

Medical Student Insider
June 22, 2006

Update on the Reauthorization of the Higher Education Act (HEA)

The AMA is pleased to report that the “Single Holder” rule was officially repealed on June 15, 2006, when the Emergency Supplemental Appropriations conference report in which it is was included was signed into law (Public Law 109-234). This is excellent news for medical students and graduates across the country. The “Single Holder” rule required students who had all their loans with only one lender to consolidate with that same lender, regardless of other potentially better consolidation packages offered elsewhere. With the repeal of this rule, *all* students can now shop around for the best package and consolidate their loans with any lender.

Congress is also considering legislation for another extension of the HEA to allow more time for completion of the reauthorization process. With the passage of this bill, the current deadline of June 30, 2006, would be extended to September 30, 2006. For more information and the history of this ongoing process, please go to www.ama-assn.org/go/HEA.

Be sure to keep an eye out for more updates and alerts, and for your opportunity to make your voices heard. The AMA and the AMA-MSS consider medical student indebtedness to be a serious concern and a legislative priority, and have been advocating strongly for the medical students during the current reauthorization process. To see the letters and comments the AMA has shared with Congress and the Administration, please go to www.ama-assn.org/go/HEA.

Medical Student Insider
April 27, 2006

Making a Difference

Get ready for a very busy May – which will include Covering the Uninsured Week and the U.S. Senate Health Week. Medical students are valuable advocates for our nation's patients and should be active in making a difference at the local and national level. Included below are information and resources, as well as opportunities to get involved in important issues such as the uninsured, medical liability reform, and Medicare physician payment reform.

Covering the Uninsured Week

Today, a substantial segment of our population lacks adequate health insurance or has no coverage at all – more than 46 million Americans are uninsured, and millions more are underinsured. Improving access to care for the uninsured and underinsured is currently the number one priority of the AMA Medical Student Section (MSS). Understanding the incredibly complex nature of this problem, the MSS has dedicated itself to educating medical students and patients about the growing crisis and the AMA's proposals for expanding access to quality health care coverage.

With the AMA as a national partner in Cover the Uninsured Week (CTUW) 2006, the AMA-MSS is one of many national supporters helping to make the issue of the uninsured a focus for public discussion and action. Join your fellow students the week of May 1-7, 2006 for the official Cover the Uninsured Week (www.CoverTheUninsured.org) to organize events that will raise awareness and build interest in covering the uninsured. Check out the following resources for more information, including AMA's plan to expand coverage and the CTUW homepage. Additionally, the AMA-MSS is an excellent source of sample event modules and possible funding if you are considering planning an event. And remember, even though CTUW officially only lasts through the first week of May, the AMA-MSS supports events occurring anytime throughout the year.

Resources for Covering the Uninsured Week:

- www.CoverTheUninsured.org
- www.coveringkidsandfamilies.org
- AMA-MSS CTUW website (<http://www.ama-assn.org/ama/pub/category/11453.html>), medical school CTUW events (<http://www.ama-assn.org/ama/pub/category/12343.html>), and sample event modules (http://www.ama-assn.org/ama1/pub/upload/mm/15/ctuw_modules.doc)
- AMA-MSS website on Covering Kids & Families (<http://www.ama-assn.org/ama/pub/category/12686.html>)
- AMA website on Expanding Coverage for the Uninsured (<http://www.ama-assn.org/ama/pub/category/7834.html>)
- AMA Talking Points on Covering the Uninsured (http://www.ama-assn.org/ama1/pub/upload/mm/399/nac_uninsured.pdf)

Medical Liability Reform (MLR)

Over the past several years, escalating jury awards and settlements and the high cost of defending against lawsuits (even those without merit), have driven medical liability insurance premiums to unprecedented levels. As insurance becomes unaffordable or unavailable, physicians have been

forced to limit vital services, close their practices, or relocate to a state with strong medical liability protections. These practice decisions are affecting millions of Americans. Indeed, access to care is suffering in 44 states. And, there are now 21 states in a full-blown medical liability crisis – up from 12 in 2002.

The AMA supports fair and reasonable reforms to our medical liability litigation system that have proven effective, including caps on non-economic damages, also known as “pain and suffering” awards. By making damage awards in medical liability cases more predictable, California, which has a \$250,000 cap on non-economic damages, and other states with similar laws have helped to stabilize and even reduce medical liability premiums and improve patient access to care.

In early May 2006, the United States Senate will vote on the soon to be introduced S. 22, the “Medical Care Access Protection Act of 2006.” S. 22 is a comprehensive medical liability reform bill based on a successful Texas law that established a “stacked” \$750,000 cap on total non-economic damages. Under this proposal, non-economic damages against physicians would be limited to \$250,000, and non-economic damages for multiple health care institutions (such as hospitals and nursing homes) would be capped at \$500,000, with no institution responsible for more than \$250,000.

Resources on medical liability reform:

- AMA website on MLR (<http://www.ama-assn.org/ama/pub/category/7861.html>)
- AMA materials on MLR: Q&A (http://www.ama-assn.org/ama1/pub/upload/mm/399/nac_mlrqa.pdf); Talking Points (http://www.ama-assn.org/ama1/pub/upload/mm/399/nac_mlrfacts.pdf); and Crisis Map (http://www.ama-assn.org/ama1/pub/upload/mm/399/nac_mlrmap.pdf)
- Medical Liability Reform Now! (<http://www.ama-assn.org/ama1/pub/upload/mm/1/mlrnowoct192005.pdf>)
- AMA Board of Trustees Report 32 (A-03) and Report 13 (I-03) on MICRA enhancements and other medical liability reform

Medicare Physician Payment Reform

Thank you to all the students and residents who contacted their Members of Congress last year asking that the 2006 cuts in Medicare payments to physicians be averted. Although this cut was halted this year, Medicare patients’ access to care is still being threatened. On January 1, 2007, physician payment rates will be cut by approximately 5% under Medicare’s physician payment formula (known as the sustainable growth rate or SGR). Furthermore, projected cuts in physician payment rates, due to the SGR, will total a staggering 34% from 2007 through 2015! While physician payments plummet, practice costs will increase 22% over this period according to the government’s own conservative estimate of practice cost inflation.

America’s seniors could face serious access to care issues in the near future because of these cuts, as many physicians will be forced to limit the number of new Medicare patients they treat. A recent AMA Member Connect® survey shows that nearly one-half (45%) of physicians will be forced to either decrease or stop seeing new patients if the 2007 cut takes effect. And by 2015, if the nine years of projected cuts occur, a majority of physicians would be forced to stop making nursing

home visits, discontinue important rural outreach programs, and delay purchasing critical new medical equipment and information technology.

Only physicians and other health professionals face such steep cuts. This is because their payment rates are based on the flawed SGR formula, rather than increases in practice costs. Other Medicare providers are not subject to the SGR and have been receiving updates that keep pace with their costs. In fact, hospital payments are projected to rise by more than 3% in 2007, and Medicare Advantage (MA) plans (which are already paid at an average of 107% of fee-for-service costs) are expected to receive an average update of 4%, with some plans receiving up to 7.1%.

If Congress doesn't act, the current system will jeopardize patients' access to care. We as medical students can get involved and make a difference. Watch for action alerts in the near-future to contact your Senators and Representative and tell them that physicians and patients need a permanent fix in Medicare physician payments.

Resources on Medicare Physician Payment Reform:

- Read more about the Medicare program in the August 28, 2005 MSI (http://www.ama-assn.org/ama1/pub/upload/mm/15/msi_8-26.pdf)
- AMA website on Medicare Physician Payment Reform (<http://www.ama-assn.org/ama/pub/category/13409.html>)
- AMA materials on Medicare Payment Reform: The Facts (<http://www.ama-assn.org/ama/pub/category/14340.html>); Q&A (<http://www.ama-assn.org/ama/pub/category/14341.html>); Physician payments vs Other providers chart (<http://www.ama-assn.org/ama/pub/category/14342.html>); Practice costs vs Medicare payments chart (<http://www.ama-assn.org/ama/pub/category/14343.html>); and Map of Medicare payment cuts 2007-2015 (<http://www.ama-assn.org/ama/pub/category/14344.html>)



MEDICAL STUDENT INSIDER

April 20, 2006

By [Heather Smith](#), AMA Government Relations Advocacy Fellow

MEDICARE PART D UPDATE

The new Medicare prescription drug benefit, also referred to as Medicare Part D, began offering coverage on January 1, 2006. Although there are millions of Medicare beneficiaries who now have prescription drug coverage, there are still more than 15 million eligible people who are without benefits. Under current law, the enrollment period for these people to sign up and receive coverage in 2006 ends on May 15, 2006. By learning more about this program and the resources available, we as medical students can offer assistance to both physicians and patients who are interested in enrolling in a plan.

To learn more about Medicare Part D, please take a look at the following general resources:

- Centers for Medicare & Medicaid Services (CMS) Web site on Medicare: www.medicare.org
- CMS Web site overview of [Prescription Drug Coverage](#)
- AMA Web site on Medicare Part D: www.ama-assn.org/go/MedicareRx
- Medical Student Insider on Medicare Part D from [November 17, 2005, MSI](#)

For those already enrolled

Medicare beneficiaries who signed up for drug benefits prior to March 31, 2006, are currently receiving coverage through one of the Medicare Part D plans. For patients who have had difficulties with enrollment or with their prescription coverage during this implementation and transition period, there is general information available on the CMS website.

The “transition period” which, expired on March 31, 2006, applied to beneficiaries who were enrolled in the first few months of the program. It was intended to offer the flexibility and time necessary for physicians and patients to manage their prescription regimen, arrange for alternative prescription drugs, and resolve prescription-related issues under the new coverage. For beneficiaries enrolling after March 31, 2006, the transition period lasts 30 days from the initiation of coverage during which they are entitled to at least a 30-day transitional supply of non-formulary drugs.

The AMA has been active in minimizing the impact of some of the issues during this transition period. In an effort to simplify administration of the new Medicare prescription drug program, the AMA, America’s Health Insurance Plans (AHIP), and a number of physician, pharmacist and beneficiary organizations have collaborated to develop standardized forms to aid physicians in communication with insurance companies and pharmacists to address prior authorizations and prescription coverage problems.



Resources to assist current Medicare Part D beneficiaries:

- CMS Web site regarding [common Medicare Part D problems](#)

Resources to assist physicians of current Medicare Part D beneficiaries:

- [CMS Transitional Drug Coverage Resource Fact Sheet](#)
- AMA Web site for the [prior authorization and coverage for non-formulary drugs form](#)
- AMA Web site on the [“Pharmacist-to-Physician Fax Form”](#)

For those not already enrolled

Under current law, the open enrollment period for 2006 coverage for patients who are currently eligible to receive benefits but have not yet signed up through Medicare Part D ends on May 15, 2006. If an eligible beneficiary does not join by May 15, 2006, and then later changes his or her mind, the next enrollment period starts November 15, 2006, for coverage in 2007. There is a strong incentive for those without any or adequate (“creditable”) coverage to sign up before May 15th, as there may be a penalty charged to the monthly premium of at least 1% per month for every month past initial eligibility. As with other insurance, this penalty may be charged for as long as the recipient is enrolled in a Medicare prescription drug plan. For those who do join before the May 15th deadline, coverage will become effective the first day of the month following enrollment and will generally last for the calendar year.

Resources to assist with Medicare Part D enrollment:

- [CMS Medicare](#) Web site: www.medicare.gov
- CMS tollfree phone numbers: 1-800-MEDICARE, or 1-877-486-2048 for TTY users
- [State Health Insurance Assistance Programs](#) (SHIP)
- [Offices on Aging](#)

Resources for physicians to assist with Medicare Part D enrollment:

- [CMS informational materials and tools](#) for office use and patient education

For those who need financial assistance

Patients with limited income and resources may qualify for extra help in paying the costs of their prescription drug coverage. Information on the following programs are all available in the online [“Medicare & You 2006”](#) informational guide.

- [Social Security Administration](#) (SSA) can assist patients who qualify based on their income and resources with the costs of prescription drug coverage. Medicare sent letters last year to those who qualified for extra help. Patients who did not receive an application, but think they may qualify, should contact their local SSA or their State Medical Assistance office. Eligible patients will have to choose and join a Medicare Prescription Drug Plan by May 15, 2006, or Medicare will enroll them in a plan effective June 1, 2006.
- [State Medicare Savings Programs](#) may be available through which Medicaid funds are utilized to help pay Medicare Part D premiums, deductibles, and coinsurance.



- Supplemental Security Income (SSI) may be able to be applied to Medicare Part D costs. Patients can contact their local Social Security office or check online to find out if they are eligible for SSI or other benefits.
- Programs of All-inclusive Care for the Elderly (PACE) Program, offered on a state-by-state basis through the Medicaid program, combines medical, social, and long-term care services. Some PACE programs may also provide Medicare prescription drug coverage.
- Medicare-approved Drug Discount Cards were introduced and distributed to Medicare beneficiaries to help defray prescription drug costs prior to the start of Medicare Part D. These temporary discount cards can still be used by patients until May 15, 2006, or until they join a drug plan, whichever comes first. And, if a patient qualified for this credit, they may also qualify for help with paying drug plan costs.

Remember, patients automatically qualify for extra help and do not need to apply for financial assistance if they are a dual-eligible (qualify for both Medicaid and Medicare benefits), receive SSI, or belong to a Medicare Savings Program. These patients, as well as those who have applied and qualified for other low-income assistance, will be automatically enrolled if they have not joined a plan by April 15, 2006. There may be additional state or local programs that are available for assistance which can be identified through the State Medical Assistance office.

Resources for financial assistance for beneficiaries:

- CMS Medicare online guide: [Medicare & You 2006](#)
- [Social Security Administration \(SSA\)](#)
- [State Medicare Savings Programs](#)
- [Supplemental Security Income \(SSI\)](#)
- [State Medical Assistance office](#)
- [Programs of All-inclusive Care for the Elderly Program](#)

March 31, 2005
MSI

March Wrap-up

Spring is finally upon us, and with that comes the advent of the warmer weather, the NCAA Championship, and increased legislative activity. As we look forward to April and the upcoming issues, we should also take a step back to appreciate the AMA's great successes in the month of March. This week's MSI will recap the exciting events of the past month.

Lobby Day

On Monday, March 13th, the steps of the Capitol Building in Washington, DC were awash with hundreds of white coats for the 2006 AMA Political Action Committee (AMPAC) Lobby Day. Coming to DC to advocate on behalf of the nation's medical students, physicians, and patients, the Lobby Day attendees had a day full of education and advocacy. Joined by AMA Alliance members, these 295 medical students and 59 residents and fellows began their day with informational sessions, including: enhancing communication skills while lobbying; building relationships with Members of Congress; AMPAC and its importance to students and residents; and issue briefs on medical student loan debt relief, medical liability reform, and Medicare physician payment reform. Finally, participants heard from Senator George Allen of Virginia, who emphasized the importance of talking with legislators about issues that affect patients' access to care. After the morning's programming, students and residents headed to Capitol Hill in small groups for an afternoon of meetings with their Senators, Representative, and their legislative staff. Hill discussions included personal stories from students and residents describing how these issues affect their patients today and influence the way they will practice medicine in the future.

AMA article: Students, residents and fellows take on Capitol Hill (<http://www.ama-assn.org/ama/pub/category/16119.html>)

Talking points on medical student loan debt relief (http://www.ama-assn.org/ama1/pub/upload/mm/15/tps_student_debt_06.pdf)

Talking points from the National Advocacy Conference on Medicare physician payment reform, medical liability reform, expanding health insurance coverage, and clinical quality improvement (<http://www.ama-assn.org/ama/pub/category/16087.html>)

Match Day

Congrats to all the graduating medical students who found out at noontime on Thursday, March 16, 2006 where they will be heading for their graduate medical training. More than 26,000 people participated in the 2006 Match, of whom 15,000 are graduating from U.S. allopathic and osteopathic medical schools. Recent trends of increased interest in the "lifestyle" specialties were seen to continue, while other trends, such as the decreasing interest in primary care, showed mixed results.

The National Resident Matching Program (NRMP) is a non-profit organization managed by the AAMC and is additionally sponsored by the AMA, the American Board of Medical Specialties, the American Hospital Association, and the Council of Medical Specialty Societies. The NRMP was established to match the preferences of applicants with the preferences of residency program directors. The AMA Medical Student Section is represented on the NRMP Board by a medical student who is appointed each year. Jona Rushing (jona-rushing@uiowa.edu) from the University of Iowa is the current AMA-MSS appointed liaison and is more than happy to respond to specific questions or concerns regarding the NRMP, "The Match," or the AMA-MSS liaison position.

AAMC brief: Match Day Ceremonies Held Across the Nation

(<http://www.aamc.org/newsroom/pressrel/2006/060316.htm>)

Frequently asked questions to the AMA regarding “The Match” (<http://www.ama-assn.org/ama/pub/category/8231.html>)

For those graduating, take a look into the RFS section (<http://www.ama-assn.org/ama/pub/category/15.html>) and join their listserv (<http://www.ama-assn.org/ama/pub/category/7091.html>)

March Madness

Working in the AMA DC office, I have had the privilege to experience much of what DC has to offer, including the great monuments, the Cherry Blossom Festival, and the return of baseball to the nation’s capital. I have to admit, I have also gotten caught up in George Mason’s Kryptonite fever, and would like to congratulate the Patriots on their great achievement.

March 3, 2006
Medical Student Insider

2006 AMPAC Lobby Day Issue Updates

The 2006 AMPAC Lobby Day is quickly approaching – more than 300 students, residents, and fellows are getting ready to visit their Congressional leaders. While in our nation’s capital, they will be discussing issues important to medical students, residents, and the future of medicine, including student loan debt relief, medical liability reform, and Medicare physician payment reform. For more information on the AMA legislative and advocacy priorities, read the [Medical Student Insider from February 16, 2006.](#)

Student Loan Debt Relief

The Higher Education Act of 1965 (HEA) governs all federal postsecondary education funding and requires reauthorization every five years. Congress has been in the midst of this process since 2003, with current student aid programs being funded for the last three years by a series of continuing resolutions. In fact, an additional extension of the HEA until March 31, 2006, was signed into law on December 30, 2005, providing Congress with more time to complete the reauthorization process.

H.R. 609, the “College Access and Opportunity Act,” and S. 1614, the “Higher Education Amendments Act of 2005,” are the legislative vehicles for the reauthorization in the House and Senate, respectively. Both pieces of legislation have been favorably reported out of their committees of jurisdiction to the floors of their respective chambers.

Recently, the budget reconciliation conference report (S. 1932, the “Deficit Reduction Act of 2005”) was passed by Congress and signed into public law (P.L. 109-171). The Deficit Reduction Act includes several of the financial aid provisions from the House and Senate HEA reauthorization bills (H.R. 609 and S. 1614, respectively). Some of the provisions specifically affecting medical students and residents include maintaining both the scheduled shift to a fixed interest rate of 6.8% on new student loans beginning July 1, 2006, as well as maintaining the current formula for calculating loan consolidation interest rates based on a weighted average. Other provisions include a reduction in origination fees and a \$2000 increase in graduate borrowing limits for unsubsidized loans to \$12,000/year. Also, graduate students will now be permitted to borrow PLUS loans.

It is important to note that the budget reconciliation conference report does not address all of the outstanding issues relating to the reauthorization of the HEA, including the repeal of the “single-holder” rule and the requirement that lenders report timely loan payments to all national credit bureaus and fully disclose consolidated loan terms to applicants.

[Higher Education Act informational webpage \(www.ama-assn.org/go/HEA\)](http://www.ama-assn.org/go/HEA)

[AMA letter to Representative Price, August 17, 2005](#)

[“Price Calls for Study on Med School Student Debt.”](http://tomprice.house.gov/html/release.cfm?id=62) (<http://tomprice.house.gov/html/release.cfm?id=62>) released Thursday, July 21, 2005

Medical Liability Reform (MLR)

Legislation to limit the size of jury awards is important in maintaining access to care. Over the past several years, escalating jury awards and settlements, and the high cost of defending against lawsuits (even those without merit), have driven medical liability insurance premiums to unprecedented levels. As insurance becomes unaffordable or unavailable, physicians have been forced to relocate, close their practices, or drop vital services. Access to care is suffering in 44 states. There are now 21 states in a full-blown medical liability crisis – up from 12 in 2002 – in which patients continue to lose access to care.

Currently H.R. 5, the “Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2005,” has been passed by the House, but has yet to be considered by the Senate. This bill is a comprehensive set of medical liability reforms that provides for reasonable limits on non-economic damages awarded to injured patients. Similar reforms have been in place in California for 30 years, keeping medical liability insurance premiums stable in the state over time. H.R. 5 would allow for injured patients to recover unlimited economic damages, including the cost of medical care, rehabilitation, lost wages and domestic services, as well as up to a quarter of a million dollars for non-economic damages, often referred to as “pain and suffering” awards. The HEALTH Act also promotes speedier resolutions to disputes, ensures fair allocation of responsibility, prevents double recovery of awards, and helps to maximize the percentage of the awards patients receive.

MLR background (<http://www.ama-assn.org/ama/pub/category/6282.html>)

Medical Liability Crisis Map (<http://www.ama-assn.org/ama/noindex/category/11871.html>)

MLR Now! (<http://www.ama-assn.org/ama1/pub/upload/mm/378/mlrnowoct192005.pdf>) – A compendium of facts supporting medical liability reform

National legislative activities - MLR (<http://www.ama-assn.org/ama/pub/category/6087.html>)

Medicare Physician Payment Reform.

Congress recently enacted a freeze in payment rates under the Medicare physician payment formula (the sustainable growth rate, or SGR), reversing the 4.4% cut that had taken effect January 1, 2006. Although recent cuts have been averted, the Medicare physician payment system still needs to be reformed. It is projected that on January 1, 2007, physician payment rates will be cut by about 5%. In fact, the 2006 Medicare Trustees report is expected to project cuts in physician payment rates, due to the SGR, totaling 34% through 2015.

America’s seniors could face serious access to care issues in the near future. Results of a 2005 Member Connect® survey show that due to Medicare payment cuts, more than a third (38 percent) of physicians plan to decrease the number of new Medicare patients they accept; more than half (54 percent) of physicians plan to defer the purchase of information technology; and a majority (53 percent) of physicians will be less likely to participate in a Medicare Advantage plan. A 2005 MedPAC survey found that 25% of Medicare patients looking for a new primary care physician had some problem finding one and that a growing number had a “big problem.”

Physician payment rates should be based on increases in practice costs, rather than the flawed SGR formula. Other Medicare providers are not subject to the SGR. In fact, hospital payments are slated to rise by more than 3% a year. Furthermore, federal policymakers’ envision a transformed Medicare physician payment system that delivers the highest quality of care to patients using health information technology and quality improvement initiatives. It is essential in fulfilling this vision to implement a stable physician payment system that provides payment increases which accurately reflect the increases in physicians’ practice costs.

Medical Student Insider, August 26, 2005: Strengthening Medicare, Part I (http://www.ama-assn.org/ama1/pub/upload/mm/15/msi_8-26.pdf)

National legislative activities – Medicare (<http://www.ama-assn.org/ama/pub/category/6583.html>)

Better visualize the disparity between physician costs and physician payment (http://www.ama-assn.org/ama1/pub/upload/mm/399/nac_costs.pdf)

The official U.S. Medicare website (<http://www.medicare.gov/>)

The U.S. Medicare 2006 Handbook (<http://www.medicare.gov/publications/pubs/pdf/10050.pdf>)

February 16, 2006
Medical Student Insider

The 2006 Legislative Year Has Begun...

The AMA recently launched the 2006 AMA Health Care Advocacy Agenda, outlining the AMA's advocacy priorities. This coincides with much activity in Washington, DC: the reconciliation budget conference report was passed by the U.S. House of Representatives and sent to the President for signature; a commitment to health care reform was made by the President in his State of the Union Address; and the proposed budget for 2007 was released by the Executive Office.

In 2006, the AMA will help doctors help patients by focusing on the most important issues facing medicine. This week's MSI will describe these very important issues facing medicine today and the [AMA's advocacy efforts](#) to achieve these reforms.

2006 AMA Health Care Agenda

(1) Medical liability reform (MLR)

To preserve patients' access to care, the AMA will continue to lead an aggressive, multi-year campaign to reduce medical liability premiums, with a focus on national MICRA-like reforms, including a \$250,000 cap on non-economic damages in medical liability cases.

The President restated in his State of the Union Address on January 31, 2006, his commitment to seeing similar federal reform be passed by Congress. Currently H.R. 5, the "Help Efficient, Accessible, Low-cost, Timely Healthcare Act of 2005" has been passed by the House, but has yet to be considered by the U.S. Senate Committee on the Judiciary to which it was referred in July, 2005. The AMA will continue to strongly advocate that such reform be passed by the Senate this year.

- [MLR background and talking points](#)
- [MLR Now!](#) – A compendium of facts supporting medical liability reform

(2) Medicare physician payment reform and regulatory relief

As the leading force in Washington for Medicare reform, the AMA will continue to press for the replacement of the flawed Medicare physician payment formula. The AMA will also push Congress and federal agencies to reduce costly and counterproductive regulatory burdens and to eliminate unfunded mandates, which interfere with access to quality care for America's seniors.

The President addressed the rising costs of the Medicare program in both his State of the Union Address and in his proposed 2007 budget. His budget includes a proposal to slow the rate of growth in Medicare spending from the current 8.1% to 7.7%, with a \$35.9 billion reduction in spending over the next five years. For physicians, the proposed Medicare budget does not offer a fix to the estimated 4.6% cut to payments in 2007.

- Medical Student Insider, August 26, 2005: [Strengthening Medicare, Part I](#)
- [National legislative activities – Medicare](#)
- [National legislative activities – regulatory relief](#)

(3) Expanding coverage for the uninsured and increasing access to care

The AMA is committed to leading the response of America's physicians to solve the health coverage crisis for all uninsured patients. Furthermore, the AMA-MSS declared that access to care for the uninsured and underinsured is the section's top priority issue for 2005-2006.

President Bush acknowledged in his Address that affordable health care is a necessity in keeping America competitive. He addressed this in his 2007 budget proposal by including new tax credits for purchasing Health Savings Accounts (HSAs) and increasing the contribution individuals can make to HSAs. Additionally, the President included a proposal to give tax credits to low-income uninsured people who have high-deductible health plans.

- Expanding Health Insurance: the AMA proposal for reform
- AMA publications on health insurance reform
- AMA Council on Medical Service: reports relating to health insurance coverage
- Reaching Equitable Access to Care for Health: AMA plan to strengthen the medical safety net system
- AMA-MSS Web site on health care access

(4) Improving public health through...

The AMA will provide effective programs and tools to help doctors improve the health of the public around: healthy lifestyles; health disparities, and disaster preparedness.

- AMA Website on promoting healthy lifestyles
- AMA-MSS 2004-2006 National Service Project: Healthy Lifestyles to Reduce Obesity.
- AMA website on eliminating health disparities
- Commission to End Health Care Disparities: a multi-specialty task force chaired by the AMA that focuses on physician leadership, quality, and system approaches to the elimination of disparities.
- Center for Public Health Preparedness and Disaster Response
- National Disaster Life Support training program

(5) Patient safety and quality improvement in health care

In 2005, the AMA and its patient safety partners led the passage of the "Patient Safety and Quality Improvement Act of 2005," a critical step in the process for improved safety and quality of health care for America's patients and their physicians. In 2006, the AMA will continue to lead physicians' efforts to ensure that the law's implementation leads to measurable improvements in patient safety and quality of care. The AMA will also continue to convene the Physician Consortium for Performance Improvement to develop evidence-based performance measures.

- National legislative activities regarding patient safety and clinical quality improvement.
- Physician Consortium for Performance Improvement
- Medical Student Insider: August 19, 2005, August Legislative Update

(6) Managed care reform

The AMA is improving physicians' ability to practice quality medicine by combating third-party interference that burdens physicians and hinders quality care.

- AMA activities regarding managed care reform in the private sector



MEDICAL STUDENT INSIDER

January 5, 2006

By [Heather Smith](#), AMA Government Relations Advocacy Fellow

Legislative Update for the New Year...

On December 22, 2005, Congress adjourned for the year without completing its work on the budget reconciliation conference report (S. 1932). This conference report contains numerous items of interest to the AMA, including higher education, the Medicare physician payment issue, vaccine liability, and Medicaid. When Congress reconvenes later this month, work on S. 1932 is expected to continue. The AMA will be monitoring developments closely and will provide updates for students, residents, and physicians.

The Higher Education Act (HEA)

For more general and background information, please go to <http://www.ama-assn.org/go/HEA>.

The Higher Education Act of 1965 (HEA) governs all federal postsecondary education funding and requires reauthorization every five years. Congress has been in the midst of this process since 2003, with current student aid programs being funded for the last three years by a series of continuing resolutions. In fact, an additional extension of the HEA until March 31, 2006, was signed into law on December 30, 2005, providing Congress additional time to complete the reauthorization process.

S. 1932, the budget reconciliation conference report, included some of the financial aid provisions from the House and Senate reauthorization bills (H.R. 609 and S. 1614, respectively). It is important to note that the budget reconciliation conference report does not address all of the outstanding issues surrounding the reauthorization of the Higher Education Act (HEA). Therefore, Congress will continue its work on the HEA reauthorization in 2006. At this point, especially with S. 1932 still not finalized, it is very difficult to predict what the final HEA legislation will look like.

Medicare Reimbursements to Physicians

For more information on Medicare, please see the Medical Student Insiders from August 25, 2005 (PDF, 93KB) and September 1, 2005 (PDF, 119KB).

Also included in S. 1932 is a one-year freeze in rates of Medicare payments to physicians to help address the scheduled cuts. But, as S. 1932 has not yet been signed into law, the previously scheduled cut in physician payments of 4.4 percent went into effect as of January 1, 2006. Although these cuts are an expressed concern of both Congress and the Centers for Medicare and Medicaid Services (CMS) alike, CMS staff say they are bound to impose the 4.4% cut until current law is changed.



By Heather Smith, Government Relations Advocacy Fellow

MEDICARE PART D – WHAT YOU CAN TELL YOUR PATIENTS

Drug costs, especially for the senior population, are a significant concern. The Medicare Current Beneficiary Survey, 1997-2002, showed that 43% of the Medicare population lacked prescription drug coverage for part or all of the calendar year. Average annual out-of-pocket drug costs in this population were \$999 in 2003, and were projected by the Kaiser Family Foundation to increase to \$1457 in 2006 if there were no changes in prescription drug coverage. Medicare Part D, the new prescription drug benefit scheduled to become available to all Medicare recipients on January 1, 2006, is intended to address this issue. With enrollment starting on November 15, 2005, it is important for the patients we serve that we learn more about this benefit and the different plans. Additional resources for students, physicians, and patients are listed at the end of the article.

What is Medicare Part D?

As enacted in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), Medicare Part D offers new prescription drug coverage beginning January 1, 2006, for all Medicare recipients regardless of their income, health, or current benefits. There are two types of Medicare plans from which to choose: stand alone Medicare Prescription Drug Plans (PDP) and Medicare Advantage (MA) Plans. PDPs offer separate coverage through insurance and other private companies, distinct from the basic Medicare coverage. MA Plans and other Medicare Health Plans, which provide comprehensive and preventive care services, cover *all* aspects of Medicare health care, including prescription drugs.

Who is eligible?

Those who already have basic Medicare coverage (Medicare Parts A and B) are eligible to sign up for a plan that meets their prescription drug needs. For those who do not yet receive Medicare, the six month period of eligibility for enrollment in the drug plans is the same as for general Medicare enrollment. Beneficiaries of both Medicare and Medicaid – Dual Eligibles – will have their prescriptions covered by *Medicare*, not Medicaid, starting January 1, 2006, with other Medicaid coverage unaffected.

Some people may already have prescription drug coverage from former employers, the military, unions, etc., and may decide to instead enroll in one of the Medicare drug plans after examining their current benefits and their projected future need for prescription drugs. Employers who provide prescription drug coverage to retirees will be sending letters to all the beneficiaries stating whether the current benefits offer the same or better coverage than would be received under Part D, also known as "creditable coverage." For those who have good drug coverage from their former employers or unions, it is not necessary to join Part D, but the letters from their employers should be saved for future reference. Additionally, Medicare will subsidize the creditable employer or union coverage to help keep it secure.

How does a patient enroll?

A patient can enroll through Medicare's online Enrollment Center, through the 1-800-Medicare toll-free number, by mailing in an application to the plan, or through the plan's website. The enrollment period for current Medicare beneficiaries begins November 15, 2005, and continues until May 15, 2006. Although Dual Eligibles will be automatically enrolled in a plan recommended by Medicare, they can still compare and choose a different plan without penalty.

Coverage will begin on January 1, 2006, for all those who join by December 31, 2005. For those who join after December 31, 2005, coverage will be effective the first day of the month following enrollment and will generally last for the calendar year. If an eligible beneficiary doesn't join by May 15, 2006, and then later changes his or her mind, the next enrollment period starts November 15, 2006. There is a strong incentive for those without any or adequate (creditable) coverage to sign up during this initial period as there may be a penalty charged to the monthly premium of at least 1% per month for every month past initial eligibility. As with other insurance, this penalty may be charged for as long as the recipient is enrolled in a Medicare prescription drug plan.

What does a patient pay?

Medicare prescription drug coverage will typically pay for about half of the drug costs, with the monthly premiums and the recipient's share of the cost of the prescriptions varying depending on the plan. While all drug plans will have to provide coverage at least as good as the Standard Coverage which Medicare has set, some plans might offer more coverage and additional drugs for higher monthly premiums. It is also important patients realize that the monthly premium will not vary based on health status or how many prescriptions are needed, and that this prescription coverage is not capped.

Under Standard Coverage, each recipient pays a monthly premium, which varies depending on the plan chosen (average in 2006 is estimated to be \$32), as well as an annual deductible (average in 2006 is estimated to be \$250). After the recipient pays the deductible, the amount of co-insurance depends on how much has been spent for the year to date. The recipient pays 25% of all drug costs from \$250 to \$2,250, with the plan paying the remaining 75%. The recipient then pays all of the next \$2,850 in drug costs, sometimes informally referred to as the "coverage gap" or "doughnut hole." Any drug costs above this total cost of \$5,100, which is \$3600 out-of-pocket spending for the recipient, is then covered 95% by the plan with a 5% co-insurance. Just like the Part B premium, prescription plan premiums can be deducted directly from Social Security checks every month. (Please refer to the [Standard Medicare Drug Benefits Chart](#).)

Extra help to cover prescription drugs is available for low-income beneficiaries. Almost 1 in 3 people with Medicare will qualify for this extra help that will cover between 85% and almost 100% of prescription drug costs. Most people who qualify for this extra help will pay no premiums, no deductibles, and no more than \$5 for each prescription. The amount of extra help one can receive will be based on income and resources (including savings and stocks, but not counting the home or car). Upon qualifying for assistance, those who are not Medicaid recipients still need to join a plan to receive drug coverage.

Can a patient change their mind?

Once enrolled in a Part D plan, beneficiaries do not have to re-enroll to maintain the benefit year to year. It is wise, though, for patients to occasionally re-evaluate their prescription needs and their plan's benefits. It is possible to change plans once enrolled in Part D during the annual enrollment period or in specific situations. Each year, beneficiaries can choose a different PDP or MA plan during an enrollment period that lasts from November 15 through December 31, with coverage under the new plan beginning the following January 1. There are also limited exceptions, such as moving out of the service area of the current plan, that would afford beneficiaries the opportunity to switch plans during the year.

RESOURCES FOR MEDICAL STUDENTS AND PATIENTS

- For more information on Medicare, read the [August 25th MSI](#).
- Visit www.medicare.gov or call 1-800-MEDICARE (1-800-633-4227) for information on plans, enrollment, and financial assistance.
- More information [for providers on Medicare prescription drug coverage](#).
- Common questions answered through the [official Medicare FAQs website](#).
- For additional information about extra help with prescription drug costs and how to apply, go to [the Social Security Administration](#) or call at 1-800-772-1213.
- Patients can find out regional information from their [State Health Insurance Assistance Program](#) or by visiting www.eldercare.gov.
- Check out more [Medicare Part D resources from the Kaiser Family Foundation](#).
- [Questions for medical students to pose to patients when choosing a plan](#).

October 28, 2005

ACTION ALERT:

Get involved. Make a difference.

America's senior and disabled populations need your help.

We've had a great response with hundreds of students joining the nationwide grassroots campaign concerning Medicare payments to physicians. If you have already made a call or sent an e-mail to your Senators and Representative, **THANK YOU**. You are making a difference for your patients. Please continue your efforts by letting your friends and fellow students know how important and how easy it is to do this.

Despite our continued efforts, the Medicare population's access to care is still being threatened. **If Congress doesn't act soon, the government will cut Medicare payments to physicians by a staggering 26% over the next six years – beginning with a 4.4% cut on January 1, 2006.** This will directly affect many of the patients and the physicians with whom we work. In fact, a recent AMA survey showed that more than a third (38%) of doctors would limit their services to new Medicare patients if this first round of cuts occurs.

Currently, a modest update increase in Medicare physician payments is being considered by Congress to replace the looming 2006 cut of 4.4%. This small increase is still less than the rate of inflation, and it is not guaranteed that Congress will enact this increase. If the projected 2006 cut occurs, the average physician payment rate will be less in 2006 than it was in 2001!

Time is running out, and it is critical that more of America's medical students make their voices heard. **We must take action *now* to help protect patients' access to health care.**

Contact your Senators and Representative, it's *really* easy.

Urge them to protect America's senior and disabled populations.

(1) **Call** the AMA's toll-free, *automated* **Grassroots Hotline** at **1-800-833-6354** using the Medicare Talking Points.

CALL ANYTIME; IT'S AS QUICK AS EMAIL; AND IT HAS A MUCH GREATER IMPACT.

or

(2) **E-mail** (only a few clicks and you're all done) your Senators and Representative through the Student Grassroots Action Center at http://capwiz.com/ama/mail/oneclick_compose/?alertid=8104176

Action must be taken now because unlike other provider groups, physicians have not had a payment update that kept up with practice expense increases since 2001. Another cut or even a freeze will force many physicians to cut services to Medicare patients in order to make ends meet. Physicians need positive payment updates that reflect the increases in their practice costs, as they simply can not absorb payment cuts while their practice costs continue to grow. Congress wants physicians to participate in proposed quality improvement measures and invest in health information technology. However, physicians are unable to bear these additional costs and practice burdens without positive updates.

→ Read more about Medicare in the [August 26th MSI](#) and the [September 1st MSI](#)

For the patients we serve today, as well as the future of our profession, these cuts in physician payments must be stopped. **Please urge your Senators and Representative to protect America's patients by supporting positive updates for Medicare payments to physicians.**

October 7, 2005

AMA CONTINUES TO HELP PATIENTS AND PHYSICIANS FROM THE HURRICANE-AFFECTED AREAS

AMA Testifies Before Congress

On Thursday, September 22, 2005, the House Committee on Energy and Commerce's Subcommittees on Health and Oversight and Investigations held a hearing titled "Assessing Public Health and the Delivery of Care in the Wake of Katrina." Along with federal agencies and other leading organizations in health care, the AMA testified on behalf of patients and physicians from the affected areas.

Representing the AMA, Board of Trustees Member, Ardis Hoven, MD, spoke to the committee members about the health care needs of evacuees and the obstacles in delivering care in the immediate aftermath of the hurricane. Dr. Hoven discussed the challenges that physicians and their patients faced following the storm, as well as the tremendous challenges facing *all* of medicine in rebuilding after the devastation. The AMA specifically called for funding to help physicians reestablish their practices, to make sure that displaced individuals have health insurance, to monitor and treat emerging infections and provide for adequate vaccination, to clean up areas flooded with toxic substances, to provide mental health services, and to continue research into disasters and disaster recovery. Dr. Hoven expressed the AMA's willingness to help lead in addressing these issues and highlighted the Center for Public Health Preparedness and Disaster Response, which has already trained more than 14,000 health professionals.

Prior to Dr. Hoven's testimony, Julie Gerberding, MD, Director of the Centers for Disease Control and Prevention, spoke about the CDC's activities, and prominently mentioned the AMA's support and involvement with the KatrinaHealth.org effort. KatrinaHealth.org is a collaborative effort of the AMA and the U.S. Dept. of Health and Human Services that allows physicians and pharmacists to electronically access the prescription records of patients affected by Hurricane Katrina. The AMA will use its Physician Masterfile, a comprehensive source containing data on all physicians in the country, to issue user names and passwords to physicians seeking access to the KatrinaHealth medications network. Additional witnesses included representatives from other major health organizations, including the American Red Cross, the American Hospital Association, the National Association of Community Health Centers, JCAHO, the National Association of Chain Drug Stores, and the American Nurses Association.

- Check out the [AMA Hurricane Katrina relief efforts](#) Web site for more information on donations and volunteer opportunities.
- Register to volunteer at [HHS health care professionals and relief personnel volunteer Web page](#) or call (866) KAT- MEDI (528-6334).
- Find out more about the House Committee on Energy and Commerce's hearing on [Assessing Public Health and the Delivery of Care in the Wake of Katrina](#)
- Check out www.KatrinaHealth.org and read [Dr. Hill's statement on the AMA's continued efforts](#).
- Find out more about the [AMA's Center for Public Health Preparedness and Disaster Response](#)

October 7, 2005

OTHER NOTES OF INTEREST FOR MEDICAL STUDENTS AND RESIDENTS...**Congress Acts to Extend the Expiration Deadline of the Higher Education Act**

The Higher Education Act (HEA) governs all federal postsecondary education funding and requires reauthorization every five years. Congress has been in the midst of this process since 2003, with current student aid programs being funded for the last three years by a series of continuing resolutions. Presently, Congress is considering two bills that would reauthorize the HEA, the "College Access and Opportunity Act of 2005" (H.R. 609) and the "Higher Education Amendments Act of 2005" (S. 1614). Although reauthorization of the HEA was initially expected to have been completed this fall, in the wake of Hurricane Katrina and nomination hearings for the Chief Justice of the Supreme Court, Congress recognized that a temporary extension would be necessary.

Funding for the current student aid programs technically expired on September 30, 2005, but the President signed into law H.R. 3784, the "Higher Education Extension Act of 2005" (Public Law 109-81). This bill extends current student financial assistance programs until December 31, 2005, providing Congress more time to address the reauthorization of the HEA. The bill was passed by the House by a voice vote on September 20, 2005, and by the Senate by unanimous consent on September 26, 2005. Even with this extension in place, there is still more work to be done in the reauthorization process. As always, the AMA will keep you fully informed and involved in this process.

→ Read more about [HEA Reauthorization on the AMA Website](#).

NIH Offers \$35,000 in Annual Student Loan Repayment

Starting September 1, 2005, the National Institutes of Health (NIH) began accepting applications to its five Loan Repayment Programs (LRPs). These student loan repayments of up to \$35,000 annually are awarded to health professionals pursuing careers in biomedical and behavioral research. The deadline for all materials is December 1, 2005.

→ Details and the online application are available at www.lrp.nih.gov.

September 16, 2005
Medical Student Insider

The devastation from Hurricane Katrina is overwhelming, displacing hundreds of thousands of Gulf Coast residents and leaving many without basic essentials. The health care community, including multiple hospitals and three medical schools, were severely affected, disrupting the lives and the training of our peers. After securing their safety and health, they will have many issues to deal with in terms of their medical education and training. These issues include, but are certainly not limited to, the interruption of their undergraduate education, loan disbursement and forbearance, the residency application process, and residency and fellowship training.

I would personally like to share my gratitude and appreciation of the incredible service and work performed by numerous medical students, physicians, and AMA staff across the country. Your perseverance and actions during this time of tragedy speak volumes about your dedication to the wellbeing of Americans everywhere. It is truly an honor to stand beside you.

Displaced Medical Students:

The AMA is working closely with the Association of American Medical Colleges (AAMC), the Liaison Committee on Medical Education (LCME), the Accreditation Council for Graduate Medical Education (ACGME), and medical schools across the country. This coordination has been strong, and is essential in addressing the education and training needs of the students, residents, faculty, and other health professionals who have been displaced by the hurricane. In an effort to provide assistance to those students affected in the Gulf Coast region, the AAMC has taken the lead and has established a Web site to serve as a central information resource for medical schools, students, teaching hospitals, and residents. This site also provides status reports from Tulane University School of Medicine, Louisiana State University School of Medicine in New Orleans, and University of South Alabama School of Medicine, as well as resources for displaced medical students and residents.

Refer to the [AAMC Web site on Hurricane Katrina](#) for more information regarding the affected medical schools and students.

Check here for information for [ERAS® applicants regarding Hurricane Katrina](#).

Read the [LCME response to Hurricane Katrina](#).

The AMA medical student representative on the LCME, Hannah Zimmerman, has been in close contact with the LCME regarding Hurricane Katrina and the status of medical students at Tulane School of Medicine and Louisiana State University School of Medicine. Please check the AAMC website above for all updates for medical students. Also, please feel free to contact Hannah via email or phone at hannahzimmerman411@gmail.com or 816-616-9852.

Displaced Medical Residents and Fellows:

The impact on graduate medical education is just beginning to emerge. There are almost 1,500 residents and fellows – one of every 68 physicians in training in the U.S. – in accredited programs in New Orleans and Mobile and at Keesler AFB. The AAMC is working with the ACGME, the National Resident Matching Program (NRMP), the American Board of Medical Specialties, the Education Commission for Foreign Medical Graduates, and the Federation of State Medical Boards to evaluate issues involved in maintaining the integrity of programs or transferring residents to other institutions.

Information regarding site placement and transfer can be found on [ACGME home page](#) and the [AAMC Web site on Hurricane Katrina](#), while questions to the NRMP should be addressed to nrmp@aamc.org.

National Volunteer and Service Efforts:

Even more astounding than the destruction is the extreme outpouring of generosity. Individuals, elected officials, and organizations nationwide are doing whatever they can to aid the survivors. The AMA is playing an active role in helping to coordinate physician volunteer efforts with the Department of Health and Human Services (HHS), and is working with key Congressional committees on health relief legislation.

Check out the [AMA Hurricane Katrina relief efforts](#) Web site for more information on donations and volunteer opportunities.

Register to volunteer at [HHS health care professionals and relief personnel volunteer Web page](#) or call (866) KAT- MEDI (528-6334).

Federal Relief Efforts:

Congress reconvened early in order to begin addressing many of the Hurricane Katrina-related issues, including Medicaid, emergency funding, and tax incentives to promote rebuilding and growth. Already, Congress has appropriated more than \$60 billion in emergency hurricane aid, with more being requested. Federal legislation has also been proposed that would assist medical students affected by Hurricane Katrina.

The Student Grant Hurricane Disaster Relief Act (H.R. 3668) and the Katrina College Student Relief Act (H.R. 3690) were introduced in the U.S. House of Representatives by Representatives Bobby Jindal (R-LA) and George Miller (D-CA), respectively. These bills authorize the Secretary of Education to waive certain requirements for repayment of federal student grant assistance by students if they were forced to withdraw from classes due to a natural disaster as declared by the President. These bills state that students must have been residing in, employed in, or attending an institution of higher education located in the designated area. These bills also state that the student must return to school within the academic year during which the major disaster occurred or during the following academic year. H.R. 3668 was passed by the House and has been received by the Senate, while H.R. 3690 is currently in the House Committee on Education and the Workforce. Two other bills with similar language, the Pell Grant Hurricane and Disaster Relief Act (H.R. 3169) and the Federal Pell Grant Hurricane and Disaster Relief Act (S. 1628), focus solely on the repayment of Pell Grants. H.R. 3169 was introduced in the House by Representative Ric Keller (R-FL) and has been passed by the House and received by the Senate, while S. 1628 was introduced by Senator Mel Martinez (R-FL) and is currently in the Committee on Health, Education, Labor, and Pensions.

As always, in this time of tragedy, our thoughts and hopes are with the survivors, their families, and the volunteers.

Fall Preview of Capitol Hill

This has been the first week back from August recess, with Senators and Representatives returning to Capitol Hill and marking the start of what already appears to be a busy period of legislative activity. Congress reconvened early in order to begin addressing many of the Hurricane Katrina-related issues, as well as continue with their already scheduled business. The AMA is playing an active role in helping to coordinate physician volunteer efforts with the Department of Health and Human Services, and is working with key Congressional committees on legislation to help assist the survivors and the health care community and facilities in the affected areas. For everyone across the country, this has been a trying time. Our thoughts are with the survivors, their families, and the volunteers.

Join the AMA in Offering Relief to the Survivors of Hurricane Katrina

- Check the [AMA Web site to see how you can contribute and help](#).

This fall, there is expected movement in Congress on a number of issues that affect medical students across the country, including the reauthorization of the Higher Education Act (HEA) and the reform of Medicare physician payment. The AMA will be lobbying Capitol Hill on our behalf; we can also do the same. Stay informed and be active through the AMA Web site. There will be posted updates on the legislation as well as Action Alerts with opportunities to contact your Senators and Representative.

Medicare Physician Payment Reform

Medicare physician payment reform, which was discussed in the [August 26th MSI](#) and [the September 2nd MSI](#), is an important legislative priority for the AMA. The U.S. House of Representatives is currently considering H.R. 3617, introduced by Rep. Nancy Johnson, and H.R. 2356, introduced by Representatives Clay Shaw (R-FL) and Ben Cardin (D-MD), while the U.S. Senate is considering S. 1081 which was introduced by Senators Jon Kyl (R-AZ) and Debbie Stabenow (D-MI). The passage of Medicare physician payment reform is imperative, as Medicare patients' access to care is threatened by the impending drastic cuts in physician payments to begin January 1, 2006. Your involvement is essential!

▪ **Stay tuned for ACTION ALERTS**

This fall, there will be a powerful grassroots campaign to reach your Senators and Representative, asking them to protect Medicare patients' access to care. The AMA appreciates the medical students' voices, and looks forward to their participation.

Check here to see if your Representative is one of the [H.R. 3617 Co-Sponsors](#) or [H.R. 2356 Co-Sponsors](#), or if your Senators are [S. 1081 Co-Sponsors](#). In the near future, we will have a letter that you can send to your Congressmen asking for their support on this important Medicare payment reform legislation.

HEA Reauthorization

Determined to help medical students manage their high educational debt burden, the AMA has lobbied for important provisions to be included in the House and Senate bills that will reauthorize the HEA (please read about HEA reauthorization in the [MSI from August 12, 2005](#)). Before the House votes on its reauthorization legislation (H.R. 609), which was favorably reported in July 2005 by the Committee on Education and the Workforce (E&W), the Committee must first act on budget issues, including those regarding student loans (referred to as the Committee's Reconciliation report). This is expected to occur in September. A similar reauthorization bill will be introduced in the Senate and considered by the

Committee on Health, Education, Labor, and Pensions (HELP) beginning this week. Both H.R. 609 and the Senate bill are expected to be brought to the House and Senate floors, respectively, sometime this fall.

The Senate version is expected to differ from the final House version, thus requiring resolution by a House-Senate conference committee. A significant amount of work must still occur before the reauthorization is completed. The AMA will keep you fully informed and involved in this process. Keep an eye out at the end of September for an Action Alert to contact your Representative and Senators to support provisions that benefit medical students and young physicians across the country.

- Read more about [HEA Reauthorization on the AMA Website](#).
- Read the [AMA letter to the House E&W Committee](#) supporting medical students and their needs.

The “Drug Addiction Treatment Expansion Act”

Signed into public law by the President on August 2, 2005, the *Drug Addiction Treatment Expansion Act* (P.L. 109-56), would lift the cap on the number of patients for which physicians in group practices can prescribe drug addiction treatments (while retaining the 30-patient limit for an individual physician). Prior to the enactment of this law, practices that dispensed narcotic drugs in schedules III, IV, or V for maintenance or detoxification treatment were limited to a 30-patient cap. These restrictions applied not only to individual physicians but also to entire group practices as a whole, limiting access to effective substance abuse treatment services. Lifting this cap will now enable group practices to treat more patients with effective regimens, such as buprenorphine for opioid dependence. The passage of P.L. 109-56 is a great success for all physicians, as it will improve access to addiction treatment, expand options for patients, and remove disincentives to the development of new treatment medications for addiction.

- Read the AMA’s letter of strong support for the passage of the [“Drug Addiction Treatment Expansion Act”](#) which was later signed into public law.

The “National All Schedules Prescription Electronic Reporting Act of 2005”

Prescription drug abuse is one of the fastest growing public health problems facing our country. The nonmedical use of prescription drugs now ranks second behind marijuana as a category of illicit drug abuse among adults and youth. The *National All Schedules Prescription Electronic Reporting Act of 2005* (P.L. 109-60), which was signed into public law by the President on August 11, 2005, offers grants to the individual states through the Department of Health and Human Services to establish or improve programs to electronically monitor the dispensing of controlled substances. These voluntary, state-based, controlled-substance monitoring programs will provide physicians with access to important patient information, allowing them to more effectively treat their patients’ pain or illness while helping to prevent the abuse and diversion of controlled substances. This legislation, most importantly, recognizes both the vital role physicians play in preventing prescription drug abuse, as well as the importance of limiting access to confidential patient information. The AMA is proud to have worked so closely with Representative Ed Whitfield (R-KY) and Senator Jeff Sessions (R-AL) in crafting legislation that will improve access to necessary pain medication and help prevent the abuse of prescription drugs.

- Read the AMA’s letter of support for the passage of the [“National All Schedules Prescription Electronic Reporting Act of 2005”](#) which was later signed into public law.

Sept 1, 2005
Medical Student Insider

STRENGTHENING MEDICARE, PART 2

Last week, the MSI discussed the basics of Medicare: who is eligible, what it covers, and how physicians are reimbursed. This information is important for all future-physicians to know; however, it is even more imperative that we fully understand it today. If Congress does not take action now, physician reimbursements through Medicare will be cut by 26% over the next six years. The first of these cuts is a reduction of 4.3% that will go into effect on January 1, 2006. America's seniors could face serious access issues in the near future if physicians are able to accept fewer Medicare patients. In addition, these cuts to physician payment rates impact more than just Medicare patients since Medicare reimbursement rates are often used by private insurers, Medicaid, and TRICARE (health insurance for military personnel and their families) to set their rates. Therefore, cuts in Medicare could also result in decreased physician reimbursement by other health plans.

Understanding the Medicare program, especially Medicare payment reform, is not simple. For more information on the Medicare program, read the [MSI from August 25, 2005](#) which discusses benefits, payments, and such terms as the Sustainable Growth Rate (SGR) and the Medicare Economic Index (MEI).

- Educate yourself and your patients with information from the [AMA Physician Kit on Medicare](#)
- **ACTION ALERTS:** Check here to see if your Representative is one of the [H.R. 3617 Co-Sponsors](#) or [H.R. 2356 Co-Sponsors](#), or if your Senators are [S. 1081 Co-Sponsors](#). If so, email your Congressmen a letter to thank them for their dedication to protecting Medicare patients' access to care by their support for [H.R. 3617](#), [S. 1081](#), or [H.R. 2356](#). These bills are discussed below.

What is Pay-for-Performance?

Pay-for-Performance (PFP or P4P), also referred to as Value-based Purchasing, is a general term that refers to programs in which participants receive financial bonuses for achieving specific quality and/or efficiency standards. PFP programs can be applied to health plans, hospitals, or other entities, but are increasingly targeted at physicians and physician groups. Most physician PFP programs provide financial bonuses to physicians or physician organizations that meet the programs' performance criteria. The size of incentive payments typically is modest – usually about 1 to 5% of a physician's total revenue from a given health plan.

Most programs focus on the use of process measures (indicators related to the methods and procedures utilized to provide health care) of quality. Some PFP programs are also now using non-clinical measures – patient satisfaction, the use of information technology (IT), and efficiency in providing care – to rate physician quality of care. Use of physician level outcome-based measures (results of treatments for a particular disease or condition in terms of mortality, morbidity, health status, and quality of life) is less common because they are not as easy to implement and analyze at an individual physician level as they are at a hospital or health plan level. It is especially important that data from outcomes measures be carefully adjusted to account for external patient factors, including age, health, and social characteristics.

AMA Recommendations:

The AMA and numerous medical specialty societies have been working extensively to generate viable short and long-term solutions to reform Medicare. Specifically, the physician community has worked together extensively to ensure that PFP programs are positively structured and appropriately applied. The AMA believes PFP programs must be aligned with the following five principles: (i) ensure quality of care; (ii) foster the relationship between patient and physician; (iii) offer voluntary physician

participation; (iv) use accurate data and fair reporting; and (v) provide fair and equitable program incentives.

The AMA has been working with the medical specialty societies to develop a consensus around a conceptual framework for PFP. Through strong collaboration, a number of proposals set forth by both primary care and surgical specialties have been merged. This product has been offered to both the U.S. House of Representatives and the U.S. Senate so that together we can develop fair and ethical value-based purchasing legislation.

Imperative to the implementation of a PFP system is the concurrent repeal of the SGR, as the two are incompatible. While PFP might save dollars for the program overall by reducing hospitalizations and lengths of stay, the majority of value-based performance measures – such as those focused on prevention and chronic disease management – ask physicians to deliver more care. As discussed last week, the SGR penalizes such volume increases in Part B spending that exceed the calculated target. Thus, if the SGR is retained while a PFP system is implemented, the physicians will actually receive additional pay cuts on top of the projected 26% in cuts over the next six years.

- Read more about [PFP](#).
- Find out more about the [Consortium for Performance Improvement](#) and the [measurement sets](#) developed for many clinical conditions.
- [AMA Board of Trustees Report, A-05 AMA policy](#), and the AMA [principles](#) and [guidelines](#) on PFP.
- [AMA testimony on PFP](#) to the House Ways and Means Subcommittee on Health.

Medicare Physician Payment Reform on Capitol Hill:

During September, the AMA will be leading a strong campaign on Capitol Hill advocating to protect seniors' access to care. There are currently three bills to help reform Medicare physician payment that the AMA supports. Your energy and involvement on this issue is vital. And, remember, you are not alone – educate yourself, your peers, and the attendings and residents you work with about this problem. Take action today, and together we *can* make a difference.

Medicare Value-Based Purchasing for Physicians' Services Act of 2005 (H.R. 3617)

Representative Nancy Johnson (R-CT), Chairman of the House Ways and Means Health Subcommittee, introduced H.R. 3617, the *Medicare Value-Based Purchasing for Physicians' Services Act of 2005*. This bill, which has 16 co-sponsors, would: (i) repeal the SGR; (ii) in 2006, implement a 1.5% payment increase; (iii) for 2007 and beyond, implement a physician payment system based on the MEI; (iv) in 2007 & 2008, provide physicians an update of full MEI if they meet certain reporting requirements, and MEI minus 1% if they do not; and (v) in 2009 and subsequent years, provide an update to physicians of full MEI if they meet *both* reporting and performance thresholds, and MEI minus 1% if they do not. Of note, the MEI is projected to be approximately 3% a year, which would mean that physicians who do not participate would still be receiving a greater payment update (approximately +2%) than if there were no Congressional activity before January 1, 2006 (– 4.3%).

The AMA and the medical specialty societies have worked extensively with Chairman Johnson on this legislation, and she has been very responsive to the concerns of the medical community about value-based purchasing. Many of the provisions in H.R. 3617, although not all, are consistent with the AMA PFP guidelines and principles. The AMA and several other specialty societies, including the American Academy of Family Physicians (AAFP), American College of Surgeons (ACS), American College of Physicians (ACP), and Alliance of Medical Societies (AMS), have sent letters supporting this legislation.

It is recognized, though, that as H.R. 3617 proceeds through the legislative process, several key areas of concern remain and additional work is still needed. Such concerns include: (i) ensuring that efficiency measures do not simply reward the lowest-cost provider and that they meet the same evidence-based standards as quality measures; (ii) the need for a reliable method to account for differences in the age, health, and other characteristics of patient populations (risk-adjustment); (iii) ensuring that public reporting provides accurate and relevant information to patients and does not inadvertently exacerbate disparities in care for minority and other vulnerable populations; (iv) the need for fair reimbursement for physicians' administrative costs, especially for information technology systems necessary for the collection and transmission of accurate, quality data; and (v) the need for pilot testing prior to full implementation.

→ [AMA remarks at Chairman Nancy Johnson's press conference](#)

→ Send your Representative a letter to [support H.R. 3617](#)

The Preserving Patient Access to Physicians Act of 2005 (H.R. 2356 & S. 1081)

In addition to the value-based purchasing legislation, other physician payment legislation is still pending before Congress. The *Preserving Patient Access to Physicians Act of 2005* (S. 1081), introduced in the Senate by Senators Jon Kyl (R-AZ) and Debbie Stabenow (D-MI) would provide positive updates to physician payments in 2006 and 2007, with an increase of not less than 2.7% in 2006. In 2007, the bill would temporarily replace the SGR with a formula that would provide physicians with an update equal to MEI (2.6%). This bill currently has 19 co-sponsors.

→ Send your Senators a letter to [support S. 1081](#)

Representatives Clay Shaw (R-FL) and Ben Cardin (D-MD) introduced H.R. 2356, the *Preserving Patient Access to Physicians Act of 2005*, in the House. H.R. 2356 calls for increasing Medicare physician payments by at least 2.7% in 2006. This bill would also stop future payment cuts in 2007 and beyond by permanently replacing the SGR with a formula that would produce updates equal to the MEI, thereby linking payment increases to practice cost inflation. This bill currently has 126 co-sponsors. The provisions in both of these bills are based on recommendations from the Medicare Payment Advisory Commission (MedPAC), the commission that advises Congress on Medicare policy.

→ Send your Representative a letter to [support H.R. 2356](#)

Other Resources:

→ The [Physician Focused Quality Initiative](#) builds upon ongoing CMS strategies and programs in other government health care settings.

→ Check out [Bridges to Excellence](#), a coalition of large employer groups that offer incentives for meeting quality goals directly to physicians who care for their employees.

→ Read more about [Integrated Healthcare Association](#), through which a system of integrated health care is promoted and supported by financial mechanisms that align the incentives of purchasers, payors, and providers as a means to achieve positive outcomes for patients and the general public.

August 26, 2005

Strengthening Medicare

There is a looming access to care crisis for Medicare patients. Beginning in 2006, Medicare payments to physicians are projected to be cut by about 26% over six years. In fact, if Congress does not act soon, Medicare will cut physician reimbursements by 4.3% on January 1, 2006! These cuts threaten patients' access to care, as many physicians will be forced to decrease the number of new Medicare patients they treat. This truly is an emergency that requires immediate attention.

Bills that would provide temporary and permanent solutions to this issue have been introduced in both the House and Senate. The AMA and numerous medical specialty societies have supported some of these bills, which will be addressed in the MSI next week. To better understand how these impending cuts and the proposed legislation will affect health care, it is important to first understand the Medicare program.

What is Medicare?

Medicare is a federal health insurance program that provides hospital and outpatient medical insurance for eligible people, including those 65 years old and older who have worked for 10 or more years or are the spouse of such an employee, younger individuals with certain disabilities, and people of all ages with end-stage renal disease. As a federal program, Medicare's basic benefits, premiums, deductibles, and co-pay requirements in Parts A and B are consistent state to state. If eligible, one can choose from the basic "fee-for-service" Plan or from the Medicare Advantage Plans.

The basic Medicare Plan is a "fee-for-service" plan, meaning that one is usually charged a fee for each health care service or supply offered. It is made up of two parts, each of which covers different aspects of care and has distinct payment methods. Part A is the "Hospital Insurance" and covers inpatient care in hospitals, rehabilitation at skilled nursing facilities, hospice care, and some home health care. Part B is the "Medical Insurance" that covers most outpatient care. This includes physician services, care in hospital outpatient departments and ambulatory surgical services, diagnostic exams, a one-time physical exam within the first six months of enrollment, limited preventive services, and durable medical equipment (such as wheelchairs, oxygen, and walkers).

Medicare Advantage, originally known as Medicare + Choice, offers more choices by allowing private companies under contract to Medicare to manage the medical services for the subscriber. These plans, which are available in many areas, include managed care (HMO) plans, preferred provider organization (PPO) plans, private fee-for-service plans, and specialty plans. These plans cover all services under Parts A and B, and may offer additional benefits including prescription drug coverage, reduced co-pays, and reduced deductibles as well.

Part D is a new prescription drug coverage that will start on January 1, 2006. This plan deserves a more in-depth explanation than will be given at this time. Please look forward to future MSIs that will offer a description of the plan, how it will affect your patients, and what you can do to better inform them.

How does a patient pay for Medicare?

Once an individual turns 65 and is receiving Social Security, they are automatically enrolled in Part A. There is no charge to the patient for enrollment or monthly premium for receiving care under Part A, as these are covered by the taxes withheld during past employment. Part B, while automatic in enrollment, is optional and has a monthly premium (\$78.20 in 2005) that is deducted from Social Security benefits. There is also an annual deductible (\$110.00 in 2005) before Medicare starts to pay its share. Once the deductible has been satisfied, the patient is then responsible for 20% of all eligible

physician charges. Medicare Advantage Plans' costs and benefits differ plan to plan, although typically there is an additional premium associated.

How are physicians reimbursed?

The Medicare reimbursement fee schedule that determines physician (Part B) payments has been calculated since 1992 using a Resource-Based Relative Value Scale (RBRVS). The RBRVS, which allows the government to set fees paid to physicians for specific medical services, is turned into the actual payment rates using a monetary conversion factor that is "updated" on January 1st each year. This update is intended to reflect increases in practice costs in physicians' payments. Since the early '90s, however, the update has *also* been adjusted by a "target-based" system to address differences between actual spending and a predetermined target. If spending exceeds the target, physicians are penalized through reductions in future payment updates over the next year(s). And vice versa, if spending is under the target, a bonus is added to future payment updates.

The current target system called the Sustainable Growth Rate (SGR) was implemented in 1999. The key change and the problem with this formula lie in the fact that the calculation of the SGR is linked to the gross domestic product. This means that it is tied to the ups and downs of the national economy, and not to physician practice costs and the health care needs or costs of seniors and disabled patients. In addition, the SGR formula seeks to limit volume, yet physician service utilization is driven by factors that are out of a physician's control, such as increased patient health needs, new technology, and public policies that encourage patients to seek care. While these are beneficial to patients and are strongly advocated by physicians, increases in spending for physician services due to these policies are not reflected in the SGR and, in fact, cause cuts in payments to physicians (because spending then exceeds the target by an even greater amount).

When discussing the funding and payment of Medicare services, the word "silo" often is heard. This refers to the fact that physician payments through Part B and hospital payments through Part A are calculated and funded through discrete entities. The recent trend of shifting health care to outpatient venues (from Part A to Part B) and the promotion of preventive services have increased utilization of physician services (Part B) while decreasing hospital (Part A) admissions and length of stays. These savings seen in Part A, though, are not transferable to a different "silo", and so the increased physician costs are solely managed within Part B. In fact, hospitals and other Medicare providers are not subject to the SGR at all, with hospital (Part A) payments slated to rise by more than 3% a year.

The Medicare Economic Index (MEI) is another method to calculate physicians' practice cost inflation. The MEI, which is similar to the consumer price index (CPI), measures inflation for the cost of goods and services that are applicable to physician office practice. The MEI accounts for costs – such as professional liability insurance (PLI) premiums, employee wages, and rent, as well as non-labor costs, including new technology – better than the SGR. In fact, the Medicare Payment Advisory Commission (MedPAC), the commission that advises Congress on Medicare policy, has recommended that the SGR be replaced with MEI.

Read more about the need for [Medicare physician payment reform as well as AMA resources for information and action](#).

Better visualize the disparity between [physician costs and physician payment](#).

[The official U.S. Medicare website](#) offers information for patients and physicians on eligibility, enrollment, and benefits.

[The U.S. Medicare 2005 Handbook](#)

Lobby your Representative and Senators

In September, the AMA will be leading a strong campaign on Capitol Hill advocating for Medicare payment reform which will help protect seniors' access to care. Your energy and involvement in this movement today is vital. Read more about the AMA's efforts and find out what else you can do to get involved and make a difference on the AMA website and in next week's MSI.

Please check out the [AMA Grassroots Action Center](#) that provides information about current action alerts on legislation to reform Medicare and what you can do to help.

MSI – August 19, 2005

Patient Safety:

President Bush signed into law P.L. 109-41, the “Patient Safety and Quality Improvement Act of 2005,” on July 29, 2005. The enactment of this law is a critical step in the process for improved safety and quality of health care for America's patients and their physicians, and is the culmination of years of hard work by the AMA and its patient safety partners who advocated for the passage of this legislation following the 1999 Institute of Medicine report “To Err is Human.” P.L. 109-41 strikes a balance between maintaining confidentiality and the benefit of reporting error information.

With strong bipartisan leadership, this bill was passed with overwhelming support by both the U.S. Senate on July 21, 2005, and the U.S. House of Representatives on July 27, 2005. P.L. 109-41 establishes a system through which physicians, hospitals, and other health care professionals and entities can report errors in a voluntary and confidential manner to newly-created patient safety organizations (PSOs). These PSOs will analyze the information and, working with physicians, identify the changes necessary to prevent these errors. The ultimate goal is to transform the existing culture of blame, which suppresses information about errors, into a culture of safety, which focuses on sharing information in order to prevent future errors.

Read more about Patient Safety efforts: <http://www.ama-assn.org/ama/pub/category/6301.html>

Medical Liability Reform:

On July 28, 2005, the U.S. House of Representatives passed H.R. 5, the Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH) Act of 2005, by a vote of 230 to 194. This bill is a comprehensive set of medical liability reforms that provides for reasonable limits on damages awarded to injured patients. Similar reforms have been in place in California for 30 years, keeping medical liability insurance premiums stable in the state over time.

H.R. 5 would allow for injured patients to recover unlimited economic damages, including the cost of medical care, rehabilitation, lost wages and domestic services, as well as up to a quarter of a million dollars for non-economic damages, often referred to as “pain and suffering” awards. The HEALTH Act also promotes speedier resolutions to disputes, ensures fair allocation of responsibility, prevents double recovery of awards, and helps to maximize the percentage of the awards patients receive.

Legislation to limit the size of jury awards is important in maintaining access to care. Over the past several years, escalating jury awards and settlements, and the high cost of defending against lawsuits (even those without merit), have been driving medical liability insurance premiums to unprecedented levels. As insurance becomes unaffordable or unavailable, physicians have been forced to relocate, close their practices, or drop vital services. Access to care is suffering in 44 states—of which 20 are in crisis and 24 are showing signs of problems.

The AMA continues to work with Senate Majority Leader Bill Frist, MD, (R-TN) and Senate Majority Whip Mitch McConnell (R-KY) to advance strong medical liability reform legislation in the Senate. Please ask your Senator to protect America's patients' access to care by passing medical liability reform this year!

Send your Senator an email asking to protect patients' access to care through support of Medical Liability Reform legislation: http://capwiz.com/ama/mail/oneclick_compose/?alertid=7887856

Read more about medical liability reform: <http://www.ama-assn.org/ama/pub/category/7861.html>

Read about the recent Wisconsin Supreme Court's decision repealing constitutionality of caps on jury awards related to non-economic damages:

<http://milwaukee.bizjournals.com/milwaukee/stories/2005/07/11/daily32.html>

Read the letter sent to the House of Representatives in support of H.R. 5.

Volunteer Physician Liability Protection:

S. 1058/ H.R. 1313, the "Community Health Center Volunteer Physician Protection Act of 2005," would expand liability protections to physicians who volunteer at community health centers (CHCs). Many physicians are willing to volunteer their services at these CHCs, but often hesitate due to the high cost of medical liability insurance. As a result, there are too few volunteer physicians to meet health care needs. Under this legislation, the liability protections provided under the Federal Tort Claims Act would be extended to volunteer practitioners at community health centers. By reducing professional liability exposure, this legislation can help increase the number of volunteer physicians in CHCs.

In June of 2005, the AMA and AMA-MSS lobbied Senators and Representatives to support S. 1058 and H.R. 1313, respectively. We showed a strong effort in outreach, with more than 600 messages received and heard by Congress. Since their introduction, these bills have been referred to their respective committees for consideration: the Senate Committee on Health, Education, Labor, and Pensions and the Subcommittee on Health in the House Committee on Energy and Commerce. Congratulations and thanks to the medical students who contacted their Representative and Senators – your energy and action are helping to make a difference.

Read AMA's press release supporting the bicameral introduction of this important legislation:

<http://www.ama-assn.org/ama/pub/category/15084.html>

Read the *letter* sent to the House of Representatives and the *letter* sent to the Senate in support of H.R. 1313 and S. 1058, respectively.

To follow further action on any of the above bills or to write to your elected official, go to the grassroots site and send your Congressman a letter: <http://capwiz.com/ama/issues/>

Read more about the issues the AMA-MSS is working on and how you can be active: www.ama-assn.org/go/COLA

Medical Student Insider August 12, 2005

August has finally come, and the summer has proven to be quite a successful one for the AMA. There has been significant movement in a number of areas that are priorities for the AMA and the AMA-MSS. As there has been such a broad range of developments, the next few MSIs will focus on one of the issues and offer a more detailed view with background information and recent events, as well as thoughts as to what to expect next. This week, we will focus on HEA reauthorization. Check back in the upcoming weeks for more details on Patient Safety, Medical Liability Reform, and Drug Monitoring. In the meantime, you can find current information at the links provided below.

HEA Reauthorization

Background Information:

Medical student indebtedness is a concern and priority for both the AMA and the AMA-MSS. With great attention and energy, the AMA has advocated strongly for the medical students during the current process of reauthorizing the Higher Education Act (HEA). The HEA is legislation which governs all federal postsecondary education funding and requires reauthorization every five years. Congress has been in the midst of this process since 2003, with current student aid programs being funded for the last three years by a series of continuing resolutions. H.R. 609, which would reauthorize the HEA, was introduced in the U.S. House of Representatives by Rep. John Boehner (R-OH), Chairman of the Committee on Education and the Workforce (E&W). H.R. 609 was recently passed by the E&W Committee on July 22, 2005.

The reauthorization of the HEA has been interesting, as there are many parties with rightful and vested interests, as well as a Budget Resolution mandate for savings from the E&W budget of \$12.7 billion over the next five years. The AMA effort has been persistent throughout these proceedings, with a strong presence and communication with the Committee regarding our concerns and our recommendations. The AMA sent a letter to the Committee requesting that provisions important to medical students and graduates, some of which are listed below, be included in the bill. Visit <http://enews.ama-assn.org/UM/T.asp?A40.442.2508.11.87365> to read the AMA letter.

Current Situation:

HR 609, as amended, was passed by the E&W Committee with a vote in favor 27 to 20, with 1 present, and reported to the House. A number provisions supported by the AMA were included in the bill:

- **preservation of the federal loan consolidation program;**
- **allowing borrowers the choice of fixed or variable interest rate on consolidated loans;**
- **repealing of the “Single-Holder” rule**, allowing loan consolidation with any lender on the market – not just the borrower’s current lender – thereby broadening consumer choice and improving market competition;
- **reduction of Stafford loan origination fees**, which would make more money available for a student’s tuition, books, and living expenses;
- **requiring lenders to report loan payments to all major national credit bureaus**, helping borrowers establish a strong credit history from consecutive on-time monthly loan repayments; and
- **mandating lenders’ full-disclosure of consolidated loan terms**, providing notice to loan applicants regarding various terms of a consolidated loan in order to assist borrowers in making informed financial decisions.

Other notes of interest to medical students from the Committee’s mark-up include an accepted amendment offered by Rep. Tom Price, MD (R-GA) to require a study by the Secretary of Education on medical student graduates’ indebtedness. Another amendment that was offered, but subsequently withdrawn due to the recognized budget constraints, by Rep. Charles Boustany, MD (R-LA), requested

extension of the loan deferment period for eligible medical residents from the current 3 years to a period of up to 8 years (note: a 5-year extension was scored at an annual cost of \$200 million).

Next Steps:

This fall, the House of Representatives is expected to vote on H.R. 609, as amended, and the Senate will likely begin consideration of its reauthorization legislation. The Senate version is expected to differ from the final House version, thus requiring resolution by a House-Senate conference committee. Therefore, a significant amount of work must still occur before the reauthorization is completed.

When the time comes, it will be *essential* for medical students across the nation to contact their Members of Congress to ask for their support of the necessary changes to the HEA. Stay tuned to find out how you can be involved to make a positive impact on this legislation.

For more information and current updates, go to the following links:

- HEA Reauthorization: <http://www.ama-assn.org/ama/pub/category/12771.html>
- “Price Calls for Study on Med School Student Debt”, released Thursday, July 21, 2005: <http://tomprice.house.gov/html/release.cfm?id=62>
- Medical Liability Reform: <http://www.ama-assn.org/ama/pub/category/6087.html>
- Patient Safety: <http://www.ama-assn.org/ama/pub/category/6301.html>

Hello!

I'm glad to finally have a chance to say hello to all of you. Having moved from central Massachusetts and taken a year off after my third-year rotations at UMass Medical School, I am thrilled to be in the DC office of the AMA starting my term as your new GRAF (Government Relations Advocacy Fellow). Capitol Hill was buzzing with activity these past few weeks as the House and Senate worked to wrap up as much legislative business as possible before the August recess. The staff here has been doing a great job keeping on top of everything, and advocating strongly for physicians and medical students.

In my first month as the medical student liaison, I've jumped right in. Already, it's been an incredible experience: attending hearings, going to committee work-ups, and witnessing bipartisan dialogues. Most importantly, I've followed the bills that affect you – medical students and soon-to-be-physicians. Over these past few weeks, there has been significant movement on key issues, including the reauthorization of the Higher Education Act (HEA), medical liability reform, and patient safety. Check back often. I'll be updating these issues frequently, and bringing you new information on other legislation and DC events through the AMA-MSS website and the Medical Student Insider (MSI).

I look forward to serving you this year by working on health policy and other medical issues. An even greater priority of mine, though, is reaching out and collaborating with medical students across the nation. I need your help! I want to know what you think about what's going on here in Washington: What do you think about proposed legislation? What information do you need? What are your ideas for taking action? I want to hear your feedback, your ideas, your concerns, and your questions. Speak up! Your contributions and energy will help me make sure that our voice is strong in our nation's capital.

You can read more about me, and how I ended up here in my bio. Also, feel free to reach me anytime by e-mail at GRAF@ama-assn.org, or by phone at (202) 789-7424.