

HEALTH CARE REFORM BECOMES LAW— with room for improvement

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Following more than a year of partisan debate and numerous missed deadlines, health care reform became law when President Barack Obama signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) on March 23, and the Health Care and Reconciliation Act of 2010—which amended the PPACA—on March 30. Throughout the development and deliberations surrounding comprehensive health care reform, the American College of Surgeons was guided by a strong commitment to four key principles that were drafted by the Board of Governors and approved by the Board of Regents. Those principles include the promotion of quality and safety, access to surgical care, medical liability reform, and the reduction of health care costs.

While committed to the passage of meaningful health care reform, after a thorough analysis and careful consideration, the College felt that PPACA fell short of meeting these four principles and, therefore, opposed the legislation when it was considered in the U.S. Senate in December 2009. The College was deeply disappointed with the Senate's decision not to address several provisions that we believe will have a negative effect on surgical patients, and on the surgeon's ability to provide quality, efficient health care, including the following:

- *Creation of an independent Medicare commission.* This commission would undermine efforts to provide transparency, fairness, and stability in the health care delivery system by leaving Medicare payment policy decisions in the hands of an unelected, unaccountable governmental body.
- *Failure to permanently repeal the flawed sustainable growth rate (SGR) formula.* The SGR formula threatens patient access to surgical care, and does nothing to address the pending 21.2 percent cut to Medicare physician payments scheduled to go into effect on April 1.
- *Lack of meaningful medical liability reforms.* These reforms include protections

for physicians who follow established evidence-based practice guidelines or who are volunteering services in a disaster or emergency situation.

Despite the law's significant shortcomings, throughout the year-and-a-half debate, the College did work extensively with key Congressional leaders to ensure that several provisions were included in the final legislation, prior to passage.

For several years, the ACS has advocated to Congress about the critical need to improve and support our nation's trauma systems, and the College leadership was pleased to learn that the PPACA includes a significant number of trauma-related provisions, which authorized funding for the following:

- *Trauma centers*—by establishing three programs to award grants to qualified public, not-for-profit Indian Health Service, Indian tribal, and urban Indian trauma centers to defray the substantial uncompensated care costs, further the core missions of the centers, and provide emergency relief to ensure the availability of trauma services.

- *Trauma service availability*—by creating a new grant program to support trauma-related physician specialties and access to trauma-related services.

- *Trauma EMS Program*—by reauthorizing the Trauma-EMS Program.

- *Regionalization of emergency care*—by requiring the Secretary to award no fewer than four multiyear contracts or competitive grants for pilot projects to improve regional coordination of emergency services. Eligible entities would design, implement, and evaluate certain emergency medical and trauma systems.

While the focus of much of the law relates to improving the primary care workforce, the College was successful in ensuring the inclusion of several provisions that make the first steps in addressing the surgical workforce crisis, including the following:

- *Creating an incentive payment program for major surgical procedures*—which provides a 10 percent bonus payment for procedures provided by a general surgeon practicing in a Health Professional Shortage Area beginning January 1, 2011.

- *Establishing a pediatric specialty loan repayment program*—by which participants, (including pediatric surgeons) would agree to work full-time

for no less than two years in pediatric medicine or surgery, or in child and adolescent mental and behavioral health care. The program would pay up to \$35,000 per year for each year of service, for a maximum of three years. The bill authorizes \$30 million per year for loan repayments for pediatric medical and surgical specialists.

- *Redistributing unused graduate medical education (GME) residency slots*—by increasing the number of GME positions in states with the lowest resident physician-to-patient ratios. Specifically, 65 percent of currently unused GME slots would be redistributed. Seventy-five percent of the redistributed slots must be used for primary care or general surgery residencies.

In addition, the College, working with many of the surgical specialty groups and organized medicine, was successful in making improvements to H.R. 3590 that included the following:

- Exclusion of a tax on cosmetic surgery
- Removing budget neutrality as the funding mechanism for bonus payments to rural general surgeons

- Removal of the Medicare application fee, which would have required physicians to pay an application fee to cover a background check for participation in Medicare

The ultimate impact of the Patient Protection and Affordable Care Act will not be known for several years, as many of the major provisions go into effect in 2014 and 2015. However, as the law is implemented, the College, guided by our core principles, will continue to work to ensure the sustainability of the practice of surgery and access to the highest-quality surgical care for all Americans. Ω