# The Affordable Care Act and Academic Surgery: Expectations and Possibilities

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As the Affordable Care Act (ACA) was deemed constitutional by the US Supreme Court and paired with the 2012 re-election of the law's primary supporter, President Barack Obama, it has become increasingly evident that this current health care reform law, in some fashion, is here to stay. Because the shortcomings of this law have been readily publicized and discussed, it is important to further consider the impact and potential benefits that this legislation could have on academic surgery. The ACA was developed with the promise of improving the health of Americans by increasing their access to affordable health insurance coverage and high quality health care.[1] The ACA's means to bring this promise to fruition included expansion of primary care services, reducing health care disparities for minority and underserved populations, mitigating costs, and promoting and rewarding innovation and quality care rendered by providers.

Understanding the plausible positive impact of the ACA on academic surgery has become, and will continue to be, valuable information for all academicians to discern. This piece provides a synopsis of how the ACA affects insurance coverage, health care services rendered, surgical academicians' practices, surgical residency training, and research (Table 1). As opposed to highlighting the conspicuous inadequacies of the legislation (such as failure to address the sustainable growth rate, tort reform, or additional Graduate Medical Education [GME] funding), this document proposes how academic surgery can conceivably thrive and at a minimum, survive, under the provisions of the new health care law.

## I. Reformed and expanded health insurance coverage

### Pre-existing conditions

Beginning in 2014, health insurance companies will no longer be allowed to charge individuals with pre-existing conditions higher rates or deny them coverage.[2] This will affect approximately 129 million US citizens who suffer from a previous ailment who will now harbor the security of affordable health coverage.[3]

### Insurance limits

The ACA prohibits health insurance providers from instituting lifetime or annual limits on patients regardless of the medical circumstance.[4,5] So patients who suffer from chronic conditions that frequently necessitate several surgical interventions and/or hospitalization will not incur undue financial strain. Additionally, there will be new limits placed on waiting periods, copayments, deductibles, and premium yearly increases to help ensure that patients are protected from other means that insurance providers use to seek revenue.[6-9]

### Young adults

The new law affords parents the options to keep their children under age 26 on their family health insurance plan.[10] This is particularly pertinent for young people seeking degrees in medicine; the average age of a graduating medical student is 26. In the ACA's first year of implementation, 3.1 million young adults have gained coverage nationwide due to this provision.[11,12]

### Medicaid expansion

Although now under the discretion of the individual states, the ACA highly encourages the expansion of Medicaid coverage to individuals under the age of 65 (not Medicare eligible) who have an income below 133% of the federal poverty level.[13] In January 2014, this will equate to an annual income of $14,000 for an individual and $29,000 for a family of 4.[14]

### Minimum coverage mandate

Starting in 2014, the ACA mandated that all federal income tax paying citizens maintain minimal essential coverage for themselves and their dependents or incur a financial penalty for each month in which coverage is not maintained.[15] By diminishing the number of uninsured, curtailing adverse selection, and expanding the risk pool in the health insurance market to now include healthy people, this provision aims to reduce insurance premiums. The penalty is capped at $695 annually,

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**Abbreviations and Acronyms**

ACA = Affordable Care Act
ACO = Accountable Care Organization
CMS = Centers for Medicare and Medicaid Services
DSH = disproportionate share hospital
GME = Graduate Medical Education
VBPM = Value-Based Patient Modifier

certain hardship exemptions exist, and credits will be offered to low income individuals and families.[16]

### Insurance marketplace

Previously labeled "exchanges," the ACA introduced a means by which individuals, families, and small businesses can shop for affordable health insurance through a state operated, federally operated, or a dual state-federally operated insurance marketplace.[17] The desired outcome is that insurance premium costs will decline due to a larger number of people contributing to the pool as well as insurance providers now having to "compete" to offer the most competitive rates. It has been estimated that an additional 16 million people will acquire health insurance via Medicaid expansion and another 16 million through the marketplace.[18]

### Changes to disproportionate share hospital provision

The Medicare disproportionate share hospital (DSH) adjustment provision enacted by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 provides for additional payments for hospitals' uncompensated care. Because academic medical centers provide care to a large proportion of the indigent community, they have been reliant on DSH payments to ensure that the hospital maintains its narrow margin of profit. With the aforementioned concerted efforts to decrease the number of uninsured, the ACA has amended the Medicare DSH adjustment provision to now take into account the number of newly insured. Effective for discharges occurring after FY 2014, hospitals will receive 25% of the amount they previously would have received under the current Medicare DSH. The remaining 75% of uncompensated care payments will be distributed but will be adjusted and likely reduced to reflect the increase in the percentage of individuals who now have insurance as a result of the ACA.[19,20] There are concerns over a potential gap between this DSH adjustment and the rate of insurance enrollment, but until the insurance marketplace and the minimum coverage mandates are closer to full implementation it is premature to objectively predict the impact.

## II. Care for patients

### Free preventive services

The ACA now stipulates that private insurance companies provide coverage for and eliminate cost-sharing on certain recommended preventive health services for new or renewing policies as of September 23, 2010.[21] As a result it is estimated that 54 million additional Americans will receive preventive services without the burden of cost-sharing.[22] Thus, mammograms, Pap smears, screening colonoscopies, and several additional screening modalities that previously required a copay or involved a deductible no longer will. The intention is to eliminate one more barriers to prevention and promote early detection of treatable conditions.

### Accountable Care Organizations

Accountable Care Organizations (ACOs) consist of health care providers that accept Medicare patients, agree to partner with other providers, frequently specialists, receive a bundled payment from Centers for Medicare and Medicaid Services (CMS), and split the reimbursement for services rendered.[23] The ACA highly promotes and encourages development of ACOs, touting the benefits of more coordinated, high-quality care that also reduces cost.[24]

### Reducing health care disparities

The new health care law calls for additional efforts to reduce health disparities along ethnic and racial lines as well as to improve in the health of citizens residing in rural dwellings.[25] Additional investments are to be made in data collection research focused on disparities.[26] Further funding is to be provided to enhance the capacity of community health centers that care for a large proportion of the minority community.[27] More emphasis on improving diversity of the health care workforce and strengthening providers' cultural competence is also a provision in the ACA to help alleviate health care disparities.[28]

### Medicare prescription drugs

The ACA reduces out-of-pocket expense for prescription drug coverage (Part D) for Medicare beneficiaries.[29] It reduces, and in some cases alleviates, the gap in coverage previously referred to as the "donut hole." With less out-of-pocket expense and another provision to enhance the medication management in persons with chronic diseases,[30] the ultimate goal is to improve prescription compliance and avoid emergency room visits or subsequent hospitalizations.

## III. Impact on surgical academicians and trainees

### Value-Based Payment Modifier

The ACA established the Value-Based Payment Modifier (VBPM), which will reflect the volume, quality, and cost

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