

Health Policy Review

 **Obamacare 2012: Prognosis Unclear for
Interventional Pain Management**

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Disclaimer: Dr. Hirsch has received fees from CareFusion in the past 12 months. He participated in an Aetrium focus group and received compensation.
Conflict of interest: None.

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The Patient Protection and Affordable Care Act (ACA), informally referred to as ObamaCare, is a United States federal statute signed into law by President Barack Obama on March 23, 2010. ACA has substantially changed the landscape of medical practice in the United States and continues to influence all sectors, in particular evolving specialties such as interventional pain management. ObamaCare has been signed into law amidst major political fallouts, has sustained a Supreme Court challenge and emerged bruised, but still very much alive. While proponents argue that ObamaCare will provide insurance for almost everyone, with an improvement in the quality of and reduction in the cost of health care, opponents criticize it as being a massive bureaucracy laden with penalties and taxes, that will ultimately eliminate personal medicine and individual practices.

Based on the 2 years since the passage of ACA in 2010, the prognosis for interventional pain management is unclear. The damage sustained to interventional pain management and the majority of medicine practices is irreparable. ObamaCare may provide insurance for all, but with cuts in Medicare to fund ObamaCare, a limited expansion of Medicaid, the inadequate funding of exchanges, declining employer health insurance coverage and skyrocketing disability claims, the coverage will be practically nonexistent.

ObamaCare is composed of numerous organizations and bureaucracies charged with controlling the practice of medicine through the extension of regulations. Apart from cutting reimbursements and reducing access to interventional pain management, administration officials are determined to increase the role of midlevel practitioners and reduce the role of individual physicians by liberalizing the scope of practice regulations and introducing proposals to reduce medical education and training.

Key words: Patient Protection and Affordable Care Act, ObamaCare, interventional pain management, Patient-Centered Outcomes Research Institute, Independent Payment Advisory Board, Centers for Medicare and Medicaid Services, Accountable Care Organizations, Medicare, Medicaid

Pain Physician 2012; 15:-E629-E640

Reception areas in interventional pain management practices across the country are overflowing, even though many interventional pain physicians are leaving their practices, and those remaining cannot afford to stay in practice due, in part, to a significant increase in regulations. The Patient Protection and Affordable Care Act (ACA) (1-4), informally referred to as ObamaCare (5,6), is a United States federal statute signed into law by President

Barack Obama on March 23, 2010. Proponents argue that it will decrease the number of uninsured Americans and reduce the overall cost of health care by providing any number of incentives – including subsidies, tax credits, and fees – to employers and individuals in order to increase the coverage rate (1-4). Furthermore, as per proponents, additional reforms are aimed at improving health care outcomes in the United States and streamlining the delivery of health

care. The Congressional Budget Office (CBO) projected that ObamaCare will lower both future deficits and Medicare spending (7,8).

Opponents, however, have long held that ObamaCare is a massive bureaucracy that will impose penalties on young workers, small businesses, and others who choose not to buy expensive health insurance. It has been said that ObamaCare is the largest handout in American history to a single interest group – the health insurance industry. In addition, as initial results indicate, ObamaCare promises insurance for all but delivers drastically reduced coverage, a reduction in choices and for some Americans, the loss of health insurance. It also has diverted funds from Medicare and created Accountable Care Organizations (ACOs), which along with hospitals may swallow up and lead to the extinction of individual practices and small groups.

In addition to there being disagreement over its logistics, the legal grounds for ObamaCare are mired in controversy. On June 28, 2012, the Supreme Court of the United States upheld by only one vote, 5 to 4 that ObamaCare falls within the taxing power of the federal government.

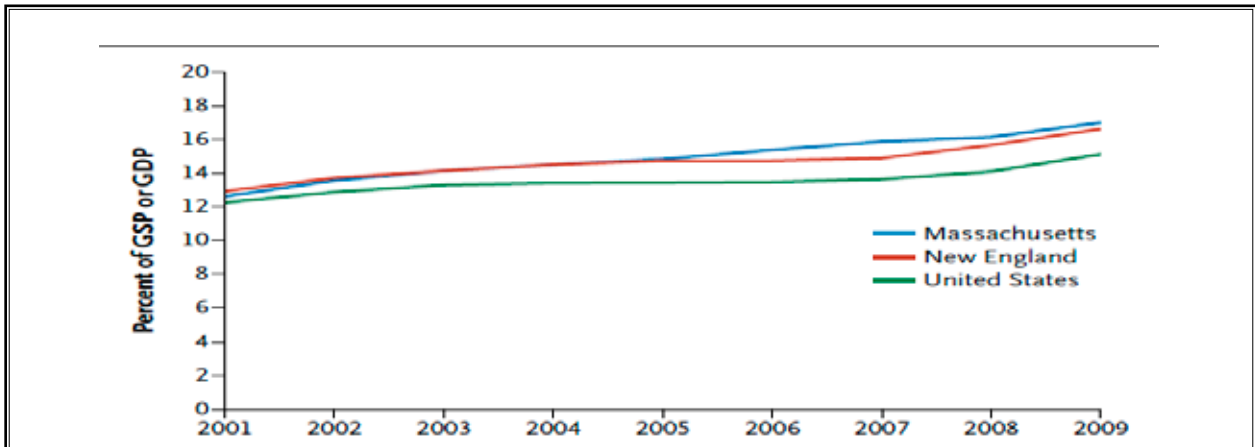
Critics continue to claim that the Obama health care plan will significantly increase the overall cost of health care for a majority of United States citizens, while at the same time reducing the quality of care that a free market system would otherwise provide. While ObamaCare will not take effect until 2014, irreparable damage has already been done to the medical profession.

In a January 5, 2012 article, long before the Supreme Court decision in favor of ObamaCare, it was noted that many doctors are going broke (9). Indeed this is not limited to interventional pain physicians, but is spread across the spectrum, including family physicians, cardiologists, and oncologists. Industry watchers observe that it is a worrisome trend. Considering that half of all doctors in the nation operate a private practice, the cash pinch may prove to be the coup de grace for independent practices. Lawmakers were warned of the potential demise of individual medical practices with independent small physician practices disappearing at an alarming rate (10). Many factors are driving private practice physicians to seek employed positions, including the specter of a decline in payments, especially with the sustainable growth rate (SGR) formula threatening cuts to Medicare payments each year, and increased reporting requirements. Many patients will have insurance but minimal coverage, with enormous copays and deductibles. Thus, hospitals and ACOs are

in the position of offering new opportunities for small groups. While this may not be true for all specialists and all physicians, the concept that hospitals, medical homes, and ACOs can save the medical profession is a myth (11,12). Even though there have been claims that ObamaCare was written by the hospital and pharmaceutical industry, hospitals may end up paying for making rash business decisions as they discover that more insured does not mean more coverage. The potential for cost saving through bundled episode payments, ACOs, and various other measures in ObamaCare may never become a reality (11,12). The renowned Massachusetts health care system arguably achieved near-universal insurance coverage. Medicare, Medicaid, and private insurers have implemented many programs in Massachusetts, yet the cost of Medicaid for low-income residents and private health insurance for state employees account for approximately 40% of the state budget in Massachusetts (12). Rising insurance premiums are also dampening wages in the private sector. Consequently, a recently enacted Massachusetts law that seeks to control health care spending may provide useful policy lessons for other states and the federal government (Fig. 1). Physicians' organizations representing traditional medicine have expressed their opinions in reference to benefit gaps allowed under the health reform that may not provide adequate benefits or control costs. For interventional pain management, however, the obstacles will be even more difficult to surmount. Medicaid expansion will become more costly to states and may become impossible to manage (13,14). Furthermore, the Supreme Court, in its decision, also provided a basis for states to refuse to participate in Medicaid expansion, which will take away a large margin of ObamaCare success. ObamaCare has taken credit for slower growth in Medicare spending even though it was related to increasing unemployment, recession, and a lack of coverage (15-18).

With one in 3 physicians planning to quit within the next 10 years (19), with the number of uninsured rising as workers lose jobs and subsequently health insurance, the number of uninsured increased from 14.8% in 2008 to 17.1% in 2011 (Fig. 2) (16,18). Furthermore, in 2011, the percentage of people with workplace health benefits fell to 44.6% from 45.8% in 2010 (20). The proportion has declined each year since 2008, with the ranks of the uninsured having increased for 4 straight years. ObamaCare has not been to the rescue in these cases.

It is also expected that with growing tax rates, the number of people with disabilities increasing each year



Based on data from the Office of the Actuary of the Centers for Medicare and Medicaid Services, the U.S. Bureau of Economic Analysis, and the U.S. Census Bureau. Personal health care expenditures are defined by state of residence, and expenditures on administration, public health, and construction are excluded.

Fig. 1. Personal health care spending per capita as a percentage of gross state product (GSP) in Massachusetts and Other New England States (Connecticut, Maine, New Hampshire, Rhode Island, and Vermont) and of gross domestic product (GDP) in the United States, 2001-2009.

Adapted from Ayanian JZ, Van der Wees PJ. Tackling health care costs in Massachusetts. *New Engl J Med* 2012; 367:790-793 (12).

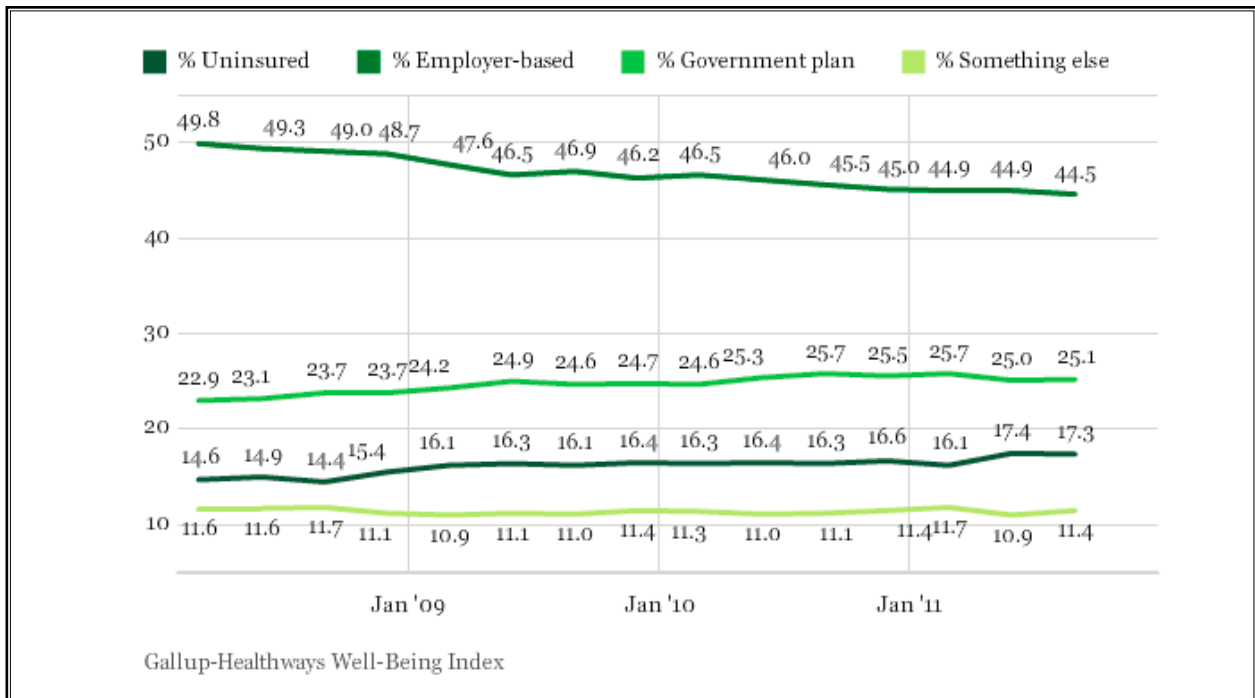


Fig. 2. State of health insurance in United States, 2008 to 2011.

by approximately 1 million (21) and a workforce at its lowest level in history, the implementation of ObamaCare, will result in employers seeking to reduce the coverage of families and enroll in exchanges that the federal government may not be able to accommodate.

Despite assertions by the Obama Administration that the ACA will save money, the CBO has determined that large increases in Medicare and Medicaid outlays as a result of ObamaCare will cause health care spending to skyrocket, surpassing discretionary spending by 2016 (20-23). The CBO summarized that the federal budget deficit for the fiscal year 2012 will total \$1.1 trillion, marking the 4th year in a row with a deficit of more than \$1 trillion (23). The federal debt held by the public will reach 73% of GDP by the end of this fiscal year, the highest level since 1950 and about twice the 36% of GDP measured at the end of 2007, before the financial crisis and recent recession (23). The CBO also expects economic recovery to continue at a modest pace for the remainder of the calendar year 2012, with real (inflation adjusted) GDP growing at an annual rate of about 2¼% in the second half of the year, compared with the rate of about 1¾% in the first half. The unemployment rate will stay above 8% for the rest of the year.

The CBO also estimated the budget, anticipating a bleak economic outlook for 2013 with increasing employment and an impending recession based on the expiration of a host of significant provisions of the Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010; the expiration of Bush era tax cuts; sharp reductions in Medicare's payment rates for physicians' services that are scheduled to take effect; automatic enforcement of the procedure established by the Budget Control Act of 2011 to restrain discretionary and mandatory spending are said to go into effect (24); and extensions of emergency unemployment benefits and a reduction of 2 percentage points in the payroll tax for social security, which are scheduled to expire. Along with other policy changes contained in the current law, the deficit will shrink to an estimated \$641 billion in the fiscal year 2013, leading to recession, with real GDP declining by 0.5% between the fourth quarter of 2012 and the fourth quarter of 2013 and unemployment rising to about 9% in the second half of calendar year 2013. They also described the budget outlook for 2014 to 2022, predicting a steady increase in debt deficit and cuts. Over the next decade, it is estimated that Medicare spending will increase from \$550 billion to \$1.064 trillion, while Medicaid will more than double,

from \$253 billion to \$592 billion. In addition, new exchanges and subsidies created by the health care law will force mandatory health care expenditures to grow from \$25 billion to \$181 billion in 2022. This is based on only a modest decrease in employer offered health insurance. Overall, health care entitlement spending may more than double, from \$828 billion this year to \$1.837 trillion in 2022. This means that health care spending will overtake all discretionary spending in 2016, if President Obama is re-elected in his last year. This is both unprecedented and frightening, since discretionary spending represents the basic functions of government, including defense, law enforcement, roads, etc., (22).

In 2011, the congressional super committee was unable to reach an agreement on where to make cuts in the budget, and so the Budget Control Act was passed in August 2011, which included an automatic \$1.2 trillion "cut" in defense and discretionary spending over the next 10 years (24). Without any further changes, this will cause a cut in physician payments of 2% sequester, along with all other health care services including . This, unless Congress acts, is in addition to 30% SGR cut.

Other issues related to ObamaCare are a device manufacturing tax of 2.3% on medical device makers, which increases the cost of medical devices. In addition, the tax provision of the high medical bills tax will hit Americans facing the highest out-of-pocket medical bills. Currently, Americans are allowed to deduct medical expenses to the extent that the cost exceeds 7.5% of adjusted gross income; however, the new provision in the ObamaCare will raise that threshold to 10%, subjecting patients to a higher tax bill. The tax will hit pre-retirement seniors the hardest. The estimated total cost for this provision alone is approximately \$15 billion.

In addition, ObamaCare will also be placing a \$2500 annual cap on flexible spending accounts (FSAs), which currently have no federal limit and are used to purchase a number of different things. The law will restrict the use of FSA funds. In 2013, an increase in the hospital insurance portion of the payroll tax from 2.9% to 3.8% for couples earning more than \$250,000 a year or \$200,000 for single filers will go into effect with a predicted revenue of \$210 billion from 2010 through 2019. However, the mandate for individuals to buy health insurance and employers to offer it to their workers does not take effect until 2014. ObamaCare already has reduced the number of medical products taxpayers can purchase using funds they put aside in health savings accounts (HSAs) and FSAs starting 2011

amounting to \$5 billion. There have been a multitude of other taxes and penalties, some of which have already in effect and others that are impending. One of the interesting taxes is a repeal of the Blue Cross Blue Shield organization's special deduction in 2010, amounting to 0.4 billion. This has been passed on to patients and providers through an increase in copays, deductibles, and reduced coverage (25). While the growth in US health spending remained slow in 2009 and 2010 at rates of 3.8% and 3.9%, slower than in any other years during the 51-year history of the national health expenditure accounts (26), in 2010, extraordinarily slow growth in the use and intensity of services led to slower growth in spending for personal health care. Thus, the share of GDP spent on health care stabilized at 17.9% for 2010. This is not because of ObamaCare, as proponents would have us believe, but instead to the impact of the recession on purchasers, providers, and sponsors of health care, to persistently high unemployment, to the loss of private health insurance coverage, and finally, to increased cost sharing that induced many people to forego care or seek less costly alternatives than they would have otherwise used. As a result, growth in the use and intensity of health care goods and services in 2010 accounted for a much smaller share of personal

health care spending growth than in previous years. Furthermore, as business, households, and state and local governments financed a smaller share of total national health care spending during and just after the recession, the federal government financed a larger share.

A 2012 annual report of the Boards of Trustees for the federal hospital insurance and federal supplementary medical insurance trust funds to Congress described that ObamaCare is another, and even larger, source of policy-related uncertainty (27). The report described that this legislation contains roughly 165 provisions affecting the Medicare program including reduced costs, increasing revenues, improving certain benefits, combatting fraud and abuse, and initiating a major program of research and development to identify alternative provider payment mechanisms, health care delivery systems, and other changes intended to improve the quality of health care and reduce its costs to Medicare. The trustees believe that while plausible, the outcome will depend on the achievement of unprecedented improvements in healthcare provider productivity. This report correctly points out that based on the current law, future Medicare costs could be substantially larger than the report predicts. Figure 3 illustrates

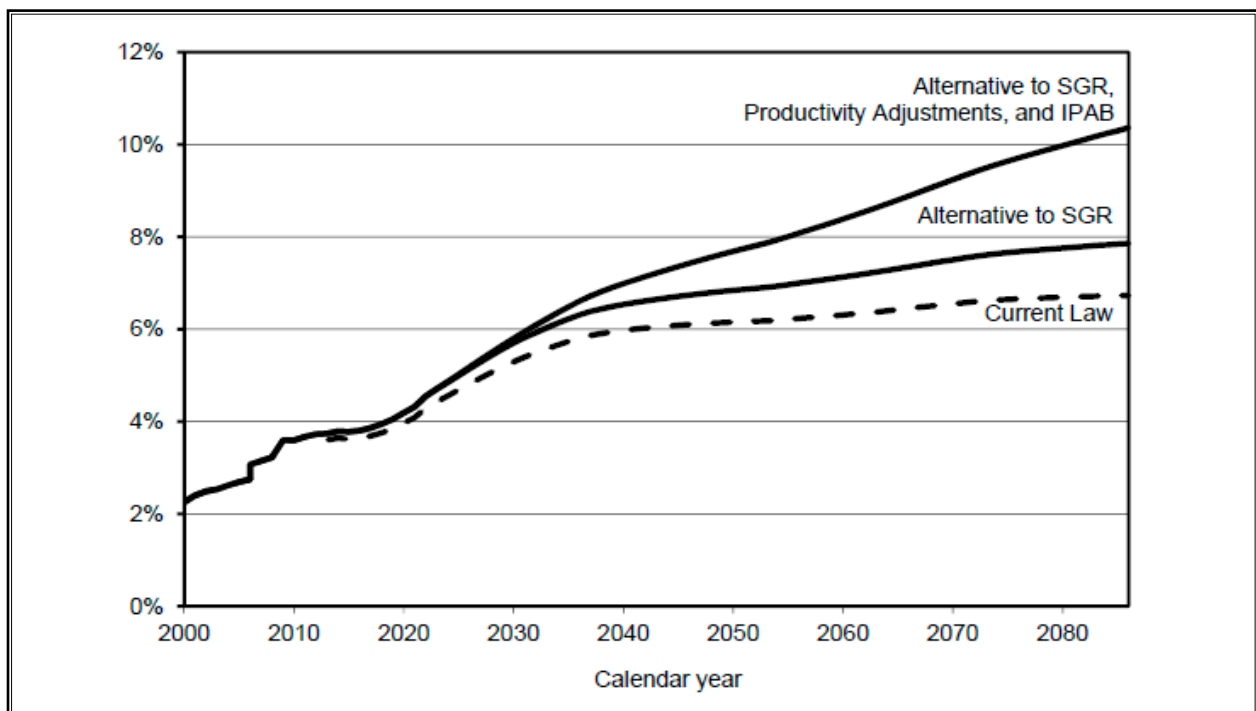


Fig. 3. Medicare expenditures as a percentage of the gross domestic product under current law and illustrative alternative projections.

how Medicare's costs would increase from the trustee's current law projections under 2 alternative scenarios.

The bottom curve in Figure 3 shows the projected total cost of Medicare under the current law as a percentage of GDP. The middle line in the chart depicts the impact of an alternative to the current SGR provision. Under this illustration, the SGR mandated physician fee schedule payment reductions are replaced with a 1% annual increase throughout the 10 year short range evaluation period, or roughly 1% slower than Medicare Economic Index (MEI). This assumption reflects the average Medicare physician fee schedule payment update that occurred from 2003 through 2012, a period during which SGR reductions had been consistently overridden by legislative action. After the short-range evaluation period, from 2022 to 2036, the assumed payment updates would gradually transition in such a way that Medicare expenditures per beneficiary for physician services would ultimately increase at the same rate as per capita national health care expenditures. The top line in this illustrative expenditure (Figure 3) assumes that the SGR payment reductions are overridden as in the prior scenario, that the productivity-related reductions in the non-physician provider updates called for by the ACA are phased down over 2022 to 2035, and that the future cost saving actions by the Independent Payment Advisory Board (IPAB) (28-30) are legislatively overridden. In addition, the impact of the Patient-Centered Outcomes Research Institute (PCORI) Act is underestimated, which may be significant in removing coverage for multiple interventions (31-33).

The trustee's report concluded that the total Medicare expenditures in 2011 were \$549 billion (27). The board projected that under the current law, expenditures will increase in the future years at a somewhat faster pace than either aggregated workers' earnings or the economy overall and that, as a percentage of GDP, they will increase from 3.7% in 2011, to 6.7% by 2086 based on an intermediate set of assumptions. If lawmakers continue to override the statutory decreases in physician fees, and if the reduced price increases for other health services under Medicare are not sustained and do not take full effect in the long range, then Medicare spending would instead represent roughly 10.4% of GDP in 2086. Growth of this magnitude, if realized, would substantially increase the strain on the nation's workers, the economy, Medicare beneficiaries, and the federal budget. The trustees project that tax income and other dedicated revenues will fall short of hospital insurance expenditures in future years un-

der the current law. The hospital insurance trust fund does not meet either the trustees' short range test of financial adequacy or their test of long-range adequacy that is close to the actuarial balance. In contrast, Part B and Part D accounts in the trust fund or adequately financed under current law, since premiums and general revenues income are reset each year to match expected costs. Such financing; however, would have to increase faster than the economy to match expected expenditure growth under the current law.

One of the major funding components of ObamaCare that has received much attention in the press and public recently consists of Medicare cuts of \$716 billion. (34,35). The CBO report updated that Medicare cuts of \$716 billion between 2013 and 2022 . Many have criticized considering this as the physician payment updates and will not affect recipients. However, this does not include the physician payment updates of SGR. According to the CBO, the payment cuts in Medicare include (23,34):

- A \$260 billion payment cut for hospital services.
- A \$39 billion payment cut for skilled nursing services.
- A \$17 billion payment cut for hospice services.
- A \$66 billion payment cut for home health services.
- A \$33 billion payment cut for all other services.
- A \$156 billion cut in payment rates in Medicare Advantage (MA)
- \$56 billion in cuts for disproportionate share hospital (DSH) payments.
- \$114 billion in other provisions pertaining to Medicare, Medicaid, and CHIP (does not include coverage-related provisions).

Amazingly, the data has been manipulated to convey that this does will not affect patients. As the Washington Post article explains, based on the John McDonough's 2011 book *Inside National Health Reform*, the majority of the cuts come from hospital reimbursements and payments to health insurance companies (Fig. 4) (35,36). Thus, a significant proportion of reductions come from Medicare Advantage program payments (37). This program allows seniors to join a private health insurance, with the federal government reimbursing at a higher level. The idea of Medicare Advantage was to drive the costs of health insurance for the elderly down, as private insurance companies would compete for their business. However, by 2010, the average Medicare advantage per patient cost was

117% of regular fee-for-service. The ACA reduced these reimbursements as a result of the Medicare cuts. The perception that this only affects the insurers and does not affect enrollees is totally false. . Even though enrollment continues to increase, enrollees do not understand the consequences. While in the past, beneficiaries had no out-of-pocket expenditures. Now based on the ACA and cost sharing features which adversely affect beneficiaries, these expenditures typically exceed \$6,700 annually. This has a significant effect on interventional pain management, as the majority of procedures cost less than \$300. Plans limiting copays to procedures \$300 will essentially curtail interventional pain management for this group of patients. In essence, Medicare Advantage plans do not have to pay anything, whereas beneficiaries forego their services due to this policy.

The second major contributor to Medicare cuts is the hospital reimbursement. ObamaCare changed how Medicare calculates what hospitals receive in reimbursement for various services, slightly lowering their rates over time. However, this deal was a negotiated expressly for hospitals, as they expected the ACA's insurance expansion to create an influx of paying patients.

ObamaCare also has been tied to increasing college expenses, which increase proportionately along with Medicaid spending (Fig. 5). According to the Budget Crisis Task Force, over the past decade, Medicaid costs have climbed an average 7.2%, nearly double the growth rate of tax revenues. At the same time, states have steadily shifted the burden for college onto students and parents. Today, tuition accounts for about 40% of costs, up from 23% in 1985 (38). As a result, the cost to attend a public 4-year university climbed 46% in real terms in the past decade, compared with 30% for private 4-year schools, according to the National Center for Education Statistics (NCES). It has been postulated that because ObamaCare relies heavily on Medicaid to expand coverage, which is already swallowing upstate budgets, forcing states to cut back on everything else, it also cuts funding for public colleges. A report from the State Budget Crisis Task Force found that even before ObamaCare kicks in, Medicaid costs have been growing faster than the economy and faster than state revenue. As a result, Medicaid now consumes 24% of state funds, and its ongoing growth can no longer be absorbed without significant cuts to other essential state pro-

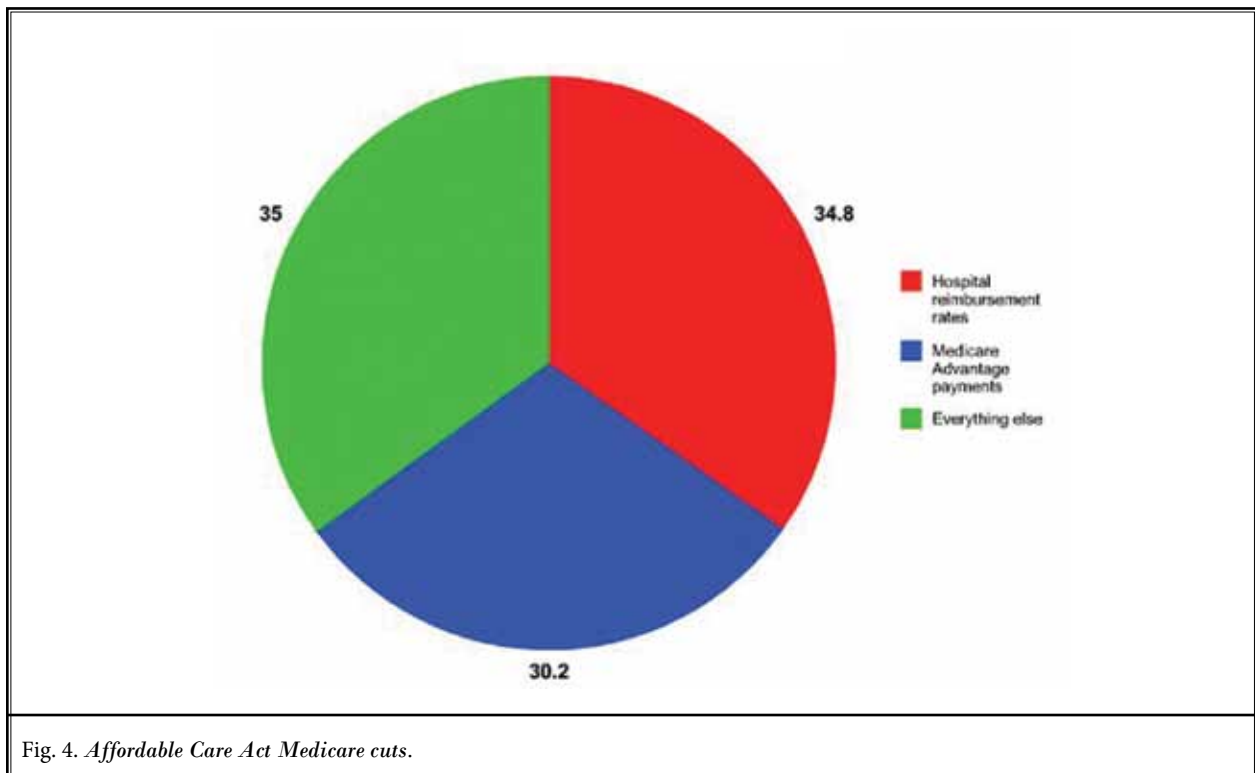


Fig. 4. Affordable Care Act Medicare cuts.

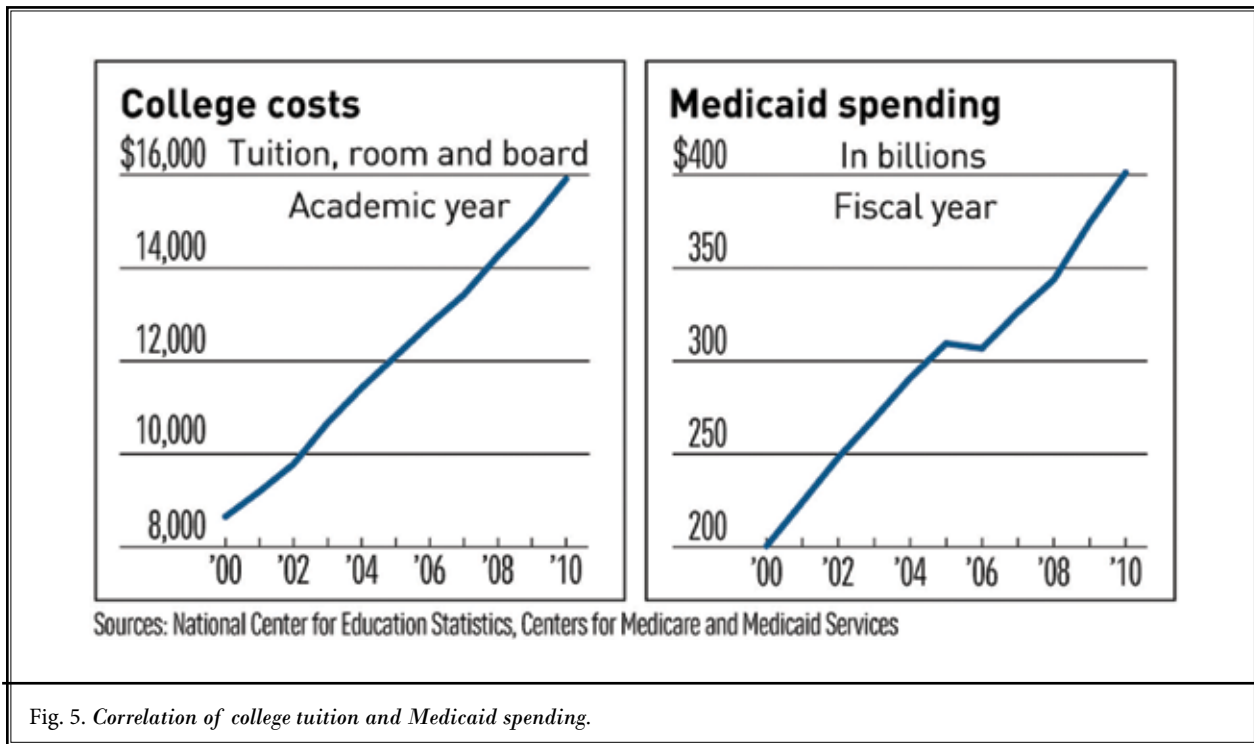


Fig. 5. Correlation of college tuition and Medicaid spending.

grams like education. Peter Orszag, who co-authored a 2003 paper for the Brookings Institution looking at this issue concluded that, "Primarily due to rising state Medicaid obligations, parents and students have been asked to pay an increasingly large share of the cost in public higher education (38,39)." However, Peter Orszag was the Budget Director of President Obama and was one of the architects of ObamaCare. Consequently, college loans are increasing and various proposals have been forwarded to solve the \$1 trillion college loan crisis (40).

Multiple regulations related to ObamaCare include IPAB, Patient-Centered Outcomes Research Institute (PCORI), International Classification of Diseases, Tenth Revision (ICD-10), and electronic medical records (EMRs) (1-4,28-33,41). In addition to the regulations pertaining to ACA, multiple other regulations, such as single-dose vial policies (42,43) have been enacted administratively, increasing costs for medical practices (41) Among the regulations, ICD-10 has been postponed by one year, whereas a new policy has been accepted by the CDC to accommodate single-dose vials.

The Patient-Centered Outcomes Research Institute (PCORI) was established by the Affordable Care Act of 2010 to promote comparative effectiveness research (CER) to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by ad-

vancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed through research and evidence synthesis (32,33).

The PCORI and CER have been described as government-driven solutions that do not follow the principles of evidence based medicine (EBM) and that focus extensively on costs rather than quality. It also has been stated that the central planning for PCORI and CER, a term devised to be acceptable, will be used by third party payors to override the physician's best medical judgement and patient's best interest. Furthermore, stakeholders in PCORI, which is not even under congressional authority, are not scientists, are not balanced, and will set their own agenda, leading to unprecedented negative changes to health care. Ultimately, PCORI suffers from a problem of comparative effectiveness as it is based on political science instead of medical science. Thus, PCORI is operating in an ad hoc manner that is incompatible with the principles of evidence-based practice (32,33).

The Independent Payment Advisory Board (IPAB) is a powerful component of the Affordable Care Act, with the authority to issue recommendations to reduce growth in Medicare spending and to provide recom-

recommendations to Congress for fast-track implementation. The IPAB works by recommending policies to Congress to help Medicare provide better care at a lower cost, including ideas on coordinating care, getting rid of waste in the system, providing incentives for best practices and prioritizing primary care. Congress then has the power to accept or reject these recommendations (29,30). Congress, however, faces extreme limitations in that they must either enact policies that achieve equivalent savings or let the Secretary of Health and Human Services (HHS) follow the IPAB's recommendations. The IPAB statute sets target growth rates for Medicare spending. The applicable percentage for maximum savings appears to be 0.5% for 2015, 1% for 2016, 1.25% for 2017 and 1.5% for 2018 and later. The IPAB Medicare proposal process involves mandatory recommendations and advisory recommendations with multiple reporting requirements. We believe that neurointerventionalists, as highly specialized physicians reliant on expensive technology, should be aware of the IPAB and its impact on the practice of medicine.

In a published article on doctored numbers (44) written by the members of the Hoover Institution Working Group on Health Care Policy, the many misconceptions about ObamaCare are addressed. The objective of the article was to examine a key justification articulated by advocates of ObamaCare, i.e., that people with private insurance pay for care for the uninsured through "cost shifting" or higher prices charged by doctors and hospitals to recover losses from uncompensated care. Thus, members of Democratic Congress and President Obama strongly believe that the way to reduce cost shifting is to require universal coverage. The supposed logic behind this is that if more people buy insurance and are covered by insurance, health care premiums would be dramatically reduced because there would be more people to share in any additional cost caused by the perceived cost shift. However, there was one major flaw in the premise of President Obama and his supporters. As usual, the Administration preaches adherence to evidence-based medicine with Institute of Medicine (IOM) regulations and fails to comply when it comes to their own regulations, including IOM, relying on a non-peer reviewed study commissioned by Families USA, a Washington DC Advocacy Group that supported passage of ObamaCare and continued to aggressively support its implementation (45-54). The study reached an incorrect conclusion, stating that physicians and hospitals were receiving an additional \$43 billion per year from insurers to recover losses incurred by car-

ing for the uninsured – so called cost shifting. In addition, the study also found that these higher charges raised annual private insurance premiums for families and individuals by \$1,017 and \$368 respectively.

However, a well conducted evaluation of the facts leads to a different conclusion. The doctored numbers article (44) points to a Health Affairs article that found uncompensated care could raise premiums by no more than 1.7% (53). The CBO concluded in the 2008 report that, "Overall, the impact of cost shifting on payment rates and premiums for private insurance seems likely to be relatively small (56)." Politicifact.com (57) rated a statement using the Families USA statistic as mostly false because of ". . . significant questions about the Families USA study . . ." However, the questions in reference to contrasting findings remain. The authors of doctored numbers note that charitable organizations and federal, state, and local governments provide physicians and hospitals \$40 to \$50 billion a year in reimbursements to provide health care for the uninsured. These payments, which amount to approximately three-fourths of the cost of such care, mitigate the extent of cost shifting. The evidence suggests an absence of factual support for a key premise of ObamaCare; that people with private insurance pay for care for the uninsured through cost shifting.

Above all, sadly, many experts believe ObamaCare will actually increase cost shifting, not reduce it. About half of the people who are expected to become newly insured under ObamaCare will be enrolled in Medicaid – roughly 17 million people, if it goes as expected (58). However, it is also a well known fact that Medicaid payments to physicians and hospitals are oftentimes well below the cost of doing business resulting in cost shift of their own. Amazingly, the cost of health care for these new Medicaid recipients will not be paid for by private insurance companies or employers, but by taxpayers. According to the CBO, once the law is fully operational, the volume of new health spending born by taxpayers will be approximately \$200 billion with the estimated total cost of the program from 2012 to 2021 at \$1.1 trillion. However, unfortunately, this is the most optimistic forecast because the sponsors of ObamaCare front loaded revenue and back loaded expenses to make the program appear to be less expensive in its early years. Furthermore, CBO also estimated that the program would increase the nation's debt by \$1.36 trillion in its first 7 years. Above all, physician payment cuts through SGR have been considered as they were taking effect and were also used as savings with doubling

of the numbers to approximately \$550 to \$600 billion, in addition to various cuts of over \$700 billion as illustrated above.

ObamaCare is forcing many interventional pain physicians into bankruptcy with cuts, taxes, and regulations providing insurance for all and practically non-existent coverage.. The problem is not limited to the United States. Many countries, specifically the NHS and the Canadian health care system are also going through transformations, with the USA follow right along (60-65). Since the Supreme Court upheld ObamaCare on June 28, 2012, it appears that ObamaCare has survived a series of life threatening obstacles since its congressional consideration, which started in mid 2009. However, while the individual mandate and the majority of the ACA survived, the requirement for Medicaid failed to survive. Parts of the ACA left undisturbed include numerous system reforms, such as ACOs, patient-centered medical homes, the Prevention and Public Health Fund, the PCORI, IPAB, and the enormous powers vested in the Secretary of Health and Human Services (HHS) and the Administrator of CMS. Thus, the health care industry will continue to feel the impact of ObamaCare.

The American Medical Association (AMA) President Jeremy Lazarus (66) commented that the Supreme Court decision was a step forward for health care. AMA has supported ObamaCare and continues to believe that AMA efforts have already played a considerable role in bringing it to this point. However, member physicians vehemently opposed this support. AMA also commented that it has long supported health insurance coverage for all, and they are pleased that this decision means millions of Americans can look forward to the coverage they need to get health and stay healthy. It appears that AMA believes it is committed to working on behalf of America's physicians (albeit a very small number) and patients to ensure the law continues to be implemented in a way that supports and incentivizes better health outcomes and improvements in the nation's health care system. The American College of Physicians (ACP) described that the day will come when the debate will no longer be polarized between repeal on one hand, or keeping the law exactly as it is on the other, but on preserving all of the good things that it does while making needed improvements (67). The American Hospital Association (AHA) which negotiated the deal and who some believe wrote the bill, stated

that the decision means that hospitals now have much needed clarity to continue on their path towards transformation. In fact though, transforming the delivery of health care will take much more than the strike of a gavel or stroke of a pen. It calls for the entire health care community to continue to work together, along with patients and purchasers, to implement better coordinated, high-quality care. The hospital industry is one of the beneficiaries of ObamaCare. They were not only involved in negotiations, but will also be in the driver's seat controlling ACOs, medical homes, and physician practices. The Federation of American Hospitals (FHA) and America's health insurance plans supported ObamaCare and hailed the Supreme Court's decision. However, many physician specialty organizations, the U.S. Chamber of Commerce, and the National Federation of Independent Business (NFIB) expressed significant concerns. Supporters argue that for many providers, it means they can continue to develop business plans they were developing or were postponing, because of the impending court decision. However, this may not be accurate in that nothing is resolved yet. For a pessimist, there are no businesses to plan on. The only business is going out of business and joining hospitals. As a final straw, ObamaCare also empowers advanced practitioners to become doctors while encouraging a reduction in medical school curriculum to narrow the gap between doctors and nurses (68-75).

In conclusion, it appears that ObamaCare is in its second stage. While the prognosis is unclear for the majority of specialties, it is a stark reality for interventional pain management as they consider possible hospital takeovers of practices, declining reimbursement, lack of coverage, and finally, the ability of midlevel practitioners to practice interventional pain management.

ACKNOWLEDGMENTS

The authors wish to thank Vidyasagar Pampati, MSc, for statistical assistance, Sekar Edem for assistance in the search of the literature, Bert Fellows, MA, and Tom Prigge, MA, Alvaro F. Gómez, MA, Laurie Swick, BS for manuscript review, and Tonie M. Hatton and Diane E. Neihoff, transcriptionists, for their assistance in preparation of this manuscript. We would like to thank the editorial board of Pain Physician for review and criticism in improving the manuscript.

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