

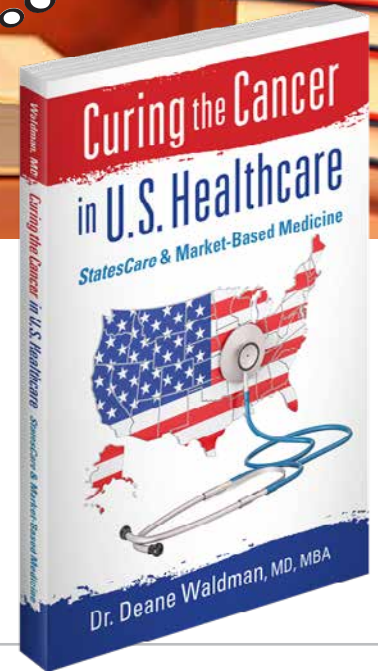
# Dr. Deane's Healthcare Decoder

**Healthcare?  
or  
Health care?**

**D**r. Deane Waldman's **Healthcare Decoder** is purely functional. It takes the mystery and confusion out of healthcare and replaces them with understanding. Whether the complexity is intentional or not, the language and terms people use in healthcare are often confusing and make no sense. Sometimes they mean the opposite of what you think they mean.

This Decoder does precisely what you want it to do: it decodes. It turns healthcare gibberish into easy-to-understand language.

Note: This decoder is part of the book, "[Curing the Cancer in U.S. Healthcare](#)."



**HEALTHCARE VERSUS HEALTH CARE** = As one word, "healthcare" means a huge system that consumes nearly 20 percent of the U.S. annual GDP. "Health care" (two words) refers to a close personal (fiduciary) service relationship, protected by law, between a patient and a provider.

**ACA** = **Affordable Care Act**, also known colloquially as **Obamacare**. Keep in mind the law's full name—Patient Protection and Affordable Health Care Act of 2010 (PPAHCA)—to remember what it was supposed to do for us.

**ADVERSE IMPACT** = where a patient is harmed during, not necessarily by, health care. This is a negative patient outcome, such as failure to improve, or being sicker or worse after treatment. Contrast this outcome or result to the words "error" or "mistake" that refer to a behavior or action, not an outcome. You can read details about the important difference between behavior and outcome in *The Cancer in the American Healthcare System*. (See Error/mistake.)

**ADVERSE SELECTION** = when an insurance carrier has a large number of sick enrollees, who therefore require the carrier to pay large medical bills. This is "adverse," i.e., a negative result, for the insurance company's bottom line. With enough adverse selection, an insurance carrier could lose enough money paying medical claims to go bankrupt. Before this happens, a carrier will simply stop selling medical insurance as several have already done.

**APTC** = Advanced Premium Tax Credit, more commonly known as "ACA subsidies." This refers to the money offered by the federal government to offset increased cost of health insurance premiums. There is a sliding scale for the amount of subsidy from 400 percent of the poverty line (\$93,132 per year) to 138 percent of the poverty line (\$23,283). Between 138 percent and 400 percent, you get a subsidy, but less as your income increases. Above 400 percent, there is no subsidy. Below 138 percent of the poverty line, you are eligible for free insurance through Medicaid, assuming you are a legal citizen. Under the ACA, 79 percent of the U.S. population qualifies for some amount of subsidy. Median household income in the U.S. in September 2014 was \$51,939.

**BALANCE BILLING** = a practice where the provider bills the patient for the difference between what insurance pays and the actual charges.

**BARRC** = Bureaucracy, Administration, Rules, Regulations, and Compliance. Acronym that stands for what a bureaucracy is and does.

**BENEFIT** = services or items that the insurance coverage will pay for. It does not guarantee that you will actually receive the benefit, only that if you can get the covered care, the insurer will pay a contracted amount to the provider.

**BIG PHARMA** = a common nickname for huge, usually multinational pharmaceutical companies, such as GlaxoSmithKline, Johnson & Johnson, Merck, Pfizer, and Roche.

**BUREAUCRACY** = excessively complicated administrative process or system. For my purposes, “bureaucracy” includes (1) administration such as eligibility, confirmation, billing, coding, payment, and distribution; (2) insurance activities from actuarial analysis to authorization; and (3) the regulatory machine from rule making through the review process to compliance oversight and accreditation or loss of accreditation.

**BURWELL V. HOBBY LOBBY:** See SCOTUS.

**BUTTERFLY EFFECT** = is a crude way of describing the Law of Disproportionate Consequences. This “law” states that small actions can have big outcomes, and conversely, grand actions can have trivial or insignificant results. As an example in healthcare, consider the massive effort and huge expense of Obamacare that produced little or no beneficial effect for We the Patients.

**CADILLAC TAX** = is part of PPAHCA. It levies a 40 percent tax on any insurance premium that costs annually more than \$10,200 for an individual or \$27,500 for a family. This tax has little to do with personal income and everything to do with benefits of the insurance plan. The Cadillac Tax will hit those in high-risk occupations such as construction workers, firefighters, and police officers.

**CANCER** = where a previously healthy cell in a human body or part of a system no longer performs its normal functions and begins to grow uncontrollably, ultimately killing the person or the system.

**CBO (contrast to GAO)** = The Congressional Budget Office is tasked with predicting the future economic and budgetary effects of congressional action. For example, the CBO has calculated the future cost of PPAHCA as low as \$1.1 trillion and as high as \$1.7 trillion. (See GAO.)

**CCIIO** (pronounced sis-eye-oh) = The Center for Consumer Information and Insurance Oversight. CCIIO is another federal agency that creates and oversees insurance rules and compliance with healthcare regulations, specifically with the Affordable Care Act (ACA).

**CHARGE** = the price, or what you see on a Bill for Payment. This has no relationship, repeat no relationship, to what is actually paid or the true cost.

**CLASS ACT** = The Community Living Assistance Services and Support Act was Title VII in the ACA. It was intended to create a voluntary, public, long-term care insurance

program, but was deleted from the act by the White House seven months after the ACA was signed into law.

**CMS** = Centers for Medicare & Medicaid Services. This is the federal agency that funds and oversees both programs.

**COBRA** = Consolidated Omnibus Budget Reconciliation Act of 1985. Allows a patient to keep insurance temporarily after employment ends. The employer no longer pays any portion of the premium: the insured pays 100 percent plus an administrative fee. There are other restrictions.

**COMPLEXITY** = According to the dictionary, complex means “composed of many different and connected parts.” It also means “not easy to understand.” Complexity in healthcare comes in two forms: inherent and artificial.

**COMPLIANCE OVER SCIENCE** = following the rules is more important than the patient. If a clinical guideline says one thing but the latest data or a doctor’s well-honed judgment says something different, the doctor must follow the approved clinical pathway.

**CONCIERGE MEDICINE** = also called “direct-pay medicine.” This refers to doctors who do not accept insurance, but rather have the patients pay them directly. This usually involves a retainer fee that covers office visits. Most direct-pay practices negotiate large discounts at labs and with hospitals as well as pharmacies, because the patients will pay cash. By cutting out the insurance carriers, these practices dramatically reduce both their administrative expenses and the time doctors now spend on bureaucratic nonsense.

**CONSUMER** = In both health care—the service, as well as healthcare—the system, the consumer is the patient. Personally, I dislike the word “consumer” as it refers to a purely one-way relationship: doctor delivers and patient consumes. We all know that good medicine is a two-way relationship, a partnership, not a delivery service. It is important to recognize that healthcare is currently a third-party payer system, meaning the consumer of goods and services is not the payer for the goods and services consumed. She or he does not pay the supplier (provider) of services and goods—the third party does. Thus, there is micro-economic disconnection, where supply and demand—that are normally connected by supplier competition and demander’s (consumer’s) money—are disconnected. This prevents the functioning of the free-market forces. (See Micro-economic disconnection.)

**CO-OP** = Consumer Operated & Oriented Plan established by the ACA law. Co-ops are not-for-profit insurance companies that were given large sums of taxpayer dollars—more than \$2.4 billion in low-interest loans (down from the

initial \$6 billion)—by the federal government to offer low-cost alternatives to insurance products sold by commercial for-profit companies. These co-ops are not co-ops in the usual sense, as the customers do not participate in profits and losses. As of June 2016, 13 of the 23 ACA-established insurance co-ops have either closed or have been declared insolvent. Nine of the remaining 10 are near insolvency. ACA co-ops are going out of business because of simple economics: they are paying out more in mandated benefits than they are taking in as revenue.

**CO-PAY** (insurance term) = a payment you make to the doctor, typically \$5–20, when you go for care. This is in addition to what the insurance company will pay the doctor on your behalf for your care services and in addition to the cost of your premiums.

**COSMOLOGY EPISODE** = a condition where the world makes no sense, where for instance, the sun rises out of the south. This is what providers of health care face every day. They think they are doing what patients want and yet the “system” in which they work obstructs, constrains, and punishes them. This makes no sense—healthcare is a cosmology episode for people who work in healthcare.

**COST** = is the most misunderstood and, therefore, misused word in healthcare language. You and I use “cost” to mean the sum of all materials, labor, and capital to produce a product or service. Using that definition, no one knows the cost of anything in health care as well as healthcare. In the world of healthcare, “cost” is allocated, apportioned, back calculated, and projected, but not the simple sum of all factors of production and distribution. Be sure you understand that anyone who claims to report the true cost of anything in healthcare is guessing.

**COST-SHARING REDUCTION (CSR)** = there are two forms of CSR and they are quite different. There are patient CSRs where the patient must pay a portion of the bill for service in addition to what was paid as a premium. There are federal CSRs where Congress will subsidize the expenses of an insurance company trying to reduce the premium costs that patients will pay. Federal CSRs are also known as “bailouts.”

**COVERED LIFE** = someone who has signed up with a qualified health plan for insurance. As soon as the insurance card is issued, the person is covered for 90 days, even if that individual does not pay the premiums.

**DEBT VERSUS DEFICIT** (U.S. national) = often confused, but quite different. The deficit is the amount the government spends per year greater than the amount the government takes in as revenue. For the past 10 years, the deficit has been approximately 30 percent, meaning if we took in \$2

trillion, we spent \$3 trillion. To cover the annual deficit, each year the government must borrow the amount of the deficit. This accumulated borrowing is called the national debt, which has increased from \$7 trillion (2004) to \$12 trillion (2009) to \$19 trillion (2016). The 2018 national debt is approaching \$21 trillion. Eventually, someone will have to pay this back. Meanwhile, the public pays debt service on the national debt. In 2015, just the service on this debt cost us \$400 billion.

**DEDUCTIBLE** (insurance term) = a predetermined amount of money you must pay before your insurance company will pay your claim. This is in addition to the cost of your premiums.

**DEFENSIVE MEDICINE** = when providers make decisions based on how their record will look, not necessarily on what is best for the patient.

**DIAGNOSIS** = literally means “the identification of the nature of an illness.” Nature can mean only the description of the ailment and/or it can mean the root cause of your problem. Many, in fact most, diagnoses are descriptive, not etiologic. (See Root cause.)

**DISSOLVE** (a problem) = is the most desirable of the four ways to “solve” a problem. It is described in detail in The Cancer in the American Healthcare System. To dissolve a problem means you change the system so the root cause of the problem no longer exists. Therefore, the problem cannot recur because the root cause is gone.

**“DONUT HOLE”** = a gap in coverage in Medicare (Part D) where the beneficiary has to pay all of his or her prescription drug costs. The gap is between where the initial, minimum coverage ends, and when the beneficiary has spent enough to reach the catastrophic coverage threshold.

**DOWN-CODE** = use of a billing code by a health care provider to give a reduced rate for health care services or goods provided. Believe it or not, this is illegal.

**EFFECTIVENESS** (contrast to efficiency) = refers to how successful a person, organization, or system is in achieving the desired effect. In baseball, an effective pitcher is one who throws strikes that people cannot hit. An effective healthcare system makes and keeps the most people as healthy and as long-lived as possible. An effective system is always efficient, but an efficient one may not be effective.

**EFFICIENCY** (contrast to effectiveness) = is classically defined in terms of work per unit time, but it really means using the least resources (money, labor, power) while working. You can be very efficient and still be ineffective. If you can produce 10 buggy whips per hour but nobody

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wants to buy them, you are highly efficient but not effective (at producing income for your company). In healthcare, if you see 10 patients per hour, you are very efficient. If they all remain ill, you are NOT effective.

**EHB = ESSENTIAL HEALTH BENEFITS.** This is a federally mandated list of health services that an insurance plan must offer in order to be compliant with the ACA.

**EMPLOYER MANDATE** = law that requires businesses with 50 or more full-time employees to provide health insurance to at least 95 percent of their employees and dependents up to age 26. If they don't, employers have to pay some steep fees, which can be as high as \$2,000 per month per uninsured employee.

**EMR = ELECTRONIC MEDICAL RECORD.** This system converts hard copy records and prescriptions to digital format. As users, doctors and nurses find EMR quite unfriendly; it is overly cumbersome, excessively time-consuming, and extreme costly. Time required to utilize EMR is time the provider cannot spend with the patient or researching the case.

**EMTALA** = Emergency Medical Treatment and Labor Act of 1986, also known as the "anti-dumping law." This requires emergency rooms to care for (rather than transfer) any acutely, seriously ill patient, regardless of whether the patient has any payment source or not. EMTALA created the unfunded mandate.

**ENROLLMENT PERIOD** (for buying insurance) — a limited amount of time, usually two–three months, when you are allowed to buy or make changes to your health insurance. The rest of the year you cannot purchase government-supported health insurance.

**ENTITLEMENT** = a legal right or just claim to receive or do something. Most people use the words "right" and "entitlement" interchangeably, assuming both are free (no payment) and that everyone gets their right or entitlement whenever they want regardless of income, location, age, and for health care regardless of whether they are citizens or not.

**ERISA** = Employee Retirement Income Security Act of 1974. Creates standards for employer-sponsored health insurance plans, especially those who are self-funded. Many large organizations, from large hospitals to Walmart and Amazon, are self-funded for health insurance. ERISA rules supersede any state-level insurance rules.

**ERROR/MISTAKE** (contrast to adverse impact) = an incorrect action or behavior. To make an error requires that the correct action or behavior is known and possible. So, in

healthcare, if there is no medical choice that is proven to be "correct," then there cannot be a mistake, even if a patient has an adverse impact. (See Adverse impact.)

**EXEMPTION** (or waiver) = means that an organization, group, or even municipality does not have to comply with the legal requirements of PPAHCA. Certain religious groups and more than 1,400 organizations—unions or businesses—have been granted exemptions.

**FFM = FEDERALLY FACILITATED MARKETPLACE.** This is the federally run program, created by PPAHCA, in which American citizens can and must purchase health insurance. The website's URL is [www.healthcare.gov](http://www.healthcare.gov).

**FPL** = federal poverty level is a measure of income determined each year by the Department of Health and Human Services. FPL is used as a base line to define eligibility for Medicaid and CHIP amongst other federal social programs. In 2017, the FPL for a family of four was \$28,290. With ACA setting Medicaid eligibility up to 138 percent of FPL, a family qualified with income less than \$39,040.

**FIDUCIARY** = a relationship between two people where person "A" gives control over himself or herself to person "B" so "B" can use this power for the benefit of person "A."

**GAO = GOVERNMENT ACCOUNTING OFFICE.** Where the Congressional Budget Office (CBO) is concerned with the future, the GAO, also called the "Congressional watchdog," looks at the past. This agency assesses federal spending. For instance, in 1990 on the twenty-fifth anniversary of the Medicare Act, the GAO calculated how much was actually spent in contrast to how much the CBO budgeted or predicted in 1965. Congress and the CBO underestimated the cost of Medicare by 854 percent. (See CBO.)

**GOBEILLE V. LIBERTY MUTUAL:** See SCOTUS.

**GUARANTEED ISSUE** = rule that requires insurance carriers to accept any patient for coverage, regardless of any pre-existing health condition the patient might have and, thus, regardless of how much that individual might cost the insurance plan.

**"HEALTHCARE IS A SICK PATIENT."** = This is my way of saying that only a medical approach can fix our dysfunctional healthcare system. Political and financial approaches over the past 50 years have made the patient called "Healthcare" sicker, not healthier.

**HEALTH INSURANCE EXCHANGE (HIE)** = a major component of PPAHCA where people can shop for health insurance and those who qualify, which is 70 percent of



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the U.S. population, can obtain subsidies to reduce out-of-pocket costs. Eighteen states are operating their own exchanges. The majority has decided not to create state-based exchanges: their citizens must obtain insurance through the FFM at [www.healthcare.gov](http://www.healthcare.gov). (See FFM.)

**HIGH-RISK POOL** = refers to those Americans with expensive, usually chronic medical conditions whose annual medical expenses make it difficult-to-impossible to obtain health insurance.

**HIPAA** = Health Insurance Portability and Accountability Act of 1996. Intended to solve the problem of losing health insurance when losing a job—it did nothing to fix this. HIPAA created a massive regulatory machine, a host of burdensome rules, and tens of billions in costs, all supposedly to protect the confidentiality of medical information—and it doesn't.

**HITECH** = Health Information Technology for Economic and Clinical Health Act. This was part of The American Recovery and Reinvestment Act of 2009. It was intended to create medical information technology standards and infrastructure, and to strengthen the security of personal health information.

**HOBBY LOBBY DECISION** = See SCOTUS: *Burwell v. Hobby Lobby*.

**HSA** = Health Savings Account. A bank account owned by an individual in which contributions are not subject to federal taxes. The funds can roll over through the years and accumulate. They can be used only for approved medical expenses. Obamacare limits the amount you can withdraw from an HSA.

**ICD-10** = International Classification of Diseases. A complex, almost incomprehensible billing and coding system that doctors, pharmacists, therapists, and hospitals are required to use if they want to be paid. In addition to illness and injuries, ICD codebooks also include procedures, devices, and anything else that has to do with paying for health care goods and services.

**IHS** = Indian Health Service is a federal agency within the Department of Health and Human Services to provide health services to approximately 2.2 million American Indians and Alaska Natives. IHS is not an entitlement (enrollees pay); is not an insurance plan (it contracts with numerous insurers); and does not have a mandated benefits package like the ACA.

**INCENTIVE** = is a motivator that either encourages someone to perform some behavior (colloquially called a "carrot" or reward) or discourages someone from doing

something (a "stick" or punishment). Low prices, say, for insurance are a positive incentive to purchase. PPAHCA's tax penalty for not buying insurance is a negative incentive or "stick."

**INDIVIDUAL MANDATE** = refers to the cornerstone of PPAHCA: a federal mandate or requirement that each citizen (does not apply to non-citizens or undocumented immigrants) purchase health insurance. This was struck down by the Supreme Court, which then said it would be constitutional if it were called a "tax." It is the first time American citizens can be "taxed" (penalized) if they don't buy something, in this case, health insurance.

**INSURANCE PRINCIPLE** = where small contributions of the many pay the great (large) expenses of the few. Lots of people put small amounts of money into a common "risk pool," and a small number of people take out large amounts of money.

**IPAB** = Independent Payment Advisory Board. Created by ACA, this federal agency is tasked with reducing health care spending. It is imperative that you read more about this secretive committee, as it will directly impact what care you can receive and what may be denied to you. IPAB was recently renamed HTAC (Health Technology Assessment Committee). IPAB was what former Governor Sarah Palin famously called a "Death Panel" in 2009. Read more about this in "The Cancer in the American Healthcare System."

**"IT JUST STANDS TO REASON."** = a phrase used by those who have no hard evidence to support their position or plan. They rely on appeal to emotion.

**JOB LOCK** = being stuck in a job you do not want to do because you will lose your insurance benefits if you leave. In February, 2014 the CBO released a report predicting that PPAHCA would cause the loss of more than two million jobs in the U.S. Nancy Pelosi (D-CA, 12th District), a strong proponent of the ACA and former majority leader of the House of Representatives, hailed this result saying that Americans would no longer "be job locked but can [as a result of PPAHCA] follow their passion," meaning they could work at what they choose, or decide not to work at all.

**KING V. BURWELL:** See SCOTUS.

**LEARN** = to acquire data, knowledge, understanding and (hopefully) wisdom. To learn requires you to question what you have been taught is true, and sometimes unlearn that so you can learn what IS true. As I have written, "Today's 'best medical practice' can be tomorrow's malpractice."

**LITTLE SISTERS OF THE POOR V. BURWELL:** See SCOTUS: *Zubik v. Burwell*.

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**MACRA** = Medicare Access and CHIP Reauthorization Act of 2015 changed how doctors are paid by the two named federal programs.

**MARKET FAILURE** = market here means a “free market,” where consumers spend their own money and where prices can vary. Market failure means that the free market does not allocate goods and services efficiently, giving the best and cheapest stuff to the most people. The usual alternative suggested to a free market is central (government) control, which has been shown over and over to be inefficient—giving the most to a small number of elite people and little-to-nothing to the public at large. This is not conservative bias. It is based on the hard evidence of history.

**MEDICAID** = (contrast to Medicare) This is an entitlement program, in contrast to Medicare. You qualify by low income, age, or having certain chronic conditions. You pay nothing and receive benefits dictated by the government.

**MEDICAL MALPRACTICE (TORT) SYSTEM** = When a patient is injured or harmed in relation to medical care, the malpractice system supposedly punishes the wrongdoer and compensates the injured. An alternative system called Office of Medical Injuries is proposed in Book 7, *We Don't Need Tort Reform . . . We Need Replacement*.

**MEDICARE** (contrast to Medicaid) = Medicare is not an entitlement program. You paid into it during your whole working career. Medicare was conceived as a giant Health Savings Account (HSA), where you put in money for 40 years. When you retire, that very large pot of money, which accumulated and grew, would pay all the medical expenses of your golden years.

**MERP** = Medicaid Estate Recovery Program. Passed as part of the Omnibus Budget Recovery Act of 1993, this law allows state governments to recoup a \$611-per-month administrative fee (which could total as much as \$73,310) and property after the death of a Medicaid recipient. To this, the states can add a bill for 10–40 percent of a patient's total medical bills that were paid through Medicaid.

**METAL LEVEL** = Insurance plans that are ACA-compliant have different amounts (percentages) of your health care costs that are covered by the Plan. Using the names of metals signifies these different levels: Bronze (60 percent of your costs are covered); Silver (70 percent); Gold (80 percent); and Platinum (90 percent). Of course, the cost of the insurance premium goes up considerably depending on which “metal” level you choose: Bronze = cheapest; Platinum = most costly. As the cost rises, the benefits also increase.

**MICRO-ECONOMIC DISCONNECTION** = refers to the separation of the consumer from control of his or her

own money. This makes it impossible for the free market to function, as supply and demand can no longer balance each other.

**MORAL HAZARD** = refers to the danger to society of some people spending other people's money and therefore having no need to economize or to act responsibly or morally.

**NAVIGATOR** = PPAHCA requires each state to have people available to help individuals through the complexity of purchasing health insurance. These individuals are presumably impartial, or not paid by or beholden to any insurance carrier, as brokers can be. Navigators are also called “in-person assisters.”

**NET** (when calculating pretty much anything) = I frequently use this word because too many people look exclusively at the short-term cost, without considering long-term costs and without evaluating benefits at all. A “net calculation” for spending on healthcare would determine value—what we really care about—by comparing long-term costs and risks to long-term benefits to patients.

**NFIB V. SEBELIUS**: See SCOTUS.

**NHS = NATIONAL HEALTH SERVICE**. This is the name of the government-run healthcare system in Great Britain. It was used as a model for the original version of Obamacare.

**N.I.C.E. = NATIONAL INSTITUTE FOR CLINICAL EXCELLENCE**. A component of the NHS that was the model for the IPAB that is part of Obamacare. Both NICE and IPAB are tasked with cost cutting by deciding what medical care will be authorized and therefore available for use in patients. These groups also decide what types of care will be denied, or deemed Not Cost Effective, even if the treatment works medically.

**PAYER** = can be confusing. In most aspects of your life, the payer IS the consumer; they are one and the same. In a free market, the consumer/payer gives money to the supplier in exchange for goods and services. Healthcare, with its third-party payer system, is not a free market. The consumer does not directly pay the supplier and therefore is not the payer. The supplier (provider) does not set his/her price. The government, not the market, determines the price. There is a third-party payer who either has no incentive to economize (the government) or is rewarded, or incentivized, when it denies payment for care (insurance).

**PBM** = Pharmacy Benefits Manager. This is a computer program implemented by many health plans that doctors must use to order medications. The program tells the doctor what drugs he or she can or cannot use (usually determined

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by cost, not medical efficacy for that patient). If the doctor wants to use a non-approved drug, there is a complex, time-consuming process to appeal the health plan's restriction.

**PCIP = PRE-EXISTING CONDITION INSURANCE PROGRAM.** A component of the Affordable Care Act that was supposed to provide insurance for those usually uninsurable because of expensive pre-existing medical conditions. Enrollment was discontinued after less than a third of the eligible people signed up. The chairman of the New Mexico High Risk Insurance Pool said, "Washington just left the sickest of Americans high and dry, holding nothing but an empty promise."

**PERVERSE INCENTIVE** = means that someone is rewarded when they do the opposite of what is wanted. In retail, this would be giving a bonus to the person who sells the least products. In healthcare, it is perverse when insurance makes profits by delaying, deferring, or denying medical care—the Strategy of the Three D's in Chapter 3 of Book 1—even though you need the care now!

**PHANTOM CODE** = a billing code used by a health care provider to charge for a service he or she did not actually provide. This is fraud.

**PNHP** = Physicians for a National Health Program. A political activist group that advocates for a single payer approach for the United States. Their position is discussed in Single Payer Won't Save Us.

**POPULATION MEDICINE** = doing what is medically best, as decided by some panel of experts (self-styled), for the population as a whole. That means the needs of the group supersede the needs of the individual. Doctors are ethically committed to the opposite: personal medicine.

**PRE-EXISTING CONDITION** = This is an insurance term masquerading as a medical diagnosis. It means a condition that is expensive to care for such as cancer, arthritis, or heart disease. We all have a pre-existing condition that eventually leads to death: it is called life.

**PRIMUM NON NOCERE** = Latin phrase considered the prime directive for physicians and is commonly but incorrectly translated as "First (above all), do no harm." A more precise interpretation of the original Latin yields, "At least, do no harm!"

Provider (of health care) = anyone whose activities directly affect a patient, such as a doctor, nurse, respiratory therapist, social worker, etc. Many others, not called providers, indirectly affect patient welfare, such as billers, coders, managers, legislators, regulators, support staff, technicians, etc.

**PSYCHIC REWARD** = an emotional or psychological, non-material payment for a service, product, or action. For most health care providers, the psychic reward for helping others is more important than the monetary reward.

**PUBLIC OPTION** = is a shorthand colloquial term for single payer, in contrast to having multiple entities, usually insurance carriers, but sometimes health organizations, who pay the costs for health care goods and services. Many use the Canadian system as an example of a public option.

**RATION** = to "make reasonable," or to apply logic and reason to a problem. In Economics, to ration is "to balance supply and demand."

**REGULATORY BURDEN** = a mountain of federal regulations that control every aspect of healthcare, from the financing to the day-to-day practice of medicine. The cost of compliance with these regulations is massive in money, in provider frustration, in medical errors, and time taken away from patient care by federal mandate. The dollar cost of the federal regulatory bureaucracy is now more than 40 percent of all U.S. healthcare spending.

**RENT-SEEKING BEHAVIOR** = where a private company seeks to obtain economic advantage through government intervention such as tariff protection or cost-sharing reductions ("bailouts"). By definition, the economic gain does not produce any benefit to society through wealth creation. Rent-seeking is government redistribution to benefit a favored commercial enterprise.

**RESCISSION** = insurance industry jargon for canceling an insurance policy, sometimes for frivolous reasons or with a trumped-up excuse.

**RIGHT (TO HEALTH CARE)** = means you are entitled to health care (the service), when you want, where you want, what you want, for free, without needing to qualify in any way. Proponents say that by simply being alive, you have this right. The relationship between a right to health care and one's personal responsibility has never been openly discussed. I believe the lack of consensus on this matter is at the heart of problems in our healthcare system.

**ROMNEYCARE** = colloquial term for the Massachusetts health care insurance reform act signed into law in April 2006 while Mitt Romney was governor. The proper name for this system is Commonwealth Care. There are many similarities between Romneycare and Obamacare, but they are not identical.

**ROOT CAUSE** ("etiology" is the medical term) = refers to the primary or first cause. This is the "why" of illness. In diabetes, the symptoms are related to elevated sugar in the blood, but elevated sugar is not the root cause, which is due

to failure of insulin to regulate blood sugar. Dysfunction or improper production of insulin is the root cause in diabetes. Has anyone shown to you what the root causes are to explain why our healthcare system is “broken”?

**SCOTUS** = Supreme Court of the United States. The five major ACA-related cases that have been heard by the Supreme Court are listed below:

**1. 2012: NFIB V. SEBELIUS** = The National Federation of Independent Business sued then-Secretary of Health and Human Services, Kathleen Sebelius, challenging both the individual mandate and the mandatory expansion of all state Medicaid programs. SCOTUS struck both down as unconstitutional. Then, in this 5–4 decision, they said the federal government could keep the individual mandate if they changed the name to a “tax.” Medicaid expansion remained voluntary.

**2. 2014: BURWELL V. HOBBY LOBBY** = Obamacare requires all insurance to provide 10 essential benefits, which include contraceptives and abortifacients. Christian-based Hobby Lobby Company sued claiming that the ACA violated their right to religious freedom (First Amendment). After years of lower-court hearings, the Supreme Court heard the case, agreed with Hobby Lobby, and prohibited the federal government from penalizing religious-based organizations for failure to offer contraceptives and abortifacients.

**3. 2015: KING V. BURWELL** = David King and three other plaintiffs sued Sylvia Burwell as Secretary of Health and Human Services. They claimed that the federal government was illegally providing subsidies because healthcare.gov is an exchange created by the federal government, but the ACA says subsidies can only be provided through exchanges “established by the state.” The IRS issued a ruling that healthcare.gov could provide subsidies even though the ACA said it could not. In a 6–3 decision, SCOTUS upheld the IRS, opining they understood that Congress wanted to give subsidies to everyone, even if the law wasn’t written that way.

**4. 2016: GOBELLE V. LIBERTY MUTUAL** = Vermont wanted to create a statewide database for healthcare. When they sought to require carriers to provide their information, Liberty Mutual refused, claiming federal law—ERISA, which is the Employee Retirement Income Security Act of 1974—prevented them from complying. The Supreme Court decided in Liberty Mutual’s favor that federal law superseded state law. The decision will reduce the amount of data available to consumers of care services.

**5. 2016: ZUBRIK V. BURWELL** = The Hobby Lobby decision (above) was written with very narrow applicability. Therefore, Obamacare was still allowed to use healthcare

dollars to support, albeit indirectly, abortion, contraception, and “birth preventative services.” A number of Catholic organizations led by the Little Sisters of the Poor sued the federal government claiming Obamacare violated their right to religious freedom (First Amendment). During oral arguments in April 2016, the justices took the unusual step of asking the litigants if they could settle their differences without a Court decision. The Little Sisters said yes, but the government said no. The Supreme Court then decided ... not to decide. Their unanimous, unsigned decision was to refer the case back to lower courts to find a compromise without holding either for plaintiff or defendant.

**SHOP** = Small Business Health Options Program. This is a part of the ACA that offers insurance plans to small businesses.

**SIGNUP (ENROLLEE)** = Washington counts anyone who has completed the application process for insurance, even if that person is not covered, no card is issued, and/or the person has never paid a premium.

**SINGLE PAYER SYSTEM** = where the government is the distribution source for payments to providers, institutions, suppliers, and (if insurance is used), insurance middlemen. Because it controls both the money and the regulations, the government dictates how much it will pay, what it will pay for, and when. There are no market forces in a Single Payer system such as those in a free market. Instead, a monopoly (government) controls both supply and demand. The U.S. Veterans Administration is a Single Payer system, as is the British National Health Service. (See Public option.)

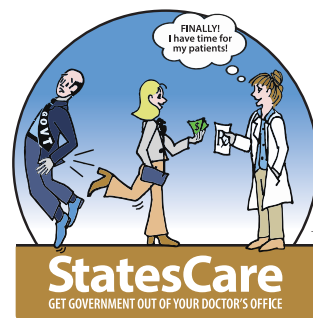
**SPENDING** (noun) = money paid. All too often, “spending” is mistakenly used to mean the same as “cost,” which is very different. (See Cost.)

**STATESCARE** = an approach to health care where you and other people in your state decide what healthcare system you want. You decide, not Washington or self-proclaimed experts.

**SUBSIDY FROM ACA:** See APTC.

**SYSTEM** = a set of connected things or parts that form a complex structure. The key is the word “connected,” because without the structure and minus the connections, parts are just a pile of stuff that can do nothing.

**SYSTEMS THINKING** = a management approach that emphasizes the need to study the intact system or entire structure as a whole. When you break it up and study each part separately, you lose the connections and its “system-





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ness." Practicing good medicine on anyone requires systems thinking. A good doctor would never do something to improve kidney function without considering how that treatment might affect other organs such as the heart, lungs, or liver.

**TANSTAAFL** = "There Ain't No Such Thing As A Free Lunch." It means that nothing in this world is free, nothing. Someone has to pay for it, whatever "it" is.

**THE THREE D'S** = a strategy used by health care payers to hold on to your money as long as possible: delay, defer, or deny.

**"TRUST ME! I HAVE YOUR BEST INTERESTS AT HEART."** = This is a common catchphrase of those who take a paternalistic attitude toward others and control them, for their own good, of course.

**TWO-MASTER DILEMMA** = the problem of who should be your first priority: your employer or your customer; your patient's best interests or following regulations. I call this the "who-master dilemma."

**UMRA** = Unfunded Mandates Reform Act of 1995. This act was intended to fix the problem created by EMTALA, which created the unfunded mandate: the law that requires hospitals to treat patients for free, which in turn makes them overcharge paying patients to avoid bankruptcy. As you can see, UMRA did not resolve the unfunded mandate, which is now an even bigger problem than it was in 1995. (See EMTALA.)

**UNCOMPENSATED CARE** = medical care that a hospital must provide by law for which it receives no payment—the unfunded mandate. This was an unintended consequence of EMTALA (See EMTALA.)

**UNDERINSURED** = The purpose of insurance is to prevent financial disaster in the event of an expensive medical catastrophe. As many as 84 million Americans have medical insurance where the coverage is too low to protect them from medical bankruptcy. These are the "underinsured."

**UNFUNDED MANDATE:** See EMTALA and Uncompensated care.

**UNINSURED** = those who have no medical insurance. Current estimates put this number at 45–50 million Americans, 24 percent of whom are not legal citizens. Because of EMTALA, sick patients can always get care whether they have insurance or not, and it is paid for by someone else—in most cases, the U.S. taxpayer.

**UNIVERSAL HEALTH CARE** = national healthcare systems where reputedly everyone gets care. I write "reputedly" because these systems are not universal (non-citizens do not get free care). Care may be denied by government decree and often is. For example, there is Canada, where people sometimes cannot get the care they need when they need it.

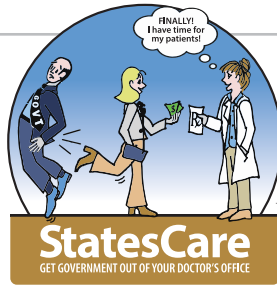
**UP-CODE** = provider submits a billing code for a service the provider did not provide, which generates a higher charge than the service actually provided.

**"WE THE PATIENTS"** = We the Patients emphasizes our commonality—every person is now a patient or eventually will be a patient. We the Patients includes Democrats and Republicans, rich and poor, all ages and stages, and American citizens as well as people here illegally. If you are alive in the U.S., you are part of We the Patients. We are all in "this" together, where "this" means life and good health for 323 million Americans.

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### About Dr. Deane:

Dr. Deane Waldman was Chief of Pediatric Cardiology at: The Children's Hospital of San Diego, The University of Chicago, and The University of New Mexico. He has seen the insides and outside of our floundering medical care systems. At present, Dr. Waldman is Distinguished Senior Fellow for Healthcare Policy at Texas Public Policy Foundation. His proposal for StatesCare has the potential to revolutionize healthcare in the U.S. and save us from the imminent imminent collapse.



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