Lately my wife and I have been looking at future budgets and the possibilities of getting a plane later (I know your post about boats/planes). We wanted to know if you thought this was reasonable.

We will either live in a small town (50K population) in Oklahoma or Texas. On our $400K gross income, we’ll be able to put about $11k per month in after tax dollars into investments. We’re considering saving only $7-8K per month and getting a boat and/or plane. At what point do you reach a saturation on investing for retirement?

After running the calculations we reasoned that we’d have less money in retirement, but figured what’s the real benefit of retiring with $10 Million instead of $5 Million?

A.

What a difference between your lifestyle and that of the physician last week considering the purchase of a starter home costing $1.25 Million! You guys can probably buy a mansion on a couple of acres for $300,000 in your small town. Your question is a good one (and one that I struggle with at times too.) At what point do you say enough is enough and go spend some money?

My rule of thumb for retirement saving is that you should save 20% of your gross income toward retirement. With your $400K income, that’s $80K, or less than $7K per month. Once you are saving that much, I don’t think you should have a lick of guilt about spending or giving away every dollar you make above and beyond that. I do think you should consider a few things first though.

First, airplanes and boats are exceedingly poor “investments.” They say a boat is a hole in the water into which you throw money, and after owning a boat for a couple of years, I can testify that’s correct. Ownership of these expensive toys is usually far more expensive than you at first realize, so
budget very conservatively for these items. Planes in particular have high fixed expenses including storage costs and annual inspections.

Second, young physicians (and I include myself 6+ years out of residency) often have other (non-retirement) financial needs and goals they need to save for. We often have inadequate emergency funds (especially given our new spending habits), some high-interest debt, and little to no college savings for our kids. These things are all above and beyond the “20% retirement savings rule.” So you should ensure your plan covers these items as well before committing to an expensive hobby.

Last, keep in mind that your income isn’t static. While we may hope our real, after-inflation, income will rise throughout our career, the trends in physician reimbursement are not reassuring in this regard. Physicians in many specialties are working harder and making less than they were 10 years ago, and between Obamacare, the growth in ACOs, bundling of payments, and the very real concerns about the cost of Medicaid/Medicare, I suspect the trend may continue or even accelerate. There’s something to be said for “making hay while the sun shines.” Saving $50-100K a year now for retirement may be far easier than it will be ten years from now. It isn’t like you couldn’t sell the plane in a few years if your income drops, but you ought to at least consider the possibility of a decreasing income in your plans.

What say you readers? How do you decide when enough is enough?

**ObamaCare Part 3 – PPACA and Your Practice**

In the first part of this series I discussed the additional taxes you may pay due to PPACA. In part two, I discussed the benefits you’ll see as a consumer from the PPACA regulations. In this part, we’ll discuss how PPACA will affect your practice.

**Primary Care Support**
We all know primary care docs have been getting shafted for years. Many of them can no longer stay in business and are being bought out left and right by hospitals. PPACA should help with this quite a bit. Since the insurance company now has to pay for three primary care visits per year without co-payments, people will be more likely to come in and see their PCP. Much of the preventive care done by PCPs is also covered without a co-pay.

In addition, for 2013 and 2014, Medicaid will pay at the higher Medicare rate, often twice as high. Medicare rates for primary care visits will also go up 10%.

OB/GYN Support

Some plans require a referral to see a gynecologist. That’s now gone, so OB/GYNs should have a bit of an increase in patient volume. There will also be an increase in people seeking contraceptives that are now available without a co-pay.

Rural General Surgery Support

From 2011-2015 rural general surgeons will get an additional 10% from Medicare as incentive payment.

Geographic Practice Index Cost Adjustment

Say what? Basically Medicare pays you more when you practice in a more expensive location. They made a recent adjustment that benefits docs in Utah, Wyoming, North and South Dakota, and Montana.

Quality Payments

From 2012-2014 you get an extra 0.5% payment from Medicare for meeting quality measures, and another 0.5% for running a quality certification program of some type (think peer review). Of course, what starts as a 0.5% carrot (actually 1% in 2011) becomes a 1.5% stick in 2015, then a 2.0% stick starting in 2016.

More Medicaid Patients

There will now be fewer “self-pay” patients and more Medicaid patients. While in many states, there is little difference in reimbursement, those specialties affected by EMTALA laws (emergency docs and those who take call from an ED) will at least get a few more bucks for their efforts. However, there is a limited pot of Medicaid money in any given state. Since that money must now be spread among more patients, it seems quite likely to me that state Medicaid reimbursements will fall even lower than the ridiculously low rates they are already at. More and more doctors are refusing to see new Medicaid patients, ranging from 1% of docs in Wyoming to 60% of docs in New Jersey. I don’t know about you, but we get about 1/4 as much money from a Medicaid patient as an insured patient. I can’t blame a physician for limiting his Medicaid population given these kinds of numbers. Many of our
politicians and citizens are going to learn that **having “insurance” won’t guarantee access**, timely or otherwise, to many specialties, at least not those who aren’t mandated to do so by EMTALA.

**Decreased Medicare Reimbursements**

It really irks me to pay more in Medicare taxes, and then get paid less by Medicare, but that’s the way it’s going to be. Something like $530 Billion is coming out of Medicare to pay for Obamacare, and most of that comes out of hospital and physician reimbursements. This will affect your bottom line. More important, it’ll affect patient access to care. In Anchorage, AK, there are no primary physicians taking new Medicare patients (if you know of one, please email me, my parents could use one.) I’m sure there are other cities with a similar situation. If there aren’t, there will be soon. Now, it’s possible that there will continue to be a “doc fix” each year, but I don’t think I’d bet my practice on that happening every year.

**Medicare Advantage Cuts**

Medicare Advantage is a Republican-designed program that injects competition into Medicare, as a general rule providing MORE benefits to seniors than traditional medicare. It provides lower co-pays and deductibles, prescription drugs eliminating the need for Medigap insurance, preventive care, vision and hearing coverage. It does cost more than Medicare, but primarily because it offers more. It will shortly see significant cuts. Seniors on these programs will be less likely to come see you, since it will cost them more. That could affect your bottom line, unless you’ve already decided not to see Medicare patients anyway.

**More Accountable Care Organizations (ACOs)**

The trend of fewer independent doctors and more employed doctors will continue as the costs of regulatory compliance and maintaining EMRs becomes overwhelming for a small business. Expect more docs working for hospitals, large physician groups, and even insurance companies.

**Increased Fraud Prevention Efforts**

The title sure sounds good, until you realize its YOU that’s being investigated. There are a number of changes to current law that PPACA puts into place that make it easier to prosecute your innocent mistakes as purposeful fraud to the government.

**Increased Trend Toward Bundling**
PPACA really has it out for the fee-for-service model. Expect to see the
trend toward bundling payments to continue, forcing doctors, hospitals, home
health agencies, and skilled nursing facilities to fight over a steadily
decreasing pie. Also expect to not get paid for care related to
complications of surgery or any readmissions to the hospital.

Longer Wait Times, More Concierge Care, and More ED Abuse

Especially with regards to primary care, with more insured patients (and
fewer co-pays for preventive services) there will be more demand for
physicians, but not more supply of physicians. That will be reflected as a
longer wait to get in to see you (or to send your patients for
consultations). This increased demand will allow more and more physicians to
go cash-only or adopt a concierge model and get out of the insurance business
entirely, especially with regards to Medicare and Medicaid. Increasingly, a
two-tiered medical system is likely to develop, with those who can paying for
a concierge doctor and those who cannot waiting for their care (or going to
the ED for primary care concerns.)

Summary

I’m not thrilled about the additional taxes I’ll be paying for PPACA. I’m
also skeptical that those additional taxes will even cover the costs of the
program. Insurance will definitely be more expensive in the future, although
it’s hard to say how much. I like most of the benefits of PPACA as a
consumer. There were a lot of insurance company abuses that will now be
illegal. However, as a doctor, I’m very unhappy with the likely scenario of
decreasing pay, increasing compliance-related overhead, and decreased
independence. As a patient advocate, I’m also very concerned with the access
to care issues that will be exacerbated by PPACA. It’ll be years before we’re
fully able to understand all the consequences, unintended and otherwise, of
this immensely complex law.

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