Editorial

ObamaCare's High-Priced Illusion of Coverage

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By now, many have lost the health insurance coverage they had and have been forced to buy a plan compliant with the Affordable Care Act (ACA or "ObamaCare"). We have been told that the new compliant plans are more comprehensive, but in most cases they include coverage that is not wanted or needed.

We also have been told that the new compliant plans are more affordable, a claim we now know is not true for millions of Americans. For those who are eligible for government subsidized coverage, the "affordability" comes at the high cost of yet another government-mandated wealth transfer scheme. Those who have pre-existing conditions or who wait until they get sick to buy coverage also benefit financially from the wealth-transfer aspect of ObamaCare at the expense of others.

And, for the millions who qualify for Medicaid under expanded Medicaid in ObamaCare, the affordability of paying nothing for their health insurance will be revealed as nothing more than a cruel hoax when beneficiaries discover that coverage is not the same as timely access to good care.

A side-by-side spreadsheet analysis of how one's prior coverage compares with one's new ObamaCare coverage is recommended. If a red font is used in each cell to indicate worse coverage than one had before, most will end up with a predominantly red spreadsheet.

Metal Tiers

The new insurance products have been divided into four metal tiers: platinum, gold, silver, and bronze. Although the names imply that platinum is a better value than bronze, the opposite is true. In the platinum tier, consumers overpay for coverage that is closer to first-dollar coverage than the bronze plan. Platinum plans, for instance, often offer first-dollar coverage for primary care visits up to some dollar amount (e.g. $250). First-dollar coverage, of course, is always a very poor value, as illustrated by the analogy of car insurance covering oil changes. So, with a platinum plan, one ends up paying a higher premium for worse-value coverage.

Comparing Coverage

In any plan tier one chooses, deductibles and co-pays are much higher than the prior plans that were not ObamaCare-compliant.

In the early days of health savings accounts (HSAs), premiums for high-deductible health plans (HDHP) were much lower than premiums for managed-care insurance. Those who chose HSA-qualified HDHPs derived significant financial benefit by accepting the risk of paying the first $2,500 or so out-of-pocket. Now, however, high-deductible plans are accompanied by premiums that are disproportionately high. The significant financial benefit previously associated with choosing an HSA-qualified HDHP has been reduced and nearly eliminated. The disproportionately high premiums of current HDHPs are the wealth transfer used to pay for care for others and to enhance insurance company profits.

The structure of ObamaCare's metal-tiered deductibles, co-pays, and out-of-pocket maximums is designed to essentially eliminate out-of-network medical care and the out-of-network physicians who provide it. The ObamaCare plans are designed to save costs by eliminating patient choice. Eliminating patient choice often results in increased wait-times and shorter office visits. And, highly restricted physician panels under ObamaCare are often accompanied by highly restricted treatment choices as well.

Some ObamaCare plans provide no out-of-network benefit at all. Out-of-network deductibles are not only much higher than in-network deductibles, but in-network and out-of-network expenses are often no longer combined to meet the deductible amount. That means, for instance, that for an in-network deductible of $3,500 and an out-of-network deductible of $5,000, the insured could end up paying $8,500 out-of-pocket in a given year before the insurer would pay anything for medical care. As few people pay more than $8,500 per year for routine medical care, the illusion of "coverage" becomes painfully apparent. The premium paid for such "coverage" is simply transferred to pay for care for others and to enhance insurance company profits.

In comparing co-insurance between prior plans and ObamaCare plans, one finds that co-insurance has increased substantially and is often double that in prior plans.

And, in many cases, the out-of-pocket maximum has gone from an out-of-network amount double the in-network amount under prior plans, to an unlimited out-of-pocket amount for out-of-network services under ObamaCare. This change destroys the concept of insurance.

The purpose of insurance is not to provide healthcare, as insurers would have us believe, but to protect one's financial assets against the cost of an expensive illness that is unpredictable and unlikely. But, in the new ObamaCare plans, where one may continue paying as much as 50 percent co-insurance with no upper limit, there is no protection from financial ruin if one chooses better-quality, out-of-network care. There is only the high-priced illusion of coverage.

The So-Called Added Benefits of ObamaCare Plans

ObamaCare plans come with pharmacy coverage, nutrition and fitness benefits, dental coverage for children (up to age 19), and coverage for abortion and abortifacients. Given the high premiums, the pharmacy benefit, which often comes with its own highly restricted tiered drug coverage favoring lower-cost generics, is a poor value for most. Overpaying for insurance to get a minimal amount of money back for buying vegetables

is also a poor value. Likewise, overpaying to obtain limited allowances for fitness club memberships, basketball camps, gymnastics, and other activities is also a very poor value.

ObamaCare plans will also force some to pay 100 percent of preventative dental care for others' children, and even for orthodontics.

Those who have religious objections to abortions and abortifacients will also be forced under ObamaCare to pay for abortions for others.

Implications for Physicians

Higher deductibles and higher co-pays under ObamaCare mean that most physicians will incur greater risk of financial loss. Patients who are accustomed to low deductibles, low co-pays, and near-first-dollar coverage may not be willing to pay the higher out-of-pocket costs ObamaCare imposes. This will lead to increased tension in the patient-physician relationship in the offices of participating physicians.

ObamaCare is also designed to enable the theft of services. The 90-day grace period allows those who obtain subsidized coverage to keep their coverage for 90 days even when premiums are not paid. The insurer must pay for covered services for the first 30 days, but thereafter claims will hang unsettled and may ultimately be denied. So, medical services provided during the second and third month of the 90-day grace period may simply go unpaid. Physicians who provide high-dollar services, or services for which they must purchase and supply expensive medications, will suffer significant financial losses. Some insurers are exacerbating the problem by advising physicians on their panel not to collect anything at the time of service because the insurer's patient eligibility/90-day grace period data may not be up to date.

Although insurers are supposed to advise treating physicians when an insured is in the grace period, there is no penalty if the insurer fails to provide such notification in a timely manner. At a time when the government and insurers are steadily demanding more electronic data from physicians, many physicians have to telephone insurers to find out whether the patient is in the-90 day grace period or not.[1] Insurers have no incentive to staff call centers adequately, because if the physician provides service in the second or third month of the grace period, the insurer pays nothing and the physician may have to absorb the entire loss. As a result, "call center lines are inundated with queries and hold times are excessive, even by today's standards."[1]

When many physicians can ill afford additional administrative costs, adding the cost of paying someone to do phone queries and wait for extended periods of time will add a significant burden to the cost of running a practice.

Moreover, once a physician has provided medical care to a patient during the first 30 days of the grace period, refusing to continue to treat the patient during the second and third months of the 90-day grace period and beyond may lead to charges of patient abandonment and other legal pitfalls. Depending on a practice's patient mix, some unfortunate physicians may be expected to suffer bankruptcy as a condition of keeping their medical licenses. According to information provided by the White House, only two-thirds of the recently enrolled 8 million people actually paid their initial premiums. In addition, the 28 percent of recent enrollees who are age 18 to 34[2] may decide at some point that paying exorbitant premiums for the illusion of coverage simply is not worth it. And, many of those may take advantage of the 90-day period of government-sanctioned theft as a means to get their "money's worth" as they exit their health plans.

To further confuse matters and increase the probability of physicians suffering financial losses, insurance cards that are familiar to a medical practice may be indistinguishable from insurance cards for one of the inferior Exchange products.[1] If the physician does not participate in the Exchange product, the claim may not be paid.

Conclusions

ObamaCare is designed to cheat both patients and physicians. It destroys patient choice and often disrupts continuing long-term patient-physician relationships. By implementing extremely high deductibles, co-pays, and out-of-pocket maximums, ObamaCare creates the illusion of coverage at the cost of unacceptably high premiums. This combination represents the largest wealth-transfer program in our nation's history. It also serves to enhance the profits of insurance companies that supported ObamaCare's creation.

In order to survive, physicians who depend on third-party payment will need to take appropriate legal measures to limit financial losses caused by ObamaCare. Many will likely reassess their plan participation as financial losses and bureaucratic impediments to care increase. Third-party-free practice models will become more attractive to many physicians. And, unfortunately, physicians who opt for hospital-subsidized employment in an attempt to escape the adversities of ObamaCare will only exacerbate the loss of choice for patients and the rationing of care by the so-called Accountable Care Organizations.

Patients will also come to recognize that they are paying a very high price for the illusion of coverage under ObamaCare. As patients increasingly realize that, for the most part, they will be spending their own money for medical care during any given year, they will begin to look for better value in their medical care. Third-party-free physicians, who are able to provide timely access to care, and more face-to-face time with patients at an affordable cost, will become more attractive to many patients.

Likewise, as high deductibles, high co-pays, and unlimited out-of-pocket costs are a reality under ObamaCare, health savings accounts will become more attractive to more patients. If one is going to spend one's own money, one might as well spend tax-free money as opposed to after-tax money.

Last but not least, the American public needs to hold accountable those who foisted this wealth transfer scheme and high-priced illusion of coverage on us.

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