

Inside the Capitol

during the
111th Congress

AGA
Legislative
Report
2010



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AGA Legislative Report

2010

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Dear colleague,

Last year was challenging for most everyone attempting to achieve their goals on Capitol Hill. We witnessed the passage and beginning of implementation of health-care reform, a spirited debate on its merits and long-term impact, and a massive shake-up in the composition of the House of Representatives as a result of a true “change” election. The political dynamics made it virtually impossible to secure passage of any legislation in Congress following the health-care reform vote prior to election day. A fiscal year 2011 funding bill for NIH never passed in 2010, and the government continues to operate under a temporary continuing resolution just to keep the government’s doors open.

Despite all the uncertainty of change and the congressional inactivity due to gridlock, the AGA has been able to maintain a vibrant public policy presence in Washington. Throughout 2010, our advocacy team has lobbied daily on behalf of the interests of practicing GIs and scientific investigators to advance our goals. We undertook the monumental task of deconstructing the massive new health-care reform law and held two webinars on its implications for GI practice and its impact on small businesses. This process has also helped us to identify the key provisions in health-care reform that we believe need to be changed to protect the quality of care we deliver to our patients. This “2010 AGA Legislative Report” will walk you through some of these key provisions and the actions AGA has taken, and will take, on your behalf.

Funding for biomedical research is another key area in which past congressional inactivity and major challenges in the future will require us to adopt different approaches to advocacy. We’ll need researchers to undertake something that they have not been known to do on a broad-based scale — advocate to their legislators the importance of robust research funding and how it affects the economy and jobs in this country. We must find ways to translate all of the outstanding work we do as scientific investigators into tangible examples of how this helps all Americans.

One of our most important endeavors over the past several months has been to prepare for a more engaged AGA membership on grassroots advocacy. The AGA launched the **Congressional Advocates Program** in 2010 to provide the tools and resources to help you become more involved in developing a relationship with your members of Congress. In 2011,



we'll offer even more resources and guidance on how to be an effective advocate for our profession. Members in clinical practice and research will greatly benefit from the continued expansion of the [AGA Congressional Advocates Program](#).

AGA also launched the [AGA Think Tank on the Future of Practice](#) to focus on important issues and trends that will shape the GI practice of the future. Through the AGA Think Tank, we hope to identify members around the country who are interested in offering their expertise to help advance the science and practice of gastroenterology. It will offer members the opportunity to become active in AGA programs and initiatives to help address the many challenges we face in the reimbursement and policy arenas, and to strategize on bold new ways to address these challenges.

Last, and certainly not least, AGA's political action committee, [AGA PAC](#), has blossomed into a true political force on Capitol Hill. AGA PAC donated \$157,000 to 64 candidates running for Congress in 2010, clearly establishing our PAC as a well recognized political entity and helping us to gain a seat at the table during major policy discussions. However, we need to continue to increase involvement in AGA PAC in order to be even more competitive with our medical society colleagues.

We continue to innovate as we explore different communications vehicles to keep you informed of the ongoing activities of our advocacy team. Facebook, Twitter and the *AGA Washington Insider*, a policy blog for GIs, are now integral parts of our communications, complementing our outreach through *AGA eDigest*, the *AGA PAC Insider* and targeted policy alerts.

I hope you will find the "2010 AGA Legislative Report" to be informative and motivating. We look forward to helping you become more involved in the AGA's advocacy activities in 2011 and beyond.

Best regards,

A handwritten signature in black ink that reads "Robert Burakoff, MD, MPH". The signature is written in a cursive style.

Robert Burakoff, MD, MPH, AGAF
Chair, Public Affairs and
Advocacy Committee

Health-Care Reform a Year Later

With the enactment of the Patient Protection and Affordable Care Act (PPACA) nearly a year ago, American medicine has entered a new era. The AGA was an active participant in the health-care reform debate and supports increased access for the millions of uninsured patients in the U.S. However, there remain serious concerns with many provisions of this legislation and how they will impact gastroenterology. Many health-care reform provisions have already been, and will continue to be, implemented over the next few years through the regulatory process. AGA has been working with federal agencies to influence the process with the goal of improving policies that impact the field of gastroenterology.

In the 112th Congress, which gave Republicans control of the House and larger margins in the Senate, there will be continued efforts to repeal and replace the health-care reform legislation since many newly elected members ran on a platform of repeal. PPACA continues to be a highly politicized topic in Congress. One of the first orders of business in the House in 2011 was passing H.R. 2, which repealed PPACA, although the Senate, which is still controlled by the Democrats, will not bring the bill up for a vote.

AGA will continue to advocate for provisions that improve the health-care system for gastroenterologists and will provide tools to help GIs successfully navigate the new health-care environment. Following is a brief chronological guide outlining parts of the law important to gastroenterology.

The AGA will continue to keep members updated on the process and provide tools to help GIs successfully navigate the new health-care environment.



Photo courtesy of Architect of the Capitol

Patient-Directed Provisions

☆ Increased Access to Colorectal Cancer (CRC) Screenings

New private sector health-care plans that were issued on or after Sept. 30, 2010, are required to provide a minimum benefits package and cover CRC and other preventive screenings with no cost sharing for the patient. For example, if a patient's plan period began on Jan. 1, 2011, the screening benefit would not be effective until the date of the new plan.

AGA submitted comments to HHS on the interim final rules for group health plans and health insurance issuers relating to coverage of preventive services, advocating for the inclusion of CRC screening in a preventive benefits package and for patients to have access to and coverage for an array of screening modalities, such as colonoscopy. AGA also encouraged HHS to adhere to professional society guidelines on screening for CRC to ensure that insurers do not limit patients' access to various screening modalities.

The Institute of Medicine (IOM) has been tasked with a study to determine essential health benefits for HHS, and AGA has provided extensive comments advocating for the inclusion

of colonoscopy and other screening modalities as essential benefits for private insurance plans.

In 2011, Medicare and Medicaid will no longer charge copayments for proven preventive screenings, such as CRC screenings. Medicare will also waive the deductible for CRC screenings regardless if a polyp or lesion is found. However, due to an anomaly in the new health-care law, the copayment is not waived when a screening colonoscopy becomes therapeutic, and **AGA has been aggressively lobbying to change this inequity.**

☆ Improved Access to Insurance Coverage

Immediate access was provided to high-risk pools for people who have no insurance because of pre-existing conditions. In addition, the law bars insurers from denying people coverage when they get sick and from imposing lifetime caps on coverage. It also bars insurers from denying coverage to children who have pre-existing conditions, and requires insurers to allow young people to remain on their parents' health insurance plan until they are age 26.

In 2014, no insurer would be allowed to deny coverage to a patient with a pre-existing condition.

Physician Reimbursement Provisions

☆ Physician Quality Reporting System (PQRS)

The PPACA extends the incentive payments for successful quality reporting to 1 percent in 2011 and 0.5 percent from 2012 to 2014. Beginning in 2015, physicians who do not report on quality measures to the PQRS will receive a 1.5 percent cut in Medicare reimbursement and a 2 percent cut in payments in 2016 and thereafter. **The AGA continues to work with the AMA's Physician Consortium for Performance**

Improvement to further expand relevant quality measures that enable our members to participate in PQRS and improve the outcome of GI care.

The AGA's Digestive Health Outcomes Registry™ has been approved by CMS to submit data for hepatitis C measures in PQRS, and the registry is on target to allow reporting of additional PQRS measures (colonoscopy surveillance, BMI, preventive services) by mid-2011.

The act requires CMS to create an appeals process for physicians and to provide timely

Health-Care Reform a Year Later

Continued from page 2

feedback for participating physicians, two positive changes to the program advocated by AGA and our partners in the Alliance of Specialty Medicine.

☆ Physician Compare Website

Beginning in 2011, HHS will develop a website in which information will be accessible on Medicare providers and those physicians who participate in the PQRS program. The website is designed to provide the public with information on quality, patient experience and assessment of patient outcomes. The comparable physician quality information will be incorporated on the website by 2013.

☆ Misvalued Codes

Effective immediately, the law gives the secretary of HHS the authority to adjust reimbursements for codes that are deemed misvalued or overvalued, specifically codes that have experienced high volume and have not been subject to review since the implementation of the resource-based relative value scale system, the so-called “Harvard codes,” which contain many endoscopy codes.

As part of the 2011 Medicare physician fee schedule proposed and final rules, CMS has requested that the AMA/Specialty Society Relative Value Scale Update Committee (RUC) review the physician work values for the codes that appear on the RUC’s multi-specialty points of comparison (MPC) list. The RUC utilizes the MPC list as a basis for relativity when determining the values for new, revised and newly reviewed codes. In the MPC screen, CMS identified four GI endoscopy codes: 43235: EGD; 43239: EGD with biopsy; 45380: colonoscopy with biopsy; and 45385: colonoscopy with removal of tumor(s), polyp(s) or other lesion(s) by snare.

The AGA continues to closely monitor this issue given its potential devastating impact on reimbursement for gastroenterology. We are actively engaged in the RUC process and will work steadfastly to ensure fair valuation and reimbursement for endoscopy services.

☆ Independent Payment Advisory Board (IPAB)

The law creates the IPAB, which will be comprised of 15 members tasked with making recommendations to Congress on lowering costs to the Medicare program. The recommendations would take effect unless Congress rejects the proposal and offers a recommendation that achieves the same savings. The board will be prohibited from making decisions that ration care or increase beneficiary premiums or eliminate benefits, thus leaving physicians more vulnerable to potential cuts. Effective 2015, IPAB will submit a recommendation to Congress. **AGA does not support implementation of the IPAB and continues to support legislative efforts to abolish it.** In the House, Rep. Phil Roe, R-TN, has introduced legislation to repeal IPAB and Sen. John Cornyn, R-TX, has introduced companion legislation in the Senate.

☆ Value-Based Payment Modifier

This provision implements a new budget-neutral value-based modifier through which physicians will be reimbursed based on the cost and quality of care that they deliver. Beginning in 2013, and likely to be part of the 2013 Medicare physician fee schedule, the HHS secretary will solicit input for quality outcomes measures on which to base the quality modifier, and the new payment system will be implemented in 2015. **AGA will keep a close eye on this process and will be working to integrate the AGA Digestive Health Outcomes Registry and its measures.**

☆ Physician Feedback Program

Beginning in 2012, physicians will receive individual reports on their resource use compared with their peers who see a similar patient base.

☆ Bundling

Effective in 2013, the HHS secretary will be required to establish a pilot program on payment bundling to encourage providers to improve care coordination to achieve savings for the Medicare program.

☆ Accountable Care Organizations (ACOs)

Beginning in 2012, physicians will be encouraged to join ACOs through which they will be eligible for enhanced payment incentives based on quality and efficiency improvement. All physicians are eligible to participate, however participation is voluntary. **AGA will work to integrate the registry to assist those physicians who choose to participate in an ACO.** HHS released its proposed rule on ACOs at press time. AGA will provide members with a comprehensive analysis on how these new rules impact GI. The AGA Think Tank on the Future of Practice provides a number of resources for physicians who are interested in learning more about ACOs to decide whether the organizations are right for them.

☆ Comparative Effectiveness Research (CER)

Effective immediately, PPACA establishes a Patient Centered Outcomes Research Institute (PCORI), an independent institute governed by patients, providers, government officials and other stakeholders. This institute focuses on clinical effectiveness research as opposed to cost-effectiveness, and ensures that CMS will not misuse CER results in ways to overlook differences in patient needs or discriminate against the elderly or people with disabilities.

The AGA continues to monitor opportunities for research in GI and to integrate the AGA Digestive Health Outcomes Registry with this process. Read Page 6 to learn more.

☆ Ambulatory Surgery Centers (ASCs)

The HHS secretary was required to submit a plan by Jan. 1, 2011, for value-based purchasing for ASCs, through which their payment would be based on quality and efficiency measures, but the report has been delayed. **The AGA will monitor this process closely and will work to integrate the AGA Registry with the new plan.**

AGA submitted comments to HHS on the “Action Plan to Prevent Healthcare-Associated Infections in ASCs” and is pleased that the plan proposed endoscopy reprocessing as a specific area that is likely to benefit from quality measures development. We indicated that the AGA Digestive Health Outcomes Registry will capture data related to CRC prevention performed in all facility and non-facility settings, including ASCs, and can be used to help improve quality.

☆ Imaging Services

Effective immediately, the law changes the utilization rate assumption to 75 percent for advanced imaging equipment (CT, PET and MRI), whereby Medicare assumes that a provider is using imaging equipment 75 percent of the time in order to be fully reimbursed.

☆ Medical Liability Provisions

Effective 2011, the law appropriates \$50 million over five years to provide grants to states to conduct demonstration projects on alternative medical liability reform programs. The HHS secretary is required to submit reports to Congress on these pilots and the Medicare Payment Advisory Commission (MedPAC) will conduct independent reviews of the pilot programs.

With Republicans in control of the House, they plan to deliberate H.R. 5, the Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act, for a vote. The HEALTH Act would reform our nation’s medical liability system by capping awards on non-economic damages.

Health-Care Reform a Year Later

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Although this legislation is not likely to pass the Senate, AGA will continue to work with our allies in the Alliance of Specialty Medicine to push for comprehensive medical liability reform that improves patients' access to care.

☆ Physician Sunshine Provisions

Effective March 31, 2013, drug, device, biological and medical supply manufacturers will be required to report any transfers of value to any physician, group practice or teaching hospital and disclose any ownership or investment that the physician may have with

the manufacturer. These provisions do not appear to apply to CME programs.

☆ Physician Workforce

Effective immediately, a National Health Care Workforce Commission will be established to provide comprehensive information and recommendations to Congress on the nation's workforce priorities. Beginning in 2011, unused graduate medical education slots will be re-distributed to help increase the training of primary care physicians.

Small Business and Personal Tax Provisions

PPACA contains several new mandates on small businesses, including changes that will impact your personal taxes. Following are a few provisions that will impact you personally and professionally.

☆ 1099 Reporting

Beginning in 2012, businesses and individuals will be required to file a 1099 tax form for every purchase made of \$600 or more. This requirement is a regulatory and paperwork burden, especially for small businesses, and both parties agree that it should be repealed. **The AGA supports repealing this provision since it will be an unnecessary burden on physician practices.** Read Page 7 to learn more.

☆ W-2 Reporting

Beginning in 2012, businesses will be required to include the aggregate cost of employer-sponsored health benefits on an employee's W-2.

☆ Unearned Income Medicare Contribution

Beginning in 2013, a 3.8 percent tax will be placed on unearned income, which will be applied to the lesser of the taxpayer's net investment income or modified adjusted gross income in excess of the threshold amounts — \$200,000 for singles and

\$250,000 for joint filers.

☆ Medicare Hospital Insurance Payroll Tax Increase

Beginning in 2013, an additional 0.9 percent Medicare hospital insurance tax will apply to individual taxpayers over the following thresholds — \$200,000 for individuals; \$250,000 for married couples filing jointly; and \$125,000 for married couples filing separately.

☆ Shared Responsibilities for Employers

Beginning in 2014, employers with 50 or more employees will be required to contribute to health-care benefits, which will vary depending on whether the employer provides health insurance. Generally, an employer that did not offer health benefits would pay a fee of \$2,000 per full-time employee (in excess of 30 employees) if at least one employee receives a premium credit through the health insurance exchange.

If an employer does offer health benefits, the employer would pay the lesser fee of \$3,000 for each employee who receives a premium credit or \$2,000 for each employee (in excess of 30 employees). ★

Recommending Prudent Use of Comparative Effectiveness Research

Over the past two years, legislation has generated funding and infrastructure for CER. PPACA created PCORI, a non-profit corporation charged with identifying research opportunities, developing a research project agenda, and executing research to better inform patients and physicians of their treatment options. The AGA and other patient advocates supported the independent nature of the institute when the legislation was crafted to ensure impartiality. PPACA also included language to ensure that CER cannot be used to make decisions to determine coverage or cost.

CER can be a valuable tool for improving health-care quality and value by empowering patients, physicians and other health-care providers, as well as health-care decision makers, with sound evidence for good decision-making. However, it can also be misapplied in ways that restrict patient access to optimal care and discourage medical advances.

As part of the American Recovery and Reinvestment Act (ARRA), \$1 billion in funding for CER was included for the Agency for Healthcare Research and Quality (AHRQ), NIH and the Office of the Secretary of HHS to help determine which treatments work best for which patients. ARRA funding has led to 422 grants and contracts focused on evidence development, evidence translation and dissemination, and establishment of CER infrastructure and methodologies. The AGA has recommended guiding principles to NIH to ensure that CER doesn't limit patient access to optimal care or discourage medical advances, including:

- ☆ CER should not be a vehicle for making centralized coverage and payment decisions.
- ☆ Public comments should be sought regarding the CER entity's research priorities, agenda, peer-review process, dissemination protocols and research

design. A formal comment period should also apply to research findings.

- ☆ Permanent and ad hoc advisory panels appointed by the CER entity should include members who are board certified specialist and subspecialist clinicians involved in treating the disorder under consideration.
- ☆ Health-care providers should be provided with medical liability protections when they follow practice guidelines recommended by the CER entity.

AGA is a member of the Partnership to Improve Patient Care, a coalition of patients, physicians, researchers and other providers dedicated to promoting CER that supports patient access and informed health-care decision-making and fosters continued medical progress.

The Partnership to Improve Patient Care continues to monitor the implementation of PCORI to ensure that it is consistent with the intent of the legislation. The AGA will continue to work with PIPC to educate the more than 90 new members of Congress about the importance of CER and of maintaining an independent entity to ensure that patients and providers have a voice in this important area of research. AGA will also continue to monitor research opportunities for gastroenterology and provide comments and input on studies that will impact gastroenterology and patient care. ★

Supporting the Repeal of the 1099 Tax Form Reporting Requirement

As part of PPACA, individuals and businesses are now required to file a 1099 tax form every time a purchase is made of \$600 or more. This provision was included by the Senate in the health-care reform negotiations, and the business community has been advocating for its repeal since. Members on both sides of the aisle agree that this requirement is a paperwork and regulatory burden on small businesses, including physician practices, and want to repeal it. President Obama highlighted his support for repealing this provision in his 2011 State of the Union address.

The AGA continues to support repeal of the 1099 provision since it places undue paperwork burdens on physician practices, especially in light of all of the other regulatory requirements with which they need to comply.

The Senate approved an amendment offered by Sen. Debbie Stabenow, D-MI, to repeal the provision in PPACA, which was overwhelmingly approved by a vote of 81 to 17. The House also approved legislation to repeal the 1099 reporting requirement, but would finance the change by recouping federal



subsidies from people who misreport their income for insurance exchange subsidies.

After discussions and negotiations, the Senate decided to deliberate on H.R. 4 and overwhelmingly approved it by a vote of 87-12. As of the time of this publication, it is uncertain whether the president will sign the measure since he has indicated he does not support how the repeal is financed. However, both chambers passed the measure with enough support to override a veto. Although this measure has bipartisan support, the vote is symbolic as it the first provision of the PPACA to be repealed by both chambers. ★

The AGA continues to support repeal of the 1099 provision since it places undue paperwork burdens on physician practices.

Pushing for a New Medicare Reimbursement System

For the past decade, AGA, along with the entire physician community, has been advocating for Medicare physician reimbursement reform that fairly compensates physicians and provides stability for physicians and their patients. Congress has long recognized that the current formula used to update physician reimbursement rates under Medicare, the sustainable growth rate (SGR) formula, is deeply flawed and must be replaced.

Members of both parties have also long agreed that this formula is not sustainable and does not provide positive incentives for physicians. The cost of repealing the SGR has always been a challenge, but every year that Congress fails to fix the formula, the price tag continues to increase and exacerbate the problem. The current cost of repealing the SGR tops more than \$300 billion, and in this current environment of deficit reduction and reducing government spending, enacting a remedy at that cost will be challenging at best. Both Republicans and Democrats have provided temporary fixes to prevent cuts from being implemented and have intervened nearly thirteen times with short-term stop gap measures since 2001.

In 2010, the 111th Congress enacted five short-term fixes to prevent a 21.3 percent cut from

being implemented and, during the post-election lame duck session, passed the Medicare and Medicaid Extenders Act of 2010 providing relief through the end of 2011. The reimbursement fix was fully financed by changing the way the government recoups

overpayments to subsidies to help purchase health insurance under PPACA. The legislation also extends several expiring Medicare provisions, such as protections for rural hospitals and physicians.

Although the AGA continues to believe that Congress must find a long-term solution to the broken Medicare reimbursement system, we were pleased that Congress was able to come to a one-year agreement that is fully financed and does not further exacerbate the cost of fixing the formula, especially given the difficulty Congress had in enacting even monthly remedies.

With more than 90 new members of Congress, the AGA must continue to educate Congress on the need to enact meaningful reimbursement reform that ensures equity and stability in the cost of care for physicians and their patients. We will continue to urge Congress to take the necessary steps to provide a permanent solution to the flawed payment formula that transitions physicians to a new system. ★

AGA believes that Congress must find a long-term solution to the broken Medicare reimbursement system.

Alliance of Specialty Medicine

AGA is one of the founding members of the Alliance of Specialty Medicine, a coalition of 10 national medical specialty societies committed to developing sound federal health-care policy that fosters patient access to the highest quality specialty care. The alliance focuses on issues of importance to the specialty physician community, such as Medicare physician reimbursement reform, medical liability reform, improving access to specialty care, patient safety and improved quality care.

Throughout the two years that Congress was developing and debating health-care reform, the alliance was intimately involved in the discussion by meeting with members of both political parties, both houses of Congress and the administration to ensure that the needs of specialty physicians and their patients were addressed. The alliance provided input and feedback to the congressional committees of jurisdiction as they crafted their health-care proposals and drafted countless letters providing suggestions on how to improve certain provisions in the legislation. Since the PPACA was signed into law, the alliance has continued to aggressively lobby Congress and the administration on areas of concern, and provide suggestions on improvements to implementation.

☆ Congressional Outreach

The alliance continues to be seen as an invaluable resource on Capitol Hill — the alliance always has a seat at the table when Congress is addressing legislation impacting physicians, such as health-care reform and the SGR.

An aggressive grassroots advocacy campaign was undertaken by the alliance throughout the year by utilizing a toll-free hotline that connected society members directly to their legislators. Given the uncertainty that physicians faced with looming Medicare reimbursement cuts literally month to

month, it was an effective method to engage physicians to reach out to their legislators directly.

AGA and the alliance distributed numerous calls to action on our support for a long-term fix to the SGR and developed fliers and action alerts for patients, educating them on the need to maintain access to specialty care.

The alliance worked collectively to respond to regulatory agencies on comments regarding rules, such as meaningful use of electronic medical records, the 2011 physician fee schedule and several other regulatory issues impacting specialty medicine. The alliance met with leaders of the FDA on issues surrounding the 510(k) process for approving devices during which we discussed the issues of post-market surveillance, off-label use and other issues impacting patients' access to the latest technologies.

☆ Annual Washington Leadership Fly-In

The alliance held its annual Washington Leadership Fly-In during which legislators from both chambers and both parties spoke to physician representatives on issues of importance to medicine. The alliance also heard from key health policy experts on quality initiatives and payment reform initiatives. The alliance fly-in was held in June 2010, shortly after the health-care reform law was enacted, and attendees were able to hear from key legislators who were intimately involved in the process, including:

- ☆ Rep. Pete Stark, D-CA.
- ☆ Rep. Phil Roe, R-TN.
- ☆ Sen. John McCain, R-AZ.
- ☆ Sen. Tom Coburn, R-OK.
- ☆ Rep. Zack Space, D-OH.
- ☆ Mark McClellan, MD, former CMS administrator and FDA administrator.



- ☆ Robert Berensen, MD, vice chairman of MedPAC.
- ☆ Chuck Todd, chief White House correspondent of NBC News.
- ☆ Tony Coelho, former majority whip and chair of the Partnership to Improve Patient Care.

AGA board member John I. Allen, MD, MBA, AGAF, attended the fly-in, representing the AGA. Dr. Allen met with several members from Minnesota and Wisconsin and provided his input on how the health-care reform law will impact gastroenterologists and their patients. Dr. Allen was able to convey to legislators the quality improvement initiatives that the AGA has undertaken, the impact that the scheduled Medicare cuts would have on patient access to care, and the dangerous precedent that IPAB sets with making global budgetary decisions on Medicare.

☆ Moving Forward

With the implementation of PPACA and an unpredictable and broken Medicare physician reimbursement system, the alliance continues to work with our congressional allies on making improvements to the law and to find a permanent solution to the SGR. The alliance also continues to educate the more than 90 new members of Congress on our legislative priorities and offer ourselves as a resource as they debate changes to important issues impacting specialty care. The AGA will continue to work closely with the alliance as we work to improve upon provisions in the PPACA through the legislative and regulatory processes.



John I. Allen, MD, MBA, AGAF, met with several members of Congress during the alliance fly-in, including Sen. John McCain, R-AZ.

Members of the alliance include:

- ☆ American Association of Neurological Surgeons.
- ☆ American Gastroenterological Association.
- ☆ American Society of Plastic Surgeons.
- ☆ National Association of Spine Specialists.
- ☆ Congress of Neurological Surgeons.
- ☆ Society for Cardiovascular Angiography and Interventions.
- ☆ American Urological Association.
- ☆ American Society of Cataract and Refractive Surgery.
- ☆ Heart Rhythm Society.
- ☆ Coalition of State Rheumatology Organizations. ★

Advocating for Research Funding

The future of federal research funding remains dire as it faces the same challenges as other components of the national budget. The research community faces a very difficult, uphill battle in its efforts to avert any reductions in funding in 2011 and 2012, however, the AGA is strongly committed to working in Washington and mobilizing its member to fight these cuts.

☆ NIH Funding

Election year politics in 2010 proved to be a major impediment to passing an appropriations bill to increase funding for NIH. Early in 2010, President Obama proposed a \$1 billion, or 3.5 percent, increase for NIH, and the House and Senate Appropriations subcommittees with jurisdiction over NIH funding passed similar budget increases. However, Democrats and Republicans could not reach an agreement on these bills, so no increase in NIH funding was approved. At the time of publication, a temporary continuing resolution was in place to fund NIH at the fiscal year (FY) 2010 level of \$30.78 billion.

Debate for funding of NIH began on an ominous note in 2011. While the president's budget proposed an increase of \$1.045 billion (3.4 percent) for NIH, the new House Republican leadership proposed scaling back funding for most federal programs to FY 2008 levels. The first piece of legislation introduced by the House Republican leadership, the Full-Year Continuing Appropriations Act, H.R. 1, would cut \$1.6 billion from the NIH budget, a reduction of more than 5 percent, for the remainder of FY 2011. Other House Republicans have called for even deeper cuts this year. AGA, working in collaboration with the Ad Hoc Group for Medical Research, has mobilized to educate lawmakers on the negative impact of such deep cuts on jobs and the economy.

AGA sent an alert to members asking them to contact their federal legislators to show their opposition to the cuts. The alert generated the

single largest grassroots response from AGA members on a biomedical research issue – more than 500 messages were sent to Congress.

☆ Veterans Administration (VA) Funding

In February 2011, President Obama proposed a \$38 million dollar, or 8 percent, cut in the budget for VA research for FY 2012. The president's proposal of \$43 million for VA research would not even meet FY 2008 funding levels for the program, and even larger cuts are expected from House Republicans.

The Friends of the Veterans Administration (FOVA), of which AGA is a member, has proposed FY 2012 funding recommendations for the VA Medical and Prosthetics Research Program at a \$30 million increase over current levels, a modest 5 percent increase. The increase is justified by the amount necessary to account for biomedical research inflation and to sustain support for ongoing VA research activities. FOVA is also requesting \$150 million for five major research construction projects and \$50 million for minor construction, maintenance and repair. For decades, the VA construction and maintenance appropriations have failed to provide the resources needed by VA to replace, maintain or upgrade its aging research facilities.

The VA drafted its Research and Development Strategic Plan for 2010 through 2014, and although most of the research priorities are in areas to address the needs of veterans, chronic disease is also a priority of the VA. The increase in research funding and their recruitment of clinicians and researchers could provide opportunities for gastroenterology. The VA has stated that they would like to recruit more internal subspecialists like gastroenterologists, and has had a challenge doing so. The AGA will continue to pursue opportunities through which we can collaborate with the VA to improve research opportunities for our members and the field of gastroenterology. ★

2010 Regulatory Affairs Highlights

Regulatory issues are a top priority of AGA. We work closely with government and regulatory agencies to ensure that the needs of GIs are being met. AGA works tirelessly to ensure members understand the regulatory environment and are kept up to date on issues and activities that may directly affect their practice of medicine and care of patients.

☆ CMS Proposed and Final Rules

AGA, in conjunction with our sister societies, commented on all major CMS payment regulations in 2010, including the 2011 proposed rule for the physician fee schedule, hospital outpatient departments (HOPDs)/ASCs, and inpatient hospitals. In addition, the AGA, as part of the Alliance of Specialty Medicine, also provided comments to CMS on the physician proposed rule.

2011 Physician Fee Schedule

AGA alerted members of the proposed changes for policies and payment rates for physicians in 2011, as well as the enactment of a number of provisions in the PPACA. In detailed comments to CMS, we addressed many important issues to gastroenterologists, including:

- ☆ Consultation code policy.
- ☆ Calendar year 2011 identification and review of potentially misvalued codes.
- ☆ High-cost supplies.
- ☆ Rebasing and revising the Medicare economic index.
- ☆ Electronic prescribing incentive program.
- ☆ The Medicare Improvements for Patients and Providers Act Sec. 131: improvements to the PQRS.
- ☆ Sec. 3003: improvements to the physician feedback program.
- ☆ Sec. 3007: value-based payment modifier under the physician fee schedule.

- ☆ Sec. 3401: productivity adjustment regarding the ASC fee schedule.
- ☆ Sec. 4103: Medicare coverage of an annual wellness visit providing a personalized prevention plan.
- ☆ Sec. 6003: physician self-referral for imaging.
- ☆ Sec. 6404: maximum period for submission of Medicare claims.

AGA is pleased to report that effective Jan. 1, 2011, the PPACA waives the Part B deductible for tests that begin as CRC screening tests but, based on findings during the test, become diagnostic or therapeutic services. AGA advocated heavily for this change. Additionally, the PPACA extends the preventive focus of Medicare coverage to provide for annual wellness visits during which beneficiaries receive personalized prevention plan services; AGA views this as an opportunity to counsel beneficiaries on CRC screenings.

In subsequent comments on the 2011 physician final rule, AGA addressed GI codes that had interim relative value units for 2011; disagreement with CMS' decision to recommend a resurvey of potentially misvalued codes affecting GI [43235 (upper GI endoscopy, diagnosis); 43239 (upper GI endoscopy, biopsy); 45380 (colonoscopy and biopsy); and 45385 (colonoscopy and polypectomy)]; and the assignment of the correct global period for current procedural terminology (CPT) code 46930 (destruction of internal hemorrhoids).

2010 Regulatory Affairs Highlights

Continued from page 14

2011 Hospital Outpatient Departments and Ambulatory Surgery Centers

AGA provided detailed comments to CMS on their proposed and final rules affecting HOPDs and ASCs focusing on:

- ☆ Upper GI CPT code reassignment within the ambulatory payment classification (APC) system (APC 0141/0422).
- ☆ Reassignment of 43240 (upper gastrointestinal endoscopy, including esophagus, stomach, and either the duodenum and/or jejunum, as appropriate; with transmural drainage of pseudocyst from APC 0141 to APC 0384, GI procedures with stent).
- ☆ Wage index.
- ☆ Secondary rescaling of APC relative weights for ASCs.
- ☆ ASC conversion factor and productivity adjustment.
- ☆ Extension of waiver of deductible to services furnished in connection with or in relation to a CRC screening test that becomes diagnostic or therapeutic.
- ☆ Cost reporting.
- ☆ Reporting ASC quality data.

As in the physician fee schedule rule, AGA was pleased that the rules waive the beneficiary cost-sharing for most Medicare-covered preventive services, including CRC screening in the HOPD and ASC settings. In subsequent comments to CMS on the final HOPD/ASC rules, AGA again advocated for creation of a new APC payment group for upper GI endoscopy and advocated that CMS update ASC payments using the same methodology it uses to update HOPD payments.

2011 Inpatient Hospital Proposed Rule

The GI societies and the American Neurogastroenterology and Motility Society sent a letter to CMS on the hospital inpatient proposed rule for 2011 regarding an issue related to gastroparesis. As a result of our comments, we

were successful in preventing an edit that would have prohibited use of idiopathic gastroparesis as a primary diagnosis. AGA also successfully addressed this issue through the International Classification of Diseases-9 Coordination and Maintenance Committee.

☆ Correspondence

Meaningful Use of EHRs

The AGA, in conjunction with our sister societies, submitted detailed letters to CMS and the Office of the National Coordinator (ONC) on Health Information Technology on the meaningful use of electronic health records to enable providers to qualify for Medicare or Medicaid bonus payments starting in 2011. Our comments helped influence a more workable final rule as CMS and ONC relaxed the threshold requirements for meeting Stage 1 criteria. AGA hosted a webinar for members on these rules.

Ambulatory Surgery Centers

In 2010, AGA attended a meeting with CMS officials on ASC issues as part of a coalition of specialties advocating for CMS to update ASC payments by the hospital market basket instead of the consumer price index-urban. We also discussed adding other procedures to the ASC list and the impact of decreases in recent ASC payments since the implementation of a new payment system.

AGA submitted comments to HHS on their “Action Plan to Prevent Healthcare-Associated Infections in Ambulatory Surgical Centers.” We were pleased that the HHS action plan proposed endoscopy reprocessing as a specific area that is likely to benefit from quality measures development. We indicated that the AGA Digestive Health Outcomes Registry will capture data related to CRC prevention performed in all facility and non-facility settings, including ASCs, and can be used to help improve quality.

FDA Initiatives

As part of the Alliance of Specialty Medicine, AGA submitted detailed letters to the FDA on their transparency initiative and on their proposed revisions of the 510(k) process used to approve new medical devices. In addition, the alliance met with FDA officials regarding post market surveillance issues and the 510(k) issues with the Center for Devices and Radiological Health.

AGA submitted comments to both the FDA and CMS on its proposed process for the parallel review of drugs and devices for FDA marketing approval or clearance and CMS national coverage determinations.

Health Reform Implementation

As a result of passage of the PPACA, AGA has addressed the regulatory implementation of a number of provisions through letters to federal agencies including:

- ☆ National health-care quality strategy and plan proposed by AHRQ.
- ☆ Interim final rules for group health plans and health insurance issuers relating to coverage of preventive services to HHS, advocating for the inclusion of CRC screening.
- ☆ Physician resource use reports to CMS.
- ☆ Physician compare website to CMS.
- ☆ IOM study on essential health benefits to HHS, advocating for colonoscopy and other CRC screening methods as an essential benefit for private insurance plans.

Electronic Prescribing of Controlled Substances

AGA submitted comments to the Drug Enforcement Administration in June 2010 on their interim final rule for the electronic prescribing requirements for controlled substances, in follow-up to our comments from September 2008. We were pleased that the interim final rule provided a number of improvements to the proposed regulation, however, AGA provided additional comments on areas of improvement such as signature and transmission requirements, audit requirements, liability concerns, recordkeeping and cost impact.

☆ Regulatory Nominations

To further ensure the needs of gastroenterology are met on a national level, AGA continues to nominate GIs to federal regulatory panels and boards. The AGA submitted a list of gastroenterologists to serve on the FDA Gastrointestinal Drugs Committee and the FDA Gastroenterology-Urology Devices Panel. These appointments are currently under evaluation by the FDA. ★

The Necessity of Grassroots Action

As the government becomes increasingly involved with health care, it is crucial for AGA to have a robust grassroots program. The results of the November 2010 elections showed the power of grassroots advocacy.

Physicians Enter Congress

A significant number of physicians understood their responsibility as medical professionals and Americans to become politically active — many wielded their power as medical professionals, ran for Congress and won. The new Republican majority is concerned about the country's deficit and will focus on making cuts to spending. Whether physicians are in Congress or politically active within their own districts, it has never been more important for gastroenterologists to take part in the legislative process.

According to Rep. Bill Cassidy, R-LA, the only gastroenterologist in Congress, "GIs should understand that there is no substitute for actively participating in a candidate's political career from the beginning. Early support is important to a successful campaign and not soon forgotten by the candidate." Constituents and national membership organizations play an ever-increasing role in public policy-making.

New Congressmen Look to Constituents

There were amazing landslides and surprising outcomes in the 2010 elections that befuddled even the most seasoned political pundits. However, making the transition from candidate to legislator is a challenge for freshmen in Congress. These new members must learn the intricacies of health-care policy in a very short period of time. Legislators must listen to their constituents' concerns and views if they want to be re-elected.

Elected officials place great emphasis on what you have to say, not only because as a constituent you will vote, but also because as a GI, you are viewed as an expert on issues affecting the practice of gastroenterology and medicine in general. As new members and their staffs adjust



to Congress, they will be seeking to build relationships with professionals in their districts, such as physicians, to educate them on the specific health-care issues affecting their voters. Issues can range from the flawed Medicare reimbursement formula, proposed cuts to NIH funding or medical liability reform.

Grassroots Advocacy Takes Hold

Political affiliation should not restrict anyone. Your legislators represent the entire district or state — Republicans, Democrats and Independents alike. You need not be a member of their political party to talk with them. This past year, AGA launched its Congressional Advocates Program (CAP) and we have seen many of our members volunteer to be the voice of our gastroenterology to their elected officials. With the PPACA being tweaked, implemented or defunded, it is important for congressional members to hear from GIs and for you to bring your message to policymakers.

This past election cycle, the American public and politicians experienced how grassroots advocacy can strongly influence campaigns. The main factor behind this surge was the increasing ease and importance of communication via social media. The majority of congressional staffers agree that personal communications from constituents have the most influence on an undecided member of Congress. Politics have their greatest impact at the community level.

AGA Provides Outreach Tools

The AGA grassroots advocacy program offers many tools to help GIs stay connected to Washington. There are many medical specialty

AGA's Grassroots Advocacy Program

groups in DC vying for the finite attention of legislators, so the more attention gastroenterology can generate on the local level, the better our chances of success.

Volunteers to the AGA CAP will be provided with an AGA advocacy guide, a thorough manual on how to effectively build relationships with elected officials. AGA members can connect with lawmakers using the AGA CapWiz system (www.gastro.org/advocacy). AGA is adding advocacy tools to the AGA Facebook page to make it even easier for members to directly contact their elected officials about the issues of most importance to them and to invite colleagues and friends to take action on behalf of gastroenterology. By subscribing to the *AGA Washington Insider* policy blog (www.agapolicyblog.org/) and the AGA YouTube channel (www.youtube.com/amergastroassn), you can keep track of the important legislative and political issues affecting gastroenterology.

What AGA is Doing on Your Behalf _____

The AGA develops and implements a rigorous public policy agenda. This agenda includes issues relating to clinical practice and biomedical research in practice and academic environments.

AGA's professional staff interacts with Congress and regulatory agencies on an ongoing basis to promote and protect the interests of gastroenterologists and their patients. We also play a leadership role in forming and participating in coalitions on many issues in order to maximize our effectiveness in advocacy campaigns.

On a daily basis, we:

- ☆ Meet with congressional offices to ensure fair payment for GI services.
- ☆ Encourage Congress to ensure patient access to life-saving CRC screening and other GI services.
- ☆ Work with congressional leaders to encourage adequate funding for digestive diseases research.

- ☆ Collaborate with NIH to advance the recommendations of the National Commission on Digestive Diseases.
- ☆ Use AGA's political action committee to help give gastroenterology a greater voice on Capitol Hill.

Ten Ways to Become More Politically Active _____

1. Learn and understand AGA's legislative positions and how to effectively communicate with your elected representatives.
2. Help educate AGA members within your community on how health-care issues will affect gastroenterology and why it is important to become involved in the political process.
3. Establish a continuing personal relationship with your elected officials. As a constituent and an expert on GI, your opinion will be asked on the current status of health-care reform and any other pertinent federal legislation.
4. Foster your constituent relationship to keep communication open and become an ally to your legislator.
5. Stay up to date on your federal legislators' voting history and activities and express your opinion. Your stature as an advocate will grow as will their understanding of AGA's policy positions.
6. Invite your legislators to various community activities, such as small social gatherings or award ceremonies with other GI members present.
7. Invite Congress members to tour your office, clinic or hospital, which will allow them to be informed of the day-to-day life of a GI.
8. Stay up to date about upcoming local political functions and fundraisers.
9. Become personally and financially involved in the campaign of local incumbents or candidates who are proponents of GI issues.
10. Contact Lauren DePutter at ldeputter@gastro.org or 240-482-3221 to join the AGA's Congressional Advocates Program. ★

The AGA PAC

The AGA uses our political action committee (AGA PAC) as a tool to show support for candidates who understand and champion issues important to gastroenterologists. The AGA PAC complements our active grassroots program, which shows legislators that their gastroenterology constituents support or oppose a specific position on an issue. Since its inception in April 2006, AGA PAC has received contributions from more than 950 members, over 360 of who have generously given more than once.

AGA PAC contributes to federal candidates who support:

- ☆ Obtaining reasonable Medicare reimbursement rates.
- ☆ Increasing federal funding for biomedical research.
- ☆ Encouraging medical liability reforms.
- ☆ Protecting Medicare beneficiary access to high-quality specialist services.
- ☆ Easing regulatory burdens on gastroenterologists.

The AGA PAC Board of Advisors followed an aggressive contribution strategy during the 2010 elections with a focus on friendly incumbents and candidates. AGA PAC contributed \$157,000 to 71 candidates and members of Congress over the course of the 2010 cycle. ★

AGA PAC’s 2010 Election Contributions: U.S. Senate



Sen. Murray



Sen. Enzi

Who	AGA PAC Contribution	Election Outcome
Sen. Daniel Coats, R-IN	\$2,000	W
Sen. Kelly Ayotte, R-NH	\$2,000	W
Sen. Arlen Specter, D-PA	\$2,000	L
Sen. Barbara A. Mikulski, D-MD	\$1,000	W
Sen. Ben Nelson, D-NE	\$1,000	*
Sen. Blanche L. Lincoln, D-AR	\$1,000	L
Sen. Charles E. Schumer, D-NY	\$1,000	W
Sen. Harry Reid, D-NV	\$4,000	W
Sen. John McCain, R-AZ	\$2,000	W
Sen. Michael B. Enzi, R-WY	\$1,000	W
Sen. Michael Bennet, D-CO	\$2,000	W
Sen. Mike Crapo, R-ID	\$2,000	*
Sen. Patty Murray, D-WA	\$5,000	W
Sen. Robert Menendez, D-NJ	\$1,000	W
Sen. Ron Wyden, D-OR	\$1,000	W
Sen. Sherrod Brown, D-OH	\$3,000	*
Sen. Ben Cardin, D-MD	\$1,000	*
Candidate Trey Grayson, R-KY	\$2,000	L
Rep. Michael N. Castle, R-DE	\$2,000	L
Rep. Kendrick Meek, D-FL	\$2,000	L
Rep. Mark Kirk, R-IL	\$3,000	W
Rep. Roy Blunt, R-MO	\$4,000	W

* Was not up for election.



AGA PAC's 2010 Election Contributions: U.S. House



Rep. Cassidy



Rep. Jackson



Rep. DeLauro



Rep. Pitts

Who	AGA PAC Contribution	Election Outcome
Rep. Bill Cassidy, R-LA	\$7,000	W
Rep. Bill Pascrell Jr., D-NJ	\$2,000	W
Rep. Bobby Rush, D-IL	\$3,000	W
Rep. Charles W. Boustany Jr., R-LA	\$1,000	W
Rep. Earl Blumenauer, D-OR	\$1,000	W
Rep. Eliot Engel, D-NY	\$1,000	W
Rep. Erik Paulsen, R-MN	\$2,000	W
Rep. Fortney H. Stark, D-CA	\$6,000	W
Rep. Frank Pallone Jr., D-NJ	\$3,000	W
Rep. Fred Upton, R-MI	\$2,000	W
Rep. Gene Green, D-TX	\$1,000	W
Rep. Geoff Davis, R-KY	\$3,000	W
Rep. James E. Clyburn, D-SC	\$1,000	W
Rep. Janice D. Schakowsky, D-IL	\$1,000	W
Rep. Jesse Jackson Jr., D-IL	\$1,000	W
Rep. Jo Bonner, R-AL	\$1,000	W
Rep. John Barrow, D-GA	\$1,000	W
Rep. John D. Dingell, D-MI	\$2,000	W
Rep. John F. Tierney, D-MA	\$1,000	W
Rep. John Fleming, R-LA	\$1,000	W
Rep. John Shimkus, R-IL	\$2,000	W
Rep. Joseph R. Pitts, R-PA	\$3,000	W
Rep. Lois Capps, D-CA	\$2,000	W
Rep. Mary Bono Mack, R-CA	\$1,000	W
Rep. Michael A. Arcuri, D-NY	\$6,000	L
Rep. Michael C. Burgess, R-TX	\$2,000	W
Rep. Michael J. Rogers, R-MI	\$1,000	W
Rep. Michael E. Capuano, D-MA	\$2,000	W
Rep. Mike Ross, D-AR	\$1,000	W
Rep. Nancy Pelosi, D-CA	\$4,500	W
Rep. Nydia M. Velazquez, D-NY	\$1,000	W
Rep. Patrick J. Tiberi, R-OH	\$1,000	W
Rep. Richard E. Neal, D-MA	\$2,000	W
Rep. Rodney Alexander, R-LA	\$1,000	W
Rep. Ron J. Kind, D-WI	\$2,000	W
Rep. Rosa DeLauro, D-CT	\$3,000	W
Rep. Paul Ryan, R-WI	\$1,000	W
Rep. Sander M. Levin, D-MI	\$1,000	W
Rep. Shelley Berkley, D-NV	\$1,000	W
Rep. Steny H. Hoyer, D-MD	\$4,000	W
Rep. Steve Kagen, D-WI	\$2,500	L
Rep. Earl Pomeroy, D-ND	\$8,000	L
Rep. Zack Space, D-OH	\$4,000	L
National Republican Congressional Committee	\$5,000	Won Majority

Physicians in the 112th Congress

The contentious debate over health-care reform motivated physicians to become politically active in a variety of ways, including running for Congress, and the historic 2010 elections ushered in several new physician members. Altering or defunding the PPACA will remain the focus of the new House Republican majority and AGA hopes the physician members of Congress will bring their expertise to the policy debate.

The AGA congratulates the congressional newcomers and looks forward to continuing its work with Congress to promote and protect the interests of gastroenterologists and their patients.

MDs in the 112th Congress

- ☆ Rep. Dan Benishek, MD, R-MI, General Surgery*
- ☆ Rep. Charles Boustany, MD, R-LA, Cardio-Thoracic Surgery
- ☆ Rep. Paul Broun, MD, R-GA, Family Medicine
- ☆ Rep. Larry Bucshon, MD, R-IN, Cardio-Thoracic Surgery*
- ☆ Rep. Michael Burgess, MD, R-TX, OB/Gyn
- ☆ Rep. Bill Cassidy, MD, R-LA, Gastroenterology
- ☆ Rep. Donna Christian-Christiansen, MD, D-VI, Family Medicine
- ☆ Rep. Scott DesJarlais, MD, R-TN, General Medicine*
- ☆ Rep. John Fleming, MD, R-LA, Family Medicine
- ☆ Rep. Phil Gingrey, MD, R-GA, OB/GYN
- ☆ Rep. Andy Harris, MD, R-MD, Anesthesiology*
- ☆ Rep. Nan Hayworth, MD, R-NY, Ophthalmology*
- ☆ Rep. Joe Heck, MD, R-NV, Emergency Medicine*
- ☆ Rep. Jim McDermott, MD, D-WA, Psychiatry
- ☆ Rep. Ron Paul, MD, R-TX, OB-GYN*
- ☆ Rep. Tom Price, MD, R-GA, Orthopedic Surgery
- ☆ Rep. David “Phil” Roe, MD, R-TN, OB/GYN
- ☆ Sen. Rand Paul, MD, R-KY, Ophthalmology
- ☆ Sen. Tom Coburn, MD, R-OK, Family Medicine
- ☆ Sen. John Barrasso, MD, R-WY, Orthopedic Surgery

**Newly elected member of Congress*
