

Richard W. Snyder II, MD
President's Page
The Reformation

When the Supreme Court ruled that the Patient Protection and Affordable Care Act was constitutional, because the penalty mandate is in reality a tax, it set off an unexpected mad scramble by yours truly to rewrite the DCMS press release concerning this verdict. It seems the three provisional versions that I wrote the night before covering the three most likely ruling scenarios under the Commerce Clause (complete affirmation, complete repeal, partial repeal) were not enough. It's a good thing because the full office and acute MI that I was dealing with just didn't fill the void in my morning that Thursday.

The Supremes, with their ruling, heralded the end of the beginning of the health system reform odyssey. This most anticipated of all health reform decisions will now unleash a process by which many more decisions will be made at the federal, state and local levels, both legislative and regulatory, that will start to determine how healthcare reform will manifest. In this regard, PPACA is not so much a health system reform directing clearly defined change as it is a health system *reformation*, triggering a *process* of change. The Act itself is more of a guideline that determines the general direction that health system reform should follow. I have not read anywhere near the entire 2,700-page document, so I do not pretend to be an authority on PPACA. However, that puts me in same company as the vast majority of the legislators who actually voted on the bill. What I do know is that the truly clarifying "rules" will be made by nonelected regulators who will interpret how the Act should transform the daily practice of medicine. Governors must make important decisions, and state legislators must vote on a myriad of bills that will determine how the Act will apply to their states (such as regarding Medicaid expansion and Health Information Exchanges). For example, some states may decide not to participate in health exchanges or expand their Medicaid programs. PPACA will take on different flavors on a state-by-state basis depending on how these decisions are made by executive, regulatory and legislative bodies. The Patient Protection and Affordable Care Act (wait for it) is just the *first act* of this drama (every pun intended!). Most of the work to bring real improvement to our healthcare system lies ahead.

As physicians we must continue to play an integral role in this process. If we are to serve as true advocates for our patients, we must do more than just talk. Now that we have certainty about the constitutionality of the Act, we must roll up our sleeves, go to work and re-elevate the patient to the pinnacle of health system reformation. We all know that the impetus for change in our healthcare system is derived from the desperate need to improve affordability and access to care. The Act aims to increase the number of Americans covered by health insurance and decrease the cost of health care. However, it neither adequately protects patients nor sufficiently provides for affordable care. The problem with the Act is that it focuses excessively on improving the affordability and access to *coverage*, while doing little to improving patient access to *care*. Coverage is not the same as access, and access to a waiting list is not the same as access to health care. Clearly the Act has some major positives that will improve access to care for many, but it falls well short of its intended goals. In Texas, 25 percent of our population is uninsured. That represents roughly 6.3 million of our fellow Texans, a number nearly equal to the population of Massachusetts. The act would add only around 2 million of the uninsured Texas patients to Medicaid. The Texas population currently covered by Medicaid stands at about 3.4 million.

The problem with expanding Medicaid is that statewide only 31 percent of all physicians are taking new Medicaid and this number is plummeting, according to a 2012 Texas Medical Association survey. The negative trajectory of this number is just as alarming: 67 percent in 2000, 42 percent in 2010, 31 percent today. In Dallas County, the numbers are even more bleak. Only 24 percent of all physicians and just 19 percent of primary care physicians are accepting all new Medicaid patients. It makes you wonder when we will see single digits! (For disclosure purposes, myself and all physicians in my group are

enrolled in and accept Medicaid.) Even if we convert all uninsured patients to a Medicaid plan, they may be covered, but that doesn't guarantee they will have access to a physician, certainly in a timely manner. For example, everyone in the Canadian and British health systems has healthcare coverage, but wait times to see a physician are well-known and are not acceptable to patients in this country. Massachusetts has "universal" coverage for its citizens; however, the Boston municipal area has the longest wait times for new outpatient visits among the largest 15 US metropolitan areas, according to a 2009 Merritt Hawkins survey. The standard for the ongoing reformation of health care must embrace not only cost-effective, quality care but also the *timeliness* of care. This concept of timeliness is key: the right care at the right time. Timing for many things in life is key, frequently trumping quality. As I tell my kids, it didn't matter how perfectly Troy Aikman spiraled the football with laser-beam precision down the field, if the timing was off, the ball got there late and was intercepted, then his effort was all for naught.

With this Supreme Court decision, we physicians must help our legislators and regulators keep what works, fix what is broken, and find what is missing in PPACA. However, before we start, let's be clear: I don't want to hear any clarion call for repeal of PPACA without a detailed, specific comprehensive plan to replace it. Better yet would be language crafted to improve and supplement the Act. We may not like all elements of PPACA, but at least it is an attempt at reform. We now are beyond the placebo stage of health system reform. A better medical analogy would be an access to care comparison proposed to demonstrate superiority as opposed to noninferiority. I want to examine some requisite changes to the current healthcare system and PPACA that we have today.

What works

Coverage of pre-existing conditions and elimination of lifetime maximum benefit limits are elements of the Act that deserve congratulations and must be preserved. The inclusion of children up to 26 years of age on their parents' health insurance plans clearly is worthy of praise. These elements make a positive impact on access to care and generally reflect the value system of our country, regardless of one's political ideology.

What's broken

Now let's focus on what is wrong with the Act. The law introduces a Medicare cost-containment mechanism, called the IPAB (Independent Payment Advisory Board), which definitely should not be confused with an iPad, but may become just as ubiquitous and transformative, although not for the better. This 15-member committee will be appointed by the president, and confirmed by the Senate. In this regard it is effectively a Supreme Court of Physician Reimbursement. This board, affectionately called "MedPAC on steroids," will have almost dictatorial powers to determine reimbursement cuts to service providers if costs rise beyond certain levels, with little hope for successful appeal. A form of rationing, ironically this Independent Payment Advisory Board will strip the independence from the patient-physician relationship and render this bond almost meaningless. IPAB has been condemned by all medical societies, including the AMA. A bill to repeal this component passed in the House on March 22, but stalled in the Senate.

A further problem with the Act's cost-containment efforts is that it focuses on the wrong area: physicians. Physician compensation is not a major driver for rising healthcare costs in the United States. A recent study found that the rate of US physician compensation is among the lowest of western nations. US physicians' salaries comprise 8.6 percent of the nation's total healthcare costs. Among western nations with modern healthcare systems, only Sweden (at 8.5 percent) devotes less money to physician compensation than the United States. Other western nations spend more – sometimes significantly more – on physician compensation as a percentage of total healthcare expenditures: United Kingdom, 9.7 percent; France, 11 percent; Australia, 11.6 percent; and Germany, 15 percent. If the goal

of healthcare reform is to take waste and excess out of the cost structure, physician compensation is not the place to start or to devote most of the efforts.

An additional element that is wrong with the Act is the prohibition on physician ownership. Physician ownership has been demonstrated by the government's own data (<http://www.hospitalcompare.hhs.gov>), as I have detailed in previous President's Pages, to excel from both a quality and a cost perspective. Physician-owned heart hospitals in Texas rank No. 1 in the nation in clinical outcomes for heart failure and heart attacks. If superior quality at a lower cost is a goal of health system reform, language prohibiting physician ownership must be stripped from the law.

What's missing

Now let's turn our attention to what is missing in the Act, where PPACA is most deficient and has the most opportunity for improvement. It is greatly inadequate in addressing physician workforce and access issues. Specifically, the Act does not effectively deal with the cancer of our medical liability environment and does not reform SGR. On the surface, these issues appear self-serving; however, both of them significantly impact cost and access to care, and determine the viability of our profession. The AMA should never have endorsed PPACA without having satisfied these two issues. By passing Texas-style liability reform that includes caps on non-economic damages, the federal government could significantly reduce cost (conservative estimates are \$60 billion – \$90 billion annually) without having to find additional funding sources.

The SGR fiasco is a recurring horror movie that is progressively eroding patient access to care. A 30-percent cut in physician payment rates is still looming on Dec. 31 of this year. Currently, only 58 percent of Texas physicians accept new patients who rely solely on Medicare, and that number is falling rapidly (from 66 percent in 2010). In regard to dual-eligibles (Medicare-Medicaid patients), only 40 percent of Texas physicians and 32 percent of Dallas County physicians accept them. Imagine what kind of access seniors would experience if a 30-percent reimbursement reduction materializes. All the while, the Medicare population is exploding as 10,000 patients a day age into Medicare eligibility.

Furthermore, the Act does not address the workforce bubble that soon will enter almost crisis proportions for nearly all specialties. For my specialty of cardiology, a 2009 survey revealed that 45 percent of general cardiologists were over age 55. This is a figure that I am sure is similar for most medical specialties. How can you claim you have implemented comprehensive health system reform without including language that solves these current and future access issues?

Finally, today's healthcare system is riddled with hundreds of regulations imposed by federal health law that do little to improve care, but instead divert our attention, time and energy from our patients. We are spending less time with patients, and more with computer screens and paper. Rather than alleviate this burden, PPACA contributes to it. The evolution of health care must free doctors to focus more on patients than on paper.

We must be forceful advocates for our patients and remain determined that the patient be paramount in health system reform. Affordability and access to care, *not just to coverage*, should be the benchmark by which we measure success. Reformation of our healthcare system must embody the guiding principles of *timely* access to quality, cost-effective care *for all of our citizens*, and the sanctity of the independent and autonomous patient-physician relationship. Now, let's get to work!