Want to be “in the room where it happens”? It starts with standing for something.

Indiana ACP Chapter
November 22, 2019
The room where it happens.

The scene:
Alexander Hamilton, Thomas Jefferson and James Madison meet over dinner in NYC, and emerge with an agreement to locate the nation’s capital (to Virginia) and Hamilton’s plan for a central banking system.

Aaron Burr is not invited.
The room where it happens

_Burr:_
Two Virginians and an immigrant walk into a room

_[Burr and Ensemble:]_
Diametric'ly opposed, foes

_Burr:_
They emerge with a compromise, having opened doors that were

_[Burr and Ensemble:]_
Previously closed

_[Ensemble:]_
Bros

_Burr:_
The immigrant emerges with unprecedented financial power
A system he can shape however he wants
The Virginians emerge with the nation's capital

And here's the pièce de résistance:
No one else was in
The room where it happened
The room where it happened
The room where it happened
No one else was in
The room where it happened (The room where it happened)
The room where it happened
The room where it happened (The room where it happened)
No one really knows how the game is played
(Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens (Assume that it happens)
But no one else is in
The room where it happens (The room where it happens)
The room where it happens

Burr:]
Two Virginians and an immigrant walk into a room
[Burr and Ensemble:]
Diametric'ly opposed, foes
[Burr:]
They emerge with a compromise, having opened doors that were
[Burr and Ensemble:]
Previously closed
[Ensemble:]
Bros
[Burr:]
The immigrant emerges with unprecedented financial power
A system he can shape however he wants
The Virginians emerge with the nation's capital

And here's the pièce de résistance:
No one else was in
The room where it happened
The room where it happened
The room where it happened
No one else was in
The room where it happened (The room where it happened)
The room where it happened
The room where it happened (The room where it happened)
No one really knows how the game is played
(Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens (Assume that it happens)
But no one else is in
The room where it happens (The room where it happens)
But what did Burr stand for?

HAMILTON/JEFFERSON/MADISON/WASHINGTON:

What do you want, Burr? What do you want, Burr?

*If you stand for nothing*  
*Burr, then what do you fall for?*
What can *Hamilton* teach us about advocacy?

*If you stand for nothing, what do you fall for?*

What does ACP stand for?
What do we stand for?

The following statements are not official ACP policy, as approved by the Board of Regents. They characterize (*in my own words*) what the College stands for, based on approved policies.

1. That advocacy must always put the interests of patients above all else.
2. That *everyone* should have coverage for the care they need, at a cost they, and the country, can afford.
What do we stand for?

3. That physicians have a responsibility to advocate for policies to lower costs without compromising care; to practice high-value, cost-effective care themselves, and be accountable for it.

4. That physicians and patients must be freed of unnecessary administrative tasks that take time away from patient care, contribute to professional burn-out, and impose enormous system- and practice-level costs.
What do we stand for?

5. That technology should support patient care and not detract from it.

6. That a well-trained internist will be shown to be the best value in American medicine.

7. That public policy must support the training, retention, and well-being of internists, and the overall primary care physician workforce, as being essential to good outcomes of care and lower costs.
What do we stand for?

8. That practices and delivery systems must center on what is best for patients and families, and be supportive of internists and other clinicians within those systems.

9. That patients and physicians benefit from having a choice of practice models, from large groups to small independent practices, and those choices should be supported.

10. That internists must be compensated for their services at a level commensurate with their value.
What do we stand for?

11. That the medical profession has a responsibility to advocate for policies to address social determinants of health, the environment, discrimination, tobacco and substance use, public health, inequality, gun violence, immigration and other societal issues affecting the health of patients and the public.

12. That all persons, without regard to where they live or work; their sex or sexual orientation; gender or gender identity; race, ethnicity, faith, or country of origin; must have equitable access to high quality medical care, and must not be discriminated against based on such characteristics.
Believing in something is essential. But you also have to know “how the sausage is made”

Burr:
No one really knows how the game is played (Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens
But no one else is in the room where it happens
Believing in something is essential. But you also have to know “how the sausage is made”

Burr:
No one really knows how the game is played (Game is played)
The art of the trade
How the sausage gets made (How the sausage gets made)
We just assume that it happens
But no one else is in the room where it happens
ACP knows “how the sausage is made”

- Coalition-building (Group of 6): ACP, AAFP, AAP, APA, AOA, ACOG: represents over 560,000 physician and medical student members!
- Lobbying: congressional and regulatory branches
- Judicial branch: lawsuits and amicus briefs
- Grass roots (AIMn and Leadership Day)
- Earned and social media
- And of course, evidence-based policy positions

*We do it all. We do it well.*
We’re in the room where it happens

- The White House, HHS, and Congress regularly consult with us on a wide range of issues, from opioids, to Medicare payment policies, to immigration, to GME and workforce, to regulatory relief, to coverage, to public health, to preventing injuries and deaths from firearms—the list goes on and on.

- Even when we disagree, we are invited because ACP is viewed as a respected, credible, and evidence-based organization that stands for policies to improve the lives of patients, and daily work of our physicians.
We’re in the room where it happens

Dr. López and the G of 6 make the rounds on Capitol Hill

Then ACP-president Dr. López, Group of 6 with Sen. Patty Murray, D-WA

Tweet from CMS admin.
Seema Verma, pictured with Dr. Lopez and ACP Staff Shari Erickson and Brooke Rockwern

Dr. Moyer and G of 6 with Admiral Brett Giroir, assistant secretary of Health at HHS
We’re in the room where it happens

Dr. Fox at the RUC

ACP’s Shari Erickson discusses Medicare payment policy with CMS administrator Seema Verma

LD attendees with Rep. Ami Bera, D-CA

LD day attendees with Senator Bill Cassidy, R-LA
Case studies of effective advocacy: being “in the room where it happens” as the “sausage gets made”

- Improve payment for internists’ services and reduce documentation and paperwork.
- Reduce injuries and deaths from firearms.
- Limit harm to immigrants’ health.
- Reduce Rx prices.
- Advance and protect women’s health.
- Ensure access to coverage.
- Reduce harm from tobacco and nicotine.
- Protect patients from surprise bills.
Improve payments for internists’ services and reduce documentation and paperwork

- Major wins in the proposed Medicare physician rule! Effective 1/1/21:
  - Reverses CMS proposal to collapse E/M code payments and de-value complex cognitive care
  - Accepts RUC recommendations to improve RVUs and payments for office visit codes (ACP lead the multi-specialty efforts to survey physicians and make the case for higher payments)
  - Reduces documentation of E/M services
  - Improves payments for care management services
In November 2018, CMS released the 2019 Medicare Physician Payment Schedule Final Rule outlining a new E/M payment structure proposal—including blended payment rates for office-based/outpatient E/M visit levels 2 through 4 and separate payment for level 5 office visits.
## Previous CMS Proposal:

<table>
<thead>
<tr>
<th>Complexity Level under CPT</th>
<th>Visit Code Alone*</th>
<th>Visit Code Alone Payment</th>
<th>Visit Code With Either Primary or specialized care add-on code**</th>
<th>Visit Code with New Extended Services Code (Minutes Required to Bill)</th>
<th>Visit with Both Add-on and Extended Services Code Added**</th>
<th>Current Prolonged Code Added (Minutes Required to Bill)*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>New Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$76</td>
<td>$130</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>$110</td>
<td>$143</td>
<td></td>
<td>$197 (at 38 minutes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>$167</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$211</td>
<td>$211</td>
<td></td>
<td></td>
<td></td>
<td>$344 (at 90 minutes)</td>
</tr>
<tr>
<td><strong>Established Patient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$45</td>
<td>$90</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td>$103</td>
<td></td>
<td>$157 (at 34 minutes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 4</td>
<td>$109</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 5</td>
<td>$148</td>
<td>$148</td>
<td></td>
<td></td>
<td></td>
<td>$281 (at 70 minutes)</td>
</tr>
</tbody>
</table>
Need for E/M Proposal Changes

- ACP was a leader, along with several other specialty societies, in creating a coalition to push to improve payments for the historically undervalued E/M services, by retaining separate payment levels for each of the E/M codes, and revising the code definitions.

- ACP’s representative to the RUC, Dr. Bill Fox (also, chair-elect, Board of Governors) presented the coalition’s recommendations, *which were accepted by the RUC, and now CMS!*
Dr. Fox in the “room where it happens”

Dr. Fox at RVS Update Committee, April 26, 2019 (2nd from right)
CMS’s Proposed Changes E/M

CMS proposes to assign separate payment rather than a blended rate, to each of the office/outpatient E/M visit codes (except CPT code 99201, which will be deleted).

Payment for a new prolonged visit add-on CPT code (CPT code 99XXX).
## Proposed E/M wRVU Changes

<table>
<thead>
<tr>
<th>CPT Code</th>
<th>Descriptor</th>
<th>Current Work RVU</th>
<th>New Work RVU</th>
<th>Work RVU Increase</th>
<th>Total Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>99202</td>
<td>New Pt, straightforward medical decision making, 15-29 min day of visit</td>
<td>0.93</td>
<td>0.93</td>
<td>0%</td>
<td>22 minutes</td>
</tr>
<tr>
<td>99203</td>
<td>New Pt, low level medical decision making, 30-44 min day of visit</td>
<td>1.42</td>
<td>1.60</td>
<td>13%</td>
<td>40 minutes</td>
</tr>
<tr>
<td>99204</td>
<td>New Pt, moderate level medical decision making, 45-59 min day of visit</td>
<td>2.43</td>
<td>2.60</td>
<td>7%</td>
<td>60 minutes</td>
</tr>
<tr>
<td>99205</td>
<td>New Pt, high level medical decision making, 60-74 min day of visit</td>
<td>3.17</td>
<td>3.50</td>
<td>10%</td>
<td>85 minutes</td>
</tr>
<tr>
<td>99211</td>
<td>Est Pt, Supervision</td>
<td>0.18</td>
<td>0.18</td>
<td>0%</td>
<td>7 minutes</td>
</tr>
<tr>
<td>99212</td>
<td>Est Pt, straightforward medical decision making, 10-19 min day of visit</td>
<td>0.48</td>
<td>0.70</td>
<td>46%</td>
<td>18 minutes</td>
</tr>
<tr>
<td>99213</td>
<td>Est Pt, low level medical decision making, 20-29 min day of visit</td>
<td>0.97</td>
<td>1.30</td>
<td>34%</td>
<td>30 minutes</td>
</tr>
<tr>
<td>99214</td>
<td>Est Pt, moderate level medical decision making, 30-39 min day of visit</td>
<td>1.50</td>
<td>1.92</td>
<td>28%</td>
<td>49 minutes</td>
</tr>
<tr>
<td>99215</td>
<td>Est Pt, high level medical decision making, 40-54 min day of visit</td>
<td>2.11</td>
<td>2.80</td>
<td>32.8%</td>
<td>70 minutes</td>
</tr>
<tr>
<td>99XXX</td>
<td>Prolonged visit new/est pt, add'l 15 min</td>
<td></td>
<td>0.61</td>
<td>New</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>

Note: The table above details the proposed changes to E/M work RVUs, with new codes 99202-99215 replacing current codes 99201-99214. The changes include updated descriptors and work RVUs, with some codes showing increases in RVUs and total time. The new codes are designed to reflect more accurately the time and decision-making complexity involved in patient visits.
Documentation Changes

- History and Exam would no longer be used for code selection; but are performed and documented as medically appropriate.

- **Medical Decision Making (MDM) or Total Time on the Date of the Encounter may be used for code selection**
  - (without regard to whether counseling and coordination of care dominate the service).
Care Management Services

- **Transitional Care Management**
  - CMS is proposing to increase the work RVUs for these services.
  - Also considering for separate reimbursement for services that are currently considered overlapping.

- **Complex Chronic Care Management (CCCM)**
  - The agency propose to adopt two G codes for complex chronic care management services in place of the two existing CPT codes.
  - Revising what must be included in the comprehensive care plan.

- **Principle Care Management**
  - CMS proposes to create two new payable codes for Principle Care Management (PCM) services, which would entail providing care management services to patients with a single serious, high-risk condition.
Adding it all up: $7 billion redistributed to primary/cognitive care

- $3 billion in work RVUs, plus another $2 billion in practice expense (PE), and an additional $2 billion for the add-on code, the prolonged service and the other care management services.
- Because by law changes in RVUs must be “budget neutral” the $7 billion is funded by across-the-board reduction in the dollar conversion factor (CF):
  - RVUs x $CF=total payment, before geographic adjustments
  - As a result, many specialties that bill mostly for procedural services, and not for E/M codes, will face significant reductions.
  - Some are seeking to pressure Congress to halt the E/M changes.
- You can help ensure that the E/M changes go into effect by asking your members of Congress to support them, without changes or delay. Click on ACP’s Action Alert to learn how.
Thank you @ACPinternists for your support as @CMSGov works to reduce administrative burden and put #PatientsOverPaperwork, so doctors can focus on providing high quality care.

Internists applaud CMS for raising payments for office visits and reducing documentation in final payment rule. Read our full statement here: ow.ly/wHae50x1KJY
Reduce administrative burdens.

ACP Patients Before Paperwork Initiative

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

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

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

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

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

For more information, visit, www.acponline.org/pb4p
ACP recommendations to put patients before paperwork.

- Reduce E/M documentation requirements
- Eliminate/standardize preauthorization
- Reduce burden of reporting under Medicare Quality Payment Program
- Fewer, better, more meaningful, relevant and actionable performance measures
Reduce injuries and deaths from firearms

- 2018 policy paper spawns #ThisIsOurLane
- Call to action
- Legislation advanced in the House of Representatives.
- ACP-supported reforms enacted by a growing number of states.
- Public support is at an all-time high.
What does ACP recommend to curb injuries and deaths from firearms?

- ACP policy paper updates 2015 policy paper.
- The paper does not threaten the 2nd amendment right to own firearms for personal defense or recreation. Rather, we seek to:
  - To keep guns out of the hands of felons, all convicted domestic violence abusers (whether against a person within their house or outside of it), those with temporary as well as permanent restraining orders, and persons at imminent risk of harm to themselves or others
  - Background checks for all sales.
  - Close domestic violence loopholes.
  - Extreme risk protection laws
  - To require safe storage of guns and ammunition
  - To prohibit sales only of “assault” rifles and large capacity magazines.
  - To study causes and solutions to reduce injuries and deaths.
In response to the most recent ACP policy recommendations on reducing firearm-related injuries and deaths published in *Annals*, the NRA tweeted saying physicians should “stay in their lane.”

Physicians were quick to respond...
Our Response

The @NRA lectures “show them the lane” and not speak with @ACPInternists policy and the stance of @AnnalsOfIM, has the same be. Read & add you.

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

Maggie Fox
@maggiemfox

The @NRA tells doctors to keep quiet about their business. Doctors @JosephSakran say they are very much the opposite.
@CDCgov release.

Esther Choo MD MPH
@choo_ek

We are not self-important: we are dedicated to the care of others.
We are not anti-gun: we are not.
We consult with everyone but we take our responsibility very seriously.
Most upsetting, actually, is that gun-related disability from gun violence is unparalleled in the world.

NRA @NRA
Someone should tell self-important, anti-gun doctors: gun deaths rose in 2015 after legislation passed, but the medical community seems to have consulted NO ONE but themselves. nraila.org/articles/20181...

Joseph Sakran @JosephSakran

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

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

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

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

First patient, father was shot. The wound to the leg looked like a stab. The mother cried in grief, asking us to save him. This is the last one eaten in America. #ThisISOurLane

Dave Morris
@traumadmo

Can't post a patient like this.

This is what it looks like.

@NRA @Josepht5180616

Breathless
@breathless2

Replying to @NRA

Now, why in the hell do you think we have something against guns? Is this sort of like the trouble you have with life? #ThisISOurLane #GunControl

Julius Cheng, MD MPH
@ChengJJ_M

Here's hoping that the @NRA and @AnnCoulter realize that this is the reality we face. We seek solutions, and we won't quit because lives depend on it. Help us with #bulletholecontrol. Join us. #ThisIsOurLane #TraumaShoes #TraumaSurgery @EAST_TRAUMA @traumadoctors @DocsDemand
ACP’s position paper on reducing firearm-related injuries and deaths published In *Annals* has received extensive coverage in light of the NRA tweet saying physicians should “stay in their lane.” ACP, and the position paper, was mentioned in several top-tier media outlets, including CNN and CBS.
Firearms Position Paper Response: Top-Tier Media Coverage

The New York Times
Doctors Revolt After N.R.A. Tells Them to ‘Stay in Their Lane’ on Gun Policy

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

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

HUFFPOST
‘This Is Our Lane’: Doctors Slam NRA After Chicago Hospital Shooting

npr
After NRA Mocks Doctors, Physicians Reply: ‘This Is Our Lane’

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

THE WALL STREET JOURNAL
After NRA Rebuke, Many Doctors Speak Louder on Gun Violence

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

Medical societies are calling for gun-control measures and other solutions to what they see as a public-health crisis
Reduce injuries and deaths from firearms.

- **Call to Action** from ACP, American Academy of Family Physicians, American Academy of Pediatrics, American College of Surgeons, American Medical Association, and the American Public Health Association, published August 7, 2019, Annals of Internal Medicine.
Universal background checks

Funding for research

Intimate Partner Violence

Safe Storage

Access to Mental Health treatment

Extreme Risk Protection Laws

Physician counseling and “Gag Laws”

Firearms with Features designed to increase their rapid and extended killing capacity
In addition to original 7 authoring organizations, 35 have now endorsed it

- Alliance for Academic Internal Medicine
- American Academy of Allergy, Asthma, and Immunology
- American Academy of Neurology
- American Academy of Ophthalmology
- American Academy of Physical Medicine and Rehab
- American Association of Clinical Endocrinologists
- American College of Cardiology
- American College of Chest Physicians
- American College of Obstetricians & Gynecologists
- American College of Preventive Medicine
- American Geriatrics Society
- American Medical Group Association
- American Medical Women's Association
- American Psychological Association
- American Society of Hematology
- American Thoracic Society
- Association of American Medical Colleges
- C. Everett Koop Institute at Dartmouth
- Doctors for America
- Everytown for Gun Safety
- Giffords
- Institute for Patient- and Family-Centered Care
- Manhattan District Attorney’s Office
- National Council of Asian Pacific Islander Physicians
- National Hispanic Medical Association
- National Partnership for Women & Families
- Newtown Action Alliance
- Prevention Institute
- Renal Physicians Association
- Scrubs Addressing the Firearms Epidemic
- Society for Adolescent Health and Medicine
- Society of Critical Care Medicine
- Society of General Internal Medicine
- Society of Interventional Radiology
- States United to Prevent Gun Violence
Common-sense legislation has advanced in the House of Representatives

- House appropriations bill provides $50 million for the CDC and NIH to fund research on the prevention of firearms-related injuries and deaths.
- Passed the Violence Against Women (VAWA) Reauthorization Act of 2019 (H.R. 1585), to provide protections for domestic violence victims by restricting access to firearms by those deemed a threat to them.
- Passed the Bipartisan Background Checks Act of 2019 (H.R. 8), to expand background checks to all firearms sales in the United States.
- Introduction of the Assault Weapons Ban of 2019 (S. 66/H.R. 1296)
More states are acting

“Ten states raised their grades in 2018. Washington, the only state to put a gun-related initiative on the ballot, enacted a robust legislative package that improved laws surrounding minimum age, safe storage, and prohibited purchasers, among others. Eleven states enacted laws that help keep firearms away from domestic abusers, and seven states added a background check requirement or improved an existing background check law. Even states with historically weak gun laws, like Florida and Vermont, took critical steps to strengthen laws and keep people safe.”

Giffords Law Center, Annual Gun Law Scorecard
Resources for chapters

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

---

**Reducing Firearm-Related Injuries and Deaths**

**ACP Chapter Action Tool Kit**

Prepared by ACP’s Division of Governmental Affairs and Public Policy

February 5, 2019

**Call to Action**

ACP requests your chapter’s immediate help in advancing legislation in your state that would keep guns away from persons most at risk of harming themselves and others: extreme risk protection laws, child access prevention laws, and laws to close loopholes in the background check system that allow many domestic violence offenders to obtain and possess firearms.

These laws, all of which are consistent with ACP policy, are explained in more detail below.

With most state legislatures currently in session (and many will be in session only a few more weeks before adjourning for the year), the time to act is now.

(We acknowledge that the political climate in some states may not be favorable to advancing the policies recommended by ACP at this time, while in other states, the environment may be the most favorable in years. ACP leaves it totally to the discretion of each chapter to decide the extent to which it is able to implement this action plan, although we encourage all to consider participating.)

This tool kit provides practical resources that can readily be used by your chapter to take action, customized to the unique circumstances of your state.
Federal judges have blocked the public charge rule, which would make it difficult for persons to legally enter the U.S. or obtain a “green card” if they would use public benefits like Medicaid.

ACP’s amicus brief with AAMC, others has been accepted in the Supreme Court case challenging President Trump’s decision to end DACA (Dreamers program).

Administration reversed decision to end deferments for undocumented persons getting treatment in the U.S.

Federal judge rejected the administration’s efforts to end Flores consent decree, which limits days that undocumented immigrant children can be detained.
Lower Rx drug costs

ACP-supported bills have been advanced by House authorizing committees to:

- Increase transparency
- Address abuse of market exclusivity
- Cap Medicare Part D expenses
- Allow the federal government to negotiate drug prices
Speaker Pelosi has introduced a comprehensive plan to lower drug prices through negotiations and benchmarking.

“On behalf of the American College of Physicians (ACP), I am writing to express our appreciation for the recent release of the Lower Drug Costs Now Act of 2019 (H.R. 3), legislation designed to address the rising cost of prescription drugs. As outlined in a recent ACP statement on the bill, we are encouraged by its provisions to empower the Secretary of Health and Human Services (HHS) to negotiate with drug companies for lower prices and to cap out-of-pocket costs for seniors enrolled in the Medicare Part D program.”

Letter from ACP President Robert McLean to Speaker Pelosi, September 25, 2019
Federal judges have blocked Medicaid work requirements in Arkansas and Kentucky. ACP was a party to amicus briefs in both cases.

ACP also is a party to an amicus brief in the Texas v Azar case, which would argues that the entire ACA is unconstitutional. The administration has refused to defend the law, and a federal judge ruled in favor of the plaintiffs. Decision by appeals court is imminent.
Ensure access to coverage.

- New ACP position paper, *Improving the Patient Protection and Affordable Care Act's Insurance Coverage Provisions: A Position Paper From the American College of Physicians* recommends steps to close coverage gaps, including lifting income cap on premium subsidies, reinsurance, and universal Medicaid expansion, public option in all exchanges.

- Congress should support the *Protecting Pre-existing Conditions and Making Health Care More Affordable Act of 2019* (H.R. 1884), which strengthens and expands tax credits; stops skimpy health plans that do not cover essential benefits and discriminate against people with pre-existing conditions; and provides funding for reinsurance programs.
Reduce harm from tobacco and nicotine.

ACP supports the administration’s proposal to ban remove all non-tobacco flavored e-cigarettes from the market, including mint and menthol flavors.

On October 30, ACP President-Elect Dr. Jacqueline Fincher participated in a National Press Club briefing with AAP and AMA on the harms of vaping, reaffirming ACP’s support for a ban on flavors.

ACP supported the call to action by the surgeons general of the Air Force, Army, Navy, and United States to address health risks of smoking in the military.

ACP supports federal legislation introduced by Majority Leader McConnell to require a minimum age of 21 to purchase tobacco products.
Protecting patients from surprise bills.

- **Hold Patients Harmless**: ACP strongly supports legislative efforts to provide protections for patients from unexpected out-of-network health care costs, when additional services are provided by out-of-network clinicians without the patient’s prior knowledge.

- **Examine Network Adequacy**: Health plans have an affirmative obligation to pay fairly and appropriately for services provided in- and out-of-network, and regulators should ensure network adequacy in all fields, including emergency care. Evidence exists that narrow networks contribute to surprise out-of-network costs.

- **Include A Dispute Resolution Process**: ACP supports creating process that would allow an independent arbitrator to establish an appropriate and fair payment level between the insurers’ in-network rate and the clinician’s charge.
Yet can’t we do more?

- What if we were to craft a comprehensive statement of what changes should be made to American health care, supported by evidence, to better serve the needs of patients and the physicians who care for them?
- And used it to challenge everyone involved to make the needed changes?
- Well, this is exactly what ACP’s New Vision for American Health Care is all about.
ACP’s New Vision for American Health Care will better define and communicate what we stand for, and why

- Offer what we hope to achieve, and why, through the public policy recommendations on coverage and cost, payment and delivery system reforms, and improving public health and reducing barriers to care, supported by a review of the evidence.

- Intended audience includes, but is not limited, to our members, legislative and regulatory policymakers, consumers/patients, health plans/payers (CMS and private payers), and industry.

- Our goal is to influence health care debate preceding 2020 elections.
Why do we need to do better?

ACP’s evidence review focused on four key questions about U.S. health care:

• Why do so many American lack coverage for the care they need?
• Why is U.S. health care so expensive and unaffordable for many?
• What other barriers do patients face in accessing high quality, equitable, and affordable care?
• What is the role of delivery and physician payment systems in contributing to higher costs, reduced access, uneven quality and lack of equity?
Lack of coverage

- Despite historic gains in coverage from the Affordable Care Act (ACA), the U.S. remains the lone high-income industrialized nation without universal health coverage, which can be defined as a system that ensures everyone can access quality health care without being subject to substantial financial burden.

- Affordability is among the most commonly cited reason for remaining uninsured.
Higher spending

- The nation spends far more per-capita on health care compared to other wealthy countries and in 2016, nearly 18% of the nation’s gross domestic product was directed to health care. Price has been and continues to be the main driver of high health care spending in the U.S.

**Prices have historically driven health services spending growth, but use is now the primary driver.**

[Diagram showing annual change in price and quantity indexes of health services, 1980-2017, index numbers 2012=100]

Source: Kaiser Family Foundation analysis of Bureau of Economic Analysis data. Get the data → NIES

**Kaiser Family Health System Tracker**
“It’s the prices, stupid.”

“The United States spent approximately twice as much as other high-income countries on medical care, yet utilization rates in the United States were largely similar to those in other nations. Prices of labor and goods, including pharmaceuticals, and administrative costs appeared to be the major drivers of the difference in overall cost between the United States and other high-income countries.”

Figure 6

Cost Concerns, Including Health Care Costs, Top List of Worries

Percent who say they are worried about each of the following:

<table>
<thead>
<tr>
<th>Concern</th>
<th>Very worried</th>
<th>Somewhat worried</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your income not keeping up with prices</td>
<td>32%</td>
<td>29%</td>
</tr>
<tr>
<td>Not being able to afford health care services</td>
<td>25%</td>
<td>24%</td>
</tr>
<tr>
<td>Losing your health insurance</td>
<td>22%</td>
<td>16%</td>
</tr>
<tr>
<td>Not being able to afford prescription drugs</td>
<td>21%</td>
<td>23%</td>
</tr>
<tr>
<td>Not being able to pay your rent or mortgage</td>
<td>19%</td>
<td>15%</td>
</tr>
<tr>
<td>Being the victim of gun violence</td>
<td>18%</td>
<td>18%</td>
</tr>
<tr>
<td>Being the victim of a terrorist attack</td>
<td>17%</td>
<td>25%</td>
</tr>
<tr>
<td>Losing your job*</td>
<td>12%</td>
<td>13%</td>
</tr>
</tbody>
</table>

NOTE: “Losing your health insurance” was asked among those who were insured and “Losing your job” was asked among those who were employed. Question wording abbreviated. See topline for full question wording.

SOURCE: Kaiser Family Foundation Health Tracking Poll (conducted December 13-19, 2016)
Direct Spending on Healthcare

A family of four with a $100,000 income and employer coverage spends $12,500 per year (13% of their income) on health. This includes $2,900 (3% of their income) in out-of-pocket health spending, $4,550 (5% of their income) in health insurance premiums, and approximately $6,050 (5% of their income) in state and federal taxes that fund health programs.

Additional Contributions by Employers

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

When combined, this family’s spending on health care and the money spent by their employer on their behalf totals $27,000.
Higher administrative costs

- Administrative costs account for 8% of total U.S. health care spending and include a myriad of services from billing and insurance related activities to quality improvement programs.

- Complex medical billing and documentation requirements, quality reporting requirements for value-based payment initiatives, and other administrative tasks have made the United States health care system one of the most, administratively burdensome in the world, contributing to less time treating patients, billions in unnecessary administrative costs, and unprecedented levels of physician burnout and dissatisfaction.
80% of billing-related costs are a result of our multi-payer US health system


Percent of total revenue spent on billing-related costs

- Emergency department visits: 25%
- Primary care visits: 15%
- Surgical procedures: 3%

Uneven and inequitable outcomes

- While the health care system of the United States excels in some areas, such as decent care process outcomes, it consistently ranks last or near-last in access, administrative efficiency, equity, and health care outcomes.
- Life expectancy has been decreasing in the United States since 2014, and ranks last when compared to other high income developed countries at 78.9 years.
- Environmental health hazards, poor nutrition, tobacco use, prescription drug abuse, firearm violence, and maternal mortality – are reversing progress made over generations of increasing life expectancy.
ACP’s New Vision will be comprehensive and connected.

Ensure coverage, lower costs

Reform payment and delivery systems

Address social determinants, reduce barriers to care

Our vision of better health care for all
And I wanted what I got
When you got skin in the game, you stay in the game
But you don't get a win unless you play in the game
Oh, you get love for it, you get hate for it
You get nothing if you
Wait for it, wait for it, wait
God help and forgive me
I wanna build
Something that's gonna Outlive me
Hamilton:
And I wanted what I got
When you got skin in the game, you stay in the game
But you don't get a win unless you play in the game
Oh, you get love for it, you get hate for it
You get nothing if you
Wait for it, wait for it, wait
God help and forgive me
I wanna build
Something that's gonna Outlive me
“I wanna build something that’s gonna outlive me.”

By standing for something, and knowing how the sausage is made, ACP is in the room where it happens.

Our New Vision initiative gives us a chance to help build a better health care system for generations to come.