

**Health Care Coverage, Capacity and Cost: *What Does the Future Hold?***

**A Report from America's Internists on the State of America's Health Care**

**January 27, 2011**

**Introduction**

The United States is facing an unprecedented crisis in access to care and rising health care costs:

- The Great Recession demonstrated that growing numbers of Americans no longer can rely on health insurance coverage from their employers. Employer-sponsored health insurance has been declining for almost a decade, but the recession accelerated the drop-off in companies offering coverage. There are more uninsured than ever, while millions more rely on under-funded public safety net programs.
- Demand for health care services is rising, yet the capacity of the health care system to meet such demand is in question because of a continuing shortage in some physician specialties, most notably, primary care physicians for adults.
- The cost of health care poses the greatest single threat to the fiscal health of the United States, yet the polarization of national discourse has stood in the way of having a serious conversation about conserving and allocating limited health care resources in a way that is in accord with American values.

Even as the U.S economy appears to be entering a period of modest economic growth, the country will still be facing the underlying challenges of a health care system that is failing to meet the needs of tens of millions of Americans and that costs more than the country can afford.

The Affordable Care Act (ACA) has *essential* policies to address the challenges of rising cost, inadequate capacity and coverage:

- By 2014, the legislation will make coverage available to nearly all Americans.
- The legislation begins to address the shortage of primary care physicians by reforming payment systems and by funding of primary care training programs, although additional initiatives likely will be needed to reduce the barriers to primary care.
- It funds pilots of innovative payment and delivery systems and research on comparative effectiveness that may begin to “bend the cost curve” yet most experts agree that further steps will be needed to reduce per capita health care spending.

Yet the future of the ACA is at risk because of efforts at the national and state levels to repeal or defund it and by challenges to its constitutionality.

This report from America's internists:

- Describes the challenges the United States faces in providing affordable health insurance coverage for all, ensuring that the system has the capacity to meet the growing demand for health care, and controlling costs.
- Discusses how the ACA begins to address these challenges and the necessity of preserving, building upon, and improving its essential policies to expand coverage, increase health care capacity, and address rising costs.
- Recommends improvements in the ACA, including changes that have the potential of attracting bipartisan support.
- Presents the recommendations of the American College of Physicians (ACP) for building upon the ACA's reforms to create a better health care system for all Americans, including release of a groundbreaking ACP position paper on conserving and allocating limited health care resources in accord with distinctly American values.

Instead of turning away from the ACA's promise of ensuring access to affordable health insurance to nearly all Americans, ACP believes that Congress should seek bipartisan common ground on making improvements to it, including giving states more freedom earlier to implement the coverage expansions in a way that best meets their own needs. We are encouraged that in Tuesday's State of the Union address to Congress, President Obama expressed a willingness to consider "ideas about how to improve this law by making care better or more affordable." In this report, ACP offers its own ideas for *sustaining and improving* on the ACA's essential policies to expand coverage, address primary care workforce capacity, and begin to bend the cost curve.

### **I. State of the Nation's Health Care: Coverage**

If the Great Recession has taught us anything, it is that Americans no longer can count on private, employer-based health insurance coverage, especially at times of great economic crisis:

- In 2009 (the most recent year for which data are available), percentage of Americans with health insurance declined—the first time this has occurred since the Census Bureau began surveying people about health insurance more than two decades ago.<sup>1</sup>
- Fewer people had health insurance through their jobs, accelerating an almost decade-long decline in the percentage of the population covered through their employer.<sup>2</sup>
- The number of uninsured persons reached an all-time high, with almost 51 million people having no health insurance coverage<sup>3</sup> and 59 million being without health insurance at least part of the year.<sup>4</sup> Just about every demographic group and area of the country reported having more uninsured persons, more were from middle-class families, and many had had chronic illnesses.<sup>5</sup>

- More Americans than ever relied on the under-funded Medicaid program: in 2009, almost 4 million more people signed up for Medicaid, the biggest increase since Medicaid was created more than 45 years ago.<sup>6</sup>

Until 2014, when the ACA will provide nearly all Americans with access to affordable health insurance coverage, “it is likely that employer-sponsored insurance will continue to decline because premiums will almost certainly grow faster than wages and salaries, and the number of uninsured people is likely to increase.”<sup>7</sup>

The ACA will ensure that Americans won’t have to worry about losing their health insurance the next time the country experiences an economic downturn. The ACA does this by “largely end[ing] the link between employment loss and insurance coverage”<sup>8</sup>:

“After 2014, self-employed Americans and most workers in small firms will be able to purchase coverage through insurance exchanges. Those with low incomes as well as those who experience severe income losses will be eligible for tax credits to subsidize the cost of coverage. The Medicaid expansion will add comprehensive coverage at little or no cost for the lowest-income adults. Both the Medicaid expansion and the tax credits will help solidify the safety net and prevent the erosion of coverage among adults in future economic downturns. As such, these provisions of health reform will constitute a critical contribution to enhancing the economic security of all Americans.”<sup>9</sup>

What happens if the ACA’s coverage expansions are repealed? According to the most recent analysis by the Congressional Budget Office (CBO):

- Repeal would leave 32 more people without health insurance; only 83% of U.S. legal residents—about the same rate as today – would be covered – compared to 94% under the ACA.
- Many people who have health insurance would pay more for it. If the ACA is repealed “on average . . . many people would end up paying more for health insurance coverage -because under [the ACA], the majority of enrollees purchasing coverage in that market would receive subsidies via the insurance exchanges, and [repeal] would eliminate those subsidies.” Premiums for employment-based coverage from large employers would be “slightly higher” under repeal than under the ACA but slightly lower in the individual group market.”<sup>10</sup>

Lack of health insurance can be a matter of life and death. Studies show that:

- Uninsured persons are less likely to see a physician for a medical problem, receive follow-up care, get a prescription filled, or see a specialist when recommended by their physician.<sup>11</sup>
- People with chronic illnesses are less likely to get needed care. “Among persons aged 18 to 64 years with diabetes mellitus, those who had no health insurance during the preceding year were 6 times as likely (47.5% vs. 7.7%) to forgo needed medical care as those who were continuously insured,” reports the Center for Disease Control and Prevention.<sup>12</sup> [Emphasis added].

- Being without health insurance leads to tens of thousands of premature deaths annually and unnecessary suffering.<sup>13</sup>

It is essential that Congress preserve and fund the ACA's policies to ensure that nearly all Americans have access to affordable coverage. At the same time, the legislation can be improved by giving states more options earlier to design their own approaches to covering their residents.

**ACP's recommendations on Health Insurance Coverage:**

**1. The ACA's coverage expansions should be retained and as needed improved and expanded--not repealed. Such essential policies include, but are not limited to:**

- **Prohibiting insurance companies from denying, rescinding or charging excessively more to people with pre-existing conditions.**
- **Covering young adults up to age 26 on their parents' plans.**
- **Helping people up to 400% of the federal poverty level (FPL) afford coverage through sliding scale tax credits linked to income.**
- **Helping small businesses afford coverage through tax credits and access to lower-cost insurance through state purchasing pools (state health exchanges).**
- **Giving families and businesses more choices of insurance through state health exchanges.**
- **Requiring insurers to provide coverage for preventive services and other medical interventions that the evidence shows are effective.**
- **Establishing a single eligibility standard for Medicaid at 133% of the FPL and providing more federal dollars to the states (initially, 100% of the cost) so that they can afford to enroll more people in the program.**
- **Requiring individuals and large businesses to participate in the insurance pool and to contribute to coverage instead of shifting costs to others.**

These policies are at the heart of the ACA and any effort to repeal, defund, or weaken them would result in tens of millions more Americans not having access to affordable coverage that covers the treatments and tests they need.

**2. Congress should consider giving states an earlier option to design their own systems to cover their residents, as proposed by the bipartisan Empowering States to Innovate Act, introduced in the 111<sup>th</sup> Congress by Senators Ron Wyden (D-OR) and Scott Brown (R-MA).**

States have diverse populations and political traditions, and state governors and legislatures should have the ability to choose their own course for ensuring coverage to all residents, within federal guidelines to ensure they provide access to comprehensive coverage to all (or nearly all) of their residents.

The Empowering States to Innovate Act would amend the ACA by moving up by three years (from 2017 to 2014) the effective date when states may seek waivers to establish their own plans to provide access to affordable coverage for their residents. They would be able to opt out of certain provisions through a waiver process, similar to that of Medicaid or CHIP, as long as the state proves it can provide health coverage at the same level as enacted in the ACA and that all residents will have coverage, among other things. To be granted a waiver, states must show that they will provide coverage that is at least as comprehensive as the coverage defined by the ACA and offered through the Exchanges, will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of the ACA, provide coverage to at least a comparable number of its residents as the ACA would provide; and will not increase the Federal deficit. States that are granted waivers would receive the same amount of federal funding to expand coverage as they would have received without a waiver.

The Empowering States to Innovate Act would give the states the ability to experiment with the best way to expand coverage, as long as they could achieve comparable or better results than the ACA's exchanges. Some states might prefer to implement a more market-based approach; others may prefer to have a stronger role for public plans, such as by offering a public option or even a single payer plan. States with existing programs, like Massachusetts, could seek a waiver to preserve the key parts of their own law without having to adapt them to satisfy many of the ACA's specific mandates. The Empowering States to Innovate Act also could provide the basis for achieving bipartisan common ground, by providing more freedom earlier for states to chart their own paths, as traditionally advocated by many Republicans, while preserving the promise of near universal coverage, as advocated by many Democrats.

**3. Congress should also consider advancing the date by which states can enter into a regulatory agreement to allow the sale of health insurance across state lines.**

The ACA allows health insurers to sell health plans across state lines, if the states involved can agree on a regulatory structure to protect consumers subject to federal rules to ensure that the plans are solvent and have other needed safeguards. But, this authority doesn't go into effect until 2016. ACP believes that this authority could be advanced to 2014, effective at the same that the state health exchanges must become operational.

The idea of selling insurance across state lines has been championed by many Republicans and some Democrats. ACP agrees that such authority could provide additional affordable options for some people in the small group or individual insurance market. At the same time, ACP believes that it is essential that such plans be subject to sufficient – not excessive – federal requirements to protect consumers, and the states involved need to agree on a regulatory structure for such plans, as the ACA requires. Absent such a state regulatory compact, consumers could be at risk if they encounter problems with a particular out-of-

state plan but have no recourse to their own state's insurance commissioner and consumer protection laws.

## **II. *State of the Nation's Health Care: Capacity***

Ensuring that all Americans have affordable health insurance coverage is essential, but insurance coverage alone does not guarantee access to care in the absence of well-trained physicians and other clinicians to provide the care that they need.

- The United States is facing a growing shortage of physicians in key specialties, most notably in general internal medicine and family medicine—the specialties that provide primary care to most adult and adolescent patients.
- A recent study projects that there will be a shortage of up to 44,000 primary care physicians for adults,<sup>14</sup> even before the increased demand for health care services that will result from near universal coverage is taken into account.
- The Commonwealth of Massachusetts has been able to achieve coverage for nearly all of its residents, but shortages of primary care physicians have led to long waits for appointments.<sup>15</sup>

A new report details the potential impact of many of the ACA's policies to begin to address the crisis in primary care.<sup>16</sup> Yet even with such policies, the United States will likely continue to face a shortage of primary care physicians for adults, as well as shortages in other critical physician specialties, but this shortage will be much more severe if the ACA's policies to ensure adequate workforce capacity are under-funded or repealed.

### **ACP's recommendations on capacity:**

- 1. Congress should fully fund, at no less than the authorized levels set by the ACA, essential "discretionary" programs to ensure a sufficient and well-trained primary care workforce. Such essential policies include but are not limited to:**
  - **Providing incentives to primary care physicians through the National Health Services Corps scholarship and loan repayment programs to practice in Health Professional Shortage Areas to ensure access to care to millions of Americans.**
  - **Training more primary care physicians through the Title VII health professions programs.**
  - **Funding for a national commission on workforce to align federal health care resources with societal needs, including examination of barriers to primary care.**
  - **Grant programs to support adoption of Patient-Centered Medical Homes (PCMH), to assist states in workforce planning, and to help establish residency programs at teaching health centers.**

ACP recognizes that Congress and the Obama administration are committed to reducing funding for discretionary programs that do not achieve sufficient value, an objective we support, but studies show that investment in primary care is essential to achieving a highly performing, efficient and effective health care system. An ACP analysis of over 100 annotated research studies show that the availability of primary care physicians in a community is positively associated with better outcomes and lower costs of care.<sup>17</sup> Other studies show that care delivered through primary care physician-led Patient-Centered Medical Homes can result in improved outcomes and reduced costs.<sup>18, 19</sup>

The programs under Title VII of the Public Health Service Act have proven to positively affect primary care, rural placement and minority opportunities. The Title VII Training in Primary Care Medicine and Dentistry grant program has been the most important federal intervention to help build and maintain the primary care medical and dental training infrastructure in this country. A study published in Academic Medicine compared students in a Title VII-supported medical education program with those in a traditional medical program and found that 86% of Title VII graduates plan to work in an underserved community, compared with 20% of graduates from a traditional medical program.<sup>20</sup> Another study found that residents in general medicine, family medicine, and pediatrics, who received their training in residency programs that had Title VII grant funding, reported being prepared to provide cross-cultural care across all 8 measures and feeling more skilled in cross-cultural care for 6 of 10 measures. This outcome significantly exceeded the self-reported skills and confidence in cross-cultural care by residents trained in programs that did not receive Title VII funding.<sup>21</sup> While the College was pleased to see a significant increase in funding for Title VII in the ACA, this funding is quite vulnerable as it is subject to annual appropriations. Title VII programs deserve a stable, robust funding source so that they can continue to fulfill the goals that have been set for them.

**2. Congress should support the ACA's programs to reform payment and delivery systems to recognize the value of primary care, including but not limited to:**

- **Preserving the Medicare Primary Care Incentive Program. This program begins to address inequities in payments for primary care by providing a 10% bonus payment, in addition to the usual Medicare fee schedule amount, for designated primary care services provided by internists, family physicians, geriatricians, and pediatricians.**
- **Ensuring that Medicaid payments to primary care are no less than the Medicare rates. Congress should begin to explore ways to re-authorize funding for the program beyond the January 1, 2015 expiration date.**
- **Supporting the Center for Medicare and Medicaid Innovation, including its emphasis on funding pilot programs to reform and improve payments for primary care.**
- **Redistributing unfilled residency positions to primary care and general surgery training programs.**
- **Giving states the option to enroll patients in primary care medical homes.**

Studies show that the disparity in payments between primary care and other specialties is a principal barrier to physicians entering and remaining in primary care specialties<sup>22</sup> and that low Medicaid payment

rates, particularly for primary care, is a major reason why substantial numbers of physicians in many states do not participate in Medicaid or limit how many Medicaid patients they will see.<sup>23</sup>

The ACA's provisions to increase Medicare and Medicaid payments to primary care are a good start in addressing such barriers. They will increase primary care payments under Medicare and Medicaid and pilot-test new models, to provide incentives for care coordinated by primary care physicians, such as through a PCMH. These provisions will help to increase the primary care physician workforce. In addition, the improved primary care payments and the potential benefits of new payment models will increase the ability of primary care practices to invest in the infrastructure required to provide more patient centered care, and care that is more effective and efficient. They need to be preserved, and as necessary expanded, to ensure a robust primary care foundation within our healthcare system.

Despite the strong disagreements between Republicans and Democrats on many aspects of the ACA, support for primary care training has a long legacy of bipartisan support. When Republicans were in control of the 109<sup>th</sup> Congress, legislation was enacted to require that Medicare initiate a demonstration project to enroll Medicare patients in Patient-Centered Medical Homes. Both parties have long supported the need to improve and reform payment policies to support the value of primary care and to fund primary care training programs.

Ensuring access to a primary care physician is not a Democratic or Republican issue, but the right thing to do for patients and constituents. ACP is hopeful that such programs will continue to have bipartisan support in the 112<sup>th</sup> Congress.

**3. Congress should enact additional legislation to facilitate additional payment and delivery system reforms to recognize and support the value of care provided by internists and other primary care physicians, including:**

- **Repealing the Medicare Sustainable Growth Rate (SGR) formula and replacing it with a new framework that provides predictable, positive and stable updates for all physician services and protects primary care from experiencing cuts in payments due to increases in utilization in other physician services. This could be accomplished by one or more of the following options, potentially in combination with each other: (1) setting a floor (e.g. at no less than the percentage annual increases in the cost of delivering services) on payment updates for primary care services, (2) providing higher spending targets for primary care than other category of services, should Congress decide to replace the SGR with separate spending targets for distinct categories of services,(3) exempting practices that are organized as PCMH, and that are recognized as such by a process established by HHS, from payment reductions in any given calendar year and (4) exempting primary care services from budget neutrality adjustments resulting from changes in relative values and behavioral offset assumptions.**
- **Ensuring that the Workforce Commission established by the ACA has the resources required to examine barriers to primary care as required by the law.**
- **Ensuring that the Center on Medicare and Medicaid Innovation has the resources required to fund pilots to reform and support primary care as required by the law.**

Although the ACA takes important steps to reform payment and delivery systems to support the value of primary care, more needs to be done. Rep. Jim McDermott, a physician, writes in the *New England Journal of Medicine* that “our foremost task this year must be to develop a strategy to ensure the sustainability of our primary care system” and observing that “we have long known that ready access to high-quality primary care permits timely and cost-effective intervention for many health conditions . . . but access is unreliable for many people in our disordered system.” He proposes payment reforms similar to the ACP recommendations presented above.<sup>24</sup> The House of Representatives enacted legislation in the 111<sup>th</sup> Congress to provide higher spending targets and updates for primary care and preventive services but the legislation was never taken up by the Senate. Recognition that reimbursement policy must recognize the value of primary care is hardly limited to Democratic members of Congress. The 2008 Republican health care platform states that “We believe in the importance of primary care specialties and supporting the physician’s role in the evaluation and management of disease.”<sup>25</sup>

### ***III. State of the Nation’s Health Care: Cost of Care***

Rising health care costs are the greatest single threat to the nation’s fiscal health<sup>26</sup> and the economic well-being of American families. Premium increases threaten to put affordable health care out of reach for many Americans, including many middle-class families.<sup>27</sup> And despite a recent and temporary slowing of health care spending increases due to the Great Recession, total spending on health care is expected to double within the next decade.<sup>28</sup>

The ACA will authorize and fund programs that have the potential to “bend the cost curve” including research on comparative effectiveness, support for shared decision-making, pilots of innovative delivery systems, and investments in primary care, wellness and prevention.

Yet experts disagree on how much of an impact such programs will have. The CBO estimates that the ACA will result in a modest increase in total national health expenditures, but have an overall positive impact on the deficit because revenue increases and reductions in payments to hospitals and certain other providers will exceed the law’s mandatory spending.<sup>29</sup> The CBO’s estimates have been challenged by Republicans and other critics as assuming levels of savings that will not realistically be achieved.<sup>30</sup> Other experts assert that the CBO has under-estimated the potential cost savings.<sup>31</sup>

#### ***ACP Recommendation on Cost:***

- 1. Congress should support and build upon the programs in the ACA that have the greatest potential to “bend the cost curve” including but not limited to:**
  - **Funding of comparative effectiveness research through the Patient-Centered Outcomes Research Institute and development of shared decision-making tools.**
  - **Funding of care delivered through Patient-Centered Medical Homes.**
  - **Funding of a new Center for Medicare and Medicaid Innovation to pilot new models to align incentives with the value of care provided.**
  - **Authority for the Secretary of HHS to ensure the accuracy of Medicare’s relative value scale through new and existing processes.**

- **Requiring insurers to spend more on direct patient care and less on administration.**
- **Investments in primary care, prevention and wellness.**
- **Pilot-testing of Accountable Care Organizations (ACOs).**
- **In addition, Congress should preserve funding authorized under the American Recovery and Reinvestment Act (ARRA) that supports implementation of Electronic Health Records (EHR) throughout the healthcare system.**

Critics of the ACA who argue that it doesn't do enough to "bend the cost curve" shouldn't support elimination of the very programs created by the legislation that have the greatest cost-saving potential. Investments in comparative effectiveness research and shared decision-making, in particular, offer the hope of beginning to reduce the enormous costs associated with misuse and over-use of treatments that have limited or no value to patients. As much as \$700 billion of health care spending *per year*, 5 percent of the nation's GDP, *is* wasted on tests and procedures that do not improve health outcomes.<sup>32-33</sup> Comparative effectiveness research would provide physicians and patients with the information that they need to make informed choices of different treatment options, improving patient care and reducing unnecessary health care spending. Research has shown that decision aids improve people's knowledge of options, create realistic expectations of benefits and harms, reduce difficulty with decision-making, and increase participation in the decision-making process.<sup>34</sup>

The preservation of funding to promote EHR implementation is critical, not only for cost savings, but also for improvements in care quality and safety. These funds are being used to provide incentives to physician practices to implement EHRs, to establish Regional Extension Services to help practices accomplish this implementation, and to establish regional Health Information Exchanges to promote the communication of healthcare information among providers. The benefits of increased adoption of EHRs, besides lowering costs, include improved communication and coordination among clinicians, reduced unnecessary and inappropriate tests and procedures, and an increase in the availability of current evidence-based information at the point-of-service to help inform clinical decisions.<sup>35,36</sup>

## **2. Congress should enact more effective medical liability reforms, including caps on non-economic damages and a national pilot program on health courts.**

ACP is heartened that President Obama said in his State of the Union address that he is willing to "look at other ideas to bring down costs, including one that Republicans suggested last year -- medical malpractice reform to rein in frivolous lawsuits." We agree with the President and Republican (and many Democratic) members of Congress that more needs to be done to address the enormous costs of defensive medicine.

The ACA authorizes grants for state programs to improve patient safety and test alternative to the traditional medical liability tort system. Although such grants may help identify effective ways to improve patient safety and reduce the costs of defensive medicine, the ACA did not do enough to address the costs of defensive medicine and to ensure that patients who are truly injured by medical negligence get the compensation they need for their injuries.

Although estimates of the cost of defensive medicine vary, one recent study estimates the cost at \$55.6 billion annually<sup>37</sup>—more than half of the estimated annual federal spending under the Affordable Care Act. \$55 billion could free up funding to provide coverage to many millions of Americans, to fund other needed programs, and/or to reduce the federal budget deficit. Other experts believe that the cost of defensive medicine is much higher.

Tort reform and changes in legal standards concerning professional liability are needed to remove a major impediment that inhibits physicians from responsibly ordering tests and procedures based primarily on clinical and cost-effectiveness in accord with practice guidelines.

ACP supports proven reforms to reduce the costs of defensive medicine, including caps on non-economic damages and limits on attorneys' contingency fees. We are one of more than 100 physician membership organizations that have endorsed H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act of 2011." Introduced by Rep. Phil Gingrey, the bill includes caps on non-economic damages and other reforms that have been proven to reduce the costs of defensive medicine.

In addition, ACP believes that health courts offer a promising approach that should be broadly tested nationwide. Under today's judicial system, judges and juries decide medical malpractice cases with little or no medical training. The majority of medical malpractice cases involve very complicated issues of fact, and these untrained individuals must subjectively decide whether a particular provider deviated from the appropriate standard of care. Therefore, it is not at all surprising that juries often decide similar cases resulting in very different outcomes.

The concept of health courts (also called "medical courts") is a specialized administrative process where judges, without juries, experienced in medicine would be guided by independent experts to determine contested cases of medical negligence. The health court model is predicated on a "no-fault" system, which is a term used to describe compensation programs that do not rely on negligence determinations. The central premise behind a no-fault system is that patients need not prove negligence to access compensation. Instead, they must only prove that they have suffered an injury, that it was caused by medical care, and that it meets whatever severity criteria applies; it is not necessary to show that the third party acted in a negligent fashion.<sup>38</sup>

### **3. Medical professional societies should take the lead in developing guidelines based on the best available evidence to reduce misuse and over-use of diagnostic tests and treatments and promote adoption of such guidelines by their members.**

Although the federal government has a role in supporting research on comparative effectiveness and shared decision-making aids, the medical profession itself needs to do more to address misuse and overuse of diagnostic tests and treatments. ACP has launched the *High-Value, Cost-Conscious Care Initiative*, a broad program that connects two important priorities for ACP: helping our physicians to provide the best possible care to their patients, and simultaneously reducing unnecessary costs to the health care system.

This initiative will provide physicians and patients with evidence-based recommendations for specific interventions for a variety of clinical problems. The *Initiative* will assess benefits, harms, and costs of

diagnostic tests and treatments for various diseases to determine whether they provide good value – medical benefits that are commensurate with their costs and outweigh any harm. The February 1, 2011 issue of the *Annals of Internal Medicine*, ACP’s peer-reviewed, flagship journal, will publish two important papers related to the *High-Value, Cost-Conscious Care Initiative*.

**4. Policymakers, including Congress and President Obama, should join with the medical profession in engaging the public in a conversation about how best to conserve and allocate limited health care resources effectively, rationally, judiciously, and equitably. To contribute to such a discussion, ACP offers the following principles for conserving and allocating resources in a way that is in accord with American values:**

- **Sufficient resources should be devoted to developing needed data on clinical and cost-effectiveness.**
- **There should be a transparent process for making allocation decisions with a focus on medical efficacy, clinical effectiveness, and need, with consideration of cost based on the best available medical evidence.**
- **The public, patients, physicians, insurers, payers, and other stakeholders should have opportunities to provide input to allocation decision-making at the policy level.**
- **Multiple criteria should be considered in determining priorities for health care resources including patient values, potential benefit, safety, equitable access, quality of life, and impact on families and caregivers.**
- **Allocation decisions should be in accord with societal values and reflect American moral, ethical, cultural, and professional standards.**
- **Allocation decisions should not discriminate against a class or category of patients.**
- **The allocation process should be flexible enough to address variations in regional needs and accommodate special circumstances.**
- **Individuals should be involved in making informed decisions about their own care and share in decision-making responsibility.**
- **Patients and physicians should be provided with objective and understandable information about the benefits and costs of different treatments.**
- **Patient cost-sharing should vary to reflect value.**
- **People should be able to purchase additional health care services and coverage at their own expense.**
- **As discussed earlier, medical liability reforms are needed to decrease the practice of defensive medicine.**

- **The resource allocation process and priority setting should be periodically reviewed to reflect evolving medical and societal values, changes in evidence, and to assess for any cost shifting or other unwanted effects.**

Today, ACP releases a new position paper, *How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?* To ACP's knowledge, this is the first time that a major physician membership society has called for a national consensus on conserving and allocating health care resources and proposed a framework on how to make such decisions.

The contentious debate over health care reform has become polarized over whether or how the United States should 'ration' care, a term that is poorly understood, emotionally-driven, and not conducive to reaching consensus. Rationing conjures up images of shortages, delays in obtaining treatment, long waiting lines, and government bureaucrats coming between patients and their physicians. But there is a difference between medical rationing, in which decisions are made about the allocation of scarce medical resources and who receives them, and *rational* medical decision-making, by which judicious choices are made among clinically effective alternatives. Engaging the public in a discussion of how to conserve and allocate resources effectively, based on evidence of their *value*, would result in more judicious use of limited resources, and help the United States avoid the overt medical rationing.

Every country makes decisions on how to allocate available health care resources, but their approaches vary widely, reflecting the different political and cultural conditions in each country. The United States limits access to services based on access to affordable health insurance coverage, insurance company decisions on covered benefits and cost-sharing, socio-economic and racial and ethnic characteristics of the population being served, the availability of physicians and health care facilities, among other factors.

Yet the U.S. has largely failed to address the reality that health care spending is increasing at a rate the country can't afford. This is a societal issue that transcends medical care itself—how much should we as a society spend using public funds on health care versus education, the environment, or the defense of our country?

Democratically elected countries have a responsibility to develop ways to determine the allocation of public resources that have broad public support; such decisions in the U.S. cannot and must not be "imposed" on the population without the consent of the people.

At the patient encounter level, physicians – in consultation with patients – have a responsibility to use health care resources wisely, based on evidence of safety and effectiveness, the particular needs and circumstances of the patient, and with consideration of cost. At the societal level, allocation decisions should be informed by evidence on the value of different interventions, be in accord with societal values, and reflect moral, ethical, cultural, and professional standards. ACP's paper explores such issues in order to encourage a non-partisan dialogue on how best to ensure that spending on health care is sustainable and doesn't bankrupt our country. Consideration of these questions also ensures that decisions on allocating resources are based on evidence and made in a way that has the support of the public and respects distinctly American values.

## Conclusion

The American College of Physicians firmly believes that Congress should preserve and build upon the ACA's reforms to provide coverage to nearly all Americans, to begin to address primary care shortages and other limits on the capacity of the system to meet increased demand for health care, and fund programs to begin to "bend the cost curve."

Yet no legislation is perfect, and ACP believes that there is an opportunity for Congress and President Obama to seek common ground on improvements. Such improvements should include providing the states with an earlier opportunity to seek waivers from many of the ACA's requirements as long as they can provide comparable coverage to as many people and advancing the date by which states can enter into a compact to sell insurance across state lines. Other improvements should include enacting a permanent end to Medicare payment cuts caused by the Sustainable Growth Rate formula, eliminating burdensome administrative requirements on small businesses (1099 reporting requirement) and physicians (requirement that they authorize flexible spending account payments for over-the-counter drugs), but these and other improvements should not be at the expense of denying funding for other essential elements of the ACA.

ACP also believes that it is critical that the United States do more to address the problem of rising and unsustainable health care spending. The ACA's cost-savings programs should be preserved, particularly funding for Comparative Effectiveness Research and the Center for Medicare and Medicaid Innovation. Congress should also enact more meaningful medical liability reforms including a national pilot of health courts. But government can't and shouldn't do it all—the medical profession has a responsibility to address misuse and overuse of health care services by developing evidence-based guidelines and encouraging their acceptance, as ACP is doing with its *High Value, Cost Conscious Care Initiative*.

Finally, instead of continuing the current polarized and unproductive argument about rationing of care, elected officials should contribute constructively to public discussion of how to allocate limited health care resources rationally, effectively, and judiciously, based on the best evidence on effectiveness and value. Fiscal conservatives should support such a discussion, because reducing the rate of increase in health care spending is critical to reducing the federal deficit and the public debt. Progressives should support such a discussion because it is critical to ensuring the continued viability of Medicare, Medicaid, and other public safety net programs and ensuring that health care doesn't crowd out spending for other national priorities. ACP's paper, *How Can Our Nation Conserve and Distribute Health Care Resources Effectively and Efficiently?* offers an approach to initiate this difficult, yet essential, dialogue with the American people.

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