An Introduction to Healthcare Policy, Reform & Advocacy

for Current and Future Medical Professionals

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"There are risks and costs to action. But they are far less than the long range risks of comfortable inaction."
- John F. Kennedy

A Missed Opportunity

It is not surprising that as healthcare has become an issue of fiscal necessity, it has become a mainstream political issue in the United States. The public are forming opinions on healthcare policy and delivery based on what they learn from partisan reporting on television and the Internet. It is imperative that physicians learn how to play an active role in contributing to the development of our national healthcare policies – the legislation that will regulate what we train so hard to do.

The motivated physician will find a way to self-educate and get involved in advocacy efforts. But how many potentially powerful voices are lost because our medical education system is failing to educate students and residents when it has their attention? Studies have shown that medical student interest in healthcare policy and leadership is growing with each new class. But sadly, those interests are strongest during the first year of study and dwindle in the later years.

If the physician profession is going to continue to stand as the premiere source of knowledge and expertise on how healthcare should be delivered in this country, education in policy, reform, and advocacy must be part of the medical curriculum from the very beginning, or our autonomy earned through experience will continue to lose out to the fickle political pressures of the moment.

From an Idea, to a Bill, Then Signed into Law

A Very Basic Introduction to the Legislative Process

You are not a **policymaker**, and to be an effective advocate you do not need to know *every* step in the complicated process of drafting and passing legislation in your state, or in Washington, DC.

However, much like there is a **language of medicine**, there is a **legislative language**, and it is important to have a general understanding of how to talk about the process of passing a bill into law. And it is especially important to understand **how and when** a bill can get **derailed** along the way.

An Idea Becomes a Bill

An **idea** for a new law can come from a number of different sources: the **People**, the **President or Governor**, or a **member of Congress** in the **House of Representatives** (HOR) or the **Senate**.

After a great deal of hard work and effort to build support for an idea, a piece of legislation is drafted and **introduced** in Congress as a **bill**, and is assigned a **bill number**. There are three general types of bills to know:

- **Authorizing Legislation** creates a **new** program, **extends** an existing program or **repeals** an existing law. This type of bill can establish a framework for a program, but does not allocate funding for the program.
- **Appropriations Bills** allocate **funding** for specific programs, and must be revisited and enacted into law **every year**.
- **Entitlement Legislation** guarantees certain **benefits** to persons who meet **eligibility** requirements (i.e. Medicare & Medicaid).

Committees, Subcommittees, and Back Again

After a bill has been properly introduced, it will be assigned to a **committee** for review. There are two types of committees:

- **Standing Committees** generally have the power to **create** law in their particular areas of jurisdiction.
- **Select Committees** are primarily created for **advisory** purposes.

Subcommittees exist within these committees, and they are often comprised of legislators considered to be **experts** in a certain field. When a bill is assigned to a committee, it is given to a subcommittee for review and revision. A **final draft** is prepared and **voted on** by the subcommittee for approval. It may also be **"tabled"** at this point, which means the bill will be set aside and eventually eliminated.

When a bill has been revised and approved by a subcommittee, it is then **recommended** to the parent committee and will undergo a similar process of review. If the parent committee **approves** it, the bill is ready to be presented to either the **HOR** or the **Senate**.

Back to Congress

The committee-approved bill will be scheduled for debate in one of the **Chambers** of Congress, where it could be **passed**, **defeated**, or sent back to the committee for **amendments**. This is another point in the process where the bill could be **"tabled."**

Upon approval of the bill in one Chamber of Congress, the bill must be sent to the **other** Chamber to, yet again, undergo a similar process of consideration.

It is not uncommon for the HOR and the Senate to be working on a **similar bill** at the same time. When this happens, a **Conference Committee** of members from both Chambers is assembled to **compromise** and combine the two bills into one piece of legislation.

Upon successful approval by **both** Chambers of Congress, the bill is then sent to the President (or Governor) to be signed into **law**. This official, of course, has the option to **veto** (reject) the bill, which can be overridden by a **2/3 majority** in Congress.

When to Get in the Game

Opportunities for influencing the legislative process through advocacy efforts exist at **every** stage, but it is certainly important to be active very **early** during the process of a bill's development.

Early involvement will give you the opportunity to play a role in **how** it is drafted, and to help **build support** to ensure its introduction.

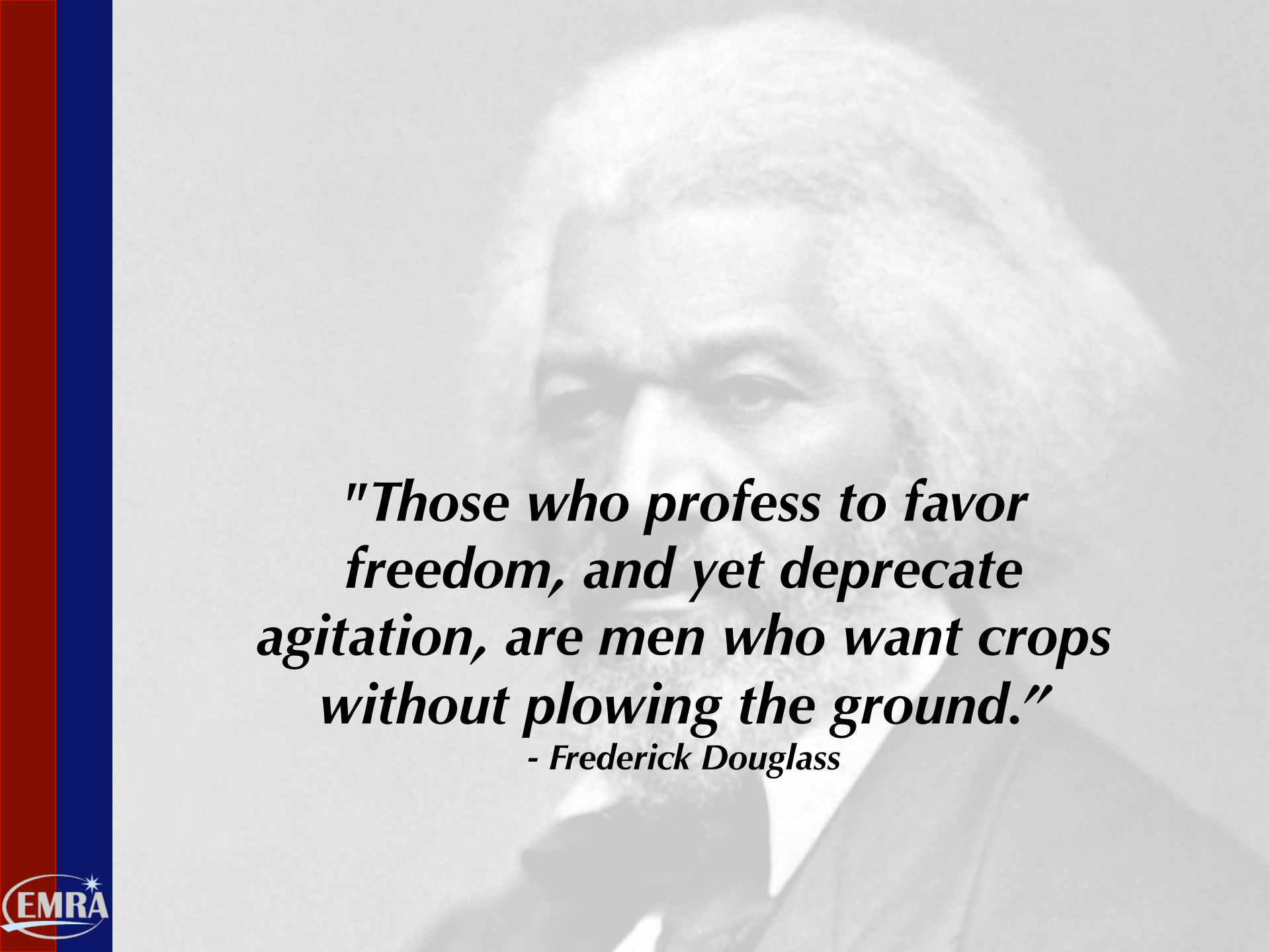
As a bill makes its way through the legislative process, it is incredibly important to stay **involved** and **updated** on how it changes, and when it may encounter **opposition**. Support should always be reinforced when a bill is up for a **vote,** or has the possibility of being **"tabled."**

Also remember how important it can be to play a role in the implementation of a law or how the message is spread after it has been approved. Opportunities for influence after the legislative process are often overlooked, but are also often extremely influential.

Staff Appreciation

In order to build **widespread** support for a bill, it is necessary for constituents to call on their representatives and encourage them to **contact** their fellow legislators who serve on the committees to which a bill has been assigned.

This kind of coordination between representatives can be difficult, but provides a good example of the importance of having a good relationship with **congressional staff** members. Legislative aids can be extremely influential in how the representative votes on different issues. Their opinions are of high value, and they can be close **allies** during your advocacy efforts.



"Those who profess to favor freedom, and yet deprecate agitation, are men who want crops without plowing the ground."

- Frederick Douglass

The Prep Course

The following information is intended to help build a better base for discussing issues in healthcare policy.

Take it from the Top

The Department of **Health and Human Services (HHS)** is the federal agency that oversees the administration of health service related centers and programs in the United States. HHS is responsible for oversight of the Agency for Healthcare Research and Quality (AHRQ), Centers for Disease Control and Prevention (CDC), Food and Drug Administration (FDA), National Institutes of Health (NIH), and many other agencies including the **Centers for Medicare and Medicaid Services (CMS)**.

The **CMS** is the agency responsible for administering **Medicare** and for working with state legislators to administer **Medicaid** and the **State Children's Health Insurance Program (SCHIP)**. Medicare and Medicaid were signed into law by President Lyndon B. Johnson in 1965. Since that time, Medicare dollars have been largely responsible for funding residency training, or **Graduate Medical Education (GME)**.

Medicare

Medicare is federally-sponsored health insurance for:

- **People 65 and older**
- **People under 65 with certain disabilities**
- **People of all ages with End-Stage Renal Disease**

There are approximately **50 million** people in US covered by Medicare. The program is funded by federal taxes and administered at the state level, so there are some differences in coverage from state to state. Medicare is divided into four parts:

- **Part A** – covers inpatient hospital costs, hospice, home health, and skilled nursing facilities. No premium payments. This accounts for roughly 30% of benefit spending.
- **Part B** – covers physician visits, and accounts for about 20% of spending. Monthly premium payments.
- **Part C** – is known as the Medicare Advantage program which allows people to enroll in private insurance programs and the government pays for the Medicare-covered services through this private insurer. More than 13 million people use this option, and payments for Part A & B services through Part C plans is about 22% of Medicare spending.
- **Part D** – is the prescription drug subsidy program that is voluntary, and available through private plans that contract with Medicare. This accounts for 11% of benefit spending, and about 32 million people are enrolled in Part D programs. Monthly premium payments.

While Medicare is very popular amongst its recipients, there are many gaps in coverage and most beneficiaries have some form of **supplemental insurance**.

Medicaid

If Medicare is government insurance for the elderly, then **Medicaid**, generally speaking, is government health insurance for the **poor**. It is the largest federal health insurance program covering more than **60 million** people (including children with SCHIP coverage). Medicaid is a **state-federal partnership program** that has a baseline series of broad federal regulations, but is largely administered by the states. Therefore, who & what is covered can vary greatly from state to state.

It is important to note that Medicaid does not just cover "the poor" as determined by the federal poverty level guidelines. There are **stipulations** on who is eligible. Currently, an individual must meet the low-income financial criteria **and** belong to one of the following categories:

- **Children**
- **Pregnant women**
- **Adults with dependent children**
- **People with severe disabilities**
- **Seniors**

The **Affordable Care Act** (ACA), however, has made changes to these requirements, which are scheduled to go into effect in 2014.

Medicaid

Medicaid covers a wide range of services including some long-term services that Medicare and most private insurance plans exclude or limit.

The state-federal **partnership** extends to the financing of Medicaid as well. The federal government pays **at least 50%** of the costs in each state – the more poor the state, the more the federal government pays. Overall, the federal government pays about **57%** of all Medicaid costs.

In 2010, Medicaid spending reached **$390 billion**, with 64% going to **acute care**. About **two-thirds** of Medicaid dollars are spent on the **elderly** and **disabled** recipients, but these groups only make up **one quarter** of all beneficiaries.

Affordable Care Act

The **Patient Protection and Affordable Care Act** (ACA) (aka: Obamacare) was passed into law in **2010** and was widely upheld by the **Supreme Court** in June of 2012 after fierce opposition.

In order to address the issues of **access to care** and the **cost of healthcare**, the ACA strives to ensure that nearly **every citizen and resident** of the US has health insurance or face a penalty. In order to achieve this, the law is set to **expand Medicaid** eligibility to all individuals with incomes up to **133%** of the federal poverty level, thus, doing away with the qualifying categories listed previously.

The law also requires employers with **50 or more** full-time employees to offer coverage, and those with 200+ to automatically enroll employees in a program (with the option for the employee to opt out). Employers with **fewer than 50** full-time employees are **exempt** from these requirements.

For individuals who must find insurance privately, the ACA will establish **state-based Health Benefit Exchanges**. These Exchanges will be online marketplaces where people will be able to compare and purchase healthcare plans from **private** companies. A similar system will also be created for employers.

Affordable Care Act

The ACA makes major changes to **private insurer practices** by allowing **dependents** to remain on a parent's insurance until the age of **26**, and making it so that people with **pre-existing conditions** will be able to find affordable coverage. Private insurance companies must also now commit to spending **85%** of premium dollars on clinical services and quality measures or **refund** the excess to policyholders.

The ACA increases Medicare and Medicaid **reimbursements** to primary care physicians, as well as establishing a number of benefits for primary care and general surgery.

An often-overlooked aspect of the ACA is the establishment of a new **trauma center program** aimed at improving emergency department and trauma center capacity. This center would also fund **research** in emergency medicine in an effort to improve quality and efficiency in the field.

Managed Care

In healthcare there are many ideas and concepts that are referred to by titles that incorporate commonly understood words in an **unintuitive** fashion. "**Managed Care Plan**" or "**Managed Care Organization**" (MCO) is such a title.

A MCO is a health insurance plan that **contracts** with hospitals, clinics, physicians, and other providers to care for members at reduced costs. Providers who have these contracts are thought of as "**in-network**" providers. More restrictive plans are usually less expensive and more flexible ones are typically more expensive.

Common types of MCOs are:

- **Health Maintenance Organizations** (HMO) typically only pay for in-network care. An individual chooses a primary care doctor who coordinates most of the care plan through referrals.
- **Preferred Provider Organizations** (PPO) pay some for out of network care and more for in-network care. The individual will often have more flexibility of which doctors to visit for different problems.
- **Point of Service** (POS) plans allow an individual to chose between and HMO or PPO each time care is needed.

Accountable Care Organization

Another confusing title is **Accountable Care Organization** (ACO), which the **ACA** has strongly promoted. ACOs are pre-arranged groups of **coordinated healthcare providers** giving care to a group of patients. This sounds a bit like the "network" of the MCOs, but the ACOs are being used specifically as a measure to cut down **unnecessary** costs.

The idea is that an ACO will be better suited to increase **efficiency** and cut down on wasteful or repetitive services. If an ACO can voluntarily meet quality thresholds, they will **share** in the cost **savings** they achieve for the Medicare program.

Consider the very general **example** of a group of primary care doctors, specialist and other ancillary healthcare service providers (perhaps even emergency services) that enter into an agreement to share the responsibilities, costs – and hopefully savings – for a panel of patients.

Medical Homes

A Medical Home, or **Patient-Centered Medical Home** (PCMH) is another similar idea where an individual's care is coordinated through a **primary care physician**. The goal is to develop a **centralized** setup to optimize a patient's relationships with his/her doctors, and the information they share between them. New **information technologies** play an important role in the PCMH.

This sounds much like an ACO, but in this model the primary care physician is a "**quarterback**" of sorts for the patient's care. It also sounds very similar to the HMO, but the key difference is that **referrals** are not required to see specialists. The HMO is, in this way, sometimes referred to as a "**gatekeeper**" model.

Concerns over PCMHs often center around how they are **defined** and what services will be included within that "**home**" that are eligible for reimbursement. One such concern is how **emergency services** will be considered, since ER physicians would typically not be considered a part of the "home" but nonetheless, emergency room visits are often **acutely necessary**.

Graduate Medical Education

Graduate Medical Education (GME) refers to the **residency** training that physicians undergo after graduating from medical school. An estimated **100,000** residents participate in a wide variety of GME annually that exists for all fields of medicine for varying lengths of time.

Funding for GME comes primarily from the CMS via **Medicare**, with contributions from the **Veterans Administration** (VA), and from some **private** insurers. The ACA includes provisions aimed at **redistributing** inefficient funding to create new residency spots in geographical areas of need, with a special focus on **primary care and general surgery**.

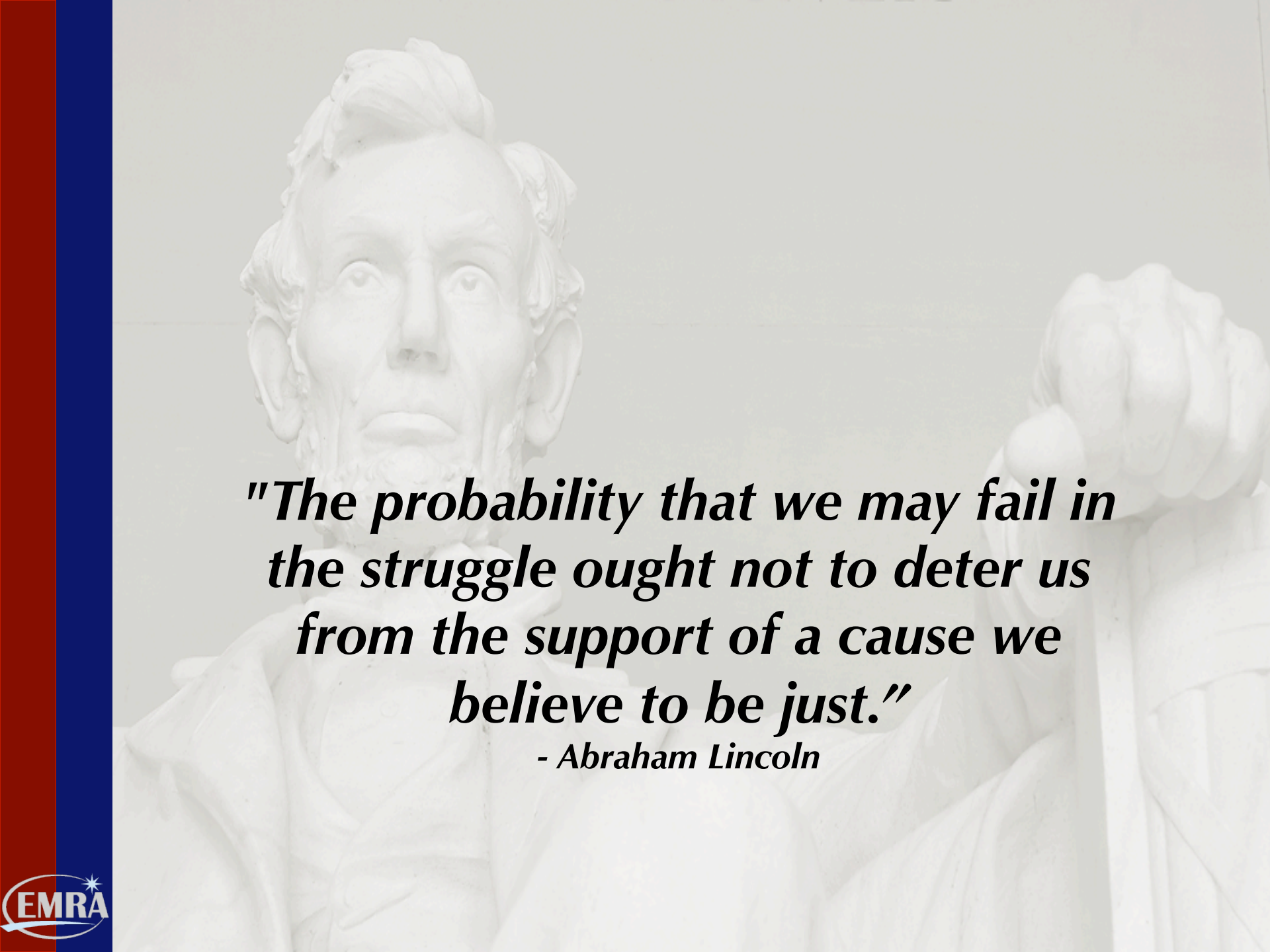
EMTALA

The **Emergency Medical Treatment and Active Labor Act** (EMTALA) took effect in 1986, and requires that patients who present to a **Medicare-participating emergency department** must be evaluated, treated and stabilized, and transferred appropriately regardless of the patient's insurance **status** or **ability** to pay. These requirements are based on the discovery of an emergency during the evaluation which is defined as:

> **"…a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health (or health of an unborn child) in serious jeopardy…"**

If the conditions are met for an emergency, the patient must be stabilized for admission or for transfer to another facility if necessary. The **transferring** hospital is responsible for the patient during transfer. If able, the **receiving** hospital must accept the patient for treatment.

The law does not provide guidelines on funding these requirements.


"The probability that we may fail in the struggle ought not to deter us from the support of a cause we believe to be just."
- Abraham Lincoln

The Issues

The following information is intended to highlight some of the commonly debated aspects of healthcare policy.

Access

Access to healthcare is one of the most prevalent topics in reform discussions, but **"access"** can mean different things depending on the **context**. There are two main access issues that are quite different, and it is important to understand the root of each problem.

Access to healthcare ***coverage*** is what the ACA is primarily trying to mitigate. This idea of access stems from the traditionally high rate of uninsured individuals in the US. Through the Medicaid expansion and other provisions such as the dependent coverage age increase, the idea is to make it so every American has health insurance, thus increasing their care options and lowering costs.

Access to healthcare ***services*** is the other main issue – and the seemingly more difficult issue to solve. Critics of the ACA's expansion measures argue that even if millions of previously uninsured individuals gain coverage, there are not enough providers willing and/or able to evaluate and treat them.

This scenario could prove to be a serious **burden** on US emergency departments. Patients unable to get appointments with a primary care doctor may wind up in an emergency room for non-acute care, or with previously non-urgent conditions that have **progressed** to emergencies.

The Doctor Shortage

It has been widely reported that there is a steadily increasing shortage of doctors in the US – especially in the primary care fields. Some estimate that by **2025** there will be a shortage of **130,000** doctors, and of those, **50,000** or more will be **family physicians**. Expanded coverage by the ACA and a growing and aging population are the common reasons given for these predictions, but there are other factors, too.

In recent years, the percentage of graduating medical students entering into primary care has **decreased** due to a lack of financial incentive (and resulting excessive workload). Also, specialty medicine is often perceived as more **challenging** and **complex** than primary care, which is attractive to medical students beginning their careers.

There are currently plans in place to open **18** new medical schools in the US. But even with more students, a renewed medical student interest in primary care fields and successful compensation changes – such as those contained within the ACA – the problem still may not be solved because of **a lack of residency opportunities**.

Funding GME

As discussed earlier, Graduate Medical Education (residency) is primarily funded through the federal government via **CMS** and **Medicare**. This funding is divided into two types:

- **Direct Costs**: salaries, overhead, faculty, etc.
- **Indirect Costs**: the unintentional costs to the hospital/facility (i.e. higher acuity patients, new technology needs, more staff, inefficiency, etc.)

About **two-thirds** of GME spending goes towards Indirect Costs ($6.5 billion in 2010).

Legislative actions, old and new, have presented challenges to GME. The **Balanced Budget Act of 1997** placed a **cap** on the number of residency positions in the US, which has not been lifted. There has been recent pressure to lower federal contributions to GME – particularly to Indirect Costs – as legislators attempt to reduce government **spending** (i.e. Sequestration).

The problem here should be clear when considering the need for more physicians, a growing medical student population, and decreased funding and availability of residency training spots. While primary care may be most affected, specialty training is certainly not immune from this **disparity**.

(Un)Sustainable Growth Rate

In addition to limiting the number of residency spots in the US, the **Balanced Budget Act of 1997** had other significant impacts on healthcare policy in the US. Perhaps the most important for healthcare providers was the implementation of the **Sustainable Growth Rate** (SGR).

The SGR is a complicated **formula** that determines how doctors are reimbursed for their services to Medicare patients. It was created in an effort to allow for reasonable updates in physician service payments while also controlling spending. The formula ties these updates to the country's **gross domestic product** (GDP), and estimations on the number of Medicare beneficiaries and on changes in physician fees.

Since the implementation of the SGR for Medicare payments to physicians, the US GDP has **suffered** greatly. At the same time, healthcare costs have **soared**, and according to the SGR formula, in this scenario, ***cuts*** to the Medicare reimbursement rates for physicians are required – cuts that would be **disastrous** to the physician community.

The "Doc Fix"

Congress has been faced with this dilemma nearly every year since 2003, and has repeatedly chosen to provide a series of **short-term** "doc fixes" that delay those **cuts**. The most recent of these was on January 2, 2013, during the highly publicized Fiscal "Cliff" negotiations. A **26.5%** cut in Medicare physician reimbursements was averted for one year.

The short-term "doc fixes" are **expensive**, however, and, eventually, they will no longer be possible. For each "fix," other programs lose funding, programs like hospital payments and bundled payments for kidney disease. This most recent fix cost **$25.1 billion** over 10 years.

These facts make repealing and replacing the SGR seem like a foregone conclusion. The problem is that do so would cost around **$300 billion** over 10 years, according to the Congressional Budget Office. A very expensive endeavor, but one that gets more and more expensive **every** year.

The "Med Mal" Debate

Medical malpractice litigation reform, or medical liability reform (or **"med mal"** for short), has long been a hotly contested issue. This is often referred to as **"tort reform,"** where the term "tort" refers to a civil law proceeding in which an injured person seeks **damages** from potentially responsible parties. It is not difficult to recognize that trial lawyer groups strive for fewer limitations and physician groups fight for more.

It is important to understand that the **direct costs** of a successful lawsuit are not the only concerns of physicians in this matter. Malpractice concerns include the substantial (often exorbitant) **rates** of malpractice insurance premiums, **scarcities** in insurers offering coverage, and the **"collateral damages"** of unregulated malpractice litigation.

The "Med Mal" Debate

Studies have shown that a great many malpractice suits turn out to be **frivolous**, but the threat of being sued still leads to the common practice of **"defensive medicine."** This is when physicians tend to **over-test** and **over-treat** out of **fear** of litigation. These practices can have ironic consequences in that can lead to unintended harm to a patient through unnecessary imaging or avoidance of risky procedures.

These problems contribute to rising healthcare costs. The frustrations and distractions they cause has also been linked to physicians limiting their practices and opting for early retirement – thus enhancing the problems of **access** and doctor **shortages** discussed previously.

Malpractice reform has traditionally been addressed at the **state** level, but physician groups consistently advocate for a **federal** policy to bring **uniformity** to a convoluted system. Many possible solutions have been proposed and experimented with, including noneconomic damage **caps**, attorney fee limitations, specialized **health courts**, and many others.

Student Loans

Student loans for medical education are an **increasing** concern. Facts and figures regarding the specifics of interest and repayments can be easily researched, so they will not be addressed here, but **alternative** consequences of massive student debt exist and they should be noted.

Medical school costs are increasing **twice as fast** as inflation. As the federal government makes strides to reduce spending, and physician reimbursement trends remain dim, avoidance of that debt seems unlikely. This burden often comes into play when medical students are choosing a **specialty**, and can be seen as yet another deterrent of students **away** from primary care, where the need is greatest.

Loan **forgiveness** programs have been developed for physicians interested in working in **underserved** areas. These opportunities are largely restricted to primary care fields, and **unavailable** to specialists such as emergency physicians.

As education costs continue to rise, and physician compensation continues to remain unclear, student loan issues will be an important component of healthcare profession advocacy. This topic, in particular, has the potential to be affected by creative new strategies.

A Crowded Room

Emergency departments in the United States have long faced the issue of be **overcrowded**. Trends in emergency medicine that have contributed to this include a steady rise in ER visits, a rise in ED closures across the country, and **boarding** – the inability of admitted patients to moved from the ED to another location within the hospital. As discussed previously, doctor **shortages** may also lead to increased ER visits and even more crowded conditions when more people are covered through the provisions of the ACA in the near future.

Crowding in the ED does more than just increase **wait times**. Studies have made it clear that these conditions contribute to delays in critical patient care via longer waits and ambulance diversion during times of maximum capacity. These delays lead to increased hospital stay **durations**, and increased **complications** – and eventually to increased **mortality**.

These consequences make the issue of ED crowding **more** than just an ED problem. This is a healthcare problem that needs to be addressed at a higher level as it affects more than just ED physicians.

The Need For Advocates

A **profession** is more than just a job or a career. Being a part of a profession implies that one has a **devotion** to the **vocation** and has made **sacrifices** of time and effort to become a professional. The physician profession is no exception. The practice of medicine is a profession of great responsibility and requires a certain degree of **autonomy**. However, medicine is more and more subject to external regulation, and if physicians intend to play a **critical** role in that regulation, they must learn to be effective advocates for **themselves** and for their **patients**.

Getting Involved

Many **avenues** exist for advocating to local, state and national legislators. **Contact** via mail, email, district & DC office visits, and **attendance** at advocacy conferences are all good ways to show your support and dedication to a cause. Don't forget that advocacy can be done with **administrators** on medical school and hospital **campuses** for more institutional issues as well.

However you chose to advocate for your cause, you must recognize that **communication** is the ultimate goal. Too often in medicine, the message from doctor to lay person is lost in complicated **terminology** or poor efforts of simplification. Effective communication must be **direct** and **efficient**, and must be **practiced**.

Getting Involved

Preparation

Like with most things, in successful advocacy efforts, there is no substitute for good preparation. Do the **research** necessary to fully understand the issue at hand, and you will be ready for most any question. Engage in **discussions** with colleagues to gain different **perspectives**. Develop a **clear** and concise definition of your **goal**.

Research your representatives, too. Be familiar with their party **affiliations**, their pre-determined **stances** on the issues, what **committees** they sit on and their responsibilities outside of direct service to their constituents.

Also, research your representatives' careers prior to public service. Often you will find that people who have spent time in some healthcare capacity (even doctors!) will find their way into politics. In any case, knowing more about their background may yield opportunities to connect more personally.

Getting Involved

The Value of *You*

Meeting with a representative in person may induce some feelings of **anxiety** or **inadequacy** because of a lack of policy or advocacy **experience**. Remember that most politicians – especially at the state level – have a **genuine** interest in hearing the concerns of their constituents, and have a great respect for their constituents with expertise in important fields, such as medicine.

Remember that when you sit down with a legislator, they may be the expert in policymaking, but ***you*** are the expert in healthcare education or delivery; ***you*** are the expert in what ***you*** have experienced. And as a medical student or physician, ***your*** experience has direct effects on ***their*** constituents, so your thoughts and opinions will be of value to them.

The old adage of **"strength in numbers"** is especially relevant in advocacy. Showing that a cause is widely supported is crucial in winning a **vote**, or changing a **perspective**. This is true when sending emails or when visiting someone's office. The larger the presence, the more effective the message.

Getting Involved

The Meeting

As with any professional interaction, you should be **appropriate** and **respectful** – even in situations of **disagreement**. Show gratitude for the representative's and staff members' **time**, as their time is often stretched very thin.

During your meeting, draw on your research and preparation for evidence and support of your cause, but remember to be **efficient** with your message. Make sure not to lose your audience in unnecessary rhetoric.

When the time comes, be sure to make your goal clear with **"The Ask."** You can present all of the anecdotes and evidence in the world, but if you fail to make it clear what you want your representative to **do** to support your cause, they may not be able to come up with a solution on their own – even if they show support.

As you bring the meeting to a close, it's a good idea to leave documentation regarding your "Ask" with key points, anecdotes and most importantly, your **contact information**. Patient stories are a great resource for examples of the importance of your goal. And finally, ask how, and with whom, you should follow up, and then…..**DO IT!**

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