Patient Protection and Affordable Care Act or *Obamacare:* Which Is the Better Descriptor?

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It has now been 2 years since Congressional passage of the most comprehensive revamping of our medical care system since the advent of Medicare in 1965. It has elicited a storm of grassroots protest, even more than what was generated by the attempt in 1993 by Hillary Clinton and Congress to create similar changes. The ultimate defeat of that effort probably lay more with intense promotion of opposition from the pharmaceutical industry, whereas the current protests seem to arise more from the widespread distrust of government intrusion into health care. The term "Obamacare" is used by many in this country to reflect the belief that this effort places far more control of health care in the hands of the government than they would choose. In their view, it takes away the ability of doctors and patients to choose the kind of medical care they think best.

One of the centerpieces of the bill is a requirement that everyone purchase health insurance, with governmental premium support for those who cannot afford to purchase a policy. This requirement has been used in Switzerland (a country that also has many medical care insurance companies) for many years, with required premiums and copayments. Just as with Social Security deductions in this country, money is taken out of every citizen's wages and each person can then choose to which company the money is paid. In the United States, to enforce this mandate, more than 17,000 Internal Revenue Service agents have already been hired, adding greatly to its cost and increasing public perception that it represents government intrusion and a "takeover" of our medical care system. In addition to cost considerations, there are philosophical issues of freedom of choice in this mandate, with opposition that has led to conflicting opinions in several court cases. The Supreme Court will hear the issue of the constitutionality of this particular measure and make a decision by June of 2012.

Another controversial part of the bill is the creation of Comparative Effective Research groups, which would have the goal of evaluating new devices, drugs, and other therapies so that physicians could benefit from expert opinion when deciding what is the best medicine in these areas. Although the groups would be composed of physicians, some in Congress are still concerned that such groups could become politicized, and that analysis may in some way be influenced by cost, which is anathema for any politician to state. Specific prohibitions in the bill are intended to prevent that occurrence.

One of the provisions of the bill perhaps most disliked by physicians is the 15-person Payment Performance Advisory Commission (PPAC), which would become a

uniquely powerful group whose mandate is solely to constrain the costs of Medicare. The concern is that this would be accomplished by cutting provider reimbursement even further than it has been. This has also given rise to the fear of "death panels," as some have thought that life-saving therapies would be denied to the sickest people, under the guise of saving money. The power of this group lies in the vast sums over which it will have control—far greater than the entire Pentagon budget.

The matter of mandates issued to state governments has tremendous influence on what this entire program will cost. Mandated coverage for everyone without regard to health status, and community ratings (which make the cost for every person in an area the same for insurance), have increased the cost of insurance in each area in which they have been utilized. Beyond this, requiring that birth control and much preventive care be free at the point of delivery to the patient causes further increase in premiums. These types of requirements, in addition to the greatly increased use of medical care in patients given it as an entitlement, have been responsible for the vast cost overruns seen in medical care in this country. After 6 years, the current health care legislation in Massachusetts costs nearly twice what was projected, and Medicare itself, in the first 10 years of its existence, cost 10 times the original projection. Douglas Holtz-Eakin, a prior head of the Congressional Office of Management and Budget, estimates that full implementation of the act will cost an extra $500 billion in the first decade, and more thereafter.

There are many innovative points in the legislation, including payment on the basis of quality measures rather than volume of services, and encouraging choice among both hospitals and physicians regarding how they are paid. Opinion among physicians seems mixed with regard to these issues. Many, especially those in solo practice or small groups, are worried about loss of autonomy, the loss of close relationships with many patients they have known for years, and a loss of a reasonable income.

The *New England Journal of Medicine*, in its February 9, 2012 issue, points out that the fate of the PPAC depends on four events:

1. State legislators must pass regulations for commercial mandates, Medicaid coverage, and exchanges by the end of summer 2012, or the regulations will be made by the federal government.
2. The Supreme Court decision on the mandate will come in June 2012.
3. By June 29, 2012, each state must apply for a health insurance exchange.
4. Election Day in November 2012. The implications of that are obvious.

This act is highly controversial and divisive. If implemented in its entirety, it will radically change much of health care delivery in this country. The costs of many of the provisions have tremendous financial implications. It is a work in progress, and political events will guide much of its future. ■

Communicating Benefits: Interest Required

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As our term as Governors comes to an end in March, 2012, it is time to reflect on our challenges and accomplishments. We will be leaving a healthy and strong Chapter—one of the finest in the American College of Cardiology (ACC) family. When we came into office in March, 2009, we had 3112 members (2597 physicians, 262 cardiac care associates, 249 fellows in training, and four practice administrators). Currently, we have 3326 members (2713 physicians, 278 fellows in

training, 297 cardiac care associates, and 38 practice administrators). By partnering with other professionals, in 2009 we were awarded the ACC Award for Education and an honorable mention in the areas of Quality, Membership, and Advocacy. In 2010, we received the Spirit of Excellence of Membership. In 2011, we won the Spirit of Excellence in Education and the ACC Award for Membership Involvement. The California Chapter of the ACC (CA ACC) continues to have 40 partner meetings per year throughout the state. We have 31 councilors who represent our state membership and have revamped our council elections during our tenure. In addition, we have worked diligently to improve the visibility of the Chapter; improve communication with our membership; nurture our relationship with our twin organization, the British Cardiovascular Society; and create traditions such as three Chapter Council meetings per year. The CA ACC holds a legislative meeting in Sacramento in March, a midyear meeting in June during the West Coast Cardiovascular Forum in San Francisco, and the annual Chapter meeting in Beverly Hills in conjunction with the *Controversies and Advances* symposium. CA ACC leadership has also participated in quality initiatives in the state, such as the California Physician Performance Initiative and the Elective Percutaneous Coronary Intervention Oversight Committee.

Our major challenges have been in the arena of communication and member apathy/noninvolvement, in spite of extensive communication from leadership via multiple means. We implemented a policy to send more personalized emails with individual photographs. We have communicated via quarterly chapter newsletters sent via email, facsimile, and US mail. We also have a robust Web site, which is updated frequently. We published our fourth edition of the CA ACC member roster, which is larger and more valuable than ever. We have encouraged councilors to hold regional meetings in the state to convey information to local membership and get feedback from the membership at the grassroots level.

In our quest for improved communication, we embarked on a relationship with *Reviews in Cardiovascular Medicine* (RICM). Dr. Norman Lepor and Dr. Peter McCullough graciously donated three pages of each RICM issue to highlight Chapter and ACC matters. This relationship was conceived as a communication portal. Many of our colleagues across the country have read and commented on these articles. One of the earliest published articles was about recertification, on which we received feedback from the American Board of Internal Medicine staff. We encouraged our British colleagues to contribute to RICM, and they have supplied excellent pieces that have given us insight into the British perspective on cardiology issues.

It has been our privilege to represent our state to the ACC at the national level. It will be my ongoing privilege to be the Chair of the Board of Governors for 1 year and I look forward to representing us nationally. We leave a healthy California Chapter in the capable hands of Dr. William Bommer (Sacramento), who will be the Northern California Governor and President for the first 18 months, and Dr. John Gordon (San Diego), who will be the Southern California Governor and President for the last 18 months of their 3-year term.

Thomas Jefferson, the third President of the United States, said, "We in America do not have government by the majority. We have government by the majority who participate." This is also true for the CA ACC: we have a Chapter by the majority who participate. We hope you decide to participate in whatever form you can and we hope you continue to read the CA ACC News section of RICM. The California Chapter, like all Chapters of the ACC, and the ACC itself, is working diligently for its members. ■

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