Fostering Excellence And Professionalism In Medicine By Leading The Way Together: Views From The American College Of Physicians
Many Thanks!

- Steve Weinberger, Bob Doherty, Shari Erickson and the DC Staff
- 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 and new models of healthcare delivery
- Review the challenges for GME funding, physician pipeline, and obstacles to the primacy of the patient-physician relationship
An All Too Familiar Patient...

A 40 year old patient with type 2 DM on insulin presents to the clinic (substitute ED) for the 4\textsuperscript{th} 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 450

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

Two areas of greatest expenditures and most rapid growth: imaging and tests
Top 1%: Dominant chronic

Top 5%: Severe significant multiple chronic conditions

Middle 14%: Multiple chronic or severe chronic

Middle 30%: Minor chronic

Bottom 50%: Healthy

Cost distribution within risk tier

Mean

$0 $800 $1,600 $2,400 >$3,200
POVERTY
and the MYTHS of
HEALTH CARE REFORM

RICHARD (BUZ) COOPER, MD
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.
<table>
<thead>
<tr>
<th>Year</th>
<th>Worker Contribution</th>
<th>Employer Contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td>$1,543</td>
<td>$4,247</td>
</tr>
<tr>
<td>2000</td>
<td>$1,619</td>
<td>$4,819*</td>
</tr>
<tr>
<td>2001</td>
<td>$1,787*</td>
<td>$5,274*</td>
</tr>
<tr>
<td>2002</td>
<td>$2,137*</td>
<td>$5,866*</td>
</tr>
<tr>
<td>2003</td>
<td>$2,412*</td>
<td>$6,657*</td>
</tr>
<tr>
<td>2004</td>
<td>$2,661*</td>
<td>$7,289*</td>
</tr>
<tr>
<td>2005</td>
<td>$2,713</td>
<td>$8,167*</td>
</tr>
<tr>
<td>2006</td>
<td>$2,973*</td>
<td>$8,508*</td>
</tr>
<tr>
<td>2007</td>
<td>$3,281*</td>
<td>$8,824</td>
</tr>
<tr>
<td>2008</td>
<td>$3,354</td>
<td>$9,325*</td>
</tr>
<tr>
<td>2009</td>
<td>$3,515</td>
<td>$9,860*</td>
</tr>
<tr>
<td>2010</td>
<td>$3,997*</td>
<td>$9,773</td>
</tr>
<tr>
<td>2011</td>
<td>$4,129</td>
<td>$10,944*</td>
</tr>
<tr>
<td>2012</td>
<td>$4,316</td>
<td>$11,429*</td>
</tr>
<tr>
<td>2013</td>
<td>$4,565</td>
<td>$11,786</td>
</tr>
<tr>
<td>2014</td>
<td>$4,823</td>
<td>$12,011</td>
</tr>
<tr>
<td>2015</td>
<td>$4,955</td>
<td>$12,591*</td>
</tr>
</tbody>
</table>

* 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, health care 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 5 specialists is a hospital employee.

2000

2012

"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

Increasing Market Concentration Leads to Higher Prices for Consumers

Percentage increase in market concentration from 1999-2003.

-5.5%
-6.7%
-7.4%
-9.4%
-7%

WEST
SOUTHWEST
MIDWEST
SOUTH
EAST

"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

FIGURE: Estimated sources of $15 billion in public funding for GME

- 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.
Figure 1
State Variation in the Supply of Primary Care Physicians (PCPs)

Source: Health Resources and Services Administration 2008 Area Resource File
Physician Workforce Age Distribution:
1985 and 2005

Number of Physicians (in thousands)

<table>
<thead>
<tr>
<th>Age Group</th>
<th>1985</th>
<th>2005</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 35</td>
<td>74</td>
<td>61</td>
</tr>
<tr>
<td>35-44</td>
<td>145</td>
<td>196</td>
</tr>
<tr>
<td>45-54</td>
<td>97</td>
<td>216</td>
</tr>
<tr>
<td>55-65</td>
<td>75</td>
<td>148</td>
</tr>
<tr>
<td>65 and Over</td>
<td>45</td>
<td>85</td>
</tr>
</tbody>
</table>
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 Democratization and Flipped Healthcare Classroom 2017...

- The Patient Will See You Now
- DPCP
- Retail and urgent clinics
- Telehealth
- Digital Media Resources
- Home Hospital
Flipping Health Care through Retail Clinics and Convenient Care Models
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
How Did We Get Here?
The Alliance of Acronyms...
"I hear there's a new ICD-10 code for carpal tunnel syndrome caused by clicking too many times in an EMR system."
We Have A Wealth Of Information And A Poverty Of Attention....
STRESS MANAGEMENT CLINIC

SORRY, CLOSED DUE TO BURNOUT.

Search ID: hsc3048
What’s Missing From The Triple Aim?

Triple Aim

1. Improved patient experience
2. Reduced cost
3. Improved population health

Source: Institute for Healthcare Improvement
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
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 (cont’d)

- 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, coordination, communication
- 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 4\textsuperscript{th} time in 3 months with a blood sugar \textasciitilde400. 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
5/13/07: Mylan announces purchase of Merck's generics unit, including EpiPen

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

Hillary 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 see 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.


For author affiliation, see end of text.

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 a drug. Pricing (the base price of a drug before negotiations, rebates, and discounts), cost (the actual dollar amount paid by 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 three 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. As new developments in the diagnosis and treatment of disease are discovered, Americans are using these drugs as part of their daily lives. Today, 7 out of 10 Americans are taking at least 1 prescription drug (2). However, not all patients can absorb 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 includes 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, Switzerland, and the United Kingdom (5). In addition, the United States tends to introduce new drugs to the market faster than other countries and use these new products more, influencing increases in prescription drug spending (5). The government and private insurance companies are the primary purchasers of drugs in the United States. Medicare, Medicaid, benefits administered under the Veterans Health Administration, and private payers have different methods for obtaining prescription drugs, re-
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.

Health plans are required to include 10 essential benefits:

1. Preventive, wellness, and disease management services
2. Pediatric services, including dental and vision
3. Emergency care
4. Prescription drugs
5. Ambulatory services
6. Laboratory services
7. Hospitalization
8. Mental health and substance abuse services, including behavioral health treatment
9. Maternity and newborn services
10. Rehabilitation and habilitation services
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>Paralytic</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>Transsexual</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.
# 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>

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
Earns just under: $30,000/year

$4,867
Increase in Annual Premiums

<table>
<thead>
<tr>
<th>ACA</th>
<th>HOUSE PLAN</th>
</tr>
</thead>
<tbody>
<tr>
<td>8%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Premiums as Percent of Annual Income

*Families USA analysis based on 2017 national average premium for the second-lowest expensive silver plan, adjusted to reflect expected premium change using 51 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)
On May 4, the House of Representative passed the American Health Care Act (AHCA)

- Just a little over 6 weeks from when Speaker Ryan pulled the original bill before a scheduled vote due to lack of support within GOP caucus.
- The new AHCA, as amended, was passed by a bare majority, 217-213, with no Democratic support.
What would the AHCA do?

- Radically restructure Medicaid.
- Allow states to opt-out of the ACA’s community-rating and essential benefits requirements.
  - Provides limited funding to states to establish “high risk pools” for previously uninsured.
- Replace progressive, income-based premium and cost-sharing subsidies with regressive age-based tax credits.
The AHCA radically restructures Medicaid

- Sets a per capita (per enrollee) cap on federal funding for Medicaid (non-expansion and expansion states) or gives states a block grant option, starting in 2020

- Eliminates higher federal funding for Medicaid expansion states except for already enrolled 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

- Bans additional states from expanding Medicaid.
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

- Enrollees under the Affordable Care Act's Medicaid expansion
- Other Medicaid enrollees

Source: CBPP analysis using Jan. 2017 Congressional Budget Office Medicaid baseline and inflation estimates from CBO and the Centers for Medicare and Medicaid Services
How Could States Fill the Gaps in Reduced Federal Medicaid Funding?

- **Dem/Ind Expansion**: 9.0%
- **Rep. Expansion**: 8.5%
- **Dem./Ind. Non-Expansion**: 5.3%
- **Rep. Non-Expansion**: 6.7%

**Median Increase in State Taxes per Resident**
- **Dem/Ind Expansion**: -15.5%
- **Rep. Expansion**: -15.3%
- **Dem./Ind. Non-Expansion**: -9.5%
- **Rep. Non-Expansion**: -10.2%

**Median Decrease in K-12 spending per Pupil**

Scenario Assumes $73 Billion Reduction from a Repeal of the ACA Enhanced Match + 20% Reduction in Traditional Medicaid (FY 2015 Dollars)


KFF.org
What would be the impact on people with preexisting conditions?

The ultimate outcome would be that premiums in the community-rated pool would have to be set at a prohibitively high level, leaving people with serious illnesses with no affordable options.

“In brief, healthy people would have a strong incentive to “opt out” of the community-rated pool and instead pay a premium based on health status. With healthy enrollees opting out of the community-rated pool, community-rated premiums would need to be extremely high, forcing sicker individuals—including those with continuous coverage—to choose between paying the extremely high community-rated premium or being underwritten themselves. Either way, people with serious health conditions would face prohibitively high premiums. As a result, community rating would be eviscerated—and with it any meaningful guarantee that seriously ill people can access coverage.”

Sick people in states that voted for President Trump are most at risk of losing coverage.

<table>
<thead>
<tr>
<th>States</th>
<th>Pre-existing Conditions (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Virginia</td>
<td>36%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>34%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>33%</td>
</tr>
<tr>
<td>Alabama</td>
<td>33%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>32%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>32%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>31%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>30%</td>
</tr>
<tr>
<td>Missouri</td>
<td>30%</td>
</tr>
<tr>
<td>Indiana</td>
<td>30%</td>
</tr>
<tr>
<td>Kansas</td>
<td>30%</td>
</tr>
</tbody>
</table>

*SOURCE: Kaiser Family Foundation analysis of data from National Health Interview Survey and the Behavioral Risk Factor Surveillance System.*
Under the AHCA, states could apply for waivers to opt-out of the ACA’s community rating and essential benefits requirements.

**Guaranteed coverage**

People with preexisting conditions could see substantial changes in what kind of coverage they could receive.

**Under the Affordable Care Act**

- Americans are able to get health insurance even if they’re sick. This puts an end to insurers denying coverage to people who have preexisting medical conditions.
- Insurers are barred from charging sick consumers more for coverage.
- Insurers cannot impose annual or lifetime limits on coverage.
- Insurers must offer a basic set of benefits, including mental health, prescription drugs, and maternity care.
- Insurers cannot charge older consumers more than three times more than younger consumers.

**Under the GOP proposal**

- The House GOP plan would not explicitly eliminate guaranteed coverage but would allow states to seek waivers from several consumer protections.
- States would be allowed to scale back benefits that insurers must cover. Because of the way the law is structured, that could allow insurers to reimpose annual and lifetime limits on some coverage.
- States would also be able to allow insurers to charge sick people more, potentially making coverage unaffordable for some.
- Insurers would be able to charge older consumers five times more than younger consumers.
Based on our analysis, we estimate that individuals with even relatively mild pre-existing conditions would pay thousands of dollars above standard rates to obtain coverage. For example, because an individual with asthma costs an issuer 106 percent more than a healthy 40-year-old, she would face a premium surcharge of $4,340. The surcharge for diabetes would be $5,600 per year. Coverage could become prohibitively expensive for those in dire need of care: Insurers would charge about $17,320 more in premiums for pregnancy, $26,580 more for rheumatoid arthritis and other autoimmune disorders, and $142,650 more for patients with metastatic cancer.

After accounting for a 1.5 percent reduction in overall premiums from the risk sharing program, the surcharges would still remain astronomically high: $4,270 for asthma, $17,060 for pregnancy, $26,180 for rheumatoid arthritis, and $140,510 for metastatic cancer.

“Under the House bill, large employers could choose the benefit requirements from any state—including those that are allowed to lower their benchmarks under a waiver, health analysts said. By choosing a waiver state, employers looking to lower their costs could impose lifetime limits and eliminate the out-of-pocket cost cap from their plans under the GOP legislation.

A company wouldn’t have to do business in a state to choose that state’s benefits level, analysts said. The company could just choose a state to match no matter where it is based.”

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
ACP opposed the AHCA because it would have caused 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.
- We oppose allowing states to obtain waivers to opt-out of community rating and essential benefit requirements.
- 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.
- Banning Planned Parenthood from obtaining federal grant funding would have denied millions of vulnerable women access to preventive care.
AHCA and premium subsidies

- The AHCA replaces 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.
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Affordable Care Act</th>
<th>American Health Care Act</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020 (3 years)</td>
<td>$4,615</td>
<td>$2,957</td>
</tr>
<tr>
<td>2022 (5 years)</td>
<td>$5,342</td>
<td>$3,160</td>
</tr>
<tr>
<td>2027 (10 years)</td>
<td>$6,648</td>
<td>$3,729</td>
</tr>
</tbody>
</table>

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.
It’s now in the Senate’s hands.

- Key Senators have already said the chamber will not take up the AHCA as passed by the House but will instead write their own bill.
- To pass anything in the Senate through budget reconciliation, it will have to go through “Byrd rule” challenges; provisions allowing states to waive consumer protections might not survive (and then would require Democratic votes).
- Senate Republicans themselves are divided.
- And any bill passed by the Senate would have to be reconciled with the House, and an identical bill passed again by both chambers and signed into law by the President.
"On behalf of the American College of Physicians (ACP), I am writing to express our extreme disappointment that the U.S. House of Representatives has passed the American Health Care Act (AHCA). We remain strongly opposed to the AHCA and urge the U.S. Senate to put aside this inherently flawed and harmful bill and instead work with us to achieve real bipartisan solutions to improve access, coverage, and consumer protections for all Americans. Any such legislation must not include policies included in the AHCA that will erode coverage and essential consumer protections for the most vulnerable patients: those who are older, sicker and poorer."

Jack Ende, MD, MACP, President, American College of Physicians
In the meantime, the administration could destabilize markets.

- Create enough uncertainty that insurers choose not to enter the markets for the 2017-18 enrollment cycle.
- Terminate the cost-sharing subsidies to insurers that they need to lower the deductibles and premiums for people with incomes up to 250% of FPL.
- Not put resources into promoting enrollment, especially of younger people.
- Not enforce the individual insurance requirement.
- Not work with insurers to pressure them to stay in.
What could the administration and Congress do to stabilize the markets?

- Create stabilization fund to offset insurer losses.
- Create a new reinsurance program.
- Create a public option.
- Increase the federal premium and cost-sharing subsidies.
- Enforce the individual insurance requirement.
Work Status of Medicaid Beneficiaries

- 41% Not Working
- 41% Full-Time
- 18% Part-Time

Reasons for Not Working:
- 35% Ill or Disabled
- 28% Taking care of home or family
- 18% Going to school
- 8% Retired
- 8% Could not find work
- 3% Other

KFF.org
Funding for key ACP priorities

- $6.46 billion for the Health Resources and Services Administration (HRSA); about $77 million more than FY2016. This includes flat funding for the Title VII Primary Care Training & Education program at $38.92 million.
- $1.49 billion for Community Health Centers (CHCs), about the same as FY2016.
- $286.47 million for Title X family planning; the same as FY2016.
- $7.26 billion for CDC, including $891 million in mandatory PPHF funding; only $21.6 million more than FY2016.
- $34 billion for the National Institutes of Health; $2 billion more than FY2016.
- $60.37 million for the Office of the National Coordinator; the same as FY2016.
- $324 million for the Agency for Healthcare Research and Quality (AHRQ); $10 million less than FY2016. However, this is somewhat of a victory considering that AHRQ is under threat to be eliminated almost every year.
- $801 million to fight opioid use disorder across CDC, HRSA, and the Substance Abuse and Mental Health Services Administration. This includes $500 million from the 21st Century Cures Act already approved by a previous spending bill and $150 million in additional funds for FY2017 that includes $20 million in Comprehensive Addiction and Recovery Act authorized resources. This is an increase of $650 million above FY2016.
Travel ban: *health impact*

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

- **Doctors and surgeons**: 656,000
  - Immigrants make up nearly **one-fifth** of all health care workers
  - **22.3%** are immigrants

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

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
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.
- Federal judge has ordered temporary injunction against implementation.
- 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.
Putting Patients First by Reducing Administrative Tasks in Health Care:
A Position Paper of the American College of Physicians

Written by Shari Erickson and Brooke Rockwern on behalf of the Medical Practice and Quality Committee


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 prevent patients from receiving timely and appropriate care or treatment.
Figure 1: A Framework for Analyzing Administrative Tasks

- **Sources**
  - External
  - Internal

- **Intents**
  - Products and Services
  - Quality and 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 performance measures
  - Innovative use of health IT
  - Eliminate or replace duplicative tasks
  - Research impacts & best practices
External Sources of Administrative Tasks

- Public and Private Payers
- Government Entities and Oversight
- Oversight by Private Entities
- Vendors and Suppliers
- Other Healthcare Organizations
- Measurement of Patient Experience and Evolving Consumer Experience
Internal Sources of Administrative Tasks

- Inefficient Workflow
- Lack of Effective Team-based Care
- Inability to use Technology Effectively and Efficiently
Intents of Administrative Tasks

- Provision of Payment
- Ensuring Care is High-Quality & Safe
- Reduction of Excess Utilization, Fraud & Abuse
- Ensuring Financial Security & Profit for the Entity
- Lacking Clear Intent
Impacts of Administrative Tasks

- Billing & Insurance-Related Activities
- Measurement & Reporting Impacts
- EHR/Health IT Impacts
- Impact on Clinical & Patient Care
- Impact on Physician Satisfaction - *Burnout*
ACP Policy Recommendations:

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.
ACP Policy Recommendations (cont.)

5. As US health care systems 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
Figure 2: Taxonomy of Administrative Tasks External to the Practice & Health Care Environment

Legend: Each circle indicates a characteristic of an administrative task

- Administrative tasks in these categories are worthwhile
- Administrative Tasks in these categories require careful consideration of alternatives
- Administrative tasks in these categories should be eliminated
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. 3, 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!
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
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
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)
Thank you . . .

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