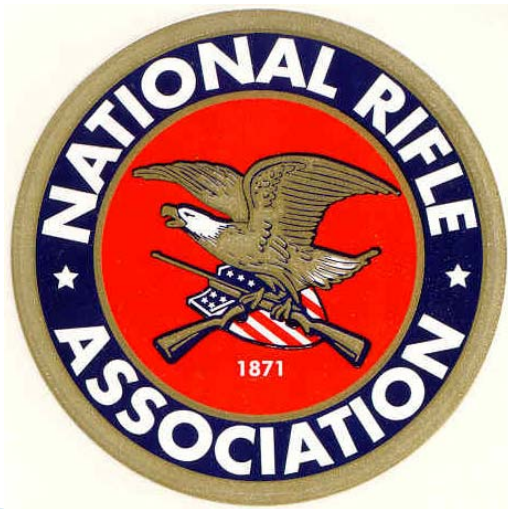
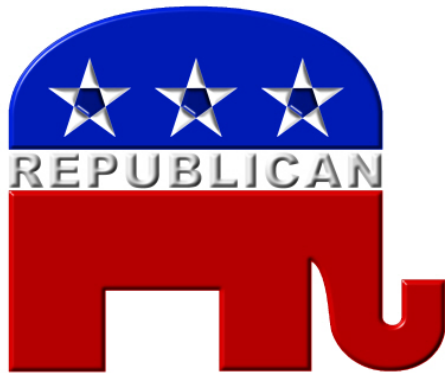


# Patient Protection and Affordable Care Act: Good For Surgeons



Jeffrey Harr MD, MPH  
Department of Surgery  
University of Colorado  
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# Disclosures



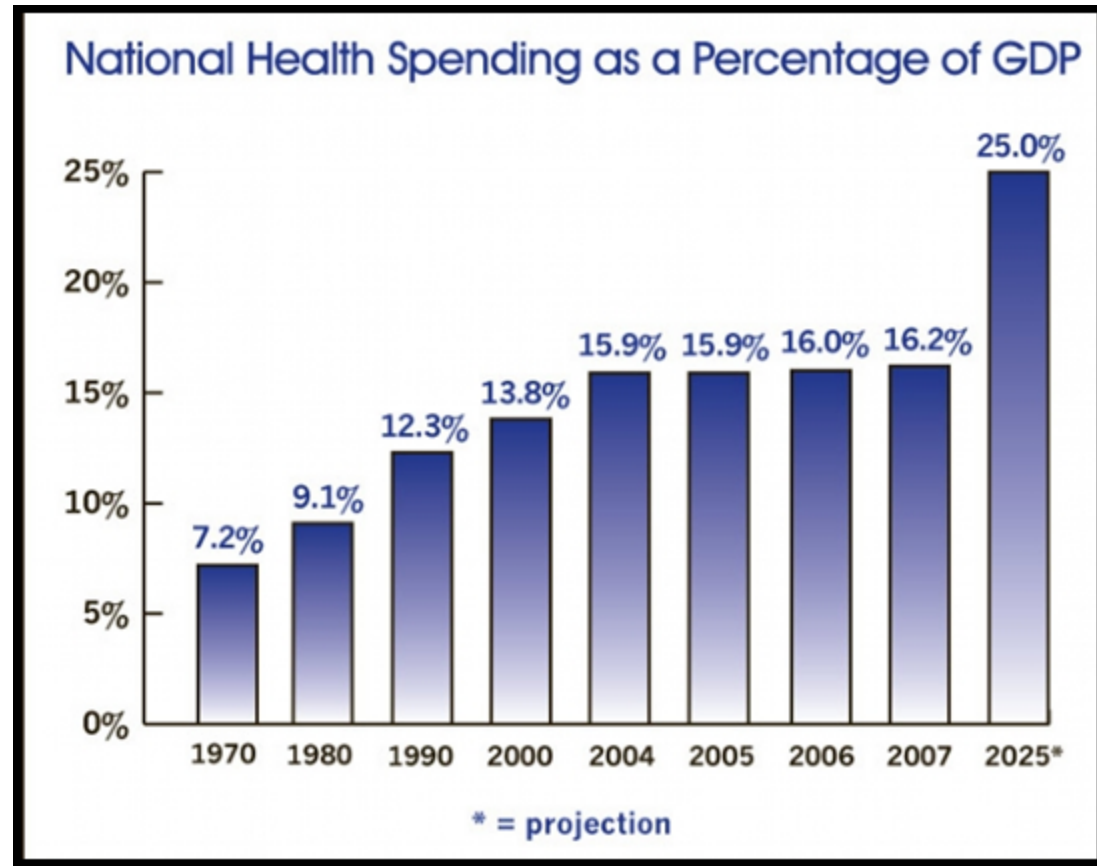
# Outline

- ▶ The Problem
- ▶ Background
- ▶ Structure
- ▶ ACA is good for surgeons
- ▶ Conclusion



# The Problem

- ▶ United States pays the most on healthcare
- ▶ Ranked 49<sup>th</sup> in the world for life expectancy
  - 78.1 years
- ▶ 50.7 Million Uninsured Americans



# The Problem

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# Background



- ▶ Patient Protection and Affordable Care Act
- ▶ Covers 32 million currently uninsured
  - 16 million added to Medicaid
  - 16 million covered through state “exchanges”
- ▶ Funded by:
  - Limits on Medicare spending (\$155 Billion/10 yrs)
  - Taxes
    - 3.8% increase if earning  $\geq$  \$200,000
    - 0.9% increase on Medicare Part A tax rate (2.35%)
    - 10% tax on indoor tanning services
    - Pharmaceuticals and Medical Devices

# Health Insurance Reform

- ▶ Prohibits life-time limits
  - ▶ Prohibits rescinding coverage when individuals become ill
  - ▶ Eliminates pre-existing condition exclusions
  - ▶ Guarantees issued coverage with adjustment in prices based on age and smoking status
  - ▶ Out of Pocket Costs capped
  - ▶ Deductibles limited
- 

# Structure

## ▶ American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges


- Subsidies on premiums up to 400% of FPL

• Businesses > 50 employees

Income % of FPL	Premium Cap of Income	Avg Premium
100–150%	2.1–4.7%	\$600
150–200%	4.7–6.5%	\$2,400
200–250%	6.5–8.4%	\$4,000
250–300%	8.4–10.2%	\$6,100
300–350%	10.2%	\$9,200
350–400%	10.2%	\$14,100


- ▶ Medicaid eligibility expanded to individuals with incomes up to 133% of FPL.

# Structure

- ▶ Accountable Care Organizations (ACOs)
    - "an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it."
    - Allows eligible providers to partner as ACOs that receive bundled payments and share in any Medicare cost-savings that might occur
- 

# Structure

## ▶ How ACOs work

- Beneficiary population identified, historical Medicare annual payment determined (\$A)
  - ACO provides value-based, efficient care to the population over the next year at a lower cost (\$B)
  - CMS subtracts \$B from \$A, and rewards the ACO with some portion of the difference
- 

# Good For Surgeons



# Good For Academic Surgeons


- ▶ Academic Medical Centers are in an advantaged position to lead in the development of networked, coordinated care models
  - Tend to be larger
    - command greater resources
  - Already connected to community hospitals in complementary ways

# Good For Academic Surgeons



- ▶ 131 Academic Medical Centers (out of ~5800 US hospitals) cover 60% of the uninsured.
- ▶ Reduces disproportionate share of patients seen in Academic Medical Centers → Reducing losses


# Good For All Surgeons

- ▶ 10% Medicare bonus for primary care and general surgeons in underserved communities
  - ▶ Mandates Physician Quality Reporting Initiative (PQRI)
    - incentive payments and penalties
  - ▶ Establishes a “value-based” payment modifier to reflect the quality, cost, and volume of care
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# Good For Surgical Education



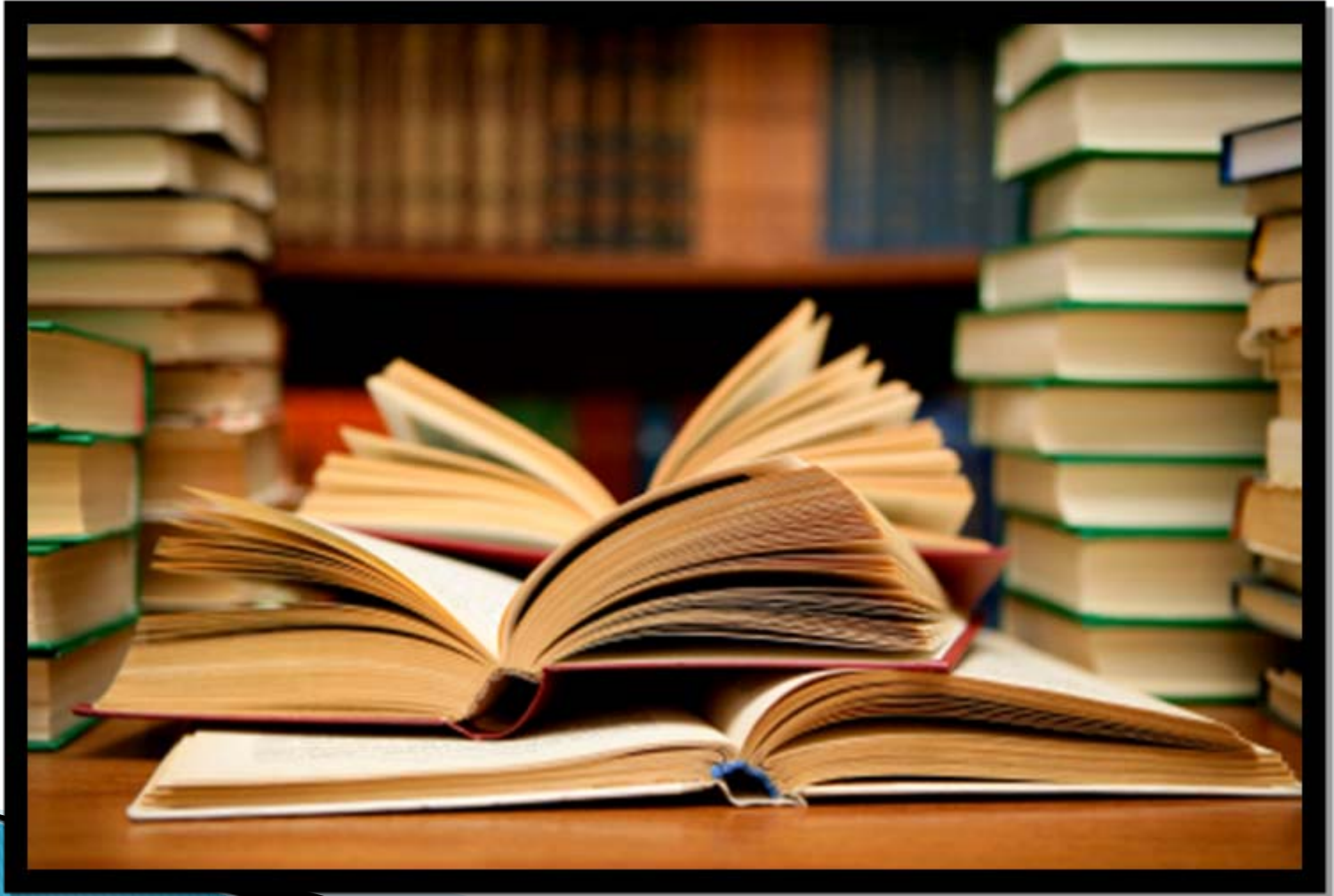
# Good For Surgical Education

- ▶ Redistributes 65% of unused or closed post-graduate positions to favor primary care and general surgery
  - ▶ Allows hospitals to count more resident time toward IME and DGME payments
    - Time spent in didactic activities
    - Approved leave won't diminish FTE count
- 

# Good for Surgical Education

- ▶ Change the way we train residents
  - Bundled payments reward providers who use tests judiciously
    - Estimated 20% of tests are unnecessary
    - Clinical acumen will be re-emphasized
  - Will help make cost/value a part of resident education


# Good For Research




# Good For Research

- ▶ Patient–Centered Outcomes Research
  - Authorizes a Patient–Centered Outcomes Research Institute (PCORI) as a nonprofit corporation that is not “an agency or establishment of the U.S. Government.”
    - \$1.1 Billion
- ▶ Coverage of Clinical Trials
  - Health plans and payers cannot deny admission into “approved clinical trials,” and must pay “routine patient costs”

# Good For Research

- ▶ Cures Acceleration Network (CAN)
    - Established within the Office of the NIH Director “to accelerate the development of high need cures.”
      - Grants (½ billion dollars in 2010)
      - Facilitate FDA reviews
  
  - ▶ Center for Medicare and Medicaid Innovation
    - Test new delivery models that improve quality of care while maintaining or reducing costs
    - Healthcare Innovation Zones (HIZs)
    - \$10 Billion
- 

# Unresolved Issues

- ▶ No Tort Reform
    - High Malpractice Insurance
    - Defensive Medicine
  - ▶ Does not increase the cap on Medicare support for residency training
  - ▶ Does not address the Sustainable Growth Rate (SGR) physician payment methodology
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# Conclusion

- ▶ ACA is not perfect....BUT
    - Offers opportunities for all surgeons, improves resident education, and funds research
  - ▶ Academic Surgery can Drive the Agenda
    - “Apply science to help transform our current inefficient and expensive health care system into a more evidence-based system of effective, coordinated, safe, and patient-centered health care”
  - ▶ Reform is OUR job
    - Incentives are put in place along with new payment structures and programs, then WE have latitude to reform, create, and transform.
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