PANHANDLE HEALTH

A QUARTERLY PUBLICATION OF THE POTTER-RANDALL COUNTY MEDICAL SOCIETY

SPRING 2014 | VOL 24 | NO. 2

Affordable Care Act

Interview Forum:

Interviews with major role players about the Affordable Care Act and the effects on our region

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1. Insurance Information Institute. "Changes in Your Life Can Mean Changes in Your Insurance, Says the I.I.I.," Press Release, January 22, 2007.

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On The Cover: *"Safari"* by Aimee L. Mouw

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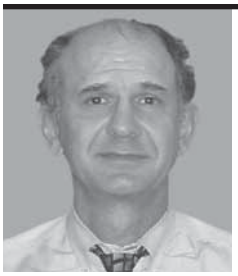

In Memoriam:

Gene Luckstead, M.D.

by Steve Urban, M.D.

We, members of the editorial board of *Panhandle Health,* declare our grief at the recent death, after a short illness, of our colleague Dr. Eugene Luckstead. Gene was a master pediatric cardiologist, a supportive mentor to students, residents, and junior faculty at Texas Tech, and an invigorating member of the *Panhandle Health* editorial board. We miss him deeply.

You didn't have to be around Gene Luckstead for very long before you knew he was a small town boy from Iowa. He maintained the optimism and the work ethic; for example, he was active at Texas Tech until a few weeks before his death at age 75. Gene attended undergraduate and then medical school at the University of Iowa, graduating with distinction. He completed a pediatric residency at the U.S. Navy Hospital in Oakland, CA and a pediatric cardiology fellowship at the University of Kansas. His academic career was distinguished. He was a faculty member at the Universities of Kansas and Oklahoma before returning to Iowa City, where he served on the academic faculty for 18 years.

In 1988, Gene came to Texas to become medical director of the prestigious Cook Children's Hospital in Ft. Worth; eight years later he was recruited to serve as executive medical director of the King's Daughters Children's Hospital in Norfolk, VA. In 2000, Gene and wife Margaret moved to Amarillo, where Gene joined the pediatric faculty at Texas Tech.

Gene Luckstead was an internationally recognized expert in adolescent cardiology, and in particular about screening sports participants for cardiac conditions. He co-wrote a respected textbook, *The Medical Care of the Adolescent Athlete,* and served as guest editor for a sports medicine issue of the *Pediatric Clinics of North America.* He sat on national commissions that wrote practice guidelines for pre-participation evaluations. Gene's CV includes invited presentations from all over the world (e.g. Jaipur India and Leiden Netherlands) and 77 academic papers (over 20 in peer-reviewed journals). The 2009 edition of the book *Pediatric Practice: Sports Medicine* was dedicated to him. Gene's work with the American Academy of Pediatrics sections on adolescent and sports medicine brought wide renown to Amarillo and to our Texas Tech pediatric department.

Gene served on the editorial board of *Panhandle Health* for 4 years and was the editor-in-chief until the time of his death. He shepherded into publication 4 issues in 2013, with topics including "Changes in Primary Care", "Pediatric Care at Texas Tech", "Pioneer Doctors of the Panhandle", and "Surgical Care in the Texas Panhandle". He devoted countless hours to rounding up guest editors, scrutinizing rough drafts, and supervising the layout and format.

A bare list of his accomplishments, impressive as they are, can't convey what it was like to work with Gene Luckstead. He loved his patients and loved working with medical students and residents. He was a master echocardiographer who didn't neglect the stethoscope. Gene was revered by his colleagues. Faculty member Dr. Golder Wilson writes: "To me he was the perfect academic faculty member, never afraid to speak out, usually jovial but very serious about patient care, gregarious with leadership qualities that were never used to overshadow or demean. He was welcoming, enthusiastic, and generous with praise; a huge asset and a huge loss for all of us."

The halls of Texas Tech ring hollower without Gene's hearty laugh; his students miss his wisdom, and his patients miss his warmth and expertise. We at *Panhandle Health* miss his enthusiasm, his energy, and his exclamation points. There will never be another one like him, and we are all diminished by his passing.

Eugene "Gene" Luckstead, Sr.

Pediatric Cardiologist,

Nov. 20, 1938 - Dec. 17, 2013

He was a member of the Potter-Randall County Medical Society for eight years.

President's Message
I'm Just a Bill

by James Reid, M.D.

1976. I'm 10 years old, and an elementary student at St. Andrew's Episcopal Day School. Most Saturday mornings are spent eyes glued to the television watching cartoons like "Scooby Doo" and "Bugs Bunny" and on ABC, there's "School House Rock!" In celebration of the U.S. Bicentennial, the producers of "School House Rock!" developed a series focusing on U.S. government and history called " America Rock," where many kids of my generation learned about the Revolution, the Constitution, and could recite the preamble of the constitution by singing the catchy tune from the cartoon. Then there was the very popular "*I'm Just A Bill, yes, I'm only a bill, and I'm sitting here on Capitol Hill…*" which during a three minute cartoon short taught us the basics of due process how a bill becomes a law.

2014. Now a few years older (I'll let you do the math) and a practicing physician in Amarillo, it's now time for me to learn how one particular bill did just that to become our new healthcare law known as the Affordable Care Act. Since we live in the age of information via the Internet, I "googled" Affordable Care Act to see what popped up in the search engine so I could learn a few things about our new healthcare legislation. Google came up with 169 million possible results in .28 seconds. Obviously, there's a lot of information out there to glean from, and, if you're like me, you may have more questions about the Affordable Care Act and how it is going to affect us and our patients than you have answers. Until now, I hate to admit, much of what I know of the ACA has come from the endless barrage by the media, which, let's face it, is not the most unbiased source of information. By browsing through various websites such as Wikipedia, HealthCare.gov, HHS.gov (U.S. Department of Health and Human Services), APHA.org (American Public Health Association), and KFF.org (the Henry J. Kaiser Family Foundation), I started on my quest for knowledge of the basic facts.

2009. It's September 17th and Barack Obama is our 44th President. In the House of Representatives, Charles Rangel (D-NY) introduces a bill entitled "Service Members Home Ownership Tax Act of 2009" a.k.a. H.R. 3590. And just like the little "Bill" from the School House Rock! cartoon, it went to the Ways and Means Committee, and was passed by the House in October 2009 and then off to the Senate where it was amended and passed on December 24th with a new title as the "Patient Protection and Affordable Care Act." The House agreed to the Senate amendment on March 21, 2010, and on March 23rd , just like that little "bill" from the cartoon, H.R. 3590 was signed into law by President Obama. The constitutionality of the ACA was challenged in the case *National Federation of Independent Business v. Sebelius*; with a 5 to 4 vote, the Supreme Court upheld the ACA's individual mandate in June 2012 as an exercise of Congress's taxing power.

The overall spirit and key features of the new healthcare law are aimed at providing access to affordable healthcare for ALL Americans, improving quality and lowering healthcare costs, and protecting the consumer. The ACA is divided into 10 titles with provisions that take effect immediately upon enactment through January 2020. One of the first provisions to take effect in 2010 was the new "Patient's Bill of Rights"

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which establishes consumer protection against abuses by the insurance industry. One of the changes in healthcare that took effect in 2011 is that people enrolled in Medicare can now receive some key preventative services for free. 2012 brought about changes with improving quality of care with the advent of a hospital "Value Based Purchasing" program and "Accountable Care Organizations." And in 2013, we saw the beginning of the open enrollment period in the health insurance "exchange" marketplace on October 1st, which for coverage in 2014, ends on March 31,2014. At the beginning of this year, eligibility for Medicaid is expanded in those 26 states participating in the "Medicaid Expansion." As many of us know, Texas opted out of implementing the federal expansion. And later this year, federal payments to disproportionate share hospitals, those that treat large numbers of indigent patients, will be reduced.

While I have attempted to point several of the highlights of the ACA, please keep in mind that I have barely scratched the surface. I am amazed at the vastness of this new law, at both its magnitude and scope. (I can't help but think of Nancy Pelosi's infamous quote right now—" We have to pass the bill, so you can find out what is in it.") Pass it did, and now we get to see what the future of healthcare in America holds for our patients and us. I don't doubt that in many ways it will affect certain aspects of *how* we practice medicine, but I sincerely hope that it doesn't change *why* we practice medicine.

This quarterly issue of Panhandle Health features discussions on the Affordable Care Act by members of our community in the Healthcare industry, as well as 13th District of Texas U.S. Congressman Mac Thornberry, and our current Texas Medical Association President, Stephen L. Brotherton, M.D. As I mentioned earlier, there are tomes of information about the Affordable Care Act available through multiple websites on the internet, but I hope that you read on and gain some insight into what has been described as the most significant regulatory legislation of our healthcare system by the U.S. Congress since the introduction of Medicare and Medicaid in 1965.

I would also like to mention at this time a couple of upcoming events of the Texas Medical Association. On Saturday, April 5th, from 8am to 11:45, Healthy Physicians: Healthy Patients will be held here in Amarillo at the Courtyard Amarillo Downtown. Then on May 2nd and 3rd , TexMed 2014 will be held at the Fort Worth Convention Center and Omni Fort Worth. I hope you can attend these events, and if you have any questions, please contact us at the Medical Society office.

Upcoming Issues:

Notice to Authors

The Next issue of *Panhandle Health* will be devoted to a review of recommended books for Summer reading. Anyone interested in writing a book review, please notify Cindy at prcms@suddenlinkmail.com or 355-6854. It does not have to be a medical book, just any book that you enjoyed and you think will be of interest to our readers.

Executive Director's Message

by Cindy Barnard, Executive Director

The 111th Annual Meeting of Potter Randall County Medical Society was held January 9th at Amarillo National Bank's Skyroom The gold-headed cane was passed from Dr. Samuel Cunningham, 2013 President, to Dr. Jay Reid, 2014 President. Officers for 2014 were installed by Dr. Stephen Brotherton, President of Texas Medical Association. New officers include President Dr. Jay Reid, President-Elect Dr. Tarek Naguib, and Secretary-Treasurer Dr. Ed Dodson. Also installed were the President of the Medical Society Alliance, Kiki Brabham, wife of Dr. David Brabham, and her Board: Vice-Presidents of Membership Development Tammy Risko and Christine Cox, Recording Secretary, Community Grants/ Scholarships Kensie Wolcott and Kenzie Jewell, Treasurer Kasey Daniel, Treasurer Elect Amy Slaton, Medical Liasons Stacia Lusby and Katherine McNeil, State Liason and VP Fundraising Kyla Hashmi, and Officers at Large Kim Artho, Heather Manderson, and Erica North. Cheryl Jones, President of Texas Medical Association Alliance, performed the installation. I want to thank the Amarillo National Bank for their continuing hospitality.

Presidential appointments to Boards and Committees of PRCMS are now ongoing. If you have an interest in serving on a Committee, please call the Society office at 355-6854. The core of the Society is its volunteers—the physicians who volunteer for Committees and Board positions, working on behalf of their colleagues. We need you!

If you would like to update your picture for our 2014-2015 Roster, or if you do not have a picture in last year's Physician Roster, please call 373-1523 to make an appointment for your portrait at Gray's Studio. There is a $15 sitting fee that PRCMS will pay, and this also includes a free session for a family portrait, if desired. Gray's is located at 3317 6th Street and is open from 9-5, Monday-Friday, and 9-12 on Saturday. We would like to have 100% of our doctors' photos in this upcoming Roster.

Get ready for "First Tuesday" at the Capitol! Pack your white coat, and travel to Austin on March 4, April 1, or May 6 to participate in TMA's First Tuesdays. Please don't miss the chance to meet with lawmakers and their staffs to make sure the voice of medicine is heard. Remember, YOU, our physicians, are the best lobbyists for our patients. You will visit with your Senator, Representatives, and their aides about key issues facing your profession, attend Committee hearings and House and Senate sessions, and learn about the obstacles medicine faces—taxes, Medicaid, CHIPS, physician ownership, and scope of practice. Physicians are asked to wear white coats while at the Capitol. Legislative talking points and other materials will be provided. A course on lobbying will be conducted early on each First Tuesday. A $25 charge for each First Tuesday covers your breakfast, lunch, and all materials. For more information, visit www.texpac.org.

We will celebrate Doctors Day on March 30 which was first observed in Winder, Georgia in 1930. According to Wikipedia, Eudora Brown Almond, a physician's wife, decided to declare a day in honor of doctors. The red carnation was chosen as the symbolic flower for National Doctors' Day. In 1958, a resolution commemorating Doctors day was adopted by the U.S. House of Representatives, and legislation was introduced both in the House and Senate to establish a national Doctors Day in 1990. President George Bush signed S.J. RES #336 (which became Public Law 101-473) in 1991, forever designating March 30 as National Doctors Day. President Bush wrote in the Proclamation, "In addition to the doctors whose names we easily recognize, there are countless others who carry on the quiet work of healing each day in communities throughout the United States—indeed, throughout the world. Common to the experience of each of them, from the specialist in research to the general practitioner, are hard work, stress, and sacrifice. All those who serve as licensed physicians have engaged in years of study and training, often at great financial cost. Most endure long and unpredictable hours, and many must cope with the conflicting demands of work and family life." President Bush urged that all Americans "observe this day with appropriate programs and activities."

And finally, this edition's cover is by local artist, Aimee L. Mouw entitled "Safari". Her B.A. in Graphic Design (1992) from Grace College, Winona Lake, IN, was the jumping off point for a "rich life of adventure, self-discovery and spiritual introspection reflected in much of her artwork." Aimee says, "I may never paint a sunset or carve a canyon like the Master-Creator can, but I can do my best to honor the gifts He has given me with how I express my perspective through the lens of God's sovereignty, beauty and abundant love." Currently, Aimee works out of her home and studio in Timbercreek Canyon, TX. She sells and exhibits at Sunset Center and on her Fine Art America and Musee d'Aimee website: aimee-mouw.artistwebsites.com.

Alliance News

by KiKi Brabham, President

The Potter Randall County Medical Alliance is off to a wonderful start this year, as we are diligently working on planning some great things! We installed a new officer team in January, and this group has some firepower! We have many upcoming events in the late spring, summer, and fall, for which more details will come! We are going to have a men's social event, a few family events, and even a couples event to name a few.

After an exceptional year last year in terms of membership, we seek to continue to rejunvenate and reenergize the Alliance by increasing new members while involving established members. There was a slight change in the format of the dues letters sent out this year, and it has greatly impacted (decreased) our membership thus far. The "Alliance option" was out of place as to previous years…so if you think you are a member, you might want to double check with us. You won't want to miss this year!

We have a few ways you can support our Alliance. In order to continue to give out our 4 local scholarships to area students in medical-related fields, as well as providing community events and awareness and social functions among our colleagues, we are arranging a few fundraisers. Most of these are more "fun" that work, and we ask you to join us! We will have several "Restaurant Nights" set up throughout the year! Just by coming to eat at the designated location and mingle with others who happen to be doing the same thing, you are helping us fundraise! Please see emails and calendars for details!

We are busy trying to update our files, so that we have the most current contact information for all current and past Alliance members, in order to contact you all about upcoming festivities and such. Please don't hesitate to contact me if you are not receiving our mailouts. We also have a facebook page, so please find us and "like" us on there!

The Potter Randall County Medical Alliance has a long and rich history of giving back to the area. We are constantly seeking feedback for ideas for fundraising and events, and we welcome your input!

We look forward to a great year full of fun and fellowship! Please join us!

KiKi Brabham
2014-2015 Alliance President
kikidee12@hotmail.com, potterrandallalliance@yahoo.com
Facebook: Potter Randall County Medical Alliance

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KiKi Brabham
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806-340-1599

Past President
Anna Holland

Vice Presidents of Membership
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Kensie Wolcott, Kenzie Jewell

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Amy Slaton

Medical Liasons:
Dr. Stacia Lusby
Dr. Katherine McNeil

State Liason and VP Fundraising:
Kyla Hashmi

Officers at Large
Kim Artho, Heather Manderson, Erica North

Upcoming Events:
Restaurant Night at Rosa's Cafe (both locations), 5pm-9pm, Monday April 7th. Please mention "Medical Alliance" when ordering so that we will receive proceeds from the event. (Both drive thru and sit down dining apply.) 3820 West I-40 and 4312 SW 45th.

Women's Spring Social, Thursday April 24, at the home of Darby (and Dr. Brendan) Albracht, 7609 New England Parkway.

Family events, Men's Social Event, Couples event,.....coming this late Spring/Summer! Stay tuned!

Editor's Message

by Jaime Zusman, M.D.

"A new type of thinking is essential if mankind is to survive and move toward higher levels."

Albert Einstein(1)

For this issue of *Panhandle Health*, the Editorial Board elected to change formats from the traditional written article to interviews with five individuals who will have a major role in how the Affordable Care Act (ACA) plays out in our region. We thought an interview would allow a more dynamic exchange of views in an informal conversational setting, because the subject is relatively new, controversial, and will have effects that are not totally foreseeable at present. Questions relating to how the ACA will impact patients, physicians, hospitals, and the nation were submitted in writing prior to the interviews, which were conducted by one or more members of the Editorial Board. We interviewed Mr. Mark Crawford and Mr. Bob Williams, the Chief Executive Officers for the two major hospitals in the area; Dr. Stephen Brotherton, President of the Texas Medical Association (TMA); Representative Mac Thornberry; Dean Richard Jordan of the Texas Tech Medical School (Amarillo); and William Biggs, M.D., founder and leader of the only Accountable Care Organization (ACO) in Amarillo.

Dean Jordan summarizes some of the main provisions of the act, listing the three E's of the ACA: "Expansion (of Medicaid coverage), health insurance Exchanges and Enhancement of Medicare coverage". His interview leads this issue of Panhandle Health because of the clarity with which he describes the essential elements of the ACA and the possible advantages and disadvantages of this legislation.

Dr. Brotherton, President of the Texas Medical Association, explains that Texas (because of its size and demographics) will face different problems in the implementation of the ACA; warns physicians about the 90 day grace period for enrollees before payment of a premium ("the gotcha clause"); and demands in no uncertain terms the elimination of the so-called "Independent Payment Advisory Boards".

Mr. Crawford, CEO of Northwest Hospital, points out that we are going to be "less of a fee-for-service provider and more a population manager. If we can convert the funds from being paid for providing services to not providing services, then maybe we will all win. The law is going to have to be rewritten several times before that

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can happen…..I think half the bill was probably good. We have got to change some things. The penalties and the incentives need to be changed to adjust people into the system, not kick them out".

Mr. Bob Williams, CEO of BSA Hospital, thinks that "initial indications on whether coverage gaps are filled are mixed" and that coverage remains confusing. He is unsure as to whether the country is ready for the massive changes that are needed to reform the system, and points out that "if coverage is mandated there has to be an enforcement provision that has meaning."

Dr. William "Reddy" Biggs, founder and leader of the only Accountable Care Organization (ACO) in Amarillo, feels that the ACA was "inevitable" and that it will allow physicians more negotiating power with insurance companies. He believes that "it was a mistake for Governor Perry not to implement a Texas based exchange", and that the end result of this decision will be to give "more control to Washington, rather than Austin". Dr. Biggs is dubious of the ability of government to run a program efficiently, and, referring to the registration glitches, quips that "Amazon would have done a better job".

Mac Thornberry, our elected representative, was not interviewed but submitted written answers to the questions. Mr. Thornberry has "voted over 40 times to repeal, dismantle, or stop funding for this plan". He opposes intervention of the federal government in the way health care is delivered and believes that H.R. 3121, the "American Health Care Reform Act," is a better alternative, but gave no additional information as to its contents.

The best way to deliver health care to the nation, an issue which should be rationally debated, has become heavily politicized and divisive. In the midst of this chaos, it is relatively unappreciated that the ACA is the "first U.S. law to attempt comprehensive reform touching nearly every aspect of our health system" (2). In addition to coverage, it addresses "quality and efficiency, prevention and wellness, the healthcare workforce, fraud and abuse, long-term care, biopharmaceuticals, elder abuse and neglect, the Indian Health Service, and other matters" (3).

Dr. Harvey Fineberg, President of the Institute of Medicine, describes the elements needed for a health care system to be ***successful*** and ***sustainable*** (4). To be successful, it has to maintain its people healthy; deliver superior care ("effective, safe, timely, patient-centered, equitable and efficient"); and be fair and non-discriminatory to the individuals who receive it and to the health professionals, institutions and businesses who deliver it. To be sustainable, a health care system must be affordable; acceptable to patients and health care professionals; and adaptable, in view of the rapidly and continuing changing environment (new diseases, scientific advances and rapidly changing technologies).

I believe that it is essential that we separate fact from emotion in assessing the benefits and pitfalls of the ACA. Its merits should be evaluated in a dispassionate way, much as we approach the solution of a complicated medical problem. The criteria outlined by Dr. Fineberg and the interviews published in this issue should help our readers do exactly that. I hope that you will find them as readable and informative as I have.

References:

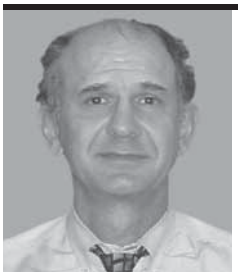
(1) Atomic education urged by Einstein: "Scientist in plea for $200,000 to promote new type of essential thinking". *New York Times.* May 25, 1946: 13.

(2) Mc Donough JE. The road ahead for the Affordable Care Act. *New Eng J Med* 2012; 367:(3), 199-201.

(3) Mc Donough J: Inside national health reform. Berkeley. *University of California Press*, 2011.

(4) Fineberg HV. A successful and sustainable health system- How to get there from here. *New Eng J Med* 2012; 366(11), 1020-1026. (Shattuck Lecture).

If you have a letter for the Editor, please email to: prcms@suddenlinkmail.com or mail it to: PRCMS 1721 Hagy - Amarillo, Texas 79106



Affordable Care Act:

Dr. Richard Jordan Interview

by Steve Urban, M.D.

Dr. Richard Jordan has extensive experience on the interface between government and health care—first as a professor of internal medicine at a state medical school in Tennessee with a university private practice, then as the chief of the medical service at a Veteran's Administration Hospital, and more recently as regional dean at Texas Tech SOM campus in Amarillo. He has supervised medical student education, residency training and faculty practice at Texas Tech (Amarillo) for over 6 years. Since Texas Tech provides medical care to many of uninsured and underinsured patients (especially inpatients) in Amarillo, he has a unique perspective about the Affordable Care Act (ACA) and its implementation. The following responses reflect his assessment of the strengths and weaknesses of this monumental change in the way health care is delivered and financed in the U.S.

Q. What are the most notable reforms of the Affordable Care Act?

A. Well, the ACA proposes some pretty dramatic changes in the U.S. health care system. Expanding Medicaid to provide coverage for most of 45 million previously uninsured patients is a huge shift. As an example, Medicaid used to insure adults whose income fell below 27% of the federal poverty level, which is currently $22,050 for a family of four. The ACA expands Medicaid up to 133% of the federal poverty level—obviously a tremendous expansion.

The use of mandates—basically tax penalties—to make both individuals and businesses participate in the ACA system is a major transformation in the way health care is financed. The Obama administration had to fight this all the way to the U.S. Supreme Court, but it was declared constitutional by a 5-4 margin, and so we're going to have to figure out how to live with it.

Q. What are the benefits of this legislation for patients, for doctors, for hospitals and for the country?

A. For patients: Many of the best changes for patients were enacted early on—in 2010, when the ACA first became law. These include: no rejections of health insurance because of pre-existing conditions, coverage of dependents up to age 26, no lifetime limits on benefits, reduced limits on annual payments, and no cancellations

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of insurance policies for frivolous reasons (such as a previous breast biopsy or a previous HIV blood test).

The ACA will have an impact on Medicare—not just Medicaid—patients. Accountable Care Organizations (ACOs) are supposed to use information technology and quality measures to improve care—hopefully at the same or reduced costs. The notorious "donut hole" in Medicare Part D (coverage for medications) will gradually be closed. By 2020, 57% of prescription drugs in the donut hole (annual medication costs $2800 to $6400 annually) should be covered by the feds.

The ACA puts a big emphasis on evidence-based medicine and on primary care. This has a chance of decreasing unnecessary tests and procedures—although many procedure-based specialties are anxious about it. We have robust data that countries that emphasize primary care rather than shunting everyone to subspecialist practitioners, as we do in the US, provide equal or better quality of care at much reduced costs. So, this emphasis may keep more patients healthier.

For doctors: Obviously, doctors who used to provide free care for indigent patients will now be paid for their efforts. In addition, Medicaid reimbursement will be improved. Historically, Medicaid payment rates have been so poor that only 31% of Texas physicians participate in Medicaid. The ACA promises to increase Medicaid payments from 60% to 80% of Medicare levels in a program called Medicaid Enhancement—hopefully this will also help those doctors who see Medicaid patients. The ACA has promised to increase support for primary care services, so family practitioners, pediatricians and internists may benefit from improved reimbursement. Unfortunately, so far, this promise has not been fulfilled.

For hospitals: Providing health coverage for previously uninsured patients will benefit providers and institutions—such as Texas Tech and most of our affiliated hospitals—who have been caring for these patients without receiving payment. On the other hand, hospitals have been receiving special payments for uncompensated care; so it remains to be seen how hospitals will come out overall.

For the nation as a whole: potential benefits of the ACA include better health care (as mentioned above) and fewer medical bankruptcies. Many of the areas where health statistics of the US lag behind other developed countries (such as infant mortality) relate more to getting the health care delivered to those who need it. Hopefully, improved access to care by the underserved will improve prenatal care, access to drug and alcohol treatment programs, and preventive services. This may help the health statistics of the US to achieve levels of other developed countries. It is also likely that medical bankruptcies (the commonest cause for bankruptcies among individuals) will diminish greatly when more people have access to insurance to prevent these catastrophic losses.

Q. What are the disadvantages of this legislation for patients, doctors, hospitals and the country?

A. Patients. Although currently uninsured patients will benefit from expanded coverage under the ACA, someone has to pay for expanded coverage (e.g. pre-existing conditions). Patients with insurance will foot part of the bill (nobody expects the insurance companies to suffer on this deal)—if not in premiums, then at least in higher deductibles and co-pays. Many experts predict a 30% increase in overall premiums. In addition, the burden will fall disproportionately on the young and healthy patients to foot the bill for older and sicker patients. This amounts to a major wealth transfer from the younger to the older generation.

Despite assurances to the contrary from the administration, many patients will lose their present doctors and providers—especially in areas of the country where few insurance carriers have entered the exchange marketplace. Some providers—especially subspecialists—will leave Medicaid or reject the Healthcare Exchanges. Patients may find that some specialized procedures recommended by their doctors will not be covered or will be covered with a very high deductible under the ACA. It also appears that some hospitals offering more expensive, specialized care may be out of network for some ACA Health Care Exchange Plans and will available to patients only with considerable additional out of pocket payments.

The clumsy introduction of the website has not reassured everyone against hidden vulnerabilities in the system—

either leaking of sensitive personal or financial data, or patients really not being covered when they think they are safely insured.

Physicians. It is very likely that physician reimbursement will sooner or later be reduced under the ACA. Physicians already caring for Medicaid patients may be overwhelmed by the volume of new patients seeking a primary care provider. Although some of the slack will be taken up by physician extenders, in Texas, care still needs to be overseen by physicians. Furthermore, if the patient defaults on payments on insurance coverage, the physician (not the insurance company) will be responsible for continued care for up to 90 days—this increases the physician's liability and may drive even more from participation in Medicaid or in the Exchanges.

Not all the provisions of the ACA have yet been enacted. It will be interesting to see what happens with the Independent Payment Advisory Board. This board will have broad powers, particularly if Medicare expenditures rise faster than the consumer price index. They can limit payment for ineffective interventions or procedures, but may also enact severe cuts in services and reimbursement. The board will start work in 2015, although their decisions will not take effect until 2018. Appointments to this board will surely be intensely political. Will procedure-based specialties be represented or will evidence-based specialists win the day? The decisions of this board may have huge implications for the practice of medicine in the future.

Finally, if there is a major dropout in physician participation, we may see more coercive legislation to bring physicians back into the fold.

Hospitals. Hospitals face uncertainty under the ACA. Hospitals who serve many unfunded patients may find that these patients suddenly have a source of funding, but these same hospitals will lose federal Uncompensated Care (and other governmental) payments. Who knows if gains in insurance coverage will offset losses of government support for uncompensated care?

Plus, the ACA inflicts penalties on hospitals for readmissions and inpatient complications. Although the idea is good, some readmissions are not preventable—especially if the patients are unable to find a primary care physician who will participate in the ACA system. Furthermore, the hoped-for disincentives for patients to use the emergency room as their PCP may not work. Uninsured patients have always used the ED as provider of last resort when they couldn't afford care elsewhere. It will take time for previously uncovered patients to learn how to use the new system.

Finally, remember that hospitals in most communities are large employers. They will incur the increased insurance costs faced by other large employers. They may be forced to downsize their workers or to use part-time employees (<30 hours/week) in order to cut costs from the employer mandate (which takes effect in 2015).

Nation. The political polarization of the nation is a terrible by-product of the ACA. Some observers say that hostility between the two parties is greater than at any time since the civil war. This is worsened by willful misrepresentation from both sides of the political spectrum. Experts really worry that the employer mandate will slow down the

| *continued on page 16*

economic recovery. The ACA mandates a whole series of taxes–including a reinsurance tax, an additional 3.9% tax on passive investment, an additional payroll tax on high-earners, a special needs children tax, and a drug company tax. Will all these taxes throw a wet blanket on the US economy?

Q. What aspects of the legislation would you change?

A. I don't think we can afford to provide everything for everybody. Benefits should be limited to essential services. Very expensive services such as cancer care should be covered under a catastrophic care option. The legislation as it is now written could be used to bail out insurance companies that struggle under the ACA. In exchange for this protection, there should be limits on windfall profits by insurance companies. Political contributions by the insurance companies should be transparent. The IRS should be removed as the enforcement arm for health care.

Q. In practical terms, do you think the act will ease the problem of caring for the uninsured?

A. It will, but at a very great economic and political cost.

Q. Do you think the Act is affordable?

A. No. Estimates of the total cost of the ACA are all over the map, but recently the Congressional Budget Office has revised the estimated 10-year cost--originally $1.075 trillion--up to $1.363 trillion. In addition to the mandates, the ACA adds a tax on passive investments, an additional payroll tax for Medicare, and taxes on insurance and pharmaceutical companies (which will probably be passed on to consumers). The individual and employer mandates are taxes by another name (as the Supreme Court has affirmed). So, the ACA puts a huge economic burden on the economy. How bad will the negative effect on large and small businesses be? Will it put us back into a recession? There seems to be a real chance of a major negative economic effect.

Q. What adjustments will Texas Tech make in response to the Act?

A. I have talked about several of the changes above. One important measure we have already taken is to apply for (and receive) grants from the Delivery System Reform Incentive Program (DSRIP) program, which is replacing some of the old stipends for uncompensated care. Texas Tech will sponsor projects involving smoking cessation, medical home, breast screening, etc. We hope that income from these projects will make up for our losses in terms of state and national support. DSRIP is a five year program and it is unclear what, if anything, will follow.

Overall, for Texas Tech, as for most providers, the ACA is a mixed bag. We'll improve our reimbursement for uncompensated care, but we may lose more in uncompensated care payments than we gain in DSRIP payments. We're in the same situation as everybody else. This act represents a major change in the way health care is administered in the United States. Its effects will be played out over the next decade, and we hope that Texas Tech as well as our other medical partners will weather the storm. We have supplied hundreds of health care providers for the Amarillo area; we hope to continue our mission for west Texas for the foreseeable future.

PANHANDLE HEALTH

A Publication of the Potter-Randall County Medical Society

Editorial Policy and Information for Authors

Purpose *Panhandle Health* strives to promote the health and welfare of the residents of Amarillo and the Texas Panhandle through the publication of practical informative papers on topics of general interest to most physicians while maintaining editorial integrity and newsworthiness.

Spectrum *The Journal* seeks a wide range of review articles and original observations addressing clinical and non-clinical, social and public health, aspects as they relate to the advancement of the state of health in the Texas Panhandle. Pertinent letters to the editor, news submissions, and obituaries listings are accepted pending editorial review. The Editorial Board accepts or rejects submissions based on merit, appropriateness, and space availability.

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Affordable Care Act: Dr. Steve Brotherton Interview


Paul Tullar, M.D.


Rouzbeh Kordestani, M.D.


Tarek Naguib, M.D.


Jaime Zusman, M.D.

Dr. Brotherton is a practicing orthopedic surgeon and President of the Texas Medical Association

This is an edited transcript of an interview regarding the Affordable Care Act (ACA, 'Obamacare'), with Dr. Steve Brotherton (Orthopedist from Ft. Worth, and TMA President) on the evening of 1/9/2014. The interview is conducted by Drs. Paul Tullar, Rouzbeh Kordestani, Tarek Naguib and Jaime Zusman. The questions were previously communicated to Dr. Brotherton. He had written some outlines of his answers, and he extemporaneously expanded on these.

Q. In your opinion, what are the most notable reforms of the Affordable Care Act?

A. Ending the 'pre-existing health conditions' exclusion for the health insurance industry.

Q. What, in your opinion, are the benefits of this legislation?

A. For patients: again, ending the 'pre-existing conditions' exclusion. The 'plain language' requirements are also beneficial. If a person makes a mistake filling out the application, the insurance company cannot claim fraud.

For doctors: requiring the insurance industry to publically disclose their "medical loss ratios", the ratio of all money collected vs. the amounts actually spent for patient care to hospitals and other providers. Also, doctors will care for more funded patients, with fewer unfunded patients to scramble around trying to find care.

For hospitals: More funded patients.

For our country: It's too early to really know; we'll have to wait & see.

Q. What are the disadvantages of the ACA?

A. For patients: Patients may lose their previous health insurance. They may lose access to their doctor, if the poor reimbursement forces their doctor to stop taking their insurance product. You may have the employer say: "I am going to cut your hours so I don't have to participate in this thing". Some of the disadvantages to patients may be state- specific: Texas and California have a LOT of people NOT eligible for coverage under the ACA [e.g., undocumented aliens], so consequences for patient access may well be state- specific.

For doctors: Again, disadvantages are likely to be state- specific. The poorly worded definition of "providers" in this law opens the possibility that podiatrists and advanced practice nurses (PhDs) may be able to hang their shingle out as "doctors", not telling the public that they are not physicians. Since the law requires "equality of all providers", they may be able to practice independently and thus may draw away some "private patients", worsening the payer mix for physicians. In addition, the law has a "gotcha" clause, providing a 90 day grace period for enrollees. Enrollees can wait up to 90 days to pay their premium before the Insurance company can formally disenroll them; if they don't pay their premium, the insurance entity can demand back from the unsuspecting provider funds paid in the 31- 90 day period for health care and medical supplies already rendered. The first 30 days after sign- up, the insurance entity will have to absorb this loss, but for days 31- 90, the provider will have to assume this risk of loss. So far, only one Blue Cross entity in Texas has agreed to assume ALL of this liability, i.e. more than the law demands. This may be a temporary ploy to gain market share, but it may also mean that this is the entity that providers want to gravitate to. A larger disadvantage for doctors is that there is no anti- trust fix for doctors. Hospitals can combine to negotiate, insurance entities can combine to restrain trade and fix prices, but no anti- trust relief is provided for doctors. And one potential conflict inherent in the ACA is that the law encourages physicians to combine, as in Accountable Care Organizations, but provides no anti- trust protection for them.

For hospitals: The same risk that doctors face is also present for hospitals in this 31- 90 day "grace period" or "gotcha period". There is a considerable economic risk here, for entities (hospitals, providers) not designed to take such risks. Additionally, there is no accounting in the ACA law for Graduate Medical Education (GME). In this country, Graduate Medical Education has been funded through Medicare- based payments to GME hospitals, as these have traditionally supplied a large proportion of in- patient care to Medicare patients. Part of the source of funding for the ACA assumes that this GME funding goes away, to make available funds for paying for the very expensive ACA. So, because of the ACA, hospitals will be left on the hook to fund their own GME, when this very important historical source (federal support of GME) disappears.

For the country: If these problems, and others, are not fixed and if the lack of GME funding drastically decreases new graduates coming out of residencies, while poor reimbursement causes many older primary care and specialty care doctors to abandon ACA or to quit medical practice, our country may see the mass retirement of older physicians and a paucity of young, recently-trained physicians to take their place, with the consequence of sudden lack of access to medical care for all. The only solution for something like this would be a dramatic and rapid migration from a predominantly private health care system in our country to a mostly public health care system.

Q. What aspects of this legislation would you change?

A. First, get rid of the "Independent Payment Advisory Board". During the legislative negotiations involved in the passage of the ACA, this Board's ability to adjust pharmaceutical payments or hospitals' payments has been taken away. The only item left for them to adjust is physicians' payments, and

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there is no pressure but to adjust these downwards. This Board is not responsible to the people, will never face an election, and is un-accountable to Congress. It should be abolished. Allow market forces to determine doctors' fees!

Additionally the Sustainable Growth Rate (SGR) must be fixed. It is NOT sustainable and discourages growth. It is actually a scheduled automatic reduction in payments to Medicare providers. It must be "fixed" or removed, if you want any physicians to continue providing health care services to Medicare patients.

The Graduate Medical Education funding must be formally restored. The anti- trust problem for physicians must be fixed. We need to pass the 'Medicare Empowerment Bill', which would allow an informed Medicare patient to separately contract and negotiate with his/her physician for cash payment for care outside of Medicare system (currently illegal). Otherwise, with the reduction in funding for Medicare, there will be a relentless loss of access to physicians for Medicare recipients, the ones who need health care services most.

We must remove the prohibition or punishment of physicians to own and manage imaging and laboratory businesses. Follow quality and utilization of these facilities, and police that, but don't take away physicians' ability to improve laboratories, imaging facilities and day surgery businesses. I look at physician ownership and management of these facilities as a positive, as opportunity for quality improvement and patient/ customer service improvement. If I own a significant part of such an entity, and one of my patients complains about a customer service or quality insult, I can DO something about that. If I am forced to send patients to an entity where I have no control, I have little ability to demand improvement or make change quickly for the better.

Q. In practical terms, do you think that the Affordable Care Act will ease problems of the uninsured?

A. I don't know; it's too early to tell.

Q. Do you think that the Affordable Care Act is affordable?

A. We don't know yet. Similar socialized care schemes in other countries are not affordable. Inevitably, rationing will be tried to make health care more 'affordable'. In orthopedics, there are already studies demonstrating that rotator cuff repairs for patients under 61 are both 'cost saving' as well as 'cost-effective'. The many future years of work by the patient, enabled after successful repair, with future work-related productivity and taxes, will more than pay the costs of the orthopedic repair. Over 61 years-of-age, rotator cuff repairs may be humanitarian, and improve quality-of-life measures, but the time left for the patient to work (thus productivity and taxes) may not make the procedure 'cost saving' for the older patient. Thus the older patient may be 'rationed out' of such quality of life health care, to make healthcare for all more "affordable".

I think it is inevitable, if our country goes to a socialized medicine model, there will inevitably arise a second tier of private pay health care, as we already see in many European countries with socialized health care– with better access to physicians, better access to life-saving and quality-of-life procedures, and less rationing. I am personally opposed to thinking of 2 kinds of patients (public and private, insured and uninsured). I try to find health care for all my patients, one way or another, now. I volunteer my time in free clinics for the uninsured, now. In our country, private health care systems have traditionally been the way we arrived at health care for the poor, when governments would not do so. It was the religious volunteers and private volunteers that made the difference in the past, not the government. I trust private initiative more than I trust government initiative for the future.

Q. Do you think that the problems of "Healthcare.gov" website will prevent the ACA from gathering enough insured lives to be workable, or do you think that, even if the website is fixed and if it succeeds in signing up enough people, the problems inherent in the system are so numerous and intrinsic, that the ACA literally 'can't succeed'?

A. I don't know: it's too early to tell. It will be vital, though, from an economic sense, to have healthy young people enrolled and paying into the system. If the system only enrolls sick, older people, no insurance entity can sustain that.

Q. How does one get young, healthy people to sign up?

A. They must see 'value' in signing up. My own children have health insurance only because I have impressed on them that they needed it, not because they thought they would ever use it. Many, if not most, young people (18- 25 years old) are convinced that they're 'bullet proof', that they're so healthy that they are never going to need health insurance, because they're never going to get sick. And many are right: they're not going to get sick this year. If they don't see 'value' in paying for insurance, if the choice is between paying for health insurance versus paying for more pizza, or a new stereo, why should they sign up?

Thank you, Dr. Brotherton, for participating in this question and answer discussion for readers of *Panhandle Health.*

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Affordable Care Act:
Dr. Brotherton At-Large


Paul Tullar, M.D.


Jaime Zusman, M.D.

Dr. Brotherton is a practicing orthopedic surgeon and President of the Texas Medical Association

The interview with Dr. Brotherton was not only interesting and informative but colorful as well.

Dr. Tullar and Dr. Zusman recorded and edited some of his most insightful and humorous comments, not otherwise included in the transcribed interview.

When discussing how to make Medicare more solvent, without rationing, Dr. Brotherton suggested that raising the Medicare-eligible age would have solved the problem, had it been done incrementally, and had it been done years ago, when Medicare reform was still on the table. Dr. Brotherton felt that, taken as a part of revenue-enhancement NOW, to pay for the ACA, such a move would be politically untenable. "Had the advancement of the Medicare-eligibility age been done years before, it would have solved this problem, but that horse is so far out of the barn, it's already across the next (section) fence, miles away".

When he was discussing how different states have different needs and will, of necessity, have different solutions to the ACA problems, he related a conversation with a legislator from Connecticut, who touted how Connecticut's solutions should become a national model for approach to all the ACA problems. "I don't see how the problems or solutions of your state are in any way comparable to those of ours. I grew up on a single ranch that's bigger than your entire state." When the legislator dismissed Dr. Brotherton's comparison as exaggeration, Dr. Brotherton suggested that he (the Connecticut legislator) 'Google' the "Four 6's Ranch in Texas". Even if it was a bit of exaggeration regarding land mass, Dr. Brotherton went on to point out that uninsured numbers in Texas dwarf the entire population of Connecticut and that our uninsured percentage is vastly different, as is the "monstrous border with another country" that Texas has to maintain, as opposed to no such problem in Connecticut. He added: "You know we border with Oklahoma". Editorial Note: Brewster Co. (Alpine), just north of the Rio Grande, is 6,192 mi2 (and thus IS larger than CT). Both Pecos Co. [4,765 mi.2] (Ft. Stockton) and Hudspeth Co. [4,572 mi.2] (Sierra Blanca) are >4,000 mi.2, close to the size of CT. For comparison to Rhode Island (RI), all 4 counties of the western Texas panhandle: Dallam, Hartley, Oldham and Deaf Smith are [1,400 to 1,500 mi.2] larger than RI.

When asked how the current physician workforce will handle 2 million extra patients, he replied: "Badly" and commented that the best and the brightest are probably not going into medicine any more. "If you want people do things, you have to pay them and respect them, preferably both, and there are less of both these days. I have to call some clerk to get permission to do something".

In addressing the glitches in registering for the plan, Dr. Brotherton describes "confusion upon confusion", like the movie "Victor Victoria": where "the gal was a woman pretending to be a man pretending to be a woman" i.e. the glitch with the website is confusing an already confusing issue". When the website is fixed, it is still going to be a very confusing issue. Look at the questions we answered "I don't know" to already. Are people going to show up not knowing if they have coverage? If I have somebody with a BMI of 42, we do a total knee on her, and she decides she wants to be a snow skier and dislocates a knee. Is her vascular surgeon going to be on the same plan I am in to fix her artery?"

Regarding market forces that could lead to a two tier system (one for the poor and one for the wealthy), Dr. Brotherton cites the example of Nicaragua, one of the most socialistic countries in the continent "where you can get care in the regional hospital but most doctors have private offices and the situation that arises is: If you want care sooner, I have a private office".

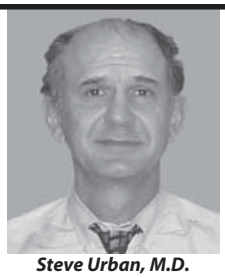
"I am 58. I would like to keep working another 10 years….you start telling me I have to participate in the exchange to get my license….I am gone…, and my next job is a taxidermist. I won't do that….Nobody wants somebody who has your life in his hands to let some clerical function dictate how he operates."

In response to ways of getting healthy people registered for the exchange: "I would not hire Moms to do ads. It is not a marketing problem; it is a value problem. How do you make someone buy something that does not have a cost value or quality value? You used to get them to buy it, because it was pretty cheap. Me getting a single policy as a 24 year old guy did not cost me. They are not going to see a cost value. I do not know how to make them do that".

Refreshingly, Dr. Brotherton closes by saying that if he had to do it all over again. he would "still go into orthopedics. I've got a Rose Bowl ring, some patients in the NFL, etc... It is a lot of fun." On the other hand, he points out that many primary care physicians may not give that answer.

Whether precise in all facts or not, he is erudite and entertaining. We certainly enjoyed our interview with the President of the Texas Medical Association.

Affordable Care Act:
Dr. William Biggs Interview


Steve Urban, M.D.


Jaime Zusman, M.D.

Dr. Biggs is a highly respected endocrinologist and diabetologist; he is affiliated with Amarillo Medical Specialists. He has been a driving force for years in improving the quality of diabetes care in Amarillo. Recently, his group has been instrumental in establishing the first Accountable Care Organization in Amarillo. He was kind enough to devote a noon hour to this interview.

Dr. Zusman: What, in your opinion, are the most notable reforms of the Affordable Care Act?

Dr. Biggs: Well, there are actually some good things hidden within the Affordable Care Act. One of those was the legislation enabling the formation of the Accountable Care Organizations, which if properly implemented can lead to improvements in patient care and reduced cost, and also allow physicians to work collaboratively to improve their practice. It allows the physicians, for instance, to negotiate collaboratively with insurance companies on items that need negotiation, such as: how do you manage your patients, what preauthorizations do you need, what kind of formularies do you have, and what kind of fee schedule do you get from the insurance companies. So, we felt that this legislation enabled us to work more directly with insurance companies and more positively with insurance companies as far as both fee schedule issues and also patient care issues.

Dr. Zusman: So you think it will give physicians more negotiating power?

Dr. Biggs: It absolutely does.

Dr. Urban: To follow up on the question, what are the differences between what is in the Affordable Care Act and what we had before?

Dr. Biggs: Well, previously physicians could not work together because of antitrust concerns, Stark concerns, kickback concerns. There is a substantial protection as far as Stark and antitrust risk for physicians that work together in an Accountable Care Organization. This was introduced in the Affordable Care Act.

Dr. Urban: Are there any other differences that you can tell between the old system is and the Affordable Care Act?

Dr. Biggs: Well, I think there are other parts of the Affordable Care Act that are improvements, such as: getting rid of pre-existing conditions, having mandates for consistent vaccination policies, improving access to insurance. I think one bad thing about the Affordable Care Act is that it has given cover to the insurance companies for a lot of bad behavior.

Dr. Zusman: Such as?

Dr. Biggs: For just about every bad behavior you see from an insurance company lately, they have blamed it on the Affordable Care Act, and that is not always the case. Termination of plans and rate increases have all been blamed on the Affordable Care Act. But, the insurance companies are now limited in terms of how much they can charge in administrative fees. They have to refund any excess, so many of the Blue Cross plans have been overcharging their patients and then refunding the difference at the end of the year to those patients. So, it is that kind of bad behavior that they blame on the ACA.

Dr. Zusman: Has the ACA really gone in to effect?

Dr. Biggs: Unfortunately I think this has been so heavily politicized that everybody makes the assumption: well, if it is included in the Affordable Care Act, it has got to be bad. The whole concept of the Accountable Care Organizations, for instance, came out during the Bush administration; so, the Republicans were actually heavily involved in the creation of these organizations. It is not a Democrat-

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Republican issue or a Tea Party issue. This is more of a common sense approach to how doctors should work together and not provide care that is as fragmented as we have had the last couple of decades.

Dr. Zusman: Let's go on to the second question. What, in your opinion, are the benefits of this legislation, first for patients.

Dr. Biggs: Well, we had, in my own practice for instance, a large number of patients who simply could not get insurance because they had diabetes or adrenal insufficiency or something that insurance companies just did not want to insure. If they could find a plan it would cost $1500.00 a month. Now they can get insurance that is affordable. We did have the Texas high-risk plan under Governor Perry but, due to changes that were made by the State of Texas, the cost of that plan went from about $400.00 a month to $900.00 a month. So even that became unaffordable. Now, a patient with diabetes or any chronic illness can get an affordable plan anywhere from, depending on their age, $250.00 to $450.00 a month, and they often qualify for a subsidy to help with that as well. That's actually a very positive thing for patients. They have to be very careful in shopping for a plan, though, because some of the plans are simply horrible.

Dr. Urban: Too high a deductible or just not good coverage?

Dr. Biggs: Either they have a physician panel that is next to nonexistent or they have an enormous deductible, making it more of a catastrophic plan. But if you actually have a chronic illness, you need something better than that.

Dr.Urban: So a patient who is shopping around needs to double check to make sure that their physician is on the panel?

Dr. Biggs: Right. Or, at least they need to know that somebody on the plan can take care of their issues. I recently looked at one low cost exchange plan, for instance, and the only pulmonary doctor was somebody who only works inside a hospital. There was no endocrinologist; in fact almost no specialties--either surgical or medical–were included in the plan. So, unless you are a relatively healthy person, you probably wouldn't want to touch that plan.

Dr. Urban: So the buyer has to beware on those kinds of plans.

Dr. Biggs: Yes, and, unfortunately, since all of this is so new, there is nobody to really guide you to look for these problems. The State of Texas abdicated on its role in that they are not going to help because they frankly are in opposition to the whole concept. I think it was a mistake for Governor Perry not to implement a Texas-based exchange. If you consider that healthcare is about 1/6th of the economy, to give control to Washington DC rather than keeping it in Austin, I think was a big mistake. They have philosophical problem with the whole concept, but it is here, it is real, I don't think it is going to go anywhere, and unfortunately now Washington is calling the shots instead

of Austin. I think strategically that was a misfire.

Dr. Zusman: Very interesting. Next question. What, in your opinion, are the benefits of the legislation specifically for doctors?

Dr. Biggs: Again the part that enabled Accountable Care Organizations was a huge plus for doctors whether you belong to an ACO or not. That is going to empower the doctors to have more control vs. the insurance companies. Also, if we consider that Texas is one of the worst states in the union as far as the number of uninsured patients, the fact that more of our patients will have some coverage to take care of their serious healthcare needs–that is going to improve the economics for physicians. There will be less unreimbursed care.

Dr. Zusman: What, in your opinion, are the benefits of this legislation for hospitals?

Dr. Biggs: Well, similarly, the unreimbursed care. As more people are insured, we will have fewer write-offs for patients that are totally uninsured. Hospitals under the ACA have a bit more risk–in that, to whatever extent improvements in care delivery reduce hospital utilization and hospital admissions, that could affect the hospital bottom line as well. Cost reductions are going to happen primarily with people who have insurance rather than people who don't have insurance. So, for instance, in our Medicare ACO, we reduced our admission rate by 12%; our CHF admissions are down 16%. To whatever extent that gets disseminated into the general community, you are going to see fewer hospital admissions, and that could adversely affect the hospital's bottom line.

Dr. Zusman: So, it's good for patients and good for healthcare in general, but may put a strain on the economics of the hospital.

Dr. Biggs: It could. And that could also more seriously impact rural or outlying hospitals that don't have access to a more organized care system. Time will tell how that plays out.

Dr. Zusman: And, what are the benefits of this legislation for the country?

Dr. Biggs: Well, to whatever extent it reduces our overall healthcare cost, that will be a huge benefit.

Dr. Zusman: Do you think that will happen?

Dr. Biggs: We are already benefiting today here in Amarillo with our ACO. You know, health care costs are a huge burden for our competitiveness level vs. other countries. Why are jobs going overseas? Twenty percent of the cost of your Chevrolet is healthcare for the guys who put it together, whereas the cost of healthcare in Japan or Mexico is less. That makes us less competitive as a country. It makes Amarillo less competitive as a city for a company to relocate here if we have a higher than average medical cost in Amarillo compared to other cities. It is not just us as a country. Think locally; if Amarillo had a lower healthcare cost base, that would make us more attractive to the Bell Helicopters and other large companies that may want to locate a facility here. I recently attended a session given by the medical director for IBM. One of the first things that they look at, when looking for a new regional center, are local healthcare costs. If you are above average, you are not even included in the first cut.

Dr. Urban: And you think the major thing that is going to bend the curve is the ACO?

Dr. Biggs: ACOs are one mechanism. The insurance companies have tried everything within their power to lower costs. Some of them obviously are maladaptive–they sometimes have these crazy formularies that require a lot of effort on the primary care physicians to comply with them. Basically, they are asking physicians to do all this extra work for relatively small benefit. But, what if we could just work smarter? What if we had a system where we didn't have to wait a couple of weeks to get each other's records, for instance?

We implemented the first Health Information Exchange in Amarillo to get around that problem. We can see hospital records quickly; we don't have to duplicate tests because we see that somebody else has already done them last week and here are the results. Another example: our ACO found that home health care costs were higher in Amarillo than average. So, we identified the home health care agencies that provided the best quality and lowest cost. We told the hospitals: for our patients we want you to use these three agencies over all the others because we think they do a better job and we think that they are more cost effective.

Dr. Urban: Before ACOs, who cared, right? As a physician, it wouldn't matter to me how much they charged, but with ACOs it begins to matter.

Dr. Biggs: It does matter and it makes the physician somewhat accountable for the total cost. But physicians have always wanted to have more cost effective treatment for their patients, it is just that they never had access to that information.

Dr. Urban: Cost information?

Dr. Biggs: We had no access to information either on quality or cost. Now our doctors do have that information and they are using it. And they are using it to the benefit of the patients. You know, yesterday I had a call from one of the home health agencies that wasn't in our top three. He was extremely disappointed, but he was also almost the highest-cost home health agency out there, and his quality was not any different than the rest. So I said we really can't work with you unless you can demonstrate to us either that you have superior quality or that you cost significantly less. How you do that is up to you, but that is what we are looking for! He had never in his life had such a conversation with a doctor. Again, that is physician empowerment. Now doctors who are referring to home health agencies have information like Consumer Reports that they have never had before. Patients will benefit and they should appreciate that, but it also returns control for the total responsibility for the patient's care to that primary care physician. That is the way it used to be, and we have gotten away from that. Now we are getting back to the physician being more of the executive director position for the benefit of his patients' health.

Dr. Zusman: Let me get on to the

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other side of the coin about some of the disadvantages of this legislation. What disadvantages do you see for patients?

Dr. Biggs: Well, it has been a very disruptive thing as far as the insurance market. It has caused charges to go up for people who are already insured. It has resulted in some availability problems, such as people getting dropped from their insurance plans, especially insurance plan that do not fully comply with ACA. How big a problem, I guess time will tell. So far, for my patient base, since I have so many people with diabetes, it has actually been more of a positive than a negative–just due to improved access to affordable insurance.

Dr. Zusman: What disadvantages do you see for doctors?

Dr. Biggs: Due to the psychological makeup of doctors, some have trouble dealing with change even though it is a constructive change. I think that we are going to see changes in payment that some doctors may not be comfortable with. We may evolve from pure fee-for-service to a system with more performance or quality measures as part of their payment mix. This may be difficult for some folks to adapt to. Inherent in some of this legislation is a push towards more information technology approach that some people will have difficulty with. We have to understand that and be prepared for that.

Dr. Urban: Let me ask you a question related to that. Some subspecialty groups are really worried about the ACA as cutting their income or decreasing the number of procedures that they can do. Do you think that is a legitimate concern?

Dr. Biggs: It is a legitimate concern. I have been asked to speak to the American Association of Clinical Endocrinology at their annual meeting this year on how the Affordable Care Act will impact an endocrine practice for instance, and I think it does have the potential to decrease reimbursement. However, particularly in Texas, we have to balance against that the fact that we should have more insured patients. I think there is going to be plenty of work for everyone. I am actually more concerned with there being an insufficiency of physician supply, rather than having specialties that are going to be underutilized. There could be some procedures that will become less popular, but these procedures may be over-utilized today under our current system. Some of these changes are more related to evidence based medicine, rather than the Affordable Care Act. But if there is not good evidence for doing a particular test, procedure or type of treatment, as we see physician collaborative groups grow and thrive and as we become more evidence based in our approach, specific types of treatment or procedures may fall into disfavor. But, that has always been the case; it is just going to happen a bit more rapidly now.

Dr. Zusman: We talked a little bit about some of the disadvantages this legislation would have for hospitals. Would you like to add anything at this point?

Dr. Biggs: Yes, again I think that the net effect for hospitals is going to be positive, just due to having more people with insurance coverage, rather than having a huge roster of unreimbursed care. I think it will be net positive for the hospital. Hospitals that are the most innovative are going to seize the opportunity as they see that payment models shifting away from fee for service; so they are going to try to set up care systems that include them in some way. Either they have their own in-house roster of physicians and have their own healthcare system, or they are strongly allied with larger physician groups. Either way, we will have a more collaborative approach.

Dr. Zusman: What are the disadvantages of the Affordable Care Act for the country in general?

Dr. Biggs: I think the worst thing about the ACA is that it has been so divisive. People have drawn the line between Republican vs. Democrat, and really healthcare should supersede all of that. We don't seem to be pulling the rope in the same direction now. It has been such a bitter battle on both sides; I don't think that has been good for the country.

Dr. Zusman: What aspects of this legislation would you change?

Dr. Biggs: Wow. Nobody has asked me that before!

Dr. Zusman: Imagine you were running for president!

Dr. Biggs: Well, the first thing is, the whole way the exchanges were organized, the way they were created and regulated, such as how insurance companies can enter their products into the exchanges, I think has been a real mess–and not just the website implementation. Just getting into the exchange is a mess and so is the fact that in our marketplace we only have two companies participating in the exchange.

Dr. Zusman: What are those companies?

Dr. Biggs: Blue Cross and Firstcare. We need to have a really robust market in order to have the level of competition necessary to really contain costs. It evolved this way because the legislation had a whole set of complex rules. Then we let employers out of the mandate for an extra year but continued it on people, and still people aren't signing up. Legislation written in such a complicated way is almost impossible to properly implement.

Dr. Urban: This leads to a related question, which is: do you think that the problems that you've alluded to are simply a matter of fixing an information technology computer glitch, or are these problems inherent to the plan? Is the plan just so complex that the regular American citizen will never be able to understand it?

Dr. Biggs: Well, I guess they can fix the website, but that is really not the biggest part of the problem. We have a government run exchange; perhaps we would have been better off with an exchange system that is run by the private sector. The private sector may have done a better job. Again, because of philosophical reasons, the State of Texas lost the opportunity to operate the exchange themselves, whereas if they had been more practical about it, the state could probably have done a better job. You know, if we had hired Amazon to run this, things would have turned out a lot differently. But there is still the problem of how insurance companies get their products into the exchange plan. For instance, we had an exchange plan in development with Coventry that was going to be a super plan. It had a lot of elements that were excellent for patients and excellent for physicians, but it was knocked out of the exchange because Coventry merged with Aetna and, due to technical reasons, could not get it into the exchange. The whole process was so burdensome that it eliminated a lot of potentially good plans from participating, and the more plans that we have the better job that they do for providing high quality healthcare at a reasonable cost, just because of the competitive nature of things.

Dr. Zusman: Do you think that the Affordable Care Act is affordable?

Dr. Biggs: I think that the Affordable Care Act was inevitable, in that there is no way that we can continue as a country to have these huge increases in healthcare costs and stay alive. You know, our deficits have been higher than ever, and an enormous amount of that goes to pay for healthcare costs. This is a tax on the American people that we shouldn't have to pay. No other country on the face of the earth has healthcare costs like the United States; this is not a sustainable situation. So in some ways the Affordable Care Act was a maladaptive response to a problem that needed to be addressed, and nobody had the guts to really address it like it needed to be done. There were political interests that came out pretty well in the Affordable Care Act; for instance, the pharmaceutical companies continue to maintain their profit structure under this whole algorithm. That was an entity you didn't ask about, but they are coming out pretty well in the Affordable Care Act at very little cost to them. They account for a very large percentage of our excess cost compared to other countries, and yet the Affordable Care Act really didn't address that issue. I don't think physician pay is a reason for excess costs, as physician income today in the USA is not much different from other industrialized countries. There are some utilization issues and waste issues built into the American system compared to other countries but, you know, if we are going to preserve a free marketplace and have freedom of choice we have to understand that we are going to pay more than other countries for our healthcare. At the same time, we are paying way too much as citizens than we need to, and a lot of it is because of the inefficiencies and fragmentation built into our system that the other countries just don't have.

Dr. Zusman: Do you think that the Affordable Care Act will be inflationary?

Dr. Biggs: I don't think it is going to be inflationary; our old system actually was quite inflationary.

Dr. Zusman: It seems to me that you have very positive view of the Affordable Care Act. What do you think should be done to encourage other physicians to see perhaps the positive sides that you have alluded to?

Dr. Biggs: Well, lost in all the rhetoric is that physicians have not been made aware of the aspects that can be positive for their practice, in that more of their patients will have insurance and that, particularly in primary care, they will have power in dealing with insurance companies and hospitals that they didn't have before. I think that physicians will realize that, but now it is getting drowned out in all of shouting. Doctors will discover that, but it may not be for a year or two.

Dr. Zusman: That is all the questions I have. Dr. Urban, do you have any other questions?

Dr. Urban: Yes, I have a couple. Regarding the implications of Texas "opting out": we opted out of the exchanges but we also opted out of the Medicaid expansion. So, Reddy, could you help our readers understand the implications of Governor Perry's approach, besides its effect on the exchanges.

Dr. Biggs: So the Medicaid expansion would have funded the majority of the cost for expanding Medicaid to higher income levels.

Dr. Urban: That is to say that funds would have come from the federal government to defray those expenses?

Dr. Biggs: Correct. And that would have been a huge boost to the healthcare industry in Texas, and so that is something that the healthcare industry in Texas has lost. Again, the concern was a philosophical one--that this would become a permanent mandate from the federal government to fund Medicaid for a number of years and, as the federal subsidies become less robust, then the state would have to pick up the tab. I have never seen a good economic analysis to help us make a decision on whether that was a good idea or not, but, at least for the short term, it was not a good idea because, as Texans, we are now sending our federal tax dollars to Washington DC to fund Medicaid patients in other states but not our own. So, we are not getting any of our money back on this.

Dr. Urban: Were there any other implications of the state of Texas opting out of the ACA?

Dr. Biggs: Some of the concern was whether government agencies, such as Medicaid, would be involved in a larger share of the healthcare market. You know, all of us have some experience with Medicaid and it has generally not been favorable, so that is a scary thought. However, since a large percentage of those patients who are currently uncovered by anything would have been picked up by

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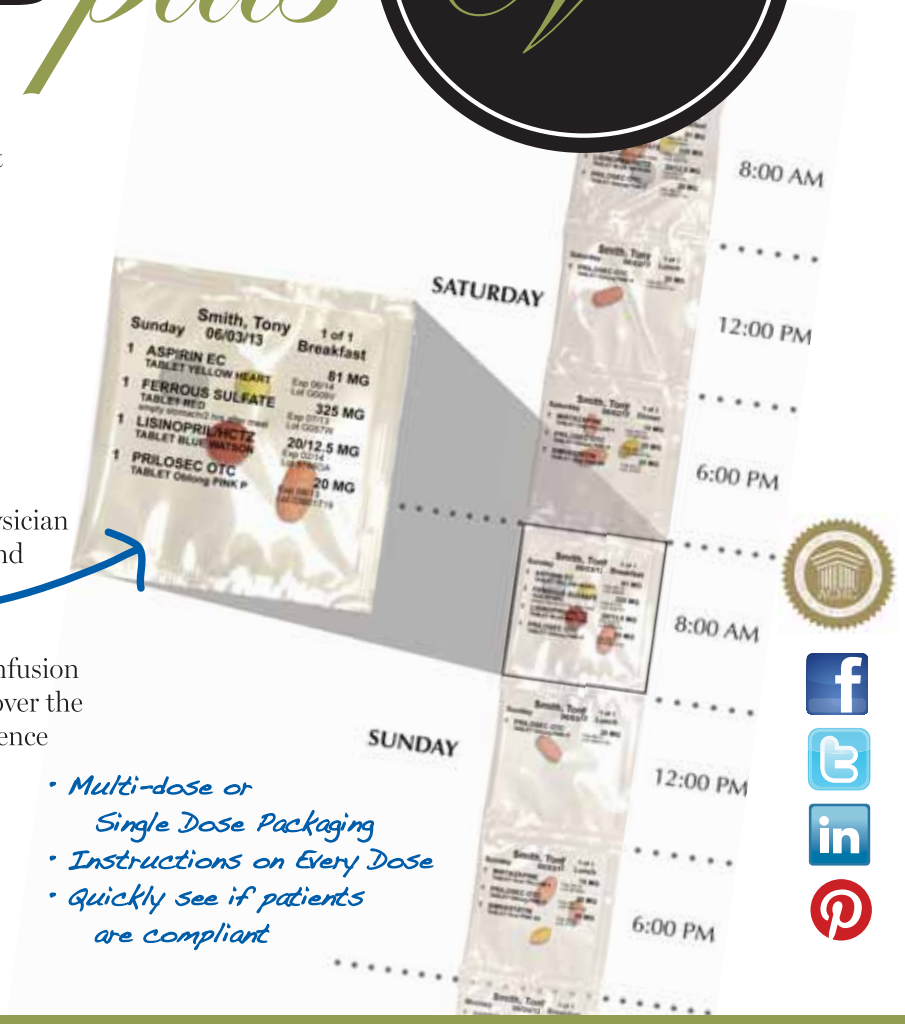

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Medicaid, I think it would be better for them to have something rather than a completely disorganized non-system, which they have now. Showing up at the emergency room quite sick without getting their problems addressed is, at the end of the day, going to be a very expensive option. As a society, that is a very inefficient way to deliver healthcare and costs us more in the long run.

Dr. Urban: Some of our readers may not understand what an Accountable Care Organization is, and how it functions.

Dr. Biggs: An Accountable Care Organization is a group of practitioners or practices that have joined together to try to have a common way of taking care of their patients so that they are accountable for the quality of their care and the cost of their care.

Dr. Urban: So it is not just a cost saving system like capitation was? Quality is as important as cost savings?

Dr. Biggs: Our ACO has no capitation contracts at all. The things that were bad about capitation obviously were that it was run and implemented by an insurance company that had no way of adapting care to an individual patient and no way of assessing different types of medical practices. For instance, one doctor's practice may have more high risk patients than another, but they would all get the same rates. This is not capitation. One of the things that is unique about our ACO is that we will have quality measures that look at the immunization rates, mammography rates, colonoscopy rates, etc.

Dr. Urban: So you are encouraging care rather than discouraging care if it is appropriate?

Dr. Biggs: Absolutely. We actually provide more care rather than less care. We try to make sure that the patients and the doctors choose wisely on the care that they are getting. So, we don't tell a doctor, "Hey, you are not giving enough flu shots." What we do is we provide to them data about how many flu shots we are giving. Here is how many all of your peers in the ACO are giving and here is how you stand. We have shown our doctors their hemoglobin A1C data on their diabetes patients. We have them all in the same room, and it is unblinded. You see the graph where you stand and you get to look at each other and have them look at you with your results up on the screen. Those are very interesting meetings! One doctor may be blowing away the national average, and compared to the State of Texas, his numbers look fabulous. But compared to his peers in the ACO he is the worst. He is sitting there thinking, gosh what can I do to just do a little bit better. Do I need to work harder on getting my patients to come back more frequently or do I need to establish more contact with them or do I need to convert them to insulin a little earlier? We are not telling him how to do his practice; we are just giving him data on how he looks compared to everybody else. That is a positive thing.

You know, when you were in school you got a grade, and you got into medical school because you made good grades. Everybody continues to want to make good grades. But the reason you got into medical school is that somebody gave you feedback on how you were doing in elementary, high school and college. And there is no reason why that feedback shouldn't continue. So, we'll again be able to help doctors know how their practices are doing in comparison to others and, by having that measurement to strive for improvement. This is basically part of a process change.

In addition, we can identify which consultants are high-quality, cost-efficient consultants. We have analytic claims data from Medicare. I have a printout that shows me all the hospital costs that we have incurred at the ACO level; the size of the graph shows me how much money is spent at each hospital--BSA, Northwest, Urgent Care Center, Surgi-hospitals, etc. We can go in and see which hospital does the most efficient job and the highest quality job.

Dr. Urban: You can drill down to specific data about back surgery or heart failure, for instance?

Dr. Biggs: Exactly. Just like we do with the home health agencies. That can lead to some very interesting conversations with the hospitals. For instance, we have found that for one particular line of DRG's one hospital was 15% higher than the other. So, we are going to work on that. The enablement of an ACO to get claims data and to have these type of conversations, that is a sea change. Whoever thought that you would have access to this kind of information and could use it for the benefit of our patients and the benefit of our practices?

Dr. Urban: And that is where Information Technology is so important to making an ACO work properly?

Dr. Biggs: Right. All the physicians in our ACO were already on electronic health records, and we have been able to knit them together into our health information exchange; so if somebody sees me today and then they go to their family physician in the ACO next week, they can see my labs, they can see my notes, they can see what the medicine list is. It makes their job easier to have that information readily available, and vice versa. You know, they can see if the patient has already had a pneumonia shot or if they had a steroid shot last week and that is why their sugars are so high this week. Having that information is a huge plus for patient care.

Dr. Zusman--Dr. Biggs that concludes our interview. Thank you very much.

In Memory

Dr. Evelyn Archer,
Dermatologist, died on December 11, 2013 at the age of 55.
She was a member of the Potter-Randall County Medical Society for 13 years.

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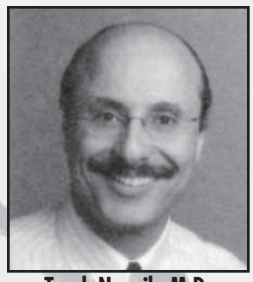

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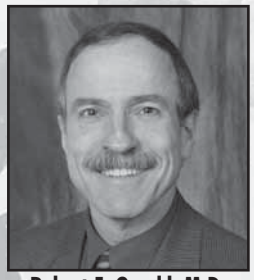

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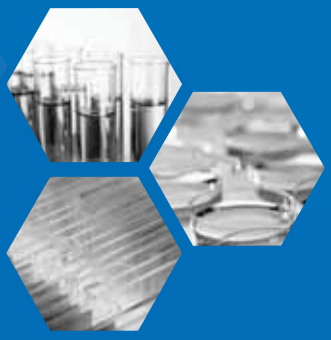

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Affordable Care Act:
Mr. Mark Crawford Interview


Rouzbeh Kordestani, M.D.


Paul Tullar, M.D.

Mark Crawford is the CEO of Northwest Texas Hospital

DR. KOREDESTANI: We are here with Dr. Mark Crawford, CEO of Northwest Texas Hospital, who will sit down with us and go through some of the questions concerning the impact of the Affordable Care Act. With me, also, is Dr. Paul Tullar, one of the other editors of *Panhandle Health*. Mr. Crawford, as you are a new CEO, what is your corporate opinion and your personal opinion of the Affordable Care Act?

MR. CRAWFORD: I think all of us would agree that the objective of increasing the insured population of America is a noble cause. And that is good for health care. It is good for hospitals; it is good for physicians; it is good for the whole system if we have more of the population that have some sort of a paying source versus not having a paying source today. I think the unfortunate reality of the roll-out is that it is probably having the opposite effect, and people are actually losing more insurance than they are gaining. I do think that will be corrected over time.

DR. TULLAR: What is your opinion of the benefits of legislation for patients, doctors, hospital, and for the country?

MR. CRAWFORD: Obviously, having health care coverage for patients will help them acquire the health care they need, hopefully limiting constant access to the emergency room as a last resort. I think that will be a benefit to patients. Obviously, staying ahead of their health versus behind their health (not as as it is today without insurance, and waiting until they are really sick—truly sick—before they go to the emergency room) is a real benefit to the patient. The benefit to the doctor has to be looked at as one and the same as the benefit to the hospital. The benefits to the two are the authority to actually work together for better management of the patient's care. I think we will see us moving from a fee-for-service provider to more of a population manager position within the industry. What we would call the "sick-care system", waiting until you are sick to access the system,

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is really one of the agendas that was meant to be changed through Obamacare. Obamacare was meant to get people into preventive programs with annual physicals, emphasizing daily health, rather than waiting until they sick to access the system. I think, in doing that, we will become population managers, and there will be different opportunities for both of us to be paid for quality of care and paid for keeping people well versus being paid when they are sick. I think that is a transformation that both doctors and hospitals are in for.

Unfortunately, the trajectory of the spending is just unsustainable. That trajectory has to be bent. We cannot spend what we are currently spending on healthcare, given the future aging populations. So, for the country, it is about reducing the cost of care. I'm not sure how that will come down to us at the end of the day. Right now it's about cut, cut, cut instead of more about changing the system of care.

If we can convert the funds in a different way from being paid for providing service to providing health, then maybe we all will win. The law is going to have to be rewritten several times before that will happen. I think half the bill was probably good. The other half needs rewriting, based on what we are already experiencing. We thought people would be covered with insurance. And they are not. We have to change something—the penalties, the incentives, etc.—bringing people into the system, not kicking them out.

On the other hand, patients are not going to have as broad a choice. There will be a narrowing of networks. If you are going to have a network focused on quality, you must make sure you have quality providers within the system: the facility, the doctors, the ancillary facilities. The patient is going to have to narrow down his choice of physicians and the services he can access and not just have open enrollment to anyone and everyone. I don't know that I really see a whole lot of disadvantages for doctors and hospitals. I do worry about where the dollars are going to come from in the future. I don't think we have successfully explained how we will convert from fee-for-service to population management yet, but I see it coming. I think that, in the end, patients, doctors, and hospitals win with more of a quality-driven system. Because the ACA draws a lot of fire from the media, this will be a topic for discussion for a long time. I am not sure we will get much other work done because of this. Certainly, this will prove somewhat of a disadvantage to the country.

DR. KORDESTANI: What are your thoughts about the complexity of the bill, given its length. Many physicians feel a great deal of angst, and people are "anti-bill" already without really knowing what the bill is.

MR. CRAWFORD: Right. I, for one, have waited for the *Cliff Notes* of the bill to come out! As they have rolled out portions of the bill, one becomes acquainted with only those portions, but the bill is so long, and therein lies the angst. The bill is over 2000 pages long. Are physicians afraid that fee-for-service—their take-home pay—will be less in the future than today? I think that's a pretty valid fear. As a hospital, we also share that fear of less revenue. I think there could be some way to start coordinating care to survive under this reduction, but I'm not sure we are thinking about those ways yet. Instead, we uselessly talk about how we can get out of the bill, and the bill really isn't going anywhere. Instead, we need to be thinking about these things in a thoughtful, prudent way and not get into the flurry of media coverage so we can tell the government and our legislators our exact needs. Then, the bill could be changed, instead of just, "Blow it up, it's no good." Clearly, we have an office that will change out with a new presidency. So as we go into a new session, we need an articulate argument, and we need to be able to say what really needs changing, and why, and not just sit here arguing about how bad the bill is.

DR. KORDESTANI: Physicians are concerned about the loss of autonomy and getting paid less. What are your thoughts about this?

DR. TULLAR: I have been through a time where the cost of practice exceeded the reimbursement from that practice. And the economics for medicine are the same as the economics for every other part of the world. If the cost of doing business exceeds the value brought in by the business, you will go out of business… I really don't trust that the insurance industry or the government knows where the bottom is.

MR. CRAWFORD: Yes, the government is still struggling to understand it's not about reducing fees for those providing service. It's more about reorganizing the delivery system so that fees could be subrogated by a more conservative approach earlier—managing the population on a healthier lifestyle as opposed to waiting until people are very sick. Also, at least 1/3 of the healthcare in the country is redundant as doctors and hospitals aren't communicating via electronic records. That is a good part of the bill. We must stop re-replicating 3 MRI's and 2 CT's, etc. Cutting the waste would save billions.

DR. KORDESTANI: If you could rewrite the legislation, on what part would you focus?

MR. CRAWFORD: The big objective of the bill is get more people covered with insurance, so you have to match up the incentive with the disincentives in order to accomplish that goal. You can't have a $75 penalty or a $5000 premium. They have to be somewhere in the general ballpark of each other so that one or the other is an equal choice. For example, take the penalty, and I could pay the fine of $2000 a year, or I could cover my employees for $6000 a year. What are employers going to do? What are patients going to do? If you are going to push people into this model, states are going to have to decide how they are going to pay their portion of it. I think a lot of states may not get involved, and that's probably a good thing, long-term. But it's hard to see what that will mean to those states. Texas has opted out of Medicaid expansion, and in hindsight, that may be one of its smartest decisions. But at some point, we will have to figure out how we are going to get involved, and if it's not Medicaid expansion, what will it be? But the reality of it is that you have to change immediately the things that cause or do not cause people to get covered with insurance. We must match the penalties and the incentives.

DR. KORDESTANI: Since Northwest Texas Hospital is a trauma institution, and since Texas has opted out of Medicaid expansion, how do you see the Affordable Care Act's impact on NWTH?

MR. CRAWFORD: This is difficult to answer because many people think negatively of a trauma system. They feel all you get with trauma is a negative payer mix because now, many people do use emergency rooms as a last resort. It doesn't really matter if you are trauma or not; the reality is that there are always accidents and injuries—hence, the need for a trauma center. On the emergency side, we must do something at some point. I don't know if it is Medicaid expansion or not. As a community, we have about 4% unemployment. What about focusing on the 96% employed and figuring out how to get them coverage, because a lot of them don't have coverage for various reasons? How do we get employers to cover more? The law does some of it. For example, if you have over 50 employees, you must provide insurance or pay a penalty, but again the penalty and the incentive do not match up. I'm not fixated on what the bill says; I'm fixated on getting greater coverage for more people. Maybe the answer is a harsher requirement for employers to cover their employees. Maybe it is Medicaid expansion. Or maybe it is something completely different. Obamacare had specific guidelines on what the minimum expectations were for a health plan for employees, and they were tall orders in some places. Clearly, Obamacare as a bill wasn't perfect. Maybe there are other mechanisms for change we can look at other than Medicaid expansion. Perhaps employer expansion is an answer. Maybe local communities footing a little more of the bill might work. Who takes care of the homeless in a community? They get shelter, and the community gives them health care. Maybe the community needs to come together in some other way. I don't know all the answers, but I'm trying to "get out of the box", and look for other alternatives for change.

DR. TULLAR: If this is truly an "Affordable" Care Act, do you think the Act is "affordable"?

MR. CRAWFORD: I think that some of the strategies and tactics will result in a better system of care. But until we have more insured, I am not sure that the Act has become more "affordable". Until more people covered, affordability is the question.

DR. KORDESTANI: Is it possible that, as we start to bring in the Affordable Care Act, we will develop a European two-tiered system in which we have health coverage for everybody, but if someone has more money and access, instead of remaining in the system, they can go outside of the system, and pay for their own care?

MR. CRAWFORD: I guess that could be a result, but I doubt it. Two issues are at play here. In America, we have always believed in the same quality and level of care for all people, not some for the "haves" and a different level for the "have-nots". We have one system of care. I think that is a system that will continue. I think that the business-minded, free-market economy-supporting nature of America will not allow this to become a government-operated system. I'm not saying that the system won't be different in 5 years, but I don't believe that the government will take over health care like a European two-tier system you describe. The second issue is that nothing that the government has ever run has been overly effective. The government has systems that cost 3 or 4 times more to operate than if outsourced to the private sector, and we all know what those examples are.

| *continued on page 34*

DR. KORDESTANI: Is it possible that we are going to come up with a system that will provide totally new healthcare changes?
MR. CRAWFORD: I think so. We all recognize the waste in our system. In Amarillo, we could create a nurse hotline, a nurse advice line, available to everyone, free of charge. You could call and tell them your symptoms. What if that nurse could answer that question and tell you to go to your drugstore, tell you what to get, and to call back in two days if you did not get better? Or, if it was more serious, the nurse would set up an appointment with Dr. X tomorrow. Or, in the worst case scenario, the nurse would tell you to go to the ER immediately. This sort of hotline would triage the patient to the appropriate level of care instead of just accessing the highest cost. I think that implementation alone would help save millions in the system.

DR. KOREDESTANI: We have talked about hopes of managed cost. Do you think if everything really works that we will end up with better care?

MR. CRAWFORD: I have to believe that. I believe the nurse advice line, or the case manager calling a person who accesses the ER 4 times a year, or taking that 20% of the population with multi-comorbidities with real issues, will help educate those patients on the severity and complexity of their illnesses, and what they must do to maintain a level of wellness. If I were successful with the nurse advice line in reducing ER volume by 5-10%, could I not get 2- 3 nurses down there, and have them rotate through that case management/nurse hotline, and then reorganize the organization, not necessarily adding cost to the system, but just re-deploying the cost in the system differently?

DR. KORDESTANI: Interesting. What should we expect in the next 6-12 months? Is there anything specifically about the Affordable Care Act that impacts Texas or Northwest Hospital?
MR. CRAWFORD: Specific to NWTH and the Amarillo area and Texas, we need to get really good at having a conversation. I think we will be supporting more conversations about how we can retool the system here in Amarillo. I don't know of anything across Texas that is any different than nationally. I know the ACO (Accountable Care Organization) stood up and has 100 members now. They invested in electronic records so they could start communicating and talking to each other. They had the conversation before most of us did. We as a community must have that conversation with them and, perhaps, start considering some of the things they have already started to deploy. If we can start managing the high-acuity patients who are absorbing a lot of dollars in the system with case managers who check in with them as opposed to waiting for them to show up in the office or the ER, we can start making a change to the system. This will have a huge impact.

DR. KORDESTANI: Thank you very much.

Affordable Care Act:
Mr. Bob Williams Interview

by Jaime Zusman, M.D.

Bob Williams is the CEO of Baptist St. Anthony Health System

Q. What in your opinion are the most notable reforms of the Affordable Care Act?

A. There are several. First, the concept of coverage for all is the most reformative, but the problem is that it is only a concept. However, it is a step in that direction. There is currently a large gap in coverage, especially in states that did not expand the Medicaid program, like Texas and Oklahoma. Initial indications on whether or not the coverage gaps are being filled are mixed. Some reports indicate that the majority of those enrolling for Exchange products are converting from some other type of coverage, like employer group health or private health insurance. Other reports indicate that the enrollees in the Exchange products are high in the formerly uninsured. There is nothing solid at this time. Second, standardized benefit designs will be helpful, but expensive. For example, the elimination of a lifetime maximum benefit, no pre-existing conditions exclusions, and the expansion of the age limits for dependents will all help some beneficiaries, but all of these will also add cost. Third, the Exchange products allow the purchaser to fashion his or her benefit plan and premium decisions based on their expected utilization. Again, while this appears consumer friendly, there is downside risk here.

Q. What in your opinion are the benefits of this legislation?

A.
a. For patients- Access to health benefits is the biggest.
b. For doctors- Theoretically, a reduced number of uninsured or underinsured is the biggest benefit, but that is yet to be seen.
c. For hospitals- Same as for doctors, reduced numbers of uninsured or underinsured.
d. For the country- Access to healthcare has been an entitlement forever in our country. This is a step toward a balanced payment system.

Q. What in your opinion are the disadvantages of this legislation?

A.
a. For patients- Coverage remains confusing. Decisions on which plans to pick remain mostly driven by premium dollars and the enrollee's anticipation of need. Picking the right plan is still an affordability issue.
b. For doctors- While the legislation is intended to decrease the uninsured, the jury is still out on whether or not this will happen. It appears that the conversion of patients to the lower reimbursing Exchange products will be an issue. This means that, while medical providers may have fewer uninsured, their reimbursement for some of their existing insured patients will be less when they convert to Exchange products. There is probably not a lot of downside financially, but there is probably not as much upside as has been touted.
c. For hospitals- Same as for physicians. However, hospitals may benefit more than physicians if expanded coverage materializes, especially with emergency room patients.
d. For the country- This is only a partial solution, if that. Real reform intended to impact the total spending for healthcare in our country has to address lifestyle, wellness, chronic disease management and care coordination. However, I'm not sure that the country is ready for the massive mind shift that such changes would require. There are some aspects of the Act that begin to look in this direction, like the creation of Accountable Care Organizations, but for the most part, the funding for the necessary infrastructure is nonexistent or inadequate to create significant momentum.

Q. What aspects of this legislation would you change?

A. Great question. The infrastructure does not exist to do so, but creating a meaningful mechanism to assist enrollees in the proper selection of their benefit design, based on their real predictable need, would go a long way to a more balanced start. This would require extensive health assessments being run through predictive modeling tools. The infrastructure just doesn't exist to do that in the kind of mass application that it would require. Additionally, if coverage is to be truly mandated, there needs to be an enforcement provision that has meaning.

Q. In practical terms, do you think the Act will ease the problem of caring for the uninsured?

A. Yes, since there will likely be fewer uninsured.

Q. Do you think the Act is affordable?

A. Initially no. The Act will increase costs initially. However, if gaining access to care through expanded coverage becomes the first step to real healthcare reform, then potentially.

Q. What adjustments will your hospital make in response to the Act?

A. BSA's response is in line with our historical operations; we evaluate the contracts offered by the Exchange products and participate based on our business analysis. We have looked at and continue to look at offering assistance in the enrollment process. We are talking with businesses and their agents to understand how they will respond to the Act – either keep their group health options or move their employees to the Exchange. We are anticipating what the next reform effort will look like and working to be sure that BSA Health System is properly positioned for that.

Affordable Care Act:
Congressman Mac Thornberry Response

Q. What in your opinion are the most notable reforms of the Affordable Care Act:?

A. The most notable reform is how Obamacare dramatically changed and increased the federal government's involvement in the delivery of health care to Americans. It includes the unprecedented requirement to either purchase a particular consumer product through the individual insurance mandate or pay a fine to the federal government. I believe this opens up a Pandora's Box by setting a dangerous precedent for the power of the federal government and its reach into our personal lives and personal decisions that should be left to us and our doctor.

Q. What in your opinion are the benefits of this legislation? What in your opinion are the disadvantages of this legislation?

A. Although there may be some individuals who may be able to get new access to health insurance, the majority of the folks that I have heard from in our area are not benefitting from this law. Many people are already seeing higher insurance premiums and deductibles, and I have personally talked with several doctors who have decided to retire or are considering retirement. As costs escalate, more people will have a harder time finding a provider.

Q. What aspects of this legislation would you change?

A. I voted against the health care bill when it passed Congress, and there are numerous aspects of the law that I would change. There have been some changes and alterations to Obamacare that have been enacted into law, like repealing the 1099 requirement that would burden small businesses and repealing the unworkable Community Living Assistance Services and Supports (CLASS) Act. In the House, I have voted over 40 times to repeal, dismantle, or stop funding for this plan. However, I believe that the only way to really fix the law is to repeal the entire thing and start over.

Q. In practical terms, do you think the Act will ease the problem of caring for the uninsured?

A. Any time the federal government steps into our lives, there are going to be unintended consequences that change and alter the decisions that we make. We have all heard the discussion of younger, healthier folks who are choosing not to sign up for health insurance. I have also heard from a number of small businesses that did offer health insurance to their employees before the law was enacted that are no longer able to afford it. Overall, I think we are still going to see problems providing access to health care for Americans.

Q. Do you think the Act is affordable?

A. Of course not – it establishes a new entitlement without a way to pay for it and forces more cuts to Medicare reimbursements. With the rise of health insurance premiums and deductibles that we have already seen and the long-term implications on federal spending, the Affordable Care Act is not affordable for Americans at the individual or national level.

Q. What adjustments will your hospital make in response to the Act? For elected officials: What adjustments will your organization make?

A. It will be difficult to get the President to repeal his own signature law; however, the House has to keep pushing where it can. It is also important to emphasize that there is a better way. We have real problems in our health care system, and I have cosponsored H.R. 3121, the "American Health Care Reform Act," with over 120 of my Republican colleagues that offers more limited, commonsense proposals to help solve those problems. These include provisions to increase health insurance competition, equalize the tax treatment to purchase health insurance, and safeguard those with pre-existing conditions, among several others.

Q. What if deadlines are not met for enrollees? Do you think the difficulties encountered in signing up for the plan are just a computer problem that needs to be solved or an intrinsic problem related to the complexity of the plan?

A. It is unacceptable how the Administration has handled the rollout of the law, especially implementation of the healthcare.gaov website. These technical issues are creating unnecessary problems for enrollees trying to purchase health insurance. I also fear the website vulnerabilities create a greater risk for the loss or theft of the personal data required to navigate the site. But, to be clear, the problems with its website are just the tip of the iceberg of problems to come.

by Tarek Naguib, M.D., M.B.A., F.A.C.P.

Olive Oil Prevents Diabetes Ann of Intern Med (1/7) – A Mediterranean diet enriched with extra virgin olive oil reduced diabetes risk in about 3500 persons with high risk for heart disease. The diet had no calorie restriction!

Multivitamins not Useful for heart or brain! Ann Intern Med (12/17) – High-dose multivitamins and minerals showed no benefit in reducing death, heart attacks, strokes, or hospitalization for angina in a study of about 1700 persons with previous heart attacks. In the same journal issue, the results of a 12-year study on nearly 6000 male physicians revealed no benefit of multivitamins on cognition, either!

Liver Failure due to Supplements JAMA (12/25) – FDA issued a recall for OxyElite Pro and VERSA-1 supplements due to liver failure risk. The supplements are used for bodybuilding and weight loss.

Measles Vaccine Important JAMA (1/22) – As US marks a decade of measles elimination, 9 outbreaks imported into the US involving 159 Americans who were mostly unvaccinated!

FDA to Curb Antibiotics in Livestock Science (1/10) – FDA plans to restrict the use of low dose antibiotics in livestock feed or water that are used to promote the healthy animals to grow faster. The move is hailed as a major step forward towards preventing the development of bacteria resistance to antibiotics that is presumed to be related to antibiotic overuse.

Tobacco & Marijuana may Cause Stillbirth JAMA (1/22) – A study on pregnant women showed that marijuana and tobacco can independently double the risk of stillbirth!

Teens Turn to Flavored Little Cigars JAMA (1/15) – The trend is noted partially due to the grape, peach, cherry, and strawberry flavors that make tobacco more appealing. The little cigars carry the same toxic risk as cigarettes.

Chicken Liver Outbreak JAMA (12/25) – First multistate campylobacter outbreak took place in the US in 2013 due to eating under cooked chicken liver. Chicken liver should be cooked at 158ºF of internal temperature for longer than 2 minutes.

Find the Chicken Market! JAMA (12/18) – Chicken market closure in 4 Chinese cities brought about a prompt control of a large avian flu (H7N9) outbreak in China in 2013.

Artificial Pancreas for Type 1 Diabetes Science (1/10) – Smart phone is used to receive transmission from a glucose sensor applied to the skin, then transmits instructions to an insulin pump applied to the skin of the stomach to administer the required dose. The system is safer and more effective than human controlled insulin pump.

Too Much Publishing? JAMA (12/18) – Out of 18,000 cardiovascular articles that were published over the last 5 years, about half went uncited or cited less than 5 times!

Fecal Transplant Pills JAMA (1/8) – Swallowing 24-36 capsules containing fecal bacteria was 100% effective in preventing C Difficile colitis recurrence. The approach was much easier than feces transplantation that requires enema, colonoscopy, or nasogastric tube placement. The procedure, stool handling with intestinal translocation, does not have an acronym, yet!

ACA Enrollment Up Los Angeles Times (1/25) – ACA enrollment reaches 3 million persons; meanwhile the uninsured rate drops by 1% from 17% to 16% in January.

One in 4 Pass up Colon Cancer Screening JAMA (1/1) - Still 27.7% of US adults above 50 do not get their screening colonoscopy test to screen for colon cancer as recommended by the CDC.

ICU Stay Effect on Cognition JAMA (1/1) – One quarter of all the patients who have had an ICU stay continue to have cognitive deficit comparable to mild Alzheimer disease at 12 months post discharge.

Affordable Care Act (ACA)

What is the ACA?
A federal law aiming to increase access to and protect consumers from insurance & improve wellness and system performance & expand health workforce & cut cost.

How to expand access to insurance?
- Employers to cover workers or pay penalty (unless small employers)
- IRS to give tax credits to certain small businesses that cover workers
- Individuals to have health insurance (unless hardship or religious belief)
- Creation of state exchanges to help individuals buy insurance
- Expanding Medicaid to cover people with income below 133% fed poverty level
- Creating high risk pool for those who can't buy insurance (preexisting condition)
- Insurance plans to cover young adults on parents policy (with limits)

How to increase consumer insurance protection?
- Prohibit life time cap on insurance coverage and limits annual caps
- Prohibit excluding children with preexisting conditions
- Prohibit insurance plans from cancelling coverage except in case of fraud
- Establish state review to block unreasonable insurance premium increase
- Establish an office of health insurance consumer assistance (ombudsman)
- Obligate insurance to spending a minimum of premiums on actual medical costs

How to improve wellness?
- Require insurance to cover certain preventive care e.g. high BP &diabetes
- Create a National council to coordinate preventive efforts e.g. for tobacco use
- Increase federal money to states for some preventive care (if states don't charge)
- Establish home-visiting initiative to help states care for at communities at risk
- Require restaurant chains (20 or more sites) to add calorie info to the menus
- Require Medicaid to cover tobacco cessation for pregnant enrollees
- Requires a federal education campaign about oral health

How to improve quality and system performance?
- Research to study effectiveness of medical treatments & health disparities
- Projects to develop malpractice alternatives and reduce medical errors
- Develop payment to improve efficiency & health information technology
- Improve care coordination of patient care between Medicare and Medicaid
- Options for states to create "health homes" for Medicaid care for chronic illnesses

How to expand workforce in healthcare?
- Reform medical education training along with increase of scholarship and loans
- Support nurses training programs and nurse-managed clinics
- Support primary care models & increase fund for community health centers

How to cut cost?
- Provide oversight of health insurance premiums
- Emphasize prevention, primary care, and effective treatments
- Reduce healthcare fraud and abuse
- Shift uncompensated care onto insurance premium costs
- Foster comparison shopping in insurance exchanges
- Implement Medicare payment reform

Prepared by Tarek Naguib, MD, MBA, FACP
Adopted with modification from: www.ncsl.org/portals/1/documents/health/hraca.pdf

Cardiac Monitoring of Tuberous Sclerosis and Cardiac Rhabdomyomas in the Pediatric Age Group

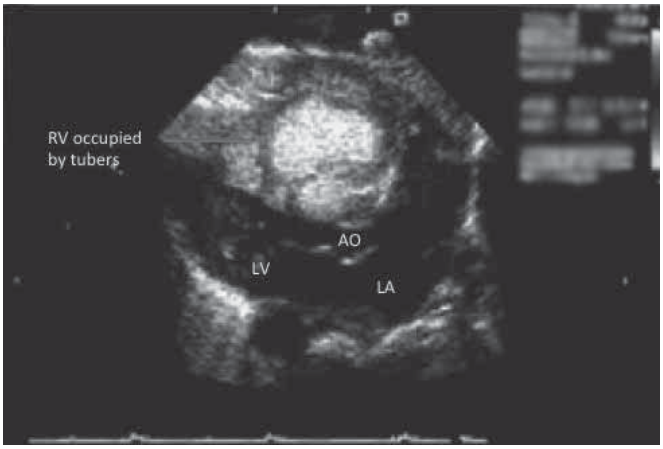
by Gunjan Banga, M.D., Srilatha Alapati, M.D. and Eugene Luckstead, M.D.

Introduction:
Tuberous sclerosis complex (TSC) is an autosomal dominant multisystem disorder characterized by hamartomas in multiple organ systems, including the brain, skin, heart, kidneys, and lungs. Mutations in hamartin (product of TSC1 gene) and tuberin (product of TSC2 gene) have been found to be causative of tuberous sclerosis. We report a case of a child who was diagnosed with cardiac rhabdomyomas antenatally. Despite the typical natural history of tumor regression, our patient had a new cardiac tumor reoccurrence. We will review briefly the recent literature of cardiac rhabdomyomas and the natural history of the disease process.

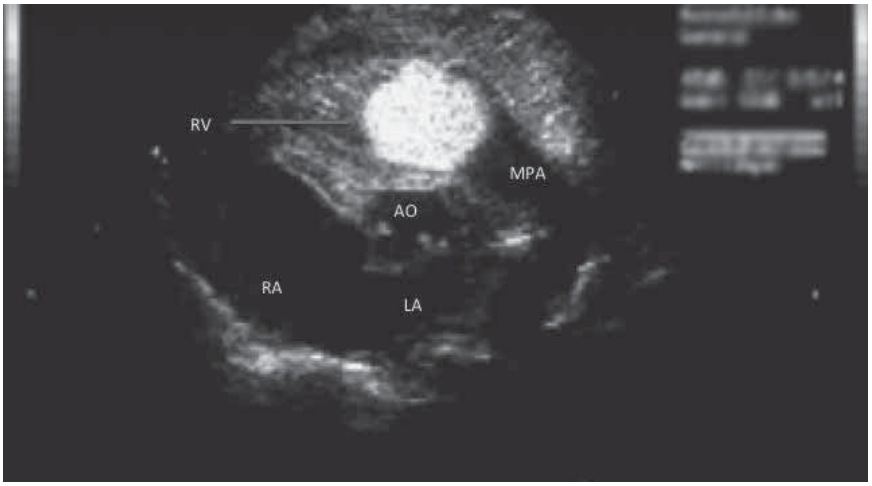
Abbreviations:
AGA – appropriate for gestational age
LV – left ventricle
RV – right ventricle
LA – left atrium
RA – right atrium
RVOT – right ventricular outflow tract
AO – aorta
MPA – main pulmonary artery
ASD – atrial septal defect
PDA – patent ductus arteriosus
SVC – superior vena cava

Case history:
A term AGA male baby was born to a primigravida mother with a prenatal diagnosis of intra-ventricular rhabdomyomas. The family history was positive in mother for tuberous sclerosis, a unilateral solitary kidney and a seizure disorder. The patient after birth had a 3/6 systolic murmur on exam and an echo confirmed the presence of multiple cardiac rhabdomyomas involving the LV, LV septal areas, RV and RVOT. Because of the worsening RV outflow tract obstruction, two tumors measuring 1.5cm x 1.2cm and 7mm x 5mm were resected via a transventricular approach on day of life 11. At that time patient also received an infundibular right ventricular outflow tract augmentation with ASD closure and PDA ligation. The patient had an uneventful postoperative course and was being followed up in cardiology clinic. On a follow up cardiac exam at 2 years of life, he was noted to have atrial arrhythmias on the holter study, and a repeat echo showed a large right atrial tumor measuring 3.6 x3.5cm occupying nearly 2/3rd of the atrial chamber but without any signs of SVC obstruction. On review of his prior echos, there was no evidence of any atrial growth and it was subsequently again surgically excised. The tumor stalk was noted to be arising from anterior limb of the superior limbic band having extensive adherence to the entire right atrial free wall, pericardium, right phrenic nerve and moderate mediastinal adhesions. Patient did have ventricular fibrillation intraoperatively, was defibrillated four times, requiring antiarrhythmics for 24hrs. The histopathology once again confirmed it to be a rhabdomyoma. An MRI of his brain showed multiple subependymal tubers (hamartomas) and some cortical atrophy. However the patient has remained seizure free; he continues to follow up with neurology yearly and cardiology every 3 months.

IMAGES AT BIRTH



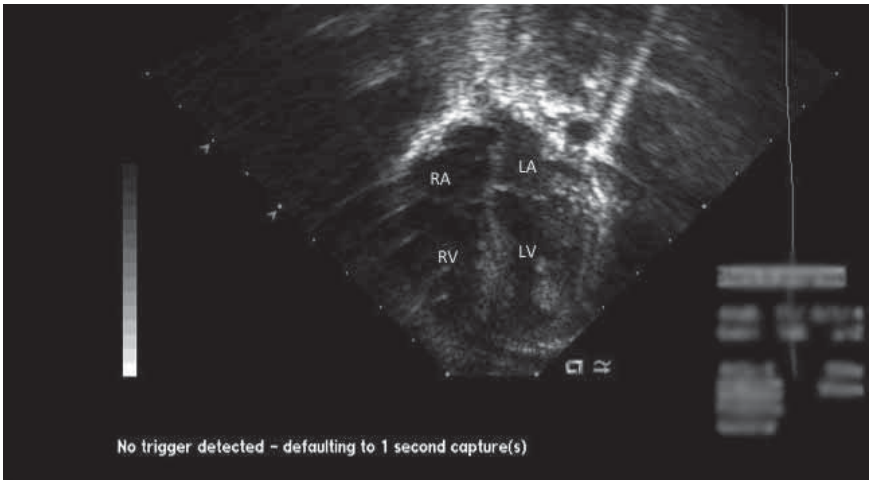
Parasternal long axis view showing multiple tubers in RV and attached to interventricular septum.



Parasternal short axis view showing a large tuber obstructing the RVOT.

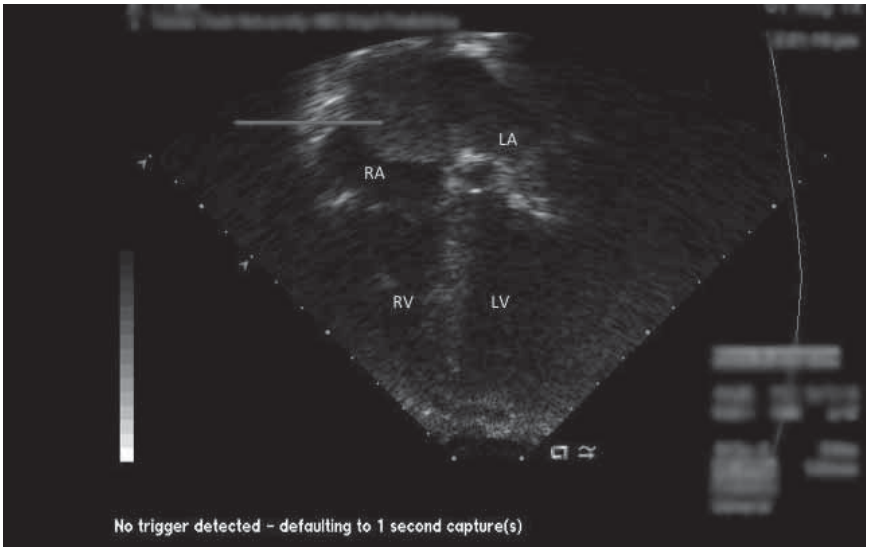
| *continued on page 40*

AFTER THE FIRST SURGERY

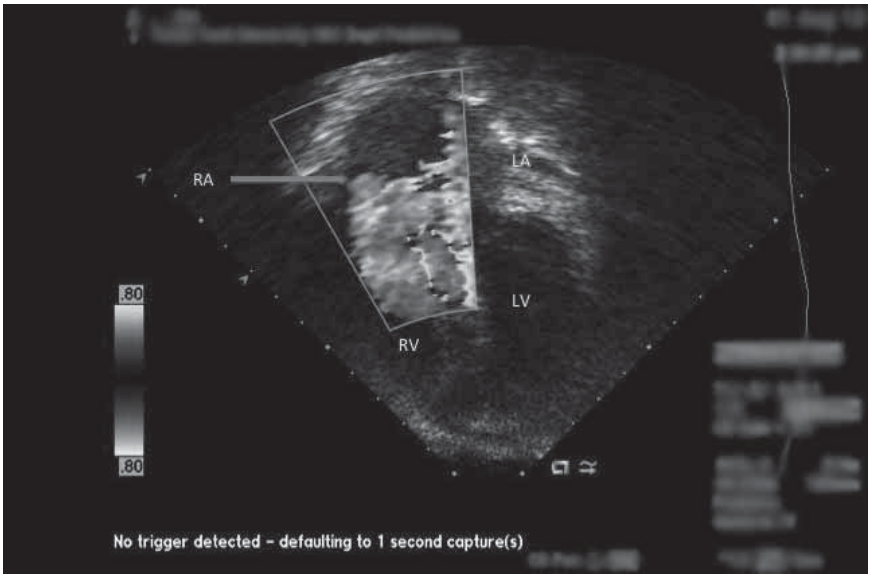


Four chamber view of the heart after the first surgery showing some residual tubers in the LV.

TWO YEARS AFTER THE FIRST SURGERY



Four chamber view of the heart showing a new growth in the right atrium (RA) marked by an arrow. The growths in other chambers have completely regressed.



Rhabdomyoma again noted in the right atrium.

Discussion:

Rhabdomyomas account for 45% of primary heart tumors in children and represent 53% of all primary benign childhood cardiac tumors (1). They are often associated with tuberous sclerosis and can be diagnosed antenatally and postnatally by echocardiography. About 51% to 86% of cardiac rhabdomyomas are associated with tuberous sclerosis (2). Recent echocardiographic studies have shown a 50% to 64% incidence of cardiac rhabdomyomas in patients with tuberous sclerosis(3). Rhabdomyomas usually tend to regress spontaneously and are not usually operated upon, unless they become obstructive or cause severe arrhythmias (4). Spontaneous regression of cardiac rhabdomyomas is well documented in the pediatric literature. The ubiquitin pathway has been proposed to be associated with degradation of myofilaments in the spider cells and thus this may play a role in tumor regression through necrosis, apoptosis, and myxoid degeneration (5). On further literature review, it was seen that on serial echocardiographic measurements, between 54% and 100% of patients showed some degree of spontaneous regression, with as many as 83% showing complete tumor resolution. In a majority of patients (~70%), tumor regression was seen initially before 4 years of age, with older patients having both smaller and fewer tumors than their younger counterparts, again suggesting an overall trend of tumor regression over time (6). While there is a possibility of an initial increase in tumor size, the recurrence of a separate new origin rhabdomyoma, to our knowledge, has never been documented before.

Conclusion:

This is an unusual case presentation of a pediatric patient with tuberous sclerosis and a new cardiac rhabdomyoma, with multiple past rhabdomyomas showing resolution. In contrast to the known past natural history of pediatric cardiac tumor regression, our patient had reoccurrence of a cardiac rhabdomyoma two years later. This case serves as a new learning point to continue conservative management and surveillance of all tumor sizes and sites in a patient with tuberous sclerosis.

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Spotlight on New Members

The following were approved for membership on January 14, 2014:

REGULAR MEMBERSHIP:

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Position of the Texas Medical Association on the ACA

Patient Protection and Affordable Care Act:

Find What's Missing. Keep What Works. Fix What's Broken.

Find What's Missing in the PPACA

Sustainable Growth Rate: Flawed Physician Payment Formula

The Sustainable Growth Rate (SGR) is a flawed funding formula the Centers for Medicare & Medicaid Services uses to pay physicians for the care they provide to Medicare patients.For the past decade, physicians have faced double-digit pay cuts because of the flawed SGR. Only emergency congressional intervention stopped cuts each year. The uncertainty surrounding the Medicare program, especially in this time of change, makes it extremely difficult for physicians to plan for the future. As a result, fewer physicians are taking new Medicare patients. The new health care law did not address this problem.

TMA Ask: Repeal the broken SGR. Enact a rational Medicare physician payment system that works and is backed by a fair, stable funding formula. Fix the broken Medicare payment system before giving additional increases to any other providers.

Medical Liability Reform

Texas has gained more than 21,000 new physicians to take care of Texas patients since 2003. Of these, around 5,000 can be attributed to Texas' medical liability reforms. Many of these new physicians practice high-risk specialties such as emergency medicine, neurosurgery, pediatric intensive care, and pediatric infectious disease. Texas patients now can get more timely and convenient care when needed. Twenty-one rural Texas counties have added at least one obstetrician since the passage of Texas' medical liability reform, including 12 counties that previously had none. The emergency care provisions have saved lives by helping ensure Texas patients have access to critical and timely care. The 2003 liability reforms have worked. They've lived up to their promise. Sick and injured Texans now have more physicians who are more willing and able to give them the medical care they need.

The rest of the nation will benefit from Texas-style reforms

TMA Ask: New medical liability reforms must measure up to the "Texas-size" reforms. New national medical liability reforms must NOT modify or change reforms now in Texas law.

Antitrust Relief for Physicians

The Federal Trade Commission prohibits a physician's ability to clinically integrate as imagined by the new health law. The new health law asks physicians to collaborate in ways government has discouraged through antitrust laws. For physicians to clinically integrate so they provide efficient care as imagined by the PPACA, a broad, bright-line rule needs to be established so physicians can work together without fear of government discipline.

TMA Ask: Congress needs to provide antitrust relief for physicians so that they can organize to provide cost-effective care and be protected from unscrupulous corporations putting profits before patients.

Direct Contracting

As baby boomers come of Medicare age, increased flexibility in Medicare will be necessary to ensure patients have access to a physician. One way to accomplish this is to allow Medicare patients to see any physician of their choice. Physicians should be allowed to enter into direct contracts with Medicare patients, even when they opt out of the Medicare.

TMA Ask: Pass the Medicare Patient Empowerment Act. Give physicians the ability to directly contract for any and all Medicare services.

Keep What Works in the PPACA

Insurance for People With Preexisting Conditions

From July to October 2009, TMA conducted 16 town hall-style meetings (aka House Call meetings) on health reform across Texas with more than 3,000 patients and physicians participating. At every meeting, both patients and physicians called on Texas legislators and Congress to prohibit health insurance companies from excluding coverage for patients with preexisting conditions. Patients need access to health care coverage, especially when they suffer from an ongoing medical condition. The PPACA now helps patients who have a preexisting condition obtain and maintain coverage when they are sick.

TMA Ask: Maintain the PPACA provision prohibiting insurance companies from excluding coverage to patients with preexisting conditions.

Prohibition on Rescissions

Patients should not lose their health insurance, especially when they need it most, because of an honest mistake when filling out health insurance paperwork or applications. Prior to the PPACA, health insurers could rescind a patient's insurance policy if they discovered an alleged misrepresentation in the patient's initial application for insurance, even an honest mistake or omission.

When coverage is rescinded by an insurer based on a misrepresentation on the application, all coverage is rescinded, leaving the patient responsible for paying for all of his or her health care services past and present. Health insurance applications are confusing, and sometimes people make honest mistakes in completing the forms.

TMA Ask: Insurers should not be allowed to cancel a patient's health coverage over technicalities in completing forms.

Medical Loss Ratios
Health insurer profits are expressed as part of the industry's term "medical loss ratio." The medical loss ratio is the percentage of premium dollars spent on payments to physicians, hospitals, and other health care providers for health care services rendered. The premium dollars left include health plan salaries and overhead, as well as profits. Simply stated, insurers can maximize their profits by spending less on a patient's health care.

Employers and employees are spending more money on health insurance coverage each year. Yet they have no idea if their hard-earned premium dollars are going toward health care or elsewhere. Prior to the adoption of the PPACA, there was not a single definition of a medical loss ratio. This made it impossible for employers and patients to compare health plans. TMA believes a consistent reporting formula for medical loss ratio works. Now employers and patients can compare health plans with others when shopping for insurance.

TMA Ask: Maintain the PPACA provision requiring health insurers to use a consistent reporting formula for medical loss ratio.

Consumer Label for Insurance and Plain Language Explanations
Purchasing health insurance coverage today is increasingly complex. Health insurance companies offer a wide range of plans with different benefits, exclusions, and costs. It is nearly impossible to decipher a health insurer's sales literature, then make a direct, product-to-product comparison.

Employers and patients need accurate, current, and honest information on copayments and deductibles to make decisions in today's health care market. The real need for this information is not when patients are sick or injured but rather when Texas businesses and their employees are shopping for health insurance coverage.

Standardized and reliable nutritional labeling has made it much easier for consumers to make better food choices. Consumers can examine 20 different boxes of cereal and easily compare the product benefits, such as number of calories and percentage of fat, sodium, sugar, or protein. TMA believes the same standardized system could aid employers and consumers when shopping for health insurance. The PPACA contains an insurance label requirement, and TMA agrees that plain-language information (like the label) will aid our patients.

TMA Ask: Maintain the PPACA provision requiring health insurance labeling in plain language so patients can better understand their insurance coverage.

Fix What's Broken in the PPACA

Independent Payment Advisory Board
The law creates a 15-member Independent Payment Advisory Board (IPAB) that has the authority to control Medicare spending, starting in 2015. IPAB can make recommendations that lead to decreases in Medicare spending ONLY through lower payment rates to physicians. IPAB recommendations would become law automatically unless Congress passes a law to reach the same budgetary savings.

The issue of Medicare spending is too important to be left in the hands of an unaccountable board with decisions based solely on cost.

TMA Ask: Repeal the Independent Payment Advisory Board. Keep Congress accountable for the Medicare system. If decisions are made to limit funding for health care services, priorities will have to be set. It should not be left, however, to an unelected and unaccountable IPAB.

Workforce/Graduate Medical Education
Texas medical schools are doing their part to expand medical student enrollments. However, graduate medical education (GME) programs are not growing in the same fashion. As a result, many of our newest physicians end up moving to other states for their residency training. GME is a necessary part of a physician's preparation for medical practice. Physicians who complete both medical school and GME in Texas are three times more likely to remain in the state to practice.

Texas' medical schools and teaching hospitals have limited funding available to expand GME. The shortage of GME slots guarantees some medical students will be forced to leave the state upon graduation. Those leaving likely will not return to Texas. They will take with them more than $200,000 of state investment in their medical school education. The current model for funding GME in the United States has not changed in more than 15 years. This significantly hurts the ability of states like Texas to offer GME programs to medical students.

TMA Ask: Maintain GME funding through Medicare and consider adjustments for future support based on population growth.

Overbearing "Fraud and Abuse" Enforcement
Healthcare Fraud Criminal Statute
Texas physicians recognize the need to rid the health care system of fraud. We want to work hand in hand with Congress to ensure our health care system operates effectively and efficiently. The PPACA includes provisions that increase funding and the government's authority to combat fraud and abuse. Language was changed in the Healthcare Fraud Criminal Statute that might have unforeseen consequences. The law removed the government's burden to show that an accused had "actual knowledge of the law or specific intent to commit fraud." It added this new language: ''(b) With respect to violations of this section, *a person need not have actual knowledge of this section or specific intent to commit a violation of this section*." As a result, many physicians may be charged as criminals for honest mistakes. Honest mistakes or errors should not result in a government crackdown.

TMA Ask: Revisit and/or remove language relating to the Healthcare Fraud Criminal Statue

| *continued on page 44*

Imaging Referrals
There also are additional written requirements regarding MRIs, CTs, and PET scans. Physicians now must inform patients in writing at the time of the referral that they may obtain services elsewhere and provide a list of others who provide such services in the area. Physicians already are required to seek preauthorization for most imaging services. They should not also be required to compile and maintain a list of other imaging providers. If the federal government mandates a list, the government should provide it. More paper, more processes, but where is the health care?

TMA Ask: Revisit the imaging referral provision and remove the arduous paperwork requirement, so physicians can spend more time taking care of patients versus pushing paper.

Antidiscrimination Provisions for Health Plans
The PPACA includes a provision stating health plans may not discriminate against any health care providers — acting within their state scope-of-practice laws — who want to participate in the plan.

TMA Ask: Ensure this provision is not misinterpreted to permit providers who have not been trained as physicians to misrepresent themselves as possessing the education, knowledge and training of physicians.

Restrictions on Hospital Ownership
Throughout the health care debate, the Mayo Clinic, Cleveland Clinics, and Texas' Scott & White Hospitals were held up as the gold standard of how to deliver efficient and high-quality care. All these institutions have one thing in common — they are physician-owned and physician-led. In the future, these types of institutions are banned. A provision in the PPACA (under the guise of "fraud and abuse") actually prevents physicians from establishing hospitals that participate in Medicare. The PPACA makes future hospital ownership illegal for physicians who go to medical school, obtain a license to practice medicine, care for Medicare patients, and then want to refer their Medicare patients to a hospital in which they may have ownership. If a physician had already owned a hospital, the PPACA severely limits how that hospital can expand and operate moving forward.

TMA Ask: Repeal legislation that limits physician ownership of hospitals. Promote responsible ownership of all health care facilities, whether owned by a physician, hospital, or other provider.

Accountable Care Organizations: Fairness
The accountable care organization (ACO) is a new concept in the PPACA. It asks for physicians to invest in a new model of health care delivery that increases efficiencies and delivers the right care at the right time. However, the incentives in the program are left to the whim of federal administrators. A participating ACO can't challenge many government decisions about the performance of an ACO, including:

1. Whether the ACO is eligible to share in any savings it creates,
2. The amount of shared savings to be paid to the ACO,
3. Which patients the government assigns to the ACO,
4. What measurements the government plans to use to determine the quality of care the ACO provides,
5. The government's assessment of the quality of care the ACO provides to patients, and
6. A determination to terminate the ACO from the program.

TMA Ask: ACO rules must be fair and equitable, and must recognize physician leadership on issues related to patient care, quality assurance, and clinical integration. Physicians should not be viewed simply as another source of labor.

Funding for Health Information Technology
The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was part of the American Recovery and Reinvestment Act, provided funding and incentives for physicians to adopt electronic health record technology. As a result, many physician practices have made significant investments in these technologies. They are working to integrate these systems into their practices and meet the "meaningful use" criteria established to receive the financial incentives. However, just as these investments are being made, Congress is considering bills that would repeal or significantly reduce its support for HIT.

TMA Ask: Protect the HITECH Act from repeal. Continue with the current incentive program to help physicians acquire electronic health record systems. This will improve health care in America in so many ways.

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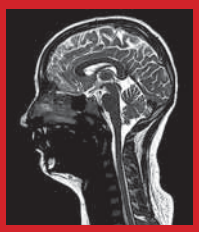

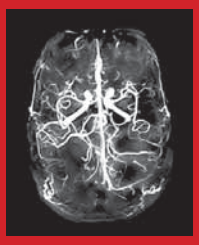

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