

Advocacy for *Patients*, Advocacy for *Physicians*

ACP's Agenda to Improve and *Reform* American Health Care

Louisiana Chapter, ACP
March 29, 2019

What's it all about?

The American College of Physicians works for you – providing internists with education, clinical support, practice resources, and advocacy for policy changes that will make a difference in your daily work, your professional development, and your patients' health.

We work to improve your daily lives, and the health of your patients, by

- Advocating for improvements within the *existing* policy, regulatory and legislative frameworks, and the overall health care system, while recognizing that they are imperfect and have unintended consequences.
- While challenging the status quo by proposing bold new policies to fundamentally reform our health care system—through our *New Vision for American Health Care Initiative*.

Making a difference in your daily work, and the health of your patients

- Through our *Patients Before Paperwork* Initiative, ACP is leading an effort within American medicine to reduce the paperwork burden on physicians and patients
 - By *pushing back* on payers, government, and others to justify *why* they are proposing a task, what it's intended to accomplish, assess what its *likely impact* will be, and then—either get rid of it or make it less burdensome, if the negative impact is greater than any good it might accomplish.

ACP's Patients Before Paperwork Initiative (started in 2015 – and going strong still...)

ACP Patients Before Paperwork Initiative



What is Patients before Paperwork?

ACP's Patients Before Paperwork initiative's goal is to reinvigorate the patient-physician relationship by reducing administrative complexities and eliminating unessential tasks that detract from patient care and contribute to physician burnout.



Policy Development

ACP policies provide a cohesive framework for identifying and evaluating administrative tasks, and offer detailed recommendations to analyze administrative tasks to determine whether they need to be challenged, revised, or eliminated entirely.



Tools You Can Use

Resources and tools help physicians put ACP's policies into practice. They include resources that assess practice efficiencies and resources on physician well-being and professional satisfaction.



Collaborating with Stakeholders

ACP engages with key regulatory agencies and stakeholders to help streamline regulations imposed by insurers, federal regulators and other external entities to reduce administrative burdens for physicians.



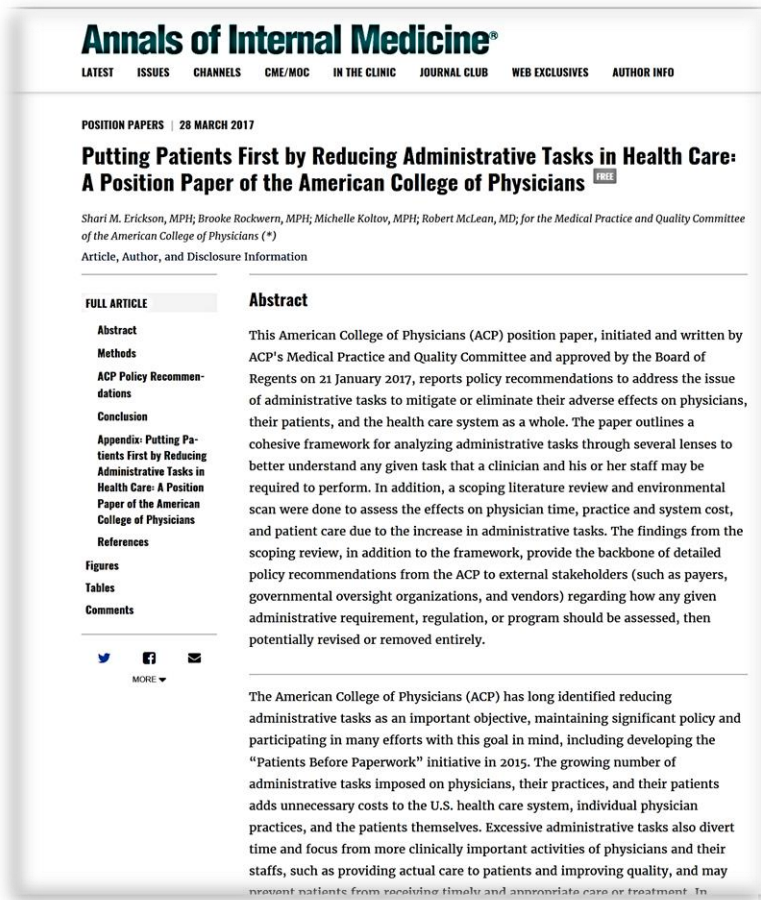
Advocating for Internists

ACP has long identified reducing administrative complexities or burdens as a priority. ACP works to advocate for changes in our health care system that simplify excessive administrative burdens that put a strain on physicians and patient care.

For more information, visit, www.acponline.org/pb4p

<https://www.acponline.org/advocacy/where-we-stand/patients-before-paperwork>

Patients Before Paperwork Initiative



ACP Position Paper, [Putting Patients First by Reducing Administrative Tasks in Health Care](#), outlining cohesive framework for identifying/evaluating administrative tasks as well as detailed policy recommendations to reduce excessive administrative tasks across the health care system.

Patients Before Paperwork

- Held recent meetings with high-level administration officials include: CMS Administrator Seema Verma, and Deputy Administrator/Director of CMMI, Adam Boehler.
- Listening session held at IM 2018 with Dr. Tom Mason (ONC).
- Group of 6 coalition—ACP, ACOG, AAP, AAFP, AOA, APA--released principles on reducing administrative burdens, major topic of June 18 fly-in.

Call it Patients *Before* Paperwork (ACP), or Patients *Over* Paperwork (CMS), the goal is the same!

October 30, 2017, Remarks by CMS Administrator Seema Verma at the Health Care Payment Learning and Action Network (LAN) Fall Summit:

Doctors are frustrated because they got into medicine to help their patients. But, paperwork has distracted them from caring for their patients, who often have waited weeks, if not months, for the brief opportunity to see them.

We have all felt this squeeze in the doctor's office...we have all seen our doctors looking at a computer screen instead of us. I hear it from patients across the country. This must change. The primary focus of a patient visit must be the patient.

*Just last week, CMS announced our new initiative "**Patients Over Paperwork**" to address regulatory burden. This is an effort to go through all of our regulations to reduce burden. Because when burdensome regulations no longer advance the goal of patients first, we must improve or eliminate them.*

Our door is open to your ideas and we invite a two-way discussion about how we can accomplish our shared mission of delivering the best possible care at the lowest cost.

ACP Encouraged by Changes in Medicare Payment Policies in 2019

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released the final rules on 2019 Physician Payments and the Quality Payment Program (QPP).

CMS Responsive to ACP Recommendations

[ACP is encouraged](#) that CMS was responsive to many of the concerns ACP raised during the comment period. Highlights include:

Physician Fee Schedule Updates



Reduced documentation requirements for physicians starting in 2019 – CMS is eliminating redundancies and only requiring physicians to document changed information since the last visit for established patients.



While CMS is moving forward with evaluation and management (E/M) coding payment reforms, they have **made revisions to their original proposal and delayed implementation until 2021.**



CMS modified its proposal of a flat rate for office/outpatient E&M level 2 through 5 visits and will **continue to pay a higher rate for the most complex patient care, or level 5 visits.** (Effective 2021)



ACP has concerns and will continue to advocate for paying level 4 visits, the second most complex visits, at a higher rate – and will work with CMS on alternate approaches that recognize the value of complex, cognitive care.



Add-on codes for level 2-4 visits in primary care and certain specialties will be allowed, as well as extended visits – to account for the value of cognitive work in treating more complex patients. This change equalizes primary care payments to specialty payments. (Effective 2021)



ACP is pleased that CMS finalized the new prolonged services codes but would like them implemented in 2019.



New payment codes in 2019 for non-face-to-face visits – including virtual check-ins, e-consultations, and remote evaluation of patient images and videos.



CMS has cancelled the Multiple Procedure Payment Reduction (MPPR) proposal.

Quality Payment Program Updates



A Merit-based Incentive Payment System (MIPS) opt-in option will be added by CMS for practices previously excluded under the low-volume threshold, expanding participation without increasing burden.



CMS continues to identify and remove low-priority, low-value quality measures – they will work with stakeholders to focus on measures that offer the most promise for improving patient care while minimizing reporting burdens.



Implementation of 2015 Certified Electronic Health Record Technology (CEHRT) for the 2019 reporting period will be required. While ACP agrees that using updated standards can help improve interoperability, we are disappointed that CMS did not call out the need to provide physicians flexibility as they implement these upgrades over the course of 2019. Rushing implementation of these upgrades to meet a reporting deadline can have serious patient safety risks and is a major expense and burden, particularly to small practices



CMS will continue the consistent risk threshold for advanced Alternative Payment Models (APMs) — this will provide consistency and predictability for advanced APM model developers and will help APMs continue to grow.



CMS finalized changes to the Cost Category – including adding several new episode-based measures, despite concerns over low reliability ratings, while simultaneously increasing the weight of the Cost Category from 10 to 15 percent, despite objections from ACP and other stakeholders.

A look back at the 115th Congress

Coverage:

- The ACA was *not* repealed and replaced (although a Texas judge's ruling creates a new threat—more on this later). Preexisting condition protections, essential benefits, ban on lifetime and annual limits on coverage, were preserved. Medicaid was not capped and cut.
- The Children's Health Insurance Program was reauthorized for 10 years.
- Women's health clinics were *not* defunded.

■ Public Health:

- Congress enacted two major laws to address the opioids epidemic.

■ Funding of workforce, public health and research

- Key ACP priorities are funded through September 30, 2019

More \$ for ACP's priorities

Community Health Centers

NHSC*

Title VII primary care grants(PCTE)**

AHRQ ***

CDC



* Dedicated to opioids misuse treatment

** Continuation of increased funding from
FY 2018

*** Proposed for elimination by President Trump

A look back at the 115th Congress

Congress enacted, and the President signed into law, a comprehensive bipartisan bill to address the opioids epidemic. As we recommended, it:

- Expands alternatives to opioid treatment,
- Lifts barriers to medication-assisted treatment (MAT) using buprenorphine and naloxone,
- Improves the interoperability of state-run prescription drug monitoring programs,
- Authorizes grants to provide additional education and training for clinicians to improve treatment for individuals with opioid and substance use disorders.
- Requires HHS develop a standard, secure, electronic prior authorization system, no later than 1/1/21, for drugs under Medicare Part D.

To learn more about how ACP advocates for you and your patients, see our [2018 Advocacy At Work](#) Infographic on ACP online.



Looking forward: 116th Congress

- The ACA will not be repealed or replaced, and more states will expand Medicaid.
- Yet the decision from a single Texas judge that the entire ACA is unconstitutional is a huge threat.
- If not reversed on appeal, the entire ACA would cease to exist:
 - No protections for pre-existing conditions.
 - No essential benefit requirements.
 - Lifetime and annual caps on benefits would return.
 - Insurers would withdraw from the markets.
 - No funding for Medicaid expansion.
 - No phasing out of the Medicare Part D doughnut hole.
 - Preventive services no longer would be offered by Medicare at zero out-of-pocket cost.
 - Mandatory funding for the NHSC would end, threatening scholarships and loan forgiveness.
 - The Center on Medicare and Medicaid Innovation would shut down, threatening Alternative Payment Models.

Looking forward: 116th Congress

- Congress and the administration may be able to reach agreement on policies to reduce Rx prices.
- Continued opportunity to advance bipartisan policies to reduce administrative burdens, improve Medicare's Quality Payment Program especially for smaller independent practices, address opioids, and provide for higher funding levels for key public health, research, and workforce programs.
- More states may enact policies supported by ACP to reduce firearms-related violence, fueled by the "This is Our Lane" movement. Congress may agree to fund research.


What does ACP recommend to curb injuries and deaths from firearms?

- New [policy paper](#) updates 2015 policy paper.
- The paper does *not* threaten the 2nd amendment right to own firearms for personal defense or recreation. Rather, we seek to:
 - To keep guns out of the hands of felons, *all* convicted domestic violence abusers (whether against a person within their house or outside of it), those with temporary as well as permanent restraining orders, and persons at imminent risk of harm to themselves or others
 - Background checks for all sales.
 - Close domestic violence loopholes.
 - Extreme risk protection laws
 - To require safe storage of guns and ammunition
 - To prohibit sales only of “assault” rifles and large capacity magazines.
 - To study causes and solutions to reduce injuries and deaths.

NRA Response to new ACP Policy Paper sparked *This is Our Lane* movement

- In response to the most recent ACP policy recommendations on reducing firearm-related injuries and deaths published in *Annals*, the NRA tweeted saying physicians should “stay in their lane.”
- Physicians were quick to respond...

Our Response

**Bob Doherty**
@BobDohertyACP

Following

The @NRA lectures lane" and not speak @ACPinternists poli with Renee Butkus, ..., and the stance o @AnnalsofIM, has t be. Read & add you

NRA @NRA
Someone should tell self-important articles in Annals of Internal Medicine however, the medical community see nraila.org/articles/20181...

8:23 PM - 7 Nov 2018 from Washington

61 Retweets 116 Likes

4 61 116


**Annals of Int Med** ✓
@AnnalsofIM

The @NRA tells re #GunViolence we pledge to ta violence whene Click the link at us bit.ly/Annals

6:17 AM - 8 Nov 2018

656 Retweets 1,393 Likes

34 656

**Annals of Int Med** ✓
@AnnalsofIM

Tell @NRA to stay in its own lane and out of the exam room. Take a stand today! Please click bit.ly/2Qr7L0N and make the commitment to talk to your patients about #gunviolence Evidence shows that your counsel could save a life #ThisisMyLane #ThisIsOurLane

6:59 AM - 9 Nov 2018

960 Retweets 2,001 Likes

23 960 2.0K

Public Response



Maggie Fox
@maggiefox

The @NRA tells d
their business. Do
@JosephSakran s
are very much the
@CDCgov release



'We are not anti-gun; we are a
Gun deaths rose in 2015 after fa
nbcnews.com

11:31 AM - 8 Nov 2018

235 Retweets 436 Likes

11 235 436



Esther Choo MD MPH
@choo_ek

We are not self-important: v
to the care of others
We are not anti-gun: we are
in our patients
We consult with everyone b
Most upsetting, actually, is c
disability from gun violence
unparalleled in the world

NRA @NRA

Someone should tell self-important anti-gun doctors
articles in Annals of Internal Medicine are pushing for
however, the medical community seems to have cons
nraila.org/articles/20181...

6:03 AM - 8 Nov 2018

4,068 Retweets 12,646 Likes

212 4.1K 13K



Joseph Sakran
@JosephSakran

Follow

As a Trauma Surgeon and survivor of
#GunViolence I cannot believe the
audacity of the @NRA to make such a
divisive statement.

We take care of these patients everyday.
Where are you when I'm having to tell all
those families their loved one has died.
@DocsDemand #Docs4GunSense

NRA @NRA

Someone should tell self-important anti-gun doctors to stay in their lane.
Half of the articles in Annals of Internal Medicine are pushing for gun
control. Most upsetting, however, the medical community seems to have
consulted NO ONE but themselves. nraila.org/articles/20181...

2:59 PM - 7 Nov 2018 from Baltimore, MD

11,797 Retweets 29,368 Likes

613 12K 29K

Annals
of Internal Medicine

Tweet your reply

#ThisIsOurLane



Brent McCaleb
@brentmccaleb

First patient, found to the mother cried i us to save him the last one ei
#ThisIsOurLane



6:11 AM - 12 Nov 2018

5,718 Retweets 15,331 Likes

435 5.7K



Dave Morris
@traumadmo

Can't post a patient

This is what it looks like

@NRA @Joseph



5:37 PM - 9 Nov 2018

33,989 Retweets 97,652 Likes

1.4K 34K 9



Breathless
@breathless2

Replying to @NRA

Now, why in the hell do you think we have something against guns? It's sort of like the trouble you have with life? #ThisIsOurLane #GunControl



12:35 PM - 10 Nov 2018

113 Retweets 300 Likes

6 113 300



Julius Cheng, MD MPH
@ChengJD_MD

Follow

Here's hoping that the .@NRA and .@AnnCoulter realize that this is the reality we face. We seek solutions, and we won't quit because lives depend on it. Help us with #bulletholecontrol. Join us. #ThisIsOurLane #TraumaShoes #TraumaSurgery @EAST_TRAUMA @traumadoctors @DocsDemand

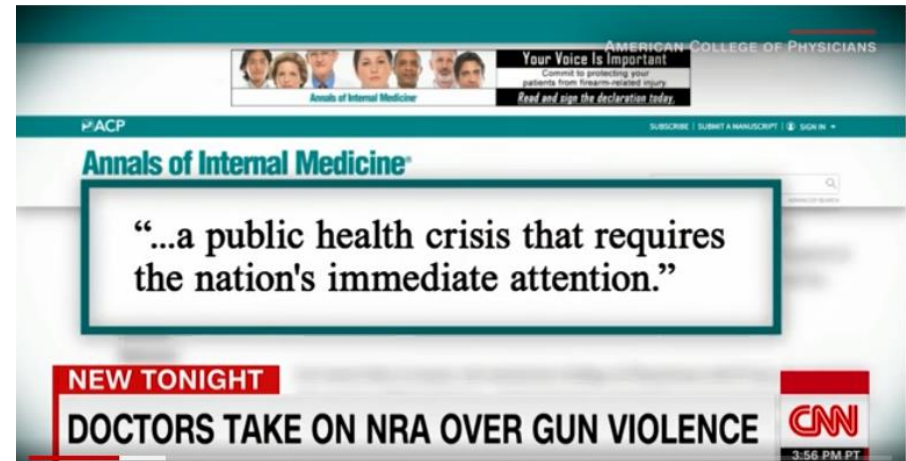
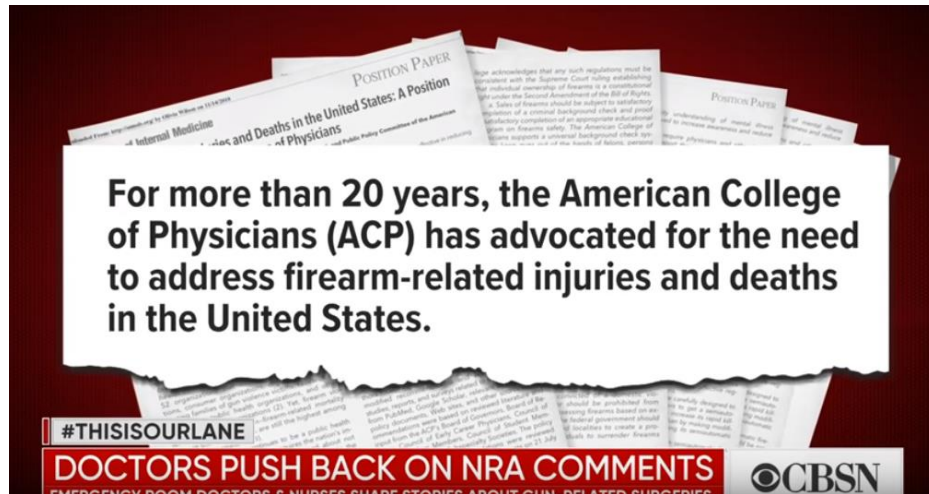


4:51 PM - 10 Nov 2018

861 Retweets 2,112 Likes

Firearms Position Paper Response

ACP's position paper on reducing firearm-related injuries and deaths published in *Annals* has received extensive coverage in light of the NRA tweet saying physicians should "stay in their lane." ACP, and the position paper, was mentioned in several top-tier media outlets, including CNN and CBS.



Firearms Position Paper Response: Top-Tier Media Coverage

The New York Times

Doctors Revolt After N.R.A. Tells Them to 'Stay in Their Lane' on Gun Policy

NEWS

NRA tweet warns doctors to 'stay in their lane' over gun control

TIME

Doctors Slam NRA's Directive to 'Stay in Their Lane' After Chicago Hospital Shooting

HUFFPOST

'This Is Our Lane': Doctors Slam NRA After Chicago Hospital Shooting

n p r

After NRA Mocks Doctors, Physicians Reply: 'This Is Our Lane'

AP

It's a Twitter war: Doctors clash with NRA over gun deaths

THE WALL STREET JOURNAL

After NRA Rebuke, Many Doctors Speak Louder on Gun Violence

Medical societies are calling for gun-control measures and other solutions to what they see as a public-health crisis

theguardian

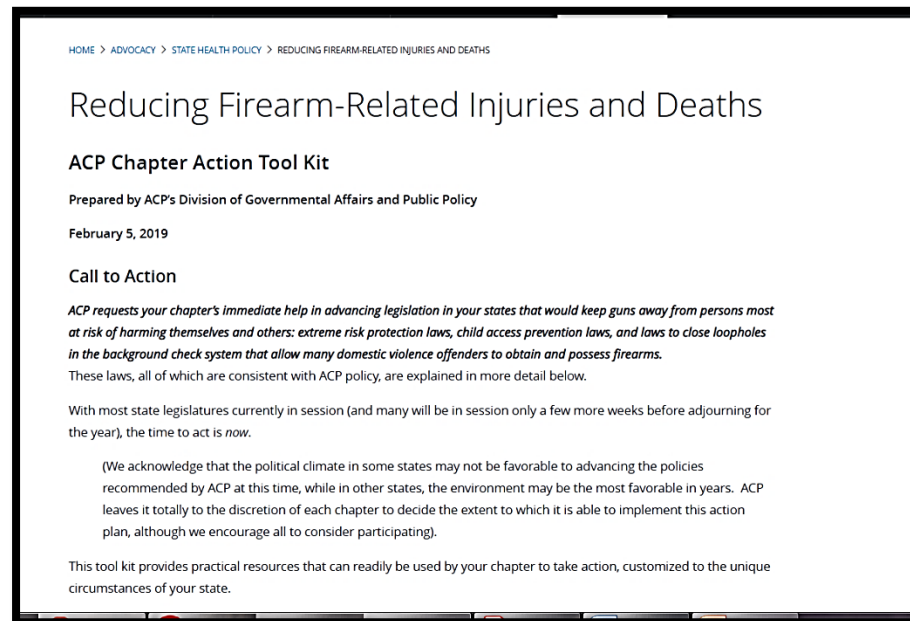
#ThisIsOurLane: NRA's criticism spurs doctors to speak out on gun violence

We are making progress.

- House of Representatives passed H.R., the Bipartisan Background Checks Act of 2019, the first major legislation addressing firearms injuries and deaths in a quarter century!
- ACP's has asked all of its Advocates for Internal Medicine to send an email (sample one provided) to their Representatives thanking them for voting yes, or expressing disappointment if they voted no, while asking all to support a bill to fund CDC research. And to urge Senators to support the same.
http://cqrcengage.com/acplac/app/write-a-letter?2&engagementId=497443&ep=AAAC2Flc0NpcGhlcjAxmzDDzC3FsgkTNme6_dclgtmkfUgzkWaQ1rHVcmKQtIMZlzs5snLDekKmaOsinL_PaoNKSfjgRsWEupeK37jwAC11Vl0dxKr4931hRNLAbaQ&lp=0

We are making progress.

- Several states have enacted, or are close to enacting, extreme risk protection laws, bans on undetectable guns, universal background checks, and closing domestic violence loopholes. ACP developed a [Chapter Tool Kit](#) to help chapters advocate with your own legislators.

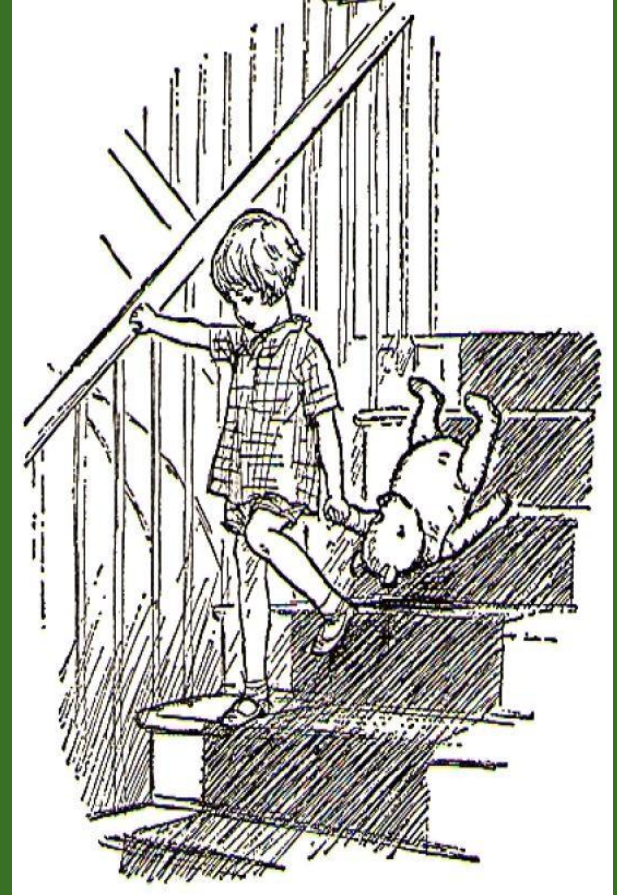


Where we are today, *is not where we want to be.*

- By necessity, much of ACP public policy and advocacy is to seek improvements within *established* legislative, regulatory and policy frameworks.
- While we challenge policies that are not serving patients or physicians, we also advocate for their interests within the current *imperfect* frameworks.
- Public policy, by its nature, will always achieve imperfect results.
 - For example: while both MACRA and the ACA are imperfect, they were *an improvement of what existed before, and as long as they remain as established frameworks, we need to work to make them better.*
- *Our system makes it very difficult to achieve huge and sudden shifts in policy.*
 - It took 18 years before Congress replaced the SGR with MACRA.
- Yet advocacy within the current policy framework does *not* mean that we can't strive for something better.

“Here is Edward Bear,
coming downstairs now,
bump, bump, bump, on
the back of his head,
behind Christopher
Robin. It is, as far as
he knows, the only way
of coming downstairs,
but sometimes he feels
that there really is
another way, if only he
could stop bumping for
a moment and think of
it.”

A.A. Milne
Winnie-the-Pooh
1920
Illustration by E. M. Shepard



Why do we need *another way* for American health care?

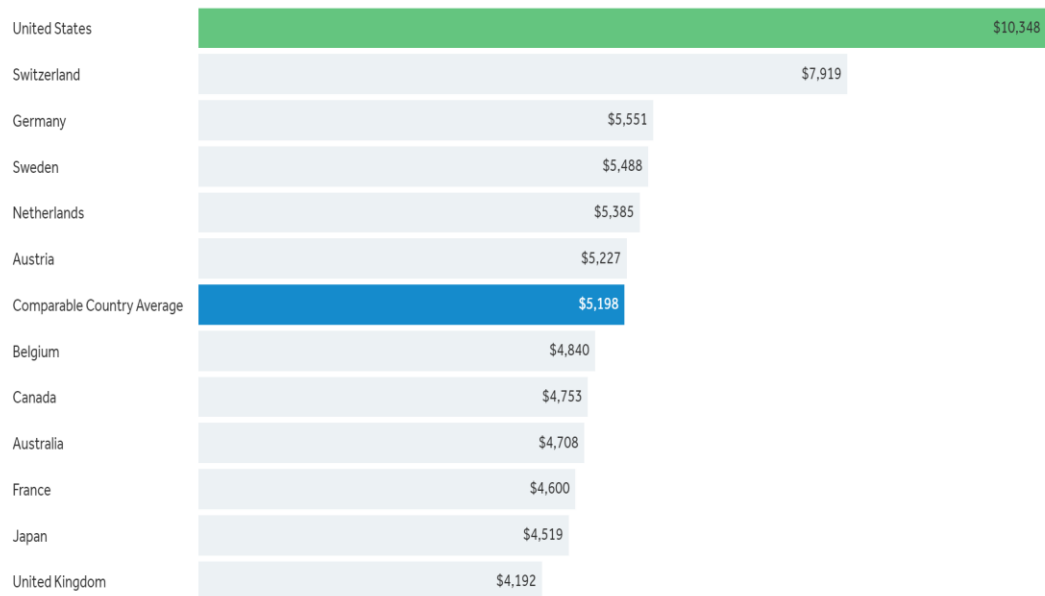
1. It costs too much
2. It leaves too many people behind
3. It is too complex
4. It produces uneven and unequal health outcomes

It costs too much

- *Price has been and continues to be the main driver of high health care spending in the U.S.*
- Prices for health care services vary within the U.S. An analysis of the price for 162 common medical services in 41 states and the District of Columbia showed prices could vary as much as three-fold.
- *The U.S. has relatively high administrative costs* . Eight percent of total U.S. healthcare spending in 2016 was accounted for by administrative cost. The average administrative costs for private insurers are around 12.4% and approximately 17.8% of every dollar goes to operating costs. Administrative costs in the Medicare program are considerably lower than those in the private insurance market at around 2% of total expenditures.
- *The health care field recently surpassed manufacturing and retail as the largest employment sector in the United States.*

On average, other wealthy countries spend half as much per person on healthcare than the U.S.

Total health expenditures per capita, U.S. dollars, PPP adjusted, 2016



Source: U.S. data are from the 2016 National Health Expenditures Account. Comparable country data are from OECD (2017), "OECD Health Data: Health expenditure and financing: Health expenditure indicators", OECD Health Statistics (database), DOI: 10.1787/health-data-en (Accessed on March 19, 2017) • Get the data • PNG

Peterson-Kaiser
Health System Tracker

In 2016 the U.S. spent 18% of its GDP on healthcare, whereas the next highest country (Switzerland) devoted 12% of its GDP to healthcare. The average amount spent on healthcare per person in comparable countries (\$5,198) is half that of the U.S. (\$10,348).

The average nightly hospital price is slightly higher in the U.S. than in Switzerland, and much higher than in Australia

Average hospital cost per day, 2014



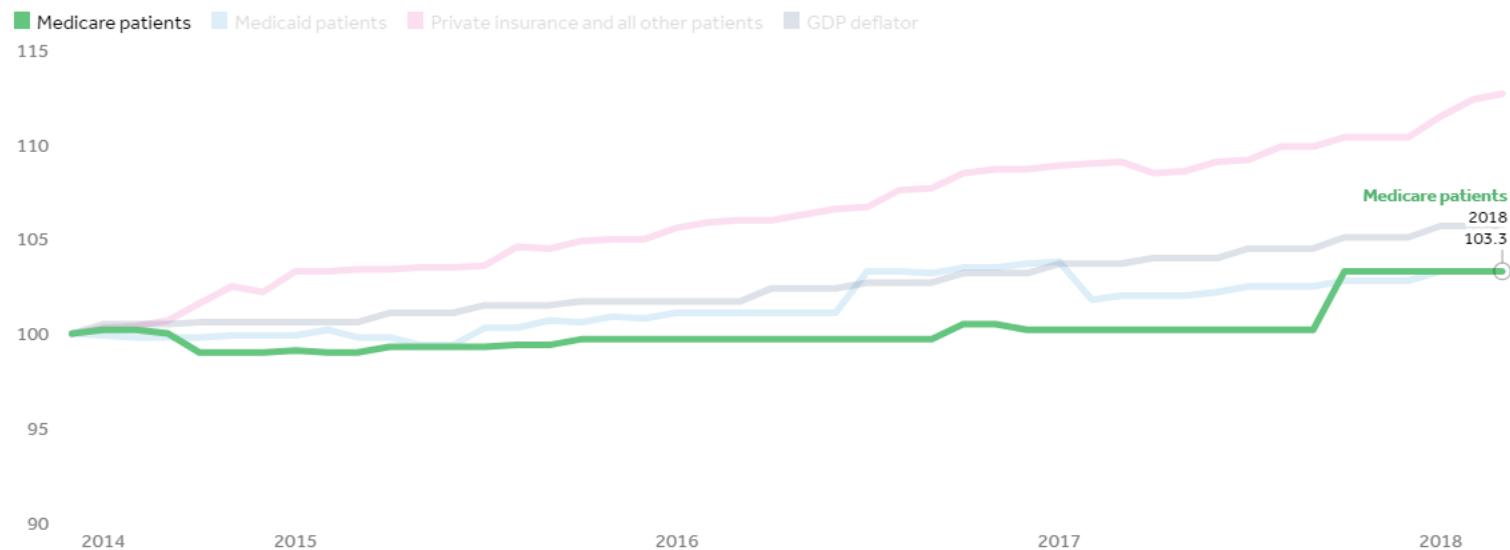
Source: International Federation of Health Plans (2015), "2015 Comparative Price Report, Variation in Medical and Hospital Prices by Country" (Accessed on January 30, 2018). • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Hospital spending represents 32% of total health spending in the U.S. Average prices for select health services in the U.S. (based on employer-based insurance claims and patient cost-sharing) and a few comparable countries are available from the International Federation of Health Plans. Although hospital stays are shorter on average in the U.S., the average price of a night in the hospital is far higher in the U.S. than in Australia, and slightly higher than in Switzerland.

Prices for inpatient hospital care have grown rapidly for privately insured patients

Producer price index for hospital inpatient care, by payer, 2014-2018

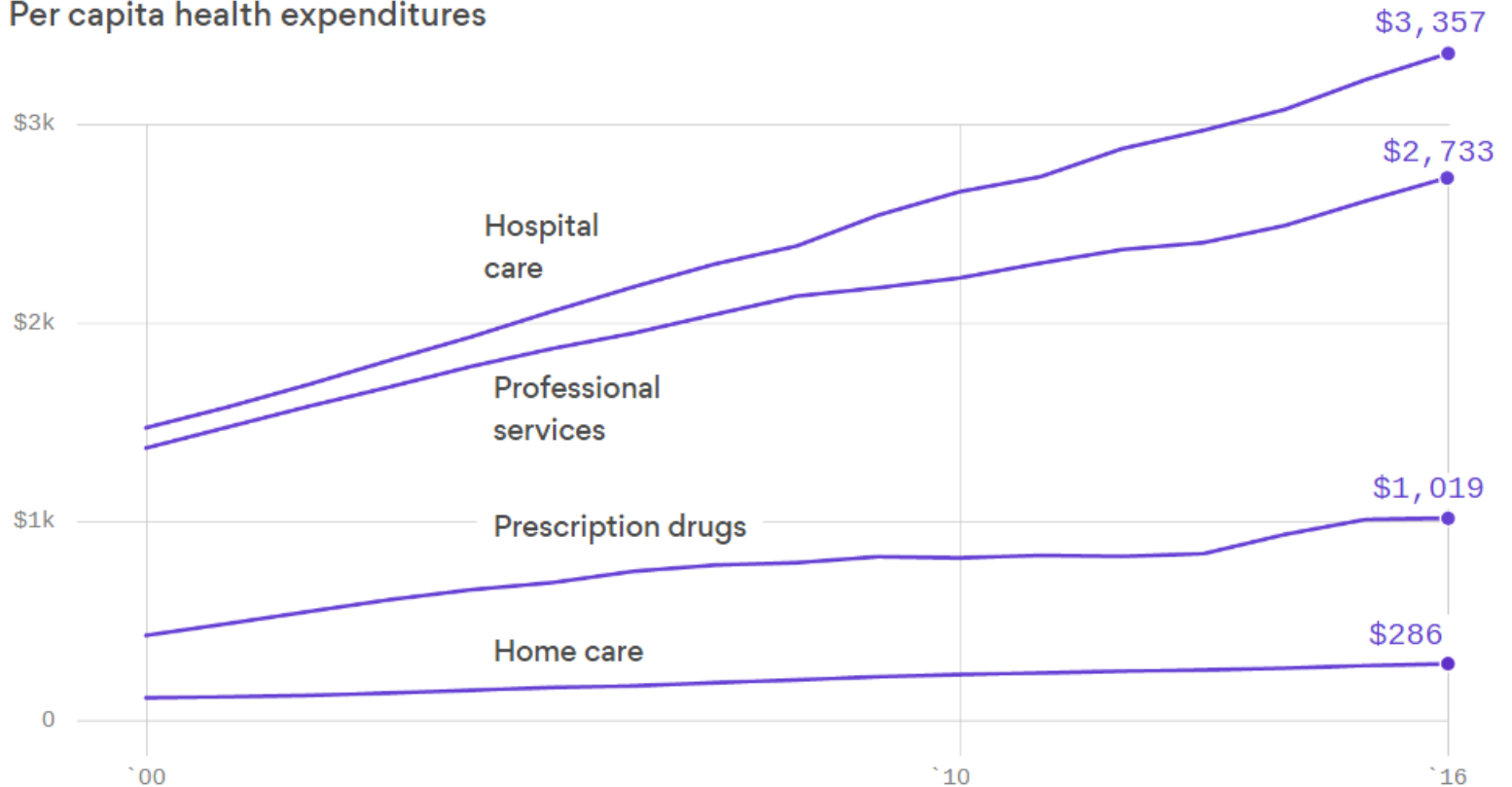


Source: [Federal Reserve Data](#) • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Think drug costs are bad? Try hospital prices

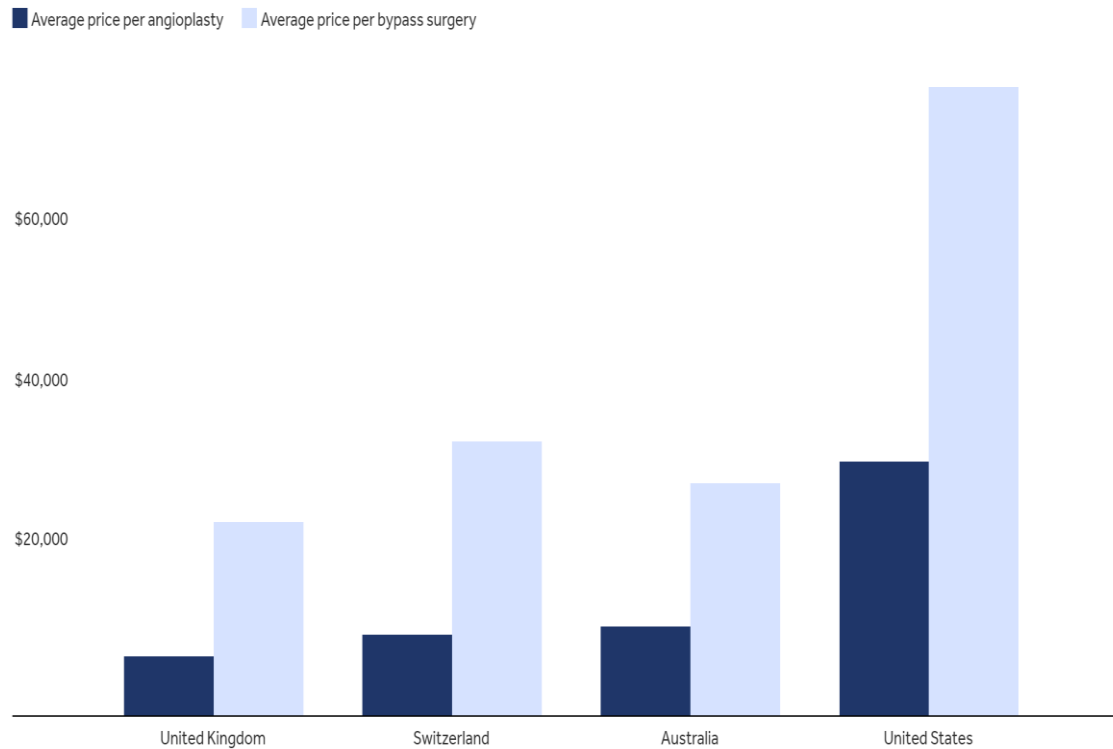
Per capita health expenditures



Data: [Centers for Medicare & Medicaid Services](#); Chart: Kerrie Vila/Axios

The average price of an angioplasty or bypass in the U.S. is higher than in comparable countries

Average price of an Angioplasty, 2014; Average price of coronary bypass surgery, 2014

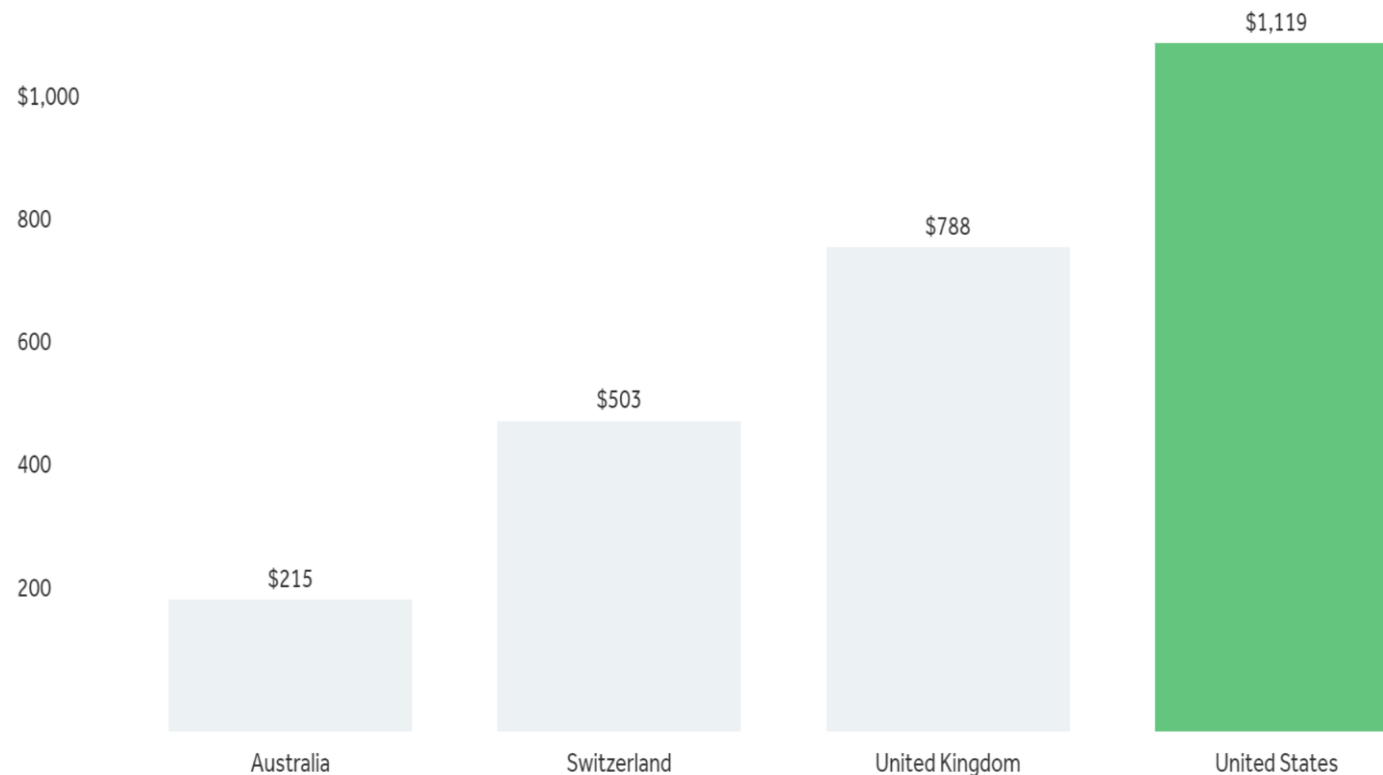


Source: Kaiser Family Foundation analysis of data from International Federation of Health Plans (2015), "2015 Comparative Price Report, Variation in Medical and Hospital Prices by Country" (Accessed on January 30, 2018). • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

The average price of an MRI in the U.S. is significantly higher than in comparable countries

Average price of an MRI, 2014

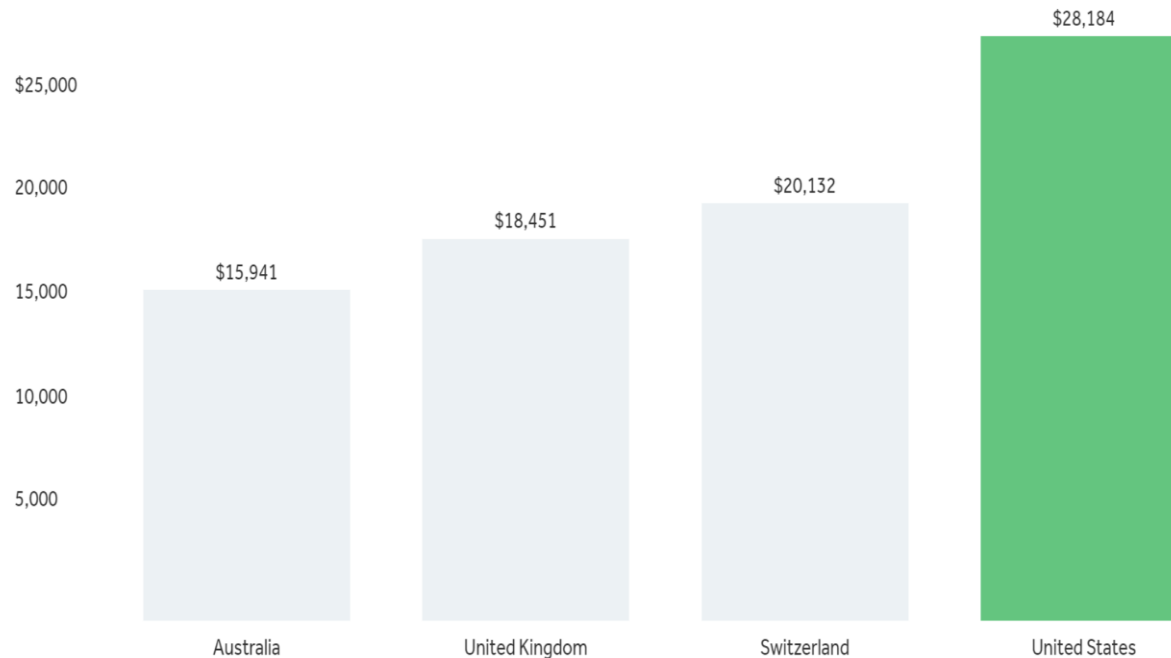


Source: Kaiser Family Foundation analysis of data from International Federation of Health Plans (2015), "2015 Comparative Price Report, Variation in Medical and Hospital Prices by Country" • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

The average price of a knee replacement in the U.S. is higher than in comparable countries with available data

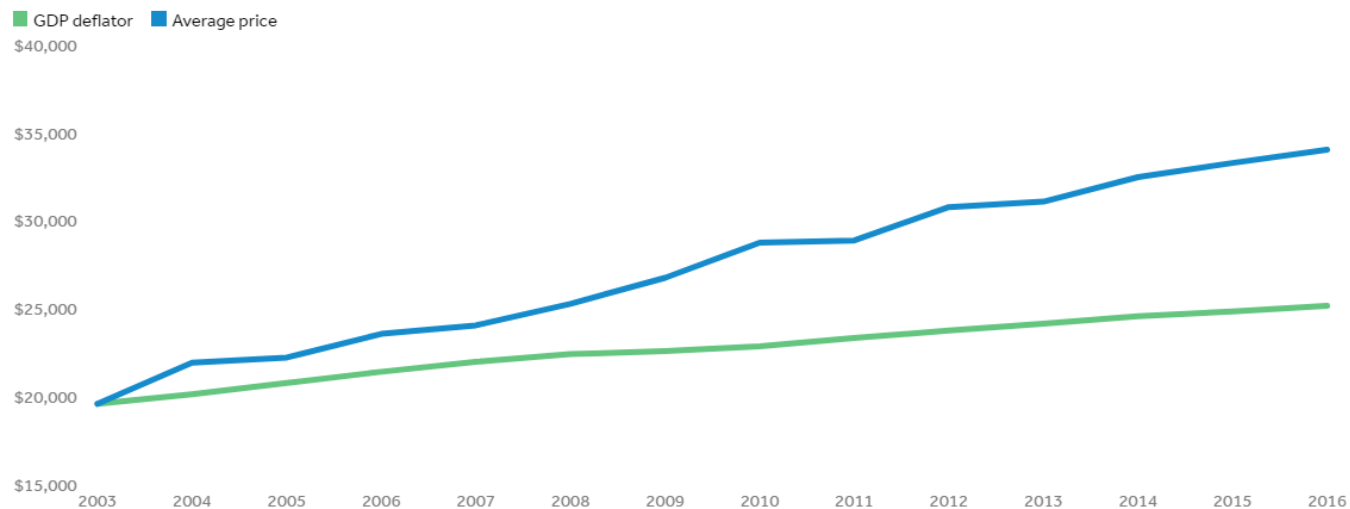
Average price of knee replacement, 2014



Source: Kaiser Family Foundation analysis of data from International Federation of Health Plans (2015), "2015 Comparative Price Report, Variation in Medical and Hospital Prices by Country" • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Average price full knee replacement in large employer plans, 2003 - 2016

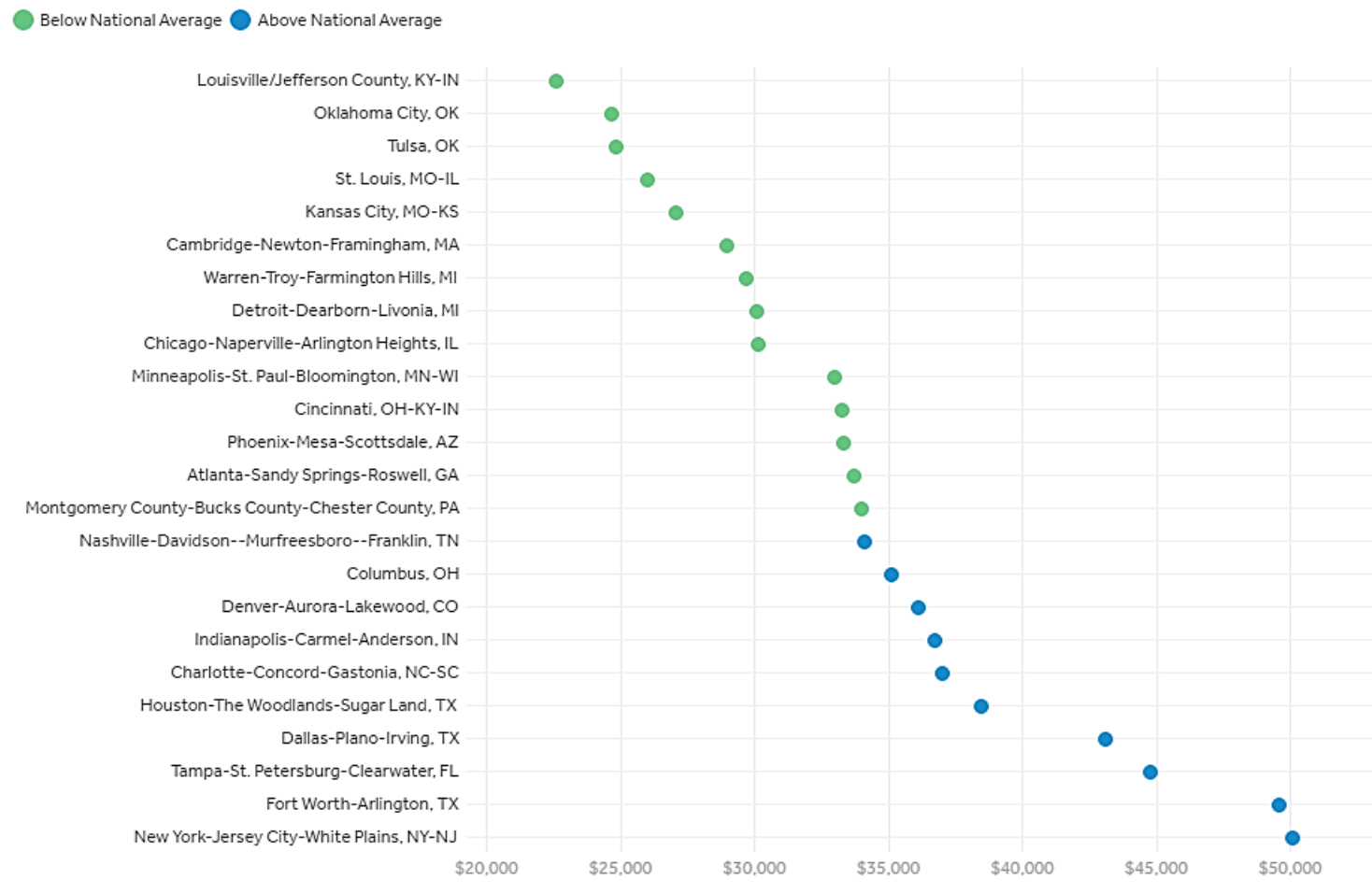


Source: Kaiser Family Foundation analysis of Truven MarketScan data, 2003-2016 • [Get the data](#) • [PNG](#)

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The average price of full knee replacements varies considerably across markets

Average price of full knee replacement in large employer plans, by MSA, 2016



Source: Kaiser Family Foundation analysis of Truven MarketScan data, 2016 • [Get the data](#) • [PNG](#)

The average price of Avastin in the United States is 124% higher than in Switzerland

Average price, Avastin, 400 mg vial, 2014



Source: International Federation of Health Plans 2015 Comparative Price Report • [Get the data](#) • [PNG](#)

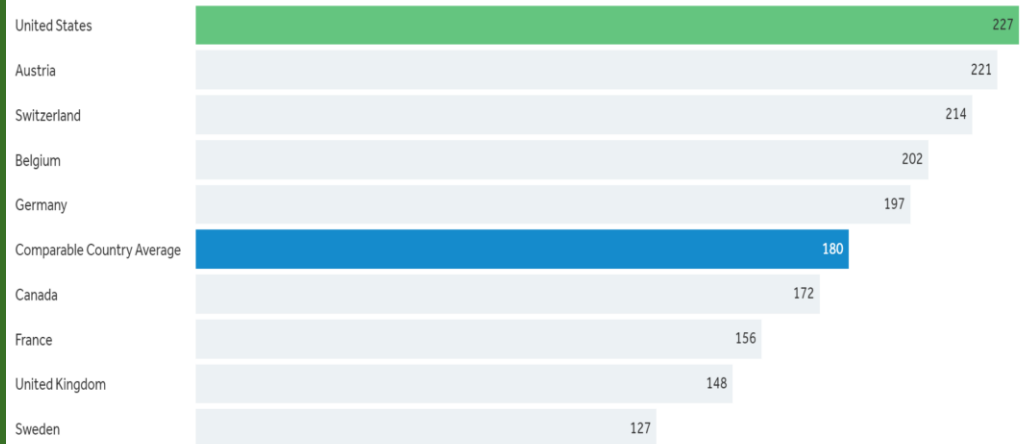
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Health System Tracker

Avastin, prescribed to treat some cancers, is priced 124% higher in Switzerland, on average, and 125% higher than in the United Kingdom. Unlike some other drugs included in the International Federation of Health Plans, the price range for Avastin is relatively large; the 25th percentile was \$2,289 and the 95th percentile was \$8,831 in 2014.

But it's not
only that we
charge
more for
procedures,
*we do more
of them*

The U.S. performs more knee replacements than comparably wealthy countries

Number of inpatient total knee replacements performed per 100,000 population, 2014



Note: Data not available for Australia, Japan, and the Netherlands.

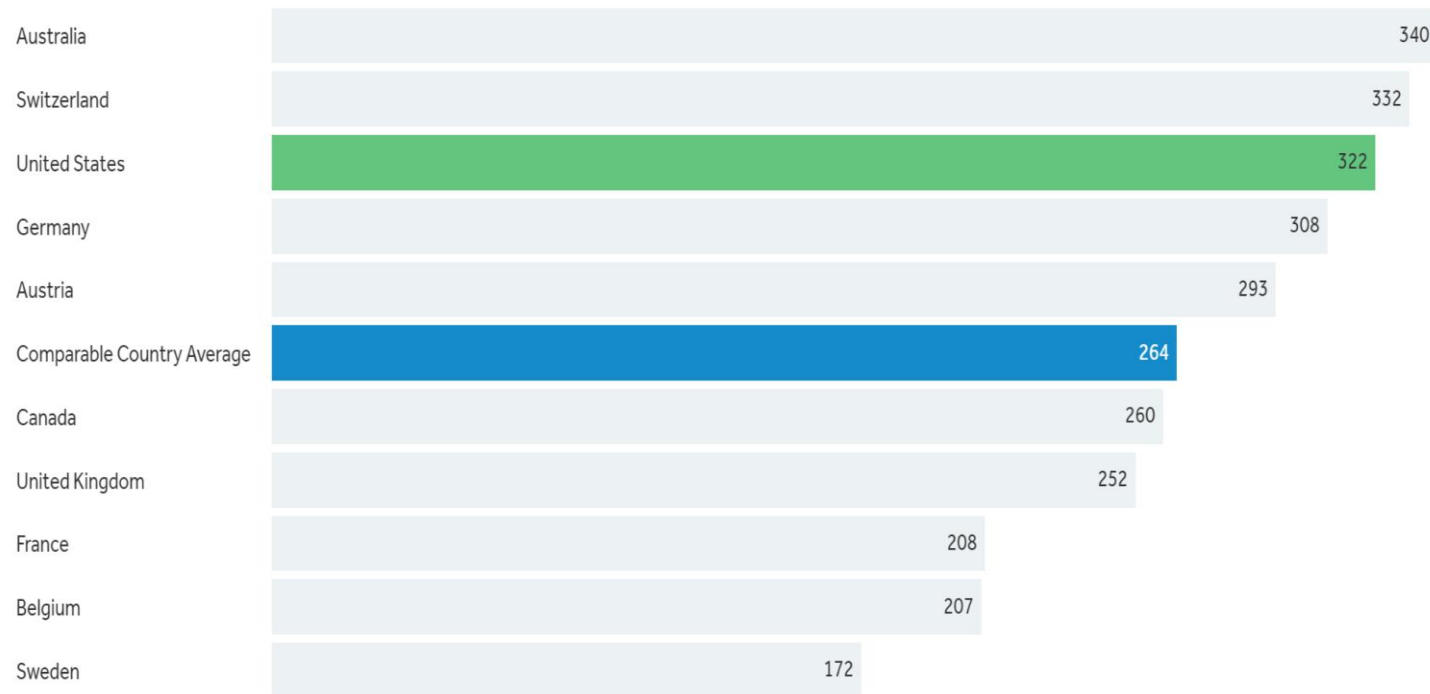
Source: Kaiser Family Foundation analysis of data from OECD Health Statistics and the AHRQ Healthcare Cost and Utilization Project (Accessed on 31 January 2018) • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Both the U.S. and similarly wealthy countries for which data are available have seen an increase in the number of total knee replacements performed since 2000, though the U.S. has consistently performed more of these surgeries. In 2014, the U.S. saw an average of 227 total knee replacements performed per

The U.S. performs more caesarean sections than most comparably wealthy countries

Number of caesarean sections performed per 1,000 live births, 2014



Notes: Data not available for the Netherlands. In cases where 2014 data were unavailable, 2013 data are shown.

Source: Kaiser Family Foundation analysis of data from OECD (2018), "Health care utilisation", OECD Health Statistics (database) (Accessed on 31 January 2018) • [Get the data](#) • [PNG](#)

Peterson-Kaiser
Health System Tracker

Other cost contributors

- *Roughly 20% of an individual's health is tied to clinical care while the other 80% are tied to socioeconomic factors, physical environment, and health behaviors.* The most important social determinant in the U.S. is socioeconomic status. The U.S., compared to other western European countries, has the highest overall poverty rate.
- Medical liability reform/defensive medicine.
- Patient-demanded care, direct-to-consumer advertising.

Cost is
not just a
macro
system
issue, it's
personal

Exhibit A:
**Average Annual Health Insurance Premiums and Worker Contributions for
Family Coverage, 2005-2015**

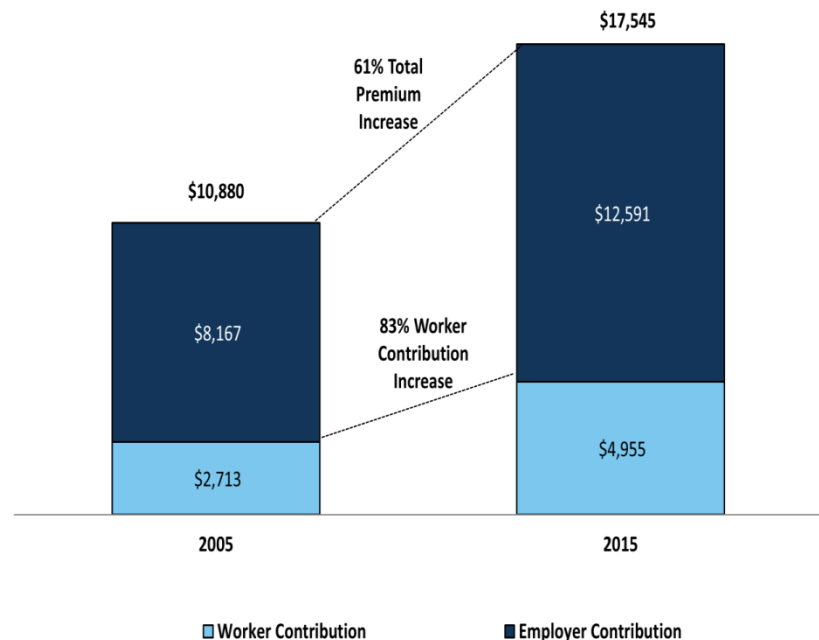
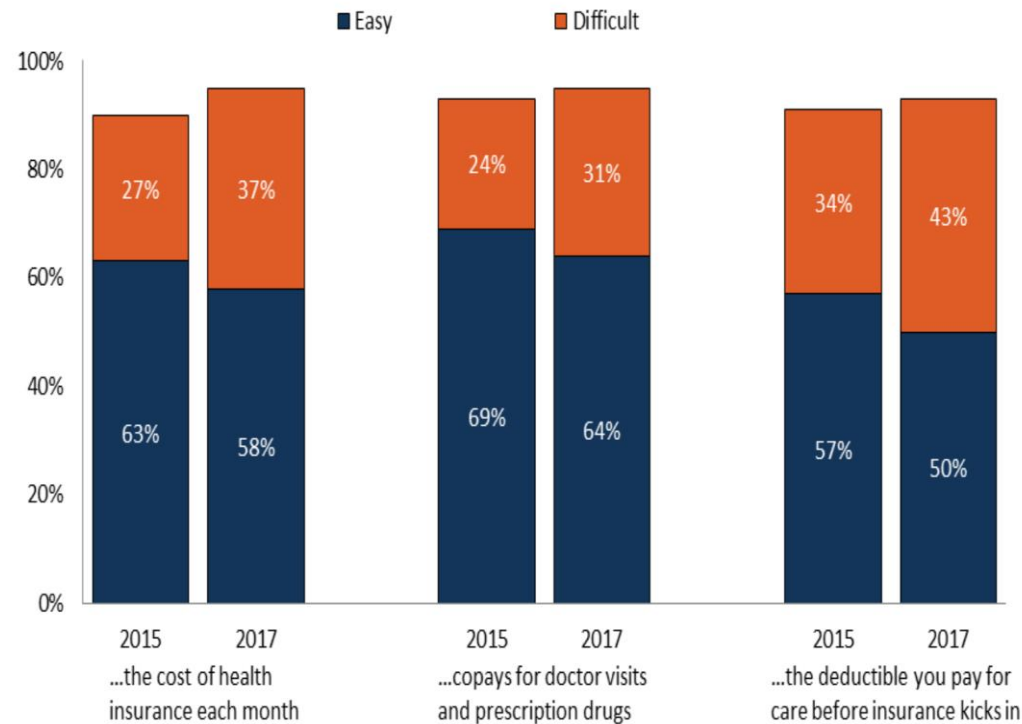


Figure 2

More Insured Americans Now Report Difficulty Affording Health Care

AMONG THE INSURED: In general, how easy or difficult is it for you to afford to pay...



NOTE: Don't have to pay (Vol.) and Don't know/Refused responses not shown.


SOURCE: Kaiser Family Foundation Health Tracking Polls



Figure 2: More Insured Americans Now Report Difficulty Affording Health Care

A family of four with a \$100,000 income and employer coverage spends \$12,500 per year (13% of their income) on health.

By Cynthia Cox

 [HHSC Charts](#) |

Posted: September 11, 2018

SHARE

Direct Spending on Healthcare

A **family of four** with a **\$100,000** income and **employer** coverage spends **\$12,500** per year (**13%** of their income) on health. This includes **\$2,900** (**3%** of their income) in out-of-pocket health spending, **\$4,550** (**5%** of their income) in health insurance premiums, and approximately **\$5,050** (**5%** of their income) in state and federal taxes that fund health programs.

Additional Contributions by Employers

Workers are not taxed on the contributions their employers make toward health insurance premiums. Economists generally believe that employer contributions offset wages. In this scenario, we estimate that the employer is contributing an additional **\$13,050** to health insurance premiums, as well as **\$1,450** in Medicare payroll taxes. These amounts are not shown in the chart above, but economists generally believe that they offset wages.

When combined, this family's spending on health care and the money spent by their employer on their behalf totals **\$27,000**.

As part of the BoR-approved strategic theme, *innovation*:

“[ACP will] develop a new vision for the future of health care policy, including recommendations for how to achieve universal coverage with improved access to care; reduce per capita health care costs and the rate of growth in spending; reduce market consolidation and ensure competition and choice (of insurers, providers, and services); reform how physicians are compensated to truly achieve better value for patients and to recognize the value of care provided by internists; and reduce the complexity in our health care system.

How will we do this?

- ✓ Conduct an evidence-based review of what is working, and what's not working well, with American health care.
- ✓ Bring these analyses to the principal policy committees (HPPC and MPQC) for discussion and direction.
- ✓ Develop evidence-based policy options for HPPC and MPQC consideration. Get direction on which to pursue in more detail. Will look at both transitional and transformative policies.
- ✓ Obtain input from other committees and councils, including experts on technical committees, and *individual members*, on proposed policies.

There really is another way

Policy options to lower costs

- Price regulation/negotiations
- Value-based payment and delivery reforms
- Invest in primary care (less money for specialists?)
- Choosing Wisely/High Value Care initiatives
- Consumer-driven health care (HSAs, high deductible plans), price transparency, “skin in the game”
 - Reward patients for healthful behaviors, penalize them if they don’t?
- Restrain anti-competitive market consolidation

There really is another way

Policy options to lower costs

- Identify Disease Conditions with Highest Potential Cost Savings
- All-payer rate-setting / global health care budgets (financial risk at the health system level)
- Limits on capacity (number of permissible MRIs)
- Comparative Effectiveness Research and Quality-Adjusted Life-Years
- Address social determinants of health

There really is another way

Universal coverage, so no one is left behind

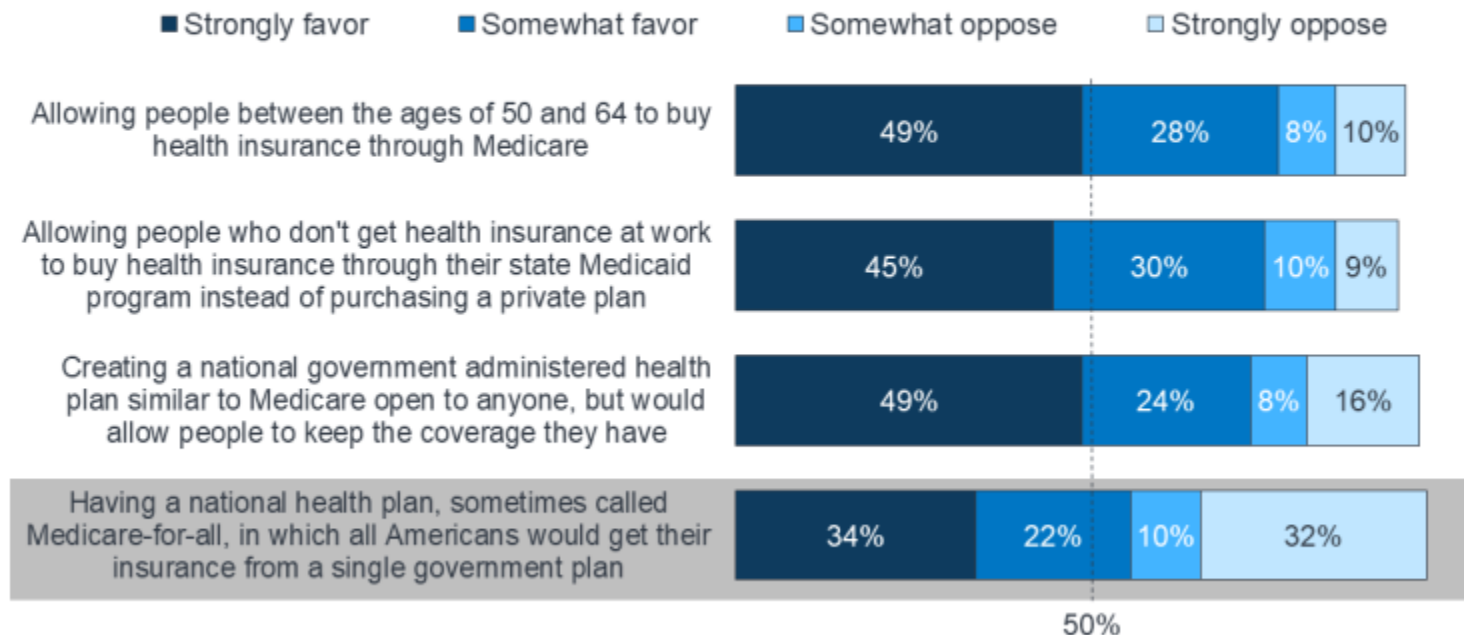
- Models found in other countries:
 - *National health model*: universal health coverage for all citizens paid for by government, financed by tax revenues, government runs hospitals and employs providers. (This describes the health care systems of the United Kingdom, Denmark and Ireland).
 - *National health insurance model*: Government ensures universal coverage and acts as single payer, financed by taxes, private hospitals and providers deliver services. (Canada's Medicare system largely fits this model).
 - *Bismarck/Social insurance model*: Health coverage is provided by non-profit, private employer based health insurance plans and in some cases individual and private insurance sickness funds. Financing may come from payroll contributions or other areas. Enrollment is compulsory and providers and hospitals are private. (Germany and France have such systems).

Coverage: examples of models proposed for U.S.

- Medicare for All/Single Payer
- Medicare Choice/Option
- Universal Catastrophic Coverage
- Universal tax credits to buy private insurance with automatic enrollment (“near universal” coverage?)
- Health Care Choices: block grants to states to design their own programs to subsidize purchase of private insurance; not intended to achieve universal coverage.

Figure 4

Public's Attitudes On Proposals To Expand Medicare and Medicaid



SOURCE: KFF Health Tracking Poll (conducted January 9-14, 2019). See topline for full question wording and response options.

Questions applicable to all models

- Does this proposal achieve universal health coverage? Does this proposal make enrollment compulsory or voluntary?
- Will this proposal allow Americans to keep the coverage they already have or enroll in a new plan?
- Is this coverage portable or is it tied to an employer, state of residence, income, or health status?
- Is coverage more affordable than what is offered through Medicare or the typical large employer-sponsored insurance plan? Will low-income individuals be able to afford coverage?
- Is coverage more or less generous than what is widely available now? Is an essential benefit package provided, how is it determined?

Questions applicable to all models

- How are private insurers treated under this proposal? How are Medicare, Medicaid, the VA system affected?
- Will enrollees have access to any participating physician or willing provider? Will limited networks be used?
- How are costs controlled? Through global budgets, price controls, cost sharing, comparative effectiveness programs?
- Is eligibility limited to United States citizens and/or legal residents? Are undocumented immigrants allowed to enroll?
- How are physicians and other health care providers affected? Would they be required to participate in the new proposal? How are they reimbursed?

Payment and delivery system reforms: *there must be another way (options)*

- Prospective, risk-adjusted primary care capitation
 - Paying primary care practices a set amount each month for all of the patients enrolled in the practice, adjusted by patients' health status (sometimes called), instead of each physician in the practice billing and being reimbursed on a fee-for-service basis.
 - The monthly prospective payments could provide predictable practice revenue and reduce the costs of billing for services.
 - The payments would need to be sufficient to sustain practices and recognize the value of caring for sicker and more complex patients.

Payment and delivery system reforms: *there must be another way (options)*

■ Direct Primary Care

- Substantially smaller number of patients compared to typical internal medicine practices.
- Charging each patient a monthly service fee for a package of primary care services.
- Better access to primary care services covered by the monthly service fee (such as email and telephone consultations and more timely office visits) and more time with their physician.
- Limited or no participation in patients' insurance: patients would directly pay the monthly service fee and bill their own insurance, or pay out-of-pocket, for services not covered by the monthly service fee.

Payment and delivery system reforms: *there must be another way (options)*

- Creating more opportunities for physician-led alternative payment models, such as patient-centered medical homes and accountable care organizations.
 - Physicians in these models would receive higher payments in anticipation of achieving quality improvements and savings; if they are unable to attain such improvements, they would be at risk of returning a portion of the payments.

Payment and delivery system reforms: *there must be another way (options)*

- Continuing to pay most physicians on a fee-for-service basis using the resource-based relative value scale (RBRVS), but with improvements, such as by increasing relative value units (RVUs) for complex cognitive care, lowering RVUs for procedural services, and paying for services that are not part of a face-to-face office visit.

Better is possible

“Better is possible. It does not take genius. It takes diligence. It takes moral clarity. It takes ingenuity. And above all, it *takes a willingness to try.*”

Atul Gawande

ACP's New Vision for American Health Care

- Affordable coverage for all Americans
- With benefits that cover essential medical care
- At a sustainable cost to the system and individuals
combined with
- Payment/delivery system reforms designed to achieve better value for patients and to support the value of care provided by internists
- With the specific objective of reducing administrative costs and tasks at the system and individual patient-physician relationship
combined with
- Policies to reduce barriers to care and improve public health

We need your thoughts on ACP's New Vision!

- All U.S. ACP members received a [survey](#) on 2/19/19 asking for your opinions on different options to expand coverage, control costs, and reform payment and delivery systems, as well as an open ended question: *In your own words, please tell us what aspects of our current health care system do you believe are most in need of improvement and should be addressed in ACP's New Vision?*
- It's not too late to complete it!

*A health care system
that costs too much,
leaves too many people
behind, is too complex,
and devalues care provided
by internists.*

What We Have Today

*ACP's New Vision for
Health Care will
propose solutions that
make our system
better for you and
your patients.*

A Clean Slate

What would you write on a clean slate?