American Medical Association
Physicians dedicated to the health of America

CONFIDENTIAL

TRANSFORMING MEDICARE

and

Other Budget Proposals

June 22,1995

TRANSFORMING MEDICARE

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Other Related Proposals

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EXECUTIVE SUMMARY

The American Medical Association (AMA) urges Congress and the Administration to enact a fundamental restructuring of the Medicare program. The AMA proposal for transforming the Medicare program is designed to enhance the value of the program and to yield savings for most elderly people. The value of the Medicare program can best be increased through improved quality and reduced costs, which, in our proposal, are complementary. Physicians are in a unique position to foster continuous clinical quality improvements and recommend streamlined administrative and financial arrangements.

A wide range of experts have independently concluded that Medicare cannot be sustained without a restructuring. Fortunately, the transformation of Medicare can be accomplished by giving effect to the three principles of operation which the Medicare program was based upon at its inception -- preservation of clinical judgment, patient freedom of choice and individual responsibility. The budgeting implications of many of our proposals have been analyzed by Price Waterhouse and for those alone they estimate scorable savings of $162.2 billion over a seven-year time frame. In addition, the AMA proposals, if continued through FY2002 and beyond, would keep the Medicare Hospital Insurance Trust Fund solvent for at least the next fifteen years.

The reforms we propose are a fundamental shift away from government control toward personal responsibility, choice and an invigorated Medicare marketplace that actually fosters price competition. The reforms are simple, essentially voluntary and they will work.

Under our proposals, a Medicare beneficiaries would have two options. They can:

- stay in the traditional Medicare reimbursement system much as it is today, or

- elect to join a system like the successful, cost-effective Federal Employees Health Benefit Plan (FEHBP). Those who select this option would be able to purchase coverage at any level in any form -- from traditional insurance to an HMO to a catastrophic plan coupled with a Medical Savings Account.

Those who elect to remain in the traditional Medicare experience three changes: (1) there would be only one form of cost sharing -- once the individual met a preset yearly deductible, all costs would be paid by Medicare; (2) there would be no need to purchase medigap insurance; and (3) prices for services would no longer be fixed by the Medicare program. Medicare would continue to reimburse providers a predetermined amount for a particular service. Then based on the price charged by the provider he or she chooses, the beneficiary could either save money or pay the balance to the provider. Through these modest changes, both beneficiary cost-consciousness and provider competitiveness are substantially enhanced.

If beneficiaries elect the FEHBP type plan -- called Medichoice -- they are credited with the amount it would otherwise have cost Medicare and can purchase any kind of coverage they desire. Again, both cost consciousness and provider competition are enhanced and personal choice -- indeed, personal ownership of the insurance subsidy -- is for the first time present. For

the longer term, medical savings accounts are created so that dependence on the program payments is substantially lessened for future generations.

In our proposals, we specifically take into account the situation of those in our society who are most dependent financially on the Medicare program. Those individuals whose incomes are at or below the poverty level are exempt from any Medicare cost sharing. Those with incomes between the poverty level and 150% of that level will face some cost sharing, but that cost sharing will be adjusted on a sliding scale based on income.

These changes will provide at least $63.5 billion in savings to the program. These savings are the result of a shared contribution of both beneficiaries and providers due to improved utilization patterns. Enhanced beneficiary cost consciousness does not mean substantial increased costs for beneficiaries. It is primarily the way that beneficiaries pay today -- not the amount -- that defeats the incentive to use the program efficiently. Our proposal will actually save most beneficiaries money.

We are calling for two additional changes: (1) raising Medicare's eligibility age over time so that it is consistent with Social Security and (2) reducing by a modest amount the Medicare subsidy of high income beneficiaries. These changes will save an additional 13.7 billion dollars. Both of these changes are in line with recommendations of the recent Entitlement Commission and many other independent experts.

Additional Medicare savings can be achieved by rationalizing the funding of our graduate medical education (GME) system. The market place in medical education needs a new set of rules. It has been distorted by three unique American circumstances:

1. the huge amount of care provided by teaching hospitals for which they are uncompensated, or compensated at levels below their actual costs.

2. the cost and length of time needed to produce competent physicians trained in the increasingly technical aspects of medicine; and

3. the widely acknowledged oversupply of some types of specialists.

We propose that Medicare's support of GME be reduced over time and that the private sector play an enhanced role in both work force planning and funding of graduate medical education. All of the entities delivering care today benefit directly or indirectly from the graduate medical education system and yet many contribute very little to it. We recommend a gradual reduction in the number of residency positions and the transition to a GME funding system supported by all payers, including government and the private sector.

The savings in the growth of Part A spending from these changes amount to $13.2 billion. The substantial additional amounts needed to restore balance to the Part A Trust fund -- some $83 billion -- are described in the attached Tab B, Appendix 2, and are drawn largely from the Congressional Budget Office "Options" book addressing the Part A problem. In addressing the

Part A Trust Fund problem, policy-makers should be sensitive to hospitals that make a substantial contribution by providing care to the uninsured and to the need for a gradual transition process.

As Medicare increasingly becomes a means for patients to exercise choice in the private marketplace, costly and complex government regulation of providers and patients can be substantially reduced. Our proposal envisions creation of an unprecedented "Partnership for Health Care Value" organization that focuses private sector efforts, promotes standards of quality, and communicates information about clinical advances that enhance the value of medical care. The Partnership can also coordinate efforts on finding, reporting and eliminating fraud and in educating providers and patients about reducing care of marginal value and increasing preventive care. According to the FBI, physicians are the least likely group to engage in fraud, yet the most useful in its prosecution. A well-publicized AMA/FBI fraud reporting hotline has already produced a substantial increase in our knowledge of where fraud is taking place.

The newly empowered Medicare patient should not be restricted in choice of plans or providers. A problem that must be corrected is the competitive disadvantage of physician-sponsored plans. We propose a simple program of regulatory relief which will stimulate these plans much as Congress did for HMOs in the 1970s. Physicians believe they can ultimately balance the cost and quality equation better than any others in the marketplace, saving substantial amounts which today go to the administration and institutional investors of giant corporate plans.

Medicare costs are rising at a rate that can be reduced by the means recommended here -- we project as much as $200 billion over the next seven years -- but the demand for the best care and for new technology will increase as the elderly population increases in size and sophistication. Even in a perfectly functioning marketplace with all the right incentives, spending on Medicare will rise faster than inflation.

As the nation attempts to strike a balance between enormous technological possibilities and clear resource limits, it is imperative that patients should have as much knowledge about and control over their health care as possible. Patients should be making the choices and their physicians should be their trusted advisors. Insurance plans and health care businesses should compete on the basis of accurate information, on a level playing field, and with recognition of the unique qualities and problems involved in providing medical care. Our proposals for Medicare transformation attempt to achieve the new balance that is required.

The transformation envisioned here will require the understanding and support of beneficiaries, policy makers, physicians and providers, and taxpayers. Physicians can undertake the educational challenge of explaining that changes, such as those outlined here, are necessary if Medicare is to keep its essential promise to all Americans--present and future. Physicians can and will communicate to their patients that quality care need not be sacrificed for budget savings.

Following are specific recommendations. They are described in detail in subsequent tabs of this proposal.

TRANSFORMING AND MODERNIZING MEDICARE (see TAB B)

The following recommendations are the basis for transforming the Medicare program to enhance its long-run fiscal integrity, improve its efficiency, and, in the short run, reduce program outlays.

Our proposal calls for the availability of voluntary, tax-advantaged Medical Savings Accounts (MSAs) to be offered to the non-elderly population to reduce future generations' dependency on Medicare, providing incentives for using accumulated balances to pay for medical care in retirement.

Each Medicare beneficiary would have an expanded set of choices that range from remaining in the restructured traditional Medicare program, to selecting from various health plans (including managed care arrangements), to Medical Savings Accounts. In general, Medicare patients would have enhanced opportunities to make prudent use of medical care resources and to be personally rewarded for those decisions.

1. Beneficiaries can elect to remain in the traditional Medicare program, modified as follows:

   - Beneficiary cost sharing will be restructured to:

     – reduce beneficiaries' average out-of-pocket outlays,

     – make purchasing supplemental medigap policies for Medicare-covered services unnecessary,

     – reward beneficiaries to be more prudent consumers of routine medical services, and

     – reduce beneficiary paperwork and other complications of dealing with Medigap supplemental insurance.

   - Beneficiaries will be provided with information on physician fees (a conversion factor that would be applied to a standard relative value scale) to enable them to shop for value, as outlined below:

     – physicians will set their own charge conversion factor and publicize it to patients,

     – the government will set a payment conversion factor, based on its desired level of beneficiary access, and

     – Patients will select their physician and either pay the difference when the physician charges exceed the government payment or

retain the balance when the government payment exceeds the physician charges.

- Medicare administrative practices will be modernized in such areas as telemedicine, administrative simplification, utilization review procedures, payment for mental health services, application of new technologies, including home health services, and adoption of computerized patient record systems.

2. In lieu of enrollment in the restructured traditional Medicare program, all Medicare-eligible individuals will be able to elect annually to participate in an optional "Medichoice" program based in concept on the Federal Employee Health Benefits Program (FEHBP). Each beneficiary electing the Medichoice option will receive:

   - advance notification of the government contribution (to be actuarially determined) toward the cost of the Medichoice plans for which the individual is eligible,
   - information on participating Medichoice plans in the individual's area,
   - the rates charged by such plans to individuals and
   - a Medichoice election and enrollment form.

   Beneficiaries will either pay the difference when the plan costs exceeds the government contribution or retain the balance when the government contribution exceeds the plan costs.

3. All Medicare-eligible individuals will have the option, in lieu of comprehensive plans (such as traditional Medicare or Medichoice) to establish a "Medical Savings Account" coupled with a catastrophic policy. This will:

   - be funded by the government's annual contribution amount,
   - consist of a fund from which the beneficiary can pay deductible medical expenses and catastrophic medical expense insurance to cover expenses that in aggregate exceed a threshold (the catastrophic insurance deductible),
   - allow unspent balances to accumulate in the fund, and
   - provide for distributions from the MSA fund (exempt from federal and state income tax) for medical expenses, health insurance premiums and/or long-term care.

MSAs would be attractive to many beneficiaries because they could provide funds for purchase of items such as prescription drugs and long-term care.

4. The Medicare subsidy to high income beneficiaries will be reduced by requiring individuals with incomes greater than $50,000 and couples with incomes greater $100,000 to pay additional premiums on a sliding scale.

5. Preventive services should be included in Medicare benefits when availability of such services can be shown to reduce overall program costs.

6. The eligibility age for Medicare will be increased to match the increasing age for full benefits in Social Security that is already law.

QUALITY AND HEALTH PLAN STANDARDS IN A TRANSFORMED MEDICARE PROGRAM (see TAB C)

There should be a minimum set of provisions that plans will meet. In order to allow the market to operate, there shall be maximum flexibility in the means of achieving the requirements. To the greatest extent possible, accreditation by voluntary private sector bodies should be recognized instead of direct government regulation.

1. A Partnership for Health Care Value should be established for the purpose of coordinating and focusing private-sector efforts devoted to practice guidelines development and organizing a structure to guide development and dissemination of improvements in medical practice and health care delivery. The Partnership should be governed by representatives from medical societies, hospital associations, insurers and national managed care companies, accrediting agencies, employers, consumer groups, and the federal government. The Partnership would marshall private sector resources devoted to the development and application of medical standards. The Partnership would work in cooperation with federal agencies such as the AHCPR, HCFA, the National Institutes of Health, and others. The work product of the Partnership would be widely disseminated so that its results could be integrated into a constantly improving health care delivery system. Therefore, federal agencies would have input in setting priorities for the Partnership and in reviewing its results.

2. Plans should disclose information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. Enrollment procedures must be fair to avoid inappropriate market segmentation.

3. Provisions for fair redress of grievances and appeals from plan decisions should be available.

4. Physicians should be involved in developing medical policies and criteria under the program. At the plan level, this should involve physicians, using a medical staff model. Quality management programs will be an integral part of each plan. Procedures will be in place for recognition of private sector accreditation programs.

5. There should be administrative simplification, including uniform electronic and paper claim forms, computerized patient records when available, single local entity to inspect facilities and a standardized credential verification system.

PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS (PCCO) (see TAB D)

1. EMPOWERING EXISTING PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS (PCCOS)

As part of a Medicare reform program that creates a defined contribution plan, PCCOs would be authorized to contract with Medicare beneficiaries without being licensed insurers under state law. These new initiatives can eliminate the higher administrative and return on equity costs of insurance sponsored plans. In order to meet legitimate regulatory needs, HCFA would develop a limited set of criteria that PCCOs would have to meet in order to become qualified. This process would be similar to the procedures for qualifying health maintenance organizations pursuant to the federal Health Maintenance Organization Act of 1974. Those procedures were largely responsible for enabling the creation of numerous HMOs. Similar procedures could facilitate the creation of PCCOs.

2. ELIMINATING REGULATORY BARRIERS TO THE FORMATION OF PCCOS

The laws that interfere with the development of physician/provider sponsored health care delivery networks were developed in an era when physicians and other providers operated independently from each other. The object of these laws is to prohibit cooperative activities between independent providers that will be harmful to the public. These laws should not be eliminated, because they protect the public from harmful conduct. However, in doing so they go too far and interfere with beneficial cooperation among physicians and other providers. Therefore, these laws need to be adjusted to recognize the new economic realities of health care delivery. The legal areas that need adjustment include:

Antitrust.

Enforcement of the antitrust laws should be adjusted to allow physicians and other providers to organize preferred provider organizations, health care delivery networks and health plans that allow for a wide choice of providers, and delivery systems or health plans that offer more than one kind of financing arrangement,

such as the "triple option" which includes an indemnity plan, a PPO plan and an HMO plan.

Self Referral.

Enforcement of bars on self referral should be adjusted to allow for the coordination of care among physicians and other providers in a health care delivery network or health plan, especially when the providers have made a common investment in facilities or equipment for use by the network or health plan.

Fraud and Abuse.

Enforcement of the fraud and abuse laws should be adjusted to allow physician/provider sponsored health care delivery networks and health plans greater flexibility in financial arrangements necessary to recruit physicians and other providers, and in the division of income obtained by the network or health plans among the providers.

Pension Plans.

Adjustments should be made in enforcement of federal tax and employee benefit laws that preclude favorable tax treatment of pension, welfare benefit, or profit sharing plans. These laws currently discourage physicians from uniting to own and govern plans and networks.

State Certificate of Need Laws.

Medicare providers should be exempt from Certificate of Need Laws (CON) laws. These laws discourage the construction of new facilities and the development of new capabilities in existing facilities. This protects existing market participants and chills new competition.

Regulation of Tax Exempt Entities.

The regulation of tax exempt entities can prevent the payment of fair value for physicians who sell their practices to a tax exempt network, and can make it difficult to include tax exempt entities in a new physician/provider sponsored network. In addition, tax regulations limit physician representation on the governing boards and tax exempt health care delivery networks.

Insurance Regulation.

The regulation of physician/provider sponsored health care delivery networks that contract with health plans and do not function as full fledged health plans, should

not be subjected to excessive regulation at the state level.

3. *CLARIFYING THE ANTITRUST LAWS FOR PHYSICIAN NEGOTIATION*

Even if the assistance recommended above is implemented, the dominant insurance systems will grow and continue to merge into even larger systems. Non-physicians will control medical decision-making. Antitrust clarification is needed to support the rights of physicians and other providers to jointly present their views on any matter to insurance plans on behalf of themselves and patients as long as no boycott and price fixing is involved.

MEDICARE FUNDING OF MEDICAL EDUCATION (see TAB E)

1. During a transitional period (FY96 and FY97), change the existing funding formulas for direct medical education payments and indirect medical education adjustment to halt the current steady increase in costs. In this period, introduce differential weighting for a preset number of training positions into the existing funding formula for direct medical education payments and limit full funding to the years leading to general certification by the 24 specialty boards recognized by the American Board of Medical Specialties plus the full length of training programs in geriatrics.

2. Create a private sector physician workforce planning initiative, with governmental participation, to make recommendations about the need for physicians and the funding of graduate medical education. In developing its recommendations, this body should consider such things as specialty mix, geographic distribution and appropriate training for the emerging health system.

3. Re-structure the financing of graduate medical education into an all-payer system and distribute funds to the entity that incurs the costs of training, whether that entity is a medical school, hospital, nursing home or ambulatory clinic.

4. Analyze the current indirect medical education adjustment (IMEA) and consider the development of an appropriate funding mechanism to reimburse for the increased complexity of care/severity of illness in teaching hospitals.

5. By FY99, decrease the number of entry level residency positions funded through the Graduate Medical Education adjustment to 110% of the number of US MD- and DO-graduates in FY95.

FRAUD AND ABUSE (see TAB F)

A public-private program will attack deliberate fraud with a coordinated, resource intensive effort, and the "Partnership for Health Care Value" will establish consensus standards to identify and eliminate waste and abuse, relying on the special expertise of the physician community in

responding to the delivery of inappropriate care.

1. A pluralistic, coordinated anti-fraud program will be established for the public and private sectors, under the leadership of the Department of Justice and the Department of Health and Human Services, with the following characteristics:

   - Clear definitions of fraud and abuse
   - Coordinated enforcement actions by public and private payers, with appropriate exchange of data and information on common fraud schemes
   - New civil and criminal anti-fraud remedies
   - Additional, targeted resources for law enforcement
   - Enhanced fraud reporting by physician and patient groups
   - Improved communication and educational programs for physicians and patients

2. As part of its charge, the proposed "Partnership for Health Care Value" will reach consensus wherever possible on medical standards. The standards developed in this process will be a resource that can be used by all plans participating in the Medicare program. The medical profession will be responsible for using its vast self-regulatory structure to implement and enforce these standards.

3. Current legislation will be amended to rationalize existing self-referral provisions (Stark I and II), and to provide for the issuance of advisory opinions by DOJ and DHHS.

4. Health care plans will be accountable for establishing a structure which permits participating physicians to provide quality health care to their patients. Review mechanisms will be established to assure that reimbursement policies do not give physicians incentives to limit care inappropriately.

5. A comprehensive study of fraud and abuse will be conducted to monitor the effectiveness of current control efforts and to identify emerging issues.

REDUCING CARE OF MARGINAL VALUE (see TAB G)

1. The Partnership for Health Care Value should support the development and use of practice guidelines, practice patterns and utilization review to reduce "care of marginal value."

2. Information regarding advance directives, living wills and medical powers of

attorney should be provided to Medicare beneficiaries upon enrollment and physicians should be encouraged to educate their Medicare patients in the use and need for such advance directives in medically futile circumstances.

3. All Medicare and Medichoice plans should utilize practice guidelines, utilization review, advance directives, and the use of hospice care to reduce care of marginal value when serving Medicare beneficiaries.

4. Congress should enhance Medicare's use of hospice care to assist dying patients and their families with compassionate care at the end of life. Support for Medicare, Medicaid and private insurance coverage of hospice care, including patients in nursing homes, should also be voiced. Efforts to increase copayments for hospice care or reduce hospice reimbursement should be opposed.

5. Outcomes research should include factors that reduce care of marginal value. HCFA should develop and support research to improve the care of patients in end-of-life situations. More empirical research through surveys or other means to evaluate the incidence of care of marginal value is needed.

HEALTH CARE LIABILITY REFORM (See TAB H)

Malpractice insurance costs are reflected in Medicare payment rates. Professional liability reform will reduce premiums and consequently have a salutary effect on Medicare costs. A baseline of liability reform provisions, proven effective in the states that have enacted them, should be established federally. Federal law should have limited preemptive effect, allowing states to exceed the federal baseline in implementing stronger reform.

California's Medical Injury Compensation Reform Act of 1975 (MICRA) provides a model for effective reform. The principal elements of MICRA, in order of impact, include:

1. A $250,000 limit on noneconomic damages (all out of pocket "economic" losses remain fully recoverable);

2. Modification of the common law collateral source rule, to end the double recovery of medical expense damages where other sources of plaintiff compensation - such as health, disability or workers compensation benefits - already have been paid;

3. Periodic payment of future damages as they accrue (with lien authority only against the liability insurer);

4. A sliding scale for the award of attorney contingency fees that decreases as the award increases; and

5. Statute of limitations reform for both adults and minors.

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CURRENT PROBLEM

Medicare's financial problems are well-known. Without a change in planned receipts or expenditures, the Part A Trust Fund would not be able to meet its obligations in 2002. In spite of repeated tax increases and physician and other provider payment cuts, spending from general revenues (75 percent of Part B) continues to outpace Congressional budgetary desires. These problems are systemic, caused by the flawed design of the program. The financial problem also is growing, caused by the inherent pay-as-you-go approach combined with the inevitable adverse impact of an aging population. In other words, the Medicare program is plagued with a funding problem as well as an problem of inefficient system design.

The funding problem has several parts. The most immediate is the impending Trust Fund imbalance, which requires that planned spending growth be reduced quickly. The longer-term funding problem is that current plans require a dwindling proportion of working age people to finance the Medicare subsidy to a rapidly growing proportion of elderly. This problem is a fault of pay-as-you-go design.

Fundamentally, the design problem that leads to inefficiency exists because of a lack of reliance on markets and an insulation from sensible incentives. Prices are controlled, limiting the incentives to physicians and other health care providers to be responsive to patients. The program should be restructured so that Medicare patients can receive adequate benefits with a single insurance plan. The limited cost-sharing in the original program design has been largely nullified by the widespread presence of supplemental insurance (purchased by most who are financially able and provided by various government programs for many of the needy). Medicare is unique in that patients are motivated to purchase multiple insurance policies. Although the typical beneficiary spends quite a bit on their health care through "medigap" insurance, Part B premiums, or cost-sharing, current incentives do not promote system-wide efficiency.

Fortunately, we do not believe that these problems are insurmountable. The American Medical Association believes that the design problems that produce inefficiency can be improved in ways that benefit current and future beneficiaries by increasing choice and sharing the benefits of those improvements with beneficiaries. At the same time, government can gain control over its outlays, slow spending growth, and prevent the Part A Trust Fund imbalance. We also believe that some initial steps can be taken to reduce the dependency of future generations on the Medicare subsidy.

RECOMMENDATIONS

The following recommendations are the basis for transforming the Medicare program to enhance its long-run fiscal integrity, improve its efficiency, and, in the short run, reduce program outlays.

Our proposal calls for the availability of voluntary, tax-advantaged Medical Savings Accounts (MSAs) to be offered to the non-elderly population to reduce future generations' dependency on Medicare, providing incentives for using accumulated balances to pay for medical care in retirement.

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5. Preventive services should be included in Medicare benefits when availability of such services can be shown to reduce overall program costs.

6. The eligibility age for Medicare will be increased to match the increasing age for full benefits in Social Security that is already law.

RATIONALE

Medicare must be transformed into a defined contribution program to constrict the open-ended entitlement promise that is a major contributor to its budgetary instability. However, to optimally serve beneficiaries under the financial constraints that a set dollar contribution presents to them, the program must provide a wide variety of choices in conformance with the wide spectrum of needs and financial means within the beneficiary population.

Many analysts have recommended the Federal Employee Health Benefits Program (FEHBP) as a model for providing such choices to beneficiaries under a defined contribution plan. The FEHBP model is recommended because of its regulatory simplicity, the spectrum of choice presented to

enrollees, the amount of information generated by the competitive environment, and its cost effectiveness. The approach is highly suited to translating legislative constraints on program growth into defined contributions to enrollees' purchase of private benefits.

Following the model of the FEHBP, HCFA would allow any plan which meets the standards for participation to offer health plans to beneficiaries within the Medichoice program. However, other federal laws and regulations, as well as some at the state level, indirectly restrict the ability of newer types of health care organizations – Provider Sponsored Coordinated Care Organizations (PCCOs) – to offer plans in this market. Therefore, we propose provisions that would enable PCCOs to compete on an equal basis with more traditional plans in the Medichoice program.

Establishing Medical Savings Accounts (MSAs) during working years and providing incentives to use accumulated balances to fund post-retirement health care needs is a promising approach to reducing Medicare's serious intergenerational transfer problem. Because the ratio of working taxpayers to beneficiaries will decline rapidly during the first half of the next century (from its current level of 4 to a level of 2 by 2030) encouraging working people to accumulate savings to use for health spending in retirement should be a priority.

Medical Savings Accounts (MSAs) are included as a Medichoice option for Medicare beneficiaries because of their potential to enhance the operation of the medical care market, competition between health care providers, and to temper the rates of price inflation of medical services.

Because 75% of Medicare beneficiaries currently purchase medigap coverage, the cost savings benefits of the cost sharing requirements of Medicare are almost completely neutralized, stimulating these beneficiaries to utilize 24% more services than they otherwise would. Furthermore, even if medigap were not neutralized, the configuration of Medicare cost-sharing requirements would be largely ineffective because deductibles are more efficient than coinsurance. Our proposal to reconfigure beneficiary cost sharing requirements into a single deductible will serve three purposes.

- It will make the purchase of medigap redundant and wasteful to beneficiaries.
- It will provide beneficiaries with the type of cost-sharing that is the most effective in promoting efficiency.
- It will actually save most beneficiaries money (estimated average of $250 a year), because it converts previous medigap costs into an insurance plan that will reduce their costs.

Under the present systems of price controls in the Medicare program, prices do not perform a market function of facilitating competition. Beneficiaries have no incentive to choose providers on the basis of price, and providers have no incentive to use prices as a means of attracting patients. As a result, providers are not as efficient as they could be, burdening the program with unnecessary cost. Since the traditional Medicare program may well be the option of choice for many beneficiaries for an extended period of time, improving the economic efficiency of the program is mandatory for budgetary control.

Competition requires that prices be decontrolled and beneficiaries rewarded for seeking lower prices in the market. Our proposal for physician service price competition builds on the current

RBRVS-based system. Beneficiaries would be rewarded for seeking value by receiving rebates if they choose providers whose charges are lower than the government rate of reimbursement, which is set to maintain certain levels of access.

We call on the Secretary of HHS to design a similar system for hospital payment in the HI program for implementation in 1997.

Researchers and analysts have identified a number of inconsistent and outdated aspects of the current HI (hospital) payment system. The ultimate objective of our market-based approach to Medicare reform is to modify the HI payment system to increase competition among hospitals and to base beneficiary reimbursement levels on parameters related to how much access to care is available at Medicare payment rates. However, there are a number of changes that can be made to correct problems in the current system. Since they are very detailed in nature, they are described in a separate appendix (Appendix 1).

Changes occurring in the organization of health care delivery since the inception of Medicare have eroded the private sector's traditional willingness and ability to contribute to graduate medical education (GME). Currently, only the federal government contributes in a standardized way to the funding of GME. As a consequence of the way that Medicare financing of GME is structured, both the Direct Medical Education payment and the Indirect Medical Education Adjustment have been rising steadily. Furthermore, the current Medicare funding formulas for GME contain certain inherent incentives that are not consistent with national needs. We recommend a transition to an all-payer system for support of GME wherein all payers that benefit from physicians will contribute to the educational costs in an equitable way.

We recommend correcting a number of burdensome administrative practices in the current Medicare Program. Additional provisions restrict the scope of administrative authority to impose harmful and counterproductive regulations on the Medicare system such as price control, specific treatment regimens, etc.

LEGISLATIVE SPECIFICATIONS: TRANSFORMING AND MODERNIZING MEDICARE

MEDICHOICE: A COLLECTION OF PRIVATE HEALTH INSURANCE OPTIONS

- The Medicare risk contract program, as established by P.L. 92-603 and modified by P.L. 97-248, will be repealed.

- In place of the risk contract program, establish an optional "Medichoice" Program within Medicare. All Medicare-eligible individuals will be eligible to annually choose to participate in either the traditional Medicare program or in the Medichoice program. Each beneficiary electing to participate in the Medichoice program would receive for the next calendar year, in lieu of traditional Medicare coverage, the appropriate actuarial value of his or her Medicare benefits, less the annual amount of any HI and/or SMI premiums the beneficiary would otherwise be required to pay, as a defined government contribution to the cost of the health benefit plan chosen by the beneficiary within the Medichoice program. A beneficiary electing the Medichoice option would not be required to pay HI and/or SMI premiums which he or she would otherwise be required to pay for traditional Medicare coverage for any year(s) for which the beneficiary elected the Medichoice option.

- Health Benefit Plan requirements: Any plan may participate in the Medichoice program provided that it complies with certain minimum standards adapted to apply to the Medichoice program from the provisions of chapter 89 of title 5, United States Code, and 5 CFR 890.201 (Minimum standards for health benefits plans).

- Types of Benefits: Benefits allowed in the FEHBP program: the benefits to be provided under plans participating in the Medichoice program include those allowed for the FEHBP [5 USC 8904], such as payment for or direct provision of hospital care, surgical care and treatment, medical care and treatment, obstetrical benefits, health prevention services, prescribed drugs, medicines, and prosthetic devices, and other medical supplies and services.

- Health Benefit Plans: Health benefit plans participating in the Medichoice program may be of the following types:

    1. Traditional Health Benefit Plans: Plans offering benefits under which payments for services are calculated according to the usual, customary, and reasonable fees or charges prevailing in the community in which a beneficiary obtains services from physicians, hospitals, or other providers of health services.

    2. Benefit Payment Schedule Plans: Plans offering benefits under which certain sums of money, enumerated in a schedule of benefits provided under the plan, are paid to beneficiaries for services obtained from physicians hospitals, or other providers of health services.

3. Prepaid Comprehensive Medical Plans: Health Maintenance Organizations, Preferred Provider Organizations, or other plans which offer comprehensive health benefits on a prepaid basis.

4. Provider Sponsored Coordinated Care Organizations (PCCOs): PCCOs are exemplified by multispecialty group practices such as the Cleveland Clinic and the Mayo clinic, academic medical centers, large independent practice associations (IPAs), and hospital systems that have partnered with physician networks. To facilitate the ability of PCCOs to compete in the Medichoice program, a set of provisions removing obstacles to their participation is provided in Tab D.

5. Medical Savings Account Plans: Plans which offer catastrophic medical expense insurance in combination with establishing a Medical Savings Account (MSA):

   a. Allowed annual deposits to an MSA are limited to the value of the annual government contribution amount. Part of the funds must be applied toward purchase of a high-deductible, catastrophic insurance policy each year which must cover the types of services provided for by the FEHBP program.

   b. Contributions to an MSA in the amount of the value of the government contribution amount should be exempt from federal and state income taxation.

   c. Distributions from a beneficiary's MSA should be exempt from federal and state income tax if used for medical expenses, health insurance premiums, and/or long-term care.

   d. Interest and dividend earnings on MSA balances should be exempt from federal and state income tax while they remain in the account.

   e. Other provisions relating to MSAs held by Medicare beneficiaries will be governed by rules applicable to IRAs, except that mandatory withdrawal at a certain age is not applicable to MSAs held by Medicare beneficiaries.

- Enrollment in Medichoice: Before the annual open enrollment period, the Secretary of HHS should mail a notice to each Medicare eligible individual informing them of the premium and deductible amount for the next year for traditional Medicare coverage, a description of any changes in coverage under the traditional Medicare program, the government contribution amount to the cost of Medichoice plans for which the individual is eligible for the next year, and information on participating Medichoice plans in the individual's area together with the rates charged by such plans to individuals in the individual's actuarial category. The individual should also be provided with a Medichoice election and enrollment form.

  To participate in Medichoice in any year a beneficiary must complete and return an election enrollment form within the time proscribed. Beneficiaries who fail to return a

completed form by that date will continue to be covered by the traditional Medicare program.

- Premium Payments: Upon election of a Medichoice plan by a beneficiary, the Secretary will transmit to the plan a payment equal to the beneficiary's actuarially determined government contribution amount. If the premium exceeds the beneficiary's actuarially determined government contribution amount, the beneficiary will be responsible for paying the difference. If the beneficiary's actuarially determined government contribution amount exceeds the plan premium, the plan should rebate the excess amount to the beneficiary within 30 days of the beneficiary's enrollment in the plan.

- Government Base Year Contribution: In the initial or "base year" of the program, the government's contribution to each Medichoice enrollee's premium cost should be calculated as an actuarially fair share of total Medicare expenditures projected on the basis of savings scored for enacting the modernization provisions to the traditional program discussed above. To neutralize the effect of adverse selection by older or sicker beneficiaries, the actuarial shares should be adjusted for factors effecting expected utilization.

- Government Contribution in Future years: In years subsequent to the base year, the growth in Medicare expenditures will be limited to seven (7) percent per anum through 2002. These limiting rates of growth will be applied to Medichoice and traditional Medicare in the following ways:

    1. HI & SMI: the HI/SMI premium will be adjusted actuarially before the beginning of each subsequent year to maintain adherence of projected growth of HI and SMI outlays to the percentage amounts enumerated above.

    2. Medichoice: the base year risk-adjusted government contribution amounts will be adjusted each subsequent year to maintain adherence of projected growth of the aggregate Medichoice contribution to the percentage amounts enumerated above.

- Increase the age for Medicare eligibility to the eligibility age for social security.

- Reduce the Medicare Subsidy to High-Income Beneficiaries

  The Medicare subsidy to high income beneficiaries will be reduced by requiring individuals with incomes greater than $50,000 and couples with incomes greater $100,000 to pay additional premiums on a sliding scale.

MODERNIZATION OF TRADITIONAL MEDICARE

- Beneficiary Cost Sharing should be restructured to provide incentives to discourage beneficiaries from purchasing supplemental medigap policies and to encourage them to be more economical consumers of routine medical services. This will be accomplished by requiring beneficiaries (with the exception of particular classes of beneficiaries enumerated below) to provide to the Medicare program, on an annual basis in monthly installments, a

"supplemental equivalent" amount equal to the market price (approximately $1,000 in 1995) of the private supplemental (medigap) policy denoted Plan C, which reimburses a beneficiary for all incurred Medicare cost sharing liability except balance billing. In return, the Medicare program will:

1. Abolish current HI and SMI deductible and copayment requirements;

2. Retain one-half of this new amount as a Part A insurance premium for the reduced cost sharing requirements;

3. Establish a Beneficiary Escrow Account (BEA) for each enrollee to accumulate the remainder of the supplemental amount as it is received from the enrollee monthly;

4. Charge each beneficiary BEA with benefit payments made on his or her behalf during the year;

5. Refund to each enrollee any balance remaining in the BEA that exceed benefit payments made on his or her behalf during the year;

6. Exempt Medicare beneficiaries eligible for Medicaid and other "qualified beneficiaries from the requirement to contribute the extra amount; and

7. Reduce the contribution required of Medicare beneficiaries who have incomes less than 150% of the poverty level. The amount of the reduction will equal 100% minus the percent by which the beneficiary's income exceeds the poverty level. For example, a beneficiary with income at 125% of the poverty level would have their all-inclusive deductible reduced by 50%. Physicians will be prohibited from charging beneficiaries with incomes less than 200% of poverty more than the amount reimbursed by HCFA. (A mechanism should be established for beneficiaries to establish their eligibility for this preferential treatment.)

8. The supplemental amount will be adjusted each year to reflect changes in the actuarial value of the insurance coverage provided by the private Plan C or its equivalent.

- Increase the age for Medicare eligibility to the eligibility age for social security.

- Set Medicare Physician Payments Competitively: The Medicare Volume Performance Standard and Conversion Factor Update provisions should be replaced with a payment system that encourages competition and bases payment levels on access to care. The competitive system should be implemented in phases, as described in Appendix 2.

- Base Medicare Part A payments on access to care: By 1997, the Secretary should submit a report to the Congress recommending specific methods for revising Medicare Part A reimbursement that increases competition among hospitals and bases payments on beneficiaries' access to care.

- Correct Problems in the Current Medicare Part A Payment System: A number of corrections to the current Medicare HI program are described in Appendix 1.

- Reduce the Medicare Subsidy to High-Income Beneficiaries

  The Medicare subsidy to high income beneficiaries will be reduced by requiring individuals with incomes greater than $50,000 and couples with incomes greater $100,000 to pay additional premiums on a sliding scale. (The reduction in the subsidy would be equivalent in budgeting savings to payment of an additional premium of 20 percent of the total value of Medicare benefits.)

- Modernize Medicare Administrative Practices: A number of recommended administrative and policy improvements are described in Appendix 3.

MISCELLANEOUS PROVISIONS

- The Secretary of HHS or administrative officials to which the Secretary's authority is delegated should be prohibited from imposing price controls, fee schedules, ceilings on premiums, or spending restrictions on any private health insurance plan participating in the Medichoice program; from organizing health plans in any region of the United States, establish or administer regional alliances or networks or sponsor insurance purchasing cooperatives; from imposing any standardized benefits package beyond the core "categories of benefits" as defined by chapter 89 of title 5, United States Code, governing the Federal Employee Health Benefits Plan; from imposing medical practice guidelines on physicians or any other health care provider providing services through private plans; and from making a determination regarding which treatments or procedures a private plan may offer.

- Procedures for individuals to appeal denial of benefits by Medichoice plans should be more direct and timely than those designed by OPM for the FEHBP.

- Retain Medicare secondary payer for disabled and ESRD beneficiaries: extend OBRA93 provisions making Medicare the secondary payer for disabled and ESRD beneficiaries so that payment for services are first required from a private payer, if the beneficiary has private health insurance coverage.

Appendix 1:

PROVISIONS RELATED TO PART A OF MEDICARE

- Reduce hospital capital payments by re-basing rates.

  According to CBO, recent data show that HCFA overestimated the initial federal and hospital-specific payment rates when prospective capital payments were established; growth in capital costs has been much slower than expected.

  Beginning in 1996, the federal rate for HI capital payments should be reduced by 5.62% and the hospital-specific rate shall be reduced by 7.13%.

- Reduce hospital capital payments by continuing OBRA 90 reductions.

  In OBRA 90, Congress reduced total capital payments made to hospitals by 10% to reflect the general perception that these payments were too high and were providing an incentive for hospitals to spend too much on capital. This proposal simply extends the original intent of Congress.

  The 10% reduction in total capital payments made to hospitals as part of the first five years of the transition to prospective rates specified in OBRA 90 shall be extended for an additional seven years (FY1996-FY2002).

- Reduce hospital capital payments by adjusting for excess capacity.

  Currently, Medicare capital payments assume that hospitals are fully occupied. By basing capital payments on actual occupancy, hospitals would have an incentive to operate more efficiently.

  Beginning in 1996, hospital capital payments should be reduced by 5% to properly adjust for hospital excess capacity.

- Cease reimbursement for bad debt.

  Beneficiaries are responsible for certain deductibles and copayments under Part A. Currently, Medicare reimburses Part A providers for any unpaid amounts as long as a reasonable effort to collect is made. This proposal would provide hospitals with more of an incentive to collect Medicare enrollees' cost sharing liability.

  Beginning in 1996, Medicare should no longer reimburse Part A providers for any unpaid coinsurance or deductible amounts.

- Restrict disproportionate share adjustment to hospitals that truly treat a disproportionate share of Medicare patients.

Congress added the disproportionate share adjustment under the belief that low-income Medicare beneficiaries were sicker and, therefore, more expensive to care for. According to the CBO, however, empirical support for this assertion is limited. Disproportionate share funding should be limited to the most needy hospitals.

Beginning in 1996, the disproportionate share payment adjustment for hospitals with a disproportionate share index below the 80th percentile should be eliminated.

- Bundle hospital acute/post-acute payments.

  Under the current system, payment for post-acute services are separate from acute care payments. Not only is this policy burdensome and overly regulatory, it also creates an incentive for hospitals, especially those with affiliated post-acute care facilities, to discharge patients too early. By bundling acute and post-acute payments, regulation would be reduced, hospitals would have an incentive to provide care more efficiently across a wider spectrum of services (because they would control both acute and post-acute funds), and growth in spending for post-acute services would be controlled.

  Beginning in 1997, a single, prospectively-determined rate should be applied to acute, all post-hospital SNF and rehabilitation services, along with 60 days of home health services. Hospitals would be responsible for deciding and paying for the appropriate acute/post acute service mix for their Medicare patients. The Secretary should submit a report to Congress by July, 1996, providing specific recommendations regarding these all-inclusive rates.

- Eliminate sole community adjustments.

  Medicare designates hospitals as sole community providers if they meet certain criteria for providing acute, inpatient services in a geographic area. These payments, however, are not well-focused on providers that are essential to the community. Thus, this well-intentioned subsidy is often misguided.

  Beginning in 1996, special Medicare payments for "sole community providers" should be eliminated.

- Lower Skilled Nursing Facility (SNF) cost limits to 100%.

  Congress froze SNF cost limits in OBRA 93 as a means to check explosive growth in payments for these services. By revising the computation of average costs in determining SNF payments, this proposal would sustain Congressional intent to control spending for these services.

  SNFs are paid on the basis of reasonable costs, subject to a limit set at 112% of the national average cost per day for free-standing facilities. (The limits are slightly higher for hospital-based units because they are assumed to have higher costs.) The limits are computed each year. OBRA 93 froze the limits until FY1996. This option would revise the computation of average costs to include the savings achieved from the OBRA-93 freeze. (Current law states that the FY1996 payments must reflect all the growth in costs

that occurred since the freeze. This option allows for only one year of growth to be reflected.) HCFA estimates this would lower the limits from 112 percent to about 100 percent of relevant average costs.

- Modify HMO payments.

  Problems associated with the current method of reimbursing Medicare HMOs are well-known and have been examined both by HCFA and the PPRC. Significant savings and improvements in access to Medicare HMOs are possible by correcting the current, flawed payment mechanism.

- Lower home health cost limits to 100%.

Appendix 2:

Implementation of a Competitive Price System for SMI

1. Transition to a single conversion factor: The current three conversion factors for primary care, surgical and nonsurgical nonprimary care services shall be equalized between 1996 and 1998. The conversion factor updates for 1996 for all three categories of service shall be equal to 1.1%, and the MVPS for all categories of service shall be 2.0% (or equivalent CF update and MVPS based on current default formulas). The Secretary shall present a plan to the Congress for accomplishing the remainder of this transition to a single conversion factor by 1998 as part of the Secretary's recommendations to Congress for the 1997 conversion factor and MVPS updates. Equalizing the conversion factors shall be budget neutral, with budget neutrality accomplished using a simple average weighted by projections of volume for each category of service.

2. Enhance competition.

    a. Beginning in 1996, each physician shall determine their own Medicare conversion factor (CF) to apply to the Medicare payment schedule when determining charges to their Medicare patients;

    b. Beginning in 1996, physicians shall be required to furnish their Medicare carrier with their conversion factor [for a year by December 1 of the year prior to the year in which the conversion factor will apply.]. Physicians shall also furnish patients, in advance of rendering services and upon request, with their conversion factor and that used by Medicare for payment purposes. In addition, Medicare carriers shall maintain and furnish upon request, directories of physician conversion factors for each payment locality. In cases where beneficiaries choose a physician whose CF is less than the HCFA reimbursement rate, the beneficiary would receive a rebate of the difference.

    c. Beginning in 1997, the current limiting charge provisions shall be changed from 115% of the charge based on Medicare's conversion factor to the greater of the physician's charge plus 25% of the difference between the physician's charge (based on their conversion factor) and the payment based on Medicare's conversion factor or 115% of the Medicare payment. This percent difference shall be increased from 25% to 50% in 1998, and from 50% to 100% in 1999.

3. Base Medicare physician payments on access to care.

    a. Beginning in 1997, the MVPS provisions and the default formula for determining CF updates shall be repealed. For 1997 and 1998, conversion factor updates shall be 0%.

b. Beginning in 1998, the Secretary shall recommend by April 15th annual increases to the conversion factor for the following calendar year based on Medicare beneficiary's access to care. The Secretary shall submit a report to the Congress by July, 1997 indicating the specific methods that will be used to evaluate access to care. The Secretary shall specifically consider differences between Medicare and physician conversion factors, Medicare and private payment rates, balance billing, physicians' willingness to accept new Medicare patients, information on access contained in the Current Beneficiary Survey, data on annual increases in the costs of providing physician services, and other measures that may be selected by the Secretary.

Appendix 3:

Recommendations to Modernize Medicare Administrative Practices

1. Telemedicine: Following timely completion of pilot projects currently underway to examine the provision of and payment for telemedicine services, HCFA should work with the AMA and other interested physician groups to develop policies that would allow appropriate payment for telemedicine services.

2. Telephone consultations: HCFA shall revise its policies to allow physician payment for telephone consultations under appropriate circumstances following criteria developed by the AMA.

3. Administrative simplification: HCFA shall simplify claims processing and adjudication by eliminating the requirement that an additional claim form be filed with a separate Durable Medical Equipment Regional Carrier (DMERC) for inexpensive, disposable items (e.g., surgical dressings and ostomy bags).

4. Utilization review procedures: In situations where a physician could not be reasonably aware that payments received from the carrier were overpayment or payments otherwise made in error, the Medicare carrier, rather than the physician, should be financially responsible to HCFA for repayment in order to increase incentives for carrier efficiency and accuracy. In addition, except in cases of suspected fraud, carriers should limit their post-payment utilization review activities and requests to recoup payments to claims that are no more than two years old from date of submission.

5. Payment for mental health services: HCFA shall eliminate its discriminatory policy for outpatient mental health services that limits Medicare payment to 62.5% of the payment schedule amount.

6. Information dissemination: HCFA shall increase efforts to more effectively disseminate information to physicians about policy changes. In the case of major policy revisions, HCFA should allow an adequate transition period to reduce program costs associated with telephone and written inquiries for further information, claims denials, and physician appeals.

7. Geographic adjustment factors (GAFs)/payment localities: The Secretary shall collect the necessary data to revise the GAFs in the Medicare payment schedule to reflect geographic variation in actual physician unit costs (e.g., rent per square foot paid by physicians) and to use these and other available data to revise the current payment locality structure to create the minimum necessary number of localities that are homogenous with respect to physician input costs, political subdivisions, and other relevant factors. In addition, the Secretary should have the authority to adjust specific GAFs account for geographic differences in access to care.

8. Payment for preventive services: "Preventive" services should be included in Medicare benefits when availability of such services can be shown to reduce overall program costs.

Payment for such services should not be deducted from beneficiary BEAs. Appendix 4 suggests several services which may qualify for inclusion under this provision.

9. Computer-based patient records. Computer-based patient records offer enormous potential advantages for clear documentation, linkage of multiple record sources, efficiency of communication, and evaluation of outcomes. Development of standards and applications in this area should be encouraged and implemented as they become available.

10. Clinical Trials and Investigational Therapies. Medicare patients (whether or not in a managed care organization) shall be eligible for coverage of investigational therapies if (1) they have a life-threatening disease or condition and acceptable standard therapy has not been developed or is not effective, or (2) they have other diseases or conditions and there is reasonable evidence that the investigational therapy may be more efficacious or cost-effective than standard therapy, and (3) the investigational therapy is under clinical investigation as part of an approved research trial. Routine care that is otherwise covered by the provider should also be covered for a patient receiving a qualified investigational therapy if it is administered as part of the investigational therapy and would have been provided even if the patient were not receiving the investigational treatment. Therapy with medications or biologics with a Treatment IND status should be covered.

11. Payment for physician house calls for the homebound elderly. HCFA should study the cost-effectiveness of providing reasonable and equitable payment for necessary physician house calls to homebound elderly Medicare patients who have medical conditions requiring urgent care but who do not need emergency department care of hospitalization. Currently, physicians who make home visits are paid less than 50% of the payment to home health nurse visits. Studies have suggested that substituting physician house calls for ambulance trips to emergency departments can yield significant savings to the Medicare program.

Appendix 4:

PREVENTIVE HEALTH SERVICES

CURRENT PROBLEM

A wide variety of medical diseases and injuries are preventable, modifiable, or can be detected at an early stage at which therapy is less expensive, less invasive or prolonged, and more effective.

Medical care plans traditionally have not covered many types of preventive health services and disease screening programs nor offered incentives either to physicians (or other providers) to provide them or to patients to utilize them. Preventive services and screening programs cover a wide array of services, some of which are clearly cost effective (eg, childhood vaccines) and others for which the cost effectiveness for a population is either marginal, unproved, or clearly not achieved.

RECOMMENDATIONS

Payment for preventive services: "Preventive" services should be included in Medicare benefits when availability of such services can be shown to reduce overall program costs. Payment for such services should not be deducted from beneficiary BEAs.

Information about preventive health services and screening programs for the Medicare population should be assessed periodically by the Secretary to assess which services might qualify for inclusion in Medicare covered services. An annual report should be submitted by the Secretary to the Congress with recommending specific services for Congressional consideration to be included as preventive service benefits.

RATIONALE

Major health-related problems for the older population include:

- Cardiovascular disease and stroke, the risks of which are higher for people who are overweight, smoke, and have uncontrolled high blood pressure.

- Falls and accidents, including vertebral compression fractures and broken hips the risks of which are higher in people who have uncorrected vision problems, who are more sedentary and do not exercise, and who are overweight.

- Breast cancer in women, the incidence of which continues to increase with increasing age (the incidence in white women 75-79 years of age is more than 500 per 100,000, a rate that is more than twice the rate of women in their 50s).

- Influenza morbidity (associated pneumonia) and mortality, which is highest in the elderly. Hospitalizations for complications is highest in the elderly. The vaccine, which should be administered annually, is approximately 40% effective at preventing

clinical illness (and the complications such as pneumonia), and 80%-90% effective at preventing death.

Medicare patients (whether or not in a managed care organization) should receive preventive care services that include risk assessment and risk reduction. The review currently recommended by the Public Health Service, DHHS, for older adults includes discussion about general health, medications (eg, screening for problems with multiple medications that may interact), prevention education (eg, for smoking, alcohol intake, fall prevention, and seat belt use), immunization review, diet, exercise, etc.

While preventive services should be considered as a part of each patient-physician encounter, the risk assessment and counseling as well as the recommended annual influenza immunization potentially make a preventive services visit an important part of health services.

The services recommended for older adults by all major prevention authorities reviewed by the Public Health Service (Put Prevention Into Practice: The Clinician's Handbook of Preventive Services) include:

- Screening Tests:
  - Blood pressure (every 2 years)
  - Height and weight assessment (periodically)
  - Hearing (periodically)
  - Mammogram (for women, every 1-2 years)

- Examinations:
  - Vision/glaucoma (every 2 years)
  - Breast (annual)

- Immunizations:
  - Influenza (annual)
  - Tetanus/Diphtheria (every 10 years)
  - Pneumococcal (once at age 65)

- Health assessment and guidance (periodically):
  - Includes: Smoking/tobacco use, alcohol use, nutrition and diet, physical activity and exercise, injury risk and prevention, physical abuse, estrogen use by women, etc.

Other types of services (eg, periodic sigmoidoscopy, cholesterol until age 70, thyroid function tests for women, etc.) have been recommended by different authorities. These and other services should be assessed for their efficacy and cost-effectiveness in the Medicare population.

Incentives for patients to avail themselves of the recommended services should enhance their use. Physicians/providers in all types of care settings should be encouraged to provide appropriate review, counseling, and other services.

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QUALITY AND HEALTH PLAN STANDARDS IN A TRANSFORMED MEDICARE PROGRAM

CURRENT PROBLEM

Transforming Medicare will bring about major positive changes in the way health care services are provided to the elderly. Instead of a centrally micromanaged system where the federal government makes all of the decisions, the new program will allow for the private sector market to operate so that products and systems meet the needs of those who use them, not the preconceived notions of central planners. Greater efficiency in the organization and delivery of care for Medicare patients will result.

There are two problems that the transformation will present. First is assuring patients that quality of care can be maintained at a high level in a market driven system focused on costs. Minimum standards and procedures are necessary to make competition work and to make it fair and balanced. These include:

- Disclosure and grievance procedures,
- A set of comparable benefits,
- Significant organized professional involvement in medical policies to permit the relaxation of Medicare's regulatory schemes, and
- A provision for continuity of care as patients and physicians become involved in exercising their choice options.

The second problem is assuring that innovations in efficiency and quality that are occurring throughout the country can be identified, evaluated and than integrated into Medicare plans. The current Medicare system is much too slow to recognize and adapt to change. This lag causes major problems because innovations take years to be recognized and accepted. Such delay is unacceptable in today's world where breakthroughs are continuous and delay unacceptable.

RECOMMENDATIONS

There should be a minimum set of provisions that plans will meet. In order to allow the market to operate, there shall be maximum flexibility in the means of achieving the requirements. To the greatest extent possible, accreditation by voluntary private sector bodies should be recognized instead of direct government regulation.

1. A Partnership for Health Care Value should be established for the purpose of coordinating and focusing private-sector efforts devoted to practice guidelines development and organizing a structure to guide development and dissemination of improvements in medical practice and health care delivery. The Partnership should be governed by representatives from medical societies, hospital associations, insurers and national managed care companies, accrediting agencies, employers, consumer groups, and the federal government. The Partnership would marshall private sector resources devoted to the development and application of medical standards. The Partnership would work in cooperation with federal agencies such as the AHCPR, HCFA, the National Institute of

Health, and others. The work product of the Partnership would be widely disseminated so that its results could be integrated into a constantly improving health care delivery system. Therefore, federal agencies would have input in setting priorities for the Partnership and in reviewing its results.

2. Plans should disclose information on plan costs, benefits, operations, performance, quality, incentives and requirements to potential and current enrollees. Enrollment procedures must be fair to avoid inappropriate market segmentation.

3. Provisions for fair redress of grievances and appeals from plan decisions should be available.

4. Physicians should be involved in developing medical policies and criteria under the program. At the plan level, this should involve physicians, using a medical staff model. Quality management programs will be an integral part of each plan. Procedures will be in place for recognition of private sector accreditation programs.

5. There should be administrative simplification including uniform electronic and paper claim form, computerized patient record when available, single local entity to inspect facilities and a standardized credential verification system.

RATIONALE

PARTNERSHIP FOR HEALTH CARE VALUE

A revolution is occurring in medicine which promises to substantially reduce costs while maintaining and enhancing quality. However, this revolution will not succeed unless a coordinated effort is made to develop the tools necessary for the revolution to take place. Medical societies, many other private sector organizations, accrediting agencies, and government agencies such as the Agency for Health Care Policy and Research are working at creating the tools necessary for the revolution. However, these efforts are fragmented and duplicative, and the tools needed are being developed at far too slow a pace. The tools being developed to achieve the revolution are inter-related. Each kind of tool depends on the existence of other types of tools in order to be effective. They include:

- Practice guidelines that synthesize medical knowledge about a topic to assist physicians in the management of patients. Outcomes research and technology assessment are important sources of information for the development of practice guidelines.

- Utilization review or coverage decision making systems that review the medical decisions made or recommended by physicians. These are based on practice guidelines and algorithms.

- An electronic patient record that allows the measurement and aggregation of outcomes information.

- Outcomes research to develop a base of information about what clinical practices are truly effective in helping patients.

- Technology assessment to determine what medical technologies are effective in helping patients, and the conditions under which those technologies are effective. Outcomes research is essential to technology assessment.

- The development of algorithms or protocols for physicians to follow in the management of patients with particular conditions. These are based on the knowledge synthesized in practice parameters.

- Profiling systems to evaluate the quality and effectiveness with which a physician manages patients. Ideally, these are based on practice guidelines and algorithms.

- Outcomes reports by providers and health plans that inform the public about their performance.

Much more could be accomplished if all of these activities were coordinated and focused. The AMA endorses establishment of a Partnership for Health Care Value.

MARKETING, ENROLLMENT AND COVERAGE

There are legitimate concerns regarding market segmentation and marketing practices designed to attract healthy enrollees. Plans should be allowed to benefit from competition and their ability to constructively improve the health care delivery process; not by seeking out and covering only relatively healthy individuals. In selecting plans, individuals need information to understand how the plan operates, what they get in benefits, what they must do to assure that services are covered, where and from whom they get services, and how plans compare on items such as quality indicators, patient satisfaction, cost control programs, and grievance procedures. As a national program there is a reasonable expectation that where the federal government is making a substantial contribution, it will be important to assure that there be some minimum set of services that each plan provides with appropriate incentives for preventive services. Plans should have flexibility as to how they provide the services and should be able to enhance the benefit package in any way that meets customer and market needs.

FAIRNESS

In order to assure fairness and that needed medical services are provided, procedures must be established that provide enrollees and providers with a system to resolve disputes within the plan. In cases where the grievance or dispute can not be resolved within the plan, participants should be able to seek independent means to address the problems.

Due to the nature of patient/physician relationships, within reasonable parameters, physicians should be allowed to seek participation in plans and to have the ability to discuss reasons why participation would not be continued.

Methods for resolving disputes can be developed by each plan as long as there is a reasonable assurance that basic fairness is achieved.

PHYSICIAN INVOLVEMENT

It is the responsibility of physicians to assure that their patients receive necessary and appropriate care. To assure that physicians are able to meet this obligation, plans need to provide a process,

such as a medical staff, for physician involvement in the medical policies of the plan, including drug formularies. It is also necessary for plans to have procedures and methods that assure that high quality care is provided. There needs to be uniform, yet flexible standards in this area. Plans can have a degree of flexibility in achieving these standards to encourage innovations in quality improvement and cost-effective care. Through the American Medical Association, the medical profession should develop a program for physician performance assessments.

In plan quality management systems and utilization review programs, it is necessary that these programs operate to enhance patient care and are based on sound scientific and medical information. Those who are involved in final decisions should be knowledgeable in the area they are reviewing. Procedures need to be fair and prompt. The Partnership for Health Care Value should establish and/or recognize medical practice guidelines and shall be responsible for evaluating outcomes research as to the effectiveness of various medical practices.

ADMINISTRATIVE SIMPLIFICATION

Accrediting bodies that now exist for managed care and other health benefit plans, such as the NCQA, properly require that each plan have procedures regarding credential verification, inspections and other mechanisms to assure that the practitioners and the facilities within their programs are capable of delivering care and meeting plan quality and other standards. Unfortunately, when a physician or a medical group participates in more than one plan, there can be multiple inspections and other administrative requirements that serve the same purpose but provide no new information and increase costs and divert attention away from patient care. Therefore, to the greatest extent possible, uniform information requirements and inspection or certification procedures should be established to avoid duplication of efforts and increased costs. The Federal government should foster this uniformity by providing grants to private sector organizations for the development of acceptable uniform standards, procedures and inspections. Provider credential verification should be made as easy as possible. To avoid duplication of efforts, a private verification service should be recognized in lieu of repeated searches. Likewise, when a Plan contracts with an Individual Practice Association (IPA) for the provision of physician services, it should delegate verification to the IPA. Large administrative savings could also be achieved if these private sector activities would be recognized by health plans for their non-Medichoice lines of business.

While Federal law requires an opportunity for public comment on proposed rules, this involvement takes place after the drafting has taken place and in a context that is not conducive to give and take. Therefore, in areas where there will be continued Federal regulation, the AMA recommends that a major emphasis be placed on using negotiated rulemaking procedures to improve the quality of needed regulations in the health care sector.

OTHER

Plans need to have arrangements so that enrollees can expect reasonable access to all medically necessary and appropriate care.

It is necessary that plans have sufficient resources to meet their obligations to provide the services that have been paid for through premiums. This has been an area of traditional state regulation and could be delegated to the states. Currently the National Association of Insurance Commissioners is working in this area.

LEGISLATIVE SPECIFICATIONS: QUALITY AND PLAN STANDARDS

PARTNERSHIP FOR HEALTH CARE VALUE

- A private sector partnership would be established. It could be formed pursuant to statute, similar to the statute which created the Institute of Medicine. The initial governing body would be appointed from the following sources: the AMA, the American Hospital Association, trade associations that represent insurers, employers, consumer groups, accrediting bodies and the federal government (AHCPR or HCFA).

The work of the Partnership would include:

- Developing standards for outcomes measurement and reporting, including the content and format of electronic patient records, and guiding and coordinating efforts to gather outcomes data.

- Developing standards for and coordinating effectiveness research and technology assessment.

- Coordinating technology assessment and establishing standards for technology dispersion and use.

- Establishing priorities for guideline development through analysis of variations in practice or important procedures.

- Creating guidelines for, coordinating the development of, and disseminating practice parameters.

The Partnership would draw upon resources and activities now ongoing in the private sector. It would focus on setting the methodologies for these activities, setting priorities for them, and in reviewing and approving of the work done by private sector organizations. For example, in the development of practice parameters, the Partnership would proceed by reviewing the efforts of various organizations to develop methodologies for the creation of parameters. These would include the attributes of practice parameters developed by the AMA/Medical Specialty Society Practice Parameters Partnership, the principles developed by the AHCPR, the principles developed by the Institute of Medicine, and by others. The Partnership would then reach a consensus on a single set of attributes or principles. The Partnership could also work with private sector accrediting bodies such as the JCAHO, NCQA, and URAQ to evaluate their programs to facilitate transfer and wide dissemination of advances in their respective areas.

Each organization represented on the Partnership would pledge to use its communications vehicles to disseminate the work product of the Partnership. In addition, the Partnership would enlist other organizations to use their communications vehicles and would look for other means of communication as well.

PROGRAM OVERSIGHT

- A federal agency, HHS or OPM shall be responsible for assuring that Medichoice plans are in conformance with plan standards. While it is necessary to have some level of

federal accountability, to the greatest extent possible, the federal agency should delegate this activity to private sector voluntary accrediting entities which have set standards and can demonstrate that their accreditation assures compliance with necessary safeguards.

- The federal agency shall provide "deemed status" to private sector accreditation programs which meet or exceed federal requirements.

COVERAGE, MARKETING, AND ENROLLMENT

- Plans could cover types of services, with incentives for preventive services, now available under the Federal Employees Health Benefit Program (5 USC 8904) such as payment for or direct provision of hospital care, surgical care and treatment, medical care or treatment, obstetrical benefits, prescribed drugs and medicines, prosthetic devices, and other medical supplies and services.

- Each Medichoice plan must assure prompt access to all necessary covered medical services and shall enter into such agreements with health care providers or have such other arrangements as may be necessary to the provision of all services covered by the benefit package to eligible individuals enrolled with the plan. Plans must have provisions for either providing or arranging for the provision of out-of-area services. Health care providers or facilities must, if required by a state, be licensed/certified by the state in which the services are provided.

- Medichoice plans must cover emergency services provided to enrollees, without regard to whether or not the provider furnishing such services has a contractual (or other) arrangement with the plan to provide items or services to enrollees of the plan and in the case of emergency services without regard to prior authorization. "Emergency services" means those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in:

    (1) placing the patient's health in serious jeopardy;

    (2) serious impairment to bodily functions; or

    (3) serious dysfunction of any bodily organ or part.

- Under Medichoice, plans would participate in a common open enrollment period (at least 1 month each year) and must accept all eligible applicant during this period up to plan capacity.

- Plans may not exclude specific individuals or medical conditions. Each Medichoice plan must accept for enrollment every eligible individual who seeks such enrollment. No plan may engage in any practice that has the effect of attracting or limiting enrollees on the basis of personal characteristics, such as health status, anticipated need for health care, age, occupation, or affiliation with any person or entity. A Medichoice plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability.

- No pre-existing condition limits or waiting periods before coverage begins initially or during the open enrollment period. No physical examinations required.

- Medichoice plans may not discriminate, or engage in any activity that has the effect of discriminating, against an individual on the basis of race, national origin, gender, language, socio-economic status, age, disability, health status, or anticipated need for health services. In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a Medichoice plan may not engage in any practice that has the effect of discriminating against a provider based on the race, national origin, gender, language, age, or disability of the provider or based on the socio-economic status, disability, health status, or anticipated need for health services of a patient of the provider. Recruiting activities must be at sites that are accessible to the disabled.

- No false or materially misleading information may be distributed. Information shall be approved by private accrediting agency or HCFA. Information provided to those considering enrollment and current enrollees shall be available in a uniform format that is easily understandable by the target population and include: the premium; the identity, locations, qualifications, and availability of participating providers; the rights and responsibilities of enrollees, including procedures necessary to obtain services; an explanation of how plan limitations impact enrollees; information on enrollee financial responsibility for payment for coinsurance or other non-covered or out-of-plan services; specific information and instructions for obtaining out-of-area services, urgent care and emergency services must be provided in easy to understand language; the medical benefit/loss ratio and an explanation that such ratio reflects the percentage of premiums expended for health services as compared to total premiums; the number of grievances/appeals and the percentage decided in favor of plan; information on the number of plan members who disenroll from the plan each year; and a "Report card" on indicators of quality.

FAIRNESS

- Each Medichoice plan shall establish a grievance/appeal procedure for enrollees and providers to use in pursuing complaints. If grievance procedure fails, the issue is to be resolved by a local area independent health plan "ombudsman" to review and resolve disputes.

- Each Medichoice plan shall establish appropriate mechanisms for participating hospitals, physicians, and other health care providers to appeal adverse findings and actions taken by the health plan in response to alleged quality concerns.

- When plans limit access to certain providers of physicians, the plan shall establish mechanisms to assure basic fairness in processing requests for initial participation and in making decisions that adversely affect participation status. Plans need not accept or act upon a request for participation if the plan is fully staffed. These mechanisms shall include:

  (1) provisions for providing requesting parties standards and criteria used to determine participation;

  (2) provisions for a physician to receive a written statement of reasons, and to have an opportunity to respond, either in writing or at a formal meeting, before a final decision is made by the governing body to deny a request for initial participation or to deny renewal; or to terminate or permanently restrict participation.

- Each claimant and physician or other provider (upon assignment of a claimant) who has had a claim or service denied as not medically necessary shall be provided a written statement of reasons for the decision, which must be clearly documented in the permanent case record, whether such record is automated or manual. The written determination letter shall include a general description of the reason the claim or service was denied, an explanation of both the claimant's and physician's grievance/appeal rights, and instructions for both the claimant and physician to enter into a grievance procedure/appeal process.

PHYSICIAN INVOLVEMENT

- Each Medichoice plan that assumes responsibility for management or delivery of health care shall establish a body, similar to a medical staff, accountable to the governing body or corporate management that involves participating health plan physicians and other health care providers and that participates in the development of the health plan's medical policies, drug formularies, and quality management program. The quality management program shall use professionally developed standards for physician performance measures and shall monitor and evaluate the quality of care provided by the Medichoice plan and its participating hospitals, physicians, and other health care providers. [See Quality Management/Utilization Review]

- Plans may not prohibit a physician from informing a patient about all medical options the physician feels is appropriate, even if the option is not covered by the plan. Plans may not penalize physicians for advocating coverage of medically necessary and appropriate care in the patient's best interest.

QUALITY MANAGEMENT/UTILIZATION REVIEW

<u>Quality Management</u>

A Medichoice plan that assumes responsibility for management or delivery of care may participate in a recognized private sector program that accredits quality management programs or the following: [See Program Oversight]

- As relevant each Medichoice plan shall employ, contract with, or appoint a licensed physician to serve as health plan medical director who is responsible for: implementation and coordination of the health plan's quality management program; supervising quality management staff; and communicating with participating hospitals, physicians, and other health care providers on quality-related issues.

- The plan shall develop or adopt quality standards and/or measures for participating hospitals, physicians, and other health care providers. Quality management plans would have demonstrated validity and reliability and reflect current professional knowledge and available medical technologies.

- The plan shall develop and implement a quality management confidentiality policy that assures compliance with applicable federal and state laws; and that confidential information is provided only to authorized health plan personnel and appropriate regulatory authorities.

Utilization Review

A Medichoice plan that uses a utilization review program may participate in a recognized private sector program that accredits the quality of utilization review programs or the following: [See Program Oversight] Such an accrediting program assures that there are fair procedures and that practice guidelines used reflect the current state of review practice.

- Screening criteria, weighing elements, and computer algorithms utilized in the review process and their method of development, must be released upon request to physicians. Plans may require a confidentiality agreement for the release of information that is of a proprietary nature. Such criteria must be based on sound medical necessity standards developed through scientific investigation.

- Any person who recommends denial of coverage or payment, or determines that a service should not be provided based on medical necessity standards, must be a physician knowledgeable in the service being considered.

- Plans may not require prior authorization for emergency care, including a medical screening exam and stabilizing treatment as defined in Section 1867 of the Social Security Act. Any prior authorization requirement for medically necessary services arising from such screening exam or stabilizing treatment shall be deemed to be approved unless a required request is denied within 30 minutes. Other patient or physician requests for prior authorization of a non-emergency service must be completed within two business days, and qualified personnel must be available for same-day telephone responses to inquiries about medical necessity, including qualification of continued length of stay.

- When prior approval for a service or other covered item is obtained, it shall be considered approval for all purposes, and the service shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained.

ADMINISTRATIVE SIMPLIFICATION

- Negotiated rulemaking procedures shall be used in all areas where federal regulations continue.

- Where claims are submitted, plans shall use a standard claim form or electronic claim submission protocol. Plans should conduct the transactions (e.g., remittance, eligibility, etc.) using standard formats.

- In order to avoid duplication of efforts in inspections and assuring that physicians and groups meet the requirements of multiple plans, the Secretary shall designate private sector organizations to accredit facility and physician office compliance with the standards of plans. To the greatest possible extent, inspections shall be performed by a single local entity that shall be accepted by all plans in order to avoid the expense and inconvenience of multiple inspections. Non-Medichoice private sector plans shall also be encouraged to recognize these standards and inspections.

- Each Medichoice plan shall verify the credentials of practitioners and facilities to ensure that all providers participating in the plan meet applicable state licensing and certification standards. To the greatest extent possible, a uniform form for obtaining information for the purpose of credential verification shall be utilized. When a plan contracts with an Individual Practice Association (IPA), the plan still relies on the IPA to assure verification of credentials. If the Secretary recognizes a private sector credential verification service, plans shall be required to recognize such credentials as if verified from the primary source.

- When available, plans shall accept patient records that are maintained in an appropriate computerized patient record system.

INCENTIVE PLANS

- No specific payment may be offered directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to an individual patient.

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PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS

CURRENT PROBLEM

Physician/provider sponsored coordinated care organizations (PCCO) have the potential to contract for Medicare beneficiaries in a Medicare system. The benefits to the Medicare program would be lower costs and higher quality of care than in non-physician/provider health plans. Costs would be lower because contracting with a PCCO instead of an insurer could eliminate a layer of profit and overhead. Quality would be higher because physicians would have direct control over medical decision-making, and physicians are best qualified to strike the balance between conserving costs and meeting the needs of the patient.

There is already a substantial infrastructure of PCCOs. The ideal PCCO is physician directed with vehicles for input from the physicians that deliver health care through the PCCO. They include large, multispecialty group practices such as the Cleveland Clinic, Oschner Clinic, and the Mayo Clinic, academic medical centers, large clinics "without walls", and hospital systems that have partnered with physician networks. Many of these PCCOs include a full range of providers and are capable of contracting to provide care for Medicare beneficiaries.

In addition, many physicians and other providers are interested in forming PCCOs. Physicians and hospitals are exploring ways to organize themselves so they can operate on a prepaid basis. There are almost no communities in the United States where physicians and other providers are not considering or actively forming a PCCO. If these explorations resulted in the formation of numerous new PCCOs, the public benefits would be substantial.

There are, however, obstacles to realizing the benefits of PCCOs. One is a trend towards treating PCCOs that operate on a prepaid basis as insurance companies that are required under state law to register as an insurer and comply with all state regulations applicable to an insurer. Treating PCCOs as insurers does not make sense because, unlike the conventional insurer or HMO, a PCCO consists of the physicians and providers capable of delivering the product that it has contracted to provide on a prepaid basis. The PCCO does not have to contract with providers to deliver the care. Requiring the PCCO to comply with insurance regulations adds unnecessary costs to their operations.

The second problem is legal obstacles to the formation of PCCOs. Physicians and other providers face substantial practical problems that must be solved in the formation of a PCCO. They lack the capital resources that insurance companies and national managed care organizations have, and they lack the management infrastructure. To make matters even more difficult, legal regulations simply bar the formation of certain kinds of PCCOs. Compliance with legal regulations adds substantial costs and time to the organizational effort.

Current trends in health care delivery and finance require that physicians and other providers cooperate to form health care delivery networks that are (1) capable of providing comprehensive health care services in a coordinated fashion and (2) capable of managing financial risk, such as capitation and fee withhold arrangements. However, our legal structure has not yet adjusted to the new economic conditions. Several sets of laws actually interfere with the ability of providers to develop health care delivery systems, including antitrust laws, bars on self-referral, fraud and abuse laws, the tax regulation of pension plans, laws regulating tax exempt entities, and others.

Enabling physicians/providers to develop health care delivery systems will benefit the public by (a) increasing competition among health care delivery systems for the patronage of payers, (b) facilitating the evolution of health care delivery systems into physician/provider sponsored health plans, thereby increasing competition among health plans, and (3) by assuring that the patient centered values of physicians and other providers remain an important influence in an era when physician decisions are increasingly being subjected to control by non-physicians interested in cost control and profit. The alternative to physician/provider sponsored health care delivery systems and health plans is systems organized and controlled exclusively by non-physicians, such as insurance companies and national managed care companies.

Even if the changes recommended here are implemented, the dominant insurance systems will grow and continue to merge into even larger systems. It may well be that insurance systems and not physician driven systems will control health care delivery. In such systems, insurers will control medical decision-making, and the role of physicians as innovative care managers and as patient advocates will be substantially reduced. To prevent physician values from being submerged, the minimum accommodation needed today is clarification of the antitrust laws supporting the rights and abilities of physicians and other providers to jointly present their views on any matter to insurance plans on behalf of themselves and patients as long as no boycott and price fixing is involved.

RECOMMENDATIONS

1. *EMPOWERING EXISTING PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS (PCCOS)*

As part of a Medicare reform program that creates a defined contribution plan, PCCOs would be authorized to contract with Medicare beneficiaries without being licensed insurers under state law. These new initiatives can eliminate the higher administrative and return on equity costs of insurance sponsored plans. In order to meet legitimate regulatory needs, HCFA would develop a limited set of criteria that PCCOs would have to meet in order to become qualified. This process would be similar to the procedures for qualifying health maintenance organizations pursuant to the federal Health Maintenance Organization Act of 1974. Those procedures were largely responsible for enabling the creation of numerous HMOs. Similar procedures could facilitate the creation of PCCOs.

2. *ELIMINATING REGULATORY BARRIERS TO THE FORMATION OF PCCOS*

The laws that interfere with the development of physician/provider sponsored health care delivery networks were developed in an era when physicians and other providers operated independently from each other. The object of these laws is to prohibit cooperative activities between independent providers that will be harmful to the public. These laws should not be eliminated, because they protect the public from harmful conduct. However, in doing so they go too far and interfere with beneficial cooperation among physicians and other providers. Therefore, these laws need to be adjusted to recognize the new economic realities of health care delivery. The legal areas that need adjustment include:

Antitrust.

Enforcement of the antitrust laws should be adjusted to allow physicians and other providers to organize preferred provider organizations, health care delivery networks and health plans that allow for a wide choice of providers, and delivery systems or health plans that offer more than one kind of financing arrangement, such as the "triple option" which includes an indemnity plan, a PPO plan and an HMO plan.

Self Referral.

Enforcement of bars on self referral should be adjusted to allow for the coordination of care among physicians and other providers in a health care delivery network or health plan, especially when the providers have made a common investment in facilities or equipment for use by the network or health plan.

Fraud and Abuse.

Enforcement of the fraud and abuse laws should be adjusted to allow physician/provider sponsored health care delivery networks and health plans greater flexibility in financial arrangements necessary to recruit physicians and other providers, and in the division of income obtained by the network or health plan among the providers.

Pension Plans.

Adjustments should be made in enforcement of federal tax and employee benefit laws that preclude favorable tax treatment of pension, welfare benefit, or profit sharing plans. These laws currently discourage physicians from uniting to own and govern plans and networks.

State Certificate of Need Laws.

Medicare providers should be exempt from Certificate of Need Laws (CON) laws. These laws discourage the construction of new facilities and the development of new capabilities in existing facilities. This protects existing market participants and chills new competition.

Regulation of Tax Exempt Entities.

The regulation of tax exempt entities can prevent the payment of fair value for physicians who sell their practices to a tax exempt network, and can make it difficult to include tax exempt entities in a new physician/provider sponsored network. In addition, tax regulations limit physician representation on the governing boards and tax exempt health care delivery networks.

Insurance Regulation.

The regulation of physician/provider sponsored health care delivery networks that contract with health plans, but do not function as full fledged health plans, should not be subjected to excessive regulation at the state level.

3. CLARIFYING THE ANTITRUST LAWS FOR PHYSICIAN NEGOTIATION

Even if the assistance recommended above is implemented, the dominant insurance systems will grow and continue to merge into even larger systems. Non-physicians will control medical decision-making. Antitrust clarification is needed to support the rights of physicians and other providers to jointly present their views on any matter to insurance plans on behalf of themselves and patients as long as no boycott and price fixing is involved.

RATIONALE

RATIONALE FOR EMPOWERING EXISTING PCCOS

Traditionally, health care insurers assumed the risk that their beneficiaries would need health care services. However, today there is a trend in the market for health care insurers to pass this risk on to physicians and other providers. The kind of arrangements which pass risk on to physicians include capitation, fee withhold arrangements, and others. The assumption of risk by physicians/providers instead of insurers creates an opportunity for the Medicare program to reduce costs through a defined contribution plan. This will allow PCCOs to contract with Medicare beneficiaries on a prepaid basis without having the insurance company as an intermediary. Allowing beneficiaries to contract directly with health care delivery systems can reduce costs by removing a layer of administrative costs and profits.

The option contemplated is a prepaid service contract between a health care delivery system capable of providing most or all of a Medicare beneficiary's medical care and a Medicare beneficiary. It differs from other prepaid plans in that the health care delivery system has the direct capability of delivering the services. The existence of this asset makes the nature of the financial risk being assumed different than the risk being assumed by a third party payer that has no delivery system of its own. The contracts are being used to make use of and generate a return on a health care delivery system that the contractor owns and operates.

The existence of these assets make it possible for the health care delivery system to assume risk more easily than a third party payer without these assets. The health care delivery system has sunk costs, therefore the marginal costs of providing a unit of health care services are lower than they are for an insurer that has no delivery system and has no sunk costs. In other words, if utilization of health care services by a set of beneficiaries turns out to be greater than expected, the health care delivery system can absorb this cost more easily than can a third party payer without a delivery system.

In addition, a health care delivery system is likely to have management systems in place for coordination of care, quality assurance, and other functions that third party payers do not have. As a result, a health care delivery system should be regulated differently than insurers. State insurance regulations tend to unnecessarily raise the costs of health care delivery systems because

they are oriented around the traditional insurance company. A set of plan standards oriented around the physician/provider sponsored health care delivery system, administered by HCFA similarly to the way it administered plan standards for federally qualified HMOs, should be designed to achieve lower costs.

However, the current regulatory structure would not allow health care delivery systems to contract for Medicare beneficiaries on a prepaid basis without obtaining an insurance license. Such a license requires the maintenance of reserves, a minimum capitalization, the generation of a minimum surplus, and contribution to funds that are used to cover claims in the event that an insurer becomes insolvent. Licensure also requires compliance with complex registration and reporting procedures, and with other regulations. This regulatory structure is not well suited to the new environment.

Certainly, there is a need to guard against insolvency and to protect patients in any scheme to allow Medicare beneficiaries to contract with health care delivery systems. However, it should be possible to develop a system that allows for this but eliminates the costs associated with insurance licensing and regulation. Health care delivery systems that contract with insurers on a capitated basis are already engaged in the process of managing risk. They are also engaged in quality assurance for the protection of the patient. It should be possible to orient the regulation around the costs that these delivery systems are already incurring without making them assume new costs.

RATIONALE FOR ELIMINATING REGULATORY BARRIERS TO THE FORMATION OF PCCOS

Enforcement of Antitrust Laws

In 1994, the United States Department of Justice (DOJ) and the Federal Trade Commission (FTC) promulgated a set of Guidelines for the formation of provider sponsored health care delivery networks and health plans. It is considered illegal under the Guidelines for physicians to form certain kinds of networks and plans. Other kinds of networks and plans are legal, but only if restrictive conditions required by the antitrust laws are met. Insurers and other non-providers may organize networks and plans without the same limitations.

Preferred Provider Organizations (PPOs). In particular, it is illegal for physicians or for hospitals to organize a PPO where the participants agree on the fee or rate discounts that they will charge through the PPO. The guidelines do allow providers to organize a PPO by using the "messenger model", which allows the individual negotiation of fee arrangements between payers and the providers in the PPO. However, this mechanism is expensive and cumbersome to use, and is no longer feasible for use under current market conditions. By some estimates there are 75 million Americans enrolled in PPOs. This is a huge market. It can be assumed that many Medicare beneficiaries in a defined contribution plan would select a PPO. It does not make sense to bar physicians and other providers from competing with PPOs organized by insurers or other non-providers.

IPA-Model HMOs. There is also a huge market for IPA-model HMOs, because this type of HMO commonly has a large panel of providers and can offer patients a wide array of choice of physicians and hospitals. However, the Guidelines bar the organization of physician/provider sponsored IPA-model HMOs with large panels, even when these panels are nonexclusive, meaning that the physicians involved are free to contract with other plans or networks. This

makes it difficult for an IPA-model HMO sponsored by physicians/providers to offer wide choice. Clear evidence that the Guidelines are too restrictive in this regard is the existence of physician sponsored IPA-model HMOs that have very large panels of physicians but which are a beneficial force in the market. These HMOs were organized before the current administration developed its antitrust Guidelines. They are not engaging in any illegal activity, and therefore they are not being challenged. However, if they were being organized today and sought clearance from the DOJ or FTC, they would not be allowed to form.

For example, the South Dakota Medical Association organized an IPA-model HMO in the mid-1980s that has 90% of the physicians in the state on its panel. It is likely that there would be no HMOs in South Dakota if the medical association had not organized one. The Connecticut State Medical Society organized an IPA model-HMO in the 1980s that has 60% of the state's physicians on its panel. It grew to have 200,000 beneficiaries, and recently the HMO was sold to another HMO, although the medical society retains the IPA. The AMA can provide information about other examples on request.

The "Triple option". Many employers or health plans like to offer more than one health plan option to beneficiaries, such as traditional insurance benefits, PPO, HMO, and benefit payment schedule. It can be assumed that PCCOs would like to offer triple options to Medicare beneficiaries in a defined benefit program. The Guidelines allow physician sponsored networks to offer the HMO option (if panel size limitations are observed), but it is illegal to offer the PPO option or other fee for service type options unless the messenger model is used. This places the physician sponsored networks and plans at a disadvantage in competing with non-physician sponsored health plans or networks.

No Exemptions are Needed. Enforcement of the antitrust laws can be modified to allow the formation of legitimate PCCOs without creating exemptions or repealing antitrust laws. It is simply a matter of interpreting existing antitrust doctrines to allow the formation of these entities instead of declaring them to be illegal organizations. There is no solid case law or statutes which state when PCCOs are legally formed or when they are illegal. For the past 15 years, the health care industry has been relying on interpretations of the antitrust laws by the DOJ and the FTC, and these interpretations have changed over time.

Finally, the changes to antitrust enforcement requested would simply allow PCCOs to be formed -- it would not give an exemption from the antitrust laws that would allow them to engage in anticompetitive activities that are illegal.

Self-referral

The bars on physician self referral were created to prevent a physician from referring patients to a facility in which the physician has a financial interest. The object is to prevent physicians from allowing the financial interest to corrupt the physician's judgement and to prevent the financial interest from causing over-utilization. In a PCCO, the providers are expected to coordinate their care in order to reduce costs, such as achieving economies of scale and controlling over-utilization by referring network or plan patients to the same physicians and facilities. These arrangements can be barred by the self referral laws when the participating physicians have invested in network facilities. This is a clear example of the law not keeping pace with economic realities.

Fraud and Abuse

The bars on fraud and abuse were created to prevent over-utilization and unnecessary costs by barring any person from paying a physician or provider to refer Medicare patients for services or products. These laws make it difficult for physicians/providers to assemble a PCCO by buying the practices of physicians or by entering into certain kinds of financial arrangements with other providers. Again, the object is to set up an efficient and lower cost system for providing care. This is another example of the law not keeping pace with economic realities.

Pension Plans

Many independent physicians have developed and funded their own pension plans. When they organize with other physicians to form a network or a health plan, tax rules may require those pension plans to be aggregated for nondiscrimination purposes. This can change the terms of the pension that the physician had developed, and can be a disincentive to enter into network arrangements.

Certificate of Need (CON) laws

When a new physician/provider sponsored health care delivery network wants to construct new facilities, it may have to obtain a certificate of need (CON). The purpose of CON laws is to limit health care expenditures by limiting the number of providers. While that kind of law had some logic under the cost based payment rules in effect at the time CON laws were passed, it is not appropriate for a defined contribution system that depends on competition among providers to lower costs and enhance quality. CON laws limit competition by restricting the number of competitors.

Regulation of Tax exempt entities

Tax rules governing tax exempt providers make it difficult for them to interact with other providers in the development of networks. An association between a tax exempt hospital and a nonexempt group of physicians can endanger the hospital's tax exemption. The rules also make it difficult for the hospital to purchase physician practices at market value. Further, tax regulations applicable to tax exempt health care delivery systems limit the representation of physicians on the governing boards of those systems. In general, no more than 20% of the governing boards of tax exempt entities may consist of physicians. This makes it difficult for physicians to direct medical policy.

Regulation of Insurance Entities

New kinds of PCCOs may accept capitation or some other type of risk sharing arrangement. An increasing number of state insurance commissioners are interpreting risk arrangements as constituting insurance, and are asserting that these PCCOs should register as insurers. Registration subjects them to onerous capitalization, reserve, and surplus requirements, among others. This level of regulation is not necessary for PCCOs that have the capacity to deliver health care services that they contract to provide on a prepaid basis, especially when they contract with health plans instead of acting as health plans. (As discussed above, qualifying PCCOs should also be able to contract with Medicare beneficiaries without being licensed insurers.)

LEGISLATIVE SPECIFICATIONS: REFORMS TO EMPOWER EXISTING PCCOs

The following suggested reforms refer only to PCCOs that have the capability to provide a broad range of care. They may include large, multispecialty group practices that have an affiliation with a hospital, physician hospital organizations, academic medical centers, hospital systems that have partnered with a substantial physicians network, independent practice associations, and others. The PCCO must be able to provide the full range of Medicare services or substantially all of those services. It is permissible for a PCCO to contract for the services that it cannot provide, but those services must be a small percentage of the services used by beneficiaries.

FISCAL SOLVENCY

Standards for reserves, net worth, stop loss and reinsurance should be developed and administered by HCFA. They shall take into account the greater ability of the health care delivery system to absorb unexpected utilization.

SCOPE OF BENEFITS

The prepaid plan offered by the PCCO should include all services covered by the program. The plan may include more than those services.

SERVICE AREA

The PCCO should be required to accept enrollees from a designated geographic radius to assure availability and accessibility of care.

STATE REGULATION

The PCCO should not be required to be licensed as an insurer or an HMO under state law. HCFA would qualify the plan. HCFA could deem state insurance commissioners to administer its criteria for qualification of these plans.

GOVERNANCE AND STRUCTURE

The PCCO must be physician/provider directed, meaning that a majority of its governing board must be physicians/providers. It should also have procedures to allow its providers to have input into management policies. The PCCO should have the administrative capability to process claims, manage financial risk, and conduct other health plan capabilities.

LEGISLATIVE SPECIFICATIONS: REFORMS TO FACILITATE THE FORMATION OF PCCOs

ANTITRUST REFORMS

Risk Sharing

- The physician participants in a PCCO should engage in risk sharing, which includes, without limitation, the following:
  - when the PCCO agrees to provide services at a capitated rate;
  - when the PCCO creates significant financial incentives for its members as a group to achieve specified cost-containment goals, such as withholding from all members a substantial amount of the compensation due to them, with distribution of that amount to the members only if the cost-containment goals are met;
  - when the PCCO agrees to provide services for global fee packages; or
  - when most of the member physicians hold significant ownership or equity interests in the PCCO, where the capital contributed by the members is used to fund the operational costs of the PCCO such as administration, marketing, and computer-operated medical information, if the PCCO develops and operates comprehensive programs for utilization management and quality assurance that includes controls over the use of institutional, specialized, and ancillary medical services.

Size

- PCCOs may have exclusive physician panels that include up to 30% of the physicians in the market, in aggregate and by specialty.
- PCCOs may have nonexclusive physician panels that include at least 50% of the physicians in the market.
- PCCOs may have exclusive or nonexclusive panels larger than those set forth above if the PCCO is not in violation of any federal law.
  - Alternatively, no size limits are set on PCCOs, and they are evaluated on whether they intend to or in fact engage in anticompetitive conduct.

Payment Arrangements

- Physician members of a PCCO may jointly determine the terms of financial arrangements between the PCCO and the physicians, including the method and amounts by which the physicians will be paid. The physician members may also jointly determine the terms of financial arrangements between the PCCO and any purchaser of the products offered by the PCCO.

- The physicians participating in a nonexclusive PCCO may not agree to boycott any purchaser, and they may not agree to fix prices for physician services when contracting with purchasers other than through the PCCO.

New Product

- A PCCO will be considered to be offering an additional or "new" product in a market for the finance and delivery of health care if it offers one of the following:
  - A preferred provider organization which has the following characteristics:
    - Physicians and other providers on the PPO's "panel" of providers agree to discount their fees or charges for treatment of PPO beneficiaries.
    - The PPO gives its beneficiaries financial incentives to use the providers on its panel. Beneficiaries may use providers who are not on the panel, but if they do so they are personally liable for larger copayments than are required when they use panel providers.
    - The PPO engages in utilization review and quality assurance to control costs and maintain quality.
    - The PPO administers and pays claims.

Studies

- Adopt the recommendation of the Physician Payment Review Commission that the DOJ and FTC conduct studies of the market for health care delivery and finance and the structure and role of PCCOs in the market. One part of the study should be directed at market definition to provide better guidance about how to define the size of the market in which a PCCO is being formed or is operating.

SELF REFERRAL

- Physician members of a PCCO may make arrangements among themselves to coordinate the care of patients who are beneficiaries of contracts between the PCCO and a purchaser. This includes referring to facilities or providers in which the other providers have a financial interest. Safe harbors should be created in the existing self referral laws for this kind of coordination of care.

FRAUD AND ABUSE

- Provider members of a PCCO may purchase physician practices and other providers or engage in other kinds of financial arrangements with providers that remain independent but commit to becoming part of the network. Safe harbors should be created for this activity.

PENSION PLANS

- Tax regulations should be developed which permit the formation of PCCOs without requiring aggregation of pension plans that have been independently developed and funded. Aggregation may be permitted on a prospective basis when a PCCO becomes fully integrated.

CERTIFICATE OF NEED LAWS

- Medicare providers should be exempt from Certificate of Need laws.

REGULATION OF TAX EXEMPT ENTITIES

- Tax regulations should be developed that allow tax exempt hospitals and tax exempt clinics to purchase physician practices at fair market value without endangering their exempt status. Tax regulations should be developed that allow tax exempt hospitals to affiliate with PCCOs without losing their exempt status. Tax regulations should allow up to 50% of the governing board members of a tax exempt health care delivery system to be physicians.

STATE INSURANCE REGULATION

- The National Association of Insurance Commissioners is asked to develop model regulations for risk bearing PCCOs that are appropriate for the function performed by those entities as opposed to treating them as insurance companies. These model regulations would not contain onerous capitalization, reserve, and surplus or registration requirements.

LEGISLATIVE SPECIFICATIONS: REFORMS TO CLARIFY THE ANTITRUST LAWS WITH REGARD TO JOINT DISCUSSION WITH PLANS

- Where physicians are unable to create effective competing plans their only avenue for making effective input into the increasingly concentrated delivery system/payer control is through joint presentation of their views and patient views about plan matters. The Court of Appeals for the Ninth Circuit recently held, " ...individual health care providers are entitled to take some joint action (short of price fixing or group boycott) to level the bargaining imbalance created by the plans and provide meaningful input....." (Alston v. United States).

  Alston demonstrates the need to correct the FTC's interpretation of the antitrust laws regarding physician involvement in the development of fees by a physician network or health plan. Antitrust officials must issue a clear statement that physicians are free to approach health purchasers and plans jointly in order to provide input on fees and other payment-related issues, as long as the physicians do not engage in a boycott or threat of boycott. An agency or trier of fact should not infer a boycott threat from the mere fact of discussions – some express or implied threat of coercive conduct by the physicians must be made. Otherwise, health care providers will be deterred from engaging in useful and potentially procompetitive activities.

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MEDICARE FUNDING OF MEDICAL EDUCATION

CURRENT PROBLEM

Medicare contributes to the funding of graduate medical education through two payment streams. The direct medical education payment (DME) covers the salaries and fringe benefits of resident physicians, supervisory time for physicians who participate in training resident physicians and allowable overhead related to teaching. The Medicare indirect medical education adjustment (IMEA) originally was introduced to compensate hospitals for the increased costs associated with the presence of an educational program that could not be attributed to resident and attending physician salaries, the greater complexity of care provided in teaching hospitals due to the generally higher severity of illness of the patient population, and the uncompensated care that is provided that could no longer be supported through some cost shifting to Medicare patients. DME payments for 1996 are projected to be $2.1 billion and IMEA payments are projected to be $3.8 billion.

There are several reasons why the funding of graduate medical education must be redesigned. First, the federal government is, in general, the only payer to directly reimburse the costs of graduate medical education. It has been estimated that Medicare pays about 30% of direct graduate medical education costs through the DME. The private sector has, in the past, contributed through paying the higher charges associated with teaching hospitals. In the current competitive environment, the private sector is becoming less willing to pay higher charges to support the training of future physicians at both the undergraduate and graduate medical education levels. Therefore, the participation of both the public and private sectors in financing medical education should be re-examined, and a mechanism developed to ensure an equitable contribution from all parties to preserve this national resource.

In addition, the current funding formulas for graduate medical education through Medicare contain incentives to increase the number of trainees, which is not consistent with current national needs and has led to a steady growth in the number of graduate medical education positions. Currently, there are about 17,000 graduates per year of U.S. MD- and DO-granting schools and 8,000 international medical graduates (IMGs) who fill about 25,000 entry-level graduate medical education positions. As a consequence of the way that Medicare financing of GME is structured, both the Direct Medical Education payment and the Indirect Medical Education Adjustment have been rising.

The growth of managed care has placed increased pressures on medical schools and teaching hospitals in two ways. First, the revenues that are used for educational program support are being impacted by the increasingly competitive environment. Second, the patient base in teaching hospitals is decreasing, as more individuals enter into managed care plans, which restrict enrollee access to certain providers and hospitals. This decrease or loss of a patient base compromises a critical element in the training of physicians. In addition, care must be taken not to create negative incentives for teaching in the ambulatory care setting outside the medical school/teaching hospital. For example, the average adjusted per capita cost (AAPCC) formula used by Medicare for risk based managed care programs includes medical education within the per capita payment made to managed care plans. There is no requirement, however, that the managed care organizations participate in medical education as a consequence of receiving the funding.

The necessary restructuring of graduate medical education financing should not, however, result in unplanned, negative consequences to teaching hospitals, which provide a high level of

specialized care and care to the uninsured and underinsured, or to medical schools, which carry out both educational and research missions. It is important to remember that resident physicians also provide a large amount of care, often to poor and underserved populations. There are hospitals in some areas of the country that are heavily dependent on the medical services of resident physicians. Therefore, any changes in funding for graduate medical education should evaluate the effects on institutions with teaching programs, taking into account specialized regional needs and circumstances.

RECOMMENDATIONS

1. During a transitional period (FY96 and FY97), change the existing funding formulas for direct medical education payments and indirect medical education adjustment to halt the current steady increase in costs. In this period, introduce differential weighting for a preset number of training positions into the existing funding formula for direct medical education payments and limit full funding to the years leading to general certification by the 24 specialty boards recognized by the American Board of Medical Specialties plus the full length of training programs in geriatrics.

2. Create a private sector physician workforce planning initiative, with governmental participation, to make recommendations about the need for physicians and the funding of graduate medical education. In developing its recommendations, this body should consider such things as specialty mix, geographic distribution and appropriate training for the emerging health system.

3. Re-structure the financing of graduate medical education into an all-payer system and distribute funds to the entity that incurs the costs of training, whether that entity is a medical school, hospital, nursing home or ambulatory clinic.

4. Analyze the current indirect medical education adjustment (IMEA) and consider the development of an appropriate funding mechanism to reimburse for the increased complexity of care/severity of illness in teaching hospitals.

5. By FY99, decrease the number of entry level residency positions funded through the Graduate Medical Education adjustment to 110% of the number of US MD- and DO-graduates in FY95.

RATIONALE

TRANSITIONAL PERIOD

It will take time to develop and implement an all payer system for graduate medical education. While this is being done, the current funding formulas for graduate medical education under Medicare should be modified so that programs are not financially rewarded for increasing the number of residency positions.

PRIVATE SECTOR TASK FORCE ON PHYSICIAN WORKFORCE/MEDICAL EDUCATION FINANCING

The American Medical Association, Association of American Medical Colleges and American Osteopathic Association should convene a Task Force of representatives from the medical profession, the institutions/programs that are engaged in graduate medical education, the federal government, the states and private payers. This Task Force should be charged to study physician workforce needs and to make recommendations about the future funding of graduate medical education, in the context of workforce needs as impacted by managed care and the use of non-physician providers. There should be appropriate protection for the Task Force from antitrust exposure arising from planning activities. The task force should submit a report to Congress in FY97.

CREATING AN ALL PAYER FUNDING MECHANISM FOR GRADUATE MEDICAL EDUCATION

Currently, only the federal government directly reimburses teaching institutions for the costs of graduate medical education. This should be changed based on a recognition that patients supported by all forms of insurance will benefit from trained physicians and so all payers should contribute to the costs of that training. The relative percent contribution of the federal government to the all payer pool should not exceed the current proportion of total graduate medical education costs paid by the government. When the total amount of funding for graduate medical education from all payers is clearly identified, it will allow more efficient planning. Also, the total costs to the government will be decreased.

CHANGING THE CURRENT FUNDING FORMULAS FOR GRADUATE MEDICAL EDUCATION UNDER MEDICARE

The current direct medical education payment and indirect medical education adjustment under Medicare are structured without limits on the number of residency positions that will be funded. This is a stimulus to increase the number of physicians in training. In addition, the indirect medical education adjustment has been used to compensate teaching hospitals for additional costs of patient care due to the presence of an educational program, but mainly for costs associated with the higher complexity of care and provision of uncompensated care in these institutions. The IMEA originally was designed to take the place of a complexity of care adjustment to diagnosis related groups in the Medicare prospective payment system. The IMEA should be analyzed and a new mechanism to allocate costs based on complexity of care should be developed. This requires careful study, to ensure that certain categories of hospitals are not bearing a disproportionate share of any funding reductions.

DECREASING THE NUMBER OF FUNDED RESIDENCY POSITIONS

There are data to support an impending surplus of certain types of physicians. Therefore, the mechanism for funding graduate medical education should not contribute to increasing the number of trainees in the educational pipeline beyond national needs. A reduction in the number of funded positions, with careful evaluation of the impact on the overall physician workforce and on medical schools/teaching hospitals, will help limit excessive growth in the physician workforce. Attempts to limit the increase in the number of physicians should be primarily directed at the

graduate medical education portion of training, since this is the portion of the pipeline best able to be impacted by Congressional action, although attention also should be paid to entering medical school enrollments, so that sufficient numbers of graduate medical education positions are available for graduating U.S. medical students.

LEGISLATIVE SPECIFICATIONS: MEDICARE FUNDING OF GRADUATE MEDICAL EDUCATION

TRANSITIONAL PERIOD

There should be a transitional period during which a new approach to funding graduate medical education through an all payer system should be developed. As a way to reverse the incentives of the previous system, which encourage increases in the number of residency positions, the following phase-in measures should be instituted.

Direct Medical Education Funding

- Utilize the total number of funded graduate medical education positions for each program in FY95 as the base year.

- Limit full funding to the years leading to general certification by the 24 specialty boards recognized by the American Board of Medical Specialties plus funding for the full length of training programs in geriatrics. Residents in programs beyond initial board certification except geriatrics should not be counted for funding purposes.

- For FY96, there should be an agreed upon number of training positions that would be given a weight of .75 FTE in the amount of DME funding that each program receives for first year residents (entry level).

- For FY97, the agreed upon number of training positions would be given a weight of .50 FTE in the amount of DME funding that each program receives for first year residents (entry level).

Indirect Medical Education Adjustment

- Use FY95 as the base year for each institution. The only exceptions would be new programs already approved that are in the process of start-up implementation. The amount of funding for FY96 and FY97 will be derived from this base year, regardless of the number of resident physicians in the institution in FY96 and FY97.

  For FY96, decrease by 5% the IMEA total dollar payment that was given to the institution in FY95.

  For FY97, decrease by 5% the IMEA total dollar payment that was given to the institution in FY96.

CREATION OF A PRIVATE SECTOR PLANNING INITIATIVE

- At the beginning of FY96, the American Medical Association, the Association of American Medical Colleges, and the American Osteopathic Association should appoint and staff a Task Force on Financing Graduate Medical Education/Physician Workforce

Planning, composed of representatives from

the medical profession;

medical education institutions/programs;

private payers, including representatives of managed care organizations;

the federal government (including the departments responsible for funding graduate medical education/HCFA, DOD, VA); and

state governments.

- Representatives of governmental agencies that are payers for graduate medical education should make up one-third of the membership of the Task Force.

- The Task Force should be authorized for two years and should submit a report to Congress at the end of that time.

- The Task Force and its staff should be protected from antitrust exposure arising from workforce planning activities.

PLANNING ACTIVITIES/TIMETABLE FOR TASK FORCE

The Task force, through its staff, should be authorized to collect data about the physician workforce and about physician workforce needs across specialties and geographic regions. The data collection process should take into account the impact of the use of non-physician providers in the health care system.

The task force should address the following issues in the timetable presented.

<u>All Payer System for Funding Graduate Medical Education</u>

- During FY96 develop and during FY97 test an all payer funding formula for graduate medical education (the Graduate Medical Education adjustment). The formula should include resident salaries and fringe benefits, the costs associated with supervision of residents physicians, and a factor related to overhead for teaching.

  The FY97 test should determine the funding implications of the changes for regions, institutions, and programs in individual specialties. The test also should explore the implications of proposed changes for teaching in the ambulatory care setting and for other medical school and teaching hospital activities that were subsidized through the current funding formulas for graduate medical education (the DME and the IMEA).

  Based on the results of the 1997 test, modify the proposed all payer formula and develop final recommendations for Congress.

- During FY96, develop a formula for the contributions of the various payers (Medicare, Veterans Administration, Department of Defense, private payers) to the funding of graduate medical education. The following guidelines should apply.

  The percent contribution of the federal government to the funding of graduate medical education should not exceed current levels.

  The Medicare funding to risk based managed care programs (based on the AAPCC) should be included in the all payer system, by removing the allocation for teaching within the AAPCC and adding that amount to the funding pool.

  The number of entry-level residency positions funded through the all payer pool should gradually decrease.

  The funding formula should apply to programs leading to initial board certification. There should be no funding from the all payer pool for positions in programs after initial board certification.

- The Task Force should develop a methodology to distribute funding.

  The distribution methodology should take into account teaching in both the inpatient and ambulatory settings, whether or not the ambulatory site is owned by the institution sponsoring the residency program.

  Payments should be directed to the entity that incurs the costs of training. This could be done through direct payment to institutions/programs or payment to consortia, where the funding is distributed among the consortium members.

  Positions should be allocated taking into account national, regional and local physician workforce needs and specialty mix.

  Congress should authorize an annual review of funding distribution, with a full evaluation of the impact of the new system on the physician workforce and on the financial status of Medicare in FY2000.

<u>Study the IMEA and Identify Appropriate Funding Mechanisms to Reimburse Complexity of Care/Severity of Illness in Teaching Hospitals</u>

- During FY96 and FY97, study how alternatives for funding and distributing the IMEA would affect teaching institutions and specific regions of the country. Beginning in FY98, the new funding formula and distribution method should be implemented.

  The following should guide the redesign of the IMEA:

  Separate IMEA from the number of resident physicians at a given institution and use FY95 as the base year for any funding formula.

Ensure that any reductions are equitably distributed among teaching institutions.

Develop mechanisms to distribute IMEA to training sites, based on the percentage of total IMEA funds received by the entity in FY95.

Study payments to training sites, to determine if a complexity of care/severity of illness factor could be added, perhaps by modification of the diagnosis related groups formula.

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FRAUD AND ABUSE

CURRENT PROBLEM

Millions, perhaps billions, of dollars are stolen from the Medicare program each year in a wide variety of fraud schemes. Fraud is intentional, illegal conduct. While the exact nature and scope of health care fraud is not known, estimates are that up to ten percent of health care expenditures are lost to fraud. The FBI has over 1,000 criminal health fraud cases pending, and collected over $480 million in restitution, fines and civil settlements in Fiscal Year 1994. Most of these losses are due to outright theft by a relatively small number of perpetrators, very few of whom are physicians. What is needed today is a dramatic new focus on deliberate fraud, with a comprehensive program involving law enforcement agencies, private payers, patients, and the provider community. The proposal outlined below includes the adoption of new civil and criminal statutes to facilitate fraud prosecution, the devotion of additional law enforcement resources to health care fraud, the coordination of public and private sector fraud control, and the implementation of an anti-fraud education program for patients and physicians, as well as improved fraud reporting mechanisms in the physician community.

Intentional fraud is not the only threat to the integrity of the Medicare program. Health care dollars are also lost to conduct which is inappropriate, but which is not obviously wrong. This conduct, often called abuse or waste, is wrong because the provider or supplier fails to meet minimum standards of appropriate behavior, such as by providing care deemed excessive under accepted professional standards. Unlike fraud, these actions cannot be defined without reference to an objective standard of conduct, such as a medical practice guideline in the case of alleged inappropriate care. Unless there is consensus on the standards against which to judge this conduct, there can be no agreement on whether particular actions constitute abuse or waste. A public-private partnership is proposed that would establish consensus standards of conduct and practice, disseminate them to payers and physicians, and monitor their effectiveness through peer review and utilization review programs.

A variety of additional provisions are needed to address specific fraud issues. The need to inject competition into the Medicare program will necessitate modest amendments to existing self-referral legislation to permit physician networks to compete for Medicare contracts. Moreover, the increased prevalence of managed care, with its shifting incentives for physicians, has changed the nature of the fraud and abuse problem. Specific recommendations for managed care plans are included in this proposal. Also recommended is a study of the effectiveness of current anti-fraud efforts and the identity of emerging fraud issues.

RECOMMENDATIONS

A public-private program will attack deliberate fraud with a coordinated, resource intensive effort, and the "Partnership for Health Care Value" will establish consensus standards to identify and eliminate waste and abuse, relying on the special expertise of the physician community in responding to the delivery of inappropriate care.

1. A pluralistic, coordinated anti-fraud program will be established for the public and private sectors, under the leadership of the Department of Justice and the Department of Health and Human Services, with the following characteristics:

- Clear definitions of fraud and abuse
- Coordinated enforcement actions by public and private payers, with appropriate exchange of data and information on common fraud schemes
- New civil and criminal anti-fraud remedies
- Additional, targeted resources for law enforcement
- Enhanced fraud reporting by physician and patient groups
- Improved communication and educational programs for physicians and patients

2. As part of its charge, the proposed "Partnership for Health Care Value" will reach consensus wherever possible on medical standards. The standards developed in this process will be a resource that can be used by all plans participating in the Medicare program. The medical profession will be responsible for using its vast self-regulatory structure to implement and enforce these standards.

3. Current legislation will be amended to rationalize existing self-referral provisions (Stark I and II), and to provide for the issuance of advisory opinions by DOJ and DHHS.

4. Health care plans will be accountable for establishing a structure which permits participating physicians to provide quality health care to their patients. Review mechanisms will be established to assure that reimbursement policies do not give physicians incentives to limit care inappropriately.

5. A comprehensive study of fraud and abuse will be conducted to monitor the effectiveness of current control efforts and to identify emerging issues.

RATIONALE

COMPREHENSIVE FRAUD PROGRAM

Law enforcement agencies and private payers should intensify their focus on a coordinated response to fraud. The greatest impact can be had with the fewest resources by attacking the conduct which is most clearly wrong: deliberate fraud. Most fraud schemes are perpetrated on both the public and private sector, and improved data and information exchange would assist in identifying and prosecuting these schemes in a coordinated manner. Moreover, private payers are currently required to rely upon statutes wholly unrelated to health care fraud in their efforts to address this problem. Legislation is needed which would clearly define health care fraud and provide remedies to private payers and others who are victimized by it. Additional resources targeted to specific agencies and programs are needed to control fraud adequately, and a coordinated public-private program will use these resources most efficiently. While substantial progress has been made in educating patients and physicians about fraud and in securing fraud reports from them, these efforts should be enhanced.

PARTNERSHIP FOR HEALTH CARE VALUE

The issues of abuse and waste cannot be defined or resolved without consistent standards against which to judge this conduct. At present, public and private payers may allege that a physician has engaged in abusive conduct based solely on standards developed by the payer itself, or without reference to any objective standard at all. Worse, cost considerations or coverage questions may be raised in the guise of waste or abuse. A partnership of public and private payers with the physician community is needed to reach consensus wherever possible on the parameters of quality medical practice. Once established, these standards must be monitored, updated, and used by payers and physicians alike. The medical profession's extensive peer review and education structure provides the appropriate vehicle for implementing this process.

LEGISLATIVE AMENDMENTS

Existing federal legislation designed to eliminate inappropriate payments for referrals of Medicare patients is overbroad in certain respects, and does not relate rationally to a pluralistic market. Modest changes in these laws are needed to permit integrated physician networks to participate in the Medicare program, and to assure that reasonable access to care is not denied to those in underserved areas. In addition, DOJ and DHHS have refused to issue advisory opinions regarding their enforcement intentions with respect to fraud and abuse statutes, even in civil cases. Because the specific application of anti-fraud and abuse laws can be uncertain in many cases, advisory opinions would assist greatly in clarifying the law and reducing the incidence of unintentional non-compliance. Advisory opinions of this kind are issued in antitrust enforcement, and should be available in the health care arena.

FINANCIAL INCENTIVES

Through the use of such devices as capitation and fee withholds, managed care plans have succeeded in shifting the financial risk of over utilization to providers. This result has dramatically increased physician incentives to limit care. If these incentives become too strong, patients may be denied needed care. While physicians have clear ethical obligations not to place financial considerations above the needs of patients, the fact remains that managed care plans often have sufficient economic power to impose abusive contract terms on physicians. Review mechanisms are needed to assure that health care plans do not impose inappropriate financial incentives on physicians. Moreover, pharmacy benefit management programs should not unreasonably deny access to medically necessary prescription drugs. A review mechanism established by the Partnership for Health Care Value should assure that pharmaceutical incentives and drug formulary policies are appropriate.

FURTHER STUDY OF THE PROBLEM

There has been no comprehensive study of the scope and, more importantly, the nature of health care fraud. There is no certainty that current detection efforts are successful in identifying most fraud schemes, to say nothing of the more difficult questions of abusive practices and medical necessity. The most significant issues in each of these areas must be identified and quantified so that effective responses can be implemented and an appropriate level of resources dedicated to them.

LEGISLATIVE SPECIFICATIONS: FRAUD AND ABUSE ISSUES IN MEDICARE REFORM

DEFINITIONS

- Fraud: an intentional deception or misrepresentation which individuals make knowing that their deception could result in some unauthorized benefit to themselves or some other person. Fraud is intentional, illegal conduct.

- Abuse: practices which, although not considered fraudulent acts, may directly or indirectly cause financial losses to the Medicare program or to beneficiaries. These practices are characterized by physicians or other suppliers of health care goods and services operating in a manner inconsistent with sound fiscal or business practice, or providing care in a manner inconsistent with accepted medical practice (as determined by the medical profession). Abuse or waste cannot be identified based on standards developed solely by payers, without physician input, or by failing to reference some objective, legitimate standard of appropriate conduct.

COORDINATED FRAUD PROGRAM

- Under the direction of DOJ and DHHS, law enforcement agencies, private payers, and the physician community will establish a coordinated anti-fraud program.

- The program will enable the exchange of information and data among law enforcement agencies and private payers regarding fraud schemes that may affect both the public and private sectors. Appropriate safeguards to assure the confidentiality of patient and physician information will be instituted.

- New civil and criminal statutes will be enacted to define health care fraud with specificity, and to provide clear remedies for private sector fraud enforcement.

- Adequate funding for the public sector anti-fraud efforts will be provided through the budget process for DOJ and DHHS. Current fraud control resources will be increased, with specific funds directed to state anti-fraud programs. While recognition should be made of the fact that fines and penalties collected by law enforcement agencies in their anti-fraud efforts will offset the cost of those efforts, the budgets of those agencies may not be determined in any direct manner by the volume of fines and penalties collected.

- The physician community will increase the incidence of fraud reporting, relying in large part on a liaison between law enforcement agencies, private payers, and physician associations. A network of fraud reporting hotlines will be established by national, state, and local medical societies, and it will be linked to counterpart law enforcement agencies and private payers.

- Law enforcement agencies and private payers will report to the physician community regularly on common fraud schemes and successful prosecution efforts. Physician associations will communicate this information to their members, both to assist in fraud reporting and to increase the deterrent effect of anti-fraud efforts.

PARTNERSHIP FOR HEALTH CARE VALUE

- The proposed Partnership for Health Care Value will identify and coordinate standards for medical practice. This group will reach consensus to the extent possible on practice guidelines in each specialty. The guidelines will not constitute specific prescriptions for medical practice, but rather will assist physicians and payers in establishing standards with which to identify abusive or wasteful practices. In the development of guidelines, the partnership may consider the relative cost of practice options, but must ultimately be guided by those practices which achieve the best outcomes for the patient.

- The medical profession will use its self-regulatory structure, including medical society and hospital medical staff peer review, continuing medical education programs, and scientific journals, to educate physicians about the consensus guidelines and to implement them.

- The AMA will modify CPT codes that are subject to abuse in billing and medical practice.

LEGISLATIVE AMENDMENTS

- Current legislation limiting self-referral in the Medicare program (Stark I and II) will be amended to:

  - adopt a new shared facility ancillary service exception;

  - create a community need exception;

  - clarify outpatient prescription drug rules;

  - eliminate restrictions on group practice compensation arrangements; and

  - assure that integrated physician networks remain feasible.

- The DOJ and DHHS will be directed to issue advisory opinions with regard to their enforcement intentions in civil cases.

FINANCIAL INCENTIVES

- Health plans participating in the Medicare program will be prohibited from subjecting physicians to excessive financial incentives to limit care. Physicians participating in any Medicare plan will have the opportunity to seek review of the financial incentives imposed by the plan.

- Pharmacy benefit management programs established by managed care plans will be prohibited from unreasonably denying access to medically necessary prescription drugs, regardless of the contents of any plan formulary or the relative costs of alternative drugs. Physicians and patients will have the right to protest the denial of access to any drug by any plan.

STUDY OF THE PROBLEM

- A public-private partnership will study the nature and scope of fraud, abuse, and inappropriate or unnecessary care. The physician community and other interested parties will have appropriate input to the study.

- The study should identify the most significant issues in fraud and abuse, and should make recommendations regarding the type and level of resources, as well as the specific actions, including any additional legislation, necessary for an effective response to these issues.

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REDUCING CARE OF MARGINAL VALUE

CURRENT PROBLEM

Medicare strives to provide the highest quality of care for all beneficiaries, but growing evidence indicates that some care of marginal value is disbursed at a sizable cost to the program and without the hope of achieving the patients' goals, particularly in end-of-life situations. Some physicians and other providers also engage in overly aggressive, unwarranted care due to the technological capability to prolong life, fear of liability, or patient/family/peer pressures.

Cultural, societal and ethical values ensure that physicians provide only that care which is in the best interests of the patient. It cannot be avoided, however, that five percent of Medicare beneficiaries die each year at a cost of over $100 billion. Many thousands of these individual are subjected to medicalization with little or no hope of survival or the prospect of living a quality life. Non-life sustaining situations are also affected by these values for care giving.

What constitutes care of marginal value is undefined under the Medicare law. For example, practice guidelines and review criteria applicable when treatment is medically futile do not exist. Such activity was expressly encouraged by the Congress when the RBRVS/MVPS system was established, but without any specific directives to those public and private sector entities involved in utilization review, peer review, or practice guidelines development.

Herculean efforts to prolong life are giving way to advance directives like "do not resuscitate" orders, living wills and the increased use of hospice care. Medicare beneficiaries and their families need further education, however, before these concepts will be widely shared throughout society.

RECOMMENDATIONS

1. The Partnership for Health Care Value should support the development and use of practice guidelines, practice patterns and utilization review to reduce "care of marginal value."

2. Information regarding advance directives, living wills, and medical powers of attorney should be provided by Medicare to beneficiaries upon enrollment and physicians should be encouraged to educate their Medicare patients in the use and need for such advance directives in medically futile circumstances.

3. All Medicare and Medichoice plans should utilize practice guidelines, utilization review, advance directives, and the use of hospice care to reduce care of marginal value when serving Medicare beneficiaries.

4. Congress should enhance Medicare's use of hospice care to assist dying patients and their families with compassionate care at the end of life. Support for Medicare, Medicaid and private insurance coverage of hospice care, including patients in nursing homes, should also be voiced. Efforts to increase co-payments for hospice care or reduce hospice reimbursement should be opposed.

5. Outcomes research should include factors that reduce care of marginal value. HCFA should develop and support research to improve the care of patients in end-of-life situations. More empirical research through surveys or other means to evaluate the incidence of end-of-life care of marginal value is needed.

RATIONALE

The recommendations above reflect the five basic elements necessary for reducing care of marginal value under Medicare: definition; education; implementation; utilization; and cost/benefit analysis.

PRACTICE GUIDELINES

"Care of marginal value" may be is defined as care that does not accomplish its immediate purpose. Others suggest that treatment is medically futile:

> "Whenever physicians, patients, or surrogate decision makers deem that medical intervention (1) is useless or ineffective; (2) fails to offer a minimum quality of life on a modicum of medical benefit; (3) cannot possibly achieve the patient's goals; or (4) does not offer a reasonable chance of survival."*

(* Jecker N., Pearlman R., "Medical Futility: Who Decides?", Archives of Internal Medicine. 1992; 152:1140-1144, at 1140.)

Physicians in the context of the patient/physician relationship bear the true responsibility for determining what level of care is in the best interests of the patient. Nevertheless, there is much debate over when and how the decision to limit care should be made. That debate is fueled by the fact that the concept of futility is not too difficult to recognize in the irreversible, physiologically moribund, but ephemeral and ill-defined when applied to the majority of critically ill patients with poor prognoses. Accordingly, it is necessary to better define "care of marginal value" and develop practice guidelines and review criteria applicable to them.

The American Medical Association has created an Intra-Council Task Force on Marginal Care to assist in this process. Once defined, the medical profession will use its self-regulatory structure, including medical society and hospital medical staff peer review, continuing medical education programs, and scientific journals, to educate physicians about the consensus guidelines and to implement them.

ADVANCE DIRECTIVES

The use of advance directives like "do not resuscitate" orders, living wills and medical powers of attorney have been proposed as methods to reduce medical costs at the end of life. The AMA, the American Bar Association, and the American Association of Retired Persons all support their development and use in these unfortunate situations. The 1990 Budget Reconciliation Act requires — as a condition of Medicare participation — that hospitals, skilled nursing facilities, home health agencies, Medicare HMOs, and hospices provide information and assistance in executing advance directives. This law should be amended to require that Medicare provide these documents to beneficiaries upon enrollment and be available to assist in their preparation as the

beneficiary may desire. In addition, physicians should be encouraged to play an educational role in their patients' consideration of and decisions to use advance directives. It is ultimately the patient's choice, but physicians and other providers should be more active in aiding their understanding and use.

HEALTH PLANS

Increasing numbers of Medicare beneficiaries are enrolling in managed care plans. Medicare reforms as implemented in the private sector should ensure that measures to reduce marginal care be translated into the policies and procedures of all health plans as well. All plans participating in the Medicare program should use practice guidelines in their utilization review efforts to identify and eliminate instances of marginal care. It is also necessary to ensure that managed care "hospice care" be defined as a benefit as provided under Medicare.

All plans participating in the Medicare program should use practice guidelines in their utilization review efforts to identify and eliminate instances of unnecessary care. Plans participating in the Medicare program should establish utilization review policies for medical practices for which no consensus guideline has been developed by the partnership.

HOSPICE CARE

Once a patient and his/her physician determine that a patient's life expectancy is six months or less, the patient is eligible for the Medicare hospice benefit. Approximately 340,000 patients utilized hospice care in the U.S. in 1994. A study released in 1995 by Lewin-VHI showed that for every dollar Medicare spent on hospice, it saved $1.52 in Medicare Part A and B expenditures. In the last year of life, Medicare beneficiaries who enrolled in a hospice program cost Medicare $2,737 less, on average, than non-users. Holistic care which seeks to treat and comfort terminally ill patients and their families is an appropriate and preferable alternative to futile, marginal or unnecessary care and its use through certified hospice programs should be expanded, including beneficiaries in nursing homes and other long term care facilities.

OUTCOMES RESEARCH

Defining care if marginal value, educating patients and physicians about unwarranted aggressive care, and implementing programs to reduce or avoid it, or seek alternatives like hospice care, will reflect society's growing acceptance of a kinder, gentler approach to all aspects of care for Medicare beneficiaries, particularly care at the end of life.

Consensus practice guidelines should not constitute specific prescriptions for medical practice, but rather will assist physicians and Medicare in establishing standards to reduce marginal. In the development of such guidelines, the Partnership may consider the relative cost of practice options, but must ultimately be guided by those practices which achieve the best outcomes for the patient.

The amount that might be saved by reducing the use of unwarranted aggressive life-sustaining interventions for dying patients is estimated to be 3.3 percent of total national health expenditures. In 1993, with $900 billion going to health care, this savings would amount to $29.7 billion. When such guidelines and performance standards are applied to non-life-sustaining situations, these savings will increase substantially over this amount.

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HEALTH CARE LIABILITY REFORM

CURRENT PROBLEM

The United States has arguably the most inefficient health care injury compensation mechanism of any developed country. Every payor of health care services bears these liability costs. As the largest payor of health care services in this country, the federal government has a strong interest in achieving reasonable, effective liability reform that will help contain health care costs and improve access to health care services.

According to RAND Corporation studies, only 43% of total costs actually represent compensation payments to patients injured by medical malpractice. Almost 60 cents of every dollar spent in the health care liability system goes to administrative costs, mostly attorney fees. The direct costs of health care liability insurance premiums (including health care system self-insurance costs) exceeds $10 billion annually.

The legal system also contributes to health care costs indirectly by stimulating over-utilization of health care services in a number of ways. Physicians are sued more than any other segment of society. Practicing physicians have almost a 40% chance of being sued sometime in their careers. If their practices include any kind of surgery, the odds increase to over 50%. The average obstetrician sustains three claims during his or her career. Most of these suits are non-meritorious. Nationwide, 75% of suits against physicians are dismissed with no compensation payment paid (although legal and other administrative costs are incurred).

These factors indicate to physicians that their chances of being sued have virtually no correlation with whether they practice good or substandard medicine, and that every patient who experiences a less than optimal treatment result is a potential litigant. "Defensive" medicine - tests and procedures motivated primarily by the desire to avoid a lawsuit - is the result. Lewin-VHI estimated that defensive medicine contributed up to $25 billion in health to care costs in 1991.

When the liability exposures of pharmaceutical and medical device manufacturers, blood services providers and the biotechnology industry are factored in, a reasonable estimate of the annual cost of health care liability is $50 billion. All of these costs are absorbed into the cost of health care services. Balanced, but effective health care liability reform has proven to stabilize liability costs in the states where they have been established, notably California. More than half the states have been unable to establish such reforms.

The legal system also stimulates over-utilization of health care services in personal injury cases where medical malpractice is not even an issue, such as automobile accident litigation and "slip and fall" cases among others. Because medical treatment expenses are an element of the damages, plaintiffs and their attorneys have strong incentives to obtain as much medical care as possible. In an April 1995 report, the RAND Corporation estimated that motor vehicle accident litigation alone may have generated $13 - 18 billion in excessive medical claims in 1992.

RECOMMENDATIONS

Malpractice insurance costs are reflected in Medicare payment rates. Professional liability reform will reduce premiums and consequently have a salutary effect on Medicare costs. A baseline of

liability reform provisions, proven effective in the states that have enacted them, should be established federally. Federal law should have limited preemptive effect, allowing states to exceed the federal baseline in implementing stronger reform.

California's Medical Injury Compensation Reform Act of 1975 (MICRA) provides a model for effective reform. The principal elements of MICRA, in order of impact, include:

1. A $250,000 limit on noneconomic damages (all out of pocket "economic" losses remain fully recoverable);

2. Modification of the common law collateral source rule, to end the double recovery of medical expense damages where other sources of plaintiff compensation - such as health, disability or workers compensation benefits - already have been paid;

3. Periodic payment of future damages as they accrue (with lien authority only against the liability insured);

4. A sliding scale for the award of attorney contingency fees that decreases as the award increases; and

5. Statute of limitations reform for both adults and minors.

Studies by the Office of Technology Assessment and others have consistently shown that the $250,000 limit on noneconomic damages has the greatest impact on containing health care costs. Liability insurance costs in California, once the highest in the nation, were effectively stabilized once MICRA passed constitutional challenges and was fully implemented. They are now one third to one half less than those in states where effective reform has not been achieved.

RATIONALE

Reforming the health care liability system has the potential for reducing Federal outlays in several ways. Generally, such reform could reduce cost either by reducing premiums for health care liability insurance or by decreasing the number of services provided as the result of defensive medicine. It is significant that in California, health care costs are rising at a slower rate that other states where effective tort reform has not been achieved. It appears that reductions in the incentives to practice defensive medicine may be assisting health care payers in reducing over-utilization and containing costs.

Decreases in either liability insurance premiums or defensive medicine could result in direct Federal savings by reducing spending for Medicare, Medicaid and other federally financed health care delivery programs.

Decrease in health care liability premiums could reduce Federal payment to providers that reflect such liability costs.

Decreased health care liability insurance costs or defensive medicine practices could reduce private health insurance costs for whatever basic benefit package is called for under health system reform. This could reduce the costs of any Federal subsidies called for under the various reform proposals.

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Washington National Tax Services
1301 K Street NW, 800W
Washington, DC 20005-3333

Telephone 202 414 1000
Facsimile 202 414 1301

Price Waterhouse LLP

June 14, 1995

James S. Todd, M.D.
Executive Vice President
American Medical Association
515 N. State Street, 13th Floor
Chicago, IL 60610

Dear Dr. Todd:

We have analyzed budgetary effects of changes in the Medicare Program that are described in the American Medical Association's (AMA) proposal, *Transforming Medicare*. We estimate that the proposal would reduce Medicare spending by $162.2 billion over the seven-year fiscal period, 1996-2002. In addition, the AMA proposals, if continued through fiscal year 2002 and beyond, would keep the Medicare Hospital Insurance Trust Fund solvent for the next 15 years.

The most significant proposed change with respect to federal budgetary savings would be from restructuring the traditional fee-for-service plan. Under the restructured plan, Medicare beneficiaries would make monthly payments to the Medicare program that would, on average, be at the level of premiums for a basic Medigap insurance Plan C with one major difference: half of this amount would be collected into a deductible that would be refunded to the beneficiary to the extent that it was not used, and the other half would be collected by Medicare as a premium. Under this plan, more than half of Medicare enrollees who currently purchase Medigap coverage, would receive a refund -- averaging about $250 in 1995 dollars. This proposal would reduce federal outlays for Medicare by almost $45 billion over the seven-year fiscal period, 1996-2002. The source of savings from this proposal are two-fold: first, overhead, or administrative costs, that are usually paid to insurance companies are used by the Medicare program to reduce federal Medicare costs. Second, Medicare enrollees would be encouraged to use medical care more efficiently in hopes of getting a refund at the end of the year.

Detailed Budgetary Effects of the AMA Proposals

The effects on the federal budget of AMA's Medicare proposals are presented in the attached tables. Table 1 summarizes the seven-year fiscal savings. The rows of Table 1 show the savings of various AMA options followed by an indicator of the source of the savings estimate. Estimates were obtained from three sources: the Congressional Budget Office (CBO), other U.S. Congressional staff (CS), and Price Waterhouse LLP (PW). The Price Waterhouse estimates are based on our in-house Medicare models. All of the estimates are adjusted for interaction effects--that is, the savings are reduced to take into account any secondary effects due to the initial reduction.

Table 2 shows year-by-year effects for each Medicare policy option in the AMA proposal. Key assumptions behind each proposal are described in Attachment A. The attachment further describes aspects of the policy options that may not be fully explained in *Transforming Medicare* and also conveys some of the key assumptions behind various estimates.

Details on Solvency of the Medicare HI Trust Fund under the AMA Proposal

The Medicare Hospital Insurance Trust Fund is expected to become insolvent in fiscal year 2002, unless Medicare taxes are increased or Medicare outlays reduced. Of more immediate concern, the ratio of Trust Fund reserves-to-outlays will fall below the actuarial acceptable level of 1.0 during fiscal year 1996.

The AMA proposal would reduce Medicare Part A spending directly by $126 billion. Moreover, under the proposal, approximately $14 billion in contributions from high-income enrollees would be also deposited into the Medicare Hospital Insurance Trust Fund. If these policies were continued through fiscal year 2002 and beyond, the Trust Fund would remain solvent for at least the next 15 years. In addition, during the budget period, 1996-2002, we estimate reserves in the Trust Fund would be above the 1.0 ratio of reserves-to-outlays as recommended by the Trust Fund actuaries.

Long-Term and Indirect Effects

Due to the constraint of limited time and resources, we were not able to consider the long-term effects and indirect effects of certain AMA proposals. For example, we have not analyzed the effects of Medicare restructuring on competition and on Medicare costs,

especially in years beyond 2002. Much of the long-term savings, by definition, lie outside the fiscal budget period, 1996 to 2002. With respect to indirect effects, we have not taken into account such effects as medical liability reform and administrative simplification.

Please feel free to call me at (202) 414-1663 if you have any questions.

Sincerely,

Jack Rodgers

Jack Rodgers
Director, Health Policy Economics

Enclosures

Table 1

Budgetary Effects
"Transforming Medicare"
FY1996-FY2002
($ Billions)

Options	Net Savings 1/ (FY1996-FY2002)	Source of Estimate 2/
Medicare Transformation & Modernization	**$62.7**	
Modernization of Medicare Coverage	**$44.7**	**PW**
Increase Eligibility Age to Match Social Security 3/	**--**	**PW**
Competitively Set Physician Payment Rates 4/	**($14.5)**	**PW**
Impose 20% Premium Contributions for High-Income Enrollees	**$13.7**	**PW**
Increase Part B Premiums by 7 Percent Annually	**$18.8**	**PW**
Restoration of Trust Fund Balance	**$90.0**	
Reduce Hospital Capital Payments		
Rebase Rates	**$2.1**	**CBO**
Continue OBRA 1990 Reductions	**$7.0**	**CS**
Adjust Payments for Excess Capacity	**$5.4**	**CS**
Cease Bad Debt Reimbursements to Hospitals	**$2.5**	**CBO**
Retarget Disproportionate Share Payments	**$33.2**	**CBO**
Bundle Hospital Acute & Post-Acute Payments	**$19.3**	**CS**
Eliminate Sole Community Adjustments	**$2.0**	**CBO**
Lower Skilled Nursing Facility Cost Limits	**$2.1**	**CBO**
Lower Home Health Cost Limits	**$3.2**	**CBO**
Restructure Medical Education Payments	**$13.2**	**PW**
Other	**$9.5**	
Modify HMO Payments	**$3.1**	**PW**
Extend Secondary Payer Provision for ESRD & Disabled	**$6.4**	**CS**
Total Savings	**$162.2**	

Health Policy Economics Group, Price Waterhouse LLP. June 14, 1995.

1/ Net savings takes into account offsets and interaction effects of each option.

2/ CBO: Estimates by the Congressional Budget Office, "Reducing the Deficit: Spending and Revenue Options," February 1995.
CS: Estimates by Congressional staff, Congressman Shays, Hobson, Miller, and Largent, "Options for Preserving Medicare," May 11, 1995.
PW: Estimates by Price Waterhouse, LLP.

3/ Savings under this proposal begin after fiscal year 2002.

4/ A zero increase in the conversion factor was assumed.

Note: * indicates savings is less than $50 million.

Table 2

Budgetary Effects
"Transforming Medicare"
FY1996-FY2002
($ Billions)

Options	Fiscal Year							Budget Period Savings		
	1996	1997	1998	1999	2000	2001	2002	Total	Offsets	Net
Medicare Transformation & Modernization	$0.6	$3.3	$9.5	$10.2	$11.5	$12.8	$14.6	$67.4	($4.7)	$62.7
Modernization of Medicare Coverage	$0.0	$5.4	$6.9	$7.6	$8.3	$9.1	$9.9	$47.2	($2.5)	$44.7
Increase Eligibility Age to Match Social Security 1/	–	–	–	–	–	–	–	–	–	–
Competitively Set Physician Payment Rates 2/	$0.0	($0.4)	($1.3)	($2.0)	($2.6)	($3.7)	($4.4)	($14.5)	$0.0	($14.5)
Impose 20% Premium Contributions for High-Income Enrollees	$0.6	$1.7	$1.9	$2.1	$2.4	$2.7	$3.0	$14.5	($0.8)	$13.7
Increase Part B Premiums by 7 Percent Annually	$0.0	$1.5	$1.9	$2.5	$3.5	$4.8	$6.1	$20.3	($1.5)	$18.8
Restoration of Trust Fund Balance	$8.3	$10.9	$12.0	$13.1	$14.1	$15.2	$16.3	$90.8	$0.0	$90.8
Reduce Hospital Capital Payments										
Rebase Rates	$0.2	$0.3	$0.3	$0.3	$0.3	$0.3	$0.3	$2.1	$0.0	$2.1
Continue OBRA 1990 Reductions	$0.7	$0.9	$1.0	$1.0	$1.1	$1.1	$1.2	$7.0	$0.0	$7.0
Adjust Payments for Excess Capacity	$0.6	$0.7	$0.7	$0.8	$0.8	$0.9	$0.9	$5.4	$0.0	$5.4
Cease Bad Debt Reimbursements to Hospitals	$0.3	$0.3	$0.3	$0.4	$0.4	$0.4	$0.4	$2.5	$0.0	$2.5
Retarget Disproportionate Share Payments	$3.7	$4.4	$4.6	$4.8	$5.0	$5.3	$5.5	$33.2	$0.0	$33.2
Bundle Hospital Acute & Post-Acute Payments	$1.9	$2.4	$2.6	$2.8	$3.0	$3.2	$3.5	$19.3	$0.0	$19.3
Eliminate Sole Community Adjustments	$0.2	$0.3	$0.3	$0.3	$0.3	$0.3	$0.3	$2.0	$0.0	$2.0
Lower Skilled Nursing Facility Cost Limits	$0.1	$0.2	$0.3	$0.3	$0.4	$0.4	$0.4	$2.1	$0.0	$2.1
Lower Home Health Cost Limits	$0.0	$0.3	$0.5	$0.5	$0.6	$0.6	$0.7	$3.2	$0.0	$3.2
Restructure Medical Education Payments	$0.7	$1.1	$1.5	$1.9	$2.3	$2.7	$3.0	$13.2	$0.0	$13.2
Other	$0.9	$1.1	$1.2	$1.4	$1.5	$1.6	$1.8	$9.5	$0.0	$9.5
Modify HMO Payments	$0.3	$0.4	$0.4	$0.4	$0.5	$0.5	$0.6	$3.1	$0.0	$3.1
Extend Secondary Payer Provision for ESRD & Disabled	$0.6	$0.8	$0.8	$0.9	$1.0	$1.1	$1.2	$6.4	$0.0	$6.4
Total Savings	$9.9	$20.2	$22.7	$24.8	$27.1	$29.6	$32.7	$166.9	($4.7)	$162.2

Health Policy Economics Group, Price Waterhouse LLP. June 14, 1995.

1/ Savings under this proposal begin after fiscal year 2002.

2/ A zero increase in the conversion factor was assumed.

Note: * Indicates savings is less than $50 million

ADDITIONAL SAVINGS IN AMA PLAN TO TRANSFORM MEDICARE

Over the seven-year deficit reduction period of the resolutions (1996-2002), Medicare would spend roughly $1.7 trillion without Congressional action. This baseline spending figure assumes an annual growth rate of 9.4 percent during this period. Because the Part A Trust Fund is in jeopardy and because of the demographic changes projected to occur in the first half of the next century, the American Medical Association does not believe that the failed policies of the past can address the Medicare program's future woes. Increasing taxes and reducing payments to providers are not solutions. What is needed is a complete transformation of the program that addresses the Hospital Insurance Trust Fund problem and redesigns the entire program for efficiency, quality and value. After considerable examination and study, we have developed a proposal that can substantially improve the program from the vantage point of beneficiaries and other stakeholders, while at the same time reducing the federal deficit.

On very short notice, we retained Price-Waterhouse to examine our proposal, identify various provisions that would be likely to produce budgetary savings and, wherever possible, to estimate the likely scorable savings associated with each provision. Price-Waterhouse was able to identify a large number of such potentially scorable items and were also able to measure seven-year savings totalling over $162 billion. This estimate, however, understates the total savings that we anticipate from our plan for several reasons:

- It is difficult to estimate the savings that will be generated from dramatic changes such as the ones we are proposing. There is little experience from the past on which to build estimates. The estimates have been made conservatively and may understate the true savings that are possible.

- Price-Waterhouse was not able to provide estimates for all our proposals within the tight timeframe of this project. Several of the proposals have significant potential to produce savings and are discussed below.

HEALTH CARE LIABILITY REFORM

Dealing with the costs imposed on health care by excesses in our liability system has the potential to save Medicare and the private sector tens of billions of dollars annually. As our discussion of health care liability reform suggests, this problem may cost the economy close to $100 billion in direct premiums, defensive medicine costs, and excessive medical claims. This is a systemic problem requiring a transformation of equal, if not greater, difficulty than our proposed transformation of Medicare.

FRAUD AND ABUSE

The GAO has speculated that fraud and abuse contribute 10% of total health care costs nationally. Although this estimate has little empirical basis, it nevertheless has credibility because substantial anecdotal evidence suggests that fraud is a large enterprise accounting for substantial economic activity. We do not offer a direct approach to dealing with this problem. It is possible that a direct approach would cost more than the reductions in fraudulent activity it prevented. We do however, offer an indirect approach that gets to the root of one of the major problems underlying waste in the system -- the lack of incentives for anyone, particularly consumers, to care about waste. In stimulating competition among providers, and in rewarding beneficiaries for seeking value on the basis of a self-interested awareness of the cost of services they consume, our proposals will go a long way toward reducing much of the excessive billing, erroneous billing,

and wasteful spending in the current system. While we realize that to estimate the impact of this effect is beyond our technical means, we believe that the potential effects we expect on the basis of economic theory and experience in other fields will certainly materialize to the benefit of the Medicare program.

CARE OF MARGINAL VALUE

While the expenditures on care of marginal value and futile care before death have not been estimated with precision, almost every physician can recount experiences in which such care was provided. We believe that pressures and incentives to carry treatment to excessive lengths are systemic flaws in the system, and that the most effective way to deal with them is through transformation of the system. The basic solution is to remove distortions in the system that prevent the alignment of costs and benefits in the decision making of patients, physicians, and the institutions in which medicine is practiced. We think that our approaches to making medical care prices meaningful, to stimulating competition among providers to increase economic efficiency, and providing incentives for patients and their families to be value-conscious are key to achieving potential economies from reducing care of marginal value. Unfortunately, it is not possible within the technical constraints of admissible scoring methodologies to explicitly quantify the potential savings of this approach.

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MEDICARE PART B SPENDING ON PHYSICIAN SERVICES IS UNDER CONTROL

The Congressional Leadership seeks to limit annual growth in Medicare spending to approximately 7% or below. Policy options under consideration include steep additional cuts in payment rates for physicians, providers, and hospitals. The American Medical Association proposal, *Transforming Medicare,* provides an alternative path to Medicare solvency that relies upon fundamental transformation of Medicare and shared sacrifice; it does not depend on additional cuts in payments for health care services provided to Medicare beneficiaries by physicians. In rejecting additional payment cuts for Part B physician services, this proposal reflects the fact that annual growth in Medicare Part B spending on physician services is already projected to be below 6%, well within the growth targets sought by the Congressional Leadership.

This modest projected growth path results from two developments. First, annual volume growth in Medicare services provided by physicians recent years has been low by historical standards. Second, because of these low volume levels, as well as changes to the Medicare Volume Performance Standard (MVPS) made by the Omnibus Budget Reconciliation Act of 1993, Medicare physician payments are projected to drop by 2-3% annually through 2002 and beyond. These dismal projections, in the face of annual increases in physician practice costs, have led the Physician Payment Review Commission (PPRC) to seek fundamental corrections to the flawed MVPS formula.

Figure 1 illustrates the projected downward path of the Part B physician conversion factor, which will cut physician payment 2-3% each year after 1996. This figure uses PPRC projections under conservative volume growth projections.

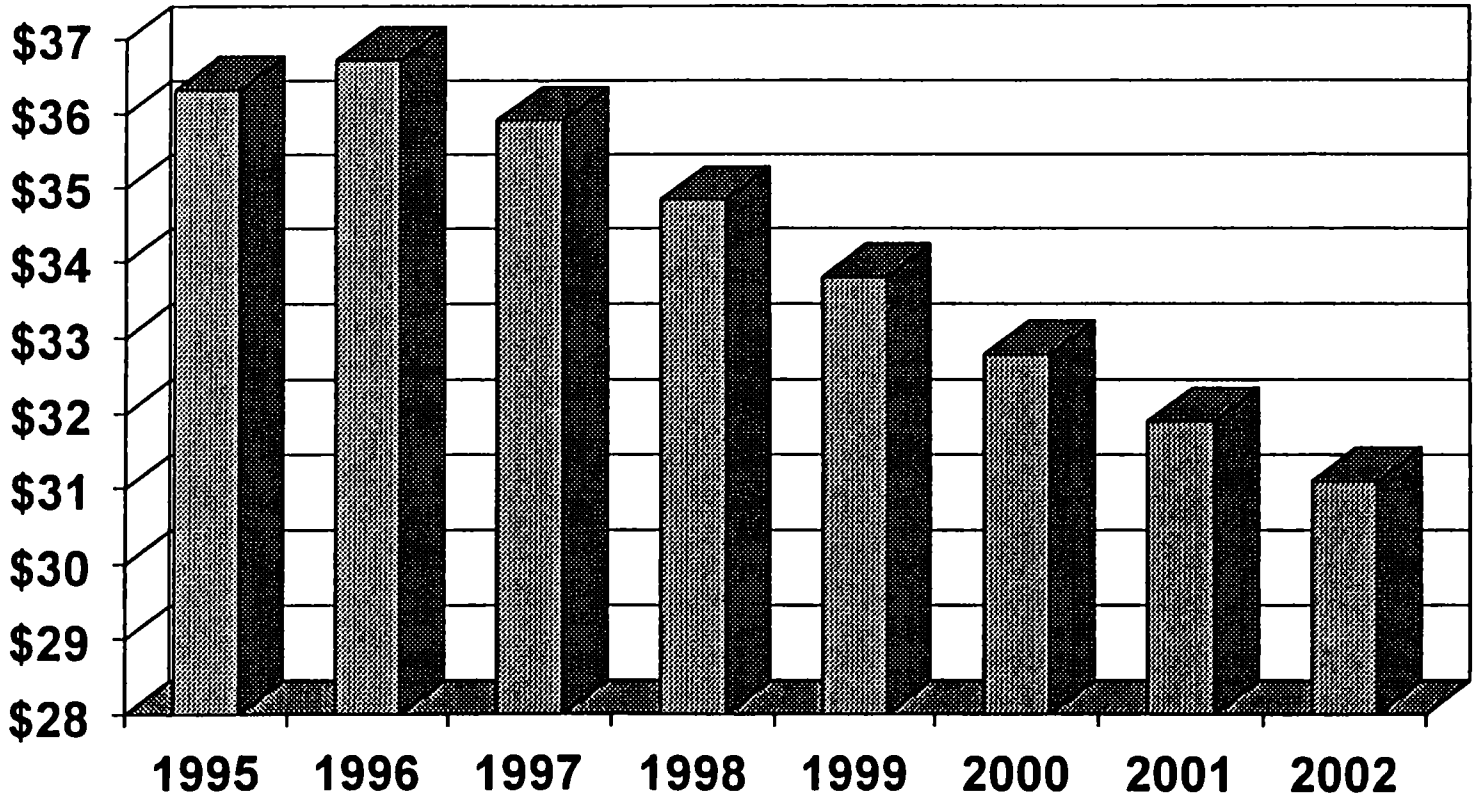
Figure 2 applies these conversion factor projections to a modest projection of private payment growth, illustrating that Medicare payments will continue to deteriorate relative to private payments over this same period, threatening access to care by converting Medicare into a Medicaid-like program.

Figure 3 uses these same conversion factor projections to demonstrate that Medicare Part B spending for physician services is projected to below 6% through 2002, well within the Medicare spending growth levels sought by the Congressional Leadership.

These three dramatic figures make the point that, although meaningful Part B savings are feasible over the next seven years, physician and provider cuts are not a realistic or appropriate option to this end. Rather, Congress should take the approach to Medicare transformation presented in this document, including the specific budget savings outlined in Tab I, if Medicare savings are needed.

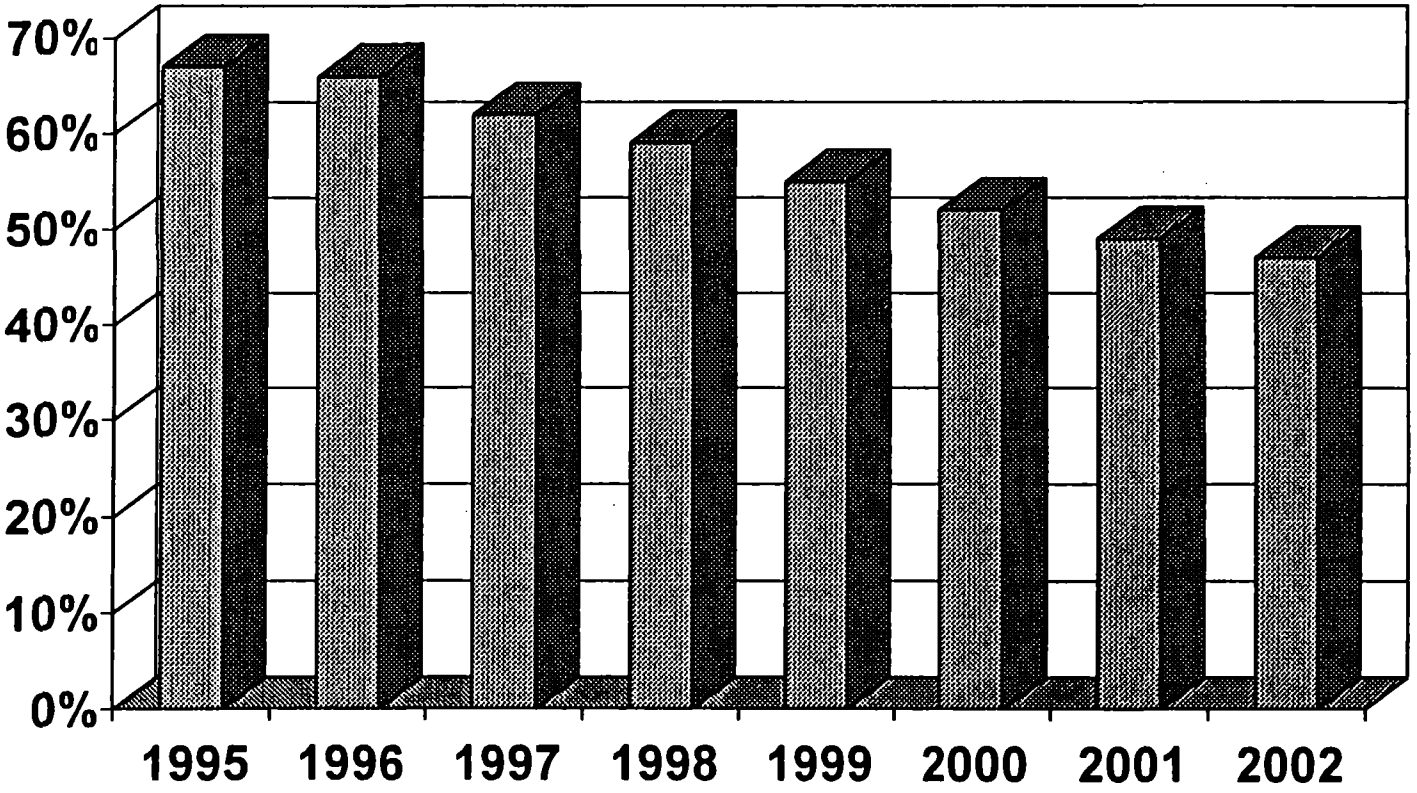
Moreover, Congress needs to consider the recent history of spending on physician services. Providers have contributed $98 billion in cumulative Medicare savings through Reconciliation budget cuts. OBRA 1993 alone imposed $47.4 billion in provider cuts over five years. Physicians, who account for 23% of Medicare outlays have absorbed 32% of these Medicare reductions.

Figure 1: Conversion Factor Simulation Baseline/Current Law



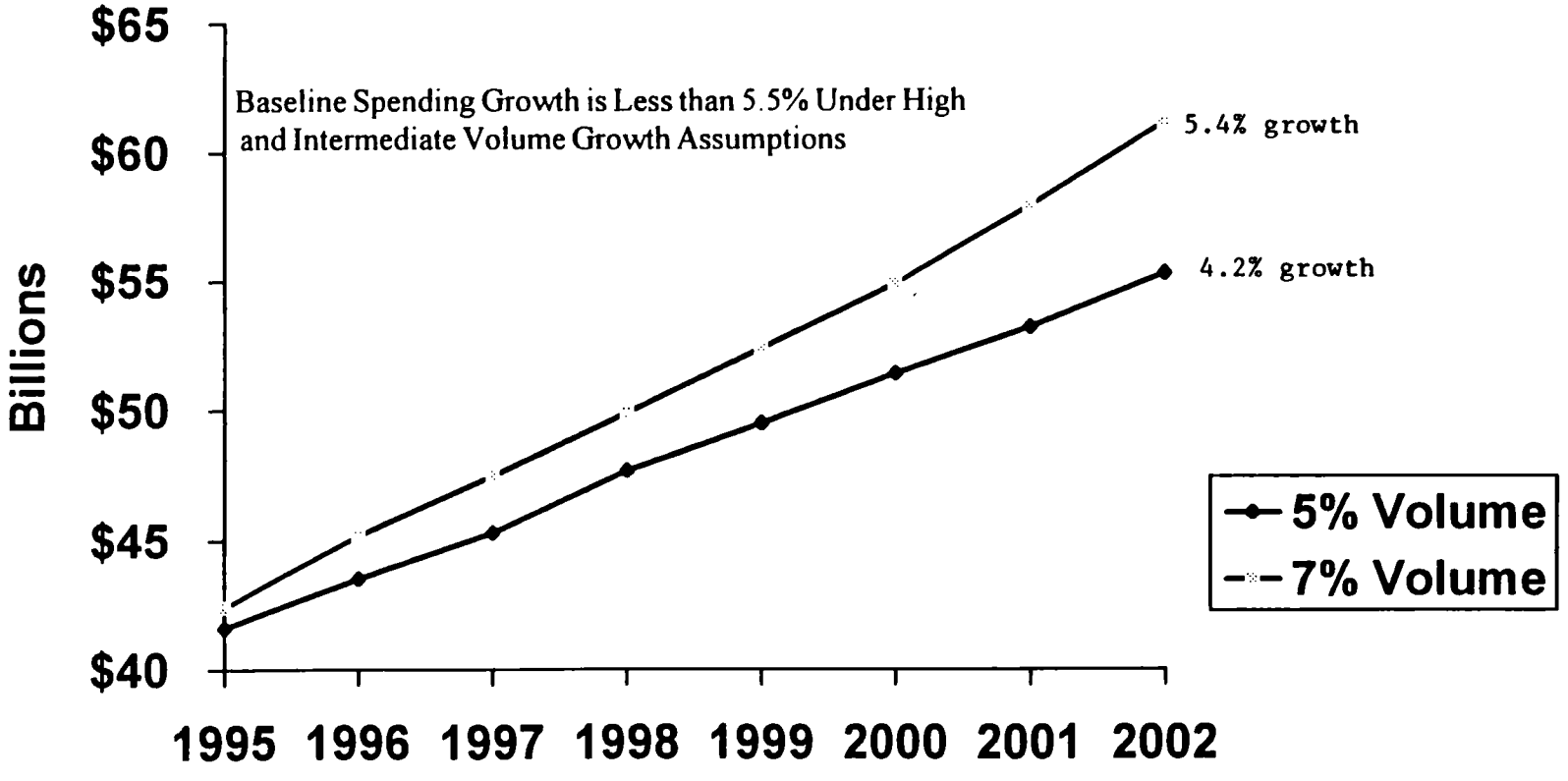
Source: Physician Payment Review Commission

Figure 2: Ratio of Medicare to Private Payments Baseline/Current Law



Source: Physician Payment Review Commission (CF Projections)
Assumes 3% annual growth in private payments

Figure 3: Projected Medicare Part B Physician Spending



Source: American Medical Association

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REGULATORY RELIEF

CURRENT PROBLEM

Over the years, layers of federal regulation have been established that directly impacts on physicians' practices, often duplicating private sector activities. These regulations are often not cost effective and significantly increase the cost of medical care. Medicare is one of the most complex laws, with literally thousands of pages of regulations, instructions and directions. Peer Review Organizations have the authorization to begin review in every physician's office. The National Practitioner Data Bank is expensive and does not provide the necessary operational safeguards to ensure confidentiality. EPA regulates disposal of medical waste. OSHA regulates workplace safety. The Americans with Disability Act has established new requirements on physicians, both as employers and in the area of public accommodations. The Clinical Laboratory Improvement Amendments of 1988 directly impacts on over 100,000 physician practices, is overly complex and will increase the cost of medical care and create new barriers to access. Even the Federal Communications Commission is establishing requirements that they are not communicating to physicians and which are of doubtful benefit.

While taken individually, each regulation is well intended. The practical effect is a regulatory overload that is often impossible to deal with. Regulations emanate from multiple sources with multiple goals that do not always work when applied to the physician's practice. Many agencies have inadequate experience in the health care area or physician practice in general and are not sensitive to the unique challenges faced in a physician's practice. Multiple enforcement agencies, unclear standards, rules that are not tailored to the individual's circumstances all lead to hassle, frustration and anger. It also must be recognized that regulatory requirements raise the costs of providing health care services and divert resources from the direct provision of necessary care.

AMA policy specifically calls for repeal of certain regulatory programs, including the Clinical Laboratory Improvement Amendments of 1988 and the National Practitioner Data Bank. Such policy recognizes the need to continue to work for administrative change as long as the laws are in place.

Clinical Laboratory Improvement Amendments of 1988 (CLIA)

- **CLIA-88 as it relates to physician office laboratories, should be repealed. Pending repeal, the Secretary should be instructed to establish a "physician test category."**

CLIA regulates all clinical laboratory testing, wherever provided, no matter how simple. Expensive compliance requirements are forcing some physicians to close their labs rather than put up with inspections, paperwork and daily administrative requirements. This massive regulatory program, effecting hundreds of thousands of sites, was developed due to problems with certain cytology tests, specifically pap smears. However, the authorizing legislation went way beyond pap smears to cover all testing, no matter where provided, without clear documentation that there was a major problem that needed to be addressed. Initial regulations were so out of touch with reality, that over 60,000 comments were filed and major changes have been made.

Although many changes have occurred since the CLIA regulations were first published, physicians remain concerned about many problems including: classification of tests in physician offices; the impact on access to laboratory services, especially in rural and underserved areas; and the cost implications of meeting the requirements and operating the program. In many cases, it appears that

the goal of accurate tests has taken a back seat to meeting bureaucratic requirements. What is important is not whether the person performing the test is a high school graduate or has an associate degree from a junior college. What is important is that the test is done correctly with accurate results and that the patient gets the needed care. Proficiency testing and recognition of private accreditation efforts should be the key.

National Practitioner Data Bank (NPDB)

- **The NPDB should be repealed. Actions need to be taken to enable the private sector and the state governments charged with the responsibility of licensing professionals to track and act on quality concerns as part of the licensure process.**

The NPDB was created to deal with the problem of physicians and other health care practitioners losing their license or privileges in one state and moving to another. However, the legislation went way beyond that problem and established elaborate reporting requirements well beyond licensure actions. The Act failed to recognize that there was a private sector activity with the Federation of State Medical Boards that dealt with problems of physicians moving between states.

The NPDB is another example of the federal government initiating a new activity rather than utilizing existing mechanisms at the state level and the private sector. Individuals involved in the credentialing area have expressed doubts as to whether the NPDB provides significant benefits, especially in light of its costs and additional burdens. Pending repeal of the data bank, a limit on the reporting of liability actions should be adopted.

Self-Referral - Stark I and Stark II

- **The Stark I and II self-referral laws should be modified. Where unnecessary care is provided in response to the economic incentive of self-referral as opposed to patient need, the matter should be dealt with as a violation of medical ethics and by enforcement of laws aimed at eliminating care provided in response to fraudulent action. The Secretary should be instructed to defer enforcement until regulations are final.**

The self-referral laws were enacted in response to an AMA Council on Ethical and Judicial Affairs Opinion, yet they failed to recognize the exception allowed under the Opinion for patient access to care. Final regulations have not been promulgated under Stark I (relating to clinical laboratory services) and proposed rules have not yet been published for Stark II (relating to other specified services). These are highly complex issues raising the specter of major restructuring of referral arrangements and carrying major penalties for violation. For example, the long recognized problem of not allowing shared labs has not been addressed even since Stark I. Implementation, or at least enforcement with penalties should be deferred until final rules are available.

Occupational Safety and Health Administration (OSHA)

- **OSHA regulations, and the bloodborne pathogen standard in particular, should be subject to a cost-benefit analysis and they should be streamlined, based on this analysis.**

Physicians recognize that employees have a right to a safe work place, but it is clear that OSHA has very little, if any, understanding of the operation of physician practices. Regulatory requirements that may be appropriate for large institutions or where high risk procedures are performed, are not always necessary for other settings. OSHA record-keeping requirements create major hassles and increase expenses. For example, health care providers are required to have "data sheets" for such common products as household bleach and the cost of these products when sold with the required information is substantially more than if purchased at a local store. OSHA has imposed very strict and burdensome workplace and record keeping standards for physician offices that in many cases are unrealistic to the risk posed. Of specific and recent concern are initiatives relating to the control of tuberculosis in health care settings, including physicians' offices, and this is another aspect of OSHA action where guidance from a cost-benefit study would be beneficial.

Americans with Disabilities Act (ADA)

- **The Secretary should be required to issue regulations that stipulate clear federal enforcement standards. Where the ADA requires practice modifications, there should be a reasonable phase-in prior to enforcement and application of the ADA should not mandate that business entities absorb all related costs of compliance.**

The ADA has created an entire new set of federal regulatory issues for the physician's practice. These relate to the physician's obligations as an employer and as a public accommodation. One of the major problems with ADA regulations is that the regulatory requirements are not well articulated. It is expected that these issues will be resolved only through expensive litigation. Clear federal enforcement standards should be established and made available so that people required to comply with the law understand the requirements. Such standards should provide clear regulatory guidance to physicians and others as to what they are expected to do to comply with ADA. Regulatory requirements must be scrutinized for their impact on physician offices and other small business. Other areas that need addressing include Medicaid reimbursement for sign language interpreters, expanded tax incentives to physicians who make expenditures for the purpose of creating greater accessibility to facilities for individuals with disabilities. The Disabled Access Tax Credit should be expanded to cover all of the costs associated with the provision of interpreters and increases in the tax credit from 50% of the expenditure to 100% of the expenditure should occur.

Medicare Administrative Burdens

- **A high level commission should be established and charged with the responsibility of making recommendations to the Administration and the Congress on Medicare regulatory requirements.**

The Medicare program is one of the most complicated and confusing programs administered by the Federal government. The statute covers hundreds of pages, and there are tens of thousands of pages of regulations, instructions, decisions and other determinations. HCFA has attempted to resolve various regulatory burdens but more needs to be done. Each year, physicians are faced with increased layers of requirements and inconsistent implementation.

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DEPARTMENT OF VETERANS AFFAIRS (DVA)

CURRENT PROBLEM

The United States has accepted a burden of gratitude for its military veterans as a national responsibility to "care for him who shall have borne the battle." This significant moral responsibility translates into the federal government having a substantial measure of accountability for the needs (health care and other benefits) for approximately 27,000,000 living ex-service people, including about 21,000,000 living war veterans. The federal government entity charged with meeting this responsibility is the DVA. The current DVA budget is approximately $38.3 billion, with about $16.3 billion dedicated to meeting veterans health care needs. There presently are about 201,000 employees in DVA's Health Administration. The DVA provides care to meet veterans' health care needs through 172 hospitals (54,000 inpatient beds), 365 outpatient clinics, 130 nursing homes and 32 domiciliaries. Coverage is extensive, with qualifying veterans eligible for unlimited coverage for outpatient mental health care, institutional long-term care, and inpatient mental health care. Approximately $688 million of the DVA budget is spent on administrative functions.

LONG-TERM DIRECTION

A high level commission should be established and charged with the responsibility of making recommendations to the Administration and the 104th Congress on mainstreaming the DVA patient population into the communities where the veterans reside.

Substantial savings, coupled with potential improvements in access to care and quality of care, could be achieved through the bold yet simple step of eliminating the DVA's responsibility to provide acute health care services. The private sector has the capability and the capacity to fulfill the acute health care needs of veterans with service-connected disabilities, and this could be done without the year after year expense of maintaining a segregated system of care for the veteran population.

Because far less radical proposals in how the DVA health system operates never got into the action stage due to a ferocious buzz-saw of opposition, the creation of the high level commission, charged to make action recommendations by the end of 1996, is the recommended course of action to initiate mainstreaming the DVA patient population into the communities where the veterans reside.

DVA PROBLEMS AND INTERIM DIRECTIONS

There is no dispute that patients receiving care through the DVA frequently face delays, inefficiency and miles of bureaucratic red tape. Pending a process that could take years to implement on mainstreaming the DVA patient population into the communities where they reside, immediate action is needed to recognize and address problems within the DVA.

- Coverage eligibility criteria is not clearly stipulated.
- The DVA operates under a central bureaucracy that is far removed from the delivery of care and the community in which the care is delivered.
- The DVA operates under an historical scheme where the presumption is that care provided

will be hospital/facility based.

- DVA facilities exist in campuses that often are not integrated into the communities where they are located.

- Even in the face of a significantly declining patient base, Congress has been unable to maintain a decision to close a DVA hospital (the last such closing occurred thirty years ago).

- DVA facilities and capabilities frequently duplicate resources otherwise available in the communities where they are located.

- To maintain its back-up role to the Department of Defense (DoD), the DVA maintains "brick and mortar" facilities that may not be necessary given the availability of excess beds in many DVA and other communities.

- Money paid in salary and bonus payments may exceed that which is necessary to attract physicians and other health care professionals to work in certain DVA facilities.

- The DVA refuses to allow its capabilities to be used by non-veterans in a manner that is consistent with capacity and DVA, community and veteran needs.

INTERIM RECOMMENDATIONS

Based on scoring for just the three suggested recommendations where either Price-Waterhouse or the CBO have provided calculations, it is reasonable to assume a **seven year savings potential of between $30 and $38 billion.** Even further savings could be attributed to the other interim recommendations.

- The DVA should not provide free or subsidized care for non-service connected disabilities. **[According to Price-Waterhouse estimates, "a strict interpretation of "service connected" and "secondary payor" could reduce VA to a third, fourth, or maybe fifth of what it is today."]**

- Inefficient or underused facilities in DVA hospitals should be closed or converted. The focus of this action should be on DVA facilities that are not affiliated with a medical school.

- DVA staffing and salary levels should not exceed what is needed to meet patient, education and research needs.

- Prior to the purchase of expensive medical equipment or the construction of facilities, efforts should be taken to meet the needs of DVA patients within existing DVA facilities or through the local communities. New equipment or facilities should be funded by phasing out services elsewhere in the DVA system.

- DVA coverage should be secondary to other non-government insurance payors.

- Within capacity limitations, DVA facilities should be allowed to care for (and bill) non-veteran patients.

- Regional management teams (comprised of key local administrators, medical and other professional staff leaders, and patient representatives) should be empowered to set directions, allocate resources, and facilitate effective management at the local facility level.

- Economic incentives should be built into the system to encourage savings. Twenty-five percent of savings generated by effective local management should be allocated to enhancing treatment capability, and twenty-five percent of these savings should be allocated to reward actions resulting in more efficient utilization.

- Regional and local decision-making bodies should integrate resources with other DVA facilities and with private sector health care capabilities within communities.

- Patients should not be receiving hospital inpatient care when their needs can be met through nursing facility or domiciliary care. The current DVA presumption in favor of inpatient treatment needs to be replaced with a goal of providing care in the least restrictive setting.

- To the greatest extent feasible, private sector capacity should be used as the first tier in meeting national readiness needs.

- DVA actions that are antithetical to optimal health care, such as the furnishing of tobacco to veterans receiving hospital or domiciliary care, should be stopped.

- A process similar to the DoD base closing commission should make recommendations on the status of DVA facilities.

INTERIM ACTION RATIONALE

MISSION CLARITY - Eligibility for benefits needs to be clearly stated. The DVA should not provide free care for non-service-connected disabilities. AMA policy is very clear on this point. Policy 510.999 (adopted in 1962 and reaffirmed in 1988) says: "Provision of care for non-service-connected disabilities is not the proper business of the Veterans Administration." Coverage for benefits that are based on non-service-connected disability must be seriously questioned. While veterans should not be discouraged from seeking care through the DVA for non-service-connected needs, personal responsibility to assure payment for such care should not be ignored. Actions should be explored to facilitate this responsibility through increased access to insurance mechanisms, collection of copayment amounts and other methods.

In a critique of the DVA published in the February 22, 1995 *JAMA*, two DVA physicians (Elliott S. Fisher, M.D., M.P.H., and H. Gilbert Welch, M.D., M.P.H. - White River Junction (Vermont) DVA Medical Center), cited a lack

> of clarity about the DVA's mission. "Although all of the 27 million veterans are potentially eligible for care, fewer than 10 percent currently use the VA and many of these receive care elsewhere as well. This lack of clarity affects the veterans and the VA. Veterans are confused about who is actually eligible for care."

Where eligible veterans have health care coverage from other-nongovernment sources, the DVA coverage should be secondary. This is consistent with current Medicare law. Current provisions in the law allowing the DVA to be secondary to other insurance payors for non-service-connected care should be extended and expanded to include all care provided by the DVA.

DECENTRALIZATION - Regional management teams (comprised of key local administrators, medical and other professional staff leaders, and patient representatives) should be empowered to set directions, allocate resources, and facilitate effective management at the local facility level. Restrictive provisions in Title 38 should be restructured to enable regional direction and to encourage local decision making. Local decision-making needs to be encouraged relating to matters ranging from contracting for the provision of care in settings and from professionals outside of DVA Centers to the purchasing of supplies and the allocation of resources within a Center.

> As stated in the February 22 *JAMA* article, the VA operates under "an excessively centralized, inflexible, and rule-bound administration that hampers local innovation." ...Even if the job were clear and the patients less sick, the VA would still be hampered by current administrative structures. The VA Central Office restricts how resources are allocated within a facility. A remarkable amount of attention is given to satisfying the specific interests of veteran service organizations and Congress (such as maintaining employment in members' districts), regardless of their relevance to the clinical mission.

This direction is consistent with the March 27, 1995 proposal from DVA Secretary Jesse Brown, "Visions for Change." There is a need to revamp the DVA by reducing the central control over the system. Secretary Brown has called for eliminating the four regional offices and creating 22 smaller staffs, or "Veterans Integrated Service Networks" (VISNs), to manage groups of five to 12 hospitals. The AMA recommends that local authority be expanded based on reasonable regional catchment areas, and that the decision-making authority should reside within a body comprised of patient representatives and the leadership from the managers and care providers within a designated region. Decisions should be made by those who are answerable to patients, not through a new bureaucratic structure.

Economic incentives should be established to facilitate greater economy and the elimination of duplicate capabilities. A percentage of savings generated by effective local management should be allocated to enhancing treatment capability. Similarly, a percentage of savings generated by effective local management should be allocated to reward actions resulting in more efficient utilization.

COMMUNITY INTEGRATION - Regional and local decision-making bodies should be encouraged to integrate resources with communities. Regional DVA "boards" should have a community advisory team comprised of representatives from key medical centers and university based health care programs in the communities that will advise on issues such as integration of DVA capacity to provide health care services, education, and research. Prior to actions being taken that would result in the purchase of expensive medical equipment or the construction of facilities, efforts should be made to assess capabilities to meet the needs of DVA patients within the local communities. Regional DVA authorities should be empowered to identify duplication and work with others within the

communities to more effectively use resources.

Where capacity to meet veteran needs would not be impeded, DVA facilities should be allowed to care for (and bill) non-veteran patients. Consistent with the movement to family practice and primary care, dependents/families of eligible veterans (as well as others) should be allowed to receive care in the same settings as the veteran family member.

NEW INVESTMENT - The DVA currently is planning on opening new facilities, including three nursing homes, and fully funded construction of new hospitals in Brevard County, Florida, and on the grounds of Travis Air Force Base in California. Such new construction is inconsistent with a shrinking population and with a Congressional Budget Office recommendation (March, 1994) to close four percent of DVA hospital beds ($1.2 billion savings from 1995 through 1999). While the Bush Administration was not successful in carrying though its recommendation to eliminate elective surgery services at thirty-three small VA hospitals with a realignment of surgical services to larger hospitals with busier and more proficient surgeons, the fact remains that there is significant room for savings from collapsing of services. If any new investments can be justified, they should be funded from existing resources.

OUTPATIENT CARE - The current DVA presumption in favor of inpatient treatment needs to be replaced with a goal of providing care in the least restrictive setting. Economic and other incentives need to be explored to facilitate earlier hospital discharges as well as more judicious use of hospital and other inpatient facilities.

COMMUNITY BACK-UP - The DVA has a readiness mission that requires a significant capacity to provide care as part of a back-up system to meet potential DoD needs. As an alternative to maintaining the large number of "mothballed" hospital beds in DVA facilities, the DVA should be required to conduct an assessment of hospital beds and other capacity within the private sector. To the greatest extent feasible, private sector capacity should be used as the first tier in meeting national readiness needs.

PROFESSIONAL RECOGNITION - DVA staffing and salary levels should not exceed what is needed to meet patient requirements. The decisions to allow special pay should be made at the regional level and they should be based on whether the added pay is necessary to attract essential personnel. Flexibility needs to be incorporated into the current rigid governmental pay structure so that payment levels will be consistent with the private sector.

PREVENTION - There needs to be an increased emphasis on prevention. DVA actions that are antithetical to optimal health care, such as the furnishing of tobacco to veterans receiving hospital or domiciliary care and the sale of tobacco product in DVA canteens, need to be stopped.

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MEDICAID REFORM

CURRENT PROBLEM

The Medicaid program, which is a joint federal-state program that provides health care coverage to the poor and disabled, has evolved through a series of legislative changes and federal policies into an inflexible, extremely costly program for the federal government and the states. For years, state leaders have called for more flexibility to fashion state Medicaid programs as they choose, largely because the programs have consumed an increasing portion of state budgets. In recent years, states have moved aggressively to enact health system reforms in both the private sector and in Medicaid programs. They view as bureaucratic and inefficient current federal requirements that they secure approval from HCFA for waivers to implement mandatory managed care, add additional uninsureds into the Medicaid program, prioritize covered benefits or implement other programs designed to control costs.

Congressional leaders seeking to balance the federal budget by the year 2002 have passed budget resolutions that include significant reductions in federal Medicaid expenditures (relative to the level that would be spent without controls), totalling approximately $180.8 billion over a seven year period. Federal Medicaid expenditures would continue to grow on an annual basis, but eventually would be limited to 4% annual increases, rather than the 10% annual increases projected under the current system. Preliminary studies suggest that this cap will have a disparate impact among states, and that the majority of states will be forced to reduce the number of Medicaid eligibles and cut reimbursement to providers, even assuming optimistic economic factors. If this occurs, the result would be an increase in the number of uninsureds, which will result in cost shifting to the private sector.

The AMA supports Congress' efforts to create a streamlined, less costly Medicaid system that will maintain its role as a safety net for the nation's poorest and most vulnerable populations. A major challenge in restructuring the Medicaid program to balance states' interest in securing increased flexibility in light of fewer federal funds for Medicaid against the very real needs of the people that the Medicaid program is intended to serve. Under any restructuring of the Medicaid program, the federal government has a substantial interest in ensuring that federal Medicaid dollars are spent on programs that provide beneficiaries with access to quality medical care. To accomplish this, a minimum level of federal standards is necessary. Such standards are also critical to assuring that state Medicaid programs will have sufficient provider participation to meet the beneficiaries' needs, without resorting to coercive approaches to securing that participation. Moreover, as states move their Medicaid populations into managed care systems in hopes of achieving savings, safeguards are necessary to ensure that Medicaid beneficiaries receive high quality, cost effective care and are treated fairly.

In addition, it is essential that federal reforms are enacted that facilitate the purchase of private health insurance for low income Americans who do not qualify for Medicaid. The American Medical Association has long supported federal and state efforts to promote access to health coverage. This will become even more critical in a time of more limited public health care programs.

OBJECTIVES IN MEDICAID REFORM

- Contain federal Medicaid expenditures by limiting increases in federal funding and giving states flexibility to fashion their Medicaid programs to achieve efficiencies, eliminate bureaucracy and reduce costs.

- Maintain the primary goal of the Medicaid program of providing access to quality health care to the poor, particularly children and pregnant women, who make up 70% of the Medicaid population but account for only 30% of the cost. Similarly, Medicaid coverage for the poor elderly must be protected.

- Restrict states from spending federal Medicaid funds for purposes other than those directly related to the state Medicaid program.

- Replace current federal micro-management of the design and structure of state Medicaid programs with a system that gives states maximum flexibility and holds states accountable for meeting basic federal standards. Appropriate areas for national standards and accountability shall be defined, particularly as they relate to access and quality.

- Incorporate into the Medicaid program private market techniques that enhance quality and choice for health care consumers, which will promote competition among providers and health plans by empowering Medicaid recipients to make informed, cost conscious health care decisions.

- Facilitate the ability of physician sponsored networks to provide care for Medicaid beneficiaries, which will increase competition for the Medicaid market, achieve efficiencies by cutting out the middleman insurer, and promote quality.

- Redirect policies and incentives underlying the current Medicaid system in order to achieve control of future Medicaid spending through measures designed to: (1) discourage reliance on welfare in order to qualify for Medicaid; and (2) encourage elderly middle-income Americans to find other means of financing their long term care costs and to discourage the current practice of divesting assets in order to qualify for Medicaid long term care coverage. Current incentives cannot be sustained in the context of shrinking Medicaid funds. States should be given maximum flexibility to fashion innovative long term care programs.

RATIONALE

INCOME-BASED ELIGIBILITY WITH NATIONAL FLOOR

- Because of limited federal and state resources for Medicaid, states will face difficult choices regarding who will be eligible for Medicaid coverage. As a first priority, the Medicaid program must be maintained as a safety net for America's most vulnerable populations. A floor eligibility level is essential to ensure that states will not cut eligibility for the poorest Americans, which would add to the growing numbers of uninsureds and exacerbate cost-shifting and uncompensated care.

- At a minimum, states must provide Medicaid coverage to those whose incomes fall under a federal floor eligibility requirement, set at a percentage of the federal poverty level. States must maintain current efforts in covering children to age 16, pregnant women, and dual Medicaid-Medicare eligibles. For purposes of this proposal, these federally required eligibles are the "core eligibles."

- States should not be allowed to spend federal Medicaid funds for uses unrelated to their Medicaid programs.

MINIMUM ADEQUATE BENEFITS

- The need for state flexibility must be balanced by the need to ensure that states will continue to provide Medicaid beneficiaries with minimum adequate benefits. Otherwise, states may use their discretion under block grants to drastically cut Medicaid benefits, resulting in inadequate coverage for beneficiaries and increased uncompensated care costs. Minimum adequate benefits also will provide some equity and comparability of Medicaid benefits across states.

MECHANISM FOR ADJUSTING FEDERAL EXPENDITURES TO ENSURE ACCESS TO CARE

- Absolute caps on federal expenditures for each state that are based on present spending levels fail to take into account current discrepancies among state Medicaid programs' benefit packages and eligibility standards. Rigid caps also ignore future variations in state economic situations and/or growth in core eligible populations. Failure to account for these interstate variations will lock in and perpetuate current inequities and could leave states without adequate funding to provide coverage to Medicaid core eligibles.

- Federal expenditure adjustments should be based solely on a state's core eligibles in order to avoid rewarding inefficient state Medicaid programs by increasing federal funding or punishing efficient state Medicaid programs by decreasing federal funding.

- Alternate methods of spreading risk among states for unanticipated increases in expenditures for core eligibles, such as reinsurance, risk pooling and a savings set-aside should be studied.

MEDICAL SAVINGS ACCOUNTS AND VOUCHERS

- Medical Savings Accounts (MSAs) provide strong incentives for patients to become cost conscious and informed about their care options. Further, MSAs allow patients--not managed care plans or utilization reviewers--to assert control over their health care decisions, options for care and choice of physicians. Through the use of MSAs and vouchers, states may integrate Medicaid recipients into the commercial insurance market which will improve access and quality in the long term.

PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS ("PCCOs")

- Innovative states have recognized the benefits of creating incentives for providers to treat Medicaid patients by enacting laws that facilitate physician sponsored entities' ability to

"manage" the care of Medicaid beneficiaries. Several states, including Michigan, Minnesota and Illinois, have already enacted such laws.

- Allowing PCCOs to contract to cover Medicaid beneficiaries creates a competitive atmosphere for Medicaid business and promotes high quality for Medicaid beneficiaries by placing medical decisionmaking and quality assurance activities in the hands of those who are responsible for providing the care. Physician sponsored entities also are able to reduce the cost of the insurance "middleman," who diverts a layer of the Medicaid dollar from patient care.

- Eliminating barriers to PCCOs' ability to contract for Medicaid business will contribute to the evolution of these entities and will result in enhancing competition in the commercial health care market, which is currently dominated by insurance companies. See the section of the AMA's "Transforming Medicare" proposal entitled *Physician Sponsored Coordinated Care Organizations* for more detail.

LONG TERM CARE

- Medicaid is the largest payor of long-term care costs in the U.S. The long term care component of Medicaid consumes 36% of Medicaid spending, and Medicaid pays for 52% of all nursing home expenditures.

- Currently, few Americans purchase long term care insurance. Instead, even middle-income Americans who require long term care often access Medicaid to cover their costs by sheltering and disposing of their assets and thus "spending down" for Medicaid coverage. A result of this phenomenon is that the taxpayer pays for long term care of individuals who could afford to purchase the care and/or long term care insurance, while ensuring inheritances for middle-class Americans. This drains Medicaid money from intended beneficiaries--America's poor. These incentives must be altered to discourage this behavior.

- The federal and state governments must establish incentives and mechanisms for individuals to plan for their long term care costs. This is consistent with the goals of the "Contract With America."

- States should be given maximum flexibility to try creative approaches to meeting long term care needs. Currently, waivers are required for states to shift long term care from costly institutional care to community- and home-based approaches. The GAO recently reported that states that have implemented case management programs for long term care have achieved savings in this area that allow funding of more individuals' long term care needs. These types of approaches should not require a waiver.

- States should also have flexibility to use Medicaid funds for public-private approaches to long term care problems. For example, The Robert Wood Johnson Foundation has initiated a four state project on long term care that promotes privately purchased long term care insurance with Medicaid-funded stop loss coverage.

ACCESS STANDARDS

- The need for state flexibility must be balanced against the necessity for federal intervention if a state's management of its Medicaid program results in significantly diminished access and/or quality of care provided to eligibles.

- Federal intervention into a state's Medicaid program should be triggered only when a state fails to meet certain "access standards" that measure recipients' access to covered health care services. Access standards shall be developed by HCFA with input from all affected interests, including physicians.

GUIDELINES FOR PROVIDER REIMBURSEMENT

- There is a demonstrated, direct link between adequate Medicaid provider reimbursement levels and access to quality health care services. Although states should have considerable flexibility in fashioning innovative financing for Medicaid, there must be basic federal standards relating to provider reimbursement designed to ensure access to quality medical care.

- In order to regain equity in Medicaid provider reimbursement and to allow states flexibility in spending their Medicaid dollars in the most efficient manner possible, the Boren Amendment should be replaced by broader reimbursement/access standards for all Medicaid providers and standards for payment to plans that are aimed at ensuring access to care.

HEALTH PLAN STANDARDS

- Regardless of the method for financing or delivering Medicaid health care services, the paramount concern must be the quality of patient care. In an increasingly competitive market, and with fewer Medicaid dollars, health plans face incentives to ration patient care, reduce choices of physicians, deny treatment and base medication and other clinical choices on cost rather than quality considerations. Plans often apply similar pressures on providers as a condition of participating in the plans. Patients must be protected from practices that are unfair or impair the quality of care that they receive. In order to promote continuity of care and protect access, states should create mechanisms for traditional Medicaid providers, such as minority physicians and community health centers, to continue to participate in Medicaid managed care, where it is implemented.

QUALITY IMPROVEMENT SYSTEMS AND QUALITY PERFORMANCE MEASURES

- Systems designed to improve the quality of both the clinical and administrative aspects of health care delivery will help to control Medicaid costs, resulting in increased value for each Medicaid dollar.

EMERGENCY ROOM CARE

- Targeted efforts are necessary to discourage inappropriate use of emergency rooms.

PROHIBITION OF COERCIVE METHODS OF SECURING PROVIDER PARTICIPATION IN MEDICAID

- Appropriately financed state Medicaid programs, which offer adequate reimbursement and safeguards for the clinical decision making process, will provide the necessary incentives for physician participation.

- Providers, like other individuals, should be free to enter into contracts that they choose and should not be subject to coercive measures, such as licensure requirements, "tying" arrangements that link provider participation in a program or plan with participation in Medicaid, or other requirements that impair a provider's ability to decline to accept Medicaid beneficiaries.

PROHIBITION OF SELECTIVE REVENUE TAXATION OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

- States have utilized provider taxes to obtain federal "matching" funds and finance other health system reform efforts. The AMA supports efforts to expand access to health coverage and firmly believes that these measures should be financed in an equitable manner that spreads the cost over the entire state, not just to providers who are actually providing necessary services within the state.

LEGISLATIVE SPECIFICATIONS: MEDICAID REFORM

The AMA supports the following principles to apply under any restructuring of Medicaid including a block grant program, a continuation of the current program with expedited state Medicaid waivers, or a program that would combine a block grant approach for certain portions of Medicaid with an expedited waiver process.

INCOME-BASED ELIGIBILITY WITH NATIONAL FLOOR

- Existing categorical requirements shall be eliminated. States shall base eligibility standards for various populations on income level. States shall establish eligibility levels that meet a federal floor, based on a set percentage of the federal poverty level. For pregnant women, children to age 16, and dual Medicaid-Medicare eligibles, states shall maintain current eligibility levels. All federally required eligibles shall be considered "core eligibles."

- States shall not spend any federal Medicaid funds for purposes other than those directly related to the state Medicaid program.

MINIMUM ADEQUATE BENEFITS

- Basic national standard of uniform minimum adequate benefits shall be established for Medicaid recipients. States can provide additional benefits to beneficiaries as they choose.

MECHANISM FOR ADJUSTING FEDERAL EXPENDITURES TO ENSURE ACCESS TO CARE

- A mechanism shall be established for adjusting federal expenditures in a state when its number of core eligibles changes, as in times when a state is experiencing a recession or significant demographic shifts. This mechanism shall also work to decrease federal funding in states that have a decrease in Medicaid expenditures due to these factors.

- HCFA shall study the feasibility of alternate mechanisms for spreading risk for unanticipated increases in Medicaid expenditures for core eligibles that would not require additional federal expenditures, including:

    - Reinsurance - establish incentives for states to purchase private reinsurance for increases in core eligibles. This would create a commercial Medicaid reinsurance market that would take on the risk that would otherwise be borne by the federal government or the states.

    - Risk pool - establish a national risk pool that states would pay into (based on a formula reflecting the number of core eligibles/per capita income) and could access if they encountered a significant increase in the number of core eligibles. States that lose a significant number of core eligibles could be assessed an additional amount.

    - Savings set-aside - each state shall deposit a set percentage of savings achieved in its Medicaid program in a fund that it establishes that will be available for future Medicaid expenditures. Savings realized beyond the "set-aside" shall be utilized for health-related expenditures.

MEDICAL SAVINGS ACCOUNTS AND VOUCHERS

- Enact federal legislation establishing medical savings accounts (MSAs), which would allow states to extend MSAs to their Medicaid eligibles. States shall be allowed to fund MSAs for Medicaid eligibles directly or to issue publicly-financed vouchers for an actuarially determined amount of insurance to allow Medicaid eligibles to choose among private health insurance plans that provide required benefits. Issuance of a voucher may be coupled with a medical savings account.

- States that employ a voucher and/or MSA approach for their Medicaid population shall ensure that Medicaid recipients are provided with a choice among types of health delivery systems.

- States shall be permitted to allow their Medicaid eligibles to carry over accumulated savings in their MSAs on a tax free basis.

- States shall be permitted to allow Medicaid eligibles to use funds accumulated in MSAs above a state-specified level for certain designated usages, i.e., education tuition, long term care expenses or purchase of a home.

- States that implement a voucher and/or MSA approach shall establish programs to educate Medicaid eligibles regarding medical savings accounts and handling health care services in a cost-effective manner while ensuring that necessary care is obtained.

PHYSICIAN SPONSORED COORDINATED CARE ORGANIZATIONS ("PCCOs")

- Establish guidelines that facilitate direct contracting between state Medicaid programs and PCCOs to provide health care coverage to Medicaid beneficiaries.

    - Includes necessary relief from federal and state laws that create barriers to provision of health services by PCCOs to Medicaid beneficiaries, consistent with the recommendations outlined in the section of the AMA's "Transforming Medicare" proposal entitled *Physician Sponsored Coordinated Care Organizations.*

LONG TERM CARE

- Establish federal rules governing individuals' ability to divest or "spend down" assets in order to qualify for Medicaid long term care coverage. Phase-in rules to allow individuals opportunity to purchase long term care insurance. Establish a spend down "offset" for individuals who purchase long term care insurance.

- Eliminate waiver requirements for states to implement long term care projects that utilize case management approaches, emphasize community- or home-based care or use Medicaid funds to facilitate the purchase of long term care insurance.

- Aggressively study potential alternative methods of financing long-term care, including but not limited to the use of the following devices: MSAs; long term care insurance,

including the possibility of Medicaid-funded stop loss coverage, and tax incentives for employers to provide and individuals to purchase such insurance; tax incentives for family caregiving.

- Require that states adopt standards for long term care insurance comparable to those suggested by the National Association of Insurance Commissioners (NAIC).

ACCESS STANDARDS

- HCFA shall develop standards by which to measure Medicaid eligibles' access to covered health care services and shall solicit formal input from all interested parties, including the American Medical Association. These standards shall include guidelines for provider reimbursement (see next section for greater detail).

- HCFA shall monitor states' progress in meeting access standards.

- Upon finding that a state has failed to meet such standards, HCFA shall establish an oversight process whereby HCFA has authority to require states to engage in certain activities designed to rectify problem areas. This oversight authority shall continue until the Secretary declares that the state is in conformance with the access standards.

GUIDELINES FOR PROVIDER REIMBURSEMENT

- The Boren Amendment shall be repealed.

- National provider reimbursement standards shall be established, either by HCFA or by the Physician Payment Review Commission ("PPRC"), to ensure access to coverage for Medicaid beneficiaries. The AMA, AHA and other interested parties shall have opportunity for formal input into the development of these standards. Access shall be defined broadly and shall encompass reasonable choice of physician and health care facility.

- States shall designate the state Commissioner of Insurance or other appropriate state agency to oversee Medicaid provider reimbursement levels to ensure compliance with national standards.

- Provider reimbursement shall be based on the following:

    - In the fee-for-service arena, state Medicaid programs shall utilize the Medicare RBRVS, with a single conversion factor.

    - Any Medicaid payments or reimbursement based on capitation shall be premised on sound actuarial and utilization assumptions.

- If plans utilize provider fee withholds or other financial incentives for providers to limit care, they shall be equitable, particularly as compared to other payors. Financial incentives shall not be linked to a provider's treatment decisions for a specific patient and should take into account a provider's "case mix" of patients.

- Federal and state incentives shall be developed, with input from physician organizations

and practicing physicians, to encourage physicians and other providers to practice in typically underserved rural and urban areas. Incentives shall include some or all of the following: reimbursement enhancements to physicians practicing in rural areas or medical service areas in the inner-city where the poverty rate exceeds a certain threshold; an exemption for physicians practicing in underserved areas from federal or state antitrust or other limitations prohibiting physicians from more effectively pooling their resources and otherwise working together; tax credits for physician practices in underserved rural and inner city areas to help make up practice-related income differentials for choosing to practice in those areas; loan forgiveness programs for practice in underserved areas; financial assistance with start-up costs; and assistance with property and casualty insurance costs.

HEALTH PLAN STANDARDS

- Accountability standards and state oversight requirements shall be established for health plans that contract to cover Medicaid beneficiaries. These standards shall be consistent, with appropriate modifications for the Medicaid context, with those delineated in the section of the AMA's "Transforming Medicare" proposal entitled *Health Plan Standards in a Transformed Medicare Program* regarding: coverage, marketing, and enrollment, fairness, physician involvement, quality management/utilization review, administrative simplification, and incentive plans.

- States shall document plan adherence to these standards.

- States shall create mechanisms for traditional Medicaid providers, such as minority physicians and community health centers, to continue to participate in Medicaid managed care, where it is implemented.

QUALITY IMPROVEMENT SYSTEMS AND QUALITY PERFORMANCE MEASURES

- The AMA and other private and public sector leaders on the issues of quality management and improvement shall serve as representatives in the Partnership for Health Care Value, which is described in the section of the AMA's "Transforming Medicare" proposal entitled *Health Plan Standards in a Transformed Medicare Program*. The standards and other work product developed by the Partnership shall be used by states in their quality improvement systems.

- States shall design quality improvement systems to assure that Medicaid beneficiaries receive medically necessary and appropriate care with the optimal use of health care resources. These systems shall be tailored to take into account the risk factors of low-income populations.

- Health plans serving Medicaid beneficiaries shall be required to have internal, physician-directed quality improvement systems, subject to state oversight, which are comparable to those used in the private sector.

    - Health plans shall be required to establish a mechanism for physician input into the plan's medical policies, utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

- Health plans serving Medicaid beneficiaries shall be required to use professionally developed quality performance measures designed to meet local needs in their quality improvement systems and shall monitor and evaluate the quality of care provided by the health plan.

- Quality performance and outcomes measures may serve as the basis for financial incentives designed to reward the provision of appropriate medical care.

- Each state shall oversee the quality improvement efforts of health plans and other providers that contract to cover Medicaid beneficiaries. States shall provide HCFA with aggregate encounter data for HCFA to use in monitoring quality and access for the Medicaid population and relevant sub-populations.

EMERGENCY ROOM CARE

- States shall create incentives for Medicaid beneficiaries to properly utilize emergency rooms. Such measures include, but are not limited to, programs for nominal copayments for emergency room visits.

PROHIBITION OF COERCIVE METHODS OF SECURING PROVIDER PARTICIPATION IN MEDICAID

- States and managed care entities with Medicaid contracts shall be prohibited from coercing provider participation in Medicaid through measures including, but not limited to, licensure requirements or health plan contractual requirements that require treatment of Medicaid patients.

PROHIBITION OF SELECTIVE REVENUE TAXATION OF PHYSICIANS AND OTHER HEALTH CARE PROVIDERS

- States shall be prohibited from imposing selective revenue taxes on physicians and other health care providers and using such provider taxes or fees to fund health care programs or to accomplish health system reform.