of American workers[19].

The professions exist to provide individuals and businesses with expertise which is only occasionally needed. Thus, a company or individual will hire an architect for a specific project. The same company or individual will hire an attorney for a specific legal problem. As professionals, physicians have largely provided services to individuals, though they may be called upon occasionally to work on a specific project for a corporation. In these capacities, these various professionals act as consultants. They are neither management nor labor. They are independent contractors paid for the service that they provide. Because of the expertise required and the episodic nature of the work contracted, the various professions have charged and have received high rates of compensation for their services.

For the profession of medicine, this is changing and the Patient Protection and Affordable Care Act is accelerating the rate of change. One industry in particular, the health insurance industry, is consolidating its grip over all of healthcare and is transforming the profession of medicine into a healthcare industry in which management is the insurer and everyone else is labor. This transformation commenced with the introduction of physician networks in the 1980s and accelerated with the introduction of fee schedules in the 1990s. Integral to the independent nature of any profession is the ability of the professional to set his/her fees and to render opinions which are based on sound reasoning and are free from the bias exerted by labor or management. Unlike all other professionals, physicians are no longer able to set the fees that they charge. Those

fees are dictated by the insurance companies in the private sector and by the federal and state governments in the public sector. This has been the first step in the elimination of the profession of medicine. The health insurance industry, once concerned only with the finance of healthcare, has transformed itself into the healthcare industry, now overseeing the management of all healthcare in the United States.

This new management created a new terminology to explain its hierarchy. Doctors, nurses and all other healthcare professionals have been equally designated as “providers”. To fully appreciate the meaning of this new terminology, read provider as labor. Management is comprised of the health insurer, the federal government and the state governments. As it is, and always will be, it is the intent of management to pay labor as little as possible. Physician incomes, relative to the hours worked, have consequently been declining for the last 20 years and will continue to do so.

This has dire implications for the quality of care and the access to care in the United States. Who in their right mind is going to spend the $250,000-500,000 and 12 years that it takes to become a physician in this country only to take on the unenviable position as labor? The physician community in America already recognizes this. 77.4% of physicians are somewhat pessimistic to very pessimistic about the future of the medical profession. 84% of physicians agree that the medical profession is in decline. 57.9% of physicians would not recommend medicine as a career to their children or other young people. Over 1/3 of physicians would not choose medicine if they had their careers to do over. Over 60% of physicians would retire today if they had the means. Over 52% of physicians have limited the access Medicare patients have to their practice or are planning to do so. Over 26% of physicians have closed their practices to Medicaid patients. Close to 92% of

physicians are unsure where the health system will be or how they will fit into it 3 to 5 years from now[21]. Such pessimism and lack of morale does not translate into quality patient care.

Also reducing the quality of care and access to care is the provision for an Independent Payment Advisory Board (IPAB) within the Patient Protection and Affordable Care Act. The baby boom generation is entering retirement age. For the next 18 years, from 2011 to 2030, Medicare will be enrolling over 10,000 new members per calendar day. The Medicare trustees consequently anticipate 80 million enrollees in Medicare by 2030, double the 39.6 million enrolled by 2010. As outlined in the next chapter, this increase in the retired population is not matched by a corresponding increase in the workforce. In fact, the anticipated working population will be much smaller than it is today. Consequently, not even the bevy of increased taxes noted above will be sufficient to cover the cost of Medicare alone. The purpose of the IPAB is therefore to implement measures by which to contain cost without requiring the approval of Congress.

Finally, the above noted excise taxe on medical devices will create shortages and barriers to care. This tax and the tax on new pharmaceuticals will have a chilling effect on research and development and further reduce the quality and access to care.

4. Massive Increase in National Debt

It is estimated that The Patient Protection and Affordable Care Act will create another $2.5 trillion in spending over the next 10 years[22]. The taxes outlined above are projected

to bring in about $500 billion in revenues over the next 10 years[23]. This leaves a $2 trillion shortfall which, if added to the $1 trillion deficit per year consequent to current spending, creates an additional $1.2 trillion added to the national debt each year. This would amount to $5 trillion added to the national debt within 4 years of full implementation of the Patient Protection and Affordable Care Act in 2014, bringing our national debt to $23 trillion by 2018.

5. Economic Stagnation and Decline

The regulations surrounding the Patient Protection and Affordable Care Act, particularly the taxes imposed by the legislation, will have a chilling effect on hiring for decades to come. There is little incentive to assume the risk of starting a business when the tax structure of a country works to limit the opportunity for success. There are fewer funds available for payroll when more of those funds are consumed by taxes. There is simply no way to tax and spend an economy into prosperity. Prosperity occurs when individuals are encouraged to work hard and invest in their businesses because they are allowed to retain a greater percentage of their efforts.

6. As Sustainable Healthcare Reform, the Legislation Has Failed

The Patient Protection and Affordable Care Act has failed as a mechanism for sustainable healthcare reform even before the legislation has been implemented. Why? Because it is employing a 40 year-old model with a proven track record of failure. Managed care has not worked. Had it worked, the nation would not be having the discussion over how to fix healthcare that we are having today. Had it worked, healthcare

costs would not be 601% higher than they were 35 years ago. Yet the Obama administration has doubled down on managed care in an effort to fix our ailing healthcare system without first asking whether the management is the reason the system is ailing. Certainly, no one is listening to the physicians who have endeavored to work within this system for the last 40 years. But then why should they? Physicians are but labor in the new healthcare cartel and since when does anyone ask labor how to run an industry? To fully understand why this system is doomed to fail, we must first explore the newly minted healthcare cartel.

7. The Formation of Healthcare Cartels

A cartel is a group of companies organized for the purpose of eliminating competition and controlling cost, usually with the assistance of the government under which they operate. One such example is the oil cartel, OPEC. Cartels do not operate to the benefit of the consumer nor do cartels offer much by way of opportunity for the labor that they employ. Cartels exist to maximize revenue for the management of the cartel.

With the passage of the Patient Protection and Affordable Care Act, the healthcare industry does now perfectly fit the definition of a healthcare cartel. Nothing about this is clearer than President Obama's statement in his second debate with Governor Romney that we must act to "reduce healthcare delivery costs". Read this as we must reduce what we pay labor. One mechanism favored by the Obama administration for doing this involves the formation of Accountable Care Organizations (ACOs). Here is how this process works. The federal government collects taxes from all workers in the form of Medicare tax. After paying the bureaucracy in Washington involved in the management

of ObamaCare, the remaining sum is then sent to the states. After the state takes a portion of those funds to pay its bureaucrats, the state then awards the remaining funds to an insurer in return for providing all medical services to the population under contract. The insurer promptly places 25% of the remaining funds into its reserves. The insurer then offers medical practices designated by the state as accountable care organizations the opportunity to bid on the contract to provide those services. The contract would presumably go to the lowest bidder. Since the amount available to the accountable care organization has already been reduced by the amount paid to the federal government, state government, and health insurer, the deck is already stacked against the ACO. The bidding process further reduces what will be paid to the ACO (labor) and simultaneously increases the profit for the insurer (management).

If this sounds like the classic HMO approach, it is because it is—only modified slightly to avoid the stigma. The doctors in the ACO are obligated by contract to provide all required care for the population under contract and are responsible for the cost of all care obtained outside of the ACO. In this regard, the ACO and HMO are identical. The difference lies in the population under contract. Under the HMO approach, individuals covered by the HMO who sought services outside the HMO without referral from physicians within the HMO were responsible for payment of those services. Under the ACO approach, the ACO is responsible for payment of services obtained outside of the ACO with or without referral. Thus, if a given person is unhappy with his/her care, he.she is free to pursue care outside of the ACO. Such behavior has the potential to substantially increase the cost to the ACO, as the ACO would be responsible for payment for that care.

This arrangement represents a form of capitated reimbursement. In other words, physicians are given a payment for each person under contract and it is the responsibility of the ACO to ensure that all necessary care can be provided for the sum alloted and still have the means to pay its staff. This form of reimbursement has always been preferred by the insurer as it shifts most of the financial risk involved in providing care for a given population from the insurer (management) to the ACO (labor), while allowing the insurer a guaranteed profit in the form of the funds deposited into its reserves. Fee-for-service arrangements in which physicians are paid for the services provided do not create such a shift in financial risk.

The ACO has limited options by which to generate profit. The doctors in the ACO can focus more on preventive care and early detection to reduce the cost of care. This alone, however, is likely to reduce overall cost by no more than 4-6%. They can try to discourage excessive utilization. They can encourage the use of less expensive alternatives to high cost care. They can directly act to limit the care provided. All of these are methods of healthcare rationing. In adopting many of these measures, however, the ACO risks having their members seek care outside of the ACO, resulting in increased cost. It therefore comes as no surprise that 62% of physicians believe that Accountable Care Organizations (ACOs) are either unlikely to increase healthcare quality and decrease cost or that any quality/cost gains will not be worth the effort.

Even if a given ACO manages to succeed initially, it is likely that the federal and state governments will reward that success by reducing what they are subsequently willing to pay the insurer in future years. The insurer will correspondingly reduce what they are willing to offer to the ACO for the contract to be awarded. Profit margins will

consequently shrink until failure is assured. This is not an undesired consequence from the cartel's perspective as I believe that it is the ultimate intent of the cartel to own the entire healthcare delivery system. As the ACOs are pushed into bankruptcy, the hospitals and clinics involved will be more easily acquired by the cartel. This consolidation will be sold to the public as a streamlining of healthcare to eliminate inefficiencies and improve productivity. However, its real purpose lies in the elimination of any resistance to healthcare rationing.

8. The Road to Socialism

As the entire healthcare delivery system in the United States falls under the control of a federally operated cartel, our nation moves substantially farther from capitalism and dangerously closer to socialism. Healthcare is, after all, 18% of the U.S. economy. From the Patient Protection and Affordable Care Act signed into law in 2010 to calls for an increase in the marginal tax rate for the top 2% of earners in the United States to efforts to increase the capital gains tax and thus redistribute the earnings on after-tax investment income in an effort to reduce income inequality, the drive toward socialism in the United States has never been clearer. At the same time, with a staggering $16 trillion dollar deficit for the U.S. Treasury and the impending financial collapse of one socialist economy after another in Europe, the stakes for Americans in the conflict between socialism and capitalism have never been higher. In the words of Great Britain's former Prime Minister, Margaret Thatcher, "The problem with Socialism is that sooner or later you run out of other people's money."

While healthcare is a social issue, the socialization of healthcare is not necessarily the best mechanism for addressing the issue. Government programs are inherently inefficient. Budgets for agencies are increased when funds are insufficient and budgets for agencies are reduced when efficient administration results in a surplus at the end of a fiscal year. Competence is punished and inefficiency is rewarded. The quality of our healthcare is too important to be relegated to such bureaucratic blundering.

At the same time, the private healthcare system as it exists in the United States is becoming unaffordable for the majority of Americans while insurance company profits and executive compensation have never been higher. Continuing the current insurance-run managed care system is no longer an option without either reducing the access to healthcare for the majority of Americans or severely rationing the healthcare provided. Neither approach is an acceptable option.

Sustainable healthcare reform therefore requires a fundamental restructuring of healthcare financing to make healthcare more affordable while simultaneously either preserving or increasing the access to healthcare. One of the strengths of employer-based healthcare is that it stands as an earned benefit for a company's employees, not yet another entitlement. It is the system through which the majority of Americans already receive their healthcare. It is the system by which remarkable advances in medical care have been achieved over the last sixty years, allowing us to live longer, healthier lives. This system need not, indeed should not, be abandoned. It does, however, need to be fundamentally restructured.

Our current systems for healthcare delivery are out of balance. The employers who pay for healthcare, the employees paying for and consuming healthcare and the

physicians and other professionals providing healthcare are increasingly denied any voice in the healthcare that they pay for, receive or provide. Power in our current systems has been increasingly concentrated in the hands of the federal and state governmental agencies and the private managed-care insurers who, in a unilateral fashion, make all the decisions about healthcare delivery for us. Restructuring employer-based healthcare requires returning power to the stakeholders in the system. The stakeholders in employer-based healthcare are the employers who pay for healthcare, the employees who pay for and receive healthcare, and the medical professionals who provide healthcare. The stakeholders in our social programs for healthcare are the tax-payers that pay for healthcare, the population receiving healthcare, and the medical professionals who provide healthcare. The book that follows this chapter is about the process of restoring power to those stakeholders. It is about fundamentally changing how we finance healthcare delivery in the United States. It is about transforming an employer's greatest liability into a sizeable asset. It is about transforming a burden into a benefit.