Physician Advocacy and the 2010 Health Care Reform Act

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Dramatic changes are being proposed in health care delivery in the United States and the main driver is reducing costs. The 2009 estimates suggest that the United States spent 2.6 trillion dollars (17.3% of GDP) on health care. The average for spending in the rest of the world was around 9% GDP.[1] While the numbers can be debated, everyone understands that the rising cost of health care cannot be maintained. What people can't agree on is how to make changes that will contain cost while maintaining quality.

Over the past eighteen months as the health care reform debate has raged in Congress, many physician organizations have ramped up their efforts to get and stay involved. Advocacy efforts have become a priority so that physician's voices can be heard in the debate. While many complain about the final bill that passed, without these efforts things would have been worse. As the famous saying goes, "if you aren't at the table you are on the menu." As physicians, we have a responsibility to our patients and ourselves to be actively involved in the process. Fortunately it is easier now than it has ever been before. Organizations such as the Rhode Island Medical Society and the American Medical Association have priorities for legislative efforts that are being proposed. They are monitoring bills that affect physicians and practices and proposing ones that are necessary to improving health care. They offer training programs for physicians who want to run for office and programs for how to become an advocate. They alert physicians to important votes taking place and provide simple means for letting congress know how they should vote. It has become easier than ever to get involved.

As physicians in the trenches providing health care, no one is better placed to advise those making decisions on what is best. We know what works and what doesn't work. Because we know what our patients need and want, we must get involved in the process.

While there is still debate about what exactly is in HR3962 Affordable Health Care for America Act, the official summary lists a variety of improvements.[2] Approximately 32 million currently uninsured Americans will be covered. Insurance companies will not be able to deny insurance based on pre-existing conditions or limit coverage with annual or lifetime caps. They cannot discriminate based on gender. The age for children to remain on their parent's insurance is raised to 26 years old. It develops insurance exchanges and tax credits to assist lower income families and individuals in obtaining insurance coverage. It supplies tax credits to small businesses to incentivize them to offer health insurance to their employees. It expands Medicaid and maintains funding for SCHIP programs. It provides a 10% incentive to primary care providers through Medicare payments. Starting this year it provides refunds to Medicare patients affected by the Part D "donut hole) and completely closes this hole by 2020. It supports and expands payment incentives for quality measures (PQRI programs) to try to shift the focus of physician payments from volume to value. It establishes pathways for FDA approvals for biosimilar medications in the hopes of bringing more treatments to the field faster. It provides for standardization and simplification of paper work for insurance companies. While it does not include meaningful medical malpractice reform, it provides for pilot programs to explore options in this area. It also did not include a permanent fix to the physician payment calculation that depends on SGR calculations. It established a non-partisan regulatory board (Independent Payment Advisory Board or IPAB) to make recommendations to control health care costs. It establishes new imaging requirements that mean patients must be informed in writing that they can obtain their test anywhere they want and that they be given a list of available locations. Because the regulatory language now has to be written by congress for this bill, the details of how all of these measures will take place and what impact they will actually have has yet to be determined. Because of the political wrangling that had to take place for the bill to get passed, it is generally understood that additional amendments will be added to change some of the current language. Over the next months to years the health care reform act will continue to be a work in progress.

In this edition of *Medicine & Health/Rhode Island* there are articles detailing different aspects of advocacy and the legislative process. Dr. Nicholas Tsiongas served in the RI House for four terms from 1985-1993. He details what it is like to run and serve in office. Dr. Vera Depalo is the current president of the RI Medical Society and will review the priorities of RIMS and the efforts they are making. Dr. Michael Migliori will discuss the priorities of the AMA and his experiences with lobbying for the AMA and RIMS including testifying before congress. Finally, I have worked with the American Academy of Neurology on developing advocacy programs and the AAN's legislative priorities and will discuss some of the basics of dealing with congress and how to be a better advocate.

References

1. OECD Health Data, 2009.
2. Summary from the House Committees on Ways and Means, Energy and Commerce, and Education and Labor, Mar 23, 2010. Available online at http://edlabor.house.gov

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