HEALTH CARE REFORM, REFORMED

What could TrumpCare mean for aesthetic medicine?

BY DENISE MANN

As the results of the 2016 US Presidential election clearly show, change is the only constant. Now that Donald Trump is US President elect, the future of the Patient Protection and Affordable Care Act (commonly referred to as “Obamacare”) is anything but guaranteed.

Whether the new President will repeal the 2010 law and replace it in its entirety or keep some parts and kill others is still largely a point of speculation among pundits, physicians and the general public. (The US Court of Appeals for the D.C. Circuit is, however, delaying a case against Obamacare—House v. Burwell—until President Trump takes office, which would make a repeal easier.)

Americans are divided on what they want to see lawmakers do to the Affordable Care Act (ACA) with one-fourth wanting to see President-elect Donald Trump and the next Congress repeal it while an additional 17 percent want them to scale back what the law does. Thirty percent of the public wants to see the law expanded and 19 percent want it to move forward as it is. These are among the main findings of a November Kaiser Health Tracking Poll, conducted one week after the 2016 presidential election.

There are definitely more questions than answers at this point. “We’re really in uncharted territory here, so it’s difficult to map out how his approach to governing will work when it’s put into practice,” says plastic surgeon Debra Johnson, MD of The Plastic Surgery Center in Sacramento, CA and President of the American Society of Plastic Surgeons (ASPS). “He has significantly softened his rhetoric, so we have to wait and see what will happen as pragmatism sets in.”

DREAM TEAM?

Here’s what we do know so far: Mr. Trump tapped Representative Tom Price as his secretary of health and human services. Dr. Price, an orthopedic surgeon and Republican from Georgia, is vehemently and vocally opposed to of the Affordable Care Act. This appointment, in and of itself, tells us which way the wind is blowing.

The Price bill, the Empowering Patients First Act, would get rid of many key facets of ObamaCare including the government-run insurance exchanges in every state, the mandates on individuals and businesses and federal tax credits to subsidize the insurance of lower income Americans.

Instead, Dr. Price wants fixed tax credits based on age not income which allows individuals to buy insurance policies in the private market and supports expanded use of health savings accounts to allow people to save income before taxes. Dr. Price would repeal Obamacare’s expanded Medicaid coverage in 32 states and the District of Columbia for able-bodied single people.

The ACA expanded Medicaid eligibility, resulting in eight to 10 million people gaining coverage, Dr. Johnson says. “As physicians we are concerned that if these patients become disenfranchised, care will be denied or delayed,” she says. “This does not make America healthier, and delayed care can be an even bigger burden on the healthcare system.”

As with Obamacare, people with pre-existing medical conditions or chronic illnesses won’t be denied coverage under Dr. Price’s plan. That said, individuals must have had continuous insurance for 18 months before choosing a new policy. He would also likely provide grants to states to insure the “high-risk” population. (Mr. Trump also wants to keep the popular provisions of Obamacare, namely allowing 26-year-olds to remain on their parents’ plan and barring restrictions based on pre-existing conditions.)

Mr. Trump also chose healthcare consultant Seema Verma, MPH to run the Centers for Medicare & Medicaid Services (CMS). “Together, Chairman Price and Seema Verma are the dream team that will transform our healthcare system for the benefit of all Americans,” Mr. Trump said in a statement.

WHAT’S AT STAKE?

Front and center in some doctors’ minds is likely the status of MACRA under TrumpCare. In April 2015, Congress repealed the Sustainable Growth Rate formula by passing
MACRA. In essence, MACRA aims to shift physician payment so that it rewards value and quality over volume via the creation of the Quality Payment Program (QPP). The QPP offers two pathways for reimbursement: The Merit-based Incentive System (MIPS) and Advanced Alternative Payment Models (APM). (MIPS comprise the Physician-Value Based Payment Modifier, Physician Quality Reporting System and the Medicare EHR Incentive Program).

Some of MACRA is tied up in the ACA, but it is likely safe, experts tell Modern Aesthetics. A repeal or delay of MACRA is unlikely given the overwhelming bipartisan support. As opposed to the ACA, MACRA passed the house 392-37 and the Senate by 92-8. "I'm not sure there will be much appetite to change anything with that kind of bipartisan support...but some people feel that with this election result, all bets are off," says Mark D. Kaufmann, MD, an associate Clinical Professor of dermatology in the department of Dermatology at the Icahn School of Medicine at Mount Sinai in New York City.

"We're hopeful that when Secretary of Health and Human Services Dr. Tom Price is confirmed, he'll approach the regulatory process from a physician's perspective and how MACRA impacts patient care and managing a practice," adds Dr. Johnson. "There's a disconnect between the overall vision for a federal reimbursement system that rewards high-quality, high-value care and the reality of the tools in place to implement that system. Because MACRA is budget-neutral, there will be winners and losers, even if every physician is providing quality care, so the system remains unfair."

There are other issues that are important to doctors and may or may not be on the chopping block in the Trump administration.

For example, "dermatologic surgeons favor repeal of the Independent Payment Advisory Board (IPAB)," says Thomas E. Rohrer, MD, of Skin Care Physicians of Chestnut Hill and the President of the American Society for Dermatologic Surgery and the American Society for Dermatologic Surgery Association. Created by ACA, the IPAB is a government board that is charged with cutting Medicare spending once it reaches an arbitrary level. "Such significant health care decisions should not be made by Presidential appointees who have little to no clinical experience and who are not subject to administrative or judicial restraint," he says. "It is predicted that the IPAB will go into effect in 2017, decreasing provider reimbursement without appropriate oversight, stakeholder input or transparency."

He adds that if the IPAB fails to report recommendations, this responsibility will rest in the hands of the Secretary of the Department of Health and Human Services. "It should be the responsibility of the Congress to create policies that meet the needs of their constituents and design a health care system that can respond to their diverse communities."

Dr. Johnson is on board with repealing IPAB. "We will continue to lobby for the repeal of IPAB, which is unfair to physicians and removes some important budgetary control from Congress," she says.

In addition, "we feel medical liability needs to be reformed. The administrative and regulatory burden doctors face is a huge impediment to running a practice and needs to be streamlined," she says. "We believe Medicare beneficiaries should be able to contract for services from any doctor they choose, even a doctor out-of-plan, and they should receive the allowed Medicare reimbursement for that service, just like many other health plans."

ASDSA members are also concerned about the way the Centers for Medicare and Medicaid Services (CMS) has handled the coding for physician payment, particularly related to the global surgery codes and requirements as set forth in the 2017 Medicare Physician Fee Schedule final rule, Rohrer says. "The ASDSA will continue to work for a fair global surgical package and we hope to work with the incoming Administration to help physicians spend more time with patients and less time on administrative work."

Another sticking point for ASDSA members is the FDA's interpretation of the Drug Quality and Security Act ("DQSA", P.L. 113-54). "This has been interpreted narrowly by the FDA, and therefore limits our physicians in providing timely care to their patients," he says. "ASDSA, along with other medical and pharmaceutical societies, have worked together to make drug compounding a safe in-office practice while ensuring patients have access to these medications without being hindered by government rules."

There's a lot at stake, he says. "Dermatologic surgeons need to stay active politically, donate to worthy candidates and make themselves available to advocate for their patients whether it be legislative, regulatory or other quasi-governmental bodies who seek to influence healthcare."

Plastic surgeons also need to step up their advocacy efforts, Dr. Johnson adds. "Via plasticsurgery.org, members can read about current legislative issues and access a link to contact their legislators," she says. "We have a weekly e-blast 'Advocacy Matters' to keep members informed and we host Legislative Fly-Ins where members descend on Washington to discuss issues with their representatives."

In June 2017, ASPS will host an advocacy summit that will bring about 100 plastic surgery advocates to the capital. "Our political action committee—PlastyPAC—is funded by member donations and uses the funds to contribute to congressional candidates friendly to our issues," she says. "The ASPS Legislative Advocacy Committee is one of our most important as its members evaluate key issues and determine our Advocacy approach."