Obamacare has been unpopular among the general public since efforts to get rid of it have so far been stymied. The election of I repeal and replace the Affordable Care Act, the sig
A look at how Obamacare has impacted our co
its inception. But in more than four dozen attempts, Republican Donald J. Trump gives the Republicans in Congress a chance to make a nature health care overhaul of President Obama.

Community and the medical profession overall.
Shimon Weinberg was enjoying a good job with a promising future, when his boss awarded him a substantial raise in 2014. However, overnight, life in the Boro Park community where he lived with his wife and young family became unaffordable for him.

Due to a yawning hole in President Barack Obama’s healthcare law passed in 2010, medical insurance has become less affordable and less accessible for millions of Americans. For the Orthodox community in New York, the new standard of insurance has led to lost doctors, sky-high rates, and a purgatory of bureaucracy with seemingly no exit.

For Republicans, the sad irony is that this “death spiral” of Obamacare is exactly what they and numerous healthcare economists predicted in the run-up to the law’s passage. It was a mathematically challenged piece of legislation, they said, which relied on unrealistic goals and income streams.

President-elect Donald Trump’s promise, reiterated last Sunday in an interview on CBS’s “60 Minutes,” to repeal and replace the Affordable Care Act, can’t come to fruition fast enough for this low- to middle-class community.

Obamacare has always been unpopular among the general public. But in more than four dozen attempts, Republican efforts to get rid of it have been stymied, first by congressional Democrats and later by Obama’s veto pen.

For Weinberg, a 30-something marketing manager for a prestigious food company, the $10,000 raise was a dream come true. But it didn’t take long to realize that he was losing more than he gained. His free health insurance came to an end. He now had to pay $800 a month in medical insurance which, at $9,600 a year, effectively canceled out his raise — but he also faced high deductibles and copays which essentially made healthcare too expensive to be useful.

“The healthcare that I was getting for $10,000 was terrible,” Weinberg told Hamodia in a recent interview. “It didn’t include dental care, everything had a copay, you had to pay for every single thing possible. It was ridiculous. I was paying so much money that it wasn’t worth it for me to have health insurance.”

Fed up, he took his family and moved to Yerushalayim, where he now works for a real estate marketing company.

“I left America for Israel because I couldn’t afford health insurance,” Weinberg says. “It would have been worth it for me not to get a raise. If that’s called affordable...Obamacare [is a total failure].”

In formal interviews with more than a dozen members of New York’s Orthodox community and informal discussions with many more, an unscientific Hamodia study found a widespread lack of knowledge about the basics of the law, as well as a visceral aversion to it.

It seems everyone has a horror story about Obamacare. Just mentioning that Hamodia was planning an article on the subject elicited a flow of anecdotes.

Barry Spitzer, the district manager of Community Board 12 which encompasses Boro Park, says that a constituent who had a “decent insurance plan” with her company was switched to Obamacare when the law was passed.

“When this person was expecting,” Spitzer said, “she needed a specialist due to a childhood illness, but Obamacare wouldn’t pay for it. Her husband ended up having to go to the doctor and pay out of pocket, as well as for the delivery.” Bottom line, it cost the couple out of pocket somewhere north of $7,000.

“As he told me,” Spitzer added, “Medicaid is better than Obamacare because Medicaid pays better, and most doctors who accept Medicaid don’t accept Obamacare.”

This dislike cuts across the spectrum. There is general agreement that Obamacare has failed in its mission both to lower healthcare costs across the board and to help the uninsured afford insurance. Conservatives slam it for interfering too much in the marketplace, while liberals don’t consider it sufficiently government-run.

During his wife’s presidential campaign last month, former President Bill Clinton famously called the program “the craziest thing in the world,” and Minnesota’s Democratic governor admitted it is “no longer affordable to increasing numbers of people.” Most of the nation’s largest insurers have left the Obamacare market after losing hundreds of millions of dollars, while those remaining have threatened to wait only one or two more years before calling it quits.

Healthcare has been a huge actor in the private sector, accounting for one-sixth of the entire U.S. economy, despite a century-long battle by progressives to bring it under government auspices and control. They finally succeeded in 2010, when Obama made it his first-term priority. But the resulting product was a compromise that satisfied no one.

Liberals wanted the government to step in and abolish privately-run insurance companies entirely, making health insurance a government service like public schools. Conservatives opposed any government interference at all.

Both groups cited the rising costs of healthcare to prove their point. Liberals said that it showed the greediness of the medical and pharmaceutical industries, while conservatives said that if arcane government regulations would be lifted, prices would go down. They took specific aim at two rules: a ban on insurance companies selling across state lines, and the high malpractice awards courts were granting plaintiffs.

The law that was crafted was a compromise. It did not insert a government-run program to compete with the private sector, but it set standards for adequate insurance coverage.

It was to be paid for in four principal ways: Forcing the states to raise Medicaid income limits to encompass more people; forcing companies with 50-plus full-time employees to provide insurance; taxing anyone who didn’t carry insurance; and taxing medical device manufacturers.

The Medicaid provision was quickly knocked down by the Supreme Court as interfering with states’ rights and therefore unconstitutional. The employee mandate has been called a job-killer, since many companies deliberately kept their workforce stuck at 49 to avoid getting into the range, and prohibited other employees from working more than 30 hours a week so as not to be considered “full-time” and thus entitled to employer-subsidized health care. The other two mandates proved insufficient to pay for the
At this point, there is little doubt that Obamacare will be done away with within a year or two and replaced with some sort of insurance voucher or tax credit to help low-income people pay for insurance. Trump has said that he would want to keep some parts of Obamacare, such as allowing children to remain on their parents’ plan until 26 and allowing companies from imposing a lifetime spending limit on consumers.

Yosef Moshe Stein, a Boro Park computer programmer, can’t wait. Stein said that under Obamacare he was able to pay for insurance, although its price was too steep for his income. But when medical bills started coming in he realized that the insurance wasn’t paying for anything.

“The thing that bothers me most about it is that it costs me more than I can afford and I get nothing out of it.” Stein said. “And when I say nothing, I mean nothing.”

One Boro Park resident, who asked not to be named, said that the only solution is to implement what Sen. Bernie Sanders suggested on the campaign trail earlier this year: Expand Medicare for all Americans, with an option to buy private insurance.

“That would be best,” he said, adding that Obamacare cannot be blamed for out-of-control healthcare costs. “I’m not a healthcare economist, but people who are all say that the costs of healthcare was rising even before Obamacare was passed.”

Chaim Asher Reisman, a manager at the Brooklyn-based Safety Fire Sprinkler Corp., disagreed, saying that the company’s fees for providing insurance for their employees have skyrocketed.

“What do you want to know — how bad it is?” he said when questioned about healthcare costs. “How it’s impossible to find insurance? How nothing is covered anymore? How as a company we’re going crazy to provide insurance when the price [of healthcare] is skyrocketing?”

Ben, who works at a luxury watch business, said that while he was initially given the runaround when he first applied for insurance under Obamacare, once he was on it he had more gain than pain.

“I had a positive and a negative experience,” said Ben, who lives in Monsey.

Before Obamacare, he says, he had family-plan coverage from his company. The $1,450 a month plan came with a high deductible, $30 copays, and no dental coverage. He now pays $1,050 a month for insurance under Obamacare, once he was on it he realized that the insurance wasn’t paying for anything.

“Then his four-year-old daughter was thrown off without warning when he finally was on the plan. The insurance companies were promised by Obama that in exchange for agreeing to join the marketplace, millions of young people who have historically eschewed insurance plans would be forced to join or pay a penalty. But they are still staying away, leading to huge losses for insurance companies.

Nearly all of the largest companies, including Aetna, UnitedHealth, and Humana, have already left the marketplace. As of the Obamacare signup season which began this month, about one-third of Americans are limited to just one company, with no competition.

Others don’t have even that. For example, the 400,000 residents of Pinal County, Arizona, do not have a single health insurer offering coverage. It wasn’t always so. Before Obamacare became law three years ago, consumers had eight health insurers to pick from. In about half of Arizona’s counties, they’re now down to one.

While consumers can buy insurance outside the exchanges, they won’t be eligible for the government-provided tax subsidies specifically targeted to help lower-income people afford insurance. The average subsidy in Arizona this year is $230 a month, and more than two-thirds of people on the state’s exchange qualified.

It’s not just Pinal County. Entire states — South Carolina, Alaska, Oklahoma, Alabama — are down to one insurance option, as are parts of other states, including Georgia and North Carolina.

Aetna announced its intention to pull out of 11 of the 15 states where it sells individual Obamacare plans, after saying earlier that it faced $300 million in projected losses this year. UnitedHealth and Humana also said the high cost of caring for sick customers helped push them from the market.

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Before Obamacare, he says, he had family-plan coverage from his company. The $1,450 a month plan came with a high deductible, $30 copays, and no dental coverage. He now pays $1,050 a month for his wife and himself, while his children are on Fidelis, on the Obamacare exchange.

But the red tape he had to loop through until he finally was on the plan was arduous. Even after he entered his personal information to bring up a list of insurance plans, the computer system kept showing that his was an “account pending.”

Then his four-year-old daughter was thrown off without warning when the system showed that someone with the same name and date of birth but living in Brooklyn was already on the rolls. It took a few months to get her back on the plan.

“From my end I’m saving money,” Ben acknowledged. “But for the country, if they would allow healthcare insurance companies to compete across state lines, it would be a lot better.”

“THE THING THAT BOTHERS ME MOST ABOUT IT IS THAT IT COSTS ME MORE THAN I CAN AFFORD AND I GET NOTHING OUT OF IT. AND WHEN I SAY NOTHING, I MEAN NOTHING.”

STEIN SAID. “AND WHEN I SAY NOTHING, I MEAN NOTHING.”
What impact has Obamacare had on health-care providers?

For better or for worse, the Affordable Care Act, dubbed “Obamacare,” has been the rule of the land for several years, now that most of its stipulations have already been in effect since 2014. Much discussion has centered around how Obamacare affects patients, and rightfully so. After all, health care is all about preventing and treating diseases and maintaining the good health of patients. However, often overlooked is how the new laws affect the doctors. Ultimately, the positives and negatives of Obamacare for the health-care provider will trickle down to the patient as well.

- Dr. Arie Blitz has been a cardiac surgeon for the last 20 years. He lives and practices in South Texas. In addition, he also has an MBA in health care, and is involved in health-care administration, management and consultations.
- Dr. Sherri Tysch, a pediatrician, had her own practice in Thousand Oaks, California, for 15 years. She has since sold her practice, and now, instead of the mistake being in one doctor’s chart, it’s in 20 different charts.
- Dr. Raphael Rosenbaum is an ophthalmologist in private practice in Boro Park. He is an associate residency program director in Nassau University Medical Center, where he teaches and supervises residents. He is also on volunteer staff in Mt. Sinai Hospital. These doctors shared with Hamodia how the Affordable Care Act has impacted their practice of medicine.

The Matter of Records

“One of the major provisions of Obamacare has been the push for EHR, electronic health records,” says Dr. Arie Blitz, “and in theory, it is a great idea for all health records to be easily accessible, especially in an emergency.” For example, if a patient is on vacation in a different state and comes to the out-of-town hospital in a coma, doctors should easily be able to look up the patient’s history for optimum and safe care. But practically, says Dr. Blitz, privacy laws such as HIPPA block some of this sharing, and since each hospital has its own computer system in place and the systems don’t necessarily communicate, this aspect of EHR hasn’t tangibly benefited patients.

Dr. Blitz says the overall idea behind electronic health records was a good one, but this has been a case of too much too soon. “Electronic records were pushed too hard and too fast, without enough priority given to solving all the potential issues, such as connectivity and infrastructure.”

Doctors are notorious for their illegible handwriting, and pushing for electronic health records should have completely eliminated the days of hard-to-read prescriptions and health records, but new problems have cropped up. Says Dr. Blitz, “When notes are written in the chart by hand, they may not be as legible as when typed; however, there is a natural tendency to be more accurate with written entries, which isn’t the same as when typing into a computer. Doctors in a rush will copy and paste notes from the previous day and make revisions as necessary, but mistakes happen all the time, and then the mistakes get passed on from day to day and are hard to fix. So often, I will find a note in a chart that says ‘patient will have heart surgery next week’ when the surgery actually took place the week before!”

Another problem with EHR is the cost. For Dr. Sherri Tysch, it’s one of the factors that made her decide to sell her practice. “It would have cost about one hundred thousand dollars to convert my records to comply with EHR, and so I made the decision to sell my practice and join a multi-specialty physician group instead. In my opinion, EHR does not improve patient care, but only increases the doctors’ workload.”

In addition to the cost in dollars, Dr. Tysch cites the increase in time EHR requires. “My normal workday is from 8 a.m. to 6 p.m., with an hour for lunch. Of that time, I see patients for only six hours, and the rest of the time is spent on EHR.” She maintains the new records are cumbersome, and the rules require doctors to fill out things they usually wouldn’t write at all. “I normally wouldn’t do a full neurological exam when a child is brought in with an earache, but that is what EHR asks for. I also must, for example, ask each patient over age 14 if they smoke, and click the appropriate button. Asking
The One Thing Missing From the Debate Over Obamacare, According to a Top Doctor

By Carolyn Y. Johnson

Little is known about the replacement plan that will ultimately emerge. But one voice angling to shape future policy is the leader of the Mayo Clinic, neurologist John Noseworthy.

President-elect Donald Trump’s promise to repeal the Affordable Care Act while preserving some key elements has triggered rampant speculation about the future of American health care — and plunged millions of patients who benefit from the law into deep uncertainty about the future of their coverage.

Little is known about the replacement plan that will ultimately emerge. But one voice angling to shape future policy is the leader of the Mayo Clinic, neurologist John Noseworthy. The issue he thinks has been strangely missing from the years-long debate over malfunctioning websites, politics and soaring premiums is this: the patient’s health.

Noseworthy argues that the Affordable Care Act that expanded access to health insurance to millions of Americans did so without nearly enough input from the patient — or the doctor.

“Patients are getting frustrated and fearful and anxious that they can’t have access to the care that’s best suited for them,” Noseworthy said. “How can you have a great country if our citizens can’t get access to world-class health care? It’s actually not a bad time to reassess.”

The nonprofit health system Noseworthy runs is one of the best-known names in medicine. The Mayo Clinic has provided guidance and advice to the federal government on health-care issues for more than a century — regardless of who is running it. Noseworthy said his team has already been in touch with the Trump transition team, offering their eagerness to help solve the complex puzzle of health care.

One of the biggest weaknesses of the Affordable Care Act, in Noseworthy’s view, is that it expanded access to health insurance — in part by creating barriers to health care. Health plans have successfully controlled costs by restricting which doctors and hospitals patients can use and by shifting the upfront costs of care to patients through high deductibles.

Noseworthy has a self-interested reason to want sick people to have more choices — narrow health insurance networks often exclude prestigious and expensive health systems like the one he runs. But surveys suggest this winnowing of consumer choice while costs rise is on the minds of Americans.

A survey by the Partnership to Fight Chronic Disease and Morning Consult found that 77 percent of respondents had trouble using their health insurance in the past year. Half of respondents said that a doctor had recommended a treatment that was not covered by insurance to them or someone they know. In a Kaiser Family Foundation poll in October, a majority of Americans said making sure health plans cover enough doctors and hospitals should be a top priority for the next administration.

A week after the election, Noseworthy spoke to The Washington Post about what lies ahead for health care.

Q. From a patient’s point of view, do you think this moment could be an opportunity?

A. I do. I think we’ve been talking much more about premiums and websites than we have been about what patients need. The voice of the patient and, I would argue, the voice of the medical profession, hasn’t been at the table for a long, long time. I think we could help.

The fact that access, which is pretty important to patients, is now being jeopardized and patients are feeling it — that has to be fixed. That’s really where the voice of the patient matters. The other, of course, is the unsustainability of the rise of the premiums for the middle class.

Most Americans are paying more for health care, and they’re kind of figuring it out now. They’ve had the Affordable Care Act for a while, but they didn’t realize what high deductible health plans really were until they got sick. And they said, “Wait a minute — I have to pay the first $1,000, $5,000, $10,000? I don’t really have insurance unless I have a catastrophic illness.”

I think a tipping point is being reached in the country, where people are realizing that year to year, there are unsustainable increases in individual citizens’ premiums, with no additional benefit to them. And they worry about what that’s all about. And they can’t pick their physician. And if they get really sick, they can’t go where they want to go.

Q. Do you think those effects are trickling outside the Affordable Care Act?

A. The narrow networks are proliferating, and that is keeping the sickness of the sick away from the centers that do most of that care [for complex medical conditions].

The commercial insurers and the employers are playing into that narrative as a way of saving money — as opposed to appropriating money appropriately for better outcomes. The fundamental mistakes are cascading through the system, and that’s why perhaps a fresh look and a surgical repair and replacement of parts of it [the law] — perhaps this is a good time for it.

Q. What would be the elements of the law most important to preserve?

A. Pre-existing conditions — to take those away would be very hard. I think some annual or lifetime cap on costs for individual citizens will probably be preserved. Keeping kids under 26 [on insurance]. It falls off pretty quickly after that. If asked to respond, “What about this one?” That’s where that measured, careful disciplined approach would have to be looked at. I think everything else is kind of up for grabs.

Q. Are you concerned at all, given the lack of clarity about the health policy positions in this new administration?

A. I don’t think anyone’s freaking out, to be honest. This is a very complex puzzle to solve, and we would encourage a very careful approach — a surgical approach. Meaning, as a physician, if a patient is ill, much of the patient is still healthy. And it’s your job to replace and repair the parts that aren’t healthy, without harming the patient.

We’re really talking about replace and repair, rather than repeal. But we haven’t seen a full approach yet from the administration. Personally, this is me speaking. I don’t think it’s a bad thing — I’d rather be called in to a careful review and assessment of the situation and a thoughtful approach to a very complex problem, rather than a quick fix, which could be fundamentally flawed.

We’re basically optimistic we can create a better system together.

Q. How would you say the Affordable Care Act has changed medical practice for doctors?

A. I think the multiple sectors are working together and recognizing they all have to work together to create a better outcome, whether it’s a device company or a payer or an employer or providers. I think we weren’t in that situation five to eight years ago, where we all saw we’re part of the solution. I think it’s a good thing.

The Affordable Care Act and the changes that have come along with that have created a very stiff regulatory environment. It’s been very, very hard for health-care professionals. And if you’ve been a patient or studied health care, you know that in today’s world, the patient is no longer at the center of the room. The physicians and nurses are spending a lot of time documenting the situation, rather than asking about and listening to. And that removes a lot of professionalism and joy of the work.

For every hour a doctor spends with a patient, the doctor spends two hours documenting the one-hour encounter. So the balance is off, and that’s created a huge threat to the profession. (The Washington Post)
Rate Hikes, New Doctors

Obama’s health secretary wants to make patients healthier by transforming how doctors and hospitals get paid.

As President Obama closes in on his final months in office, few parts of his legacy loom larger than the Affordable Care Act, the health-care law he signed in 2010 that helped extend health coverage to more than 20 million previously uninsured Americans.

But largely out of the spotlight, Obama administration officials have labored on an equally sweeping project to transform how America’s doctors, hospitals and other medical providers deliver care.

The foundation of this effort involves scrapping the way medicine has traditionally been paid for — a system in which each service a doctor or hospital provides is billed separately, no matter how well it is performed and what the long-term outcome is.

In place of that, the Obama administration is trying to build a system that pays doctors, hospitals and others based on how their patients recover and how much their care costs.

Among the biggest advocates for this initiative is Health and Human Services Secretary Sylvia M. Burwell.

Recently, Burwell traveled to a hospital in Jacksonville, Fla., to talk about a new part of this effort — a proposal by Medicare to make all hospitals in selected metropolitan areas responsible for the quality and total cost of care for patients undergoing heart and hip surgeries, including what happens after the patients leave the hospital.

Burwell sat down with The Los Angeles Times to discuss the initiative, why it’s important and whether it would continue even under President Donald Trump.

Q: Why, when so much attention is focused on Obamacare’s insurance marketplaces, did you come to Jacksonville to talk about paying differently for medical care?

A: It’s frustrating. The Affordable Care Act was about so much more than coverage. Yet it’s become defined by these marketplaces, which provide coverage to just about 12 million people.

We have to broaden the concept. The increased access is tremendous, but health outcomes are the place where we have to make historic changes.

This is about health and well-being. And when you get medical care, it’s about how you experience that care and what the outcome is.

Can you play basketball again, if that is what you want to be able to do? Or, can you walk to the beach, if that is your thing?

Q: So, by paying differently for care, the federal government can improve outcomes for patients?

A: Yes. Financial incentives will cause better coordination of care. That will lead to better quality and lower costs.

We already see example after example of this around the country.

Sometimes it is simple stuff. Your mom isn’t rehospitalized because she didn’t fall at home because someone told her to move a rug in her house that she could have tripped on.

Or a physical therapist knows that a hip-surgery patient had a bad reaction to the anesthesia, so the therapist can plan differently and take the right approach with the patient.

That’s a more complex example, but it is exactly what we are driving toward.

Q: You say better coordination will make medical care more affordable, but the opposite seems to be happening: Americans see deductibles spiking while insurance premiums continue to rise.

A: That’s why when I arrived at HHS, we met about delivery system reform in my first week. Because it needs to be accelerated.

The growth in premiums is slower than it has been historically, and the growth in total out-of-pocket spending is about the same. But we need to do better.

Q: Then why not require all doctors and hospitals to participate in these new payment systems, rather than rolling them out in select parts of the country?

A: We have evidence from the best players that this can work. But to understand how we can scale it to the whole nation, you have to take it step by step.

Some people thought this step was too aggressive. We are trying to be as aggressive as we can.

What we are doing is creating a model for the nation.

Q: When you look five or 10 years in the future, will all doctors and hospitals be paid in this new way?

A: Certainly by 2018, 50 percent of all Medicare payments will be linked to the value of the care that is being delivered. That was our goal. We are on that path.

And the fee-for-service system of paying for medical care will go away.

What will come in its place, I’m not sure. But the idea that doctors practice medicine based on doing individual tests or procedures will go away.

Q: You obviously can’t talk about the presidential election, but as you look into the future, are you worried these changes could be reversed?

A: There is a ball that is rolling, and part of what this new proposal is about is keeping that going. The reason for that is that people do not want to go back.

I’m confident that the energy behind this is big enough that the ball is going to keep rolling.

The private sector is behind this, and medical providers want this.

I think they want to be at a place where they can practice medicine for the reasons they went into medicine.

And young people, they are all about it, especially using data and information.

Q: So, what will keep up the momentum?

A: Everybody has to understand that the customer is at the center of these changes. The federal government has to understand that, too.

That is the key concept. We need to focus on outcomes and remember the people who are experiencing those outcomes. (Tribune Washington Bureau/TNS)

Continued from page 12

about smoking can be appropriate in some situations, but being mandated to do it in what’s referred to as “meaningful use measures” sometimes makes no sense. It is extremely tedious to document everything EHR requires. As a result, patients are frustrated that the doctor isn’t looking at them, but rather clicking on a computer or tablet during the entire visit.”

Electronic health records do have many positives, says Dr. Raphael Rosenbaum. “EHR allows us to easily send patients’ medical records to other doctors, and patients can access their own records through an online patient portal. E-scripts, the electronic program that sends prescriptions directly to pharmacies, is also useful, as it allows doctors to instantly check which medications the insurance will cover and will help you get prior authorizations.”

On the other hand, he says, patients are locked into one pharmacy, and can no longer shop around to get good prices for prescriptions, and if a pharmacy is out of the required medication, they can’t use the original prescription, as they aren’t transferable. “Before Obamacare, if a pharmacy didn’t have a medication, or it was too expensive, patients would just go to another pharmacy down the block, paper prescription in hand. Now they have to call our office to get a new prescription emailed to the new pharmacy.” For doctors, this means they must field many more prescription requests by phone, adding even more tasks to an already busy day.

Universal Coverage

One of the most important provisions of the Affordable Care Act is universal coverage, the idea that everyone in this country, including those with pre-existing medical conditions, can get insurance coverage. Also, yearly physical exams are free, and children up to the age of 26 still living at home are covered under their parents’ plans. All the doctors interviewed agreed that this aspect of Obamacare was positive, and has increased the pool of patients who now have health insurance. But even on this front, not all is rosy.

The price of premiums has gone up, contrary to what President Obama assured the country, and low-cost plans do not cover all that much, as some patients are dismayed to discover. Doctors now need to deal with frustrated patients who don’t understand why they must pay so much money. “Instead of buying an expensive insurance plan, patients buy cheaper plans
on the exchange. But they either don’t read the fine print, or no one is reading it to them. The plans cover hospital visits only in dire emergencies, and even if they visit only in-network doctors, they are responsible for a large deductible,” says Dr. Rosenbaum. The average policy that costs just $10,000 a year for a family can have a $5,000 deductible, or more. That means before the patient shells out at least $15,000, insurance doesn’t pay anything. “I had a husband and wife from Pakistan visit my office this year. They both needed cataract surgery, and were certain it would be covered by insurance. When I told them it wasn’t, as both surgeries were less than the deductible, they decided it was worth it for them to go back to their native Pakistan and have the surgeries done there.” So much for doctors having more patients!

When visits and procedures aren’t covered, doctors have to hope patients will pay them. “Even for the sickest population, some Obamacare plans allow for just one office visit after the free physical. For a patient with asthma, for example, we see them for the first attack, and then for visits after that, we hope they pay their bill. Alternatively, the patient will skip the doctor’s office altogether and head straight for the emergency room, knowing the hospital can’t turn you away,” says Dr. Tysch.

Another factor in Dr. Tysch’s decision to close her private practice was the difficulty in obtaining affordable health insurance coverage for her own staff. “It’s harder for doctors to maintain their own practices when they have to pay so much for their employees’ health insurance.”

Art vs. Science

In the famous Hippocratic Oath doctors take upon graduating medical school, they pledge to “remember that there is art to medicine as well as science...”

“As much as it would be ideal if medical decisions would be scientific, and evidence-based, many people, and certainly career politicians, don’t realize that much of medicine isn’t science, but an art. No patient is like another, and those composing the Affordable Care Act have a flawed view of how doctors practice, and [this] leads to unintended consequences,” says Dr. Blitz.

Dr. Blitz gives us an example: “There’s a rule that after heart surgery, the Foley catheter (a urinary catheter put in place during the surgery) must be removed within 48 hours, or else a reason must be documented. This makes sense, because a Foley left in too long can cause infection. But in many elderly patients, doctors are removing the Foley catheters too early. Their patients might need a catheter for a few more days until they can eliminate on their own, so they will remove the catheter to comply with the rule, then insert a new one, to the patient’s extreme discomfort.”

Rules are set up to be easy for an outside reviewer to measure. “Just because you can measure something, doesn’t mean you should, especially if it creates new problems and does not lead to behavior that truly benefits patients,” says Dr. Blitz.

The government has shifted much of the risk of payments to doctors and hospitals. For doctors, it means it just isn’t worth it to keep their own practices. When the government controls hospitals by their purse strings and hospitals are penalized, they will tell doctors what to do or not do. Worse, hospitals struggle to remain open. Yet many of the rules of Obamacare penalize hospitals for things completely irrelevant to patient care. “The regulations stipulate that patients undergoing certain surgical procedures must be given prophylactic antibiotics for no more than 48 hours. If a patient is administered their last dose at 49 hours, which doesn’t harm them at all, the hospital is penalized,” says Dr. Blitz.

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Jim Vetsch shifted uncomfortably as Dr. Paul Gordon leaned in and asked him about Obamacare.

The two men — one a retired power plant operator, the other a medical school professor — were standing in Vetsch’s kitchen at the Horse Creek Bed and Breakfast in eastern Montana where Gordon had stopped for the night.

Vetsch wasn’t happy about the country’s direction, he told Gordon at last. And he definitely didn’t like the Affordable Care Act — it was too expensive, and the government shouldn’t be providing health insurance.

“It’s a crutch,” Vetsch declared.

Gordon tried to press Vetsch, asking what should happen to people who couldn’t afford health coverage. Vetsch didn’t answer directly. “I’ve worked all my life,” he stated, noting he’d always had jobs with benefits.

Gordon had heard a lot of that in recent months. On sabbatical from the University of Arizona, he had set off in the spring on a cross-country bicycling trip and “listening tour” from Washington, D.C., to Seattle, talking along the way to Americans about the health-care law that President Barack Obama signed six years ago.

Much of what Gordon uncovered was as unsettling as the current presidential campaign. Americans raged at the government, at the health-care system, at fellow citizens who’d gained coverage through Obamacare.

The outpouring of resentment and apparent lack of empathy disturbed Gordon at first. “Not a lot of generosity of spirit,” he noted glumly over the phone early in his trip.

But as he made his way west, Gordon’s feelings evolved. His depression gave way to a new sense of resolve. As a doctor, he could and should do something about the anger he was hearing.

“I saw this could make me a better teacher, a better clinician, a better human being,” he said.

Gordon, 61, a compact man with sharp features, black half-rim glasses and a gray beard that gave him a distinctly academic look, conceived his ride as a scholarly exercise that would generate academic papers about perceptions of the health-care law while fulfilling his 40-year dream of biking across the country.

Eager to learn what his unusual project might reveal about a bitter national health-care debate I’d been covering for nearly eight years, I met up with him in eastern Montana to bike along and listen for a day.

We started in Forsyth, an aging railroad town in the wide Yellowstone Valley where long coal trains rumble past at all hours. Gordon was moving into the arduous final third of his 3,255-mile journey, which would go up through the Rockies and the Cascades before ending on the West Coast.

We planned to ride west along the Yellowstone River paralleling the route Lewis and Clark had taken, then south into the foothills of the Big Horn Mountains where Custer was famously ambushed.

All around us, mammoth ranches stretched across valleys dotted with sage brush and lazy cattle sheltering under stands of cottonwood...
trees. On either side, pine-studded ridge lines offered shelter to elk, mountain lions and wolves.

Gordon and his team — which at times had included his wife, his adult children, a couple he’d befriended in Arizona and a medical student, Laurel Gray, who made the trip a research project — had endured far harder rides: long slogs across the Dakotas where towns were separated by 60 miles or more, and cold days of freezing rain in the Midwest.

But what had proved most challenging for Gordon were the conversations. In Pennsylvania, a restaurant owner complained about her rising insurance bills and told Gordon she was sick of her insurance payments covering other people’s medical care.

In a small cafe in western Minnesota, a 64-year-old woman accused the law of spawning widespread abuse. “Obamacare encourages people to take advantage of the system,” she told Gordon.

Outside a convenience store in eastern South Dakota, another woman said — somewhat ashamedly — that everyone in town thought Obamacare and Obama were terrible. “He just gives all the taxpayers’ money away to poor people,” she said.

“I thought, ‘Oh, my G-d, how did we get here?’” a dispirited Gordon told me as he struggled to decipher the anger.

“I am having these beautiful days riding through the country, and then at the end of the day, I sit down to talk to people and hear this terrible stuff. … It’s overwhelming how little care people seem to have for others.”

Equally jarring, Gordon found that few of the people he met seemed mean-spirited.

“These were people who would help you on the side of the road,” Gordon said. “They are good people. But what was coming out of their mouths was so ugly.”

Gordon, who has spent 30 years as a family physician caring for patients, had been prepared to hear frustrations. He expected complaints about rising premiums and deductibles that were making growing numbers of Americans skip medical care.

He also knew many people he met wouldn’t share his liberal political views.

Gordon had resolved he wouldn’t argue or try to sway opinions. He wanted to record what Americans were thinking.

But as his conversations uncovered basic misunderstandings about health care and health insurance, Gordon tried to push people to think about how they would fix the system.

Rarely did he get much of an answer.

“There just weren’t solutions,” Gordon told me at one point, venting his frustration with the misinformation and the cable news sound bites he was hearing. “All we had were complaints.”

Over time, however, Gordon began to see that those complaints represented an opportunity.

Doctors, he concluded, could step in and begin to correct some of the misinformation and help Americans better understand their health-care system.

“I actually feel inspired,” he said at one point.

As we rode up out of the Yellowstone Valley, climbing gently but steadily along a meandering stream called Sardy Creek, Gordon expanded on what he had come to appreciate.

“The U.S. health-care system is numbingly complex. It’s difficult for patients to understand why it costs so much, even how health insurance works.

At the same time, Americans’ anger about how much they are paying is justified. These are legitimate concerns, the kind of concerns my patients could have when they come into the office,” Gordon said.

If these patients worried about a medical issue — a sore throat, an aching leg — he would consider it a professional duty to investigate and seek a remedy.

Physicians have been reluctant to talk to patients about the health-care system, however, perhaps leery of being drawn into the partisan political debate.

That is a mistake, Gordon concluded.

“I’m not saying, ‘Be political.’ … I’m not going to tell someone to vote for this candidate or that.”

He reasoned physicians could do far more to guide their patients through the system and explain how it works. Armed with better information, perhaps Americans would base their opinions about health policy on more than the kind of emotional responses he heard across the country.

“We, as doctors, need to help people understand,” he said.

As we neared the end of our 50-mile ride that day, the hills got steeper and the temperature soared to more than 100 degrees. Conversations quieted.

By midafternoon, we made it to a turnout about halfway up the valley. There, Vetsch picked us up, saving five miles of pedaling down a dirt road to his inn.

He greeted us warmly, helping to put the bikes on a trailer before driving us to his ranch house on a slight rise overlooking the valley.

Vetsch offered tall glasses of iced tea as we gathered in his kitchen, surrounded by photos of his family. After the awkward conversation about Obamacare, we all helped chop vegetables as Vetsch cooked chicken breasts.

I caught a ride back to Forsyth after dinner with a local hunting guide Vetsch knew.

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Later, as Gordon reflected on the conversation, he said it once would have frustrated him. By Montana, it was another reminder of how much explaining Gordon and other doctors needed to do.

A few weeks later, after he arrived in Seattle, Gordon told me he was feeling good about the journey and the more than 100 conversations he’d had across the country.

“I’m tired,” he admitted. But he was thinking about another potential project — a ride across the U.S. to talk with Canadians about their health-care system. (Tribune Washington Bureau/TNS)