



Frequently Asked Questions about Health Care Reform March 23, 2010

Below you will find a series of questions and answers addressing health care reform legislation, the political landscape, and the outlook for enacting comprehensive health reform this year. To achieve a final health reform bill, Congress and the President are building upon the Senate-passed health reform bill, H.R. 3590, through a process called reconciliation. This document focuses on those proposals that are central to that process. This document also provides answers to general policy questions raised in the context of overall health care reform.

This document is generally organized in terms of ACP's priorities for health reform and how the current proposals reflect these priorities. ACP's priorities include:

- Providing all Americans with access to *affordable* health insurance;
- Creating incentives to reverse a growing and catastrophic shortage of general internists and other primary care physicians;
- Ending the annual cycle of Medicare physician payment cuts; and,
- Reforming the medical liability system

Overview

1. What is the current state of health reform legislation in Congress?

The majority leadership in the House and Senate are working on a process to allow for a final series of votes on comprehensive health care reform legislation, which is based on a bill already passed by the Senate (H.R. 3590) as revised through a separate "corrections" measure, using a parliamentary process called "reconciliation." This would enable Congress to enact the legislation by a simple majority vote, as requested by President Obama.

2. Whatever happened to the bills passed earlier by the House and the Senate?

The House passed H.R. 3962, the Affordable Health Care for America Act, on Nov. 7, 2009 by a mostly party-line vote (one Republican voted for the bill). On Dec. 24, 2009, the Senate passed its health reform bill, H.R. 3590, by a super-majority of 60 to 39 votes (with one Senator not voting), the minimum number of votes needed to overcome a Republican filibuster (i.e. preventing a vote on a proposal by prolonging the debate) against the bill. All Democrats voted for the bill, and all Republicans voted against it. Typically, at that point, Congress would move forward through a House-Senate conference committee to reconcile the two versions into a final bill, which would then be voted on by each chamber. However, the process has been far from typical. With the election in January of Republican Scott Brown (R-MA) to the Democratic Senate seat previously held by the late Ted Kennedy and interim Senator Paul Kirk (D-MA), the Democrats lost the super-majority needed to get the 60 votes needed for final passage. As a result, the legislation has not advanced since December, due to many contentious provisions and an inability to muster 60 votes in the Senate to stop a filibuster.

The President hosted a Feb. 25th summit at the White House for invited members of Congress from both parties in order to find common ground between Democrats and Republicans on health reform issues. At that juncture, the President also released a discussion "framework" of policies that would build upon and make improvements in the Senate-passed health reform bill. He then offered to include several Republican ideas in the final legislation: improved enforcement of fraud and abuse laws, expanded use of health savings accounts, and more funding for state pilots to test alternatives to the medical liability tort system. These changes, though, were not enough to win Republican support for a bill. Instead, the GOP continued to urge the President to "start over" with smaller reforms.

To achieve a final bill, on March 3, President Obama called on Congress to move forward using a process that would allow them to pass the bill with a simple majority without the threat of a filibuster. This process is known as reconciliation, and the President's "framework" of policies served as the basis for the reconciliation bill currently moving through Congress.

3. Specifically, what does the final bill do for each of ACP's four priorities, as noted above?

Coverage: ACP supports the provisions to make affordable coverage available to the vast majority of Americans, increase security for those who already have coverage, and make coverage more affordable for small businesses, the principal engines of job creation in the United States.

- We support expanding coverage to 32 million people—95% of all legal residents—by filling gaps in our current system.
- We support providing sliding scale tax credits to help businesses and individuals afford coverage.
- We support making all persons up to 133% of the Federal Poverty Level eligible for Medicaid.
- We support increased Medicaid "matching funds" to all states to finance most of the cost associated with such expansion.
- We support reauthorization of the Children's Health Insurance Program.
- We support requiring individuals to buy coverage or pay a penalty if they do not, with a hardship exemption.
- We support requiring all health plans to provide affordable and non-discriminatory coverage to people with pre-existing conditions.
- We support requiring all health plans to provide essential and evidence-based benefits including preventive services with no cost-sharing, with the ability to compete by offering more benefits.
- We support requiring large employers to contribute to coverage or pay the costs associated with subsidies to their employees if they do not.
- We support creation of health exchanges to offer one-stop-shopping for qualified health plans and to negotiate affordable premiums with participating plans.

Primary Care: We are encouraged by the policies in the final package to train more primary care physicians and to reform payment policies to support the value of primary care, but we believe improvements are needed to reverse an anticipated shortage of more than 40,000 primary care physicians for adults. Specifically:

- We support increased funding for the National Health Service Corps and Title VII health professions funding, but believe that all health professions programs, not just the National Health Service Corps, should receive mandatory funding.
- We support establishing a loan repayment program for "front line" health professionals facing shortages, as the House proposed. However, the final package did not contain this provision.
- We support creation of a national workforce commission, but believe that the commission must include representation of primary care physicians, which the final package did not specify.
- We support the provision in the final package to increase Medicare payments to primary care physicians, but believe it should be improved by applying a bonus of at least 10% to all office, nursing home, home health care, emergency room and hospital visits by internists, family physicians, pediatricians and geriatricians who bill at least half of the time for such primary care services. The language in the final package would exclude hospital visits from the bonus and also may exclude some primary care physicians who continue to see their patients in the hospital.
- We support the provision in the final package that raises Medicaid payments in 2013 and 2014 for evaluation and management services provided by internists and other primary care physicians to no less than the applicable Medicare rates. ACP championed this change as an important step to permanently increasing Medicaid rates to be on par with Medicare. The increase takes effect the same year that Medicaid will cover persons up to 133% of the Federal Poverty Level.

Delivery and Payment System Reforms: We support the provision to create a new Center on Innovation to accelerate pilot-testing of innovative payment and delivery system reforms, including Patient-Centered Medical Homes, but we believe improvements are needed.

- We support mandating dedicated funding for two Medicare Medical Home pilots, as the House proposed. The final package does not include such dedicated funding.
- We believe that the provision to create an Independent Payment Advisory Board needs to be modified to allow Congress to reject the Board’s recommendation by a simple majority vote, to require adequate representation on the Board of primary care and other physicians, to require specific safeguards to ensure that the public has the opportunity to comment on the Board’s recommendations before they are sent to Congress, and to include hospitals, hospices and other providers under the Board’s authority to make recommendations. These modifications were not included in the final package.
- Although we support positive incentives for reporting on evidence-based quality measures, we do not support penalties on physicians who do not successfully report on such measures, as the final package requires.
- While we support research by the Institute of Medicine on payment policies to reduce inappropriate regional variations in the cost and quality of care provided, we do not support imposing an untested “value” index adjustment on payments to physicians as the final package would do.
- We support the provision to fund research on comparative effectiveness to inform clinical decision-making.
- We also believe that it is essential that Congress repeal the Medicare Sustainable Growth Rate (SGR) formula and enact a new, permanent update system that provides stable and predictable updates that reflect increases in physician practice costs. The final package does not address the SGR.

Medical Liability Reform: We are encouraged by the authorization of \$50 million in demonstration grants for state innovations in medical liability reform, as proposed by the Senate and included in the final package, but believe that more substantial incentives are needed for states to pursue a wide range of alternative reforms including, health courts, administrative determination of compensation, early offers, and safe harbors for the practice of evidence-based medicine, as well as to include proven liability reforms like those enacted in California and Texas.

4. Does ACP want members of the House and Senate to vote “yes” on the final votes needed for health reform legislation to become law?

Yes. ACP believes that Congress should cast the final votes needed to get comprehensive health care reform enacted into law. Without reform, tens of millions of Americans stand to lose access to affordable health care and out-of-control spending will trigger an unprecedented fiscal and budgetary crisis.

As noted above, the final bill has essential policies to expand coverage to almost all legal U.S. residents, increases the subsidies to help people buy coverage, provides equitable funding to all states to offset most of the cost of expanding Medicaid to the poor- and near-poor, increases funding for programs to train more primary care physicians, and accelerates pilot-testing of innovative payment and delivery system reforms to improve outcomes and reduce unnecessary cost.

The final package advances long-standing ACP policies to provide all Americans with access to affordable health insurance coverage. It fills gaps in our current system by providing families and small businesses with competitive and portable private sector options to buy affordable coverage, providing subsidies when they need help, and ending egregious insurance company practices that deny patients with pre-existing conditions access to affordable coverage. It has policies to begin to address the growing shortage of primary care physicians. It begins to improve reimbursement for primary care services. ACP has long-advocated for such reforms, and we are pleased that they are in the final bill.

5. Does this mean ACP supports *everything* in the proposal?

No, it is not possible for any single bill to ever meet all our policy objectives. There always will be things we like in a bill and things we do not like, and the decision on support for a “yes” or “no” vote must be based on whether the legislation does more to advance ACP policies than to harm them. In this case, for the reasons discussed above, we believe that the final bill has enough policies, consistent with ACP’s, to merit a “yes” vote even though it falls short in some important respects. ACP will continue to advocate for improvements in future legislation.

More specifically, the final bill includes some important first steps to begin to reverse a catastrophic shortage of primary care internists, but we will continue to urge Congress to make improvements through subsequent legislation to ensure that all primary care internists can qualify for Medicare payment bonuses, some of whom will be excluded under the current language. Medicare and Medicaid payments need to be increased to ensure access to primary care and other services.

Congress must also permanently end the cycle of Medicare physician payment (SGR) cuts. ACP also believes that Congress should have the final say, by a simple majority vote, on accepting or rejecting cost-cutting recommendations from an unelected Medicare payment advisory board to be created by the legislation. We also believe that reporting on quality measures should be totally voluntary, with no penalties for non-reporting. We do not support prematurely adjusting payments to physicians based on outcomes and efficiency measures, using an unproven methodology, but we do support continued study of regional variations in quality and cost and ways to address them. These, and other concerns, need to be addressed by Congress in future legislation.

Finally, ACP notes that while the final bill increases funding for state pilots of alternatives to the broken medical liability tort system, although welcome, it is not enough by itself to reduce the huge costs imposed by excessive and unnecessary litigation. We will continue to advocate for additional measures to reduce the costs associated with our broken tort system, including dedicated funding for innovative models, like health courts, to create alternatives to trials by lay juries.

6. What is reconciliation and how does ACP feel about using it to get a final vote?

Reconciliation is a process that allows for legislative changes that only directly impact federal spending or revenue (taxes) on entitlement programs (e.g. Medicare and Medicaid). For example, a provision that would directly affect Medicare spending could be included in a reconciliation bill whereas federal restrictions on abortion cannot be addressed through reconciliation. It takes 60 votes for the Senate to overrule a ruling by the Senate parliamentarian that a particular provision is not germane to budget reconciliation.

A reconciliation bill cannot be filibustered in the Senate, but senators can offer an unlimited number of amendments to delay a vote. In the past, reconciliation has been used to enact welfare reform, the Children's Health Insurance Program (CHIP), and COBRA health coverage for the unemployed.

We understand that some ACP members may have concerns about using the reconciliation process to make the final changes needed in the Senate bill for comprehensive health care reform to become law. Other ACP members may support its use to allow for a simple "up or down" majority vote on health reform.

ACP did not determine the process that the majority party in Congress, and the White House, has chosen to move the legislation to a final vote, nor the actions of the minority party in trying to stop the legislation from becoming law. In an ideal world, we would have preferred that health care reform be done on a bipartisan basis, but the political environment has not allowed this to happen. We strongly believe, though, that the current health care system is not sustainable and reform is essential. Congress and the President must reach a final agreement on legislation that would build upon key elements in the bills passed by the House and Senate. ACP's support for a "yes" vote on the final steps needed to get health reform enacted that advances ACP policy is based solely on our view that the legislation, although imperfect, will advance important policy goals supported by the ACP, not an endorsement of the process or politics involved.

7. Why doesn't ACP support just starting over on brand new bills, or passing incremental reforms in scaled-down bills?

The current package is far from perfect, but it has enough good policy, developed over many months with broad public participation and debate, to serve as the basis of a final agreement. In addition, we are doubtful that starting over will yield bipartisan agreement on policies that will be effective in making the U.S. health care system sustainable and affordable. More likely, the result would be an indefinite postponement of any genuine reform for years to come.

As for passing small, incremental reforms, ACP does not believe this is a viable approach. For instance, requiring that all insurers accept people with pre-existing conditions, and limiting how much more they can charge them, likely will be ineffective without policies to incentivize individuals to purchase insurance coverage while healthy, instead of waiting until they are ill and more expensive to insure. Similarly, subsidies would be needed to make coverage affordable. Also, small-bore bills are likely to leave out many of the above reforms needed to make health care sustainable.

8. Will enactment of this legislation lead to health care rationing or government-run health care?

ACP does not believe that this legislation will lead to rationing of care, elimination of private insurance, or a government-run health care such as a single-payer system. While the House-passed health reform legislation, H.R. 3962, included

language that would have established an optional public insurance plan to be offered alongside private insurance options in the health care exchange, the Senate-passed legislation and the President's framework do not include such a provision. The final package will permit the establishment of two multi-state or national plans that operate under contract with the Office of Personnel Management, the same agency that oversees the health insurance program available to Members of Congress, federal employees and their families. This provision reflects ACP policy. Furthermore, the federal government is not given any authority in the current language to ration or limit care based on cost or other criteria. The Congressional Budget Office estimates that the vast majority of Americans—more than 160 million—will get coverage under private insurance if the legislation is enacted.

9. I have heard reports that this legislation will cut Medicare benefits. Is that true?

No. This legislation does not cut benefits under Medicare. Rather, savings are generated by addressing numerous inefficiencies in Medicare and Medicaid that, over the years, have cost taxpayers billions of dollars. This legislation would, among other things: eliminate the over-payments to Medicare Advantage plans which, on average, are paid 14 percent more than traditional fee-for-service, costing taxpayers \$12 billion a year; phase down payments to disproportionate share hospitals, on the assumption that hospitals will have fewer indigent patients to treat if coverage is expanded; clamp down on waste, fraud and abuse in both Medicare and Medicaid; drug manufacturers will provide 50 percent discounts on brand name drugs in the donut hole to reduce beneficiaries' out of pocket costs beginning in 2011. Trade associations representing hospitals and pharmaceutical manufacturers' agreed to the savings in the legislation.

On balance, these elements will actually add to the long-term sustainability of the Medicare program because by spending less over the next ten years, the date when the Medicare Part A trust fund (hospital insurance) runs of money will be delayed by almost a decade. Medicare's actuary estimates that the Senate-passed health reform bill, which is the basis of the final legislation passed by Congress, will **postpone the exhaustion of Medicare Part A trust fund assets by 9 years – that is, from 2017 under current law, to 2026 under the legislation.**” This will give Congress more time to come up with long-term reforms to ensure the sustainability of Medicare than if health reform had not passed. Beneficiaries will even see an improvement in benefits under this legislation, such as *elimination of cost sharing* for preventive services, greater access to primary care services through increased reimbursement to and training of primary care physicians, and greater access to promising payment models, like the patient centered medical home, through the creation of a new Center for Medicare & Medicaid Innovation.

Beneficiaries' out-of-pocket costs will also decrease. Medicare's actuary reported that **“there would be a steadily increased savings to Part B and associated reductions in the Part B premium and coinsurance averages. Similarly, the Medicare Part A savings under the PPACA [Patient Protection and Affordable Care Act] would result in lower beneficiary coinsurance payments for inpatient hospital and skilled nursing care.** As a result of this legislation, it is estimated that in 2019, Medicare premiums would be reduced by \$12.50 per month – which translates to a savings for seniors of \$300 per couple per year. Medicare coinsurance payments, like doctor's office co-pays, will fall as well – by \$370 per couple per year by 2019—for a total annual savings of nearly \$700 for seniors.

The legislation also prohibits a new Independent Medicare Payment Advisory Board, which the legislation would establish to make recommendations for reducing Medicare costs, from recommending any policies that would reduce benefits for Medicare beneficiaries.

This is what www.factcheck.org, an independent and non-partisan organization that evaluates the accuracy of statements made by politicians, journalists and others, described on March 19 stating that Medicare will be “cut” by \$500 billion as one of the biggest “whoppers” <http://factcheck.org/2010/03/a-final-weekend-of-whoppers/> about the new health reform legislation.

For more information, see also <http://finance.senate.gov/press/Bpress/2009press/prb121409.pdf>.

10. How can ACP support this legislation when it doesn't repeal Medicare's Sustainable Growth Rate (SGR) formula that continually threatens physician practices with payment cuts virtually every year?

On March 3, 2010, the President signed legislation that keeps the 2009 rates in effect until March 31, 2010, thereby preventing a 21 percent cut that was supposed to go in effect on January 1 and was temporarily delayed until March 1 by

legislation. Congress will need to pass additional legislation to keep the 21 percent cut from going into effect after March 31.

ACP has long-advocated that a permanent solution to the SGR is needed; one that provides positive, stable and predictable physician payment updates under Medicare. While this final health reform package does not address the SGR issue, ACP's qualified support for the legislation was never based principally on the SGR, but how it advanced ACP's overall advocacy goals, including our support for providing all Americans with access to affordable coverage. The SGR problem pre-dated the current reform legislation and would have had to be dealt with, regardless of what happened with the health care reform bill itself.

Congressional leaders and the Administration continue to indicate that they are committed to solving the SGR problem this year. ACP has been working with lawmakers, in good faith, on a pathway to that end stating that short term, year-to-year, fixes are simply not acceptable.

ACP supports the final package because it advances many long-standing ACP policies, such as: providing all Americans with access to affordable health insurance coverage, filling gaps in our current system by providing families and small businesses with competitive and portable private sector options to buy affordable coverage, providing subsidies when they need help, and ending egregious insurance company practices that deny patients with pre-existing conditions access to affordable coverage. It has policies to begin to address the growing shortage of primary care physicians and begins to improve reimbursement for primary care services. Based on the advancement of these principles, ACP believes that this legislation merits a "yes" vote and, at no time did ACP state that support for health reform legislation was conditioned upon enactment of a long-term solution to the SGR.

That being said, the College realizes that the improvements established through the reform legislation are muted if an SGR cut is allowed to take effect. The College has repeatedly stated that it is not viable for physicians to sustain the level at which they care for Medicare beneficiaries in the face of an SGR cut and even late Congressional action to avert a cut before it takes effect. The College will continue to insist on a permanent SGR solution that provides a foundation on which legislative improvements can fully materialize.

11. Won't fixing the SGR be so expensive that it would literally wipe out all the deficit reduction that would come about through enactment of this health reform package?

ACP firmly believes that Congress was responsible for creating the flawed SGR formula and is therefore responsible for fixing the problem, including finding the necessary funds to pay for it. Every year, for the better part of the last decade, Congress has been enacting short term "fixes" to delay looming physician payment cuts under Medicare that have accumulated over those many years. It is time for Congress to own up to this accumulated debt from the SGR and account for it honestly in the budget. According to calculations done by the AMA, the cost of a Congressional fix to the SGR problem in 2005, when physicians faced a 3.3 percent cut, was about \$49 billion. The cost of the fix in the face of the 2010 cut of 21 percent is over \$200 billion. Through short-term SGR fixes and arcane rules for determining the amount of the cost associated with legislative action, Congress has created a dilemma that it must resolve.

The cost of eliminating the SGR and providing all physicians with predictable and positive updates pre-dated the current health reform legislation and would have had to be dealt with by Congress, regardless of whether or not health care reform was enacted into law or even proposed by the Obama administration. The accumulated costs of the SGR, which were the results of many years of Congress (under both Republican and Democratic leadership) failing to deal with the problem in a forthright and fiscally responsible manner, has nothing to do with the costs associated with expanding health insurance coverage or the other reforms in the health reform legislation. The health reform legislation passed by Congress more than covers its own costs, according to the Congressional Budget Office, generating an overall budget surplus.

Also, the budget "cost" of repealing the SGR is a budget fiction, because it assumes that Medicare would save money by allowing the cuts to go into effect. Honest budgeting would account for the costs of providing physicians with positive updates in Medicare's baseline spending, even though doing so will increase the deficit "on paper" because the current budget assumptions assume that the cuts will go into effect.

The President recently signed into law "pay-go" legislation that would require Congress to pay for much of its future spending without adding to the deficit, but it exempted \$82 billion from the requirement to prevent reductions to doctors'

Medicare reimbursement rates. The \$82 billion available without offsetting revenue increases or expenditure cuts provides Congress with some latitude toward solving the SGR problem. For instance, it provides enough funding for Congress to prevent up to five years worth of cuts. Absent some currently unidentified solution that creatively resolves the SGR issue with the \$82 billion available, Congress will need to find the additional money needed for a permanent fix. It is not for the ACP to identify ways to increase revenue and/or decrease expenditures to offset the additional costs of the SGR fix. It is imperative, however, that Congress do what is needed to preserve beneficiary access to physician services and to ensure that the Medicare payment system provides adequate support to ensure the level of physician participation needed to realize reform package improvements.

12. I have heard that this legislation would prohibit private contracting? Is that true?

No. We have found nothing that takes away existing rights for physicians and patients to enter into voluntary contracts.

13. Does the College support the Independent Payment Advisory Board (IPAB) included in the final health reform package?

While ACP supports the concept of an independent payment board, the current provision does not meet key ACP conditions for support, as outlined below. As written, the IPAB is a 15-member board of healthcare experts appointed by the President, with the consent of the Senate, which would submit proposals to Congress to extend Medicare solvency and improve quality in the Medicare program. More specifically, beginning in 2014, proposals for Medicare cost reductions from the Board would be required when Medicare costs are projected to increase faster than inflation indicators. The targeted level of cost reduction would be the lesser of the level of excess spending or a defined level that would increase each year. The target growth in 2019 and beyond would be GDP per capita plus 1 percent. The Secretary of HHS would be required to implement the provisions included in the IPAB proposal, unless Congress passes an alternative proposal with an equivalent amount of budgetary savings.

The ACP Board of Regents, in September 2009, discussed and approved a position on entities like the IPAB that provided significant regulatory and budgetary authority to a non-elected body. The College's position supports the concept of an independent body developing proposals to implement payment reform that promotes quality and value (and not simply focus on cost) on a fast-track basis. The College believes that making difficult Medicare payment and budgetary decisions is very difficult within a political process so influenced by lobbying, and that an independent board serving in this role should have some protection from undue influence. Within this framework, the College developed a set of criteria that such an independent body must meet to receive the College's support. The current IPAB provisions do not fulfill the following critical criteria, and therefore the College does not support the provision as written:

- It does not ensure adequate primary care representation on the Board.
- It does not provide sufficient protections to ensure that the cost reductions will not adversely affect the delivery of quality services. While the provisions do address quality considerations, the emphasis is too strongly focused on cost reduction.
- It does not provide the elected members of Congress with sufficient ability to override the IPAB proposals. The College believes that the proposals offered by the IPAB should be subject to a simple majority vote.
- It does not treat all providers and suppliers under Medicare equally. The current provision exempts hospice and hospitals from any consideration for reductions based on the Board's recommendations over the first several years. This unfairly leaves physician payments as one of the few remaining means of obtaining required savings.

ACP will continue to seek changes to the IPAB through future legislation.

There has also been concern expressed that, under the current provision, the IPAB is protected from any repeal or modification by a future Congress. Clearly, this is a position that the College would not support. Our understanding is that this concern is not substantiated. Repeal, while difficult, can be achieved by a supermajority, three-fifths vote, and some legal scholars believe that a future Congress would not be bound by the rules established by a predecessor Congress. More information about this issue can be found at: <http://www.factcheck.org/2010/01/medicare-board-unrepealable/>.

14. Has ACP looked at the Republican alternative? If so, why don't you support it?

The House Republican leadership developed a bill that was offered as an alternative to the House-passed bill, H.R. 3962. The GOP alternative would create state risk pools, allow insurance to be sold across state lines, and prohibit insurers from rescinding coverage, but it does not provide any real financial support to help people buy coverage. Although the bill has some policies that ACP supports, like caps on non-economic damages in medical liability lawsuits, it does not address ACP's priorities of ensuring that all Americans will have access to affordable coverage or reforming physician payments to support primary care.

Click here http://www.acponline.org/advocacy/where_we_stand/access/hr_3962_snap.pdf to see a snapshot analysis of how the House GOP bill compares to key ACP policies. The Congressional Budget Office has estimated that the bill would reduce the number of nonelderly people without health insurance by about 3 million in 2019 and leaving about 52 million nonelderly residents uninsured. The share of legal nonelderly residents with insurance coverage in 2019 – 83 percent– would be roughly in line with the current share.

There are no known comprehensive GOP alternative health reform proposals in the Senate. However, the President did agree to incorporate several GOP principles in his framework proposal, which are included in the final package, such as expansion of Health Savings Accounts and provisions to eliminate fraud in Medicare and Medicaid.

15. I am worried that we cannot afford this. Won't it add hundreds of billions of dollars to the deficit?

The Congressional Budget Office says that the health reform legislation will **lower** the deficit by more than one hundred billion dollars over the next decade, and continue to reduce the deficit by over a trillion dollars over the 20 years. It will also accelerate pilot-testing of innovative payment and delivery system reforms to achieve better value for the money being spent, and fund research on comparative effectiveness to help inform clinical decisions. It will establish standards for financial and administrative transactions to allow doctors to spend more time with their patients and to reduce the costs of health care. It will expand coverage of preventive services, and fund innovative work-site and community programs to support wellness. Such policies, over time, are expected to “bend the cost” curve, making the entire system more affordable and sustainable. The Medicare savings in the bill will push back the date when Medicare Part A is projected to become insolvent. A recent study shows that the reforms will also substantially reduce the average premiums charged to small businesses.

ACP firmly believes that we can't afford NOT to pass comprehensive health reform. While the lagging economy and high unemployment rate certainly exacerbate the significant problems inherent in our health care system, an economic turnaround will still leave these deep-rooted, long-standing problems unaddressed. The current health care system is not sustainable and reform is essential. In the absence of reform:

- Medicare Part A, which covers elderly inpatient visits, will run out of money by 2017, <http://www.ssa.gov/OACT/TRSUM/index.html> . But if the health reform bill is enacted, it is estimated that the Medicare savings in the legislation will delay by seven years the date when the Medicare Part A trust fund will run out of money.
- Also by 2017, an average middle-income family will spend four out of every 10 dollars they earn on health care alone, putting it out of reach for most. Economist Uwe Reinhardt, <http://economix.blogs.nytimes.com/2008/11/07/the-health-care-challenge-sailing-into-a-perfect-storm>.
- By 2020, the number of uninsured is expected to climb from 46 million to 60 million, which is about one in five of our population, <http://www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html>, compared to 95 percent of legal residents having coverage if the health reform bill passes.
- Even those with insurance will not be able to find a primary care doctor because of a pending primary care physician shortage of tens of thousands, http://www.medpac.gov/documents/20080916_Sen_Fin_testimony_final.pdf.
- And although we rightly take pride in having some of the highest quality care in the world, at least some of the time, such care will increasingly become out of reach to many because of the cost.

On the other hand, we have within reach enactment of legislation that would:

- Expand coverage to 95 percent of all legal residents;

- Ensure that no one would be turned down, charged exorbitant rates, or have their insurance cancelled because they are sick;
- Ensure that no one would go bankrupt because of health care;
- Ensure that insurers would compete by offering better value rather than cherry-picking;
- Ensure that everyone would have access to essential services, including prevention; and,
- Create workforce policies and payment reforms that would begin to address the primary care workforce crisis.

The U.S. health care system is a train wreck in waiting, and the current health reform effort is our best and perhaps only chance to put it on a safer track. The U.S. has within its grasp the chance to enact legislation to provide affordable coverage to most Americans, to make the cost affordable and sustainable for families and businesses, and to begin to rebuild the primary care physician workforce. It is understandable why so many internists are unhappy with the way things are, and yet distrustful of the changes being proposed to make things better. But there will be far more reasons for internists to be discontented if health care reform is allowed to fail.

16. Does ACP support raising my taxes to pay for the legislation?

The current legislation would impose an excise tax on high cost “Cadillac” insurance plans and increased Medicare taxes on “higher income” persons. ACP does not determine tax policy, as that is Congress’ domain. We only take positions on taxes that have a direct impact on health care spending and quality, such as our support for raising tobacco taxes to help fund the State Children’s Health Insurance Program, and our support for placing a limit on how much of employer-sponsored coverage is treated as tax free compensation to the employee. Each of these taxes would have a direct impact on health care by encouraging better health outcomes (in the case of the tobacco tax) and prudent purchasing decisions by individuals and employers (in the case of the cap on employer-sponsored health insurance). ACP has no policy on the increase in Medicare payroll taxes. ACP also believes that paying for this legislation should involve common-sense approaches that lead to better, and more efficient methods of delivering care, such as through the medical home, greater access to preventive care, which reduces costs in other parts of the system, a greater support for primary care, and addressing waste, fraud and abuse in the current system.

17. Where do ACP’s policies come from? No one has asked me my view. How can you say ACP represents me?

ACP has a process for developing factual, evidence-based public policy positions that are representative of its members’ views. These policy positions then serve as the basis for our legislative advocacy efforts. The process involves ACP membership, leadership, committee members, chapters, councils, and staff.

The process begins with the College’s Strategic Plan. It sets forth ACP’s high-level priorities, such as improving access to care and eliminating disparities. The objectives are developed by ACP’s content-focused committees and its councils, which represent key member groups, with oversight by the Strategic Planning Committee and ultimate approval by the Board of Regents. Staff then develops programs to achieve these objectives. Governance and staff annually follow developments in the health care arena to adapt the College’s positions.

The Health and Public Policy Committee (HPPC) develops ACP’s positions on issues affecting the health care of the American public and the practice of internal medicine. Policy on payment and regulatory issues are developed by the Medical Services Committee (MSC), and ethics policies are developed by the Ethics, Professionalism and Human Rights Committee (EP&HRC). Membership on the committees includes a diverse mix of generalists and specialists, academics and private practitioners, ACP Regents and Governors, and representatives of ACP councils. Special attention is paid to assuring representation of all ACP members.

Development of public policy papers generally commence with ACP staff conducting a literature search and preparing background materials for the policy committee. Draft policy papers are then prepared for committee review and discussion. Following initial committee approval, a draft policy paper is circulated for comments to Governors, Regents, ACP chapters and/or their health policy committees, and the ACP councils representing subspecialists, students, residents and young physicians. Occasionally outside experts also are invited to review the confidential drafts. Comments and proposed revisions are then shared with the policy committee prior to submission of a final draft to the Board of Regents for final review and approval.

Some internists who disagree with the ACP positions on health reform assert that we should survey membership before taking a position. They assume that a survey would show that most other ACP members share their opposition to policies advocated by the College. ACP does not develop policies based on an opinion survey, as noted above. However, in October and November, ACP's Research Center fielded a web survey of a random sample of 2,000 U.S. non-student, non-retired, current ACP members ages 65 and younger. It received 290 responses, a 15% response rate and a margin of error of plus or minus 8%. In that survey, large majorities of ACP members support the College's priorities and positions on even the most controversial issues - like individual and employer mandates, subsidies for health insurance, health exchanges, higher payments for primary care, and the public plan option - that are addressed by the House and Senate bills.

18. How can I participate in the College's policy development process?

Every ACP member has the opportunity to participate directly in the College's policy development process by becoming involved in your state chapter. Through your state chapter, you can recommend resolutions to be introduced by your state chapter to the ACP Board of Governors to modify existing policy or create new policies. Any ACP member can also comment on resolutions that have been submitted by chapters for consideration by the Board of Governors. For example, the current resolutions that will be considered and voted on by the Board of Governors in April, 2010, are now posted online <http://www.acponline.org/private/resolutions/spring2010/> (an ACP members only page) for member comment and review until April 1.

You can also ask to be considered for appointment to an ACP policy committee. The most effective way to be considered for appointment is for you to become active in the ACP at the state level, and to seek the support of your chapter's governor for appointment to a national policy committee. As a "bottom up" organization, ACP believes that involvement first at the state level is the most effective way for internists to influence national policy. At the same time, the national ACP wants to hear from you, and we work hard to address any concerns that members may have about ACP policies, even though we may not always agree on a particular position.

You can also sign up to become an ACP key congressional contact, which will give you access to timely information and upcoming votes in Congress and the ACP's position on each vote. The program http://www.acponline.org/advocacy/key_contacts/ is also an excellent way for you to provide your views to ACP on our legislative priorities.