



Perspectives

The Patient Protection and Affordable Care Act: causes and effects

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Introduction

The passage and implementation of the Patient Protection Affordable Care Act (PPACA), also known as Obamacare, has met with anxiety, apprehension, and opposition from nearly half of all physicians and from Republicans and their allies in the Tea Party and in libertarian groups. Although it is understandable that such a broad-ranging social program would cause concern, it is important for physicians (and other citizens) to understand the need for change in the health care system, what problems the specific provisions of the bill are meant to address, what can be expected from these changes, and, for health care providers, what the changes will mean for them and what challenges and opportunities the PPACA will provide them.

Calls for health care reform are not new. The first proposals came during Theodore Roosevelt's presidency, not long after Bismarck initiated the system in Germany in the late 19th century that still exists today. Harry Truman, Richard Nixon (in whose term managed care began), and Bill Clinton recognized the deficiencies in our system and made attempts to change it, without success. However, by 2008, with an economy teetering on the edge of collapse and health care costs continuing to skyrocket, putting American business at a competitive disadvantage in an increasingly globalized world economy, and a Democratic White House enjoying majorities in the House of Representatives and the Senate, the time seemed right to finally achieve the goals that had eluded policy makers for 100 years.

So, what were the issues driving the legislation? And, critics asked, what was so wrong with our health care? Did we not enjoy the most advanced, highest tech medical care provided by the smartest and best-trained physicians in the best hospitals to which the whole world came?

The answers lie in the numbers.

Costs were continuing to rise, occupying increased percentages of the gross national product. In 1980, health care accounted for 9%

of the gross national product, but by 2008, it was 16% and projected to be 19.5% by 2017.^{1,2}

Access to medical care caused by lack of insurance was limited for the approximately 50 million uninsured, a number that was increasing, in part aggravated by prevailing high unemployment rates and the loss of employer-sponsored health insurance.³ It has been known for a long time that lacking regular medical care, relying on emergency departments, and seeking care only when urgent result in poorer outcomes in sicker people. The Institute of Medicine's report on America's uninsured in 2009 looked closely at how being uninsured results in poorer outcomes for patients. Evidence shows that uninsured adults with heart disease, cancer, stroke, asthma exacerbation, chronic obstructive pulmonary disease, hip fracture, and seizures are more likely to have poorer health outcomes, greater limitations in quality of life, and premature death.⁴ Further, the American public was getting poor value despite the huge expenditures for health care. In 2000, our health care system ranked 37th in the world and among developed countries ranked 16 of 17 in life expectancy in 2007.⁵ Something had to be done.

Therefore, the PPACA was conceived and passed, based on ideas first put forward by the conservative think tank, The Heritage Foundation, in the mid-1980s and instituted in Massachusetts by Republican governor Mitt Romney in 2006.

Its primary purpose was the expansion of coverage for millions of uninsured Americans, which it proposed to do by expanding Medicaid for those with incomes less than 138% of poverty (approximately \$11,490 for singles and \$19,530 for a family of 3 in 2013) and by providing subsidies for insurance, on a sliding scale, for people with incomes from 138% to 400% of poverty.⁶ As originally legislated, every state was required to participate in Medicaid expansion in exchange for which the Federal government would pay 100% of the cost of this increased coverage for 3 years and 90% after that.⁷ The Supreme Court struck down this provision so that participation is now voluntary and 25 states have agreed to increase Medicaid coverage.⁸ In addition, the legislation calls for the creation of insurance exchanges to allow for more marketplace competition among insurers, thus decreasing premiums and

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increasing consumer choice. This part of the PPACA was supposed to be operational by October 1, 2013, but implementation thus far has been difficult for states and patients.⁷ The government Web site for exchanges was wrought with glitches within the first weeks. There is some promise, however, because the Obama administration reported that by late October 2013, approximately 700,000 applications had been received for participation in exchanges and by November 30, 2013, many of the initial problems with the federal website had been substantially improved.

Also increasing coverage are provisions allowing people younger than 26 years to be covered under their parents' insurance (so far, more than 3 million have been added to insurance roles as a result)⁹; life time caps on insurance coverage have been removed, affecting 105 million Americans; exclusion for pre-existing conditions has been abolished to the benefit of 17 million children¹⁰; 6.6 million seniors will pay less for prescription drugs because of elimination of the "doughnut hole" in Medicare drug coverage¹¹; and preventative services have been extended to 71 million people without cost sharing.¹²

It has been argued that this is a very expensive program and actually will increase the cost of health care. In fact, health care inflation has plateaued in the 3 years since passage of the bill, attributed at least in part to the legislation.¹³ Projections of the cost of insurance have varied somewhat based on methodology,¹⁴ but a recent report from the Kaiser Family Foundation¹⁵ has indicated that premiums will be lower than projected by the Congressional Budget Office because of the increase in the risk pool with the addition of many healthy young people.¹⁶ (The idea of "free riders," which include the young and healthy, is one that is at the heart of why an individual mandate was needed. In several states, insurance coverage without a mandate resulted in a "death spiral," increasing health costs and premiums without those "free riders" who are lower risk to balance the insurance pool and regulate costs.)

Impact of PPACA on Allergists and Other Physicians

Two of the major attributes of health care, cost and quality, also are addressed through innovative and potentially transformative programs designed to restructure the way health care is delivered. These are the Patient-Centered Medical Homes (PCMHs) and Accountable Care Organizations (ACOs), which are designed to improve care coordination by encouraging use of electronic medical records, changing providers' financial incentives by including quality measures in reimbursement, and ultimately moving away from a fee-for-service to a "value-based" compensation system. It is in this arena, we believe, that physicians will be most affected and which will provide the greatest opportunities (and risks) for physician practices. These new practice entities, although encouraged and supported under the PPACA through the Centers for Medicare and Medicaid Services, also are evolving in the private marketplace independent of government action and should be carefully scrutinized by all practicing physicians.

These organizations seek to lower health care costs and improve quality by improving care coordination and by changing payment methods to providers to decrease incentives for volume care and to reward meeting quality performance standards. This adds additional regulatory burdens on physicians, carries the potential for penalties if baseline requirements are not met (what are incentives that may become mandates in the future), imposes extra capital requirements to incorporate electronic records necessary for facilitating compliance, and can increase overhead to meet expanded staffing necessary for working in a more team-based environment. However, if these efforts are successful, they may improve care and lower costs for patients.

Allergists can partner with PCMHs as PCMH Neighbors (PCMH-N). The PCMH-N is a concept developed by the American College of

Physicians with an accreditation process being implemented by the National Committee for Quality Assurance. It sets up a structure that formalizes the relation between primary care physicians (PCPs) and specialists, providing protocols for their interaction.¹⁷ Compensation for participating as a PCMH-N also may include payments to cover higher overhead and participation means assuring the referral stream for the allergist.

The ACO movement has accelerated consolidation and integration in the medical marketplace. Hospitals are buying practices, which means that physicians are ceding autonomy to belong to the organizations to keep their market share intact and to have access to electronic record systems and other infrastructure that are expensive to capitalize. Centralizing these systems can lead to decreases in administrative costs, known to be responsible for much of the high costs of health care, which can lead to further cost savings. The Bureau of Labor Statistics estimates that more than \$12 billion could be saved annually.¹⁸

Specialists can belong to ACOs as participating members or as contract physicians. Participating members have a role in governance and can benefit from savings generated by the organization in shared-savings programs but may have to share in downside risk. Contract physicians will have access to referrals but may not have any management or profit participation.¹⁹ In contrast, contracting with numerous ACOs, rather than participating in them, allows for greater flexibility and avoids problems of needing a separate tax identification number for each ACO to which one belongs.¹⁸

This puts a lot of pressure on allergists who, for the most part, have been used to working in solo or small group settings. It is important for allergists to stay informed about the formation of ACOs in their community and carefully evaluate whether they wish to or need to participate and at what level.

Exactly what the repercussions of the PPACA are for allergists can be only speculative and, as with any major change, carries risks and opportunities. Becoming part of a large organization requires a major adjustment in attitudes about what it means to be an autonomous physician, about ceding control, and following rules of someone else's making. For example, PCMHs and, by extension, ACOs are encouraged to expand hours of operation to accommodate patients' needs around work and child care. This means that physician offices may need to be open during the early morning, evening, and/or weekends. Specialty physician compensation also may be adversely affected in a budget-neutral or declining environment as PCPs are increasingly rewarded. However, physicians will be able to expand their patient population and, through many incentives afforded through the PPACA, have opportunities to be rewarded for providing cost-effective care. These factors, it is hoped, will balance potential adverse effects on physician compensation. Further encroachment of other specialties on allergy also might occur, especially if there is no attempt by the authorities to assure that only the most qualified allergy specialists (ie, allergists) deliver allergy care.

Nevertheless, there is an opportunity to enrich an allergy practice by having access to better patient information when consulted by PCPs, gaining access to wider referral networks, collaborating on clinical research projects with larger patient bases and larger data banks, and improving one's special skills by being able to and needing to focus on more difficult cases.

This will take some work on the part of allergists to remind their colleagues that "allergists do it better" and that allergists are expert in many conditions other than urticaria and allergic rhinitis. Allergists need to get into hospitals, give grand rounds to speak about anaphylaxis and drug allergy, work on medical committees, and go to lunch in the physicians' cafeteria to assure their rightful place in the medical community. We believe there is a large unmet need for service that only allergists can provide but that other practitioners need to be reminded that such care exists.

Although it is not possible to know exactly what additional impact the PPACA will have on physicians, some provisions address physicians directly and others may have indirect consequences, good and bad.

The law promotes primary care several ways. Medicaid reimbursement for evaluation and management services and vaccinations will increase to equal that for Medicare.²⁰

Primary care physicians also have been receiving a 10% bonus under Medicare, which will continue until 2015.⁷ The part of the legislation forming PCMHs and ACOs also favors primary care because organizing care around PCPs is seen as the best way to control cost by insuring care coordination and decreasing the use of more expensive specialty care.

Another potential benefit of the PPACA for all physicians is that more patients will be insured, thus decreasing uncompensated care and allowing currently uninsured people to seek medical care. This will increase volume, which may or may not be good for one's practice.

For allergists, one benefit of this is that many younger patients, who have frequently not been insured, have become insured through their parents or will become covered because of mandated coverage. Allergists may expect many newly insured children and young adults coming into their practices with further implementation of the new law.

There are downsides for physicians, too. There will be penalties, which could affect physician reimbursement. Failure to comply with meaningful use of electronic medical records and/or to meet Physician Quality Reporting System standards starting in 2015 could result in fines totaling up to 7% of Medicare reimbursement by 2017.²¹ Balancing this is that physicians will be able to charge value-based modifiers in the beginning of 2015 that can enhance incomes.

The Centers for Medicare and Medicaid Services has set up a new Web site, Physicians Compare (<http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/physician-compare-initiative/index.html>), which currently provides only names, specialties, and locations for physicians but will start including quality data in 2014 for group practices and ACOs. Physicians will be able to review their data for 30 days before posting. It will be very important for physicians to do so because there are already multiple errors on the site. One of us (D.E.) is listed with the wrong practice address and wrong place of medical residency and changing the information is cumbersome.

There will be higher deductibles and copays under the health insurance exchanges that will have to be collected up front. This imposes additional administrative burdens on physician offices but the advantage is rapid payment.

The PPACA has already shown some significant benefits for our patients and for our society. What the future holds is, of course, unpredictable except for the certainty that there will be problems and errors and unforeseen consequences to the implementation of a program as large and complex as this. Some things will work, others will not, and there will be lessons to be learned. The Medicare of today is not the Medicare of 1965. It must be remembered that this is PPACA version 1.0 and there will be continued revision and modification to improve it and to fit the prevailing contemporary conditions. That said, the PPACA is the law of the land and, to quote President Bill Clinton, who recently discussed the PPACA, "The health of our people, the security and stability of our families, the strength of our economy are all riding on getting health care reform right and doing it well, which means we will all have to do it together."²²

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