Leading The Way Together: Views From The American College Of Physicians
Many Thanks!

- Steve Weinberger, Bob Doherty, Shari Erickson and the Philadelphia and DC Staffs
- To all on the frontlines of care who do the heavy lift of patient care
Disclosures

- I am a full time staff member of the American College of Physicians
- I have no financial interests to disclose
Educational Objectives

- Review trends in healthcare financing and costs, industry consolidation, and advocacy initiatives
- Review provocative trends in the democratization of healthcare including telehealth, healthcare teams, and “the patient will see you now,” phenomena
- Review the challenges of the GME funding and physician pipeline
An All Too Familiar Patient...

A 40 year old patient with type 2 DM on insulin presents to the clinic (substitute ED) for the 4th time in 3 months with a blood sugar ~400. VS are stable, PE shows no signs of dehydration, trace ketones and 4+ glucose in UA, BMP nl except for BS 425. What do you think could be going on?
IF YOU DON'T KNOW WHERE YOU ARE GOING YOU MIGHT WIND UP SOMEPLACE ELSE

Yogi Berra
Some background about ACP’s perspective

- Largest medical specialty society in the world: 148,000 members
- Represents the diversity of internal medicine
  - Ambulatory generalists, hospitalists, subspecialists
  - Academics, practitioners, educators, researchers, administrators
  - From solo practice to large groups
  - Medical students, residents, fellows, practicing clinicians, retired physicians
  - Domestic and international membership
- Welcomes non-physician affiliate members
2017-2018 Priority Initiatives

- Help ACP members experience greater professional satisfaction and fulfillment
- Facilitate the transition to value based payment and new delivery models
- Deliver authoritative, comprehensive, evidence-based information and education in innovative formats at key points of need
- Work towards universal access to affordable, high quality, and high value healthcare
- Increase ACP’s role and critical input as a national leader in optimizing performance measurement
- Expand ACP’s work in reducing the cost of healthcare and increasing the value
- Increase the number and engagement of ACP members
- Continue to advocate for timely reforms to ABIM’s MOC process
- Foster innovation within the College to strengthen ACP’s support for members and its work to increase the quality, value, and effectiveness of healthcare
ACP’s focus at a glance

- The science of medicine
  - Annals of Internal Medicine
- The clinical practice of medicine
  - Clinical standards, guidelines
- The education and professional development of physicians
  - MKSAP, meetings and courses
- The ‘quadruple aim’ of healthcare
  - Better care, better health, physician professional satisfaction, lower per capita costs
- The future of medicine
  - Students, residents, fellows
- Professional satisfaction
  - Payment reform, practice redesign
Membership Trends

Data from ACP’s 2016 Member Survey has revealed some major trends that paint a portrait of an evolving physician workforce:

- Half of post-training physicians are internal medicine specialists (GIMs), two in ten are hospitalists, and three in ten are subspecialists. Survey respondents under age 40 are more commonly hospitalists and less commonly GIMs or subspecialists.

- One in three works in a small practice with five or fewer physicians, one in four in a medium setting with 6 to 20 physicians and four in ten in a large setting with more than 20 physicians.

- Most physician-owned practices (58%) have five or fewer physicians, while those owned by health care systems (56%) or the government (57%) have more than 20 physicians.

- Six in ten report respondents that they or their practice use digital technology such as email or text to communicate with patients and/or their families, with seven in ten (74%) primary care physicians and eight in ten (81%) physicians in academic medical centers reporting use for this purpose.

*Source: 2016 Member Survey Detailed Report (random sample of 2,000 U.S., non-student, ACP members ages 65 and younger between March and June 2016)*
Healthcare Costs 1960 – 2020
(In Billions)

Centers for Medicare and Medicaid Services 2012 California Healthcare Foundation
Factors That Fuel Health Care Costs

- Physician Services: 21%
- Hospital Inpatient: 17%
- Outpatient (Freestanding & Hospital): 18%
- Prescription Drugs: 15%
- Medical Liability & Defensive Medicine: 10%
- Other Medical: 5%
- Insurance Profits: 3%
- Consumer Services, Provider Support & Marketing: 5%
- Gov’t Payments, Compliance Claims, Other Admin.: 6%

• Two areas of greatest expenditures and most rapid growth: imaging and tests
Total health care investment in US is less

In OECD, for every $1 spent on health care, about $2 is spent on social services.

In the US, for $1 spent on health care, about 55 cents is spent on social services.
Average Annual Worker and Employer Contributions to Premiums and Total Premiums for Family Coverage, 1999-2015

* Estimate is statistically different from estimate for the previous year shown (p<.05).

Physician Employment Dynamics

Changing employment dynamics: Private versus hospital-owned practices, 2002-2011

Source: Physician Compensation and Production Survey, Medical Group Management Association, 2011 Survey
We Will See More HCP Consolidation

Provider Consolidation
LESS COMPETITION AND HIGHER COSTS

Research demonstrates that when hospitals consolidate, either merging with other hospitals or buying up physician practices, healthcare costs go up. Provider consolidation gives hospitals greater negotiating strength and limits competition, resulting in higher prices for services, higher costs for patients, and no improvement in the quality of care delivered.

Physicians Are Becoming Hospital Employees

In 2000, 1 in 20 specialists was a hospital employee... Today, 1 in 4 specialists is a hospital employee.

Percentage increase in market concentration from 1999-2003.

WEST +5.5%
SOUTHWEST +6.7%
MIDWEST +7.4%
SOUTH +9.4%
EAST +7%

Increasing Market Concentration Leads to Higher Prices for Consumers

“Last year, a 15-minute visit to a doctor in private practice cost $69...that same visit to a hospital-employed physician cost $124.”
- Orlando Sentinel

“Research suggests that hospital consolidation in the 1990s raised prices by at least five percent and likely significantly more. Prices increase 40 percent or more when merging hospitals are closely located.”
- Robert Wood Johnson Foundation
The $15 Billion Dollar GME Pyramid

- **Medicare**: $9.7 billion
- **Medicaid**: $3.9 billion
- **U.S. Department of Veterans Affairs**: $1.437 billion
- **Health Resources and Services Administration**: $0.464 billion

**NOTE**: Additional unreported funding comes from the Department of Defense, state sources, private insurers, and other private sources. 'a' = data from 2012; 'b' = data from 2011 and 2013.
State Medicare Graduate Medical Education
Cap Per 100,000 Population, 2010

Cap Per 100,000 Population

- 1.63 - 13.84
- 13.84 - 18.5
- 18.50 - 22.58
- 22.58 - 38.46
- 38.46 - 202.87
Figure 1
State Variation in the Supply of Primary Care Physicians (PCPs)

Source: Health Resources and Services Administration 2008 Area Resource File
Growth in Nurse Practitioner Graduates*
2001 - 2013

* Counts include master’s and post-master’s NP and NP/CNS graduates, and Baccalaureate-to-DNP graduates.

Source: American Association of Colleges of Nursing (AACN) and National Organization of Nurse Practitioner Faculties (NONPF) Annual Surveys
Physician Assistant Pipeline Growth*

Newly Certified PAs, 2001 - 2014

Growth from 2013 to 2014: 14.7%
The Flipped Healthcare Classroom 2017...

- The Patient Will See You Now
- DPCP
- Retail Clinics
- Telehealth
- Digital Media Resources
- Home Hospital
- Patient Wearables, etc...
The Drugstore Will See You Now

Major pharmacy chains and big box retailers like Walmart are looking to draw customers by offering health care services. Since 2007, the number of clinics at these stores increased more than sevenfold.

Retail clinics at the start of the year

Notes: Walmart locations include primary care clinics and basic care clinics operated as joint ventures. Walgreens also operates clinics inside the company’s Duane Reade stores. The Little Clinic offers medical care at Kroger brands including Fry’s Food Stores, King Soopers and JayC Food Stores.

Source: Merchant Medicine
“I hear there’s a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system.”
STRESS MANAGEMENT CLINIC

SAD TO REPORT
DUE TO BURNOUT.
How Did We Get Here?
The Alliance of Acronyms...
And it's not just physicians who are dissatisfied. A patient’s perspective:

“When at last we are sure you’ve been properly pilled, then a few paper forms must be properly filled, so that you and your heirs may be properly billed.”

From “You Only Get Old Once” by Dr. Seuss
What’s Missing From The Triple Aim?

![Triple Aim Diagram](image)

Source: Institute for Healthcare Improvement

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ACP American College of Physicians™
Leading Internal Medicine, Improving Lives
What is the one professional challenge that concerns you most?

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited time with patients</td>
<td>14.5</td>
</tr>
<tr>
<td>Too much paperwork</td>
<td>11.9</td>
</tr>
<tr>
<td>Work/life balance</td>
<td>11.8</td>
</tr>
<tr>
<td>Loss of physician autonomy</td>
<td>10.7</td>
</tr>
<tr>
<td>Physician burnout</td>
<td>6.9</td>
</tr>
<tr>
<td>Maintenance of certification (MOC)</td>
<td>5.8</td>
</tr>
<tr>
<td>Malpractice threats/need to practice defensive medicine</td>
<td>5.6</td>
</tr>
<tr>
<td>Staying current on clinical knowledge</td>
<td>5.5</td>
</tr>
<tr>
<td>Electronic health records (EHRs)</td>
<td>4.7</td>
</tr>
<tr>
<td>Physician reimbursement and payment issues</td>
<td>4.1</td>
</tr>
</tbody>
</table>

Source: ACP 2015 Member Survey
Why are EHRs so bad? Because they are designed to document billing, not improve patient care.

“The primary purpose of clinical documentation should be to support patient care and improve clinical outcomes through enhanced communication.”

ACP 2015 position paper, **Clinical Documentation in the 21st Century**, developed by our Medical Informatics Committee.
Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians

Shari M. Erickson, MPH; Brooke Rockwern, MPH; Michelle Kolb, MPH; Robert McLean, MD, for the Medical Practice and Quality Committee of the American College of Physicians (*)

Article, Author, and Disclosure Information

Abstract

This American College of Physicians (ACP) position paper, initiated and written by ACP’s Medical Practice and Quality Committee and approved by the Board of Regents on 21 January 2017, reports policy recommendations to address the issue of administrative tasks to mitigate or eliminate their adverse effects on physicians, their patients, and the health care system as a whole. The paper outlines a cohesive framework for analyzing administrative tasks through several lenses to better understand any given task that a clinician and his or her staff may be required to perform. In addition, a scoping literature review and environmental scan were done to assess the effects on physician time, practice and system cost, and patient care due to the increase in administrative tasks. The findings from the scoping review, in addition to the framework, provide the backbone of detailed policy recommendations from the ACP to external stakeholders (such as payers, governmental oversight organizations, and vendors) regarding how any given administrative requirement, regulation, or program should be assessed, then potentially revised or removed entirely.

The American College of Physicians (ACP) has long identified reducing administrative tasks as an important objective, maintaining significant policy and participating in many efforts with this goal in mind, including developing the “Patients Before Paperwork” initiative in 2015. The growing number of administrative tasks imposed on physicians, their practices, and their patients adds unnecessary costs to the U.S. health care system, individual physician practices, and the patients themselves. Excessive administrative tasks also divert time and focus from more clinically important activities of physicians and their staffs, such as providing actual care to patients and improving quality, and may present patients from resolving timely and appropriate care or treatment.
Figure 1: Framework for Analyzing Administrative Tasks

Sources
- External
- Internal

Intents
- Products & Services
- Quality & Safety
- Cost & Fraud Reduction
- Financial Security
- Lack of Clear Intent

Impacts
- Cost & Time – Billing/Insurance Related
- Cost & Time – Measurement & Reporting
- EHR/Health IT
- Appropriate & Timely Patient Care
- Physician Satisfaction & Burnout

Solutions
- Assessment of Tasks by Stakeholders
- Transparent Alignment & Streamlining of Tasks
- Collaborate to Improve Quality Measures
- Innovative Use of Health IT
- Eliminate or Replace Duplicative Tasks
- Research Impacts & Best Practices

Figure 2: Taxonomy for Categorizing Administrative Tasks as Worthwhile and Should Remain in Place, or Tasks that are Burdensome and Should Be Revised or Eliminated Entirely

Legend: Each circle indicates a characteristic of an administrative task
- **Admin**: Administrative tasks in these categories are worthwhile
- ?**: Administrative Tasks in these categories require careful consideration of alternatives
- **Admin**: Administrative tasks in these categories should be eliminated

- Task questions physician judgment
- Task promotes timely and appropriate care
- Task has negative financial effect
- Task improves quality of care
ACP’s Patients Before Paperwork Initiative

ACP Policy Recommendations to Reduce Administrative Tasks:

1. Stakeholders who develop or implement administrative tasks should provide financial, time, and quality of care impact statements for public review and comment.

2. Tasks that cannot be eliminated must be regularly reviewed, revised, aligned and/or streamlined, with the goal of reducing burden.

3. Stakeholders should collaborate to aim for performance measures that minimize unnecessary burden, maximize patient- and family-centeredness, and integrate measurement of and reporting on performance with quality improvement and care delivery.

4. Stakeholders should collaborate in making better use of existing health IT, as well as develop more innovative approaches.

5. As the US health care system evolves to focus on value, stakeholders should review and consider streamlining or eliminating duplicative administrative tasks.

6. Rigorous research is needed on the impact of administrative tasks on our health care system.

7. Research on and dissemination of evidence-based best practices to help physicians reduce administrative burden within their practices and organizations.
What does this *practically* mean for your practices?

- The number 1 thing that can be done to improve physician satisfaction with practice is to ease unnecessary regulations and tasks. The new administration and Congress offers us an opportunity to make our case.
- Patients will also benefit as their physicians are able to spend more time with them with less distraction.
- Making EHRs more clinically relevant and useful requires that we examine and simplify the embedded federally-mandated documentation requirements.
- We also need an entirely new way of looking at administrative tasks, to assess their intent, impact and possible alternatives.
2016 Member Survey-ACP members have become more demographically diverse

- Respondents are slightly younger with a greater proportion of women at younger ages.

- The majority of ACP members, particularly the younger ones, report an evolution toward the employed model:
  - 72% are employees; 22% are full/part owners; 5% are independent contractors; 1% are volunteers (2015: 67% employee and 26% full/part owners).
  - 57% report ownership of their practice by hospitals (20%); health care systems (23%), or academic medical centers (14%).
  - Ownership by physicians has decreased from 31% in 2013 to 25% in 2016.

- With the employment model comes an increase in physician practice size.
  - 43% of those providing patient care report working in a “large” setting having more than 20 physicians.
  - The proportion working with more than 100 physicians grew from 17% in 2013 to 28% in 2016.
Most members report being satisfied with their career in medicine, but . . .

- 85% of respondents report being “satisfied” with their career in medicine (43% very satisfied and 42% somewhat satisfied).
  - However, only 53% would recommend medicine as a career to their children.
  - The more time spent on bureaucratic tasks, the unhappier they are about having chosen medicine as a career.

- For just under half (49%), administrative tasks unrelated to patient care “significantly contributes” to their loss of enthusiasm for work or to their low sense of personal accomplishment.
  - Other factors significantly contributing to their loss of enthusiasm for work include EHRs (33%), too many patients in a day (28%), MOC requirements (28%), and inadequate financial incentives from payers (26%).

- The majority rate their time for documentation as being “marginal” or “poor”. Therefore, it is not surprising that reducing documentation requirements provide the greatest opportunity for increasing satisfaction.
Factors affecting physician satisfaction and fulfillment

- Increased regulatory requirements: performance reporting; meaningful use of EHRs
- Burdensome documentation requirements
- Prior authorization; other approvals
- Electronic health records
- Inefficient practices
- MOC requirements
- Professional isolation (for some)
- Short visits; unrelenting time pressure
Financial Cost of Administrative Complexity Burden in a Physician Organization

<table>
<thead>
<tr>
<th>Category</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Processing and billing of claims in professional billing office</td>
<td>5.6</td>
</tr>
<tr>
<td>Time costs incurred by physicians and office staff</td>
<td>33.1</td>
</tr>
<tr>
<td>Revenue lost because of claims initially rejected</td>
<td>6.0</td>
</tr>
<tr>
<td>Total</td>
<td>44.7</td>
</tr>
</tbody>
</table>

Strategies To Reduce Burnout

- **Align leadership values with clinicians’ values**
  - Leaders model work-home balance; value well-being
  - Understand and promote work control
  - Alter our “culture of endurance”

- **Support work-home balance**
  - Support needs of parent clinicians
  - Offer flexible/part-time work options

- **Wellness focus – reflection, exercise, share concerns with colleagues**

Make internal medicine practice more satisfying...

- Clinical documentation
- EHRs: functionality, usefulness, clinical relevance
- Patients Before Paperwork (Captures all of ACP’s activities to reduce administrative burdens)
- Payment reform: pay more for cognitive care, chronic care
- Quality measures: relevance, burden of reporting
Have Empathy and Each Day Do Something for Another

Whatever your background or whatever you are, it doesn't matter. Treat everyone the same, that's how it should be.

Yogi Berra, Baseball Hall of Famer
An All Too Familiar Patient...

A 40 year old patient with type 2 DM on insulin presents to the clinic (substitute ED) for the 4th time in 3 months with a blood sugar ~400. VS are stable, PE shows no signs of dehydration, trace ketones and 4+ glucose in UA, BMP nl except for BS 425. What do you think could be going on?
RISING INSULIN PRICES

SOURCE: Truven Health Analytics
Stemming The Escalating Costs of Prescription Drugs- A Classic Case of Grass Roots Advocacy

Several years ago, several members of an ACP Chapter brought this topic to their Health and Public Policy Committee.

The ACP Chapter submitted this as a resolution to the ACP Board of Governors for policy development.

The Board of Governors and Board of Regents passed the resolution.

In 2016, this became policy for the ACP.
Position Paper

Stemming the Escalating Cost of Prescription Drugs: A Position Paper of the American College of Physicians

Hilary Daniel, BS, for the Health and Public Policy Committee of the American College of Physicians

This American College of Physicians position paper, initiated and written by its Health and Public Policy Committee and approved by the Board of Regents on 16 February 2016, reports policy recommendations from the American College of Physicians to address the escalating costs of prescription drugs in the United States. Prescription drugs play an important part in treating and preventing disease; however, the United States often pays more for some prescription drugs than other developed countries, and the high price and increasing costs associated with prescription medication is a major concern for patients, physicians, and payers. Pharmaceutical companies have considerable flexibility in how they price drugs, and the costs that payers and patients pay are dependent on how payers are able to negotiate discounts or rebates. Beyond setting list prices are issues of regulatory approval, patents and intellectual property, assessment of value and cost-effectiveness, and health plan drug benefits. These issues are linked, and comprehensive efforts will be needed to affect how drugs are priced in the United States.


This article was published at www.annals.org on 29 March 2016.

High-profile cases of high-priced drugs entering the market and price increases for traditional, generic, specialty, and biologic medications have thrust the issues of prescription drug price, value, and spending to the forefront of health care discussions. In a Kaiser Family Foundation poll, over 70% of those surveyed felt that drug prices were too high and that companies were too concerned about making profits (1). Patients, physicians, payers, and politicians have taken notice of the potential effect of drug price on access to needed medications and are asking questions not only about how pharmaceutical companies determine a drug’s price, but also how we can better assess the pricing, cost, and value of drugs. Pricing (the base price of a drug before negotiations, rebates, and discounts), cost (the acquisition drug pricing), The payers, patients, health plans, or the government for a drug, and value (the benefit of a drug relative to its cost) are intertwined, and as policymakers look for solutions, they must consider all 3 issues in order to understand the broader implications of policies or regulatory action.

The benefits associated with prescription drugs cannot be ignored. The drive to create new drugs and seek improved treatments has resulted in a broad and constantly evolving market for prescription drugs in the United States, Canada, and Europe. As new drugs and treatments of disease are discovered, Americans are living longer, and with increased longevity, drug prices are rising, and the cost of drug treatment is rising at an unprecedented rate. In the United States, the cost of health care is on the rise; between 2007 and 2012, prescription drug spending increased by 36%, or $20 billion (2). However, not all patients can afford the out-of-pocket costs for these drugs. Approximately 18% of retail prescription drugs were paid for out of pocket in 2012, and patients used various techniques to reduce costs, including not taking a medication as prescribed (7.8%), asking the doctor for a lower-cost medication (15.1%), purchasing drugs from another country (1.6%), or using alternative therapies (4.2%) (3). Whereas drug prices are variable, demand for prescription medication is fairly inelastic.

Although the current U.S. market includes important advances in disease treatment, the United States is the only country in the 34-member Organisation for Economic Co-operation and Development (OECD) that lacks some degree of government oversight or regulation of prescription drug pricing. The OECD has 13 countries that are considered high-income: Australia, Canada, Denmark, France, Germany, Japan, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States. Comparatively, the United States spends more on pharmaceuticals than these other high-income countries (4). An analysis of OECD data showed that the United States had the highest level of per capita spending on prescription drugs in 2010 compared with Australia, Canada, France, Germany, the United Kingdom (5). In addition, the United States tends to introduce new drugs to the market faster than other countries and use these newly produced medicines. As the government and private insurance companies are the primary purchasers of drugs in the United States, Medicare, Medicaid, benefits administered under the Veterans Administration, and private payers have different methods for obtaining prescription drugs, resulting in different levels of spending.

See also:

Web-Only
Appendix: Full Position Paper

* This paper, written by Hilary Daniel, BS, was developed for the Health and Public Policy Committee of the American College of Physicians. Individuals who contributed to the paper included: John Pollock, MD (Chair), Douglas M. Delong MD (Vice-Chair), Mirah Bechley, PhD, Matt Siemens, Sue T. Bernstein, MD, James F. Rush, MD, Gregory A. Hood, MD, Carrie A. Mack, MD, Gregory E. Nema, MD, Robert H. Lohr, MD, Kenneth E. Olise, MD, Shabab C. Rahman, MD, and Fatima Syed, MD. Approved by the ACP Board of Regents on 16 February 2016.
CDC: Uninsured rate has fallen below 9%

% of uninsured U.S. residents, based on CDC survey data

Source: CDC National Health Interview Survey

Graphic by @ddiamond
The share of people without health insurance keeps falling.
The rise and fall of ACA repeal

- **March 7**: the House version of ACA repeal, the American Health Care Act (AHCA), introduced in the House.

- **March 24**: House Speaker Ryan withdraws the AHCA because of lack of support.

- **May 4**: modified AHCA narrowly passes House, 217-213, with amendment that allows states to waive essential benefits and modified community-rating requirements.
The rise and fall of ACA repeal

- **June 22:** draft of Senate version, the Better Care Reconciliation Act (BCRA), released.
  - Incorporated many of the elements of the AHCA: Medicaid caps/block grants, end of higher federal match for expansion, repeal of individual and employer mandates; state waivers of essential benefits and community rating, $ for high risk pools and market stabilization, repeal of most ACA taxes; tax credit subsidies that would increase premiums and deductibles for older, sicker and poorer patients.
The rise and fall of ACA repeal

July 17: Majority Leader Mitch McConnell decides not to go forward with vote on BCRA, after 4 Senate Rs declared opposition. Issues statement that the current effort to immediately repeal and replace the ACA through BCRA “will not be successful.”

Headlines declare the bill is dead.
The rise and fall of ACA repeal

**July 18:** Majority Leader McConnell announces he would push ahead with vote in “coming days” to partially repeal the ACA with a 2-year delay before the repealed provisions would sunset. Based on 2015 repeal bill vetoed by President Obama.

**July 25-27:** Motion to Proceed passes the Senate, 51-50 with Vice President Pence casing the tie-breaker. Senators Murkowski (R-AK) and Susan Collins (R-ME) are only Republicans to vote no. Senator John McCain (R-AZ) votes yes while decrying the process. Hours later, a revised version of BCRA fails on procedural vote, 43-57. Senate votes down repeal with 2-year delay, 45-55. Consideration moves to “skinny repeal”—repeal of individual and employer mandates and medical device tax.
ACA repeal timeline

**July 28:** At 1:30 a.m., the Senate voted by 49-51 to reject the “skinny repeal” amendment offered by Senator McConnell, with Senator McCain joining Murkowski and Collins in voting no. Leader McConnell says “it’s time to move on.”
ACA REPEAL WITH NO REPLACEMENT WOULD LEAD TO 32 MILLION LOSING COVERAGE AND INDIVIDUAL MARKET COLLAPSE

Source: Congressional Budget Office, January 2017
CENTER ON BUDGET AND POLICY PRIORITIES | CBPP.ORG
Per Capita Caps and Block Grants Shift Medicaid to a Fixed Funding Structure

- Today, federal funding of Medicaid is open-ended—the federal government contributes a fixed share of each state’s actual spending.
- Medicaid reform proposals limit federal spending to a target.

**Core Components of the Federal Funding Formula**

- **Per Capita Cap**
  - Fixed federal funding per beneficiary
- **Block Grant**
  - Fixed federal funding for a group of beneficiaries

**Source:** Avalere presentation to National Governors Association
Majorities Favor Many ACA Provisions, But Not Its Individual Mandate

- Allowing young adults to stay on their parents’ plans until age 26: 85%
- Eliminating out-of-pocket costs for many preventive services: 83%
- Allowing states to expand Medicaid to low-income adults: 80%
- Prohibiting insurers from denying coverage for pre-existing conditions: 69%
- Requiring nearly all Americans to have insurance or pay a fine: 35%

KFF.org

Cost of Marketplace Coverage under BCRA for People Losing Medicaid

Even with tax credits, the cost of care for adults losing Medicaid would consume from 60% to 104% of their total annual incomes.

NOTES:
(a) Premiums are the net premiums paid for the BCRA benchmark plan (58% AV), after tax credits are applied.
(b) Deductibles are based on the 2017 national average for a bronze plan ($12,393 for a family). Bronze plans have a 60% AV.

Low-Income Individuals May Face Increased Deductibles with Repeal of CSRs and Change to Lower Benchmark Plan

Average Deductibles for ACA Benchmark Plans with CSRs versus BCRA Benchmark Plan

- **100-150% FPL**
  - ACA Benchmark Plan: $243
  - BCRA Benchmark Plan: $6,014

- **150-200% FPL**
  - ACA Benchmark Plan: $785
  - BCRA Benchmark Plan: $6,014

- **200-250% FPL**
  - ACA Benchmark Plan: $3,070
  - BCRA Benchmark Plan: $6,014

- **250% FPL and above**
  - ACA Benchmark Plan: $3,703
  - BCRA Benchmark Plan: $6,014

Source: Avalere presentation to National Governors Association
Average Annual Cost of Health Care in Individual Market (64 Year Old, as % of Income)

Source: CBO, CMS OACT, authors’ calculations; Note: Graph assumes a Medicaid expansion state
## The ACA Made Many Insurance Reforms Affecting Women

<table>
<thead>
<tr>
<th>ACA</th>
<th>At Risk Under Repeal</th>
</tr>
</thead>
</table>
| ✓ No pre-existing condition exclusions | At risk to be treated as pre-existing condition:  
  • Pregnancy (~ 4 million births per year)  
  • Prior C-section (1/3 births)  
  • Depression (1/10 women)  
  • History of domestic violence (1/3 women) |
| ✓ Gender rating banned | Individual plans may charge higher premiums to women for same coverage  
  • 1/3 of plans charged 25 and 40 year old women at least 30% more than men  
  • This practice costs women an estimated $1 billion more annually |
| ✓ Maternity care required in all plans | Individually purchased plans and small employer-based plans could exclude maternity care  
  • Included in only 12% of plans (2012)  
  • 7% of plans offered maternity riders (2012)  
  • Riders can cost more than $1000/month |
| ✓ Plans must offer dependent coverage up to age 26 | Women in their twenties had the highest uninsured rate before ACA  
  • 30% of women age 19-26 uninsured in 2009 |

**Sources:** Centers for Disease Control and Prevention (CDC), [Births: Method of Delivery 2013](https://www.cdc.gov/nchs/data/nvsr/nvsr63/nvsr63_11_2015.pdf).  
National Coalition Against Domestic Violence (NCADV), [National Statistics](https://www.ncadv.org/).  
National Women’s Law Center (NWLC), [Turning to Fairness Report](https://www.nwlc.org/reports/turning-to-fairness-report).  
### The ACA and mental health coverage

Before the start of the ACA’s coverage expansions, HHS estimated more than 62 million Americans with mental health and substance abuse disorders would gain coverage or parity protections from the law.

<table>
<thead>
<tr>
<th>Insurance status in 2013</th>
<th>Number gaining benefits (in millions)</th>
<th>Number benefiting from parity protections (in millions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual plans</td>
<td>3.9</td>
<td>7.1</td>
</tr>
<tr>
<td>Small group plans</td>
<td>1.2</td>
<td>23.3</td>
</tr>
<tr>
<td>Uninsured</td>
<td>27</td>
<td>n/a</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>32.1</strong></td>
<td><strong>30.4</strong></td>
</tr>
</tbody>
</table>

Note: Numbers assume grandfathered plans would be phased out.

*Source: HHS*
Federal Funding Reductions Range from 27% to 39% by 2036

Annual Percent Reduction in Federal Medicaid Funding to States under BCRA, 2036

BCRA: Better Care Reconciliation Act
Estimates relative to current law. Assumes states choose per capita cap option. Includes Medicaid expansion changes as well as equity adjustment.
Note: See Appendix for a chart with the associated dollar reductions by state.
Source: Avalere analysis of BCRA per capita cap with equity adjustment, July 2017
Who loses if insurers can again waiver coverage or charge more for preexisting conditions? *Your patients.*

### DECLINABLE MEDICAL CONDITIONS

Before the ACA, individual market insurers in all but five states maintained lists of so-called declinable medical conditions. People with a current or past diagnosis of one or more listed conditions were automatically denied. Insurer lists varied somewhat from company to company, though with substantial overlap. Some of the commonly listed conditions are shown in Table 2.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV</td>
<td>Lupus</td>
</tr>
<tr>
<td>Alcohol abuse/Drug abuse with recent treatment</td>
<td>Mental disorders (severe, e.g. bipolar, eating disorder)</td>
</tr>
<tr>
<td>Alzheimer's/dementia</td>
<td>Multiple sclerosis</td>
</tr>
<tr>
<td>Arthritis (rheumatoid), fibromyalgia, other inflammatory joint disease</td>
<td>Muscular dystrophy</td>
</tr>
<tr>
<td>Cancer within some period of time (e.g., 10 years, often other than basal skin cancer)</td>
<td>Obesity, severe</td>
</tr>
<tr>
<td>Cerebral palsy</td>
<td>Organ transplant</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Paraplegia</td>
</tr>
<tr>
<td>Coronary artery/heart disease, bypass surgery</td>
<td>Paralysis</td>
</tr>
<tr>
<td>Crohn's disease/ulcerative colitis</td>
<td>Parkinson's disease</td>
</tr>
<tr>
<td>Chronic obstructive pulmonary disease (COPD)/emphysema</td>
<td>Pending surgery or hospitalization</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Pneumocystic pneumonia</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>Pregnancy or expectation parent</td>
</tr>
<tr>
<td>Hemophilia</td>
<td>Sleep apnea</td>
</tr>
<tr>
<td>Hepatitis (Hep C)</td>
<td>Stroke</td>
</tr>
<tr>
<td>Kidney disease, renal failure</td>
<td>Transplantation</td>
</tr>
</tbody>
</table>

**SOURCE:** Kaiser Family Foundation review of field underwriting guidelines from Aetna (GA, PA, and TX), Anthem BCBS (IN, KY, and OH), Assurant, CIGNA, CoverMyCare, Humana, United Healthcare, Wisconsin Physician Service. Conditions in this table appeared on declinable conditions list in half or more of guides reviewed. **NOTE:** Many additional, less-common disorders also appearing on most of the declinable conditions lists were omitted from this table.
Even if the legislative effort to repeal the ACA fails, the administration could sabotage implementation

- Discontinuing cost-sharing reduction payments to plans.
- Failing to encourage or actively discourage enrollment.
  - HHS has re-directed funds meant for enrollment through www.healthcare.gov website to anti-ACA talking points.
  - Did not renew contracts with groups helping people sign up.
- Not enforcing individual insurance mandate.
- Easing essential benefit requirements, conscience exemptions.
- Not supporting legislative and regulatory actions to stabilize markets.
So what’s the *practical* impact on your practice and your patients if the ACA is repealed?

- Reduced Medicaid payments.
- Fewer patients on Medicaid, many of whom would be enrolled instead in high deductible plans.
- Millions will just go without coverage.
- Higher out-of-pocket costs for older, sicker and poorer patients.
- Loss of coverage/higher premiums for patients with preexisting conditions like Crohn’s.
- Colonoscopy no longer covered as an essential benefit with zero cost-sharing.
- More uncompensated care.
- Loss of lives.
In 2002, an Institute of Medicine review concluded that lack of insurance increases mortality, but several relevant studies have appeared since that time. This article summarizes current evidence concerning the relationship of insurance and mortality. The evidence strengthens confidence in the Institute of Medicine’s conclusion that health insurance saves lives: The odds of dying among the insured relative to the uninsured is 0.71 to 0.97.

What did the ACP do? Unprecedented effort involving:

- Grass roots
- Coalitions
- Communications to Congress
- Social media
- Earned media
Travel ban: health impact

Nearly 30 percent of doctors and surgeons in the US are immigrants

<table>
<thead>
<tr>
<th>Doctors and surgeons</th>
<th>Immigrants make up nearly one-fifth of all health care workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>656,000</td>
<td></td>
</tr>
<tr>
<td>254,000</td>
<td>27.9% are immigrants</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Nurses and home health aides</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.6M</td>
</tr>
<tr>
<td>489,000</td>
</tr>
</tbody>
</table>

23.8% are immigrants

Source: Migration Policy Institute, 2015
These IM residents (ACP members) were prohibited from re-entering the US because of the Executive Order.
What is ACP doing about it?

- January 30: ACP releases statement of concern, reaffirming policies against non-discrimination based on religion.
- January 31: ACP releases comprehensive statement on immigration and refugee policies and health, calls for the EO to be rescinded, including travel restrictions on doctors and medical students, and refugees.
- February 7: ACP, AAIM, 8 other IM organizations issue joint recommendations to Homeland Security.
- February 10: Statement applauding 9th Circuit ruling to reject administration’s request to lift temporary injunction against the executive order.
ACP: A Global Community

- Over 14,000 ACP members reside outside the United States

- International chapters: Bangladesh, Brazil, Caribbean, Canada (6), Central America, Chile, Colombia, India, Japan, Mexico, Saudi Arabia, Southeast Asia, and Venezuela
Big wins for advocacy! Courts block insurer mega-mergers

Judge Blocks Aetna’s $37 Billion Deal for Humana

By REED ABELSON and LESLIE PICKER  JAN. 23, 2017

The Hartford headquarters of Aetna, which was interested in Humana for its position in the Medicare Advantage market. Michael Nagle/Bloomberg

Judge, Citing Harm to Customers, Blocks $48 Billion Anthem-Cigna Merger

By MICHAEL J. de la MERCE and LESLIE PICKER  FEB. 8, 2017

The Anthem Health Insurance headquarters in Indianapolis. On Wednesday, a Federal District Court judge blocked the company’s proposed $48 billion merger with rival Cigna. Aaron P. Bernstein/Getty Images
ACP Public Policy & Advocacy
Your Advocate for Internal Medicine on Capitol Hill

Work in a constructive and bipartisan way with President-elect and with Congress, to achieve progress on the College’s policy objectives.

ACP’s advocacy themes:

- Reduce barriers to access (i.e. ACA, behavioral/mental health, health disparities, Medicaid expansion, telemedicine, VA)
- Make healthcare affordable (i.e. RX pricing, high value care)
- Improve population and public health (climate change, firearms, opioids)
- Improve health care delivery to achieve greater value (i.e. MACRA/QPP, fee schedule, quality measures)
- Ensure there are enough well-trained internists in the numbers needed (i.e. GME reform, primary care workforce)
- Make internal medicine practice more satisfying (i.e. quality measure relevance, reducing administrative burdens)
Opportunities!

- Are there opportunities for progress on issues of concern to ACP?
- Yes, on
  - Funding for Medical Research (CURES Act)
  - Funding for Opioids (CARA)
  - *Improve MACRA, value-based payment!*
  - *Medical Liability Reform!!! (Safe harbors for following practice guidelines, no-fault health courts?)*
  - *Regulatory relief!!! Huge opportunity!*
ACP Public Policy & Advocacy
Your Advocate for Internal Medicine on Capitol Hill

Work in a constructive and bipartisan way with the President and with Congress to achieve progress on the College’s policy objectives.

ACP’s advocacy themes:

- Reduce administrative complexities and burdens
- Reduce barriers to access (i.e. ACA, behavioral/mental health, health disparities, chronic care, Medicaid expansion, telemedicine, VA)
- Make healthcare affordable (i.e. RX pricing, high value care)
- Improve population and public health (climate change, firearms, opioids)
- Improve health care delivery to achieve greater value (i.e. MACRA/QPP, fee schedule, quality measures)
- Ensure there are enough well-trained internists in the numbers needed (i.e. GME reform, primary care workforce)
- Make internal medicine practice more satisfying (i.e. quality measure relevance)
2016 ACP/AAIM GME Financing Positions

- Maintain societal commitment
- All payer
- Try to get at true costs
- Selectively lift caps
- Infuse transparency
- Combine DME/IME
- Examine potential Performance Measures
- Ignite innovation
- Fund ambulatory training
Resources for Educators

- Teaching Medicine Series
  *Theory and Practice of Teaching Medicine, Teaching Methods, Teaching in the Hospital, Teaching in the Clinic, Teaching Clinical Reasoning, Mentoring in Academic Medicine, and Leadership in Medical Education*
- *Annals of Internal Medicine* teaching tools
- Internal Medicine In-Service Training Examination for residents
- ACP Board Prep Curriculum for residents
- High Value Care Curriculum for trainees at all levels
- IM Essentials for medical students
Recent ACP Policy Papers

- Addressing the Increasing Burden of Health Insurance Cost Sharing (July 2016)
- Financing U.S. Graduate Medical Education: A Policy Position Paper of the Alliance for Academic Internal Medicine and the American College of Physicians (May 2016)
- Climate Change and Health: A Global Call to Action (April 2016)
- Stemming the Escalating Cost of Prescription Drugs (March 2016)
- Medicaid Expansion: Premium Assistance and Other Options (March 2016)
Advocates for Internal Medicine Network (AIMn)

- Grassroots advocacy network designed to help ACP members engage with federal lawmakers on policy issues important to internists
- AIMn members receive legislative updates and alerts as key policy issues unfold, including sample messages to members of Congress
- Enroll at https://cqrcengage.com/acplac/
- To learn more, contact Shuan Tomlinson:
  - Tel: 202-261-4547
  - Email: stomlinson@acponline.org
ACP’s New Online Learning Center

A centralized gateway for ACP’s online learning activities

- Available at ACPOnline.org/OLC
- Enhanced search and browsing functionality for ACP’s online learning
- Easy access to more than 350 activities, including:
  - Video-based learning
  - Webinars
  - Interactive cases
  - Quizzes

The majority of activities offer both CME and MOC.
Resources to Help You Transform Your Practice: Prepare for New Payment System

ACP is helping you transform your practice, choose the right path, keep up-to-date and meet deadlines through tools and resources: (ACPOnline.org/MACRA)

- **MACRA/QPP Information**: Online FAQs, fact sheets, webinars (live and recorded), articles in ACP publications
- **Practice Transformation**: Information, resources, tools to support practices in making strategic changes to successfully care for patients in the value-based payment environment
- **New: Quality Payment Advisor**: Online tool to assist practices in determining the best path to take—MIPS or APM.
- **ACP Practice Advisor**: Online tool to help practices analyze and improve patient care, organization and workflow
- **Physician & Practice Timeline**: Online tool helps track deadlines for regulatory, payment, educational and delivery system changes and requirements. Members can sign up by texting ACPtimeline (no space) to 313131 from mobile phones
ACP’s Main Website for the QPP

MACRA and the Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015, and became final in October 2016.

The MACRA law eliminated the sustainable growth rate (SGR) formula that had previously been used to calculate Medicare payments to physicians and had resulted in repeated threats of severe payment cuts. The law provides a more predictable Medicare payment schedule for physicians and other clinicians, while moving the payment system away from a volume-based system toward a system that rewards value. This new payment system is called the Quality Payment Program (QPP).

Read how ACP advocated on behalf of clinicians and influenced the MACRA 2017 Final Rule:

- Statement on 2017 Final Rule
- Detailed analysis and comments on 2017 Final Rule

MORE ACP ADVOCACY ON MACRA

www.acponline.org/qpp
Encouraging High Value Care

Resources to help provide the best patient care while reducing health care costs:

- High Value Care Online Cases: Earn free CME credits and MOC patient safety and medical knowledge points through web-based cases and questions
- Curriculum For Educators, Residents and Students: Created by ACP and the Alliance for Academic Internal Medicine (AAIM), features six one-hour interactive modules
- HVC Course For Medical Students: Students evaluate the benefits, harms and costs of tests and treatment options so they can make HVC a reality in clinical practice
Encouraging High Value Care (cont’d)

Resources to help physicians provide the best patient care while reducing costs to the health care system:

- High Value Care Coordination (HVCC) Toolkit: Resources to facilitate more effective and patient-centered communication between primary care and subspecialist doctors.
- Pediatric to Adult Care Transitions Toolkit: Resources to facilitate more effective transition and transfer of young adults from pediatric to adult care.
- Collaboration with Consumer Reports: A series of new High Value Care Resources to help patients understand the importance of seeking appropriate care.
Support the Next Generation of IM

- Encourage a young person to understand the rewards of internal medicine as a career
- Convince a medical student to see the bright future of internal medicine
- Recommend general internal medicine to a resident
- Invite another internist to become an ACP member
- Sponsor a qualified ACP Member for Fellowship (FACP)
ACP . . . Get Connected

- **MyACP 2.0** – a personalized web experience, making it easier for members to access and discover pertinent ACP content and resources while visiting ACPOnline.org.

- **ACP Member Forums**
  ACP Member Forums allow ACP members to instantly participate in discussions on a range of clinical, professional, and practice-related topics.

- **Join your local IM community through ACP Chapters**
  - Network, gain CME, develop leadership skills
  - Mentor medical students and early career physicians

- **Develop skills through the ACP Engagement Program**
  - Volunteer to help in development of ACP products
  - Judge abstracts and mentor early career physicians

- **Follow on social media**
  ACP and *Annals of Internal Medicine* are using social media more than ever to communicate and share information relevant to internal medicine.
Community and Engagement

- Engage online with ACP Forums
  - Instant participation
  - Subscribe to alerts
  - Receive daily digest of online discussions

- Join your local IM community through ACP Chapters
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  - Mentor medical students and early career physicians

- Develop skills through the ACP Engagement Program
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  - Judge abstracts and mentor early career physicians

- Join ACP’s Advocates for Internal Medicine
  - Advocate at the national level for IM physicians and patients
Internal Medicine Meeting 2018
April 19-21, 2018
New Orleans
Register online at
https://im2018.acponline.org/

- Over 200 educational, interactive workshops and case-based sessions and feedback on patient management problems taught by speakers
- Networking events including Women’s Networking luncheon, African American Reception and various early career events
Thank you . . .

...for your continued support of ACP and your commitment to internal medicine.