

Health Care Reform 2012

Significant changes are expected in coming years.

BY GEORGE A. WILLIAMS, MD

Since its enactment in March 2010, the Patient Protection and Affordable Care Act (PPACA) has elicited much debate. While supporters favor the law's expansion of health care coverage, others challenge its constitutionality. Regardless of the controversy surrounding health care reform, it is important that we physicians understand the key provisions of the PPACA and how they will affect us, our patients, and our practice in the coming years.

SPENDING

In 2010, national health expenditures totaled \$2.6 trillion, or 17.9% of the gross domestic product (GDP). This spending was divided into the following percentages: 31% hospital care; 22% physicians/providers; 11% prescription drugs; 7% nursing homes; 5% private insurers profits/administrative; 2% government administrative; and 22% dental, home health, and over the counter. Since 1999, the cost of health insurance has increased by 131%. In 2010, the average annual premiums for employer-sponsored coverage were \$5049 for single coverage and \$13 770 for family coverage.

One aspect that is not well understood by the public and perhaps by politicians as well is that 10% of the beneficiaries generate two-thirds of the expenses. Of the general population, the top 1%—the sickest patients—consumes nearly 25% of total health care spending. The top 5% consumes nearly 50% of health care costs. Therefore, there is an opportunity to take better care of these individuals. Insurers have acknowledged the need for improved care of patients with chronic conditions such as diabetes and asthma, which are expensive to treat on an ongoing basis and contribute to higher health care costs. Insurer costs may be reduced by better chronic care.

WORKERS PER BENEFICIARY

When the baby boom generation joins Medicare, the number of beneficiaries will increase more rapidly than the labor force. From 2000 to 2030, the number of Medicare beneficiaries is projected to increase from 39.7 million to 79.2 million; however, the number of workers to support

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beneficiaries is expected to decrease from 4 workers to 2.4 workers per beneficiary. The United States is in better shape than most other developed economies. In Japan, the number of workers per beneficiary is less than 2, and in Western Europe, it is barely 2. In the developing world, there is a huge dichotomy, as the birth rates are not keeping up with the aging population.

SUSTAINABLE GROWTH RATE

The sustainable growth rate (SGR) was enacted in the Balanced Budget Act of 1997 to amend Section 1848(f) of the Social Security Act. The SGR attempts to ensure that the yearly increase in the expense per Medicare beneficiary does not exceed the growth in the GDP. If expenditures exceed target expenditures, physician payments will decrease; if expenditures are less than expected, physician payments will increase. By attempting to correlate GDP growth with increases in health care spending, the SGR is based on a fundamentally flawed formula.

Eliminating future SGR cuts carries a high budget score of about \$350 billion over 10 years. In actuality, that \$350 billion has not been spent; this value is based on an accounting scheme called budget scoring, in which SGR-based future savings are already accounted for. Any postponements of the cuts are counted as increases.

When the SGR went into effect in 1997, physicians received raises because the economy was booming. Then the bubble burst, the economy went in the tank, and there was the first prolonged recession in a long time. That year, physicians took cuts; however, there was enough screaming and yelling that, politically, we were able to prevent future cuts. Each subsequent year, Congress has overridden the required cuts on the SGR,

but it did not override the budget scoring. So the actual cost does not include the money that will be spent; it includes the money that should not have been spent. Medicare payments will be stable until December 31. If there is no change to SGR, the cuts will be even greater—30%.

There is a new proposal supported by the American Medical Association and American Academy of Ophthalmology called the Overseas Contingency Operations Fund, or OCO Fund. This is basically all of the money that we were projected to spend in Iraq and Afghanistan. The money that would have been spent on the wars would be used here instead. The OCO Fund is an accounting gimmick that is not likely to pass.

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

The PPACA will expand coverage to an additional 32 to 34 million people; however, 23 million will still not be covered. The PPACA will put 144 million people either in Medicare or Medicaid by 2019, meaning half of the US population will be enrolled in a federal program. The PPACA will also put 41 million people in individual coverage via insurance exchanges, but there will still be 165 million people in employer-sponsored coverage.

The Congressional Budget Office (CBO) maintains that the PPACA decreases the deficit. The Centers for Medicare and Medicaid Services (CMS), however, says the legislation increases costs. It turns out that if everything in the bill actually happens, there will be some Medicare savings. Under the new law, national health spending will increase by \$311 billion over the next 10 years. The net increase in federal expenditures for the PPACA through 2012 will be a net total of \$251 billion. The PPACA also includes \$575 billion in cuts to Medicare to pay for Medicaid expansion and a new entitlement program. The cost of the act's coverage provisions is approximately \$856 billion over the next decade.

In a CMS memorandum,¹ Chief Actuary Richard S. Foster stated, "Because of ... the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates ... do not represent a full 10 year cost for the new legislation." In essence, 10 years of revenue is being counted against 6 years of expenses; that is how money is saved. "The actual future impacts of PPACA on health expenditures, insured status, individual decisions and employer behavior are very uncertain," Mr. Foster wrote.

One controversial provision of the PPACA is the individual mandate, which requires people to carry a minimum level of health insurance or face a penalty. This provision is currently before the Supreme Court. There

are a variety of employer requirements, changes to private insurance, the Independent Payment Advisory Board, and state-sponsored health insurance exchanges. There will be an increase in the Federal Insurance Contributions Act (FICA) tax—0.9% on people who have individual incomes greater than \$200 000 or family incomes greater than \$250 000. There is also a 3.8% unearned income Medicare contribution tax. Basically, this is a way to increase the capital gains and will be added onto the capital gain tax that is in effect in 2013, when this tax goes on. This tax, however, is not allocated for health care expenditures, so it will have no effect on Medicare. It is, in fact, a tax increase and will be placed on those who earn more than \$200 000 per year.

In 2009, branded prescription drug sales were \$226 billion in the United States. In an effort to reduce health care costs, President Obama announced an agreement with pharmaceutical companies that will reduce prescription drug costs by \$80 billion over the next 10 years. Total public and private pharmaceutical spending is anticipated to equal \$3.4 trillion. So the pharmaceutical companies will really only be giving back about 2% in the next decade.

Additionally, under the PPACA, Medicaid is set to expand its eligibility for coverage to include all individuals whose income levels are at or below 133% of the federal poverty level, resulting in a projected expansion of 20 million people. The government will cover 100% initially, but this will drop down to 90%. In 2013, primary care physicians (family medicine, general internal medicine, pediatrics) will receive an increase in Medicaid rates to 100% of Medicare fee-for-service, regardless of their state Medicaid rates.

There will also be insurance reforms, which are necessary. Private insurance companies are often abusive. High-risk pools will be created, and lifetime caps and rescissions will be prohibited. Preexisting conditions for children can no longer be denied, and dependent coverage will be available for individuals until age 26.

TIMELINE 2011–2015

In 2011, we began to see a bonus to primary care as well as some prevention/wellness changes and Medicare Part C and D reform. Also, Medicare Advantage has gone down in percentage, making 2011 the first year it has not grown.

In 2012, there will be Medicare Part D changes. We have already seen the phase-in of accountable care organization (ACOs). There is also some value-based purchasing that is being addressed at hospitals, ambulatory surgery centers, and skilled nursing facilities.

By 2013, each state is supposed to have set up an insurance exchange, and there will be further closure of

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the Part D gap and increased payments to primary care physicians. Additionally, there will be full disclosure of industry payments to physicians, so this information will be accessible. There will also be a 3.8% tax on unearned incomes.

In 2014, individual and corporate mandates will start, and many of the insurance reforms will be enacted on factors such as rating, issuance, renewability, and deductibles. The IPAB will also begin in 2014, and Medicare will be provided to all individuals who are at less than 1.33 times the federal poverty level.

By 2015 and beyond, there will be increasing penalties for hospitals for acquired conditions. We are going to finally have the ability to have interstate insurance competition, and the so-called Cadillac tax for people who have very expensive health insurance will go into effect in 2018.

INDEPENDENT PAYMENT ADVISORY BOARD

Section 3403 of the PPACA established the IPAB, a panel of 15 appointed members who are responsible for reducing the per capita rate of growth in Medicare spending. The concept behind the IPAB is to eliminate political input into payment policy. This does not occur in the Relative Value Scale Update Committee (RUC), but it does occur after we make our recommendations. The reason for this is that there is a perception that the RUC/CMS process has been too generous to physicians, and in particular to specialists.

Members of the IPAB will submit legislation to reduce per capita spending growth if spending exceeds a target growth rate. Interestingly, in order to get this concept through, hospitals, hospices, and clinical labs had to be exempted through 2019. That leaves physicians—we are the only ones who will be able to be cut under this system.

The IPAB will submit yearly proposals to the President and Congress for immediate consideration. These proposals cannot ration health care, increase out-of-pocket expenses, or restrict eligibility in Medicare. Recommendations made by the IPAB cannot be modified by the President or Congress and will automatically go into effect unless Congress replaces the proposal with one that yields the same amount of sav-

ings. The CMS estimates that this will save about \$24 billion. In essence, the IPAB is a RUC/SGR substitute.

PPACA SEQUELAE

Under the PPACA, there will be the development of new payment systems to reward quality and control costs. There will be increased bundling, as Part A and Part B payments will be bundled into “episodes of care” or a return to capitation.

The long-term goal of the PPACA is very simple—to end fee-for-service (FFS) payment. In a statement² to Congress 5 years ago, from the Institutes of Medicine’s primary advisory body said, “The current Medicare FFS ... is unlikely to promote quality improvement because it tends to reward excessive use of services, high cost, complex procedures, and lower quality of care.” It continued, “A more fundamental change in payment policy would be to transition out of a FFS structure to a greater reliance on per episode or capitated payment incentives.”

FUTURE IMPACT

In the future, there will be increased bundling, certainly in Parts A and B. There will be gain-sharing between providers and institutions as well as ACOs. There will be 1 payment per episode of care to the ACO, and the ACO will receive that payment. The ACO will then allocate that payment among the various providers and institutions. This model provides the opportunity to incentivize both to be aware of the other’s costs.

On January 18, 2012, the CBO released a report³ entitled “Lessons from Medicare’s Demonstration Projects on Disease Management, Care Coordination, and Value-Based Payment.” Disease management and care coordination demonstrations have sought to improve the quality of care of beneficiaries with chronic illnesses and those whose health care is expected to be particularly costly. Value-based demonstrations have given health care providers financial incentives to improve the quality and efficiency of care rather than payments based strictly on the volume and intensity of services delivered.

The CBO reviewed the outcomes of 10 major demonstrations evaluated by independent researchers. The evaluations showed that most programs have not reduced Medicare spending. Demonstrations that were aimed at reducing spending and increasing quality of care face significant challenges in overcoming the incentives inherent in Medicare’s FFS payment system. The report’s concluding paragraph states, “Substantial changes to payment and delivery systems will likely be necessary for programs involving disease manage-

ment and care coordination or value-based payment to significantly reduce spending and either maintain or improve the quality of care provided to patients.”

In considering the future of health care, it is necessary to recognize how politically powerful hospitals are; they are major economic engines. In most communities, they are either the major employer or are among the top employers. Therefore, if hospitals were to experience substantial cuts, jobs would be lost. The detrimental impact this would have via a “trickle-down effect” on the economy provides some incentive for Congress not to cut hospital payments. This strengthens hospitals’ overall positions, and, as a result, the physician-hospital relationship is going to change. In some specialties, it already has changed. Ophthalmology has not yet been affected, but it will be eventually.

For major episodes of care, such as coronary artery bypass grafts, coronary stents, or congestive heart failure, physician costs are less than 5% of the total. Physicians control the spending pattern, but physician fees will continue to decline while Part A will continue to grow. Bundling Part A and Part B for some services will allow physicians to share in the Part A growth and incentivize them to control Part A costs. The net effect will be more hospital-employed physicians. This trend will continue.

Specifically, for ophthalmology and retina, there will be a continued transition away from hospital-based care to ambulatory surgery centers and office-based care. There will be increased competition from hospitals for outpatient payments, as hospitals transition to more outpatient care. This competition will be both market-based and political. ■

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