

**Understanding the Current Fiscal Environment**  
**Leadership Day on Capitol Hill**  
**May 21-22, 2013**

Background

**Where Things Stand**

This year, lawmakers are particularly focused on the budget, which means all of ACP's priority issues will need to be understood in the context of how they impact the budget and the national deficit. This spring, several key dates triggered significant changes to the federal budget and consequently to key federal programs important to internal medicine.

- On March 1, a process known as sequestration was triggered and set into motion billions of dollars in automatic across-the-board reductions in virtually all federal agencies, which has devastating consequences for many federal health programs.
- On March 27, dollars that fund the federal agencies through the annual appropriations process were scheduled to run out but, at the last hour, Congress stepped in and passed legislation to extend funding through the end of this fiscal year, but at reduced levels.
- On May 18, the federal government will reach its statutory borrowing limit, although the Treasury Department will be able to extend the deadline using extraordinary measures for a few additional weeks after that.

These circumstances all conspire to create a very difficult budgetary environment on Capitol Hill, one that ACP members need to be aware of and one that poses challenges to our advocacy efforts. Members attending Leadership Day should be advised that congressional offices, particularly Republican offices, will likely question any ACP policy reforms that have a cost associated with them, regardless of whether they agree with the merits of the reforms. While this is the "fiscal reality" that we face in bringing our requests before Congress, ACP members should focus on advancing ACP's issues on the basis of their expertise as physicians/future physicians and how those issues impact their practices, patients, and local communities. That said, ACP does acknowledge the fiscal constraints of the federal government and, in the spirit of being constructive, has provided Congress with suggestions on how to find savings in the system while improving the value of care at the same time. Those suggestions can be found at the end of this document.

The information to follow is intended to provide you with a basic understanding of the federal budget, the fiscal challenges that underlie virtually every policy decision being considered by Congress, and how that influences the College's priorities.

**Background**

**BUDGET 101**

The federal government runs on a fiscal year, from October 1 to September 30. We are currently in fiscal year 2013 (FY2013). This is not to be confused with Medicare, which operates on a calendar year, from January 1 to December 31; for Medicare, we are currently in calendar year 2013 (CY2013).

By law, the President must submit a budget proposal to the legislative branch, no earlier than the first Monday in January, and no later than the first Monday in February. The budget proposal is essentially a blue-print for spending and contains specific proposed spending amounts for each federal department and agency and also usually contains legislative proposals on presidential priorities.

The House Budget Committee and the Senate Budget Committee each develop a budget resolution, which is introduced in their respective chamber and voted on by their respective members. The budget resolution lays out the framework for Congress and sets forth spending targets and broad legislative proposals. The budget resolution includes a top line number, meaning the total amount of discretionary spending (defined below) that can be allocated by the Appropriations Committees but it does not tell the Appropriations Committees how much each department gets in funding. The budget resolution includes legislative text with broad revenue and spending numbers but it does not give explicit language to the authorizing committees how to reach those numbers. The budget resolution is a non-binding resolution, meaning it does not have the force of law and the President does not sign it. The statutory deadline for having a conference budget

resolution, meaning both chambers of Congress have passed the same resolution, is April 15, but Congress routinely misses the deadline.

The spending side of the federal budget has two main components: mandatory spending and discretionary spending.

- **Mandatory spending** is not subject to the annual appropriations process and congressional approval. It includes programs funded by eligibility rules or payment rules, and includes programs such as Medicare, Medicaid, and Social Security. In FY2012, mandatory spending consumed 57 percent of the federal government's spending.
- **Discretionary spending** is subject to the annual appropriations process and congressional approval each year. In FY2012, 17.3 percent of the federal budget was spent on non-defense, non-homeland security departments, agencies, and programs (including the Department of Health and Human Services), and 18.9 percent was spent on defense and homeland security-related departments, agencies, and programs. Discretionary spending can also be called appropriated spending because the money is given out each year through the annual appropriations process, which Congress must approve. Departments, agencies and programs that receive discretionary funding are not guaranteed a specific funding amount from year-to-year.

**Authorization Bill versus Appropriation Bill:** Authorization bills fall under the jurisdiction of a committee other than the House and Senate Appropriations Committees. And, in the case of health care issues, those authorization committees include: Senate Finance Committee, Senate Health, Education, Labor, and Pensions Committee, House Energy and Commerce Committee, and House Ways and Means Committee. A program authorization establishes or continues the operation of a federal program or agency, either indefinitely or for a specified period (typically five years). In short, the authorizing committees provide the authority for a federal program to exist but they do not provide the dollars to fund the program or agency. The next step is for the Appropriations Committee to provide the funds for the authorized program, which is done through the annual appropriations process in Congress each year. The House and Senate Appropriations Committees write annual appropriations bills, in which money is given to each program in order for the program to operate. Typically, programs are funded at specific levels, and the committee may provide additional instructions on how the funds can be used. Although the authorizing legislation may authorize a certain amount of dollars for a given program, it is up to the Appropriations Committee to decide how much, if any, might be appropriated for the program. For example, the Affordable Care Act (ACA) authorized the National Health Care Workforce Commission at such sums as may be necessary to support the Commission's operations (including to serve as a national resource on health care workforce policy for the Congress, the President, states and localities; communicate and coordinate with federal departments; develop and commission evaluations of education and training activities; identify barriers to improve coordination at the federal, state, and local levels and recommend ways to address them; and to encourage innovations that address population needs, changing technology, and other environmental factors affecting the health care workforce), but the appropriations bills have failed to provide any funding for the Commission to convene or carry out its activities.

## **FY2014 BUDGET**

There are three budget proposals, noted below, of which ACP members should be aware.

- House Republican FY2014 Budget Resolution  
On March 12, House Budget Chairman Paul Ryan (R-WI) released *The Path to Prosperity: A Responsible, Balanced Budget*, his vision for reducing the size and scope of federal spending, in order to reach the targets laid out in H. Con. Res. 25, the Concurrent Resolution on the Budget for FY2014. In his budget resolution, Chairman Ryan proposed drastically reducing the federal budget by cutting spending, reducing taxes, and restricting the Medicare and Medicaid program. The budget resolution sets out broad policies, with numbers as targets, indicating how much the government can spend on programs, and the specific proposals on how to reach those targets are under the jurisdiction of the authorizing and appropriations committees in Congress. The *Path to Prosperity* is simply a framework proposal that is a vision for the future. While many details are still unclear, the proposal has several components that the College would like to highlight:
  - Setting non-defense, non-homeland security discretionary spending at pre-FY2008 levels (ACP has no policy on total discretionary funding levels; however, ACP recognizes that Congress and the Obama

Administration are committed to reducing funding for discretionary programs that do not achieve sufficient value, an objective we support, but studies show that investment in primary care, medical research, public health and other important health programs is essential to achieving a highly performing, efficient and effective health care system);

- Changing Medicare into a premium support system for persons age 55 and younger. ACP opposes proposals to convert Medicare into a defined contribution program, and instead recommends that a defined benefit program first be tested on a demonstration project basis before a decision is made to implement it on a national basis. The demonstration project should assess the impact of a defined benefit voucher system on adverse selection, continuity of care, fairness, access (especially for lower income beneficiaries) and administrative costs of care. Any demonstration project of premium support must include risk adjustments that both are analyzed regularly to ensure accuracy and include health-status, geographic, and other relevant demographic issues that affect Medicare beneficiary health so that beneficiaries have chronic care options in both Fee-For-Service and Medicare Advantage;
- Turning Medicaid into a block grant to states. A Medicaid block grant would fundamentally change the nature of the program. ACP policy supports the ACA's requirement that states cover all legal residents with incomes up to 133 percent of the Federal Poverty Level (FPL), while also calling for more state flexibility to design and implement innovative payment and delivery models. The Medicaid block grant proposal, as outlined in the Path to Prosperity, would be inconsistent with ACP policy, with no assurance that sufficient funds are available to meet the needs of the Medicaid population as health care costs continue to increase and the eligibility for Medicaid increases; and
- Capping non-economic damages in medical liability lawsuits. ACP supports caps on non-economic medical liability damages, as well as testing alternative mechanisms, such as use of health courts.

Chairman Ryan's budget does not address the Sustainable Growth Rate at all. On March 21, the House passed its FY2014 budget resolution.

- Senate Democrats FY2014 Budget Resolution

On March 13, Senate Budget Committee Chairman Patty Murray (D-WA) released the *Foundation for Growth: Restoring the Promise of Opportunity*, her vision for the future, as laid out in S. Con. Res. 8, the Concurrent Resolution on the Budget for FY2014. In her budget resolution, she calls for the preservation of the current Medicare, Medicaid, and private insurance coverage reforms already underway as a result of the ACA, as well as those scheduled to go in effect over the next several years. Again, while many details are unclear, the budget explanation encourages enactment of a permanent fix to the physician Sustainable Growth Rate (SGR) formula in order to ensure that Medicare beneficiaries will continue to have access to quality care. On March 30, the Senate passed their FY2014 budget resolution.

- President's FY2014 Budget Proposal

On April 10, President Barack Obama released his FY2014 budget proposal. The President has proposed a total federal budget of \$3.78 trillion in spending, \$3.0 trillion in revenue, and several legislative proposals, including, among others, reform of the Medicare physician pay rate and additional reforms to Medicare, which are offered in the context of an agreement that would include tax reform. At this point in the process, Republicans do not appear willing to consider major tax reforms, but not in a way that would result in more revenue government programs. In order to provide additional details on the President's proposal, ACP developed a separate document, in which you can find an abbreviated comparison of key elements of the President's budget proposal to ACP policy, which can be found [here](#).

The next step in the process would be to reconcile the House and Senate budget resolutions in a conference committee in order to come to one budget resolution. However, because the two resolutions are so far apart on federal government expenditures, revenue targets, and policy, there is wide-spread understanding that no consensus resolution will emerge. The two chairmen of the budget committees released a joint statement stating, "We recognized the many differences between the House and Senate budget resolutions and the challenge we face in reaching an agreement. We are committed to working to find common ground. We look forward to continuing the conversation..."

## **FY2014 APPROPRIATIONS**

In order to fund the federal government, Congress must pass their annual appropriations bills by the beginning of the fiscal year, which is October 1. If the October 1 deadline is not reached, Congress must pass a continuing resolution—a CR—which funds the government for a set amount of time, routinely at levels equal to the past fiscal year. If an appropriations bill is not passed, then the federal government, departments and agencies do not have any funds and will shut down.

The annual appropriations process for FY2014 is currently underway, with both the House and Senate Appropriations Committees moving bills through Committee in hopes of bringing the bills to their respective floors for debate and approval. However, the House and Senate have diverging views on a top line discretionary number, meaning the total amount of discretionary spending that can be allocated by the Appropriations Committee. That top line number discrepancy will need to be worked out prior to enactment of any of the bills. Additionally, through their respective budget resolutions, the House and Senate have reached different total dollar figures for the defense bill and the other ten remaining non-defense discretionary bills. Many of the workforce training programs the College supports, such as National Health Service Corps and Title VII health professions workforce funding, are given funds through annual appropriations.

## **THE DEBT CEILING**

In addition to the FY2014 appropriations process, the next fiscal battle confronting Congress will be over increasing the national debt limit. The debt ceiling authorizes the U.S. Treasury Department to borrow money up to a certain amount in order to meet the United States' current obligations, which includes spending authorized by Congress as well as interest on the debt; it is not authority to borrow money for new spending. On February 4, 2013, the President signed legislation suspending the debt limit until May 18, 2013; as a result, the debt limit does not apply for the period from February 4, 2013 through May 18, 2013. By May 19, the debt limit must be raised in order for the federal government to pay its bills and keep the full faith and credit of the U.S. The Treasury Department will be able to make some accounting maneuvers to not allow the U.S. to default on its international responsibilities; however, should the debt ceiling not be raised by May 19, the debt ceiling will be breached and the government will default on the financial obligations it has already incurred.

As of this writing (April 18), little is known about the next steps once the debt ceiling is reached. Republicans want to use the debt limit deadline to fight for additional spending cuts and major changes to entitlement programs – Medicare, Medicaid, and Social Security – potentially demanding that any debt cap increase be matched with commensurate budget savings. President Obama and Congressional Democrats would like an overhaul of the tax system, simplifying the code by eliminating tax “loopholes” (deductions, credits, etc) in a way that would also result in more revenue to the federal government. Republicans have also expressed an interest in reforming and simplifying the tax code, but not in a way that would result in more revenue for government programs. Congressional failure to address the debt ceiling would likely mean another down-grade in the nation's credit rating.

There continues to be speculation in Washington that the debt ceiling could result in a “Grand Bargain” among Congressional Republicans and Democrats and President Obama that would consist of: (1) tax reform that would produce more revenue, (2) reforms in Medicare, Medicaid, Social Security and other entitlement programs, and (3) replacing sequestration cuts (explained below) with more targeted savings and/or revenue. However, this would require Congressional Republicans to compromise on their opposition to raising revenue (taxes and fees), which likely would not be acceptable to many of the party's more conservative members and outside advocacy organizations, and Congressional Democrats and the White House to compromise by agreeing to cuts in entitlement programs that may not be acceptable to many of the party's more liberal members and outside advocacy organizations.

## **SEQUESTRATION: ACROSS-THE-BOARD CUTS**

Under the Budget Control Act (BCA), which became law in 2011, automatic across-the-board cuts - called sequestration – of \$1.2 trillion went into effect in March and affects almost every single federal agency, with half the cuts on domestic

programs and the other half on defense. Under sequestration, virtually every federal program, project, and activity will generally be cut by a specific, set amount for the remainder of 2013:

- Reduce funding for discretionary defense programs by 7.8 percent; the cuts will include funding for health care for uniformed personnel and their families.
- Reduce funding for non-exempt discretionary programs by 5.0 percent; the cuts will interrupt funding for health professions training programs (HHS Title VII primary care training), medical and health services research (including the National Institutes of Health and Agency for Healthcare Research and Quality), ensuring the safety of food and drugs (Food and Drug Administration), and preventing and controlling diseases (Centers for Disease Control and Prevention). These ill-considered and arbitrary cuts will affect almost every federal program that protects the health and safety of the American people, as outlined in ACP's [2013 State of the Nation's Health Care](#) report.
- Impose a 2 percent cut in Medicare payments to physicians, hospitals, graduate medical education programs, and other providers. To better understand how this may impact your practice, please see [here](#).

Because the sequestration cuts are set by formula, they do not take into consideration the importance or effectiveness of any particular program or activity—highly effective and critically important programs are cut as much as less effective and less important ones. ACP acknowledges that the United States must make some tough budget decisions; not all worthwhile programs can be fully funded, and spending on many programs will need to be reduced to relieve the economy from the consequences of exploding deficits and debt. Yet cuts that undermine public health, safety and medical research, reduce access to needed care for vulnerable populations, or exacerbate the shortage of primary care physicians will harm health and increase future costs.

## **A FRAMEWORK FOR A BETTER APPROACH TO LOWERING HEALTH CARE**

ACP believes that sequestration or across-the-board cuts will compromise essential programs to improve the access, quality and safety of health care in the United States and must not be allowed to stand. Instead, a fiscally and socially-responsible alternative should build on the progress being made in reducing healthcare cost increases and focus on the real cost-drivers behind unnecessary spending.

Across-the-board cuts that do not take into consideration the importance and effectiveness of different health care programs is the wrong way to reduce the deficit. The right way is to enact a balanced package of reforms that focus on changes that can be made to further restrain health care cost increases and eventually reduce per capita health care spending. Such reforms could include:

- Transition to new payment systems aligned with value;
- Establish a national, multi-stakeholder initiative to reduce marginal and ineffective care and promote high-value care;
- Provide patients and clinicians with information on the comparative effectiveness of different treatments;
- Establish patient incentives and insurance designed to encourage high-value care and reduce use of low-value treatments and tests;
- Reduce the costs of defensive medicine;
- Preserve and broaden financing for Graduate Medical Education (GME) and allocate GME funding more strategically, based on an assessment of national workforce priorities and goals;
- Authorize Medicare to negotiate prescription drug prices;
- Enact a cap on the deductibility of employer-sponsored health insurance; and
- Create a single shared cost-sharing structure for the different parts of Medicare.

More information on ACP's recommendations to reduce costs, with estimates of potential savings, is available at: [http://www.acponline.org/advocacy/where\\_we\\_stand/medicare/super\\_comm\\_menu.pdf](http://www.acponline.org/advocacy/where_we_stand/medicare/super_comm_menu.pdf).

For more information on ACP's positions on federal budget issues, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where\\_we\\_stand/federal\\_budget.html](http://www.acponline.org/advocacy/where_we_stand/federal_budget.html).

**FY2014 President’s Budget  
Released April 10, 2013**

The following ACP staff analysis outlines those provisions in the President’s FY2014 budget that are of significance to the College and its priorities.

| <b>Provision in FY2014 President’s Budget</b>  | <b>ACP Policy</b>   |
|--|---|
| <b>Sequestration:</b> The President calls for the cancellation of sequestration and has proposed several revenue raisers, making it a revenue neutral proposal.  | In the 2013 State of the Nation’s Health Care address, ACP “urges Congress and the administration to reach agreement on a plan to replace across-the-board sequestration cuts and prevent potential future disruptions in funding for critical health care and instead enact fiscally- and socially-responsible alternatives to reduce unnecessary health care spending. A fiscally and socially-responsible alternative should build on the progress being made in reducing healthcare cost increases and focus on the real cost-drivers behind unnecessary spending.” |
| <b>Primary Care Training and Enhancement Program: Section 747.</b> The FY 2014 Budget Request is \$50,962,000 to fund activities that will improve the quality of primary care providers, increase the capacity of physician assistant (PA) education programs, promote inter-professional practice, enhance medical education through curriculum innovation and improve the distribution and diversity of the healthcare workforce. The increase in dollars is earmarked for 28 new physician assistant programs. | Mainly consistent with ACP policy, which supports increasing funding for health professions and nursing education through Title VII. Disappointing the increase is only going towards physician assistant programs and not to physician programs.   |
| <b>National Health Service Corps.</b> In FY 2014 there is no discretionary funding request. The Affordable Care Act has appropriated \$305,000,000 for the NHSC in FY 2014. This appropriation will fund 195 new scholarships, 16 scholarship continuations, 2,373 new loan repayment awards, 2,140 loan repayment continuations, 100 new Students to Service loan repayment awards, and 285 new State loan repayment awards.  | Consistent with ACP policy. ACP supports increasing funding for the National Health Service Corps.  |
| <b>Centers for Medicare &amp; Medicaid Services, Discretionary program management:</b> The Budget supports the operation of the Health Insurance Marketplaces, also known as Exchanges, scheduled to begin enrollment in October of 2013. CMS will operate some or all Marketplace functions in over 30 states in 2014. The Budget requests \$803.5 million for CMS activities to support Marketplace operations in FY 2014.   | Consistent with ACP policy, which calls for the funding for planning and establishment grants to help states create and implement their individual state exchanges.   |
| <b>Adjustment to the Medicare Baseline. Prevent Reduction in Medicare Physician Payments.</b> The Administration supports a period of payment stability lasting several years to allow time for the continued development of scalable accountable payment models. Such models would encourage care coordination, reward practitioners who provide high-quality efficient care, and hold practitioners accountable, through the application of financial risk, for consistently providing                           | Since exact specifics are unknown in the President’s budget regarding reforms to Medicare’s Sustainable Growth Rate (SGR) formula, it is difficult to comment except to say the proposed framework is largely consistent with ACP policy. Generally, ACP policy calls for repeal of the SGR, elimination of the SGR accumulated debt, and implementation of a system that provides stable, positive and predictable annual updates. Specifically: Congress should enact legislation that would permanently replace the current flawed Medicare SGR                      |

| Provision in FY2014 President's Budget  | ACP Policy   |
|---|--|
| <p>low-quality care at excessive costs. Following the period of stability, practitioners will be encouraged to partner with Medicare by participating in an accountable payment model, and over time, the payment update for physician's services would be linked to such participation. Cost: \$15.399 billion for one year; \$249 billion for ten years.</p>  | <p>payment system with one that includes different payment models that meet criteria for value to patients. The legislation should provide stable payments for all physician specialties for at least five years while providing higher updates for undervalued evaluation and management services, require that different payment models (including Patient-Centered Medical Homes) be pilot-tested on a voluntary basis during the five year period of stable payments, and designate a specific transition period for broad adoption of the new models that have been shown to be the most effective based on the pilots.</p> <p>ACP has endorsed H.R. 574, the <i>Medicare Physician Payment Innovation Act of 2013</i>, as introduced by Reps. Schwartz (D-PA) and Heck (R-NV) on Feb. 14, 2013, which is consistent with ACP's specific policy as noted above.</p> |
| <p><b>Better Align Graduate Medical Education Payments with Patient Care Costs:</b> The Medicare Payment Advisory Commission (MedPAC) has found that existing Medicare add on payments to teaching hospitals for the indirect costs of medical education significantly exceed the actual added patient care costs these hospitals incur. This proposal would partially correct this imbalance by reducing these payments by ten percent, beginning in 2014. In addition, the Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high value health care delivery. Savings of \$780 million over one year; \$11 billion over 10 years.</p> | <p>This proposal is consistent with the December 2012 deficit reduction negotiations, but not consistent with ACP policy.</p> <p>ACP believes funding to primary care training programs should be increased and they should receive enough in order to have the most robust programs, therefore, we would oppose any cuts - whether IME or DGME.</p> <p>ACP policy states: "There should be a substantially greater differential in the weighted formula for determining direct GME payments for residents in primary care fields, including internal medicine. Training programs should receive enough funding to develop the most robust training programs and meet the requirements stipulated by their Residency Review Committees (RRCs).</p>   |
| <p><b>Medicaid:</b> As a central component of the nation's medical safety net, Medicaid is the primary source of medical assistance for millions of low-income and disabled Americans, providing health coverage to many of those who would otherwise be unable to obtain health insurance.</p>   | <p>The Medicaid program should serve as the coverage foundation for low-income children, adults, and families regardless of categorical eligibility. Medicaid minimum eligibility standards should be uniform on a national basis and federally mandated Medicaid coverage expansions should be fully subsidized by the federal government. Further, policymakers should refrain from enacting policy changes that would result in vulnerable persons being dropped from Medicaid coverage.</p>  |
| <p><b>National Health Care Workforce Commission</b> (the Commission) was established in the Affordable Care Act to serve as a national resource on health care workforce policy for the Congress, the President, states and localities; communicate and coordinate with federal departments; develop and commission evaluations of education and training activities; identify barriers to improve coordination at the federal, state, and local levels and recommend ways to address them; and to encourage innovations that address population needs, changing technology, and other environmental factors affecting the health care workforce. The budget request includes \$3 million.</p>  | <p>Consistent with ACP policy. ACP supports funding of the Commission, which has appointed members but no funds to meet and do work.</p>   |

**The Affordable Care Act at Age Three**  
**Leadership Day on Capitol Hill**  
**May 21-22, 2013**

Background

**Where Things Stand**

Comprehensive health reform legislation, known as the Affordable Care Act (ACA), was enacted just over three years ago in March 2010 amidst much controversy. Since then, debate in Congress and in the court of public opinion continues to ebb and flow but the ACA remains the law of the land and we do not expect that to change. To date, [Republicans and Democrats](#) in Congress still remain sharply divided on the law, with Democrats seeking to ensure its full implementation while Republicans continue to push for dismantling it, if not calling for its full repeal. The [public](#), while also divided, seems to be more confused than anything about the ACA and how it will affect their lives.

Implementation of the many provisions of the ACA began in 2010 and will continue to be rolled out over a ten year period, with the majority of the provisions taking effect in [2013-2014](#). ACP offered a qualified endorsement of the ACA when it was enacted in 2010 because, on balance, it advances many of ACP's key priorities related to: expansion of health coverage to nearly all legal U.S. residents; payment and delivery system reforms to support primary care; and workforce improvements that will help ensure that all patients have access to an internist. While the ACA is by no means a perfect product, and improvements to the law should be considered, it takes substantive steps to improve upon the current health care system, which is not sustainable without such reforms.

Over the past few years, the College has urged Congress to fully fund the ACA but to also improve upon it and advance other reforms, such as enacting more meaningful medical liability reforms, not only through caps on damages in malpractice cases but also in the piloting of health courts as an alternative to traditional attempts at reform (explained in more detail in the *Finding Common Ground in Congress on Medical Professional Liability Reform* backgrounder); doing more to ensure an adequate supply of internists and other specialties facing shortages; providing more options, earlier, for states to design and implement their own approaches to expanding coverage; and [eliminating a burdensome requirement](#) that physicians provide written authorization for OTC drugs paid for out of a flexible spending account. Equally important to the College is the need for Congress to repeal once and for all Medicare's flawed Sustainable Growth Rate (SGR) formula and transition to new physician payment models that are aligned with value, as outlined in the backgrounder *Medicare Physician Payment Reforms and Their Impact on Practices*.

The background information below outlines key ACA provisions of importance to the College, some of which have a state advocacy component. Each provision includes a description at enactment in 2010, its status today and, if applicable, what ACP advocates for the future. Leadership Day attendees should be familiar with these key provisions as they are routinely discussed in congressional offices. ACP also developed, and has updated each year since 2010, an [Internist's Practical Guide to Understanding Health System Reform](#), which was designed to serve as a resource for ACP members.

**Background**

**HEALTH INSURANCE EXCHANGES AND SUBSIDIES**

The ACA establishes [health insurance exchanges](#), which are marketplaces that offer one-stop-shopping to eligible individuals and small businesses to purchase more affordable health insurance coverage that fits their own needs. Each state has to establish its own exchange and make it operational by October 2013. If a state fails to do so, the federal government will create and operate the state's exchange or states can enter into a partnership with the federal government to jointly run their exchanges. The federal government has distributed over \$3.8 billion to states to help fund their exchange planning and implementation activities. To view where each state currently stands on establishing an exchange, please see [here](#).

Equally important are the subsidies provided through the ACA, not only to individuals and families but to small business as well. The ACA provides tax credits, starting in 2014, to assist U.S. citizens and legal residents who do not have access to health coverage through the exchanges to purchase it on their own. The tax credits will be made available on a sliding-scale basis to people with incomes between 133 percent and 400 percent of the Federal Poverty Level. The specifics on



who is eligible for these credits and how they work can be found [here](#). As for small businesses, the ACA provides tax credits to small businesses to help them purchase employee health insurance. Beginning in 2014, the amount of the tax credit will be a maximum of 50 percent of the employer's contribution (35 percent for non-profit firms) towards their employees' health insurance premium. A smaller tax credit began in 2010 and continues on a sliding scale through 2013. More information on who qualifies can be found [here](#).

Conservatives in Congress remain skeptical that the federal government has the ability, man-power, and resources to operate exchanges in those states that choose not to do it on their own. However, the Secretary of the Department of Health & Human Services, Kathleen Sebelius, has provided assurances that her agency is on track to assume that role.

ACP believes that the successful implementation of these health insurance exchanges, along with coverage expansions for the uninsured, is critical to ensuring near universal health coverage for this nation's citizens and legal residents, a long-held [policy goal](#) of the College. This provision of law is designed to help those people who do not have access to health insurance through their employer and who, in today's market, are too often priced-out of any type of affordable health coverage to fit their needs. Small businesses often have similar problems, since they do not have the negotiating power of large employers and may face a significant increase in premiums if an employee gets sick. ACP also continues to encourage the involvement of its chapters in [state-based advocacy](#) on the exchanges as they are in the formative stages.

## **MEDICAID EXPANSION**

Beginning in 2014, the ACA includes a provision giving states the [option to expand Medicaid](#) eligibility to individuals with incomes at or below 133 percent<sup>1</sup> of the federal poverty level, which translates to \$14,856 for an individual and \$30,657 for a family of four, although actual income amounts will be updated in 2014. The federal government pays the full cost of this expansion from 2014 through 2016 and finances no less than 90 percent of the cost in subsequent years. When the ACA was enacted in 2010, this provision required states to expand their Medicaid programs or risk losing their federal Medicaid funds for their existing Medicaid programs. However, after numerous states filed lawsuits against the federal government citing that this provision of law was unduly coercive, the U.S. Supreme Court ruled that the financial penalty on the states for not expanding their Medicaid programs was unconstitutional. Therefore, on June, 28, 2012, the Supreme Court gave states the option to expand their Medicaid program without the threat of a reduction in federal funding.

Most Republicans in Congress are strongly opposed to the ACA's Medicaid expansion, for ideological (overall opposition to the ACA), fiscal (concern that it will cost federal taxpayers too much), and other reasons. Instead, congressional Republicans generally support movement toward a finite "block grant" to states for use in caring for their uninsured and underinsured. Under a block grant, the federal government would provide a set amount of money to the states to use as they see fit to provide coverage to the poor, providing flexibility to the states to determine eligibility, benefits, and other decisions now set by federal law but ending Medicaid as a guaranteed benefit (entitlement) program for eligible persons. The block grants also would likely provide much lower levels of funding to the states compared to the current federal "match" and the additional funds being provided through the ACA.

Most Republican governors have so far declined to accept the offer of federal dollars to expand Medicaid to persons up to 133 percent of the FPL, again for ideological reasons (opposition to the ACA) and also, because of concerns that Medicaid expansion will cost the states too much, that the federal government cannot be counted on to provide the funds authorized by the ACA, and because they want more flexibility in how the program would be implemented in their states. However, as many as eight Republican governors have come out in favor of accepting the ACA's dollars to expand Medicaid, arguing that it is in the best interests of their states, both fiscally and in terms of access to care for their poorer residents. Other Republican governors may decide in the future that it is in the best interest of their state to expand Medicaid. (Under the ACA, there is no deadline for a state to expand Medicaid, although the amount of federal funding will gradually decline from 100 percent to 90 percent over the next seven years—so states that wait will be leaving federal

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<sup>1</sup> The ACP expands Medicaid to 133 percent of the federal poverty level plus a 5 percent technical adjustment, which increases the eligibility level to 138 percent.

dollars behind for each year that they wait.) In exchange for agreeing to expand Medicaid, some governors from more conservative states (Republicans but also some more conservative Democratic governors) are seeking waivers from the Obama Administration to “privatize” Medicaid by turning it over to managed-care plans. The Obama Administration has indicated a willingness to allow such privatization as long as the benefits, eligibility and cost-sharing standards for enrolled persons are generally the same as conventional Medicaid. The Obama Administration, congressional Democrats, and virtually all Democratic governors strongly support the ACA’s Medicaid expansion provision, arguing that it is essential to ensure access to care for the poor and near-poor. To view where each state stands on expanding their Medicaid program, please see [here](#).

As noted earlier in this document, ACP believes it is critical that states choose to participate in Medicaid expansion in order to achieve near universal health coverage for all citizens and legal residents in this country. This provision is consistent with long-standing ACP policy for expanding Medicaid to all of the poor- and near-poor. If all states participate, this provision would expand coverage to up to 33 million previously uninsured people in 2022—resulting in coverage for about 94 percent of all legal residents. ACP is particularly concerned that people with incomes at or below the federal poverty level *will have no access to subsidized coverage* if their states turn down ACA’s Medicaid expansion. This is because under the ACA, Medicaid coverage is the *only* coverage option available for persons with incomes at or below the FPL—they are ineligible for subsidized coverage through the health exchanges, because Congress, when it enacted the ACA, could not have anticipated that the Supreme Court would have made the Medicaid coverage optional for the states. This means that many of the most vulnerable and poorest persons will have no access to coverage in states that turn down the Medicaid expansion.

In September 2012, ACP initiated the involvement of its chapter governors to influence state governments to accept federal funding to extend Medicaid coverage to their poorest residents. Dubbed the *ACP Medicaid Patient Advocacy Campaign*, this effort provided chapters with uniquely-customized state-specific reports on the benefits of states accepting federal dollars to expand their Medicaid programs. Based on available information to date, almost all ACP chapters are participating in this campaign.

## **PATIENT PROTECTIONS AND INSURANCE MARKET REFORMS**

The ACA also created new patient protections and other reforms designed to curb abuses by health insurers. Starting in 2010, new requirements for health insurers were put in place, many of which will be expanded in 2014. Some key examples include: increasing the age to 26 for which dependents can remain covered under their parents’ health insurance, banning pre-existing conditions exclusions for children in 2010 and for all starting in 2014, restricting insurers from imposing annual or lifetime dollar limits on coverage, requiring insurers to cover core preventive services such as immunizations and other services recommended by the U.S. Preventive Services Task Force. And, starting in 2011, if an insurer in the small group market directs less than 80 percent of an individual’s premium to anything other than to clinical and quality care improvement costs (85 percent in the large group market), the insurer will be required to refund the difference to the enrollee. More detail regarding these reforms can be found [here](#).

## **MEDICARE BONUS PAYMENT FOR PRIMARY CARE SERVICES**

In calendar years 2011-2015, the ACA provides a 10 percent bonus payment on select primary care services furnished by primary care physicians. To qualify for the bonus, a physician must be self-designated in a primary care specialty, defined as general internal medicine, family practice, geriatrics, and pediatrics, and he or she must predominantly provide select primary care services to be eligible. To view the specifics on eligibility, please see [here](#). To better understand how this bonus could impact your practice, please visit [here](#).

Mandatory funds have been provided in the ACA to fully implement this bonus, which means the funds are not subject to the annual appropriations process in Congress. The bonus begins to address disparities in payments that are major barriers to physicians entering and remaining in primary care specialties. A report by the Council on Graduate Medical Education (COGME) recommends that compensation to primary care physicians be increased to 70 percent of the average payment for other physician specialties in order to train and retain a sufficient supply of primary care physicians. While the

Primary Care Incentive Program falls considerably short of COGME's recommendation, it will result in the largest sustained increase in payments to primary care physicians in decades.

## **ENHANCED MEDICAID REIMBURSEMENT RATES FOR PRIMARY CARE SERVICES**

The ACA includes a provision to increase Medicaid payment rates for certain primary care services to at least the level of Medicare in 2013 and 2014. This is often referred to as the [Medicaid Parity](#) provision of the ACA. This initiative provides for higher Medicaid payments to physicians practicing a specialty designation of family medicine, general internal medicine or pediatric medicine. It also provides for higher payment for subspecialists related to those specialty categories as recognized by the American Board of Medical Specialties, American Osteopathic Association and the American Board of Physician Specialties. Physicians who are in those designated specialties but not board certified (are Board eligible) can also qualify if at least 60 percent of the codes billed by the physician for all of CY 2012 (or the prior month if the physician is new to Medicaid) be for the E&M codes and vaccine administration codes specified in this regulation.

Mandatory funds have been provided in the ACA to fully implement this program at no cost to the states. However, to qualify for the payment increase, physicians must first self-attest to a covered specialty or subspecialty, then they must attest that they are either board certified in an eligible specialty or subspecialty or that 60 percent of their Medicaid claims for the prior year were for E&M or vaccine administration codes specified in the regulation. Each qualifying physician must complete and file a self-attestation form created by his/her state Medicaid program. The attestation form and other state specific resources should be available on each state's Medicaid website. A list of the contact information for the offices of each state's Medicaid Director is available at <http://medicaiddirectors.org/about/state-directors>.

Studies show that the disparity in payments between primary care and other specialties is a principal barrier to physicians entering and remaining in primary care specialties and that low Medicaid payment rates, particularly for primary care, are a major reason why substantial numbers of physicians in many states do not participate in Medicaid or limit how many Medicaid patients they will see.

ACP strongly supports this provision as a step in the right direction, as it will help ensure that the growing numbers of individuals who are expected to enroll in Medicaid will be able to find primary care physicians to care for them, especially as Medicaid eligibility for the program is expanded in 2014. Congress should sustain and ensure continued dedicated (mandatory) funding for this program and begin to explore ways to re-authorize funding for the program beyond the January 1, 2015 termination date.

## **CENTER FOR MEDICARE AND MEDICAID INNOVATION**

The ACA established a new Center for Medicare & Medicaid Innovation that allows the Centers for Medicare and Medicaid Services (CMS) to test models that promote broad payment and practice reform within Medicare, Medicaid and the Children's Health Insurance Program (CHIP) while preserving or enhancing the quality of care. Most relevant to the College, the law specifically suggests the consideration of models that promote broad payment and practice reform in primary care, including patient-centered medical home models for high-need applicable individuals, medical homes that address women's unique health care needs, and models that transition primary care practices away from fee-for-service based reimbursement and toward comprehensive payment or salary-based payment.

The Innovation Center is now testing numerous payment and delivery system models including: Accountable Care Organization models, Bundled Payments for Care Improvement, Comprehensive Primary Care Initiative, and the Independence at Home Demonstration. For more information on these models, please visit [here](#).

Congress should ensure continued dedicated (mandatory) funding at the current levels authorized by the ACA. This dedicated funding is needed to ensure that the Center has the resources needed to accelerate broad pilot-testing and adoption of new payment and delivery models to improve access to primary care services, improve outcomes, and achieve better value for beneficiaries and taxpayers.

## **SUPPORT FOR PRIMARY CARE**

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. In 2010, COGME told Congress that in order to have an adequate supply of primary care physicians we need to increase their ratio to 40 percent of all physicians, an 8 percent increase over what was at the time 32 percent.

The ACA contained numerous key provisions to enhance the primary care workforce, including [improvements](#) to loan and scholarship programs under Title VII of the Public Health Service Act that help recruit and retain medical students in the practice of primary care. The ACA also permanently reauthorized the National Health Service Corps (NHSC), a federal program that provides scholarship and loan forgiveness to enable primary care physicians to be trained to serve in underserved communities. It includes an increase in full-time awards for the NHSC from \$35,000 to \$50,000 per individual and a new part-time award program. The ACA also redistributes unused residency slots to hospitals that agree to maintain their current primary care levels and use the new slots for primary care and general surgery. Sixty-five percent of the slots must be redistributed to primary care and general surgery. More information on these programs can be found in the backgrounder, *Federal Programs and Legislation Addressing Physician Workforce Shortages*.

## **NATIONAL HEALTH CARE WORKFORCE COMMISSION**

The ACA establishes a [National Health Care Workforce Commission](#), a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy beginning in 2010. The Commission is to analyze and make recommendations for eliminating barriers to entering and staying in careers in primary care, including physician compensation among other things. However, to date, Congress had not provided the necessary funding for the Commission to be convened.

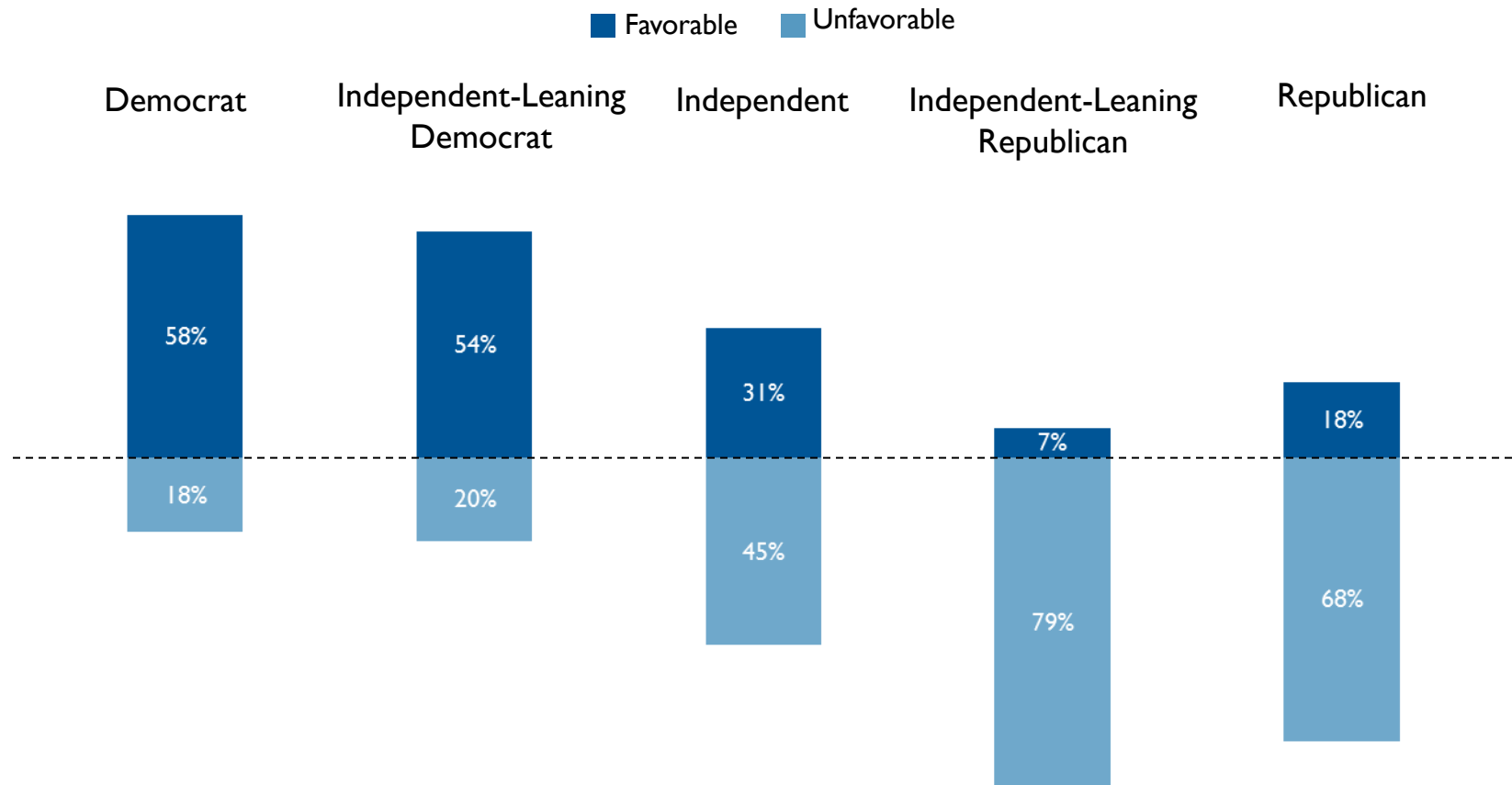
ACP is disappointed that Congress has chosen not to fund this important commission, which is subject to the annual appropriations process in Congress. We have urged Congress to appropriate funds so the commission can begin its work. However, in this difficult environment of fiscal constraints, Congress has focused its appropriations on other priorities. ACP is pleased that the President's FY2014 budget request does call for \$3 million for the commission but his budget request only serves as a blueprint for spending and does not have the force of law.

On March 28, Bob Doherty, ACP's SVP for Governmental Affairs and Public Policy, blogged about his assessment (reflecting ACP policies) of the Affordable Care Act at Age Three. You can read his post [here](#).

For more information on ACP's positions on the ACA and health reform, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where\\_we\\_stand/affordable\\_care\\_act.html](http://www.acponline.org/advocacy/where_we_stand/affordable_care_act.html).

# Dems Have Favorable Opinion of ACA; GOP Unfavorable

Public Opinion of ACA Across Party Lines\*  
(March 2013)



\* Respondents who answered "Don't know/Refused" not shown.

Source: Kaiser Health Tracking Poll.

# Most ACA Reforms Implemented 2013-2014

## Implementation Timeline for Major ACA Provisions

■ Medicare/Medicaid   ■ Insurance   ■ Finance/Taxes

### Jan. 2013

- Establishment of pilot Medicare bundled payment program
- Phase-out of Medicare drug coverage gap
- Increase in Medicare Part A (hospital insurance) tax rate
- Increase in Medicaid coverage of preventive services
- Increase in Medicaid payments for primary care
- Elimination of tax-deduction for employer retiree coverage subsidy
- Creation of 2.3% excise tax on medical devices
- Cap on flexible spending accounts

### April 2013

- Requirement to disclose financial relationships between health entities and manufacturers/ distributors

### July 2013

- Creation of Consumer Operated and Oriented Plan (CO-OP) for member-run health insurance companies

### Oct. 2013

- Reduction in Medicare and Medicaid Disproportionate Share Hospital (DSH) allotments

### Jan. 2014

- Guarantee of insurance availability regardless of health status
- Prohibition of annual limits on coverage
- Enforcement of employer insurance requirements
- Implementation of health insurance exchanges
- Provision of health insurance premium and cost sharing subsidies
- Imposition of fees on health insurance sector
- Creation of essential health benefits package
- Requirement of health insurance (individual mandate)
- Requirement of minimum 85% medical loss ratio for Medicare Advantage plans
- Expansion of Medicaid coverage

### July 2014

- Establishment of wellness programs participation incentives

### Oct. 2014

- Reduction in Medicare payments to hospitals for hospital-acquired conditions by 1%

**Medicare Physician Payment Reforms and Their Impact on Practices  
Leadership Day on Capitol Hill  
May 21-22, 2013  
Background**

**Where Things Stand**

Over the past decade, one of the most vexing problems that Congress has failed to solve has been how to reform the flawed Medicare physician payment formula known as the Sustainable Growth Rate (SGR). Unless Congress intercedes, physicians are again facing scheduled cuts of nearly 25 percent on January 1, 2014. Although a vast majority of Congress understands the need to eliminate this flawed formula, they have failed to advance any agreement resolving the issue, largely due to the high cost of repealing the SGR. The Congressional Budget Office (CBO) recently reduced the estimated cost of repealing the formula to just under \$150 billion, a considerable drop from previous estimates, which was welcomed news in this tight fiscal environment.

From the outset of this new Congress, which began in January, there are some signs of hope from congressional leaders that they will introduce and attempt to advance a comprehensive SGR reform proposal this year. What form that proposal will take remains to be seen but we have seen early movement by the key committees of jurisdiction in the House, those being Energy & Commerce and Ways & Means, on a draft GOP joint committee proposal as well as recently-introduced legislation by Reps. Schwartz (D-PA) and Heck (R-NV). The Energy & Commerce Committee also held a [hearing](#) earlier this year to engage key stakeholder groups in the formulation of ideas about new payment systems, which is encouraging. The outlook in the United States Senate is more uncertain, as the Senate Finance Committee has not yet produced a draft SGR reform proposal of its own and has not held any hearings on the issue for a considerable period of time. We remain guarded but hopeful that this year Congress will succeed in passing comprehensive legislation to repeal the SGR and move toward new valued-based models of care.

The enactment and on-going implementation of the Affordable Care Act (ACA) has resulted in positive changes in Medicare and Medicaid payments for physicians providing primary care services. In 2011, the ACA began providing a 10 percent bonus payment for five years on select primary care services furnished by primary care physicians. ACP estimates that this bonus has resulted in a typical office-based, general internist who qualifies for the bonus getting approximately \$8,000 in Medicare revenue each year through 2015, depending on their mix of services. In 2013, the ACA also began increasing Medicaid payment rates for certain primary care services to at least the level of Medicare through 2014. More detail about the status of these, and other, key provisions in the ACA can be found in the background, *The Affordable Care Act at Age Three*.

The background information below outlines details surrounding the various SGR proposals in development, how ACP has sought to influence those proposals, and where we have succeeded in making advancements in payment reform over the past year.

**Background**

**REPEALING MEDICARE'S SUSTAINABLE GROWTH RATE**

The SGR was enacted by Congress in 1997 as part of the Balanced Budget Act to control spending on physician services. This outdated formula determines payments to physicians for the services they provide under Medicare. For the past several years, this formula has threatened to enact steep payment cuts to physicians at the end of each year that would harm all physicians, particularly those who practice in primary care. The threat of sharp payment cuts to physicians looming every year makes it difficult, if not impossible, for physicians to budget for overhead expenses or to invest in the capability to enhance care coordination to improve the quality of care they provide to their patients. At the final hour, before SGR cuts are scheduled to take effect, Congress typically steps in to avert the cuts, although on several occasions in recent years Congress has allowed the scheduled SGR cut to go into effect, and then days or weeks later enacted legislation to retroactively reverse the cut and restore payments to physicians.

## SGR REFORM PROPOSALS IN CONGRESS

### *House Energy and Commerce and Ways and Means Proposal*

In February of this year, the Chairmen of the House Committees on Energy and Commerce and Ways and Means released a draft joint GOP proposal to repeal the SGR. It includes a temporary period of predictable payment rates for physicians, reforms Medicare's fee-for-service system to reflect the quality and efficiency of care provided, and provides options for physicians to transform their practices into new models of care. It was released as a framework, without legislative text, and physician organizations were asked to comment. ACP provided the committees with substantial feedback on their initial framework, the details of which can be found [here](#). On April 3<sup>rd</sup>, the committees released a second iteration of their framework proposal, again without legislative text, that provided additional clarity on the three phases of their proposal. The plan includes the following elements (*as prepared by the Energy and Commerce and Ways and Means Committee*):

- It would repeal the SGR, eliminating the 24.4 percent across-the-board cut slated for 2014 and any future SGR cuts
- Establish a period of stable payments, enabling physicians to prepare for payment changes
- Engage the physician community in efforts to improve, reform, and update reimbursement systems
- Provide options that enable physicians to select the Medicare payment system – whether performance-based fee-for-service or an alternative model — that best fits their practice situation
- Aim to improve the physician practice environment by reducing practice costs and administrative burdens

ACP again provided feedback on this second iteration, which can be found [here](#).

We are pleased to see that the basic framework is largely consistent with ACP policy in that it:

- Eliminates the SGR as a factor in determining payment updates.
- Provides for a period of stable, predictable fee schedule updates during a transition period to value-based payment and delivery models
- During a transition period, allows physicians the time to assess the applicability of private sector and Medicare alternative payment models.
- Allows physicians to begin qualifying for higher updates for participating in approved performance measurement/reporting/improvement programs or other quality improvement programs, or for participating in new payments models like Patient-Centered Medical Homes or Accountable Care Organizations, with some flexibility for individual practice needs.

ACP made several recommendations for improving the draft, however:

- The current draft does not specify for how long “stable” updates would be in effect or the amount of the updates. ACP recommends that there be a period of at least five years where positive updates would be provided to all physicians, with the opportunity for physicians to qualify for additional updates for participating in approved quality improvement or value-based payment models.
- The current draft does not provide higher updates for undervalued evaluation and management services. As noted in our comments, we continue to believe that such incentives are critical to improving care coordination and addressing historical payment inequities that contribute to severe shortages in internal medicine, family medicine, internal medicine subspecialties, neurology, and other fields that principally provide evaluation and management services.
- We recommended that to ensure a level playing field, no specialty should be exempted from having its performance measured or held to a higher or lower standard than any other.
- We recommended harmonization and improvements in the current measures used to assess physician performance in the PQRS, e-RX and meaningful use programs; re-consideration of the current penalties if most physicians, because of limitations in the existing reporting programs themselves, are unable to report successfully on the measures; opportunities for physicians to review and appeal adverse determinations based on performance



measurement programs; improved data sharing with physicians; and other steps to prevent unintended adverse consequences from performance measures.

We continue to work closely with the committees as they transform their framework proposal into legislation, which we understand could come before the full House for a vote before the August recess.

### ***The Medicare Physician Payment Innovation Act of 2013***

ACP's ideas for SGR reform were incorporated in bipartisan legislation H.R. 574, *the Medicare Physician Payment Innovation Act*, which was introduced on February 6<sup>th</sup>, by Representatives Allyson Schwartz (D-PA) and Joe Heck (R-NV). ACP has endorsed H.R. 574, which would eliminate the SGR once and for all and transition to better payment and delivery systems that are aligned with value. Specifically, this legislation would repeal the SGR formula, provide more than 5 years of stable physician payments, with positive increases for all physician services, and higher payments for primary care, preventive and care coordination services, and establishes a process for practices to transition to new, more effective, models of care by 2019.

Reps. Schwartz and Heck introduced similar legislation, H.R. 5707, last year that unfortunately did not advance before the end of the 112<sup>th</sup> Congress, which rendered it inactive. With the dawning of the 113<sup>th</sup> Congress in January, H.R. 5707 was modified and re-introduced as H.R. 574. The changes reflected in H.R. 574, not previously found in H.R. 5707, include removal of the Overseas Contingency Operations (OCO) funds as a "pay-for" in repealing the SGR, which proved too controversial, and other technical changes.

Details on H.R. 574 are provided below:

- **Permanent Repeal of the Sustainable Growth Rate:** This legislation permanently repeals the SGR formula by eliminating the \$300 billion debt to the Medicare program, restores stability and fiscal transparency to the payment system, and sets out a clear path to comprehensive payment reform.
- **Stabilize the Current Payment System:** In order to ensure a workable transformation of the Medicare payment system over the long term and provide short term stability in the Medicare program, this legislation would freeze 2013 physician payment levels through Dec. 31, 2014. Thereafter, a five year transition period would replace cuts that threaten access to care with positive and predictable updates to all physicians.
- **Provide Positive Updates for All Physicians:** It would provide positive annual updates of 0.5 percent for all physician services each year for four years starting in 2015.
- **Institute Interim Measures to Ensure Access to Care Coordination and Primary Care Services:** It would provide a 2.5 percent increase in payments for primary care, preventative and care coordination services from 2015 to 2018. Physicians would qualify for this increase in payments if 60 percent of their Medicare allowable charges are for primary care, preventive, and care coordination services.
- **Aggressively Test and Evaluate New Payment and Delivery Models:** Ongoing demonstration projects under CMS will inform the development of payment models to replace the SGR. This legislation directs CMS to identify, test, and evaluate multiple care models that can be successfully replicated in more than one geographic region. Recognizing that such evaluations cannot be successful without the input of those on the front lines of patient care, the legislation requires ongoing collaboration with state and national physician membership organizations.
- **Identify Best Practices and Develop a Menu of Delivery Model Options:** By Oct. 1, 2017, the Centers for Medicare and Medicaid Services (CMS) must issue a menu of no fewer than four health care delivery and payment model options based on an analysis of its relevant evaluations and input from physician organizations. These models will have demonstrated success in containing costs while improving quality.
- **Establish a Transition Period:** Physician will have until 2019 to transition to new CMS-approved models. In order to minimize disruption in the transition to new delivery models, fee for service payments in 2019 will be continued at 2018 payment levels.
- **Establish an Alternative Fee-For-Service System:** The legislation provides options for physicians with a demonstrated commitment to quality and efficiency, who are not able to participate in one of the other CMS-approved payment and delivery models described above, to participate in a new alternative fee-for- service system

that would include incentives for care coordination, management of high-risk patients, and other policy objectives to improve the quality and reduce costs.

- **Reward Clinicians for High-Quality, High-Value Care While Dis-incentivizing Fragmented, Volume Driven Care:** Beginning Jan. 1, 2019, physicians practicing within a CMS-approved health care delivery model will continue to receive stable reimbursements consistent with their specified payment system, with opportunities to earn higher reimbursements for achieving gains in quality, effectiveness and cost of patient centered care. Clinicians who choose to retain the current fee for service model rather than participating in one of the new CMS approved coordinated care system or a new alternative fee for service models will be subject to disincentives in the form of reduced updates to both primary and non-primary care services. The goal of the bill is for there to be enough validated models, with enough positive payment incentives, so that just about all physicians will have a model that will work for them, so the penalties need not apply. It will be important for Congress to hold CMS accountable to ensuring that a viable model is available for all physicians in all specialties, so that physicians are not subject to penalties because the agency was unable to develop an appropriate and workable model for them. It also is important to recognize that the penalties, should they go into effect for some physicians, are far smaller than the scheduled SGR cut of more than a quarter of total payments that will be prevented by the *Medicare Physician Payment Innovation Act*.

## REVISED CBO SCORE LOWERS COST OF SGR REPEAL

A major impediment to SGR reform has been the high cost of complete repeal of this formula. In 2012, the cost of repeal was estimated at \$244 billion, a huge outlay at a time when Congress focused on reducing spending and decreasing budget deficits. In February of this year, CBO issued a revised estimate for the cost of SGR repeal due to lower than expected growth in Medicare spending. CBO's new estimate for full repeal now stands at \$138 billion, a significant reduction from 2012 estimates. While \$138 billion is still a significant cost, this reduction in the cost may improve the likelihood of enactment of SGR repeal, especially in this very tight budget environment.

## IMPACT OF MEDICARE PHYSICIAN PAYMENT CUTS THROUGH SEQUESTRATION

The Budget Control Act (BCA), which became law in 2011, mandates billions of dollars in automatic across-the-board cuts (called sequestration) across all federal agencies, half on domestic programs and half on defense. Under sequestration, almost all federal programs are subject to a specific percentage cut. Medicare payments to physicians, hospitals, graduate medical education programs, and other providers will be cut by 2 percent. While the sequester cuts officially took effect on March 1, the 2 percent Medicare cut to providers applies to payments for all Medicare services rendered on or after April 1, as announced by CMS on March 8. To understand more about the impact of the 2 percent sequester cuts on your practice, please see [here](#).

ACP remains opposed to the across-the-board cuts in health programs and payments to providers and has [commented](#) numerous times to Congress urging them to stop these cuts and enact alternative policies that address the true underlying causes of rising health costs. To read more about ACP's views on the sequester cuts, please see the backgrounder, *Understanding the Current Fiscal Environment*.

## ACP'S ADVOCACY EFFORTS PAY OFF FOR PRACTICES!

ACP, in collaboration with allied organizations, has been very successful over the past year [in advancing reforms](#) that are intended to improve your practice environment. Through advocacy with Congress and especially with federal health agencies, we want you to be aware of the progress that has been made on your behalf to not only increase physician payments but to make your professional life easier. While we have more work to do, advocacy does make a difference, which is why your participation in advocacy and Leadership Day is so important.

For more information on ACP's positions on payment and delivery system reforms, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where\\_we\\_stand/physician\\_payment.html](http://www.acponline.org/advocacy/where_we_stand/physician_payment.html).

**Federal Programs and Legislation Addressing Physician Workforce Shortages**  
**Leadership Day on Capitol Hill**  
**May 21-22, 2013**  
Background

**Where Things Stand**

According to the Association of American Medical Colleges (AAMC), the United States faces a shortage of more than 90,000 physicians by 2020; about half of the shortage will be in general surgery and medical specialties, while the other half will be in primary care. Increasing graduate medical education funding and using such funding more strategically are essential toward addressing the physician workforce crisis. In addition, funding for federal programs aligned to improving the primary care workforce and ensuring access to a primary care physician must be preserved.

More than [100 studies](#) show that increased availability of primary care in a community is positively associated with lower costs and better outcomes of care. Yet the United States is facing a growing shortage of primary care physicians for adults—including internal medicine specialists who provide a substantial portion of primary care for millions of Medicare and Medicaid enrollees. Other physician specialties, including many internal medicine subspecialties, also are facing shortages.

Medical students who enter internal medicine residencies are choosing to subspecialize at increasing rates and of those who stay within general internal medicine a significant portion are choosing hospitalist care over office-based practice. With our population aging and chronic conditions increasing, we need to be providing the public with more, not fewer physicians trained to take care of their health care needs. In 2010, the Council on Graduate Medical Education (COGME) told Congress that in order to have an adequate supply of primary care physicians we need to increase their ratio to 40 percent of all physicians, an 8 percent increase over what was at the time 32 percent.

A study published in *The Journal of the American Medical Association (JAMA)* in December 2012 shows that at the rate that medical students and residents are currently choosing general internal medicine there will not be enough internal medicine specialists in primary care fields to care for all of the patients who need them. In 2012, only 21 percent of third-year internal medicine residents intended to pursue careers in general internal medicine, down from 54 percent in 1998. Even more disheartening, only 18 percent of first-year internal medicine residents intend to pursue general internal medicine. An accompanying editorial in the same issue of *JAMA* pointed to the COGME report from 2010 and noted that even if half of all internal medicine residents were to choose general internal medicine, we would still be falling well short of the recommended increase in primary care. The solution to this problem must address both attracting medical students into primary care and retaining primary care physicians once they enter the field.

**Background**

**THE NATIONAL HEALTH SERVICE CORPS (NHSC)**

This federal program is vital in that it addresses the supply of primary care physicians for adults, which is dwindling while the demand for primary care is expected to grow at a rapid rate. The NHSC provides scholarships and loan forgiveness to enable primary care physicians to be trained to serve underserved communities. The program receives mandated dedicated funding from the Affordable Care Act (ACA).

The College urges \$893,456,433 in appropriations for the NHSC for FY2014, which begins on October 1, 2013 and ends on September 30, 2014, and is the amount authorized for FY2014 under the ACA; this is in addition to the \$305 million in enhanced funding the Health and Human Services Secretary has been given the authority to provide to the NHSC through the Community Health Care Fund created by the ACA. Since enactment of the ACA, the NHSC has awarded over \$900 million in scholarships and loan repayment to health care professionals to help expand the country's primary care workforce and meet the health care needs of communities across the country. There are nearly three times the numbers of NHSC clinicians working in communities across America than there were three years ago, increasing Americans' access to health care. With field strength of nearly 10,000 clinicians, NHSC members are providing culturally competent care to

more than 10.4 million people at nearly 14,000 NHSC-approved health care sites in urban, rural, and frontier areas. The programs under the NHSC have proven to make an impact in meeting the health care needs of the underserved, and with more appropriations, they can do more.

## **TITLE VII HEALTH PROFESSIONS**

Within the Title VII Health Professions program, ACP urges \$71 million for FY2014, which begins on October 1, 2013 and ends on September 30, 2014, to fund the program the Section 747, Primary Care Training and Enhancement, in order to maintain and expand the pipeline of primary care production and training. The recommended funding level for the Section 747 program was determined by a multi-stakeholder process involving organizations and other experts that assess the resources required for the program to achieve its objectives, recognizing today's very tight fiscal environment. The Section 747 program is the only source of federal training dollars available for general internal medicine, general pediatrics, and family medicine. For example, general internists, who have long been at the frontline of patient care, have benefitted from Title VII training models that promoted interdisciplinary training that helped prepare them to work with other health professionals, such as physician assistants, patient educators and psychologists. With the grant dollars, residency programs are able to fund new initiatives relating to increased training in inter-professional care, the patient-centered medical home, and other new competencies required in our developing health system.

## **GRADUATE MEDICAL EDUCATION (GME)**

GME is a formal clinical training provided by approved residency and fellowship programs to physicians who have received an MD or a DO degree (or a foreign equivalent). It involves a period of training lasting at least three to seven years in which physicians are directly supervised in their learning as they progressively assume more responsibility for patient care.

GME is a public good—it benefits all of society, not just those who directly purchase or receive it. The federal government recognizes the importance of supporting medical education and is the single largest explicit contributor to GME. Funding is primarily provided through the Medicare program, which subsidizes education and training for over 90,000 residents in more than 1,100 hospitals. The number of federally funded GME positions were capped in 1997 and this limit has remained in place ever since, though there have been some exceptions that have allowed for some minor growth. Other forms of government support come through state Medicaid programs, the Department of Defense or the Department of Veterans Affairs. In addition to government funding, private payers, philanthropy, and institutional resources may provide support.

With the federal deficit at an all-time high and an increased commitment to fiscal responsibility, entitlement programs, such as Medicare, face greater scrutiny. There has been an increased interest in transparency and accountability for the nearly \$10 billion that the federal government spends on GME annually.

The costs of GME are recognized by Medicare under two mechanisms: (1) direct graduate medical education payments (DGME) to hospitals for residents' stipends, faculty salaries, administrative costs, and institutional overhead, and (2) indirect medical education (IME) adjustment developed to compensate teaching hospitals for the higher costs associated with teaching, the involvement of residents in patient care, and the severity of illness of patients who require the specialized services that are available in teaching hospitals. Because the results from IME payments are not as concrete as DGME payments, since the amount is tied to a hospital's Medicare inpatient volume and case mix along with their training program size (subject to their resident cap number), more scrutiny is being given to IME payments. The Medicare Payment Advisory Commission (MedPAC) has consistently found that the IME payments teaching hospitals receive are higher than the actual cost of treating Medicare patients. MedPAC studied Medicare inpatient costs per case and found that costs increased about 2.2 percent for every 10 percent increase in the ratio of residents to hospital beds, less than half the current IME adjustment of 5.5 percent. MedPAC and some legislators have proposed using the "excess" funds to develop a performance based GME payment system. Several deficit reduction proposals have cited the MedPAC study and proposed IME cuts ranging from 2 percent to 60 percent.

In his FY2014 budget request, President Obama also called for an \$11 billion reduction of IME payments, citing the aforementioned MedPAC study. His proposal would reduce IME payments by ten percent, beginning in 2014. In addition, the Secretary would have the authority to set standards for teaching hospitals receiving Graduate Medical Education payments to encourage training of primary care residents and emphasize skills that promote high-quality and high value health care delivery. ACP is not supportive of the proposal, and believes that GME funding should be preserved so that training programs can develop the most robust programs and meet the requirements stipulated by their Residency Review Committees (RRCs). However, the College acknowledges that there needs to be more transparency and accountability to ensure funds are appropriately designated toward activities related to the educational mission of teaching and training residents with the skills and experiences necessary to meet the nation's health care needs.

The federal government's vital investment in training physicians also is threatened by an automatic two percent across-the-board cut in Medicare program payments to physicians and hospitals, including Medicare GME payments, as a result of the "sequester" mandated by the Budget Control Act of 2011. The sequestration cut took effect on April 1, 2013. ACP has strongly urged Congress to reverse across-the-board sequestration cuts and preserve funding for essential health programs such as Medicare GME by adopting alternative measures addressing the true cost drivers that are responsible for rising health care costs. The [AAMC](#) estimates the Medicare GME sequestration cut will result in the "average major teaching hospital having nearly \$14 million less to support critical patient care services they provide in their communities."

As outlined in ACP's recent paper entitled, [Aligning GME Policy with the Nation's Health Care Workforce Needs](#), ACP makes the following key recommendations to Congress.

- GME financing should be transparent, and all payers should be required to contribute to a financing pool to support residencies that meet policy goals so that the costs of GME financing are spread across the health care system.
- Payment of Medicare GME funds to hospitals and training programs should be tied to the nation's health care workforce needs and place a priority on primary care in order to create a well-functioning health care system.
- GME caps should be strategically lifted, as needed, to permit training of an adequate number of primary care physicians, including general internists, and other specialties facing shortages.

As discussed below, several bills have been introduced that address the need to increase funding for GME and to strategically lift the caps on GME residency positions, particularly for primary care specialties.

## **VISA PROGRAMS FOR INTERNATIONAL MEDICAL GRADUATES**

The College has long recognized the value of international medical graduates (IMGs) and their contributions to health care delivery in this country. ACP supports streamlining the process for obtaining J-1 and H1B visas for non-U.S. citizen international medical graduates who desire postgraduate medical training and/or medical practice in the U.S. ACP supports the expansion of J-1 visa waiver programs, such as Conrad 30, to help alleviate physician shortages in underserved urban and rural areas; this program should also be made permanent. ACP supports the exemption of physicians trained in specialties that are facing shortages in the United States from the annual H-1B visa cap. Specific legislative initiatives supported by ACP regarding IMGs can be found below.

For further information, please read ACP's policy paper entitled [National Immigration Policy and Access to Health Care](#).

## **OTHER FEDERAL PROGRAMS AFFECTING THE PHYSICIAN WORKFORCE**

The Affordable Care Act initiated several programs which are impacting the physician workforce; those of note are highlighted below.

**Redistribution of Residency Slots:** The Centers for Medicare and Medicaid Services (CMS) was required to take 65 percent of the DGME and IME residency slots that have gone unused by a hospital for the past three years and to redistribute them according to certain criteria. The DGME and IME resident caps of hospitals with three years of unused

residency slots were permanently reduced beginning July 1, 2011. In 2011, CMS announced that it has redistributed roughly 1,354 Medicare residency positions. The 628 indirect medical education and 726 direct graduate medical education positions were allocated to 58 qualifying hospitals from 267 hospitals that were not training up to their residency caps. In accordance with the ACA redistribution formula, 70 percent of the positions were allocated to 39 hospitals in states with resident-to-population ratios in the lowest quartile, and 30 percent were allocated to 19 hospitals in rural or health professional shortage areas.

**Teaching Health Centers (THC):** As established and authorized in the ACA, the THC program provides grants and Graduate Medical Education funding to THC to train primary care physicians in community-based, ambulatory patient care settings. The THC development grants can be used for activities associated with establishing or expanding a primary care residency training program including curriculum development, faculty and trainee recruitment, training, retention, and accreditation. Since 2011, twenty-one THC have received grant dollars, ensuring residents are able to train in community-based settings.

**Medicare primary care bonus:** In calendar years 2011-2015, the ACA provides a 10 percent bonus payment on select primary care services furnished by primary care physicians. To qualify for the bonus, a physician must be self-designated in a primary care specialty, defined as general internal medicine, family practice, geriatrics, and pediatrics, and he or she must predominantly provide select primary care services to be eligible. For more in depth information, including eligibility and the impact on your practice, please see the backgrounder entitled *The Affordable Care Act at Age Three*.

**Enhanced Medicaid Reimbursement Rates for Primary Care Services:** The ACA includes a provision to increase Medicaid payment rates for certain primary care services to at least the level of Medicare in calendar years 2013 and 2014. Often referred to as the Medicaid pay parity provision, this initiative provides for higher Medicaid payments to physicians practicing a specialty designation of family medicine, general internal medicine or pediatric medicine. For more in depth information, including eligibility and state-specific information, please see the backgrounder entitled *The Affordable Care Act at Age Three*.

**National Health Care Work Force Commission:** The ACA establishes the Commission, a multi-stakeholder workforce advisory committee charged with developing a national health care workforce strategy beginning in 2010. Unfortunately, Congress has yet to fund the Commission so it has not yet convened. For more in depth information about the Commission, please see the backgrounder entitled *The Affordable Care Act at Age Three*.

## **ACP-ENDORSED LEGISLATION OR INITIATIVES**

There are several bills which ACP supports that would address the physician workforce shortage, with an emphasis on primary care. Those of note include:

- ***The Resident Physician Shortage Reduction Act (S. 577 and H.R. 1180)***, introduced in the Senate by Senators Bill Nelson (D-FL), Charles Schumer (D-NY), and Harry Reid (D-NV) and in the House by Representatives Joseph Crowley (D-NY) and Michael Grimm (R-NY), will increase the number of Medicare-supported training positions for medical residents who choose careers in primary care. Specifically, the bill will provide for approximately 15,000 additional GME positions for medical residents. It will require at least 50 percent of the new positions to be allocated to specialties such as primary care that are currently facing a shortage. The current Medicare GME funding limits on residency training positions are impeding the establishment of new residency programs and additional training positions in existing programs. Increasing the overall pool of physicians will not assure that adequate numbers enter and remain in practice in primary care (general internal medicine, family medicine, and pediatrics). Instead, a more targeted approach is needed, as S. 577/H.R. 1180 strives to do, recognizing the nation's increasing demographic demands for health care, by strategically increasing the number of Medicare-funded GME positions in adult primary care specialties.
- ***Training Tomorrow's Doctors Today Act (H.R. 1201)***, introduced in the House by Representatives Allyson Schwartz (D-PA) and Aaron Schock (R-IL), authorizes the Secretary of Health and Human Services to increase

the number of GME slots by 15,000 over the next five years, providing additional opportunities for residents who choose careers in primary care or general surgery as it mandates that any hospital that receives funding for additional residency positions shall ensure that not less than 50 percent of the new slots are used to train residents in primary care or other residents in specialties facing shortages.

H.R. 1201 would also establish and implement procedures under which payment for indirect medical education is adjusted based on the reporting of quality measures of patient care specified by the Secretary of Health and Human Services. ACP believes that the concept of a performance based GME payment system is worth exploring but cautions such a system must be thoughtfully developed and evaluated with input from a variety of stakeholders including physicians involved in primary care training.

- ***The Primary Care Workforce Access and Improvement Act (H.R. 487)***, introduced in the House by Representative Cathy McMorris Rogers (R-WA), authorizes the Secretary of Health and Human Services to conduct a five year Medicare pilot project that would direct a share of Graduate Medical Education funding to medical education entities to test different models of primary care training. This bill gives the HHS Secretary the authority to test new models of care that demonstrate the capability of improving the quality, quantity, and distribution of primary care physicians. Improved models of ambulatory training and exposure to team-based approaches to patient care, such as the patient centered medical home, are essential to making careers in general internal medicine and other primary care specialties more attractive and relevant.
- ***The Conrad State 30 and Physician Access Act (S.616)***, introduced in the Senate by Senator Amy Klobuchar (D-MN), permanently reauthorizes the Conrad 30 State J-1 Visa Waiver program and makes improvements to the immigration laws affecting IMGs outside of the Conrad 30 program with the same goal of increasing access to physicians in underserved communities. For example, IMGs would be eligible for a National Interest Waiver green card if they serve for 5 years in a medically underserved area or Veterans Affairs medical facility. The bill would also exempt these physicians from the worldwide cap on employment-based green cards (e.g., H-1B visas).

On a related note, on April 17, a bi-partisan group of Senators introduced S.744, the *Border Security, Economic Opportunity, and Immigration Modernization Act*, a comprehensive immigration reform bill. While the College does not have policy on the overall immigration issue or the bill itself, ACP does have policy stating that (1) there should be a national solution to the immigration problem and (2) any immigration legislation enacted by Congress should include changes in visas as they affect IMGs (noted in the preceding paragraph). Sen. Klobuchar's legislation, S. 616, has largely been incorporated into S. 744.

For more information on ACP's positions on workforce issues, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where\\_we\\_stand/workforce.html](http://www.acponline.org/advocacy/where_we_stand/workforce.html).

## **Finding Common Ground in Congress on Medical Liability Reform Leadership Day on Capitol Hill**

**May 21-22, 2013**

Background

### **Where Things Stand**

For the past decade, Congress has been unable to muster the political will to pass substantive tort reform legislation. Despite numerous years of legislation having been introduced to address the growing practice of defensive medicine, mainly through attempts to cap non-economic damages in medical malpractice cases, Republicans and Democrats remain sharply divided on the issue. The Democratic Senate majority and the Administration are sympathetic to the need for medical liability reform but tend not to favor an approach that imposes caps on damages as they believe doing so would severely hamper a person's right to have their day in court. Republicans do support such an approach but cannot succeed in enacting such legislation without at least some Democratic votes. Thus, a stalemate continues in Congress on how best to address the broken medical liability system.

ACP continues to work with members on both sides of the aisle to find common ground on medical liability reform. One area where we believe there is bipartisan support is on the concept of health courts. We saw encouraging results from Congress at last year's Leadership Day when we proposed a legislative framework to fund a national pilot on health courts. However, 2012 having been an election year meant that we faced practical challenges in having our legislative framework progress from the concept stage to that of introduced legislation. We continue to see high potential for advancing this concept of health courts in Congress and, with the elections now completed and a new 113<sup>th</sup> Congress awaiting us, we see an opportunity to break the gridlock and are again urging Congress to introduce legislation to fund a pilot on health courts.

In 2013, ACP has identified numerous members of Congress with interest in health courts and potentially in introducing legislation on the issue. These members include: Reps. Chabot (R-OH), Cooper (R-TN), D. Ross (R-FL), Polis (D-CO), Fitzpatrick (R-PA), Price (R-GA), and Senator Enzi (R-WY). Discussions with these member offices are continuing. We are also seeking to combine efforts with other organizations on the national level that have interest in advancing health courts and those discussions are on-going. These groups include: The National Coalition on Health Care, the American College of Surgeons, the American Congress of Obstetricians and Gynecologists, and the Common Good. In addition, the Agency for Healthcare Research and Quality (AHRQ) is funding numerous [on-going projects](#) on medical liability reform, such as patient safety initiatives and alternative dispute resolution demonstrations, all of which will conclude in 2013.

### **Background**

ACP remains concerned about the rising cost of health care and the inability of Congress to address medical liability reform. While the U.S. medical liability system is designed to compensate and deter injuries caused by medical care, the current system does not provide timely compensation to injured patients or resolve disputes in a fair and timely manner. Medical liability premium increases have slowed in recent years, but physicians are still seeing high premiums. The current medical liability system encourages physicians to increase the volume or intensity of health care services they provide to protect themselves against possible lawsuits. The Congressional Budget Office (CBO) estimates that as much as \$62 billion could be saved each year by reforming the medical liability tort system. ACP has [long-standing policy](#) supporting meaningful medical liability reforms.

### **AUTHORIZE AND FUND A NATIONAL PILOT OF NO-FAULT HEALTH COURTS**

ACP has developed a framework for legislation that authorizes a national pilot on health courts and is actively seeking a member of Congress in both chambers to introduce it. A section-by-section summary of the framework will be available in future briefing materials.

This dispute resolution process would provide a new system to resolve medical malpractice claims. Health courts (also known as health care tribunals or medical courts) utilize an administrative process and specialized judges, experienced in medicine and guided by independent experts, to determine cases of medical negligence without juries. Health courts



would provide fair compensation for injuries caused by medical care, reduce costly and time-consuming litigation, reduce malpractice liability costs, provide guidance on standards of care, reduce the practice of defensive medicine, and improve patient safety. The health court model is predicated on a “no fault” system, meaning compensation programs that do not rely on negligence determinations. The central premise behind no-fault is that patients need not prove negligence to access compensation. Instead, patients must only prove that they have suffered an injury, that it was caused by medical care, and that it meets the severity criteria. The goal of the no-fault concept is to improve upon the injury resolution of liability.

Health courts have received widespread and bipartisan support from Congress, interest groups, and physician organizations. President Obama included funding for pilot projects for health courts in his Fiscal Year 2012 budget and former Governor Mitt Romney supports funding for states to adopt the health court model to resolve medical malpractice lawsuits. Former Senate Majority Leader Bill Frist proposed health court legislation in 2004, and the following year Senators Max Baucus (D-MT) and Mike Enzi introduced legislation that would provide grants to states to administer health courts. Representatives Jim Cooper (D-TN) and Mac Thornberry (R-GA) introduced similar legislation in the House.

The National Commission on Fiscal Responsibility and Reform noted that the current tort system in the United States leads to an increase in health care costs, not only because of direct costs – higher malpractice insurance premiums – but because of indirect costs in the form of over-utilization of diagnostic and related services (sometimes referred to as “defensive medicine”). The Commission recommended numerous policies aimed at addressing this problem, one of which is the creation of specialized “health courts.”

In recent years, the literature recognizing the potential of health courts has grown. The [Common Good](#), the [Robert Wood Johnson Foundation](#), the [Commonwealth Fund](#), the [Journal of Health Politics, Policy and Law](#), to name just a few, have all examined the concept of health courts as an alternative to traditional reforms. And, a recent [blog](#) in *Health Affairs* by Philip Howard, shows the growing bipartisan support for health courts.

## LIMIT DAMAGES IN MEDICAL MALPRACTICE LAWSUITS

ACP acknowledges that the likelihood of Congress enacting caps on non-economic damages is remote, as explained above. However, consistent with College policy, we continue to believe in caps on non-economic damages as a viable approach to help reduce the costs of medical liability insurance. Such caps would in no way limit the amount of money that an injured plaintiff could receive to cover his or her hospital costs, doctor bills, other medical expenses, lost wages, or future damages.

The College also supports medical liability reforms that:

- ✓ Limits awards for noneconomic damages at \$250,000
- ✓ Eliminates punitive damages
- ✓ Eliminates the collateral source rule (eliminates double compensation to plaintiffs for certain items);
- ✓ Allows for periodic payment of future damages and structured settlements; and
- ✓ Provides for attorney fee regulation in personal injury and medical malpractice cases

In 2012, the House passed H.R. 5, the *Protecting Access to Health Care Act*, comprehensive tort reform legislation offered by Rep. Phil Gingrey (R-GA) that included caps on non-economic damages and other reforms that have been proven to reduce the costs of defensive medicine. While ACP supported the medical liability provisions in that legislation, the College did not take a position on House passage of H.R. 5 on last year because a provision was added to the bill repealing the Independent Payment Advisory Board, which created a conflict with ACP policy. To read more on ACP’s position on the IPAB, please see [here](#).

Also in 2012, the House passed H.R. 5652, the *Sequester Replacement Reconciliation Act of 2012*, which included legislative language providing for caps on non-economic damages and other reforms. However, it also contained many cuts in other programs (such as repeal of the “maintenance of effort” requirements on states for Medicaid and the

Children's Health Insurance Program (CHIP) and elimination of the Prevention and Public Health Fund) that ACP did not support.

For more information on ACP's positions on medical liability reform, please visit the Advocacy section of ACP Online, [http://www.acponline.org/advocacy/where we stand/medical liability reform.html](http://www.acponline.org/advocacy/where_we_stand/medical_liability_reform.html)