



STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

**Democratic Steering and Policy Committee
United States House of Representatives**

Re: Urgent Need for Health System Reform

Presented by: J. James Rohack, MD

September 15, 2009

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The American Medical Association (AMA) appreciates the opportunity to testify on behalf of our physician and medical student members before the House Democratic Steering and Policy Committee regarding health system reform. We commend Speaker Pelosi and the chairmen of the Committees on Energy and Commerce, Ways and Means, and Education and Labor for their leadership in developing a framework to transform our nation's health care system and in successfully moving H.R. 3200 through committee mark-ups prior to the August recess.

With millions of Americans uninsured and millions more afraid of losing their health insurance, the status quo is unacceptable. The AMA is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms this year that include the following seven critical elements:

- Provide affordable health insurance coverage for all Americans
- Enact insurance market reforms that expand choice of affordable coverage and eliminate pre-existing conditions
- Assure that health care decisions are made by patients and their physicians, not by insurance companies or government officials
- Provide investments and create incentives for quality improvement and prevention and wellness initiatives
- Repeal the Medicare physician payment formula that will trigger steep cuts and threaten seniors' access to care
- Implement medical liability reforms to reduce the cost of defensive medicine
- Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

The challenges in our health care system are many and complex. Enactment of the above policies will create the foundation for a stronger, better performing health care system, improve access to affordable, high-quality care, and reduce unnecessary costs. Further, those who are currently insured, including Medicare patients, and those who are uninsured

will all benefit from greater security and stability. The AMA and our individual members are working hard to improve health care delivery through a broad range of initiatives to promote quality and reduce unnecessary costs.

Congress has an historic opportunity to improve the health and well-being of the American public by enacting health system reform this year that includes the elements outlined above and discussed in further detail in our testimony. We reaffirm our commitment to work with you and the President to adopt and implement health system reforms that will benefit all Americans.

Affordable Health Insurance Coverage and Health Insurance Market Reforms

The AMA supports making affordable health insurance available to all Americans. Improving access to health insurance is the first step toward assuring that all Americans have timely access to the health care services they need. According to the Institute of Medicine, those without insurance are more likely to die prematurely than those with coverage—18,000 unnecessary deaths are attributable to lack of health coverage every year. Patients without health insurance are less compliant with treatment plans, avoid preventive services, and miss appointments to manage their chronic conditions.

A key component to providing all Americans with health insurance coverage is ensuring that individuals can afford such coverage. The average annual premium for employer-sponsored health insurance has increased by 119 percent since 1999, making health insurance coverage out of reach for many Americans. Thus, as provided in the bill, **we support providing tax credits or subsidies that are inversely related to income, refundable, and payable in advance to low-income individuals who need financial assistance to purchase private health insurance.** Upon implementation of subsidies or tax credits for those who need financial assistance obtaining coverage, the AMA believes everyone should have the responsibility to obtain health insurance.

The AMA believes that a combination of insurance market reforms and health care exchanges offering a variety of affordable private insurance plans can also increase access to health insurance coverage. Market reforms should create a more competitive insurance market in which plans compete on price and quality, allowing patients to gain more control over their choice of health insurance coverage and their own care. **The AMA supports the insurance market reform provisions in H.R. 3200 relating to guaranteed issue, guaranteed renewability, modified community rating, pre-existing condition limitations, nondiscrimination based on health status, adequacy of provider networks, and transparency.**

A health insurance exchange or exchanges will increase individual choice, facilitate plan comparisons, and streamline enrollment to assist individuals in choosing coverage that best suits their needs. Insurance should also be portable. Insurers should provide understandable and comparable information about their policies, benefits, and administrative costs to empower patients, employers, and other purchasers and consumers to make more informed decisions about plan choice. Moreover, the AMA supports transparency to prospective enrollees and regulatory bodies regarding reporting of medical loss ratios by insurers, including the development and implementation of a uniform,

national accounting and reporting system to report administrative expenses and medical expense ratios.

The AMA supports the provisions in H.R. 3200 that build on the current employer-based system of providing coverage, while encouraging new sources of health insurance that would be available to both the uninsured and the currently insured through an improved insurance market. Individuals who are satisfied with their existing coverage should be able to maintain that coverage. Those who are uninsured or dissatisfied with their current coverage should be able to purchase the coverage they want. One of the goals of reform should be to give patients more control over their choice of health insurance coverage and their own care, and to preserve and improve the patient-physician relationship. **It is essential to ensure that health care decisions are made by patients and their physicians, not by insurance companies or government officials.**

Health insurance coverage alone cannot ensure access to care. The AMA supports helping low-income individuals obtain health insurance coverage, and believes the safety net provided by public programs needs to be maintained and strengthened. **We support basic national standards of uniform eligibility for all persons below the poverty line, and the elimination of existing categorical requirements, which would allow for the coverage of low-income individuals based solely on financial need.** All individuals eligible for Medicaid and Children's Health Insurance Program (CHIP) should be allowed to purchase coverage through a health insurance exchange, and should have the option of using public funds to help them purchase employer-sponsored health coverage. Outreach efforts to encourage enrollment in Medicaid and CHIP should be improved and expanded, with adequate funding. The provisions in the bill are generally consistent with AMA policy.

Access to care for Medicaid beneficiaries becomes more limited when physicians cannot afford to accept them as patients. Limited access to care significantly impacts the level, frequency, and location (e.g., emergency room) of care recipients receive, potentially resulting in increased costs and poorer health outcomes. To encourage widespread physician participation, payment levels must be sufficient to cover provider costs. While we support enhanced primary care rates, we believe that reimbursement rates should be increased for all services, and enhanced rates for primary care should not come at the expense of other physician payments.

The AMA believes that a reformed private insurance market, with a health insurance exchange that provides a variety of plans from which to choose, would achieve the goals of expanding health insurance coverage and lowering costs. We remain open, however, to considering alternatives to provide competition from a non-profit entity that is self-supporting, subject to the same solvency requirements as private plans, does not receive special advantages from government subsidies, does not link physician payment rates to Medicare rates, and where enrollees have access to the sort of out-of-network benefits that are available in private plans. **We are pleased that H.R. 3200 would not mandate Medicare provider participation in a public health insurance plan, and that an amendment was adopted providing that physician payment rates in the public option would be negotiated and not directly linked to Medicare. We view this as a significant improvement and urge Congress to retain these provisions.**

At our annual meeting last June, the AMA House of Delegates renewed our support for protecting the fundamental right of patients to privately contract with physicians, without penalties for doing so and regardless of payer within the framework of free market principles. The current two-year Medicare program exclusions for physicians who privately contract unnecessarily limits choices for beneficiaries as well as for physicians. **We will continue to advocate for language in health system reform legislation to ensure that patients have the ability to privately contract with their physician, free of any penalties and regardless of payer.**

Enhancing Patient/Physician Decision-Making and Investing in Quality, Prevention, and Wellness

Physicians understand the value of keeping patients healthy, and improvements in the overall health status of all Americans will serve to rein in costs and improve productivity. As provided for in the bill, insurance benefit designs should be aligned with current evidence on disease prevention and should also support early access to care for mental health and substance abuse disorders. There also should be increased investment in research to fill gaps in knowledge about the most effective health promotion strategies. Public investments are needed in education, community projects, and other initiatives that promote healthy lifestyles, as well as in core public health infrastructure. In addition, because racial and ethnic health disparities are a major public health problem in the United States and a barrier to effective medical diagnosis and treatment, special emphasis should be placed on collecting data and developing strategies to eliminate regional, racial, ethnic, and gender health disparities. We urge Congress to retain these important prevention and wellness provisions in the bill.

Further, the AMA has long been and continues to be committed to the development of quality improvement initiatives that increase the quality of care provided to patients. To assist in these efforts, the AMA has been the leading developer of physician-level measures and has been actively involved in engaging private sector health insurers and the Centers for Medicare and Medicaid Services (CMS) regarding implementation of various quality programs using physician data. We also support various quality improvement initiatives, discussed below, in connection with Medicare physician payment. We urge Congress to include quality improvement provisions in health system reform legislation that support providing real time data at the point of care and using measurement as a quality improvement tool. We appreciate that the House bill improves the Physicians Quality Reporting Initiative (PQRI) by requiring more timely feedback, an appeals process, and extension of PQRI bonus payments through 2012. These are welcome changes that will go a long way toward helping physicians participate successfully in the program. We also believe it is important for the physicians to have a prior opportunity to verify that the data CMS uses to determine whether they successfully participate in the PQRI are the correct data, as reported to CMS by the physician. This verification process should be user-friendly as well.

The AMA believes that an essential component of health care reform entails the investment in research that will expand the evidence-base of clinical information that supports patient and physician decision-making. Currently, there remains far too little

rigorous evidence available about which treatments work best for which patients. The AMA strongly supports establishing an independent entity to support comparative effectiveness research (CER) and believes that increasing funding for CER and the networks used by physicians to utilize evidence-based medicine promises to transform and dramatically improve health care outcomes. **CER must not be used as a tool by the government or insurers to dictate patient care. As stated above, it is essential that health system reform legislation ensure that health care decisions are made by patients and their physicians.** We are pleased that amendments to H.R. 3200 were adopted that would clarify that CER will not be used to deny or ration care nor be used as a basis to make Medicare national coverage determinations. Widespread adoption and trust of CER will be heavily correlated to the role and participation by practicing physicians in the CER enterprise. We strongly urge Congress to support CER, and ensure that a new CER entity provides a central role for practicing physicians. Although there are a broad array of areas where CER would bring benefits, the AMA supports strategically targeting funding for CER where it will significantly improve health care value by enhancing physician clinical judgment, foster the delivery of patient-centered care, and produce substantial benefit to the health care system as a whole.

Repeal the Medicare Physician Payment Formula

The AMA greatly appreciates the House of Representatives' recognition that the Medicare physician payment formula, called the "sustainable growth rate" (SGR), is fatally flawed and must be fixed to avoid steep cuts that threaten Medicare access to care and undermine broad-based health reform efforts. Repealing the SGR is a critical element that must be included in any health system reform legislation passed by Congress. We are pleased that the new target growth rates proposed in the House legislation are not limited to GDP growth; however, we are concerned that the new system could still lead to significant pay cuts in future years, and we urge inclusion of design features that will preclude negative payment updates.

The physician and allied health community face over a 21 percent Medicare payment cut on January 1, 2010, and further substantial cuts over the next several years. Physicians and allied health professionals cannot absorb cuts of this magnitude nor continue to face the threat of cuts each year. In addition, the Centers for Medicare and Medicaid Services has released data showing that, even before the cuts, physicians are only being reimbursed for half of the labor, supply, and equipment costs that go into each physician service, which further exacerbates the effect of these payment cuts. Without Congressional action to repeal the SGR, Medicare seniors and disabled patients stand to lose significant access to their physicians.

A stable, predictable payment system is needed to allow physicians to plan ahead for practice innovations, investments, and personnel decisions that are fundamental to improved care coordination, chronic disease management, and quality of care initiatives. It will also help sustain the physician workforce, which policy makers acknowledge will experience severe shortages in the near future, just as the baby boomer generation begins entering the Medicare program.

Further, a stable Medicare physician payment foundation is essential for new payment models and delivery reforms that promise incentives for high quality care and improved care coordination, promote primary care and preventive services, and encourage wellness initiatives and management of chronic conditions that are responsible for a high proportion of costs for Medicare and privately insured patients.

We understand that the status quo is not sustainable, and the physician community is willing to embrace significant changes to help reform the Medicare program. This has been demonstrated by our support for comparative effectiveness research, our support for incentive programs to encourage electronic prescribing and the adoption of health information technology, and our efforts to develop new performance measures and appropriateness criteria. We also support and are encouraged by the pilot programs in the House legislation (*e.g.*, the medical home, accountable care organizations, gainsharing) that will help develop and test innovative alternative payment reforms.

We believe these programs should be undertaken in a flexible and dynamic process in which multiple models in a variety of practice settings can be tested and refined, and where information about problems and solutions are collected and shared across programs and regions to facilitate mid-course corrections. This effort will allow us to accumulate the data and experience needed to enable wider implementation of beneficial reforms (although we would not support a mandatory requirement that physicians participate in any particular reform model).

We fully expect that these initiatives will generate system-wide savings over the long-run by avoiding hospitalizations and other costly interventions. However, with expanded access to these services the volume of physician visits and other services will increase in the short-term. If a target system remains in place, the activities policymakers want to promote are likely to trigger additional payment cuts in future years. Therefore, any efforts to build new payment models to promote health care delivery system improvements and practice innovations simply cannot succeed without first addressing the barrier presented by the SGR formula.

While we continue to believe Medicare must move away from a target-based approach based on volume rather than value, we appreciate that the House legislation makes a considerable investment dedicated to repealing the SGR and look forward to working with Congress to further develop an approach that ensures that Medicare payments for physicians' services accurately reflect increases in medical practice costs while rewarding value-based, high-quality, cost-effective services.

Finally, we do not support an independent council that would establish budget-neutral Medicare payment updates for physicians and various other providers, and appreciate that the House bill does not include such a provision. This type of proposal would allow little significant opportunity for Congress, the Centers for Medicare and Medicaid Services, and stakeholders to provide input into the process. Further, the budget neutrality aspect of such proposals could exacerbate physician payment cuts since a Medicare physician target system remains in place.

Implement Medical Liability Reforms to Reduce the Cost of Defensive Medicine

The AMA was very pleased to hear the President acknowledge last week before a Joint Session of Congress that medical liability reforms should be explored to address the costs associated with defensive medicine. The cost of our liability system is borne by everyone as defensive medicine adds billions of dollars to the cost of health care each year, which means higher Medicare spending and health insurance premiums for patients. **We are encouraged by the medical liability reform amendments to H.R. 3200 adopted by the House Energy and Commerce Committee, and urge Congress to retain these amendments as health system reform legislation progresses.**

The House Energy and Commerce Committee's amendments to H.R. 3200 include financial incentives to eligible states that enact alternative medical liability reforms such as early offers and certificate of merit programs, and liability protections for volunteer physicians in qualifying health centers. These provisions exemplify the potential liability reform solutions needed for protecting patients' access to care and slowing the rising cost of health care. Although the AMA strongly favors the proven reforms enacted in California and Texas, including a \$250,000 limit on non-economic damages, we also support alternative reforms that have demonstrated potential to help improve the medical liability system. For states that have not been able to pass comprehensive medical liability reform laws, we support federal funding to support pilot projects on a wide range of liability reform alternatives, including health courts, early disclosure and compensation programs, administrative determination of compensation model, expert witness qualifications, and liability protections for use of evidence-based medicine guidelines. **We also believe it is imperative that existing effective state-level medical liability reforms be preserved.**

Streamline and Standardize Insurance Claims Processing Requirements

The AMA believes that health system reform must include finding solutions to promote transparency and achieve the simplification of health care administration and its associated cost savings. The AMA's National Health Insurer Report Card demonstrates that there is enormous variability and lack of transparency in the current health care billing, payment and claims reconciliation process. The AMA's "Heal the Claims Process[™]" campaign aims to reduce administrative waste from the health care system, and specifically focuses on reducing the cost physicians incur just to get paid from a current industry average of 10–14 percent of revenue to 1 percent. However, everyone involved in the health care system—payers, employers, patients and health care providers—would benefit substantially from the simplification and streamlining of the current claims process. **Studies indicate that billions of dollars could be saved through standardization and simplification of the health care billing, payment, and claims reconciliation process.**

To accomplish administrative simplification, the AMA specifically recommends the following be incorporated in the final version of H.R. 3200: (1) the adoption of a single, binding, uniform companion guide for each of the standards for version 5010 and require its use within a specified period of time (version 5010 is the updated version of the HIPAA electronic transactions required for use by physicians and others on January 1, 2012); (2) the adoption and use of a single, mandated ICD-9 CM to ICD-10 CM and ICD-10 PCS

cross walk, which must be effective October 1, 2013, and which must be available publicly without charge; (3) the adoption and use of binding operational guidelines and instructions for each of the standards code sets; (4) the adoption and use of uniform claim edits and payment rules; (5) increased enforcement of the HIPAA requirements, facilitated with an annual audit and certification process to ensure that all health plans and clearinghouses are both syntactically and functionally compliant with standard transactions; (6) clear definitions for critical terms such as “companion guide,” “code set,” “standard,” and “operating rules” to avoid multiple interpretations; and (7) assurance that the Secretary of HHS utilizes and coordinates existing entities, both public and private, and other multi-stakeholder organizations (including physicians) that are engaged in efforts to improve the functionality of the HIPAA transactions and code set standard.

Other Issues

In order to provide affordable, high-quality health care coverage to all Americans, we need a well-prepared, well-distributed, and diverse health care workforce to ensure patient access to care. While we are encouraged with H.R. 3200’s focus on graduate medical education (GME), the AMA believes that the proposal to fill vacant GME resident slots alone will not be enough to address the predicted physician shortages, and ensure that we have a fully trained physician workforce available to serve the needs of patients. An article published in the *Journal of the American Medical Association (JAMA)* in 2008 projects that at least 21,000 additional residency positions will be needed within the next decade to keep pace with the projected increment of more than 5,300 additional MD and DO graduates from U.S. allopathic and osteopathic medical schools. **The AMA recommends the following additional GME actions to ensure an adequate physician workforce: (1) maintain adequate and stable Medicare and Medicaid GME funding levels; (2) investigate additional sources of GME funding (e.g., private payers); (3) authorize new funding to increase Medicare supported GME positions in primary care, general surgery, and other undersupplied specialties, as well as in underserved areas; and (4) bring together a variety of health care experts (including practicing and teaching physicians and other health professionals) to assess and make recommendations on (a) our physician workforce needs, (b) the number of needed GME positions, and (c) the source, use, and distribution of GME funds.**

Along with fully supporting GME, the AMA urges Congress to authorize adequate funding for programs that address the current and future physician workforce needs of the nation, particularly in specialties that face shortages and in underserved areas. The AMA supports increased funding for the National Health Service Corps (NHSC) and Title VII health profession and diversity programs to increase the supply of physicians and other health care professionals, especially in medically underserved communities. The AMA also supports funding for basic nursing education and training programs. We recommend including provisions that would alleviate high medical student debt burdens through lower interest rates on student loans, tuition assistance, loan deferment, and loan forgiveness for service programs for all undersupplied specialties, including programs for medical teaching faculty. In addition, the AMA supports health care workforce assessments that cover all specialties, not just primary care. Further, the AMA recommends a permanent reauthorization of the Conrad State 30 J-1 Visa Waiver Program,

which allows international medical graduates to remain in the U.S. after their residency if they have agreed to practice in a medically underserved location for at least 3 years.

We also urge Congress to include antitrust reforms that provide relief from legal and regulatory impediments to physician collaboration. Antitrust reforms should be considered an essential element of health system reform. Today's health care market warrants a revision of current physician antitrust policy. Professional, market, and regulatory developments are encouraging physicians to collaborate in new ways. In particular, the federal government is encouraging physicians and other providers to invest in health information technology (Health IT) to facilitate the collection and sharing of clinical data. However, the adoption of Health IT requires a level of physician investment and network integration that pose significant barriers to implementation. Also, the emergence of new quality improvement initiatives and reimbursement mechanisms place a premium on physicians' ability to collect and share data and use Health IT. For physicians, who still practice predominantly in small groups, network arrangements provide one way of achieving the economies of scale necessary to participate in these initiatives. Meaningful health system reform should remove obstacles that prevent physicians from forming networks that can jointly negotiate with health plans for the purposes of participating in quality improvement programs and Health IT initiatives. This would enable physicians to invest in and sustain systems that are likely to reduce errors, improve care coordination, and improve quality.

The AMA appreciates the opportunity to provide our views on health system reform, and we look forward to working with Congress and the President to achieve enactment of health system reform this year.