The ACA: Here Are (Mostly) Reasons Why *Not*

It's no surprise that our mailbag overflowed with responses to Marie-Eileen Onieal's editorial, "The ACA, Six Years Later ..." (*Clinician Reviews.* 2016;26[5]:10, 12). Everyone has an opinion about health care reform—including a nursing legend.

POLITICS AND POINTS TO PONDER

Your commentary on the ACA "six years later" provides an insightful historical perspective, discussion of the current political dilemma, and overview of this, as you put it, "step in the right direction." I hope all NPs and PAs will consider their political agendas in terms of the rights of our citizenry, along with their rights to practice: the right to health care, to choose health care providers, to change their social determinants of health, and to the preservation, promotion, prevention, and protection of their family's and community's health, as well as their own. All in the national and public interest!

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DOC, CURE MY BOREDOM

I am a seasoned, dedicated, and (according to my colleagues and patients) terrific clinician. I have been practicing as an APRN since the mid-80s. I cut my teeth in primary care and geriatrics for more than 10 years, then spent the next 14 in cardiology. With the enactment of the ACA and the shifted focus on primary care, I returned to primary care practice in 2012.

After three years back in primary care in rural Vermont, where I had my own panel of patients, I finally had enough. I was recruited by our local VA to develop a heart failure program; I have been with them since the beginning of this year. (What a godsend! I love my job again.)

The problems in health care, especially primary care, were more than I could sustain. My younger, less experienced colleagues were dropping like flies. I agree the ACA is a first step. But in our rural state, it resulted in many people with health care coverage (a very good thing) but the majority on Medicaid (not a good thing). At the risk of sounding unsympathetic, the problems lie with the government's control of this enterprise. These patients deserve health care, but they *don't* deserve an open checkbook. With our help (I can assure you, in Vermont, there are tremendous resources to help the poor), patients need to take some responsibility for their health.

Despite biweekly office visits, case managers, home care, and social work involvement, patients get bored and decide to visit the emergency department (ED) for minor issues. Medicaid pays for it, no questions asked. One patient, for example, came to my office in the morning, where I did tests and outlined a plan of care. She went home and one hour later presented to the ED for the same (nonacute) issue, because she didn't want to wait for the plan to work.

Credit: Tupungato / iStock

Unhappy with *that* visit, she presented to our local tertiary medical center later that day. Since that hospital doesn't access our records, this patient underwent yet a third evaluation (including x-rays) on the same day, with the exact same plan of care outlined. Medicaid paid for every single thing—my tax dollars at work.

This isn't an anomaly. Every day, I had endless encounters with this "open checkbook" approach and patients' need for immediate gratification (despite being educated on their health problem, its expected duration, and a clear plan of care). Our culture has become centered on immediate gratification, and there is a lack of personal responsibility for one's health. Patients—*all* of us—need to take responsibility for our health.

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With so many people on state-sponsored plans as a result of the ACA, patients have no "skin in the game," so to speak. They are poor, and I sympathize with that. Yet, unless they are made aware of the cost of these "boredom ED visits" and expensive tests, etc, this behavior will only continue to bankrupt the system.

Unfettered health care expenditures are not only unsustainable, they are also beyond aggravating for my many patients who pay exorbitant amounts of money on high-deductible plans. *Those* are the people I worry about most. They are being priced out of their health care!

So yes, the ACA is a first step—but not a good one. It simply didn't go far enough, and it has led to burnout and chaos in the frontlines, increasing costs, and a boon to the insurance companies.

Until we eliminate private insurance companies from the equation, put every citizen on a level playing field, and expect a collaborative approach with our patients (as well as ownership of their health), it will only get worse.

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GOOD CONCEPT, POOR EXECUTION

I feel you are looking at the issue incorrectly; the failure of the ACA is due not to the *opponents* but to the *proponents*. Passed by a one-party vote, it has been opposed by an ever-increasing majority since its inception in 2009. Its passage can only be defended by those who benefitted monetarily (such as the administrators of AARP, insurance companies, and politicians from districts with large entitlement constituents.)

You direct your defense from a conceptual bias—that 60% of Americans polled would like to see some form of legislated health care. They do not want this particular piece of legislation, which was written by insurance companies and validated by this administration.

Why do you think it's opposed by so many? "Unconstitutional overreach" to some, but the argument that 30 million people were without insurance was fiction. Many were covered by their spouse yet counted as uninsured, some were not citizens, some were between jobs and employer health insurance, and all had access to the ED.

Rethink your premise for this article. You defend a worthy concept, but a bad law.

Gerard Fischer, PA-C
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RURAL HEALTH CARE: DEARLY DEPARTED

I'd like to get you up to date on the rural health care crisis that the ACA has directly caused, as you make no mention of this tragic disaster in your editorial. My wife and I are an MD/PA team and have been the only medical providers in our town since 2003. More than 90% of our patient base was federally designated poor folks, but the ACA forced us to close our doors in August 2014.

The National Rural Health Association has been tracking rural hospital closures, but no one is tracking the hundreds of clinics like mine that closed as a direct result of the ACA. I know of seven practices within a 30-mile radius that have closed. One of our hospitals, with a payroll of $11.3 million, recently closed. All of these clinicians will now be on unemployment, further increasing our deficit.

In our community, 11,000 people now must drive long distances or use the ED for health care. People who do not live rurally do not understand the situation—and many don't care, as the focus is on urban and city medicine. Early in my career, I worked with the National Health Service Corps to pay off student loans; our entire *county* in Minnesota had a population of only 10,000—a thousand people less than the northern California town my clinic was in. But we had a full hospital and clinic (albeit with little in the way of funds to support them).

The President could have assembled a Healthcare Advisory Taskforce of city, urban, and rural CEOs, docs, advanced practice providers, etc, to evaluate how the ACA would impact each sector. Instead, we now have a rural health care crisis as a result of "health care reform." **CR**

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