State of the Nation’s Health Care 2014

Progress, Challenges and Opportunities:
Taking the Next Steps to Reduce Barriers to Access and Reform Medicare Physician Payments

Oral Remarks
Bob Doherty
Senior Vice President, Governmental Affairs and Public Policy
American College of Physicians

Thank you, Dr. Cooke.

I am Bob Doherty, ACP’s senior vice president of governmental affairs and public policy. I have overall staff management responsibilities for ACP’s public policy office, located here in Washington, DC.

As Dr. Cooke noted, 2014 marks the beginning of a historic journey toward the destination of providing affordable health coverage to nearly all Americans.

Because of the Affordable Care Act, millions of us who in the past were left behind are now getting covered. They are our neighbors, our family members, our co-workers.

Because of the ACA, millions of us can now get coverage from health insurance marketplaces, giving us a choice of qualified health plans that must cover essential services, including no-cost preventive services.

Because of the ACA, millions of us will get help in affording coverage, through the sliding scale premium subsidies applied to qualified health plans.

Because of the ACA, millions of young adults--including my own 24-year old-son!--are covered by their parents’ plans.

Because of the ACA, millions of our poorest residents can now enroll in Medicaid, at least in the states that have agreed to expand the program.
Because of the ACA, my 84-year-old Mom, and tens of millions of seniors like her, now has Medicare coverage for no-cost preventive services, and better coverage of prescription drugs under Medicare Part D.

Our State of the Nation’s Health Care report breaks down by the numbers how many people will benefit from the Affordable Care Act and in what ways.

The journey to expanding coverage will take years to complete. Like any journey, especially one that takes us into entirely new territories, there will be bumps and detours along the way. And let’s admit it: too many people had trouble even getting started on the journey, because of the repairs needed to the federal enrollment portal. Yet improvements are being made, and the path to coverage is getting smoother.

We know also that there are huge variations in how willing the states have been to help their residents navigate the journey to ACA-guaranteed coverage. In some states, enrollment is off to a very fast pace, in others it is still backed up—like my drive to work this morning. But like any journey worth taking, we can’t turn back because we run into heavy traffic. Or because we get a flat tire, or hit a pothole, or miss a turn-off. We have to keep on going until we arrive at our destination. We have to keep on going even though we know more improvements are needed. We have to keep on going even though the political opponents of the Affordable Care Act keep putting up roadblocks in our way.

The American College of Physicians is committed to doing everything we can to help the United States arrive at the destination of affordable health insurance coverage for all.

And as we find barriers along the way that make the journey more difficult, we must speak out about them and propose ways to overcome them.

We are concerned that the promise of providing all Americans with access to affordable health insurance is undermined when health plans impose excessive restrictions on patients’ ability to continue to see the physicians they trust or receive the medications they need. We believe that the federal government, the insurance industry, and state regulators have a responsibility to address such barriers, not only in qualified plans offered through the ACA’s exchanges, but also in the Medicare Advantage program.

The College is pleased that on February 4, the Centers for Medicare and Medicaid Services released a letter to insurers in the federally-facilitated marketplace that would strengthen network adequacy requirements, increase the supply of essential community providers, and provide greater transparency and scrutiny of prescription drug formularies. In letters sent today to HHS Secretary Kathleen Sebelius, the National Association of Insurance Commissioners, the Blue Cross and Blue Shield Association, and America’s Health Insurance Plans, the College calls on CMS, state regulators and insurers to take further steps, in addition to those just announced by the agency:

1. Improve the current network adequacy standards by taking into account additional criteria—including patient-to-physician ratios, use of out-of-network clinicians and hospitals, and urban, suburban, and rural area-relevant standards—as indicators of access.
2. Continuously monitor network adequacy. We are encouraged that CMS will be monitoring network adequacy via complaint tracking and random spot checks of
qualified health plan network data. We recommend that such compliance and complaint information be made available to the public.

3. Strengthen requirements for the inclusion of essential community providers, such as federally qualified health centers, Ryan White HIV/AIDS providers and safety net hospitals.

4. Mandate that qualified health plans provide physicians and their patients advance notice of network changes and the opportunity to appeal.

5. Ensure that physicians have the option of applying to any health care plan or network in which they desire to participate and to have their application judged based on objective criteria that are available to both applicants and enrollees.

6. Require transparency in the criteria used by qualified health plans to determine who will be allowed into networks.

7. Prohibit qualified health plans from excluding health care clinicians because their practices contain substantial numbers of patients with expensive medical conditions.

8. Require qualified health plans to provide up-to-date network directories in real-time when a potential enrollee is choosing a plan, including making prompt updates upon receipt of new information relating to network participation.

9. Create an enrollment period to allow patients to choose another qualified health plan if an outdated network directory has incorrectly listed an enrollee’s preferred physicians as being part of the network.

10. Require qualified health plans to establish “Health Care Provider Hotlines” to connect physicians, hospitals and other providers to plan representatives to answer questions, verify patient enrollment, and obtain other information.

11. Create an appeals process to authorize in-network cost-sharing if a medically necessary service is not available within the network but is available from an out-of-network physician willing to accept terms of the service. This exception is permitted for preventive services, but it should be expanded to include other essential health benefits.

12. Qualified health plans with restrictive formularies should allow patients to continue to receive disputed medication during an entire exception review process, and if an exception is granted, continue to provide coverage for the exception drug during subsequent plan years. There must be a mechanism for expedited internal and external review and appeals in urgent health situations.

13. Closely monitor formularies and other benefit design features to ensure that coverage does not exclude patients with complex chronic conditions, including patients with cancer, transplants, mental health treatment, HIV/AIDS, and hepatitis C. Such limited formularies and plan restrictions would violate the spirit of the ACA’s nondiscrimination provisions which prohibit discriminations based on factors including health status, disability, age, race, gender, and sexual orientation.

Our report and letters provide a fuller explanation of these and other ideas for addressing the barriers to care created by excessively narrow networks and drug formularies.

To be clear, the College is not advocating that health plans provide unfettered access to every physician, hospital or medication. We recognize that some physicians and hospitals have higher and possibly unjustifiably higher utilization rates, poorer outcomes, and higher admission and readmission rates. We do not advocate that every medication be on a plan’s formulary when there is an equally effective and less expensive alternative.
Rather, we are offering constructive and balanced safeguards that emphasize consideration of additional elements in addressing network adequacy, transparency in network selection criteria and physician performance measures, consumer access to real-time network directories, improvements in the health plan selections shopping experience, and exceptions to ensure continuity of care.

Now, I’ll turn my attention to another barrier to access: the continued unwillingness of some states to expand Medicaid to the poor and near-poor. As a result, 5 million low-income people who were supposed to get coverage under the ACA will be left behind in 2014, just because they live in a state that is not expanding Medicaid.

The encouraging news is that a majority of states have expanded Medicaid or expressed the intent to do so, with the Republican governor of Utah being one of the most recent. Leaving Utah’s poorest residents without health insurance “is not fair and it is not right” Governor Herbert said in his January 29, 2014 “State of the State” speech to Utah lawmakers. “Assisting the poor in our state is a moral obligation that must be addressed.” He is right, and ACP is committed to doing everything it can to encourage the remaining states to meet their moral obligation to cover their poorest residents.

In October 2013, ACP urged all of its chapters to encourage their states to expand Medicaid. Despite a very difficult political environment in some states, our chapters came through for their patients. Armed with state-specific data we provided them, they told their states that expanding Medicaid is the right thing to do, for the health of their populations, and also, the right thing to do for the health of their state budgets.

The College is now in the process of updating the information we provided to our chapters, to help those in states that have not yet agreed to the expansion, to again make the case that:

- Opening up Medicaid to the poor and near-poor is the fiscally smart thing for states to do. Even though the federal contribution declines gradually over the next 10 years, at no time will it pay less than 90 percent of the cost, and when other savings to the states are considered, many state budgets will end up better off than if they don’t expand Medicaid. States that wait another year or more will be leaving federal dollars at the door that otherwise would go to the benefit of their residents, and their treasuries.
- It is wrong to leave the poorest of the poor without coverage. Without access to Medicaid, people with incomes below the poverty level will have no access to coverage under the ACA, while higher income residents will get subsidies to buy coverage through the exchanges.
- Medicaid coverage also is associated with better self-reported health and preventive service use, and people enrolled in Medicaid are less likely to report that costs are creating a barrier to getting the care they need.

We recommend that all states authorize expansion of Medicaid to persons with incomes up to 133 percent of the FPL, by no later than the end of this year. CMS should work with the states to consider options and grant waivers to states to expand Medicaid in a manner that best meets the state’s needs, provided enrollees are not subjected to fewer benefits or higher cost-sharing or eligibility requirements than is required under the federal government’s current Medicaid standards.
We also recommend that Congress do its part to ensure that Medicaid enrollees will have access to a personal physician by reauthorizing a program to raise Medicaid payment rates for primary care to no less than the applicable Medicare rates.

Finally, let me turn my attention to Medicare physician payment reform. Last week, agreement was reached between the three congressional committees with jurisdiction over Medicare to permanently reform Medicare physician payments. We are pleased that the bill they’ve agreed to, *The SGR Repeal and Medicare Provider Payment Modernization Act of 2014* (H.R. 4015/S. 2000), includes key reforms advocated by ACP. Specifically, the bill:

- Removes the imminent threat of physician payment cuts and ensures a 5-year period of annual updates of 0.5 percent to transition to the new system.
- Improves the existing fee-for-service system by rewarding value over volume.
- Consolidates the three existing quality programs into a streamlined and improved program that rewards physicians who meet performance thresholds and improve care for seniors.
- Rewards physicians that engage in clinical practice improvement activities that will help facilitate their future participation in Alternative Payment Models (APMs).
- Implements a process to improve payment accuracy.
- Creates incentives for care coordination efforts for patients with chronic care needs.
- Creates incentives for physicians to move into alternative payment models, include a 5 percent bonus to physicians who receive a significant portion of their revenue from Patient-Centered Medical Homes.
- Establishes a process to review and recommend physician-developed alternative payment models based on criteria developed through an open comment process.
- Expands the use of Medicare data for transparency and quality improvement.

ACP will continue to work with members of Congress to get this bill to the President for his signature no later than March 31, 2014, in time to prevent a scheduled nearly 24 percent payment cut on April 1, 2014. The College strongly opposes another temporary patch or freeze: with agreement having been reached on a bipartisan, bicameral bill to reform Medicare physician payments and repeal the SGR, there is no reason for Congress to put off acting now to send real reform to the President for his signature.

To summarize:

The recommendations presented today by the American College of Physicians are offered in the spirit of making sure that even as we expand coverage, we build upon the positive steps being taken by the administration to address potential obstacles to patients accessing care from a physician they trust and getting the medications they need. They are offered in the spirit of building upon the progress being made by Congress to reform Medicare physician payments, highlighting the policies that we believe are essential to real reform.

Dr. Cooke and I will be pleased to answer your questions.