

The State of the Nation's Health Care 2012:
How Bad Budget Choices and Broken Politics Are
Undermining Progress in Health

And What Should be Done About It

American College of Physicians
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Executive Summary

American health care in the year 2012 is a story of progress in slowing annual health care cost increases, reducing barriers to affordable coverage, and beginning to address a shortage of primary care physicians, coupled with the enormous challenges of costs still increasing at a rate the nation cannot sustain, tens of millions who still lack access to health care, scheduled cuts in Medicare payments to doctors and congressional paralysis on coming up with a permanent solution, and unwise budget cuts that threaten to do great harm to the health of the public. A broken political culture has made it close to impossible to find bipartisan common ground on solutions to these challenges. This report calls on Congress to replace automatic budget cuts with an alternative framework for fiscally and socially responsible policies and health care savings while preserving funding for critical programs. It concludes with a call to the candidates to rise above our broken politics and provide clear answers, not vague rhetoric, on how they would improve American care.

Introduction

There are some encouraging signs in American health care: a dramatic slowing of health care spending increases, improvements in several key indicators of the health of the American people, and millions of people benefiting from reforms to reduce barriers to affordable health insurance coverage. Nevertheless, health care will continue to pose enormous challenges for policy-makers. Even with almost a decade-long slowdown in annual growth, health care cost increases are expected to rise at an unsustainable level, representing the biggest single contributor to the

fiscal crisis facing the federal government. Quality and access to care remain uneven, with significant disparities for ethnic, racial and some demographic groups, and the progress being made in reducing barriers to coverage is at risk.

As we enter a 2012 election that may determine the direction of health care for decades to come, our broken politics make it harder to achieve a national consensus on necessary reforms. Instead of seeking bipartisan solutions, American politics today are characterized by deep ideological polarization, cynical and deceptive attacks on the ideas of others, an aversion to compromise, and a failure of politicians to level with the public about the choices that must be made. Many of the choices being made by politicians to reduce health care spending are the wrong ones, because they endanger rather than improve health care access, quality, and public health and safety. And the political proposals also focus on spending, not cost.

In today's report, the American College of Physicians:

- Offers an unvarnished account of the state of American health care today, both the progress made and the challenges remaining;
- Assesses the impact of scheduled cuts in funding for critical health programs;
- Offers an alternative framework for achieving savings in a fiscally and socially responsible way; and
- Discusses how our broken politics are undermining solutions to unsustainable costs and uneven quality and access.

The report concludes by challenging the candidates seeking office in 2012 to explain how they would improve health care access and quality, reduce costs, and address the difficult choices involved.

American Health Care in 2012: A Story of Progress and Challenges

Health Care Spending

- **There has been a dramatic slow-down in annual health care spending growth.** U.S. health spending grew at a slower rate in 2009 and 2010 [the most recent years for which data are available] than in any of the past 51 years.¹ According to a recent study on health care spending, “In 2010 extraordinarily slow growth in the use and intensity of services led to slower growth in spending for personal health care. The rates of growth in overall US gross domestic product (GDP) and in health spending began to converge in 2010. As a result, the health spending share of GDP stabilized at 17.9 percent. . . Continued slow growth in private health insurance and out-of-pocket spending (which

grew just 2.4 percent and 1.8 percent, respectively) and decelerations in Medicare and Medicaid spending growth (which slowed to 5.0 percent and 7.2 percent, respectively) contributed to overall low growth in 2010.”²

- Although the recent reduction in health care spending increases would appear to be a positive development, some of it may be caused by patients forgoing needed care because of the prolonged economic downturn. “Persistently high unemployment, continued loss of private health insurance coverage, and increased cost sharing led some people to forgo care or seek less costly alternatives than they would have otherwise used,” noted the study’s authors.³

Another study observed that the recession doesn’t fully explain the trend toward lower spending growth, however, since there have been steady declines in health spending growth for eight consecutive years.⁴

- **Yet even with the slow-down, health care spending is at an all-time high, and the United States continues to spend much more than other countries without achieving better outcomes.** Also despite the slowdown, health care spending reached record levels in 2009, both in absolute terms and as a share of GDP, and continues to outpace growth in the economy. Total spending exceeded expected levels—based on spending patterns in other developed countries and adjusting for wealth, compared to the United States—by approximately \$570 billion. This excess amounted to 23 percent of total spending on health care in 2009.⁵
- **Health care spending will continue to grow faster than the economy and threaten the fiscal health of the United States.** The Congressional Budget Office (CBO) projects that “spending on the major mandatory health care programs alone will grow from less than 6 percent of GDP today to about 9 percent in 2035 and will continue to increase thereafter. Altogether, the aging of the population and the rising cost of health care will cause spending on the major mandatory health care programs and Social Security to grow from roughly 10 percent of GDP today to about 15 percent of GDP 25 years from now. (By comparison, spending on all of the federal government’s programs and activities, excluding interest payments on debt, has averaged about 18.5 percent of GDP over the past 40 years.)”⁶

Health and Access to Health Care

- **There has been significant improvement in several key measures of population health:** In 2010, life expectancy increased, death rates fell for all five leading causes of death, and the death rate from homicide was as low as it’s been in a half a century, according to the National Center for Health Statistics.⁷
- **The prevalence of obesity in the United States increased during the last decades of the 20th century, but more recently the rate of increase appears to have slowed or even leveled off.** Obesity increases the risk of a number of health conditions, including hypertension, adverse lipid concentrations, and type 2 diabetes.⁸

- **Many Americans continue to experience major barriers to needed medical care.**
 - Between 1997 and 2009, among adults 18–64 years of age, the percentage who reported not receiving, or delaying, needed medical care in the previous 12 months due to cost increased from 11 percent to 15 percent, the percentage not receiving needed prescription drugs due to cost rose from 6 percent to 11 percent, and the percentage not receiving needed dental care due to cost grew from 11 percent to 17 percent.⁹
 - In 2009, 37 percent of adults 18–64 years of age who were uninsured did not receive, or delayed, needed medical care in the past 12 months due to cost, compared with 9 percent of adults with private coverage and 14 percent of adults with Medicaid; 19–21 percent of adults 18–64 years of age in families with income below 200 percent of poverty did not receive needed prescription drugs due to cost in the previous 12 months, compared with 12 percent of those with a family income 200–399 percent of poverty and 4 percent of those with a family income 400 percent of poverty or higher.¹⁰
 - States are seeing improvements in health care quality, but disparities persist for their minority and low-income residents.¹¹
- **Many millions still do not have health insurance.** From January through June 2011, 46.6 million persons of all ages (15.3 percent) reported that they were uninsured, 60.0 million (19.7 percent) said that they had been uninsured for at least part of the year, and 34.2 million (11.2 percent) reported that they had been uninsured for more than a year, based on a preliminary analysis of interviews conducted by the Centers for Disease Control and Prevention (CDC).¹²
- **Health reform is beginning to reduce barriers to care for millions.** As a direct result of the Affordable Care Act of 2010 (ACA):
 - 2.5 million young adults kept their health insurance coverage because they were allowed to stay on their parents' plans.¹³ The percentage of people between ages 19 and 25 being carried as a dependent on a parent's employment-based coverage increased from 24.7 percent in 2009 to 27.7 percent in 2010. The number of young adults with employment-based coverage as a dependent increased from 7.3 million to 8.2 million.¹⁴
 - Through the end of July 2011, 1.28 million Americans with Medicare received discounts on brand name drugs in the Medicare Part D coverage gap — up from 899,000 through the end of June and 478,000 through the end of May. These discounts have saved seniors and people with disabilities a total of \$660 million.¹⁵
 - More than 18.9 million Medicare beneficiaries, or 55.6 percent, have received one or more preventive services at no out-of-pocket cost to them.¹⁶

- Children with pre-existing health conditions can no longer be excluded from coverage, and all Americans benefit from a prohibition on life-time limits on coverage.

These improvements have been achieved without adding more than a nominal amount to overall health care spending in the United States.¹⁷

Physician Workforce

- **There has been a substantial increase in the number of primary care physicians, and other health professionals in designated fields experiencing shortages, who are receiving scholarships and loan forgiveness through the National Health Service Corps (NHSC), resulting in improved access to care for millions of people in medically underserved communities.**
 - Recently, the U.S. Department of Health and Human Services announced that “the number of participants in NHSC has nearly tripled, with more than 10,000 National Corps members – doctors, nurses and other health care providers – enrolled in the program. The NHSC has awarded nearly \$900 million in scholarships and loan repayment to health care professionals to help expand the country’s primary care workforce and meet the health care needs of communities across the country. . . There is nearly three times the number of NHSC clinicians working in communities across America than there were three years ago—increasing access to health care and supporting local jobs.”¹⁸
 - In 2008, approximately 3.7 million patients were provided service by 3,600 NHSC providers. Now in 2011, with field strength of more than 10,000 clinicians, NHSC provides health care services to about 10.5 million patients.”¹⁹
- **Yet the United States is projected to face a shortage of more than 44,000 primary care physicians by the end of the decade.**²⁰ Many other specialties are also facing severe shortages. As a result, there will not be enough physicians in many fields, particularly internal medicine and other primary care specialties, to meet the demand.

To sum up, the state of America’s health care in 2012 is a story of progress and continuing challenges:

- Annual health care cost increases have slowed dramatically, but some of this may be due to Americans forgoing needed care.
- Spending on health care has reached an all-time high, and is projected to continue to grow faster than the economy, consuming a larger share of the economy as measured by GDP.

- Increased federal spending associated with an aging population and rising costs of health care continue to pose the greatest challenge to the fiscal health of the United States.
- Health status has improved on several key indicators of population health, but more than 46 million still went without health insurance, even as the ACA has begun to reduce barriers to care for tens of millions of persons, and disparities within these indicators continue for many demographic groups and poorer residents.
- There has been a dramatic increase in primary care physicians and other health professionals who are benefiting from scholarships and loan forgiveness under the NHSC, providing improved access to care for millions of persons in underserved communities—yet the United States still is facing a projected shortage of more than 40,000 primary care physicians, and many other critical fields also are facing severe shortages.

How Bad Budget Choices Can Result in Bad Health Care

Despite the progress being made to improve access, reduce costs, and address physician shortages, recent and proposed cuts in funding for many critical health programs threaten to turn back the clock, endangering the health of millions and threatening access to care for the most vulnerable Americans.

There is no question that the United States has to make some tough budget decisions. Not all worthwhile programs can be fully funded. Spending on many programs will need to be reduced to relieve the economy from the consequences of exploding deficits and debt. Later in this report, ACP proposes a comprehensive approach to reducing health care spending through policies that address the real drivers behind rising costs.

As lawmakers make decisions on how to allocate scarce budget resources, they have a responsibility to ensure that programs crucial to the health of persons receive sufficient support. *Cuts that undermine public health, safety and medical research, reduce access to needed care for vulnerable populations, or exacerbate the shortage of primary care physicians are unwise because they will put the health of millions at risk and may result in higher costs in the future:*

Programs to Protect Public Health and Prepare for Disasters

- **Cuts to public health programs will endanger the health of the public.** Public health funding is discretionary spending in most states and is at high risk for significant cuts during economic downturns. In FY 2010-11, 40 states decreased their public health budgets; 29 of these states decreased their budgets for a second year in a row and 15 for the third year in a row. Since 2008, more than 49,000 state and local public health department jobs have been lost.²¹
- **Cuts in disaster preparedness will undermine the ability of federal, state and local governments to prepare for natural and man-made health care emergencies.**

Federal funds for state and local preparedness have declined by 38 percent from fiscal year (FY) 2005 to 2012 (adjusted for inflation).²²

Programs to Provide Access to Care to Under-Served Populations

- **Medicaid budget cuts will reduce access to care for the most vulnerable Americans.**
 - Eighteen states in both FYs 2011 and 2012 reported eliminating, reducing or restricting Medicaid benefits. Elimination of, or limits on, dental benefits, therapies, medical supplies and DME (durable medical equipment) and personal care services were most frequently reported.
 - A total of 39 states restricted Medicaid payments to physicians and other providers in FY 2011, and 46 states reported plans to do so in FY 2012.
 - Five states in FY 2011 and 14 states in FY 2012 increased copayment amounts or imposed new copayments. In contrast, only one state did so in FY 2010. Most copayment changes were for pharmacy and emergency room visits, although a few states, including Arizona, California and Florida, are requesting broader authority through waivers to impose copayments beyond nominal levels and to exempt populations.²³
- **Cuts in programs to serve the medically vulnerable create barriers to care for millions of poor Americans.**
 - The FY 2012 federal appropriations law funds the Health Resources and Services Administration (HRSA) at a program level of \$6.46 billion, which is \$53 million below last year's level and \$860 million below the President's budget request. HRSA is the primary federal agency responsible for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Programs to Address the Shortage of Primary Care Physicians

- **Reduced funding for the National Health Services Corps will undermine progress in training more primary care physicians to serve in underserved communities.** The FY 2012 federal appropriations bill eliminated all discretionary funding for NHSC. Although NHSC will continue to receive mandated federal funding, cuts in discretionary funding will likely reduce the number of clinicians who will be able to receive scholarships and loan forgiveness from the program, thus further reducing access to care in underserved communities.
- **The failure to fund programs to align federal resources with national workforce needs will result in money being spent ineffectively and slow progress in reversing the growing shortage of primary care physicians.** An expert commission authorized

by the ACA to assess the nation's workforce needs and barriers to primary care has been unable to meet because Congress failed to fund it. A program to provide grants to medical schools to improve training, faculty and curricula development in primary care received no increase over FY 2010 levels, even as the shortage of primary care physicians continues to grow.

- **Quality will be put at risk because of cuts in the federal agency responsible for improving the quality, safety, efficiency and effectiveness of care.** The Agency for Healthcare Research and Quality (AHRQ) received \$368 million, which is \$4 million less than FY2011. AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. AHRQ supports research that helps people make more informed decisions and improves the quality of health care services.

Coming Soon! More Unwise Budget Cuts

Of even greater concern to ACP than the reductions made to date is the devastating impact that more across-the-board budget cuts—*sequestration*—will have on critical programs to protect public health and safety, support medical research, and provide access to the medically underserved.

The Budget Control Act of 2011 placed statutory limits, or caps, on discretionary spending for each of the next 10 fiscal years. CBO estimated that these discretionary spending limits, which grow by approximately 2 percent each year, will reduce federal spending by \$917 billion between FY2012 and FY2021, compared to the projected level of spending if annual appropriations were to grow at the rate of inflation.²⁴

Because Congress' Joint Select Committee on Deficit Reduction (the “Super Committee”) failed to reach an agreement on a deficit reduction package, the law mandates that across-the-board cuts be imposed on defense and non-defense programs, with certain exemptions and limitations set by the law. The cuts will occur each year, starting in 2013 and continuing for 10 years. Most of the discretionary spending arising from the authorization of appropriations in the ACA is subject to automatic spending reductions.²⁵ These include many of the ACA's programs to fund the training of more primary care physicians.

The automatic enforcement process specified in the Budget Control Act in general will:

- Reduce funding for defense programs by 10.0 percent (in 2013) to 8.5 percent (in 2021), yielding total outlay savings of \$454 billion. The cuts likely will include funding for health care for uniformed personnel and their families.
- Reduce funding for non-exempt discretionary programs by 7.8 percent (in 2013) to 5.5 percent (in 2021), resulting in outlay savings of \$294 billion.

- Impose a 2 percent cut in Medicare payments to physicians, hospitals, graduate medical education programs, and other providers.²⁶ For physicians, this cut will be in addition to annual scheduled cuts resulting from Medicare's Sustainable Growth Rate (SGR) formula.

Because the sequestration cuts are set by formula, they do not take into consideration the importance or effectiveness of any particular program or activity—highly effective and critically important programs are cut as much as less effective and less important ones.

A Framework for a Better Approach to Health Care Costs

ACP believes that budget cuts that will compromise essential programs to improve the access, quality and safety of health care in the United States must not be allowed to stand. Instead, policymakers should embrace an alternative approach that addresses the true cost drivers behind rising health care costs while preserving funding for essential programs.

Last summer, ACP sent to the Joint Select Committee on Deficit Reduction a menu of options, generally supported by ACP policies, to reduce health care spending in a fiscally and socially responsible manner. According to estimates by the CBO and other experts, the options submitted by ACP would reduce spending on health care by \$500 to \$800 billion over the next 10 years. Specifically, ACP recommends the following:

1. **Congress should enact a budget package to replace the \$1.2 trillion in sequestration cuts mandated by the Budget Control Act.** Such an alternative should achieve equivalent or greater savings while allowing for continued and adequate funding for critical programs to provide access to vulnerable populations, fund graduate medical education, improve and protect public health and safety, prevent and control disease, train more primary care physicians, respond to natural disasters and bioterrorism, and support medical research.
2. **To achieve health care savings while ensuring funding for critical health care programs, Congress should:**
 - a. **Repeal the Medicare Sustainable Growth Rate (SGR) formula and establish a process to transition to more effective, patient-centered delivery and payment system.**
 - b. **Enact reforms to reduce the costs of defensive medicine.**
 - c. **Support efforts by the medical profession to promote high-value, cost-conscious care.**

- d. **Enact structural improvements in entitlement programs that will make them more effective for patients and result in more efficient use of limited resources.**
- e. **Reform federal tax policy to encourage consumers to be more cost-conscious in their selection of health insurance.**

The complete menu of options is attached, along with the estimates of potential savings. More details on each proposal are summarized below.

Reform Physician Payments

ACP also advocates that Congress enact permanent reform of the Medicare physician payment system. Last year, the leadership of the House Energy and Commerce Committee, both Republicans and Democrats, wrote to ACP and other medical organizations to request our ideas to reform physician payments. The letter stated the Committee's determination to "achieve a permanent, sustainable solution to the Medicare physician payment problem" in 2011. ACP was asked to "provide specific ideas and proposals . . . on how to reform the physician payment system and move to a system that reduces spending, pays providers fairly, and pays for services according to their value to the beneficiary."

ACP and other physician organizations responded by submitting comprehensive plans to eliminate the Medicare SGR formula and achieve permanent reform of physician payments. ACP's proposal would:

1. **Eliminate the SGR.**
2. **Provide for at least 5 years of stable updates to physicians. From 2012-16, updates would be set by statute rather than the SGR. Primary care services would receive annual updates of at least 2 percent and all other services would be protected from any reductions.**
3. **During the same 5 years, the Centers for Medicare and Medicaid Services (CMS) would engage in broad dissemination and assessment of innovative models to align payments with the value of the care provided.**
4. **At the end of the 5 years, the most effective models would then be implemented throughout the program, and physicians would be required to transition to the new models by a date that would be established in statute.**

Since then, ACP has endorsed a framework developed by Rep. Allyson Schwartz (D-PA-13) that would similarly provide more than 5 years of stable payments, positive increases for all physician services, higher updates for primary care, a process for CMS to evaluate and select the most effective models, and incentives for physicians to transition to the new models no later than 2019.

Regrettably, Congress did not reach an agreement on permanent reform in 2011. Instead, it agreed to continue 2011 Medicare payment rates through February 29, meaning that physicians are again facing a 27.4 percent cut on March 1, 2012.

ACP has told Congress that it can no longer support short-term patches that do not ensure stable updates and will result in deeper cuts in future years. We again call on Congress to enact permanent reform of the SGR in 2012, based on the framework described above.

In addition, ACP supports the use of Overseas Contingency funds to help pay for full repeal of the SGR. Overseas Contingency Operations (OCO) funding refers to the discretionary funds for the wars in Afghanistan and Iraq and similar activities. Because OCO funds are discretionary and subject to annual appropriations, CBO assumes that OCO will be funded at the current year's level for each of the next 10 years when estimating OCO expenditure over the 10-year budget window. Even though operations in Iraq have ceased, and operations in Afghanistan are expected to wind down significantly in the coming years, CBO cannot downwardly adjust its estimate for OCO spending over the next 10 years until the next (FY 2013) Defense Appropriations bill is passed. In other words, CBO's budget estimates assume spending for Overseas Contingency Operations that will never occur. At the same time, CBO assumes savings from scheduled annual Medicare cuts to physicians that Congress almost certainly will not allow to occur. By using OCO funds to offset the costs of SGR repeal, Congress would be correcting assumptions of higher spending (OCO funds) and expected savings (SGR payment cuts to doctors) ***that will never take place***, effectively cancelling out each other and ***producing a more honest and accurate budget***. Use of the OCO funds to pay for repeal of the SGR also would eliminate the need for budget offsets affecting other health care providers and/or Medicare enrollees.

Reduce the Costs of Defensive Medicine

The CBO estimates that as much as \$62 billion could be saved each year by reforming the medical liability tort system.²⁷ ACP believes that this is a conservative estimate of potential savings. We specifically call on Congress to:

- **Enact caps on non-economic damages, limits on contingency fees, and other reforms that have proven to be effective in California and other states.**
- **Authorize a national pilot of no-fault health courts, which would give patients the option of having expert judges make a determination on compensation for actual damages incurred instead of the traditional jury trial.**

Promote High Value Care

Studies suggest that as much as \$700 billion is spent annually in the United States on ineffective, marginal, wasteful and even harmful care. ACP has been a leader in promoting high value, cost-conscious care. Our "High-Value, Cost-Conscious Care Initiative," www.acponline.org/clinical_information/resources/hvccc.htm provides clinicians and patients with evidence-based and consensus recommendations on providing care of high value while

reducing care of no or marginal value. We have issued guidelines on use of imaging to diagnose low back pain, and just this month, the Annals of Internal Medicine, ACP's peer-reviewed flagship journal, published recommendations from ACP on common clinical scenarios that can result in better health outcomes if physicians and patients discuss the benefits and harms of screening and diagnostic tests that are often unnecessary or might cause harm.²⁸ We are working with medical educators to teach medical students and residents on delivery of high-value care and with consumer groups on promoting shared decision-making.

However, no organization can do it alone: changing behaviors and practices to encourage care that has the greatest value to patients requires a coordinated effort that engages all stakeholders. Accordingly, to promote high-value care, ACP proposes:

- **A national, multi-stakeholder initiative to reduce marginal and ineffective care and promote high value care.** ACP proposes that Congress support the establishment of a multi-stakeholder initiative, consisting of representatives of leading physician membership and specialty societies (including ACP), health plans, federal health agencies (CMS, AHRQ, the Patient-Centered Outcomes Research Institute, National Institutes of Health, and the U.S. Department of Veterans Affairs), consumer groups, health services researchers, and experts in shared decision-making, to develop a national strategy to reduce the use of treatments and diagnostic tests that have no or marginal effectiveness and increase use of treatments and diagnostic tests of higher value. ACP has identified several policies that could be the basis for this multi-stakeholder initiative to improve the value of health care spending. Specifically, ACP recommends that this multi-stakeholder initiative develop strategies to:
 - **Provide patients and clinicians with information on the comparative effectiveness of different treatments.** A recent study finds that “Perhaps the most important contribution that public policy could make to system-wide efficiency would be to generate more information - for both patients and providers - about what care is in fact high value.”²⁹
 - **Redesign payment and delivery systems to promote high-value care and shared decision making between patients and their physicians.**
 - **Redesign insurance benefits in both public and private plans to allow for consideration of comparative effectiveness in coverage determinations and patient cost-sharing.**

Make Structural Improvements to Medicare

ACP supports changes in Medicare to spend health care dollars more wisely. Our recommendations include:

- **Authorize the federal government to negotiate drug prices and/or require drug manufacturers to pay a rebate under Medicare Part D.** ACP believes that as a prudent buyer, the federal government should be able to negotiate drug prices for

Medicare, just as it does for the Department of Veterans Affairs. The CBO should be requested to reconsider potential savings from allowing the federal government to negotiate Part D drug prices in light of other studies that project substantial savings.

- **Create a single deductible for Medicare Parts A and B.** The ACA includes a provision that provides United States Preventive Services Task Force-recommended preventive services to Medicare beneficiaries without cost-sharing. ACP supports combining A and B into a single cost-sharing structure if this provision remains intact, the deductible is set at an actuarially appropriate level, and a lower cost-sharing level is set for lower-income beneficiaries.
- **Ensure more accurate pricing of services.** ACP supports recommendations by the Medicare Payment Advisory Commission to establish a process for expert review of potentially misvalued physician services to supplement existing processes for determining relative values.
- **Require that all payers contribute to Graduate Medical Education (GME) and spend GME funds more strategically based on assessments of workforce needs.** ACP opposes cuts in Medicare funding for GME that will worsen the shortage of physicians in many specialties, including primary care. Because GME is a common good, benefiting all of the public, we believe that all payers should contribute to GME, which would allow the federal government to gradually reduce its share of the funding while preserving needed support for GME programs.
- **Authorize Medicare to consider the comparative effectiveness of different treatments in coverage decisions.** Medicare currently makes decisions on coverage based on whether a new service, treatment, device or procedure is medically safe and effective. ACP believes that Medicare coverage decisions also should reflect consideration of the *comparative* effectiveness of different services, treatment, devices or procedures in improving clinical outcomes.

Reform Federal Tax Policies

Current tax policies encourage consumers to select more expensive health benefit plans because unlike wages, such benefits are not treated as taxable income to the employee. ACP supports changes in federal tax policies that would limit the tax deductibility of health plans, above which the benefits would become taxable income to employees. The ACA has a variation of this concept by imposing a tax on high cost “Cadillac” health plans beginning in 2018. Specifically, ACP recommends that Congress:

- **Modify or accelerate the ACA’s tax on high cost health plans; or**
- **Enact a statutory limit on the deductibility to the individual of health insurance benefits at a level that ensures access to essential benefits while reducing incentives to purchase high cost plans with excess and unnecessary coverage.**

ACP supports a cap, but not a complete phase-out, of the tax exclusion for employer-sponsored health insurance with safeguards to protect older and sicker employee populations and to ensure that the cap is indexed to measures of the cost of delivering health services.

Overcoming Our Broken Politics

The 2012 election should inform voters about what the candidates would do about health care so that they can make informed choices. Yet for the most part, the candidates have offered little other than vague generalities on many of the most critical issues.

Republican candidates without exception have advocated for repeal of the health care law, but have offered little on what they would replace it with. The GOP candidates' positions to date do not explain how they would ensure access, control costs, or address other pressing concerns, like the growing shortage of primary care physicians.^{30 31}

More is known about the direction that President Barack Obama would take, because he supports continued implementation of the ACA. But he has offered little on how he would reform Medicare and Medicaid, what additional steps he would take to reduce health care spending, or how he would address the billions wasted on defensive medicine.³²

Instead of a discussion of solutions, the elections could result in even more inflammatory and misleading rhetorical attacks intended to fire up voters—causing even more cynicism, polarization, and lack of confidence in the ability of elected governments to deal responsibly with health care:

- From the right, programs to help patients make informed choices about their care, such as comparative effectiveness research and end-of-life advance planning, are deceptively labeled as government “rationing.”³³
- From the left, proposals to address the structural problems with Medicare by offering or transitioning to a premium support model are deceptively labeled as “ending Medicare” as we know it.³⁴

Further, the 2012 elections are taking place in the context of Washington’s repeated failures to act responsibly throughout the past year, including the failure of the “Super Committee” and Congress’ inaction on a long-term solution to the Medicare SGR and physician payments.

Looking to the future, in less than thirteen months from Election Day 2012, the ACA will provide affordable coverage to some 30 million previously uninsured Americans and provide more choices of coverage to small businesses and individuals. Every American will benefit from new safeguards on insurance companies limiting or excluding coverage for people who need it and from guarantees of essential benefits. Unless, that is, the country votes to turn its back on such reforms. With the future of health care reform at stake, the ACA’s critics—and especially the candidates—have a responsibility to offer clear alternatives for voters to assess before they cast their votes.

A Challenge to the Candidates

ACP believes voters should insist the candidates for federal office, president and Congress alike, answer several critical questions about their ideas to improve health care.

Three Key Questions for the Republican candidates for President and Congress:

1. If the Affordable Care Act is to be repealed, are there any policies authorized by the law that you would maintain? Specifically, would you retain or repeal rules and programs to:
 - Prohibit insurers from excluding or rescinding coverage for persons with pre-existing conditions?
 - Provide advance refundable health insurance tax credits for individuals and small businesses?
 - Expand Medicaid to cover more low-income persons?
 - Create state health exchanges?
 - Require that insurers offer a range of standard benefits packages?
 - Require insurers to cover preventive services at no out-of-pocket cost to enrolled patients?
 - Phase out the Medicare drug benefit "doughnut hole"?
 - Require higher Medicare and Medicaid payments to primary care physicians?
 - Expand scholarships and loan forgiveness for physicians in primary care specialties who agree to provide medical services to undeserved communities?
 - Study the comparative effectiveness of different treatments?
 - Initiate pilots of new patient-centered and value-based Medicare and Medicaid payment and delivery models?
2. If you favor eliminating any or all of the above policies, what policies do you advocate to increase access to health insurance, to address the shortage of primary care physicians, and to reduce costs and improve value? Specifically:
 - Do you believe it should be a goal of federal policies to ensure that all legal residents have affordable health insurance coverage?
 - If not, what do you propose to reduce barriers to affordable care?

- How many people would be covered under your proposals?
- How would you propose to increase the supply of primary care physicians, given current projections of a shortage of more than 40,000 primary care physicians?
- What specific plans do you have to reduce health care costs and increase value?
- If the individual insurance requirement is eliminated, do you favor another approach to encourage people to buy insurance when healthy, and to discourage them from waiting until they get sick to buy coverage?
- How would you reduce the costs of defensive medicine? Do you support caps on non-economic damages and/or a national pilot of no-fault health courts?

3. If you believe that states, not the federal government, should have the principal responsibility for health reform, how would you address the problem of states having unequal resources to provide coverage, and the considerable variation among states that now exists in the percent of residents with coverage?

Three Key Questions for President Obama and Democratic congressional candidates:

1. What changes, if any, would you consider making in the Affordable Care Act, to address concerns that it gives the federal government too big a role and that it doesn't do enough to reduce costs? Specifically:
 - If the insurance requirement is found to be unconstitutional, what alternatives, if any, would you consider to encourage people to buy insurance when healthy and to discourage them from waiting until they are sick to buy coverage?
 - Would you give Congress more authority over an Independent Payment Advisory Board, such as allowing it to reject the board's recommendations by a simple majority vote?
 - Would you give states more options to design their own programs, beyond what is currently in the ACA?
 - Would you support giving consumers more options to purchase high deductible health savings accounts?
 - Would you support providing more options, in addition to those included in the ACA, for consumers to buy insurance across state lines, and if so, what consumer protections and benefit requirements should be required?
 - What additional policies would you advocate to address the projected shortage of 40,000 primary care physicians?

2. What specific policies would you advocate to reform Medicare and Medicaid in order to sustain their financing and reduce their impact on increasing the deficit and debt? Specifically, would you support:

- A pilot test of offering Medicare beneficiaries the choice of a premium support program or traditional Medicare?
- Increasing the age of Medicare eligibility if alternative sources of coverage are available?
- Requiring higher income Medicare beneficiaries to pay more?
- Creating a single deductible for Medicare Parts A and B?
- Giving states more flexibility and an improved waiver process for Medicaid?
- Increasing Medicare payroll taxes?

3. What specific policies would you support to reduce the costs of defensive medicine? Specifically, would you support:

- Caps on non-economic damages?
- A national pilot of no-fault health courts?

We believe that answers to the above questions will help voters discern how candidates from both parties propose to address the challenges of unsustainable cost increases and uneven quality and access, and help move the debate from the polarizing ideological fight over repeal of the ACA to discussion of solutions that could command bipartisan participation.

Conclusion

American health care in the year 2012 is a story of progress in slowing annual health care cost increases, reducing barriers to affordable coverage, and beginning to address a shortage of primary care physicians, coupled with the enormous challenges of costs still increasing at a rate the nation can't sustain, tens of millions who still lack access to health care, scheduled cuts in Medicare payments to doctors and congressional paralysis on coming up with a permanent solution, and unwise budget cuts that threaten to do great harm to the health of the public. A broken political culture has made it close to impossible to find bipartisan common ground on solutions to these challenges. This report proposes an alternative framework to achieve fiscally and socially responsible policies to obtain health care savings while preserving funding for critical programs. It concludes with a call to the candidates to rise above our broken politics and provide clear answers, not vague rhetoric, on how they would improve American care.

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Menu of Deficit Reduction Options That Are Generally Consistent with ACP Policy

American College of Physicians
September 12, 2011

The following policy options are provided for illustrative purposes to show how it might be possible to reduce the government's expenditures on health care in a socially and fiscally responsible way consistent with policies established by the American College of Physicians.

Specific citations to demonstrate the potential impact on cost reduction are provided whenever available, including references to Congressional Budget Office (CBO), Commission on Fiscal Responsibility and Reform, Bipartisan Policy Center, and other credible sources. As noted in the comments section, ACP policy may deviate in some respects from the specific referenced option from CBO and other sources, so the estimated savings may differ if the proposal was modified to fully satisfy ACP policy. Combined savings of some or all of the options may be more or less than presented.

ACP recognizes that many of the policy options presented below are controversial so Congress likely will select only some of the options presented and may substitute different options. Yet the table shows that it is possible to achieve savings of hundreds of billions of dollars from lower health care spending from policies that improve the quality of care for patients, allow for repeal of Medicare's sustainable growth rate (SGR) formula, and allow for continued funding of critical programs to improve access and ensure a sufficient supply of physicians.

Policy option	Potential Savings (10 years)	ACP Comments
<p>High Value Care Initiative: Establish a national Initiative of key stakeholders, with physician leadership, to decrease the use of low value services and increase use of high value services.</p> <p>1. Provide patients and clinicians with information on the comparative effectiveness of different treatments.</p> <p>2. Establish patient-side incentives and insurance design to encourage high value care and reduce use of low value treatments and tests.</p> <p>3. Transition to new payment and delivery models for clinicians, hospitals and other providers aligned with value, as discussed below.</p>	<ul style="list-style-type: none">• No specific <i>federal</i> deficit reduction estimate available. But the CBO projects that the U.S. spends \$700 billion annually on marginal and ineffective care.ⁱ Even a modest 20 percent reduction over the next 10 years in such expenditures would reduce national health care spending by \$1.4 trillion, much of which would accrue to the federal budget.• Commonwealth Fund estimates that the effective dissemination of comparative effectiveness information and its use in the development of insurance benefit designs would save an estimated \$174 billion over 10 years for the federal government.ⁱⁱ• New Harvard study estimates national health care savings of trillions of dollars (not limited to the federal budget) from	Initiative should have physician leadership with other key stakeholders represented. Modeled on ACP's High Value, Cost Conscious Care Initiative, www.acponline.org/clinical_information/resources/hvcc.htm . CBO should be requested to develop potential savings estimate for this initiative.

Policy option	Potential Savings (10 years)	ACP Comments
Physician Payment: Transition to new payment models aligned with value and repeal of the SGR.	smarter health spending ⁱⁱⁱ <ul style="list-style-type: none"> Although repeal of the SGR would initially be scored as adding costs to the federal budget (approximately \$300 billion) to make up for Congress' past decisions not to fully fund short-term reprieves, the budget costs of repealing the SGR will increase to an estimated \$600 billion by 2016 if Congress doesn't act now to permanently repeal the SGR (analysis by the American Medical Association based on CBO estimates). Transitioning to new payment models aligned with value could result in very substantial savings—as much as 30 to 50 percent in total national health care spending (not limited to the federal budget), according to Harvard researchers.^{iv} 	A transition to new payment models by a defined timetable is essential, but is not possible as long as physicians are facing a 30 percent SGR cut and the uncertainty created by future scheduled cuts. ACP has proposed a five-year transition, during which payments would be stabilized and set by statute (and not the SGR), new models based on value would be broadly tested and evaluated, and then most physicians would transition to the new models by the end of the decade.
Graduate Medical Education (GME): Preserve and broaden the base on GME funding by requiring all payers to participate and allocate GME funding more strategically based on assessment of workforce needs and skills required.	<ul style="list-style-type: none"> No current budget estimates are available, but legislation introduced 10 years ago to require an all-payer system was estimated to result in \$4.0 billion in federal revenue through a 1 percent premium tax on private payers and \$1.5 billion in <i>annual</i> savings to the federal government through reduced Medicare IME payments. (Ten year savings estimates from that time are not available.) Some of the savings would have gone to teaching hospitals to increase support for GME. (Because all payers would be making indirect graduate medical education (IME) payments, the bill would have reduced Medicare's IME formula from 5.5 percent to 4.8 	Broadening the base of GME financing over time would lower the federal government's share while preserving and even increasing overall GME funding to meet the country's workforce needs. CBO should be asked to produce a new 10 year savings estimate.

Policy option	Potential Savings (10 years)	ACP Comments
<p>Strengthen Primary Care and Care Coordination: Favored policies include raising payments for primary care services, providing additional payments for providers who serve as a patient-centered medical home accountable for quality and efficiency, rewarding providers for high-quality and coordinated care, and offering incentives that encourage patients to enroll in medical homes.</p>	<p>percent.)</p> <p>\$83 billion (Commonwealth Fund)^v</p>	<p>The Commonwealth Fund refers to research reflecting that easy access to primary care is key to both better patient outcomes and lower costs. A related Commonwealth survey reflected that a substantial majority (61 percent) of health care opinion leaders feel that increasing the supply of primary care providers through payment reform would be an effective strategy for reducing the growth in health care costs.</p>
<p>Defensive Medicine: Reduce the costs of defensive medicine by enacting the following policies in the CBO options paper:</p> <ul style="list-style-type: none"> • A cap of \$250,000 on awards for noneconomic damages; • A cap on awards for punitive damages of \$500,000 or two times the value of awards for economic damages, whichever is greater; • A statute of limitations of one year from the date of discovery of the injury for adults, and three years for children; • A fair-share rule (replacing the rule of joint and several liability) under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to that defendant's share of responsibility for the injury; and • Permission to introduce evidence of income from collateral sources (such as life insurance payouts and health insurance) at trial. 	<p>\$62 billion (CBO)^{vi}</p>	<p>The College favors a \$250,000 cap on noneconomic damages. Additionally, the College supports a \$50,000 cap on noneconomic damages for any doctor performing immediate, life-saving care. The College strongly believes that a cap on noneconomic damages is the most effective way to stabilize premiums and should be the centerpiece of any legislative proposal to reform the medical professional liability insurance system. ACP also advocates for enactment of a national demonstration to pilot-test health courts.</p>
<p>The Commission on Fiscal Responsibility and Reform recommended the following be considered: (1) Modifying the “collateral source” rule to allow outside sources of income collected as a result of an injury (for example workers’ compensation benefits or insurance benefits) to be considered in deciding awards; (2) Imposing a</p>	<p>\$17 billion (National Commission on Fiscal Responsibility and Reform)^{vii}</p>	

Policy option	Potential Savings (10 years)	ACP Comments
<p>statute of limitations – perhaps one to three years – on medical malpractice lawsuits; (3) Replacing joint-and-several liability with a fair-share rule, under which a defendant in a lawsuit would be liable only for the percentage of the final award that was equal to his or her share of responsibility for the injury; (4) <i>Creating specialized “health courts” for medical malpractice lawsuits</i>; and (5) Allowing “safe haven” rules for providers who follow best practices of care. [Emphasis added]</p>		
<p>Part D Drugs: Require Manufacturers to Pay a Minimum Rebate on Drugs Covered Under Medicare Part D for Low-Income Beneficiaries</p> <p>Give the federal government broad authority to negotiate prices of drugs paid by Medicare.</p>	<p>Rebate only: \$110 billion (CBO)^{viii}</p> <p>Negotiate prices: \$300 billion (Center for Economic and Policy Research, as CBO projects only nominal savings).^{ix}</p>	<p>ACP believes that as a prudent buyer, the federal government should be able to negotiate drug prices for Medicare, just as it does for the Department of Veterans Affairs. The CBO should be requested to reconsider potential savings from allowing the federal government to negotiate Part D drug prices in light of other studies that project substantial savings.</p>
<p>Place Dual Eligibles in Medicaid Managed Care: Approximately nine million low-income seniors and disabled individuals are covered by both Medicaid and Medicare. The divided coverage for dual eligibles results in poor coordination of care for this vulnerable population and higher costs to both federal and state governments. The Bipartisan Commission on Fiscal Responsibility and Reform recommends giving Medicaid full responsibility for providing health coverage to dual eligibles and requiring that they be enrolled in Medicaid managed care programs. Medicare would continue to pay its share of the costs, reimbursing Medicaid. Medicaid has a larger system of managed care than does Medicare, and this would result in better care coordination and administrative simplicity.</p>	<p>\$12 billion (National Commission on Fiscal Responsibility and Reform)^x</p>	<p>ACP generally supports better care coordination for duals (particularly between services financed by Medicare and Medicaid), but managed care arrangements in which duals would be enrolled, would need to be carefully designed to protect a very vulnerable population with more extensive health care needs compared with the average Medicaid managed care population and this should be considered (along with other issues such as utilization controls and network requirements).</p>

Policy option	Potential Savings (10 years)	ACP Comments
Employer-sponsored Health Insurance: Accelerate the excise tax on high cost health plans or replace it with an overall cap on the tax exclusion for employer-sponsored health insurance.	\$309 billion if excise tax is accelerated and modified (CBO)^{xi} \$113 billion if capped and then gradually phased out (Bipartisan Policy Center)^{xii}	ACP supports a cap, but not a complete phase out, of the tax exclusion for employer-sponsored health insurance with safeguards to protect older and sicker employee populations and to ensure that the cap is indexed to measures of the cost of delivery services. Although neither the CBO nor BPC proposals fully meet ACP's requirements for support, ACP encourages Congress to consider options to make the existing excise tax more effective in influencing purchasing and coverage decisions while ensuring adequate protection for workers.
Single Deductible: Replace Medicare's current mix of cost-sharing requirements with a single combined annual deductible of \$550 covering all Part A and Part B services, a uniform coinsurance rate of 20 percent for amounts above that deductible (including inpatient expenses), and an annual cap of \$5,500 on each enrollee's total cost-sharing liabilities.	\$32 billion (CBO)^{xiii}	The Affordable Care Act includes a provision that provides United States Preventive Services Task Force-recommended preventive services to Medicare beneficiaries without cost-sharing. ACP can support combining A and B into a single cost-sharing structure if this provision remains intact, the deductible is set at an actuarially appropriate level, and a lower cost-sharing level is set for lower-income beneficiaries. Otherwise, the elevated deductible for Part B services may discourage beneficiaries from receiving recommended care.
Add a "Public Plan" to the Health Insurance Exchanges: Under this option, the Secretary of Health and Human Services would establish and administer a public health insurance plan that would be offered alongside private plans through the exchanges beginning in 2014. The public plan would have to charge premiums that fully covered its costs for benefit payments and administrative expenses. The plan's payment rates for physicians and other practitioners would be set to exceed Medicare's rates in 2010 by 5 percent and would rise annually through 2014 and beyond to reflect estimated increases in physicians'	\$88 billion (CBO)^{xiv}	ACP could support a public plan provided it reflects ACP policy. The CBO option would make participation voluntary and payment models would not include an SGR-like mechanism. However, the CBO option lacks many important details, including which entity will manage the public plan, and whether the public plan will be required to establish primary care-based delivery models such as the Patient-Centered Medical Home (PCMH).

Policy option	Potential Savings (10 years)	ACP Comments
costs; those payment rates would not be subject to the future reductions required by Medicare's sustainable growth rate formula. The public plan would pay hospitals and other providers the same amounts that would be paid under Medicare, on average, and would establish payment rates for prescription drugs through negotiation. Health care providers would not be required to participate in the public plan in order to participate in Medicare.		
Total Deficit Reduction, From all of the options, above:		
High Value Care Initiative	N/A but studies show that hundreds of billions could be saved by encouraging high value care.	
Transition to new payment systems, repeal SGR	N/A. SGR repeal will be scored as adding close to \$300 billion to costs but without a permanent solution, budget cost will grow to \$600 billion. New payment systems offer potential to achieve hundreds of billions in net savings.	
All payer GME	No current estimates available, but gradual savings to federal share would occur as other payers contribute.	
Primary care/ Medical homes	\$83 billion*	*ACP believes that this is an overly modest estimate of the potential savings from primary care and medical home, given extensive evidence that primary care is associated with lower costs and positive results from PCMH pilots.
Defensive medicine	\$62 billion	
Require Part D rebate/negotiate drug prices	\$110 to \$300 billion	
Dual eligibles care coordination	\$12 billion	
Excise tax/cap on employer-sponsored health insurance	\$113 billion to \$309 billion*	*ACP supports a cap but not a complete phase-out, also,

Policy option	Potential Savings (10 years)	ACP Comments
Single Medicare Part A and B deductible	\$32 billion	protections need to be included so that employees in high cost areas, or with costly illnesses are protected. Actual savings of cap that would satisfy ACP policy would be less than shown here.
Public option in exchanges	\$88 billion	
Total range of potential savings (for illustrative purposes only)		\$500 to \$886 billion, not counting potential savings of hundreds of billions from high value care and new payment models aligned with value, and some modest potential savings from broadening and preserving GME financing. High value care, in particular, has the potential to reduce health care spending by hundreds of billions beyond the estimates shown in this table.

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