



American College of Physicians

The Declining State of the Nation's Health Care *And the Urgency of Moving Forward on Essential Reforms*

February 17, 2010

Introduction

Health care in the United States is facing an unprecedented challenge of affordability and sustainability.

Yet a highly-partisan and polarized debate over health care reform legislation regrettably has taken the country's "eye off the ball"—from the urgency of implementing reforms to make health insurance coverage more affordable, available and secure; to ensure a sufficient supply of primary care physicians and other specialties facing shortages; and to reform payment and delivery systems to achieve better value.

The year-long effort to enact comprehensive health care reform remains stalled in Congress, with no clear route forward, yet the urgency of reform is greater than ever.

Much of the attention in Washington these days necessarily is focused on improving the economic security of middle class working families and reducing unemployment, **but health care reform is an integral part of providing economic security to small businesses, middle class working families, and the millions of Americans who are out of work:**

- ✓ Small businesses face the greatest challenge in finding affordable health coverage for their employees.
- ✓ Rising premiums will soon place affordable health care out of reach for many middle class working families.
- ✓ People who lost their jobs because of the recession are at the greatest risk of also losing their health coverage, because most people get health insurance from an employer.

Washington also necessarily is focused on reducing the federal deficit and the public debt, **but health care reform is integral to reducing the federal government's structural deficit:**

- ✓ It is not possible to achieve substantial and lasting reductions in the deficit and public debt without reducing the Medicare and Medicaid spending—the single greatest contributors to the fiscal crisis facing the United States.



The American College of Physicians, representing 129,000 internal medicine physicians and medical student members, releases this report today in an effort to re-invigorate the effort to enact and implement essential reforms to improve health care delivery in the United States.

What the Evidence Tells Us

ACP views health reform not from a partisan or ideological perspective, but from the standpoint of what the evidence tells us will be the most effective course of action, in a way consistent with consensus policies adopted by our physician and medical student members. Our review of the evidence tells us that comprehensive health care reform is essential:

1. Without health reform, rising health care costs will soon put affordable care out of reach for tens of millions more Americans, *including many middle class families*.

- ✓ If premiums for employer-sponsored insurance grow in each state at the projected national rate of increase, then the average premium for family coverage would rise from \$12,298 (the 2008 average) to \$23,842 by 2020 —*a 94 percent increase*.

[Source: Commonwealth Fund, www.commonwealthfund.org/Content/Publications/Data-Briefs/2009/Aug/Paying-the-Price-How-Health-Insurance-Premiums-Are-Eating-Up-Middle-Class-Incomes.aspx]

- ✓ By 2017, a middle-income family that earns \$80,000 could end up *spending more than four out of every 10 dollars they earn on health care alone*, before any deductions for taxes or fringe benefits are taken out of their gross wages.

[Source: economist Uwe Reinhardt, <http://economix.blogs.nytimes.com/2008/11/07/the-health-care-challenge-sailing-into-a-perfect-storm/>]

- ✓ CBO projects that, without any changes in federal law, *spending on health care will rise to 25 percent of GDP in 2025 and close to 50 percent in 2082*.

[Source: <http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-LTBO.pdf>]

2. Without health reform, many millions more will join the ranks of the uninsured or have problems paying their bills, especially as middle class families are priced out of the private insurance market, out-of-pocket costs increase, and more people with pre-existing conditions are denied affordable coverage.

- ✓ In 2007, *an estimated 116 million adults were uninsured, underinsured, reported problems paying a medical bill, and/or did not access needed health care because of cost*.



[Source: Commonwealth Fund, www.commonwealthfund.org/Content/Charts/Report/Front-and-Center-Ensuring-that-Health-Reform-Puts-People-First/An-Estimated-116-Million-Adults-Were-Uninsured-Underinsured-Reported-a-Medical-Bill-Problem-and-or.aspx]

- ✓ Health plans covered slightly fewer expenses in 2007 than in 2004, *but out-of-pocket spending grew more than one-third* during this period of economic expansion because of growth in overall health spending. Recession since 2007 has resulted in further increases in cost-sharing and decline in employer provided insurance.

[Source: Gabel et al. Trends In Underinsurance And The Affordability Of Employer Coverage, 2004–2007. Hlth Affairs June 09]

- ✓ By 2020, the Census Bureau projects that the number of uninsured will climb from 46 million to 60 million—*one out of every five people*.

[Source: U.S. Bureau of the Census, <http://www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html>]

3. Without health reform, many more small businesses will find that they can't afford to purchase health insurance for their employees, and rising costs will place an economic strangle-hold on those who do.

- ✓ The average premium paid by businesses for health coverage for their *workers increased 131 percent* from 1999 to 2009, and *the employee contribution increased 128 percent* over the same period.

[Source: Kaiser Family Foundation, <http://ehbs.kff.org/pdf/2009/7937.pdf>]

- ✓ In 2007, *only 25 percent of employees in small businesses had coverage through their own employers, compared with 74 percent of workers in large firms*. Because there are few sources of affordable coverage outside the employer-based system, millions of employees in small businesses are uninsured or have inadequate health insurance. In 2007, *52 percent of workers in small businesses were uninsured or underinsured during the year*, compared with half as many employees in large businesses.

[Source: Commonwealth Fund, http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2009/Sep/1316_Doty_out_of_options_ib_FINAL_v2.pdf]

- ✓ *Over the next decade, small business will pay \$2.4 trillion for the health care costs of their workers.*

[Source: Small Business Majority, http://www.smallbusinessmajority.org/pdfs/SBM-economic_impact_061009.pdf]

4. Without health care reform, the overall cost of health care no longer will be sustainable for the country as a whole.

- ✓ The country now spends more than \$2.5 trillion, *more than 17 percent of gross domestic product (GDP)*, on health care services and products, far more than other industrialized country. Yet, the US scores average or worse on many indicators of health care quality, and many may not get appropriate standards of care.

[Source: CRS 1/29/09]

5. Without health reform, Medicare and Medicaid spending growth will add hundreds of billions of dollars annually to the federal deficit and to the cumulative public debt, consume a growing share of federal and state budget resources at the expense of other priorities, and lead to Medicare's insolvency.

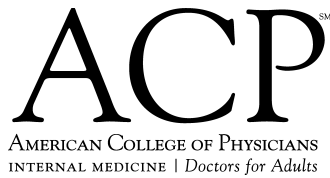
- ✓ By 2017, Medicare's Part A trust fund, which pays for hospital care, *will run out of money* and become insolvent.

[Source: Social Security Administration, <http://www.ssa.gov/OACT/TRSUM/index.html>]

- ✓ "The single greatest threat to budget stability is the growth of federal spending on health care—pushed up both by increases in the number of beneficiaries of Medicare and Medicaid (because of the aging of the population) and by growth in spending per beneficiary that outstrips growth in per capita GDP. For the nation's fiscal situation to be sustainable in future decades, growth in such spending will have to be reduced relative to its historical trend and to CBO's projected path. Today, outlays for Medicaid and Medicare combined (excluding offsetting receipts) equal about 5.5 percent of GDP. Under current law, spending for those two programs is expected to keep growing faster than the economy, reaching 6.6 percent of GDP by 2020 and potentially reaching 10 percent by 2035. Without changes to federal fiscal policy—involving some combination of lower spending and higher revenues than the amounts projected under current law—those rising costs will rapidly drive the size of federal debt held by the public well beyond the 67 percent of GDP projected for 2020."

[Source: Congressional Budget Office, The Budget and Economic Outlook: Fiscal Years 2010 to 2020, January 2010 <https://www.cbo.gov/ftpdocs/108xx/doc10871/Chapter1.shtml>]

- ✓ In 1966, 19 million people were enrolled in Medicare. In 2010, enrollment will have reached 47 million people. *Ten years from now, the number of Medicare recipients will be 62 million, and by 2030, 79 million, yet the number of workers paying taxes to support the program will continue to decrease.* Ten years ago, there were four working taxpayers for every one beneficiary. Today, there are 3.7 workers per beneficiary. In 2020, it will be 2.9 workers, and by 2030, there will be only 2.4



workers paying into the system for each Medicare beneficiary eligible to receive services.

[Source: Kaiser Family Foundation, based on 2001 and 2008 Annual Reports of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.]

6. Without health reform, there will not be enough primary care physicians—and other specialties facing shortages—to take care of an aging population with more chronic illnesses, resulting in long delays in getting needed care, unnecessary trips to emergency rooms, rushed office visits, poorer outcomes, and higher costs.

- ✓ Medical student preference for primary care is at an all-time low: only one out of every five physicians is expected to practice in a primary care specialty.

[Sources: AAMC Graduation Questionnaire (preferences), AMA Masterfile (practice), Altarum analysis (forecast)]

- ✓ The U.S. will experience a *shortage of 35,000–44,000 primary care physicians for adults* by 2025. Population growth and aging will increase family physicians’ and general internists’ workloads by 29 percent between 2005 and 2025.

[Source: Colwill JM, Cultice JM, Kruse RL. Will generalist physician supply meet demands of an increasing and aging population? *Health Aff (Millwood)*. 2008 May-Jun;27(3):w232-41. Epub 2008 Apr 29]

- ✓ This shortage will occur even though more than 100 studies *show primary care consistently is associated with better outcomes and lower costs* of care.

[Source: American College of Physicians. *How Is a Shortage of Primary Care Physicians Affecting the Quality and Cost of Medical Care?*. Philadelphia: American College of Physicians; 2008: White Paper. Available from American College of Physicians, 190 N. Independence Mall West, Philadelphia, PA 19106.]

7. Without health reform, physicians and patients alike will find that the crushing administrative burden imposed by health plans will continue to take time away from patient care to filling out forms.

- ✓ On average, *physicians reported spending forty-three minutes per workday—equivalent to three hours per week and nearly three weeks per year—on interactions with health plans. . . Primary care physicians spent significantly more time (mean = 3.5 hours weekly) than medical specialists (2.6 hours) or surgical specialists (2.1 hours). When time is converted to dollars, practices spent an average of \$68,274 per physician per year interacting with health plans. The median value was \$51,043. Primary care practices spent \$64,859 annually per physician—nearly one-third of the income plus benefits of the average primary care physician* (median spending for a



primary care practice: \$47,707). Practices comprising primarily medical specialists and surgeons spent \$78,913 and \$66,954 per physician, respectively.

[Source: Health Affairs, <http://content.healthaffairs.org/cgi/content/full/28/4/w533>]

8. Without health reform, the medical liability tort system will continue to drive up health insurance premiums for individuals, families, and taxpayers.

- ✓ The Congressional Budget Office estimates that tort reform would "lower costs for health care both directly, by reducing medical malpractice costs - which consist of malpractice insurance premiums and settlements, awards, and legal and administrative costs not covered by insurance - and indirectly, by reducing the use of health care services through changes in the practice patterns of providers" and "reduce federal budget deficits by about \$54 billion during the 2010-2019 period."

[Source: CBO <http://cboblog.cbo.gov/?p=389>]

All of these were true when Congress began debating health care reform one year ago, and they remain true today—except in many respects the problems have gotten worse. The only thing that has changed is that some Washington politicians may be on the verge of throwing in the towel on health care reform.

The Way Forward

ACP does not underestimate the political challenges in achieving consensus on health reform legislation.

We recognize that the difficult and contentious political process has left many people disillusioned and highly distrustful of the health reform legislation.

We believe that misinformation about the health care reform legislation has contributed to a poisonous atmosphere that has made consensus more difficult.

We acknowledge that advocates of health care reform have not been able to persuade many Americans that they and their families will be better off if health care reform passes.

We recognize that many Americans are concerned about the ability of Washington to deliver on its promises and to keep spending under control.

We recognize that there are strong and legitimate philosophical differences among Democrats, Republicans and Independents on how best to reform the health care system.



We believe that neither political party has a monopoly on good ideas for reform of health care, but excessive partisanship has accentuated the differences rather than promoting common ground.

Nevertheless, we believe that President Obama and Congress must press forward on enactment of legislation to address the immediate – and long-term – threats to the sustainability and affordability of U.S. health care.

We also believe that there are a number of important executive branch actions that the Obama administration could take to improve health care affordability and sustainability—not in lieu of, but in complement with, enactment of health reform legislation.

ACP offers the following recommendations to move forward on health reform:

- 1. Congress and the President should reach an agreement on a legislative pathway to enact a final bill that builds upon – and improves – the bills passed by the House of Representatives and the Senate.**

It is not for us to define today the best process for moving the legislation forward. We strongly believe, though, that *Congress and the President must soon reach an agreement on a legislative pathway that would preserve key elements in the bills passed by the House and Senate*, while making improvements to address public concerns and to reconcile differences between two versions.

We specifically recommend that Congress maintain the following key elements in a final health reform bill:

- A. Create a pathway to providing affordable coverage to all Americans.** The bills passed by the House and Senate would provide coverage to 94-96 percent of all legal residents. ACP firmly believes that the final legislation must not back off on the commitment to create a pathway for all Americans to have access to health insurance coverage. We continue to support creating sliding-scale tax credits, expansion of Medicaid to cover the poor- and near-poor, insurance market reforms, and providing individuals and small businesses a wide choice of affordable health plans through a health exchange.
- B. Include the strongest possible workforce and payment policies to ensure a sufficient supply of primary care physicians and other specialties facing shortages.** Both the House and Senate bills would increase Medicare payments for designated services by primary care physicians but they differ on the amount of the bonus, the services it would apply to, and the criteria for a physician to qualify. We urge that the House's overall approach be adopted, but at the 10 percent bonus level, as passed by the Senate. We also urge adoption of the House

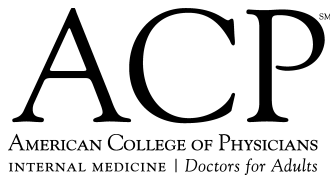
provision to increase Medicaid payments for visit services provided by primary care and other physician specialists. We urge adoption of the highest possible mandated funding levels for primary care training programs (including the National Health Service Corps and Title VII health professions funding) and the House’s provision to create a new loan repayment program for “front line” health professionals facing shortages. We support the House provision to redistribute 90 percent of unused Graduate Medical Education (GME) positions to primary care. We support provisions in both bills to create a workforce commission to recommend policies to ensure a sufficient supply of primary care physicians and other specialties facing shortages.

- C. Accelerate pilot-testing and adoption of innovative models, including the Patient-Centered Medical Home, to improve payment and delivery systems to achieve better value.** We support provisions in both bills to establish a Center on Medicare Innovation, but we urge adoption of the House provision to fund two Medicare pilots of the Patient-Centered Medical Home. The Patient-Centered Medical Home has been shown to be one of the most promising models for improving the efficiency and outcomes of care. It requires dedicated funding to allow for broader testing and adoption by Medicare and other payers.

We also believe that legislation can be improved to make the health insurance options more affordable to qualified families and small businesses, to ensure that the proposed health exchange has sufficient purchasing clout and enrollment to restrain health care premium increases, to ensure that Congress has the final say—by a simple majority vote—over any recommendations from an Independent Payment Advisory Board, and to address concerns about special provisions made for some states but not to others.

It has been suggested that key policies in the bills could be broken into smaller pieces, but such an approach can result in “Swiss Cheese” reforms that have so many holes that they simply won’t work. For instance, requiring that all insurers accept people with pre-existing conditions, and limiting how much more they can charge them, likely will be ineffective without policies to incentivize individuals to purchase insurance coverage while healthy, instead of waiting until they are ill and more expensive to insure. Similarly, subsidies would be needed to make coverage affordable. Also, small-bore bills are likely to leave out many of the above reforms needed to make health care sustainable. If Congress chooses to advance some of the reforms through separate bills, we believe that the effectiveness of each bill and the overall approach should be evaluated based on:

- ✓ Their impact on reducing the number of uninsured.
- ✓ Their impact on providing more security to those with health insurance.



- ✓ Their impact on ensuring a sufficient supply of primary care physicians and other specialties facing shortages.
- ✓ Their impact on making health care more affordable and sustainable over the short- and long-haul for individuals, businesses, and taxpayers.

We also disagree with those who have called on Congress and the President to start over and craft entirely new bills. The current bills are far from perfect, but they have enough good policy, developed over many months with broad public participation and debate, to serve as the basis of a final agreement. In addition, we are doubtful that starting over will yield bipartisan agreement on policies that will be effective in making the U.S. health care system sustainable and affordable. More likely, the result would be an indefinite postponement of any genuine reform for years to come.

At the same time, we are deeply troubled that the hyper-partisan atmosphere in Washington has obscured the fact that there are many issues relating to health reform that have had broad bipartisan support in the past, and likely would continue to have such support today, including:

- ✓ **ensuring a sufficient supply of primary care physicians**
- ✓ **improving payment and delivery systems and accelerated adoption of the Patient-Centered Medical Home**
- ✓ **creating positive incentives for adoption of health information technologies and reporting on evidence-based quality measures**
- ✓ **reducing administrative burdens associated with health plan interactions**
- ✓ **making health insurance more portable**
- ✓ **giving small businesses and families more options to buy coverage**
- ✓ **providing sliding scale tax subsidies to help families and businesses buy coverage**
- ✓ **and putting an end to the cycle of Medicare physician payment cuts.**

Many of these are addressed by the bills passed by the House and Senate, but they also have been included in other bills with bipartisan support and co-sponsorship. **We are encouraged that President Obama has invited leaders of both political parties to meet on February 25 to share ideas on moving forward on consensus reforms, and we urge them to address the common ground – and common sense – reforms suggested above.**



2. President Obama should specifically reach out to both Republican and Democratic members of Congress to develop bipartisan proposals to reduce the costs associated with the medical liability tort system.

We are encouraged that President Obama, in his State of the Union address, said “if anyone from either party has a better approach that will bring down premiums, bring down the deficit, cover the uninsured, strengthen Medicare for seniors, and stop insurance company abuses, let me know.”

According to the Congressional Budget Office, “tort reform would lower costs for health care both directly, by reducing medical malpractice costs—which consist of malpractice insurance premiums and settlements, awards, and legal and administrative costs not covered by insurance—and indirectly, by reducing the use of health care services through changes in the practice patterns of providers.” It estimated that such reforms “would reduce federal budget deficits by about \$54 billion during the 2010–2019 period.”

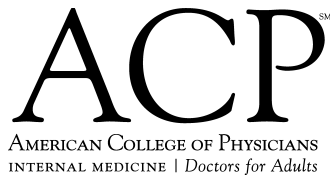
The current bills have modest grant proposals to fund state liability reform initiatives, but they fall far short of the reforms needed to bring down premiums, lower the deficit, and reduce overall health care costs. We urge President Obama to seek a bipartisan agreement on alternatives to the current medical liability tort system, including dedicated funding to test health courts as an alternative to trial by jury.

3. Congress should give preferred funding for discretionary programs to advance the goals of expanding coverage, ensure a sufficient supply of primary care physicians, and encourage testing and dissemination of models to improve health care delivery.

ACP supports the need to reduce spending on ineffective or unnecessary discretionary programs as part of a broader strategy to reduce federal budget deficits. We believe, though, that Congress must provide sufficient funding for programs that will result in longer-term improvements in health outcomes and reductions in health spending growth—not in lieu of, but to complement, enactment of the broader health care reform bills. The President’s budget proposal includes funding for important initiatives to train more primary care physicians, improve care coordination, support prevention and wellness programs, encourage adoption of health information technologies, and help states maintain current Medicaid coverage.

In particular, we strongly urge Congress to:

- A. Expand funding for the National Health Service Corps and Title VII primary care health professions training.** These programs have a demonstrated track record in producing more primary care physicians in under-served communities. Studies show that the availability of primary care physicians is positively



associated with better care at lower costs. We also support increased funding for community health centers.

- B. Increase funding to HHS to pilot-test and expand innovative payment and delivery models to deliver patient-centered care and improve care coordination, including the Patient-Centered Medical Home.** While ACP supports the concept of a new Center for Medicare Innovation, as included in both the House and Senate bills, we also believe that Congress needs to provide HHS with the resources needed to design and pilot test innovative payment and delivery models, including the PCMH, under existing demonstration and research authority.
 - C. Provide for an extension of the increased federal match for state Medicaid programs.** This is needed to ensure that states are not forced to reduce benefits and eligibility until such time as the broader Medicaid reforms proposed in the House and Senate bills are enacted and implemented.
 - D. Expand funding for research on the comparative effectiveness of different medical treatments.** ACP strongly supports provisions in the House and Senate health reform bills to increase federal support for Comparative Effectiveness Research (CER). At the same time, we strongly urge Congress to increase funding to the Agency for Health Care Research and Quality and the National Institutes of Health to support and expand existing CER initiatives.
 - E. Increase funding to accelerate adoption of health information technologies with the capabilities needed to improve patient care.** The President’s budget includes \$110 million for continuing efforts to strengthen health IT policy, coordination, and research activities.
- 4. Congress must permanently end the cycle of Medicare physician payment cuts caused by the Sustainable Growth Rate (SGR) formula.**

The constant threat of Medicare payment cuts inhibits access to care for millions of America’s seniors and military families insured by Tri-Care. In addition, a foundation of stable, predictable and positive Medicare payments is a pre-requisite to adoption of innovative payment reforms to create better value and to support patient-centered primary care. The House has passed legislation to replace the SGR with a system to eliminate devastating payment cuts, provide higher updates to all physicians, and allow for increased payments for primary care and preventive services. The Senate must now do the same. We cannot support another temporary “patch” that kicks the can down the road and with it, the cost to taxpayers of enacting a permanent solution.



5. The Obama administration should use its executive authority to:

- A. Reduce barriers to primary care under all federal programs and among private contractors that contract with the federal government to deliver or insure health care services.**
- B. Accelerate pilot-testing of the Patient-Centered Medical home.**
- C. Ensure the appropriateness and accuracy of physician payments.**
- D. Require private health plans that contract with the federal government for health care services and delivery to reduce the administrative burdens associated with health plan interactions.**

The bills passed by the House and Senate have important provisions to reduce barriers to primary care, accelerate pilot-testing of innovative payment and delivery models including the Patient-Centered Medical Home, improve the accuracy of physician payments, and reduce administrative burdens associated with health plan interactions. These measures should be included in a final health reform legislative agreement. At the same time, we believe that the administration has the ability to use existing executive branch authority to begin advancing such reforms pending enactment and implementation of health reform legislation.

Specifically, we urge President Obama to issue an Executive Order on Increasing Primary Care Workforce Capacity—a recommendation that we first made in January 2009 but that has not yet been adopted by the administration. This executive order should direct all federal agencies with an impact on health care in the United States to develop and implement policies to increase primary care workforce capacity in the United States to meet the needs of the currently insured, people who will become newly insured as a result of health reform initiatives to expand coverage, and the growing demand for primary care associated with an aging population with increased incidence of chronic illnesses. It should specifically require that all federal health-related agencies:

- ✓ Develop, describe and initiate plans to encourage or require private sector entities that contract with the federal government to provide care to patients funded or subsidized by the federal government – including health plans that participate in the FEHBP and the Medicare Advantage programs or the new Health Exchange proposed in the House and Senate bills – to implement policies to increase primary care physician workforce capacity.
- ✓ Develop, describe and initiate plans to support innovative models for delivering primary care, including the Patient-Centered Medical Home.



- ✓ Develop, describe and initiate a research agenda to facilitate an understanding of the factors affecting choice of specialty, the demand for primary care, and policies to assure a sufficient primary care workforce capacity.
- ✓ Develop, describe and initiate payment reforms to make primary care competitive with other career and practice options and create measurable objectives for assessing the impact of such reforms on increasing primary care workforce capacity.
- ✓ Develop, describe and initiate plans to reduce ineffective, duplicative or inefficient regulatory and paperwork requirements on primary care clinicians.
- ✓ Develop, describe and initiate plans to assist physicians, especially those in smaller practices, to acquire the capabilities and health information systems to manage and coordinate care, including health information technology.
- ✓ Develop and describe a timeline for implementing all such programs.
- ✓ Develop and describe goals for each program and metrics for evaluating success.
- ✓ Develop and describe a process for recalibration of such programs should they prove to be having an insufficient impact on increasing the primary care workforce capacity.

We also urge the administration to begin implementation of the Medicare Medical Home Demonstration Project authorized by current law. This project, which was authorized by Congress in 2007 and again in 2009, will reimburse qualified physician practices for coordination of care for Medicare patients with one or more chronic diseases. HHS has indefinitely put the demonstration project on hold, though, pending the outcome of provisions in the health reform legislation to fund additional pilots of the medical home model. Although ACP supports such provisions in the pending bills, we believe that the administration needs to move forward with the existing demonstration project without further delay. At the same time, we recognize and appreciate the administration's existing initiatives to support the PCMH model, including the advanced primary care demonstration project announced last year.

We also urge the administration to establish a process, within the Center for Medicare and Medicaid Services, to improve the accuracy of the relative value units under the Medicare physician fee schedule. The Medicare Payment Advisory Commission has recommended that HHS establish an expert panel to review the RVUs of services that potentially may be mis-valued, to supplement, but not replace, existing private sector advisory processes outside the agency. ACP supports the MedPAC recommendation. The House and Senate health reform bills have provisions to establish



and fund such a process, which we support, but we believe that the agency already has the authority to establish such a process.

ACP is encouraged that the House and Senate health reform bills include important reforms to streamline and reduce the burden of health plan interactions. Such reforms should be included in any final legislative agreement. **We believe, though, that the administration does not need to wait for legislation to conduct a systematic review and elimination of unnecessary, redundant, and ineffective paperwork requirements imposed by CMS and other federal agencies—a recommendation that we made last year but that has not yet been implemented.** Such policies should include:

- ✓ Simplifying the Medicare physician enrollment process;
- ✓ Improving physician ability to help beneficiaries obtain needed prescriptions through Medicare Part D;
- ✓ Ensuring physician interaction with regional Medicare Administrative Contractors (MACs);
- ✓ Studying the use of real-time Medicare claims adjudication; and
- ✓ Requiring standardization and streamlining of insurance credentialing, billing, claims review, and other administrative procedures that fall disproportionately on primary care physicians associated with private sector health plans that participate in the Federal Employee Health Benefits Program, Medicare Advantage, or that may be offered through a Health Insurance Exchange as proposed in the health reform bills.

Physicians should, among other things, have the ability to:

- ✓ Contribute the information health plans need for credentialing to a single source – from which individual plans can draw – rather than providing the same information to numerous payers;
- ✓ Access information on which a health plan covers a patient and the benefits the coverage affords in real-time through a single electronic platform;
- ✓ Use standard processes to navigate payer authorization-related programs, including those for prescription drugs and radiology services; and
- ✓ Receive payment for services that meet a health plan’s conditions for payment at the time of the service.



The mechanisms to achieve these administrative efficiencies have been or are being developed. A requirement that private health plans that participate in federal programs use these mechanisms will help to streamline these programs while providing an example that health plans insuring a commercial population can follow.

Reducing the administrative burden will free physician practices to further focus on clinical care, improve physician satisfaction, and lower overall health care costs.

Conclusion

Health care in the United States is not sustainable—for families, for businesses, and for taxpayers.

In the absence of comprehensive health care reform, our country will face a bleak future.

Affordable and high-quality health care will simply be out of reach for millions more Americans, including middle class families.

Rising health insurance premiums will break the backs of small businesses, the primary engines of job creation in the United States.

Primary care physicians will become almost impossible to find, leading to long waits for appointments, delayed care, hurried visits, and more visits to the emergency room for conditions that could have been treated in a doctor's office.

Patients will also have difficulty finding physicians in other specialties that also are facing shortages.

Continued physician payment cuts will create enormous access problems for seniors and disabled persons on Medicare and for military families insured by Tri-Care.

Physicians will spend increasing amounts of time filling out paperwork instead of taking care of patients.

Medicare will become insolvent, and increased spending on Medicare and Medicaid will drive an unprecedented budgetary and fiscal crisis—likely leading to drastic cuts in benefits and eligibility, reduced payments to physicians and other providers, tighter controls over utilization, and higher taxes.

And the medical liability tort system will continue to drive up health care costs and premiums without providing fair, appropriate and predictable compensation to those patients who are truly injured by medical malpractice.



President Obama and Congress must not pass up an historic and unprecedented opportunity to institute fundamental reforms to make health care more affordable and sustainable.

Such reforms should build upon and improve the bills passed by the House and Senate, and specifically include key policies to create a pathway to provide affordable coverage for all Americans, increase the supply of primary care physicians, and accelerate testing of the Patient-Centered Medical Home and other innovative delivery systems.

Concurrently, Congress should provide expanded funding for essential discretionary programs to improve health care delivery and increase the supply of primary care physicians.

Congress must also repeal the SGR and put a permanent end to the cycle of Medicare physician payment cuts.

The administration should also use its executive powers to require that all federal agencies and health care contractors institute reforms to reduce barriers to primary care and to streamline and reduce the time that clinicians and patients spend on unnecessary administrative transactions.

And the President should seek a bipartisan agreement on broader testing and implementation of alternatives to the current medical liability tort system, including health courts.

ACP is under no illusion that overcoming the remaining political hurdles to enactment of comprehensive health reforms will be easy.

We know that funding is tight.

We understand that re-directing federal agencies to implement health care reforms on their own authority is difficult.

We know that the contentious, polarized, and partisan debate has undermined the public's confidence in the ability of Washington to produce a good legislative outcome.

But the alternative to moving forward on comprehensive health reform is an unconscionable abdication of responsibility by our elected leaders to ensure that high quality health care remains available and affordable for American families today, tomorrow and for years to come.