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

South Dakota and Nebraska Chapter, American College of Physicians
October 3, 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)
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.
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.
We stand for patients and physicians, by urging Congress to take action on the following priorities:

- Lower the High Cost of Prescription Drugs
- Address the Epidemic of Firearms-Related Injury and Death
- Expand Coverage and Stabilizing the Insurance Market
- Fund Federal Workforce, Medical and Health Services Research, Public Health Initiatives
- Improve Physician Payment under Medicare
- Reduce Unnecessary Administrative Tasks on Physicians and Patients
- Support Healthy Women and Families
- Support Medical Education and Reduce Student Debt
- Protect patients from surprise bills
We stand for policies to reduce Rx costs.

- Increase transparency and accountability in prescription drug pricing and improve access to lower-cost generic medications by co-sponsoring/supporting:
  - The Fair Accountability and Innovative Research (FAIR) Drug Pricing Act (H.R. 2296/S. 1391), which would require drug companies to disclose and provide more information about imminent drug-price increases, including data about research and development costs.
  - The Reforming Evergreening and Manipulation that Extends Drug Years, REMEDY Act (S. 1209), to aid in the approval of more generic drug applications by the FDA and therefore improve patient access to those medications.
  - The Prescription Drug STAR Act (H.R. 2113), to promote drug pricing transparency by requiring manufacturers to justify and explain price spikes on their drugs as well as reveal the price and quantity of the drug free samples that they give to clinicians.
  - The Medicare Prescription Drug Price Negotiation Act of 2019 (H.R. 275/S. 62), to allow the federal government to negotiate lower drug prices on behalf of Medicare beneficiaries.
  - The Creating and Restoring Equal Access to Equivalent Samples (CREATES) Act of 2019, (H.R. 965/S. 340), to prevent egregious practices by manufacturers that keep generic drugs from coming to the market.
We stand for policies to reduce injuries and deaths from firearms.

- ACP advocacy is driving the national debate
- Spawning the #ThisIsOurLane movement.
What does ACP recommend to curb injuries and deaths from firearms?

- New [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... lane” and not speak... @ACPInternists policy... Butkus, ... and the stance of... @AnnalsofIM, has this be. Read & add your... 

The @NRA tells... #GunViolence... and we pledge to take... violence when... Click the link at... bit.ly/Annals... 6:17 AM - 8 Nov 2018

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

6:59 AM - 9 Nov 2018
Public Response

Maggie Fox
@maggiefox
The @NRA tells doctors to stay out of their business. Doesn’t matter if @JosephSakran says gun deaths are very much the responsibility of @CDCgov release of that data.

Esther Choo MD MPH
@choo_ek
We are not self-important: we are devoted to the care of others. We are not anti-gun: we are doctors taking care of our patients. We consult with everyone but doctors. Most upsetting, actually, is that disability from gun violence is unparalleled in the world.

NRA @NRA
Someone should tell self-important anti-gun doctors that gun deaths rose in 2015 after firearm-related deaths fell for 40 years. Articles in Annals of Internal Medicine are pushing for gun control, however, 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
11,797 Retweets 29,368 Likes
#ThisIsOurLane

First patient, first wound to the head. Mother cried in the last one. Can't post a picture. #ThisIsOurLane

Dave Morris
@traumadmo

Can't post a patient pic. Mother cried in the last one. Can't post a picture. #ThisIsOurLane #GunControl

@JosephKoeller

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"
- The Guardian: "#ThisIsOurLane: NRA's criticism spurs doctors to speak out on gun violence"
- AP: "It's a Twitter war: Doctors clash with NRA over gun deaths"
- HuffPost: "‘This Is Our Lane’: Doctors Slam NRA After Chicago Hospital Shooting"
- The Wall Street Journal: "After NRA Rebuke, Many Doctors Speak Louder on Gun Violence"
- NBC News: "NRA tweet warns doctors to 'stay in their lane' over gun control"
Reduce injuries and deaths from firearms.

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
We stand for policies to reduce firearms-related injuries and deaths.

- Congress should support the following bills to address the public health consequences of firearms:
  - Cosponsor and pass the Gun Violence Prevention Research Act (H.R. 674/S. 184), to provide $50 million for the CDC and other federal agencies to fund research on the prevention of firearms-related injuries and deaths.
  - Senators should follow the action taken by the House and pass 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.
  - Senators should follow the action taken by the House and pass the Bipartisan Background Checks Act of 2019 (H.R. 8), to expand background checks to all firearms sales in the United States.
  - Cosponsor and pass the Assault Weapons Ban of 2019 (S. 66/H.R. 1296), to ban the sale of certain types of semi-automatic rifles and high capacity magazines.
Six in 10 Fear a Mass Shooting; Most Think Gun Laws Would Help, ABC News/Washington Post poll, September 9, 2019 [link]
We are making a difference.

- 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.
We stand for ensuring all Americans have access to affordable coverage.

- A Texas judge ruled that the entire ACA is unconstitutional, because the 115th Congress repealed the individual tax penalty for not having coverage, without repealing the coverage requirement itself.

- Instead of defending the ACA, the Trump administration supports the judge’s view that the entire law should be struck down. ACP joined with AMA, other organizations urging reversal on appeal.

- If not reversed, the result would be catastrophic:
  - No protections for pre-existing conditions.
  - No essential benefit requirements.
  - Lifetime and annual caps on benefits would return.
  - No premium subsidies to make coverage affordable.
  - No funding for Medicaid expansion.
  - No phasing out of the Medicare Part D doughnut hole.
  - Preventive services no longer would be offered by Medicare at zero out-of-pocket cost.
  - The Center on Medicare and Medicaid Innovation likely would shut down, threatening APMs
We stand for ensuring all Americans have access to affordable 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.
We stand for reforming physician payments to support value of care by internists.

- Major wins in the proposed Medicare physician rule! If finalized:
  - 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>Current (2018) Payment Amount</th>
<th>Revised Payment Amount***</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$76</td>
<td>$130</td>
</tr>
<tr>
<td>Level 3</td>
<td>$110</td>
<td>$143</td>
</tr>
<tr>
<td>Level 4</td>
<td>$167</td>
<td>$197 (at 38 minutes)</td>
</tr>
<tr>
<td>Level 5</td>
<td>$211</td>
<td>$210</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$344 (at 90 minutes)</td>
</tr>
<tr>
<td>Established Patient</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Level 2</td>
<td>$45</td>
<td>$90</td>
</tr>
<tr>
<td>Level 3</td>
<td>$74</td>
<td>$103</td>
</tr>
<tr>
<td>Level 4</td>
<td>$109</td>
<td>$157 (at 34 minutes)</td>
</tr>
<tr>
<td>Level 5</td>
<td>$148</td>
<td>$170</td>
</tr>
<tr>
<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 makes to case to the RUC for value of complex cognitive care!

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>0.61</td>
<td></td>
<td>New</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
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).
MDM is based on the **number and complexity of problems addressed**, the amount and/or complexity of **data** to be reviewed and analyzed and the **risk** of complications and/or morbidity or mortality of patient management.

**THERE IS NO REQUIRED MINIMUM TIME** (for 99202-99215) as long as your MDM supports the required documentation for the level of service selected.

**Time is an option** for code selection.
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.
ACP stands for reducing 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

https://www.acponline.org/advocacy/where-we-stand/patients-before-paperwork
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
We stand for 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.
You need to stand for something to be in the room where it happens. *But that’s not enough.*

You also have to know “how the sausage is made”
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 gun violence—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

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

ACP-president McLean, Group of 6, on Capitol Hill, 9/16/19

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

LD attendees with Rep. Ami Bera, D-CA

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

LD day attendees with Senator Bill Cassidy, R-LA
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.

- Timed to be released in early 2020, to influence health care debate preceding 2020 elections and next administration, Congress.
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.
“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:

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

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)
A family of four with a $100,000 income and employer coverage spends $12,500 per year (13% of their income) on health.

By Cynthia Cox

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 $2,800 (3% of their income) in out-of-pocket health spending, $4,550 (5% of their income) in health insurance premiums, and approximately $5,050 (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.


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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.
New Vision framework (subject to change)

- Four papers:
  - Call to action on what ACP envisions a better health care system for all would look like and a call for others to join us.
  - Three companion policy papers on *coverage and cost, payment and delivery system reforms,* and *improving public health and reducing barriers to care*
The 3 companion papers will propose specific policies to:

- Achieve universal coverage at a cost the country and the patient can afford—including lowering costs at the system-level (slow rate of increase, reduce per capita spending), and making care more affordable at the patient-physician level (affordability).
- Address excessive spending on health care administration and associated burdens on physicians and patients.
- Reform payment and delivery system with an emphasis on supporting primary care and specifically the value of care provided by internal medicines specialists.
- Propose specific policies to improve public health, address social determinants, and end disparities and discrimination based on personal characteristics.
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.