“The future ain’t what it used to be”
Health care policy in a new political era

ACP Louisiana Chapter
March 10, 2017
The one, and maybe only, thing that is certain about health care . . .

“The future ain’t what is used to be.”

Yogi Berra
The new political realities:

1. Donald Trump and his administration will be highly disruptive, upsetting long-held assumptions on the direction of U.S. health care policy.

2. The total GOP-controlled Congress means that they have the votes to carry out much of this disruptive agenda—if they stay united; Democrats have limited ability to influence action in Senate.

3. Trump presidency has unleashed a passionate grass roots progressive backlash, resulting in most Democrats favoring confrontation over cooperation.

4. Federal courts will play a key role in limiting or allowing the administration’s expansive view of its power to disrupt.
What does this mean for ACP advocacy?

- We have done a comprehensive threats and opportunities assessment—policies that are under threat, policies that could be advanced.
- Will need to be recalibrated as circumstances change.
Working in the ACP DC office is like playing this boardwalk game. . .

- ACA repeal!
- Immigration/refugee executive order!
- Climate change?
- What’s next?
“The future ain’t what it used to be.”

- Before the election, we anticipated a future of advocating for continued expansion of coverage, building and improving on the ACA.
- Now, the questions is whether the ACA will be repealed, all or in part; replaced with “something” else, and how many might lose coverage and access as a result.
The GOP checklist to repeal Obamacare

✓ Budget resolution instructs committees to come up with legislation to repeal much of it through reconciliation [COMPLETED]

• Reconciliation can be passed by simple majority in both chambers, Senate Dems can’t filibuster
  • Can only be used to repeal provisions that have direct impact on federal spending (e.g. premium and cost-sharing subsidies, $ for Medicaid expansion, taxes, and individual and employer mandates).
  • ACA provisions affecting essential benefits, annual and lifetime limits, other non-spending items likely can’t be repealed through reconciliation.
The GOP checklist to repeal Obamacare

✓ Reconciliation “repeal and replace” bill introduced 3/6/17, called American Health Care Act (AHCA)

✓ House committees “mark up” (report and amend) reconciliation repeal bill [In Progress]

✓ Reconciliation legislation voted on by House and Senate and signed into law by President Trump [NOT COMPLETED]

✓ Congress enacts legislation to replace all or parts of the ACA; most would require Democratic votes in the Senate [NOT COMPLETED]
GOP is finding that . . .

- Replacing the ACA with “something” that does not cause tens of millions to lose coverage is nearly impossible.
- There are deep divisions within its own ranks on how much the government should do to subsidize health care, and particularly, on Medicaid.
- Voters are besieging GOP lawmakers not to take their coverage away.
What has the ACA achieved?

**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
Number of People Enrolled in 2016 Affordable Care Act Marketplaces by Congressional District

2016 Marketplace Enrollees by Congressional District and Representative Party Affiliation
- R Representative / <20,000 enrollees
- R Representative / 20,000-30,000 enrollees
- R Representative / >30,000 enrollees
- D Representative / <20,000 enrollees
- D Representative / 20,000-30,000 enrollees
- D Representative / >30,000 enrollees

Source: Kaiser Family Foundation analysis of 2016 plan selections by county released by ASPE for the 2016 open enrollment period.
What has the ACA achieved?

- More than 20 million covered by Medicaid expansion or ACA subsidized plans.
- Insurers are prohibited from
  - imposing annual or lifetime dollar caps on benefits
  - charging more or excluding people with pre-existing conditions
- All health plans must cover 10 categories of “essential benefits” including preventive services with zero cost-sharing.
What has the ACA achieved?

- 1 out of 4 Americans, 52 million, have a pre-existing medical condition that was “declinable” before the ACA. [Link](http://kff.org/health-reform/issue-brief/pre-existing-conditions-and-medical-underwriting-in-the-individual-insurance-market-prior-to-the-aca/)
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 expectant 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>Transsexualism</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, Coventry, Dean Health, Golden Rule, Health Care Services Corporation (BCBS in IL, TX) HealthNet, 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.
What has the ACA achieved?

### The ACA Made Many Insurance Reforms Affecting Women

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

What has the ACA achieved?

### 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

House GOP repeal bill (AHCA) would:

- Radically restructure Medicaid:
  - Sets a per capita (per enrollee) cap on federal funding for Medicaid (non-expansion and expansion states), starting in 2020
  - Continues higher federal “match” (90%) for expansion states like Louisiana until 2020, then higher match eliminated except for already enrolled expansion-eligible persons who maintain “continuous” (uninterrupted) coverage afterwards
  - If they leave Medicaid, the state loses the higher expansion funding for them; if then re-enroll, it will be at the regular lower match; over time, expansion funding and coverage would disappear
Expansion states are split between Republican and Democratic governors as of January 2017.

NOTES: Coverage under the Medicaid expansion became effective January 1, 2014, in all but seven expansion states: Michigan (4/1/2014), New Hampshire (8/15/2014), Pennsylvania (1/1/2015), Indiana (2/1/2015), Alaska (9/1/2015), Montana (1/1/2015), and Louisiana (7/1/2016). Seven states that will have Republican governors as of January 2017 originally implemented expansion under Democratic governors (AR, IL, KY, MA, MD, NH, VT), and one state has a Democratic governor but originally implemented expansion under a Republican governor (PA). *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 expansion waivers.
Figure 6

From January 2014 - June 2015, spending for the expansion group totaled $84 billion ($79 billion in federal funds).

Medicaid Spending, January 2014 - June 2015

- Total Spending for Traditional Medicaid: $664 Billion ($306 Billion Federal)
  - Traditional Medicaid - State 37%
  - Traditional Medicaid - Federal 51%
  - Expansion Group Federal 11%
  - Expansion Group - State 1%

Total Spending for Expansion Group: $84 Billion ($79 Billion Federal)

Total Medicaid Spending = $748 Billion ($385 Billion Federal)

Medicaid Cost Shifts in House GOP Plan Would Total an Estimated $370 Billion Over 10 Years and Grow Over Time

Cost shifts to states, relative to current law

- '18
- '19
- '20
- '21
- '22
- '23
- '24
- '25
- '26
- '27

- ACA expansion group*
- Other Medicaid enrollees

-$80 billion

*Enrollees under the Affordable Care Act’s Medicaid expansion

Source: CBPP analysis using Jan. 2017 Congressional Budget Office Medicaid baseline and inflation estimates from CBO and the Centers for Medicare and Medicaid Services
Medicaid in Louisiana: what’s at stake

- 1.4 million are covered by Medicaid and CHIP; 400,635 enrolled in Medicaid because of the expansion.
- Uninsured rate in Louisiana has decreased by nearly half to 12.5 percent in 2016, down from 21.7 percent in 2013.
- Many of them would be at risk of losing coverage if the higher federal match is phased out, starting January 1, 2020.
  - Those who gained coverage from expansion would lose it if they left the program for a month or more; state likely could not afford to have them re-enroll without higher federal match.
  - State would be unable to afford to add new expansion enrollees,
- Per capita cap on federal contribution could result in loss in coverage for many of the other 1 million enrolled.
Former CMS administrator Andy Slavitt:

“But the most lasting effects of this bill would be the significant steps it took toward forcing permanent changes to Medicaid and Medicare. The Medicaid changes are more obvious and dangerous. First, the bill would effectively end the popular and largely bipartisan Medicaid expansion created by the ACA, which extended care to millions of working Americans. Dropping the federal funding contribution for new enrollees after 2020 — and violating a promise the federal government made to the states — would rapidly end the expansion. In today’s world, taking away funding for such a program is the same as killing it; it’s just a different weapon.”
Former CMS administrator Andy Slavitt:

“More draconian is a permanent capping of the Medicaid program. In my time overseeing the government agency that runs the program, we dealt with many unexpected shocks — Zika, high-cost drugs and the national opioid epidemic, to name a few. Under the changes sought by Republicans, states would no longer have the resources to manage these crises, with devastating results for our communities. Medicaid pays for nearly half the births and half the long-term care in this country, to say nothing of the millions of Americans with disabilities who rely on it. If the federal government retreats on its commitment to Medicaid, the repercussions will be felt quickly — by our neighbors and by our care providers and hospitals.”

House GOP repeal bill would:

- Replace income-based premium subsidies to buy private insurance with age-based ones for persons with incomes up to $75,000
  - “Regressive” because the dollar subsidy is the same dollar amount per person for low-income and higher income persons.
  - While the tax credits are higher for older persons than younger ones, allows insurers to charge people over age 60 five times more than those under 60 compared to three times under ACA.
  - Repeals ACA’s cost-sharing subsidies for persons with incomes up to 250% of FPL, meaning their deductibles, co-payments would increase.
  - Fixed tax credits are the same regardless of where you live and cost of care in your community, meaning you will pay more for insurance in high cost areas.
AHCA’s tax credits:

- Starting in 2020, replace ACA income-based tax credits with flat tax credit adjusted for age. Credits are payable monthly; annual credit amounts are:
  - $2,000 per individual up to age 29
  - $2,500 per individual age 30–39
  - $3,000 per individual age 40–49
  - $3,500 per individual age 50–59
  - $4,000 per individual age 60 and older
- Families can claim credits for up to 5 oldest members, up to limit of $14,000 per year.
- Amounts are indexed annually to CPI plus 1 percentage.
Under the AHCA’s tax credits, older, sicker patients will pay much more for private insurance

- “For all but the youngest individuals, it increases both overall costs and the risk of a financially devastating event.”
- Would increase costs for the average enrollee by $1,542, for the year, if the bill were in effect today. In 2020, the bill would increase costs for the average enrollee by $2,409.
- “Impact of the Republican bill would be particularly severe for older individuals, ages 55 to 64. Their costs would increase by $5,269 if the bill went into effect today and by $6,971 in 2020. Individuals with income below 250 percent of the federal poverty line would see their costs increase by $2,945 today and by $4,061 in 2020.”
Seniors’ Premiums Skyrocket under House Repeal Bill*

Jennifer

Individual: 60-year-old
Ears just under: $30,000/year

$4,867
Increase in Annual Premiums

<table>
<thead>
<tr>
<th></th>
<th>ACA</th>
<th>HOUSE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Premiums as Percent of Annual Income</td>
<td>8%</td>
<td>25%</td>
</tr>
</tbody>
</table>

FAMILIESUSA
THE VOICE FOR HEALTH CARE CONSUMERS

* Families USA analysis based on 2017 national average premium for the second-least expensive silver plan, adjusted to reflect expected premium change using 50 age rating bands, and changes in premium tax credits. Source: Health Insurance Marketplace Calculator, (Washington, DC: Kaiser Family Foundation, November, 2016); Impact of Changing ACA Age Rating Structure (Milliman, January 2017)
60 year old, $40,000 annual income
State: Louisiana, County: Orleans

ACA tax credit in 2020: $7,130
House tax credit in 2020: $4,000
$ change from ACA to House tax credit: -$3,130
% change from ACA to House tax credit: -44%

Over time, the average tax credit received under Republican replacement plans would grow slower than under the ACA.

Average Annual Premium Tax Credit for Current Marketplace Enrollees

- Affordable Care Act
- American Health Care Act

2020 (3 years): $4,615
2022 (5 years): $5,342
2027 (10 years): $6,648

Source: Kaiser Family Foundation analysis of data from Healthcare.gov, state-based exchanges, and Congressional Budget Office.
Note: Amounts above represent the average tax credit received based on the age distribution of current Marketplace enrollees.
House GOP repeal bill:

- Keeps the ACA’s prohibition against insurers charging more or declining coverage for pre-existing conditions, but only for those who have continuous, uninterrupted coverage.
  - If a patient with a pre-existing coverage loses their continuous coverage and doesn’t enroll in another plan within 63 days, insurers can charge them a 30% higher premium.
  - Combined with inadequate tax credits, many would be forced to go without coverage.
House GOP repeal bill would:

- Keep requirement (for now) that insurers cover 10 categories of essential benefits, but repeals the ACA’s “actuarial value” requirements, meaning that insurers may be able to impose higher-cost sharing for those services.
- Keeps the ACA provision that keeps young adults up to age 26 on parents’ plans.
- Allows insurance companies to deduct their entire CEO’s salaries from federal taxes; current limit is $500,000; Humana could deduct entire $17 million salary for its CEO.
ACP opposes the AHCA because it will cause millions to lose coverage and benefits.

- We oppose provisions to cap future federal contributions to Medicaid and phase-out the higher federal match in states that have opted to expand Medicaid.
- Repeal of the current law “actuarial value” requirements for essential health benefits could result in increased out-of-pocket costs for many necessary health care services, such as mental health benefits, maternity care and contraception, and preventive services.
- AHCA’s continuous coverage requirements for patients with pre-existing conditions could result in vulnerable persons being unable to afford coverage for conditions that prior to the ACA were treated as “declinable” by insurers.
- The AHCA’s regressive age-based tax credits, combined with changes that will allow insurers to charge older people much higher premiums than allowed under current law, will make coverage unaffordable for poorer, sicker and older persons, as well as for persons who live in high health care cost regions.
OPPOSING GOP HEALTH CARE PLAN

FIRST 100 DAYS

TRUMP MEETS WITH CONSERVATIVE HEALTH BILL FOES
Senator Cassidy’s bill:

- Also does not meet ACP’s criteria for support
- While it would in theory allow states to “keep Obamacare” including Medicaid expansion, the overall funding would be reduced by at least 10 percent.
- States could choose to do absolutely nothing to ensure coverage.
- Also includes Medicaid federal per capita spending caps, similar to House GOP bill, which would cause funding to erode and millions to lose coverage.
What else is ACP doing about coverage, access and the ACA?

- Gave Congress our recommended priorities for coverage and consumer protections.
- Developed 10 questions to evaluate impact of any legislation to improve or replace the ACA.
- Formed a coalition with AAFP, AAP, ACOG, and AOA—collectively represent a 500,000 physicians and medical student members, leaders met with Senators on 2/2 and House members on 3/7.
- Action alerts to AIMn members in Medicaid expansion states
- State chapter advocacy campaign
- Twitter social media campaign: hashtag #Docs4Coverage.
Doctors Make the Case for Obamacare or Something Like It

by MAGGIE FOX

Congress should improve Obamacare without taking away what’s best about it, doctors said Thursday.

Doctors who treat women and children, as well as general practitioners, made a daylong dive across Senate offices to make the case for keeping important aspects of the Affordable Care Act. And they rebuked Republicans in Congress for talking up repeal without having a plan for replacement in place.

“Currently insured individuals should not lose their coverage as a result of any action or inaction by policymakers,” five medical organizations said in a statement released as part of the lobbying push.

“Acceptable reform must continue to ensure access to comprehensive, safe, and affordable care,” said Dr. Thomas Gelhous, president of the American Congress of Obstetricians and Gynecologists.

A doctor uses a gloved hand to touch the hands of a woman and her daughter at All Children’s Hospital in St. Petersburg, Florida on Sept. 18, 2015. © Lara Cerri / The Tampa Bay Times via AP

Presidents of Five Medical Organizations Representing 500,000 Physicians and Medical Students Meet with U.S. Senators With One Message: Protect Patients’ Access to Health Care

(Washington, February 2, 2017)—Leaders of five medical organizations representing 500,000 physicians and medical students today urged U.S. senators to maintain affordable and meaningful coverage and access to health care for the millions of Americans who are now covered under current law and benefit from other consumer protections.

In meetings with Republican and Democratic senators, the presidents of the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, the American Congress of Obstetricians and Gynecologists and the American Osteopathic Association laid out five recommendations for any legislation that would make changes to our current health care system.

Doctors swarm Congress on Obamacare repeal

By PAIGE WINFIELD CUNNINGHAM (@PW_CUNNINGHAM) • 2/2/17 4:30 PM
Primary Care Physician Support for ACA Repeal

Republican 32%
Democrat 0%
Overall 15%
Trump Voters 38%
Clinton Voters 0%

Source: Pollack, Armstrong and Grande, NEJM 2017

Increase use of health savings accounts: 68.7%
Public insurance option to compete with private plans: 66.5%
Pay physicians for value rather than volume: 61.7%
Tax credits for Medicaid-eligible people to purchase private insurance: 58.6%
Require state Medicaid expansion: 47.4%
Expand Medicare to people 55–64 yr of age: 42.8%
Deregulate private insurance: 42.0%
Increase use of high-deductible health plans: 29.4%

The future ain’t what it used to be: Immigration policy

- President Trump’s *original* executive order suspended travel for 90 days from 7 Muslim-majority designated countries, including for physicians and medical students (ACP members) with valid visas.

- Also barred refugees from 6 of those countries for 120 days, Syrian refugees indefinitely.
Travel ban: **health impact**

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

- **Doctors and surgeons**
  - 656,000
  - 254,000 (27.9% are immigrants)

- **Nurses and home health aides**
  - 1.6M
  - 489,000 (23.8% are immigrants)

Source: Migration Policy Institute, 2015

Foreign-trained doctors make up half the workforce in some medical specialties

<table>
<thead>
<tr>
<th>Speciality</th>
<th>American-trained doctors</th>
<th>Foreign-trained doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric medicine</td>
<td>50.7%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Nephrology (kidneys)</td>
<td>47.2%</td>
<td>52.8%</td>
</tr>
<tr>
<td>Cardiology</td>
<td>43.6%</td>
<td>56.4%</td>
</tr>
<tr>
<td>Critical care</td>
<td>41%</td>
<td>59%</td>
</tr>
<tr>
<td>Internal medicine</td>
<td>38.6%</td>
<td>61.4%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>30.2%</td>
<td>69.8%</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>25.4%</td>
<td>74.6%</td>
</tr>
<tr>
<td>Family medicine</td>
<td>22%</td>
<td>78%</td>
</tr>
</tbody>
</table>

Source: Association of American Medical Colleges, 2015
Iran and Syria are among the top 10 countries that send physicians and surgeons to the US

Immigrant doctors and surgeons by country of birth in 2015

- 5,000 doctors were Syrian born in 2015
- 9,000 doctors were Iranian born in 2015

Source: Migration Policy Institute, 2015
Foreign-born physicians provide disproportionate share of care in underserved communities

International medical graduates (IMGs) account for approximately one quarter of the nation’s practicing physicians,\textsuperscript{1,2} a similar proportion of primary care physicians,\textsuperscript{2} and a quarter of U.S. physician office visits.\textsuperscript{3} National data suggest that IMGs play an important role in providing care to disadvantaged communities.\textsuperscript{4,5} They disproportionately serve low income patients in shortage areas,\textsuperscript{2} including non-metropolitan areas.\textsuperscript{3} One reason is that many IMGs are able to remain in the United States under the sponsorship of Conrad State 30 J-1 Visa Waiver Programs (Conrad 30 programs). A waiver of the J-1 visa post-residency requirement to return to the home country for at least two years allows residency graduates who are not U.S. citizens or permanent residents to remain in the U.S. To obtain the waiver, IMGs must commit to three years’ employment serving Health Professional Shortage Areas (HPSAs) or Medically Underserved Areas or Populations (MUA/Ps), or populations from those areas.\textsuperscript{6} In contrast to the 1990s, when federal “interested government agencies” (those that are eligible to request J-1 visa waivers, such as the U.S. Department of Agriculture and U.S. Department of Health and Human Services) requested the vast majority of waivers, in the 2000s states have become the primary source of J-1 visa waiver requests via Conrad 30 programs.\textsuperscript{7}

These IM residents 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
It is already clear to us that the executive order is resulting in discrimination based on religion against physicians and medical students from the designated countries who are getting their training, and caring for patients, in the United States.

These are physicians who have already been thoroughly vetted and had been granted visas. They are now at risk of not being able to reenter the U.S. if they go abroad or may currently be abroad and being prevented from returning to their homes and their patients.

The College is greatly concerned about the devastating impact on public health of a ban on refugees from war-torn countries that are most at risk of injury, death, persecution and deprivation.”

The American College of Physicians is the largest medical specialty organization in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness. Follow ACP on Twitter @ and Facebook.
the Government’s “authority and expertise in [such] matters do not automatically trump the Court’s own obligation to secure the protection that the Constitution grants to individuals,” even in times of war. *Humanitarian Law Project*, 561 U.S. at 34 (quoting id. at 61 (Breyer, J., dissenting)); see also *United States v. Robel*, 389 U.S. 258, 264 (1967) (“‘[N]ational defense’ cannot be deemed an end in itself, justifying any exercise of legislative power designed to promote such a goal. . . . It would indeed be ironic if, in the name of national defense, we would sanction the subversion of one of those liberties . . . which makes the defense of the Nation worthwhile.”); *Zemel v. Rusk*, 381 U.S. 1, 17 (1965) (“[S]imply because a statute deals with foreign relations [does not mean that] it can grant the Executive totally unrestricted freedom of choice.”).
ACP, AAIM, 10 other groups make recommendations to Homeland Security

1. Reinstate the Visa Interview Waiver Program. Suspension of the program “risks creating substantial backlogs in the processing of new and renewal visas for trainees from any foreign country — delays that create substantial problems for residency programs with trainees on visas and that could interfere with the residency match process this year.”
   [Link](http://www.nejm.org/doi/full/10.1056/nejmp1701339)

2. Remove restrictions on entering the U.S. for physicians from the seven designated countries who have been approved for J-1 or H-1B visas and students from those countries with F-1 visas who have been accepted to U.S. medical schools.

3. Develop and implement a plan to allow physicians from the seven designated countries to obtain travel visas to travel to the U.S. for medical conferences and other medical and research related engagements.

4. Make it a priority to implement a process to admit refugees, without further delay, who had already been vetted and approved for entry prior to the executive order and who are in need of urgent medical care.

[Link](https://www.acponline.org/acp-newsroom/acp-and-11-health-care-organizations-offer-joint-recommendations-on-executive-order-on-immigration)
Revised executive order

- Removes Iraq from the travel ban,
- Eliminates restrictions on travel for those who have approved visas (including physicians and medical students),
- **No new visas will be issued from the 6 countries for 90 days,**
- Continues to ban refugees for 120 days.
- While ACP acknowledges the improvements, we remain concerned that the order is discriminatory, will restrict free travel by physicians, and make it more difficult for physicians to achieve visas for this year’s residency match.
Other priority issues

- Rx Pricing
- Insurer mergers
- Administrative burdens
- Quality Payment Program/MACRA
ACP has comprehensive policy on rising RX prices, and is the leading physician voice in campaign to address it.
Big wins for ACP advocacy! Courts block insurer mega-mergers

Judge Blocks Aetna’s $37 Billion Deal for Humana

By REED ABELSON and LESLIE PICKER  JAN. 23, 2017

But Anthem has said in court that it expects the Trump administration’s DOJ to drop its opposition to the merger with Cigna. ACP wrote to DOJ on 3/9/17 to urge it to reject any settlement that would allow the merger to proceed.
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!*
Regulatory relief

- *Patients Before Paperwork* policy paper will propose a new framework for challenging regulations that do not improve patient care.
- Our regulatory affairs team is preparing specific recommendations to reduce burden on physicians.
- We are working with leading business and consumer groups to re-imagine quality measurement so it is less burdensome, more meaningful and relevant to clinicians and patients!
- And we are working to ease and simplify reporting, and create more opportunities for physician-led Alternative Payment Models, under Medicare’s new Quality Payment Program.
What can you do?

- Help us grow ACP membership.
- Tell us what you think is important.
- Stay informed, follow me on Twitter @BobDohertyACP and #Doctors4Coverage, read my blog [http://advocacyblog.acponline.org/use](http://advocacyblog.acponline.org/use), use ACP advocacy resources [https://www.acponline.org/advocacy/where-we-stand/affordable-care-act](https://www.acponline.org/advocacy/where-we-stand/affordable-care-act),
- Call, write members of Congress, attend Town Halls.
- Sign up to be an Advocate for Internal Medicine [https://www.acponline.org/advocacy/advocates-for-internal-medicine-network](https://www.acponline.org/advocacy/advocates-for-internal-medicine-network)
- Most importantly, make a commitment to become an advocate for your profession and your patients!
Conclusion

- Elections have consequences, this one especially!
- While there are major threats to many ACP priorities, there also are major opportunities, particularly on easing regulatory burdens.
- While compromises will need to be made, ACP will remain committed to what we believe to be best for patients.
Final words of wisdom from Yogi:

“You’ve got be careful if you don’t know where you are going, ‘cause you might not get there.”