

REPORTS OF COUNCIL ON MEDICAL SERVICE

The following reports, 1-8, were presented by F. Maxton "Mac" Mauney, Jr., MD, Chair:

1. TRICARE CONTRACT AND BILLING ISSUES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

At the 2000 Interim Meeting, the House of Delegates adopted Resolution 114, which calls for the American Medical Association to seek solutions to the problems of: (1) low numbers of physicians voluntarily entering into contract with TRICARE; and (2) the inability of noncontract physicians to bill outside TRICARE's restrictions for services to beneficiaries. The Board of Trustees referred the requested study to the Council on Medical Service for a report to the House at the 2001 Interim Meeting.

This report summarizes TRICARE's structure, billing, and contracting issues, and civilian physician network participation. Information contained in the report was gathered from representatives of TRICARE Management Activity (TMA), the Department of Defense (DoD) organization that oversees TRICARE; the General Accounting Office (GAO); the Congressional Research Service (CRS); and The Retired Officers Association (TROA), a beneficiary advocacy group; and two AMA member physicians with extensive TRICARE experience. The sponsor of the resolution, the American Society of General Surgeons, did not respond to the Council's request for additional comment.

OVERVIEW OF THE TRICARE PROGRAM

TRICARE History

Government-provided medical care for uniformed services personnel and their dependents has been US policy since 1884. When Military Treatment Facilities (MTFs) could not meet the demand for care of active duty personnel and their dependents in 1943, Congress authorized the Emergency Maternal and Infant Care Program to provide maternity care and care of infants up to age one to families of servicemen in the lowest four grades. When the Korean conflict stretched MTFs to capacity in 1956, the Dependents Medical Care Act was enacted. In 1966, amendments to the act created the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and authorized outpatient and psychiatric care for active duty family. Retirees, their family, and some survivors came into the program in 1967. TRICARE evolved out of demonstration projects begun in 1988, which offered service families health care benefit choices as a way of improving access to care and controlling costs. It was rolled out nationally in 1993 and fully phased in by 1998.

TRICARE is a health insurer/provider system operated by the DoD with a budget of approximately \$17 billion. It purchases or provides inpatient, outpatient, pharmacy, and behavioral health care for active duty and retired service personnel (those who draw retirement benefits) and their eligible dependents (minor offspring; spouses; some unremarried former spouses) through HMO, PPO, and Medicare-style fee-for-service (FFS) products using military and civilian resources and administration. Military resources include 88 medical centers and 516 clinics. TRICARE is not to be confused with the Veterans Health Administration (VHA). The VHA is a unit of the Department of Veterans Affairs. It is a direct provider of hospital, outpatient, pharmacy, behavioral health, and nursing home care to honorably discharged veterans who qualify on the basis of low income and means or service-connected disability; to enrolled veterans; to dependents of veterans with service-connected disability; low income, means, or paid enrollment; to dependents of veterans with service-connected disability; and to survivors of veterans who died in the line of duty (not as a result of misconduct). The VHA makes health care available to 26 million veterans (more than 3 million unique patients in FY2000) through 173 medical centers, 771 clinics, 134 nursing homes, and 206 counseling centers by 180,000 staff, and has a budget of approximately \$20 billion.

TRICARE: Three Military Health Benefit Programs

TRICARE offers three options to active duty family members and retired personnel and their dependents:

- TRICARE Prime (HMO-style coverage) - Beneficiaries select a Primary Care Manager (PCM), including clinics, practice sites, or MTFs that provide or arrange for all health care services required by enrollees. Beneficiaries are assigned to MTF PCMs until that capacity is exhausted and then to civilian PCMs in the Managed Care Support (MCS) contractor's network. TRICARE Prime provides access to free preventive clinical services and lower cost sharing requirements relative to TRICARE Extra or Standard coverage options. Enrollment in TRICARE Prime is mandatory for all active duty personnel.
- TRICARE Extra (PPO-style coverage) - Beneficiaries may opt for care from an expanded network including civilian physicians and bear cost shares 5% below that of TRICARE Standard. No enrollment is required. Physicians are paid by rates they negotiate with the MCS contractor, typically at a discount off the Medicare participating fee schedule rates.
- TRICARE Standard (Medicare-style FFS coverage) - Beneficiaries obtain treatment from civilian physicians who file assigned or unassigned claims for covered services according to rules almost identical to those of Medicare, including payment according to the Medicare participating fee schedule and the same balance billing restrictions. No enrollment is required.

In addition to the three program options, nonactive duty beneficiaries are always eligible to receive their care free of charge at MTFs whenever space is available (i.e., after Prime enrollees have been cared for and if there is remaining capacity). Prime enrollees (other than active duty personnel) may obtain covered care out of network using a point-of-service (POS) option. To use the POS option, enrollees must pay a deductible and a cost share of 50% to 65% of the TRICARE Maximum Allowable Charge (TMAC). Appendix A contains the beneficiary cost share requirements under each of the benefit options described above.

Managed Care Support Contractors

TRICARE operations are largely administered through managed care support contracts. Managed Care Support (MSC) contractors hold separate contracts in 12 US regions. MCS contractor responsibilities include developing and maintaining civilian provider networks, ensuring adequate beneficiary access to health care, administering enrollment, authorizing referrals and paying for benefits, processing claims, managing utilization and quality, and educating beneficiaries and providers. MCS contractors are paid by the DoD according to the bid price of the contract plus negotiated adjustments due to geographic shifts in MTF workload and new benefit mandates or regulations. The contracts provide for limited gain/loss sharing and risk for cost overruns up to negotiated stop-loss threshold has been negotiated.

TRICARE Senior Pharmacy Program

An estimated 1.6 million military retirees age 65 or older and their dependents became eligible for TRICARE Senior Pharmacy (TSRx) benefits in April 2001. TSRx beneficiaries pay \$3 for generic drugs and \$9 for branded drugs when they use TSRx's network of retail pharmacies or its National Mail Order Program. Users of non-network pharmacies must meet an annual deductible and incur higher copayments (the higher of \$9 or 20%). Beneficiaries also may fill their prescriptions at a military pharmacy at no cost. TSRx will cost about \$1 billion per year and will not significantly impact civilian physician practices.

TRICARE for Life Program

As of October 2001, 1.6 million military retirees age 65 or older and their qualifying dependents became eligible for TRICARE for Life (TFL), which is a "Medigap" policy covering most of the Medicare deductibles and copayments. TFL and TSRx beneficiaries must be eligible for Medicare Part A and enrolled in Medicare Part B. All Medicare providers may participate in TFL without recredentialing. Claims will be filed only once with the local Medicare carrier. TFL will coordinate benefits with Medicare and pay physicians directly. This will reduce physicians' collection expense per assigned claim while increasing physicians' total collections for TFL patients. TFL will cost \$60 billion over ten years, with first-year costs of about \$4 billion.

CONTRACT/BILLING ISSUES

Resolution 114 (I-00) refers to emergent and nonemergent situations in which noncontract physicians are required to care for TRICARE beneficiaries and accept TRICARE's terms of payment. It appears that the sponsor of the resolution may have been concerned about nonemergency cases in which physicians fear exposure to liability for patient abandonment if they decline to perform elective surgery on a TRICARE beneficiary after establishing a patient-physician relationship. A physician who does not participate in TRICARE is not obliged to provide non-emergent care, including elective surgery, even after establishing a patient-physician relationship through diagnosis, treatment, and care planning during a previous encounter.

A related concern may have been that of physicians being required by hospital medical staff rules to treat TRICARE beneficiaries whom they otherwise would decline to see because of the burden of low payment or excessive administrative work. Although hospital medical staff rules may require medical staff members to treat TRICARE beneficiaries admitted to the hospital, participation in TRICARE is voluntary for individual physicians. Similarly, the hospital-based physician's obligation to bill TRICARE on a participating basis (to accept the TMAC as payment in full) may be required pursuant to the contract between the physician and the hospital. All hospital-based physicians employed by or contracted to provide services with a Medicare participating hospital are required to participate in TRICARE, whether or not such consent to participation is articulated in a professional service contract or employment agreement.

To summarize, in the absence of hospital medical staff rules, employment agreement or other contract terms to the contrary, a private physician is not required to treat a medically stable TRICARE beneficiary, (even though all Medicare hospitals are legally bound to provide inpatient care for TRICARE beneficiaries). However, should a private physician choose to treat the beneficiary anyway, or is compelled to do so by hospital staff rules, the physician is bound by the same billing restriction that applies in the case of all Medicare beneficiaries, (i.e., the physician can never balance bill the TRICARE beneficiary for more than 15% of the fee schedule amount for covered services). In addition, if the physician is under contract to the hospital, the physician is bound to bill for covered services through the hospital on a participating basis, accepting the local TMAC as payment in full. If the service is not covered by TRICARE, then the physician will collect nothing from TRICARE and may bill the patient for the full amount.

With respect to emergency cases, the Council notes that base closures and other factors constrain TRICARE beneficiaries' access to military or contracted emergency services in many geographical regions. As a result, noncontract providers are required to care for emergency patients, as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), and to accept TRICARE's terms of payment (maximum of 115% of the Medicare participating fee schedule). As the DoD's shift of this burden to private physicians is not offset by a right to set and collect their own fees, it raises an equity issue which the Council believes merits the attention of the AMA and the DoD.

CIVILIAN PHYSICIAN PARTICIPATION IN TRICARE

TRICARE measures physician participation as the percent of claims filed on an assigned basis. These "assignment" rates bear no relation to physician service capacity. Analyses by the GAO, TMA; and the Center for Naval Analyses/Institute for Defense Analyses (CNA/IDA) find physician participation levels are generally adequate but, in some geographical areas, inadequate to provide all the specialty coverage needed. Areas underserved by civilian physicians tend to be rural or characterized by a low degree of managed care penetration. The most significant variables associated with the tendency of physicians to participate in MCS contractor networks (i.e., to accept negotiated payment rates discounted below Medicare fee schedule as payment in full) were the proportion of military patients in a given physician's patient panel and the degree of market penetration by managed care.

TRICARE uses monetary incentives to increase local participation as needed. MCS contractors can raise TMAC rates to achieve market parity (up to a limit of 1992 levels, which averaged 150% of Medicare) and can negotiate rates of payment to individual physicians up to 115% of TMAC. However, a recent GAO study of rural Alaska found that a 28% across-the-board increase in TMACs did not increase physician participation. The GAO found access impeded mainly by nonmonetary factors including a short supply of physicians; the prevailing tendency of public and private payors to pay physicians in full or nearly in full; previous reductions in TRICARE's payment levels; TRICARE's reputation for slow payment and onerous administrative requirements; the transient nature of

TRICARE's beneficiary population compared to the local Medicare population; a local culture of self-reliance and independence that encourages reluctance to participate in government managed care programs; and geographical constraints such as the lack of passable roads.

MEASUREMENTS OF NETWORK ADEQUACY/ACCESS TO CARE

To evaluate the adequacy of the contractor's networks, the Council sought ratios of full-time equivalent (FTE) physician specialists to the beneficiaries served, and utilization per beneficiary by CPT code, to compare to standard utilization rates. Unfortunately, TMA declined to furnish this type of information, which makes it impossible for the Council to determine the specific types of specialty coverage that are lacking in those local areas in which there are specialty coverage deficits. However, TMA and others furnished other subjective and quantitative data for assessing the networks in terms of beneficiaries' access to care without regard to specialty.

In its FY2000 Annual Report to Congress (FY1998 data), the CNA/IDA reported that the percentage of TRICARE Prime enrollees satisfied with their access to care when needed was 74%, compared to 63% before TRICARE was implemented; the percentage of all TRICARE Prime enrollees satisfied with the overall quality of care was 82%, compared to 73% before TRICARE; and quality of care, as measured by use of preventive care services, generally increased during the period and attained levels consistent with the standards set by the Healthy People 2000 program of the Department of Health and Human Services.

The CNA/IDA report also compared TRICARE's performance against civilian standards of access to care. TRICARE beneficiaries who obtained care from MTFs experienced better perceived access to prescription services. However, compared to the TRICARE beneficiaries who had access to nonmilitary sources care, and compared to the general civilian population, MTF users experienced greater difficulty in making appointments for routine care; more calls to make appointments; longer wait times for medical appointments; less convenient treatment locations; poorer perceived access to emergency care; poorer perceived access to specialists; and greater problems with claims processing.

In the March 2000 TRICARE Operational Performance Statement (TOPS) reports, Prime enrollees' satisfaction with their access to needed care was significantly less than civilian benchmark (61% versus civilian mean 71%) for those with civilian network PCMs. The underlying data suggest enrollees experienced unhappiness with their nurse or doctor; problems getting referrals to specialists; delays in care pending approval; and difficulty obtaining care deemed necessary by their physicians. Overall satisfaction with TRICARE Prime was significantly less than civilian benchmark for Prime enrollees who had civilian network PCMs (41% versus civilian mean 57%). The DoD assessed these performance deficiencies as cause for immediate redress. The TOPS reports also indicate substandard performance in several other categories, including the percentage of MTF Prime enrollees meeting appointment waiting standards (74% actual versus 88% benchmark), and rates of preventable hospital admissions (higher than civilian benchmark for 13 out of 18 diagnoses). Local areas in which access is impaired can be identified through examination of performance versus access standard by catchment area according to the TOPS reports available at the TRICARE web site.

INFORMATION TO HELP CIVILIAN PHYSICIANS UNDERSTAND TRICARE

Improved Service to Physicians

Although TRICARE has a reputation among many civilian physicians for low payment, slow payment, and administrative hassle, TRICARE claims great improvement in paying physicians. In addition to increases in physician payment levels, TRICARE's data show reductions in claims processing times to 12 days (14% below industry average) and 97% and 99% reductions in claims pending over 60 and 120 days, respectively. TRICARE also claims to have several other initiatives under way to further reduce the financial and administrative burden to civilian physicians who participate in TRICARE's network. Specifically, TRICARE claims to have added personnel to reduce wait times for telephone customer service; loosened some of its referral, benefit authorization, and prepayment review restrictions, allowing MCS contractors to apply more efficient best practices; and initiated programs specifically designed to improve the adjudication process by reducing deferrals and denials through electronic claims submission and education of providers and beneficiaries. To assist beneficiaries in instances where payment remains in dispute, TRICARE reports that it makes "extensive reconsideration and appeals options available."

Important Points About Contracting With TRICARE

The Council believes the following information may be of assistance to those physicians who are considering contracting with TRICARE:

- Physicians can see TRICARE patients on a contract or noncontract basis. Payment to noncontract physicians is limited to TMAC plus collections from balance billing the beneficiary up to 15% of TMAC. The logic of signing a network contract is to provide services at a discount off TMAC in exchange for patient volume. In rare instances in which the local supply of specialists is inadequate, physicians may be able to individually negotiate payment rates up to 115% of TMAC or local TMACs might be raised, across the board, above the Medicare participating fee schedule levels, or both events might occur.
- Physicians should perform the same due diligence in contracting with TRICARE as when they contract with other payors. This includes understanding all the provisions of the network contract and being aware of information resources that detail scope of benefits, limits of coverage, and authorization procedures for referrals and treatments.
- Civilian physicians who wish to contract with TRICARE should refer to the regional MCS contractors. Appendix B contains the list of MCS contractors and their telephone numbers.

Preparing For The TFL and TSRx Benefit Expansions

Similarly, the Council believes physicians should be aware of the following information regarding the TRICARE for Life (TFL) and TRICARE Senior Pharmacy (TSRx) programs:

- The TFL and TSRx benefits are intended to be seamless from the perspective of the physician. TFL is a Medigap policy and is always secondary to Medicare and any private insurance. MCS contractors are required to accept standard claims forms HCFA 1500 and UB92, as well as the Medicare electronic billing format. TFL will automatically pay Medicare's deductibles and copayments directly to the physician without an additional claim filing. All physicians authorized to treat Medicare beneficiaries are automatically authorized TRICARE providers. The TFL allowance is equal to the Medicare participating fee schedule rate for covered services.
- TFL-eligible patients are primarily seniors drawing uniformed services retirement pay, plus their qualified dependents of all ages and some unremarried former spouses (i.e., those who were married to the sponsor during the sponsor's period of active duty). Each military retiree must have a Uniformed Services ID card, be eligible for Medicare Part A, and be enrolled in Part B. Information in his or her Defense Enrollment Eligibility Reporting System (DEERS) files must be current.
- To ensure prompt payment of deductibles and copayments, physicians should identify their TRICARE-eligible patients and help them fill out and transmit the enrollment form.
- Refunding of TRICARE payments will be required when providers treat patients who have both Medigap and TFL policies and both payors pay the same claim. TFL is the payor of last resort when the beneficiary has coverage from multiple sources.
- Physicians must understand and explain to their TRICARE patients that TFL coverage applies only to the services that are covered according to their TRICARE policy. TFL will not pay any portion of the charge for services (e.g., chiropractic) that are not covered by TRICARE, even if those services are covered by a different payor. Beneficiaries must expect to pay for noncovered services out of their own pockets.
- TRICARE provides greater coverage than Medicare for some services (e.g., skilled nursing; inpatient hospitalization) and also provides a benefit that is not offered by Medicare (i.e., senior prescription drug coverage). In those cases, standard TRICARE copayments and deductibles apply, but only up to a catastrophic limit of \$3,000 per year.
- Physicians who are in TRICARE's network already will be paid on the basis of Medicare rates for their TFL patients. TRICARE network discounts do not apply to TFL beneficiaries. TFL will pay Medicare copays and deductibles.

DISCUSSION

As discussed in this report, TRICARE is DoD's managed health care program for active duty service members, military retirees, and their dependents. It was established to increase the capacity to treat uniformed service personnel and their dependents through payment to civilian providers for selected care services. TRICARE blends the military's direct care system of hospitals and clinics and CHAMPUS with networks of contracted civilian physicians. In addition to three main benefit programs corresponding to HMO, PPO, and Medicare-style FFS structures, TRICARE expanded its pharmacy benefit in April 2001 and expanded its eligibility criteria in October 2001 to include retired military personnel over the age of 65 and their dependents within the TRICARE for Life (TFL) program. TFL will be their secondary payor to Medicare--a "Medigap" policy--at no extra cost to the beneficiary. TFL will be a primary payor for dependents of retired personnel who have no other health insurance. By law, TFL is secondary when an eligible individual has coverage from other sources.

The Council believes that TRICARE was created in view of several objectives besides the augmentation of MTF capacity. These objectives include improvement of beneficiary access and choice, and the adoption of civilian best practices to achieve higher quality, higher satisfaction, and lower cost. TRICARE's commitment to the latter should not be underestimated, as the program was created largely in response to the rapid escalation in health care costs during the 1980s. It seems evident that TRICARE management has concluded that most access issues have been resolved or are being resolved satisfactorily, and that only isolated and local instances of impaired access remain. TRICARE management also appears to have concluded that in most of these cases, increases in physician payments will not lead to improvements in network access and performance. MCS contractors share in gains and losses to some degree and consider some local access problems (largely confined to rural markets) to be intractable. For some reason, one can assume that TRICARE will continue to bargain aggressively on payment rates when negotiating network contract with civilians physicians.

Physicians' complaints, in and of themselves, will not motivate MCS contractors to increase payment of physicians. Such motivation may possibly arise, however, when certain conditions exist. Physicians will have greater leverage with the MCS contractors when:

- local survey results indicate substandard performance with respect to measure of access;
- beneficiaries directly complain to TRICARE about inadequate access; and
- the local supply of specialists would be sufficient to treat the local TRICARE beneficiaries if enough of the specialists were willing to see those beneficiaries or sign network contracts.

The Council believes that recent enhancements to TRICARE and general information about TRICARE and TRICARE contracting will be of value to some physicians, including those contemplating participation in the TRICARE network and those already seeing TRICARE beneficiaries who are eligible for the enhanced benefits. As a result, the Council believes that this information should be communicated by the AMA to all its members.

The Council believes that in some cases the DoD may have taken advantage of EMTALA to shift the burden of providing emergency care for some of TRICARE's beneficiaries from the military direct care system to civilian physicians. The legally binding nature of TRICARE's billing restrictions prevents civilian physicians from obtaining fair payment for assuming this unsolicited burden. The Council believes the AMA may be able to accurately determine the magnitude of this problem by eliciting and analyzing physician complaints on this matter. The AMA could then, if warranted, present the cumulative evidence to the DoD and pursue appropriate regulations, legislation and/or judicial remedies.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association communicate to its members information regarding recent TRICARE program expansions, as well as related information to assist physicians in TRICARE contracting decisions.

2. That our AMA inform its members that TRICARE Managed Care Support contractors have the authority to increase Maximum Allowable Charges (MACs) in effect under this program, and to negotiate payments above such charges with individual physicians in order to recruit or retain adequate supplies of physicians for their networks.
3. That our AMA elicit information from civilian physicians who have unfairly incurred the costs of treating TRICARE beneficiaries without a right to balance bill and, based on analysis of the collected complaints, consider legally appropriate regulatory, legislative, and/or judicial remedies.

APPENDIX A - TRICARE BENEFICIARY COST SHARING REQUIREMENTS

Active Duty Personnel and their Family Members

	TRICARE Prime	TRICARE Extra	TRICARE Standard
Annual Deductible	None	\$150/individual or \$300/family for E-5 & above; \$50/\$100 for E-4 & below	\$150/individual or \$300/family for E-5 & above; \$50/\$100 for E-4 & below
Civilian Outpatient Visit	\$0/visit	15% of negotiated fee	20% of allowable charge
Civilian Inpatient Hospital Admission	\$11/day (\$25 minimum)	Greater of \$25 or \$10.85/day	Greater of \$25 or \$10.85/day
Civilian Inpatient Mental Health	\$20/day	\$20/day	\$20/day

Retirees, Their Family Members, and Other

	TRICARE Prime	TRICARE Extra	TRICARE Standard (CHAMPUS)
Annual Deductible	None	\$150/individual or \$300/family	\$150/individual or \$300/family
Annual Enrollment Fees	\$230/individual or \$460/family	None	None
Civilian Provider Copays: Outpatient Visit Emergency Care Mental Health Visit	\$12 \$30 \$25 (\$17 for group visit)	20% of negotiated fees	25% of allowed charges
Civilian Inpatient Cost-Share	\$11/day (\$25 minimum charge per admit)	Lesser of \$250/day or 25% of negotiated charges plus 20% of negotiated professional fees	25% of billed charges plus 25% of allowed professional fees
Civilian Inpatient Mental Health	\$40/day	Lesser of \$390/ day or 20% of institutional & negotiated professional charges	Lesser of \$144/ day or 25% of institutional & professional charges

TRICARE Point-of Service (POS) Option

TRICARE Prime enrollees are entitled to obtain covered care from nonnetwork providers. They are responsible for an annual outpatient deductible of \$300 per person and \$600 per family plus 50% of the TMAC for the covered service plus additional balance bill charges up to a maximum of 15% of TMAC.

Source: <http://TRICARE.osd.mil/TRICAREHandbook/part1.htm#top1>. As of October 30, 2000, exposure to total annual out-of-pocket costs was reduced from \$7,000 to \$3,000 (\$1,000 for Active Duty family). As of April 1, 2001, outpatient copays for Active Duty family members enrolled in Prime were eliminated (formerly \$6/visit and \$12/visit for grades E-4 and lower and grades E-5 and higher, respectively).

APPENDIX B - MANAGED CARE SUPPORT CONTRACTORS BY STATE AND REGION

State	Region #	Region Name	Lead Agent	Contractor	Contractor Phone
Alabama	4	Gulfsouth	Keesler TTC MC, Keesler AFB, Mississippi	Humana Military Healthcare Services	800-444-5445
Alaska	12	Pacific		Health Net Federal Services	800-242-6788
Arizona	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Arkansas	6	Southwest	Wilford Hall MC, Lackland AFB, TX	Health Net Federal Services	800-406-2832
California (northern and central)	10	Golden Gate	David Grant AF MC, Travis AFB, CA	Health Net Federal Services	800-242-6788
California (southern)	9	Southern California	Naval MC, San Diego, CA	Health Net Federal Services	800-242-6788
Colorado	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Connecticut	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
Delaware	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
District of Columbia	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
Florida	3	Southeast	Eisenhower Army MC, Fort Gordon, GA	Humana Military Healthcare Services	800-444-5445
Florida (panhandle)	4	Gulfsouth	Keesler TTC MC, Keesler AFB, Mississippi	Humana Military Healthcare Services	800-444-5445
Georgia	3	Southeast	Eisenhower Army MC, Fort Gordon, GA	Humana Military Healthcare Services	800-444-5445
Hawaii	12	Pacific	Tripler Army MC, Fort Shafter, HI	Health Net Federal Services	800-242-6788
Idaho (northern)	11	Northwest	Madigan Army MC, Fort Lewis, WA	Health Net Federal Services	800-982-0032
Idaho (southern)	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Illinois	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Indiana	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Iowa	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Kansas	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Kentucky	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Louisiana (southeast)	4	Gulfsouth	Keesler TTC MC, Keesler AFB, Mississippi	Humana Military Healthcare Services	800-444-5445
Louisiana (west)	6	Southwest	Wilford Hall MC, Lackland AFB, TX	Health Net Federal Services	800-406-2832
Maine	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
Maryland	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
Massachusetts	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195

State	Region #	Region Name	Lead Agent	Contractor	Contractor Phone
Michigan	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Minnesota	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Mississippi	4	Gulfsouth	Keesler TTC MC, Keesler AFB, Mississippi	Humana Military Healthcare Services	800-444-5445
Missouri	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Montana	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Nebraska	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Nevada	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
New Hampshire	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
New Jersey	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
New Mexico	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
New York	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
North Carolina	2	Mid-Atlantic	Naval Hospital Portsmouth, VA	Anthem	800-931-9501
North Dakota	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Ohio	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Oklahoma	6	Southwest	Wilford Hall MC, Lackland AFB, TX	Health Net Federal Services	800-406-2832
Oregon	11	Northwest	Madigan Army MC, Fort Lewis, WA	Health Net Federal Services	800-982-0032
Pennsylvania	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
Rhode Island	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
South Carolina	3	Southeast	Eisenhower Army MC, Fort Gordon, GA	Humana Military Healthcare Services	800-444-5445
South Dakota	7	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Tennessee	4	Gulfsouth	Keesler TTC MC, Keesler AFB, Mississippi	Humana Military Healthcare Services	800-444-5445
Texas	6	Southwest	Wilford Hall MC, Lackland AFB, TX	Health Net Federal Services	800-406-2832
Texas (west)	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Utah	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Vermont	1	Northeast	National Capital	Sierra Military Health Services	888-999-5195
Virginia	2	Mid-Atlantic	Naval Hospital Portsmouth, VA	Anthem	800-931-9501
Washington	11	Northwest	Madigan Army MC, Fort Lewis, WA	Health Net Federal Services	800-982-0032

State	Region #	Region Name	Lead Agent	Contractor	Contractor Phone
West Virginia	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Wisconsin	5	Heartland	Wright-Patterson MC, W-P AFB, OH	Anthem	800-941-4501
Wyoming	8	Central	Evans Army Community Hospital, Fort Carson, CO	TriWest Healthcare Alliance	888-874-9378
Puerto Rico	15	Latin America/Canada			888-777-8343
Latin America	15	Latin America/Canada			888-777-8343
Canada	15	Latin America/Canada			888-777-8343
Europe					888-777-8343

2. TRANSITIONAL ISSUES IN MOVING TOWARD A SYSTEM OF INDIVIDUALLY SELECTED AND OWNED HEALTH INSURANCE

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

At the 2000 Interim Meeting, the American Medical Association House of Delegates adopted Substitute Resolution 116, which established policy that encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance (Policy H-165.864, AMA Policy Database). The resolution also called on the AMA to study the potential problems in transitioning to a system of individually selected and owned health insurance, including but not limited to the price disadvantage of the individual with a Medical Savings Account (MSA) or other high-deductible insurance policy. The Board of Trustees referred the requested study to the Council on Medical Service for a report back at the 2001 Interim Meeting. The following report addresses two issues in addition to the individual price disadvantage raised in Substitute Resolution 116 (I-00): venues for individuals to purchase health insurance prior to the widespread establishment of health insurance marts; and individuals' ability to choose health plans.

THE INDIVIDUAL'S PRICE DISADVANTAGE

Recent media reports suggest that uninsured patients typically face higher fees for medical services than insured patients. Not only are uninsured patients subject to paying fees out-of-pocket, but also physicians charge higher fees to the uninsured than they charge insurers for the same services. The discrepancy arises from the fee discounts that managed care insurers have negotiated with physicians over the last 10 to 15 years. Like the uninsured, patients with traditional indemnity (fee-for-service) insurance pay for services out-of-pocket until they reach their deductibles, and even after reaching their deductibles, they may initially pay out-of-pocket. The uninsured and those with traditional indemnity insurance fall outside the managed care system, thus lacking the leverage to negotiate fee discounts.

Historically, it was the norm for patients to pay physicians directly out-of-pocket because they either had no health insurance or had indemnity coverage, and it was common for physicians to charge patients on a sliding-scale basis. More recently, a variety of factors have reduced the scope for physicians to reduce or waive fees for individual patients. Deeper and deeper fee discounts to managed care insurers, obtained unilaterally in many instances, have created financial pressures that hinder physicians from reducing fees for patients who pay out-of-pocket. The trend toward larger group practices has shifted the locus of decision-making about patient fees from individual physicians to group administrators, possibly making it more difficult for individual patients to obtain fee discounts or waivers. In some cases, legal and contractual barriers might also interfere with the use of sliding-scale fees or payments.

Self-Paying Patients Under a System of Individually Based Insurance

Patients who lack first-dollar coverage for whatever reason can be classified as “self-paying” because they pay out-of-pocket or out of some sort of individual account. Self-paying patients include those who are uninsured; those with fee-for-service insurance who have not yet reached their deductibles; and those paying for care out of MSAs, flexible savings accounts or individual accounts under other “consumer-directed” health plans. Accordingly, from a practical and a possibly even a legal standpoint, the issue of the individual’s price disadvantage applies to all self-paying patients.

There is a concern that the self-paying individual’s price disadvantage will discourage the adoption of MSAs and similar insurance products, thereby impeding acceptance and development of a system of individually based health insurance. Although it would be possible in principle to have an individually based system without MSA-type coverage, a large part of the rationale for such a system is individual freedom of choice in coverage. Further, AMA policy supports patient cost-consciousness not only in purchasing coverage but also in purchasing health care, and MSA-type products promote cost-consciousness at this level.

Legal and Contractual Barriers to Offering Discounts to Self-Paying Patients

Although not required by law, many physicians for purposes of administrative simplicity effectively have a single fee schedule used to bill for services to all patients. It is not unusual, however, for physicians to accept payments less than billed amounts, particularly for financially disadvantaged patients. It is unlikely that occasional granting of discounts or waivers to low-income patients would be seen as a violation of any legal or contractual requirements. From the perspective of implementing the AMA proposal for individually based insurance, the main issue is how much latitude a physician has to offer a discount to a non-indigent patient who is paying out-of-pocket because he or she has MSA-type coverage and has not reached the deductible (assuming that the physician has not entered into a preferred provider or other agreement with the patient’s insurer that would specify negotiated fees to be paid by the patient). The degree of flexibility the physician has appears to depend largely on the following factors:

- Medicare and Medicaid rates in the physician’s locality;
- Payment provisions of contracts the physician has entered into with private insurers;
- How low the discount is relative to payments collected from other payors;
- How routinely discounts are offered to self-pay patients;
- The proportion of the physician’s business made up of services to self-pay patients;
- Whether the patient pays in cash or is billed; and
- State Medicaid laws and other state laws.

In 1987, a federal law was enacted prohibiting physicians from billing Medicare or Medicaid “substantially in excess” of their usual charge (US Code Title 42, Section 1320a-7[b][6][A]). Since 1992--when the old Medicare charge-based payment system was replaced with a Medicare fee schedule determined through a resource based relative value scale (RBRVS), and physicians were to be paid the lower of their actual charge or the fee-schedule amount--federal officials have issued conflicting statements about whether the 1987 law still applies. Most recently, the Office of the Inspector General and the final rule on the fraud and abuse provisions contained in the Health Insurance Portability and Accountability Act of 1996, have taken the position that physicians are still prohibited from collecting more from Medicare than they usually accept from private payors. In theory, providing discounts to individuals could result in a physician being barred from participation in Medicare and Medicaid. At present, this scenario is unlikely given that the law was clearly never intended to discourage fee discounts to low-income or uninsured patients, and that the physician would have to charge a large portion of his or her fees substantially below Medicare and Medicaid rates in the physician’s locality. In the future, however, the proportion of a physician’s patients who had MSA-type products and who were not necessarily low-income could become large enough to trigger concerns about violating the law, if such patients routinely paid less than Medicare and Medicaid rates, and if the physician did not reduce charges to Medicare and Medicaid accordingly.

Certain contractual agreements between physicians and private insurers may pose a more immediate impediment to offering discounts to self-paying patients. Although payment for physician services under most private-sector contracts is determined by fee schedules or the RBRVS, a relatively small number of contracts are still based on “uniform, customary, (prevailing), and reasonable” (UCR) physician payment methodologies. Under such agreements, the insurer agrees to pay a discounted amount of the physician’s UCR fee as determined by some algorithm or guidelines specified in the contract. A problem could arise, however, if the UCR fees reported to the

insurer do not factor in lower amounts accepted from self-paying patients. Similarly, routinely offering discounts to patients with MSA-type coverage could potentially be construed as de facto establishment of a separate fee-schedule for such patients. Furthermore, physicians who have signed “most favored nation” contracts might be in violation of their contracts if the payments from self-paying patients are below the fees charged to a “most favored nation” insurer. The extent to which payments from self-paying patients factored into UCR, “most favored nation,” and similar arrangements also could depend on whether the payments were billed or made on a cash basis. Depending on the exact contract language, cash discounts to self-paying patients might be treated differently from billed payments, especially given that cash discounts reduce the administrative costs associated with services.

State laws, including Medicaid laws, also could impact physicians offering discounts to self-paying patients. For example, in 1998 California enacted legislation authorizing physicians and other health care providers to grant discounts to patients who do not have any private or public coverage for the services provided. The law explicitly overrides provisions in contracts between physicians and private insurers, and prohibits insurers from factoring cash payments made by such individuals into UCR calculations or counting them as “most favored nation” fees. The law applies to individuals who are not eligible for “insurance reimbursement” for “the health or medical care provided” and makes no mention of income. Thus, depending on the specific policy provisions of the MSA-type plan, the law would likely apply to the self-paying patient before he or she has reached the deductible. It should be noted, however, that the California law is unusual if not unique, and that physicians practicing in other states do not generally have explicit flexibility to vary fees to self-paying individuals free of UCR and “most favored nation” considerations.

Relevant AMA Policy

AMA policy promotes cost-conscious health coverage choice through fixed-dollar, refundable tax credits for individual purchase of health coverage (Policies H-165.920[12] and H-165.865[1f]) and through employer defined contributions toward employee-selected health coverage (Policies H-165.881, H-165.895, H-165.890, H-40.969, H-164.920[3], and H-165.889). AMA policy also encourages patient cost-consciousness at the level of day-to-day health care consumption through MSAs and other mechanisms that involve having patients pay for medical care directly out-of-pocket and/or allow patients to retain control over unspent funds in individual accounts (Policies H-165.869; H-165.879; H-180.957; H-165.920[7, 8, 16]; H-165.865; H-185.982; and H-165.894).

Several AMA policies bear upon the issue of fees paid directly by patients to physicians (Policies H-165.864, H-380.996, H-380.994, H-185.983, H-165.884, H-385.991, H-385.990, H-380.985, and H-385.986). These policies generally advocate for physicians’ freedom to establish fees and to balance bill. As noted previously, Policy H-165.864 encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance. Policy H-380.996 favors continued commitment to programs for voluntary restraint of physician fees. Policy H-380.994 affirms the basic right of each physician to set reasonable and appropriate fees, and to selectively reduce or waive fees on the basis of courtesy or charity. Policy H-385.990[3] encourages physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible. Additionally, Policy H-385.935 opposes granting Medicare “most favored nations” status by interpreting “actual charge” as meaning the negotiated rates a physician obtains from a private third party payor or any other source. Similarly, Policy H-385.938 opposes insurance contract “most favored nation” clauses that require a physician or other health care provider to give the third party payor his most discounted rate for medical services.

Factors Mitigating the Individual’s Price Disadvantage

Several factors are likely to mitigate the individual’s price disadvantage under an individually based system. Foremost, self-paying patients increasingly have access to discounted fees. MSAs and other consumer-directed insurance plans may be accompanied by networks through which patients can obtain services at negotiated discounts. For example, in Pennsylvania, First MSA, Inc. has arranged a network of over 16,000 physicians, 150 hospitals, and 40 ambulatory centers, as well as laboratories, and pharmacies. For enrollees who do not opt for access to the network, or for patients going out of network, First MSA offers coaching on determining reasonable fees and on negotiating with providers. Even the uninsured can have access to health care at discounted fees through a new breed of companies offering “medical discount cards.” Companies such as HealthAllies and Care Entrée set up provider networks for the uninsured and underinsured. Patients pay their own bills but they receive discounted fees because the company has negotiated for them as a group or purchased preferred provider lists.

Other factors that will mitigate the individual's price disadvantage, perhaps only modestly in the short run, are voluntary restraint of physician fees charged to individuals as supported by Policy H-380.996, and increasing market pressure to restrain fees to individuals as more people choose MSAs and other arrangements involving out-of-pocket payments. Although an individually based system might indeed put patients and physicians across the proverbial negotiating table from each other, explicit negotiations will not necessarily occur between individual physicians and patients or at every encounter, particularly in the presence of uniform billing requirements. Rather, physicians will increasingly have to take self-paying patients into account when determining fees. Eventually, as price information disseminates and online and other systems for providing such information develop, the time and discomfort of fee negotiations will lessen. Another factor favoring adoption of MSA-type products is that many physicians will be eager to offer self-paying patients cash discounts in order to bypass the costs, hassles, and delays of submitting insurance claims.

IMMEDIATE VENUES FOR INDIVIDUALS TO PURCHASE INSURANCE

As outlined in Council on Medical Service Report 3-A-01, the market for health insurance is expected to eventually transform along several dimensions including: new venues for purchasing health insurance, particularly group coverage; containment of premium prices due to competitive pressures; and expanded range of product offerings, including low-premium options such as MSAs. AMA policy encourages the formation of health insurance marts (i.e., voluntary choice cooperatives) as alternative venues for pooling risk beyond employment-based groups (Policies H-165.882[14, 15] and H-165.895[3]), and Council on Medical Service Report 5-A-99 reviewed existing employer health insurance purchasing alliances that could serve as prototypes for health insurance marts.

A potential problem in transitioning to a system of individually based health insurance is the question of where individuals, newly equipped with tax credits and defined contributions, would purchase coverage prior to such market transformations. If tax credits are initially introduced for a limited segment of the population (e.g., the working uninsured), the transformation of health insurance markets will not be as rapid or pervasive as under more general reform (i.e., replacing the tax exclusion with tax credits). Until the full-fledged development of health insurance marts, even individuals of below-average expected cost could face higher premiums on the individual market than under employment-based coverage, due to the loss of administrative savings from group purchasing. Even after the transition to an individually based system, people with chronic or high-cost conditions might have difficulty obtaining coverage without special assistance.

Recent Studies of the Individual Market

Two common misconceptions about an individually based system are that insurance would not be purchased through groups and that all individuals would face strictly risk-rated premiums. Although these notions are mistaken, it is possible that a relatively large number of individuals would purchase coverage on the individual market during a transitional period. Several recent studies consider how well the individual market functions, with particular attention to risk rating and the impact of risk rating on access to coverage.

Pauly and Herring. Pauly and Herring (1999) examined risk rating of premiums using data from 1987, prior to the widespread adoption of state regulations on premium rating and terms of issue. Their study focused specifically on the question of whether employment-based group insurance is more effective than individual insurance at cross-subsidization from low-risk to high-risk individuals, i.e., by charging group premiums that are higher than the expected costs of low-risk individuals and less than the expected costs of high-risk individuals. Although they found premiums in the individual market to be generally high, they found that the differences in cross-subsidization between the individual and group markets to be much less than commonly believed. They also found that, although individual-market premiums for a given level of coverage vary considerably, the variation is far from proportional to risk. Specifically, people with estimated expected costs twice the average pay premiums only about 20-40% higher for a given policy. Further, in contrast with the Kaiser Family Foundation findings discussed below, premiums do not appear to vary with the presence of high-risk chronic conditions.

Kaiser Family Foundation and Commonwealth Fund. A recent study by the Kaiser Family Foundation (KFF) found that individuals with even relatively minor health conditions sometimes face higher premiums, restricted benefits or outright rejection by insurers (Pollitz, Soriano, and Thomas, 2001). In the study, hypothetical people applied for health insurance with specified cost sharing features (a \$500 deductible and a \$20 copayment per physician office visit). Each of the six individuals and one family with conditions ranging from hay fever to HIV-positive status

applied to multiple insurers in eight different markets across the country, all in states with few restrictions on premium rating or terms of issue. The study found that, compared to employment-based coverage, individual insurance tends to provide limited coverage of maternity services, mental health care, and prescription drug medications; and that applicants for individual coverage are less likely to be offered a policy if they have been previously rejected, making comparison shopping a risky prospect.

A similar study conducted by the Commonwealth Fund found that adults aged 50-64 face individual-market premiums two to four times higher than premiums (for the same benefits) for 25-year-olds, and that they face higher out-of-pocket premium payments than their peers with employment-based coverage (Simantov, Schoen, and Bruegman, 2001). Premiums were found to climb steeply with age: nearly half of older adults with individual-market coverage pay annual premiums over \$2,000, and the median cost for a 60-year old is nearly \$6,000. The conclusion of the two studies was that commonly proposed individual tax credits (e.g., \$1,000 for individuals and \$2,000 for families) would be insufficient to make coverage affordable for many low-to-moderate income people, particularly for those whose age, geographic location, or health status make insurance relatively expensive.

Families USA. A 2001 study by Families USA concluded that a \$1,000 tax credit for individuals would not be enough to purchase “standard” coverage on the individual market, and that even with the tax credit, “standard” coverage would be unaffordable for most low income individuals. The study used two hypothetical applicants, age 25 and 50, both healthy, non-smoking females. The applicants sought coverage in 25 states, primarily through eHealthInsurance.com and QuoteSmith.com, two online health insurance brokers. Two types of plans were sought: a plan costing \$1,000 and a “standard” plan comparable to the most popular plan in the Federal Employees Health Benefits Program, the FEHBP Blue Cross/Blue Shield PPO. The study found that in many states \$1,000 plans were unavailable, particularly for the 55-year-old applicant, and that available \$1,000 plans provided “substandard” or “deficient” coverage (i.e., fewer benefits and/or higher cost-sharing than the FEHBP BC/BS PPO plan). “Standard” plans were found to be more widely available but more expensive, averaging \$2,395 for the 25-year-old and \$4,734 for the 55-year-old. Compared to the healthy applicants studied, applicants with health conditions would find coverage to be less available and more expensive.

eHealthInsurance. A 2001 by eHealthInsurance.com, the largest online broker of individual health insurance, refutes the perception that individual-market premiums are unaffordable. Based on a sample of 20,000 policies recently sold through the company, the study found individual-market coverage to be comprehensive, affordable, and widely available. The 20,000 single and family policies sold were for 7,000 different health plans offered by over 70 insurers (including Blue Cross/Blue Shield) in 42 states covering 95% of the U.S. population. Eighty-seven percent of the policies purchased had coverage at least comparable to Medicare Parts A and B plus some level of Medicare supplemental coverage (Medigap), most of these (85%) with some drug coverage. Average per-person annual premiums--\$1,200 to \$1,500--were far lower than in the KFF and Commonwealth Fund studies. The eHealthInsurance study concluded that proposed tax credits would substantially offset premium costs and significantly reduce the number of uninsured Americans. Refundable tax credits of \$1,000 per individual and \$2,500 per family would fully cover premiums of half of the policies studied, and would cover at least 75% of the premium for 75% of the policies studied.

Pauly, Song, and Herring. Pauly, Song, and Herring (2001) used a variety of approaches to study health insurance premiums in the individual market and the possible impact of a \$1,000 individual tax credit on the likelihood of purchasing insurance. To study the likely beneficiaries of a targeted tax credit, people without employment-based coverage, the authors used data on both those who purchased individual market coverage and the uninsured. They also used data on both actual premiums and premium quotes from eHealthInsurance.com. The authors point out that average premium quotes overestimate premiums of policies actually bought because a rational buyer who has obtained multiple premium quotes will choose coverage toward the low end of the range, not the plan with the average or median price. With this in mind, they estimate annual premiums on the individual market for comprehensive indemnity, PPO or HMO plans with annual deductibles under \$1,000. They found premiums to range from about \$700 to \$4,000. Premiums for the median individual were estimated to be in the \$1,400 to \$1,800 range. Their findings indicate that a \$1,000 tax credit would fully cover the premium for approximately one-fourth of individuals and would cover at least half the premium for about two-thirds of individuals (only somewhat less optimistic than the eHealthInsurance findings). Based on estimated premiums, the authors simulated the percentage of eligible individuals purchasing health insurance under a \$1,000 tax credit. The simulated take up rates were highly sensitive to methodology and assumptions about individual purchasing behavior, with the most reasonable assumptions yielding take up rates in the 50% to 75% range.

Analysis of Individual Market Studies

How can such divergent conclusions about the state of the individual market--and the prospects for individual tax credits--be reconciled? The answer lies to some extent in different research questions, methods, and empirical findings, but also to some extent in different inclinations to call the glass "half empty" rather than "half full." For instance, the Commonwealth Fund study reported that nearly half of all older adults pay annual premiums of more than \$2,000 on the individual market, rather than reporting the more remarkable finding that over half of all older adults pay less than \$2,000 per year for individual coverage. Similarly, the Families USA study reported that in six of 25 states, no \$1,000 plans were available for a healthy, non-smoking 25-year-old woman, rather than that \$1,000 plans were available in 76% of the states surveyed (and 28% of states for the 55-year-old). Likewise, there is nothing surprising about the fact that premiums vary on the basis of age, gender, health history, and geographic location; that premiums are higher in the individual market than in the group market; or that insurers sometimes impose benefit limitations based on pre-existing conditions (a practice not uncommon even for employment-based coverage). The more surprising finding, consistent across studies, is that the approach to setting premiums (i.e., medical underwriting) varies widely across insurers, as do premiums offered by different insurers, even for the same individual. Thus, it pays to shop around for coverage in the individual market.

Although the KFF study emphasized the low percentage of all applications accepted (63%), the relevant unit of analysis is the applicant. Independent analysis of the study data by the AMA's Center for Health Policy Research shows that most applicants obtained coverage in most markets. Four of seven applicants found coverage without pre-existing condition limitations in all eight markets studied, albeit two-thirds of the time with increased premiums or cost-sharing requirements. Remarkably, a seven-year breast cancer survivor got "clean offers" (with premiums the same as if she had a history of perfect health) in all markets. On average, applicants found coverage without pre-existing condition limitations in 73% of markets (excluding the HIV-positive applicant, who was rejected by all insurers, brings this figure up to 85%).

A closer look at the data also paints a somewhat different picture about premiums relative to proposed tax credits. The KFF study found that, for single individuals, a tax credit of \$1,000 would cover only 25% of the average premium offer (\$3,996). Because the data is skewed towards high-cost individuals, a more meaningful statistic is the percentage of average premiums covered for the average applicant--a more generous 37%. (For comparison, the existing tax exclusion covers 20% of the typical working insured's premium, assuming a 25% marginal tax rate and an 80% employer share of the premium.) Proposed tax credits would go even further than these calculations imply because applicants can, and usually do, choose plans with premiums below the average premium offered--as noted by Pauly, Song, and Herring. In addition, both the KFF and Commonwealth Foundation studies focused on single individuals, whereas per-person premium costs are generally lower for those with family coverage.

Finally, compared to the KFF, Commonwealth Fund, and Families USA studies, the eHealthInsurance and Pauly, Song, and Herring studies found lower premiums, and the Pauly and Herring study found less individual risk-rating. The major source of discrepancy in premiums between the eHealthInsurance and Families USA studies most likely arises from different health plans studied; eHealthInsurance premiums were based on a range of plans purchased by individuals, whereas the Families USA premiums were based on a defined "standard" plan, i.e., the FEHBP BC/BS PPO. Despite the Families USA assertion that this "standard" plan meets "the public's perception of a basic, decent health insurance plan," it is actually quite generous, with features such as 75% coverage for out-of-network office visits, zero cost-sharing for maternity care, 75% coverage for prescription drugs (greater coverage if purchased by mail), \$15 copayments for in-network mental health care office visits with no limit on the number of visits, and an annual out-of-pocket limit of \$3,000. Another source of discrepancy in premiums is the fact that the eHealthInsurance study was based on policies actually purchased, whereas the KFF and Commonwealth Fund studies looked at multiple policy offers faced by an individual; policies actually purchased tend to be a lower-cost subset of all policies offered. Finally, the eHealthInsurance study might represent a younger, healthier population than the KFF and Commonwealth study populations (i.e., those with less-than-perfect health and those aged 50 to 64). Unlike the other studies, the eHealthInsurance report did not provide details about the study population; the degree to which premiums varied with health history and other individual characteristics; or how often applicants were rejected or subject to pre-existing condition limitations. Still, the study, along with the Pauly, Song, and Herring study, provides strong evidence that the individual market can work well for a large portion of the population, and that proposed tax credits would substantially offset premium costs and significantly reduce the number of uninsured Americans.

Options for Individuals

In addition to the individual market, several other opportunities exist for individuals to use tax credits or defined contributions to purchase coverage. The eHealthInsurance study demonstrates that the Internet can reduce the premiums of individual insurance by reducing administrative and marketing costs. Internet purchasing of health insurance also serves to restrain prices and enhance quality by giving individuals ready access to price and quality information about competing plans. Access to the Internet varies with factors such as income, education, type of employment, and immigrant status, underscoring the importance of making plan information readily available to all groups. However, it is not necessary for all individuals to seek elaborate plan information in order for health insurance markets to respond for the benefit of all patients. Further, with the increased use of the Internet by individuals to purchase health insurance, the online individual market will increasingly resemble a group market. This is because as more low-to-average-risk individuals switch to Internet-based purchasing, the payoff to insurers of risk rating premiums will diminish, thus preserving cross-subsidies from low- to high-risk individuals. Council on Medical Service Report 5-A-01 documented the rapid rate of development of virtual health insurance marts already under way. An influx of formerly uninsured individuals equipped with tax credits would accelerate development of online health marts, hastening the transformation of the individual market into an effective group market.

Another key issue is whether employees with defined contributions can continue to purchase coverage through groups. For example, health economist Uwe Reinhardt distinguishes between the “you’re on your own” and “maternal” models of defined contribution systems. The former involves giving people defined contributions (or tax credits) and turning them loose on the individual market, whereas the latter resembles the FEHBP, with a wide choice of pre-screened plans, negotiated group premiums, and extensive support for plan choice and enrollment. The so-called maternal model is already taking place, mostly through Internet-based insurance brokers and plans.

Some tax credit proposals, including the AMA’s, allow individuals to use tax credits toward their share of premiums for employment-based coverage. Depending on the location and individual characteristics, a limited number of individuals have other opportunities to purchase group coverage outside of the employment-based system. A majority of states have high-risk pools with subsidized premiums for those with chronic illness. In a small number of states, private purchasing alliances accept individuals as well as small employment groups. Some policy analysts have even proposed making such private purchasing pools the only venue through which tax credits could be used to purchase coverage (Curtis, Neuschler, and Forland, 2001). In the near future, individuals may be able to buy coverage through state employee purchasing pools or the FEHBP. Tax credits could also be used to buy into public programs such as Medicaid or the State Children’s Health Insurance Program (S-CHIP).

Finally, even with widespread eligibility for tax credits and defined contributions, and even after market transformation, individuals with predictably high health costs may need special assistance in order to obtain coverage. Approximately one to two percent of those who apply for private coverage are turned down based on their health status (Froge and Turner, 2001). As described in Council on Medical Service Report 3-A-01, AMA policy favors public policies that address the needs of high-risk individuals without undue disruption of health insurance markets for the general population. Policies H-165.920[11, 15], H-165.995, H-165.988, H-165.882[9], and H-165.992[1] support the use of state high-risk pools. Policies H-165.992[1], H-185.968, H-90.995, and H-165.979 support direct premium subsidies or other support for people who are disadvantaged by low income, expensive or chronic illness, or disability. Policies H-165.915 and H-330.933 support the use of risk adjustment and reinsurance in order to make high-risk individuals more attractive to insurers.

INDIVIDUALS’ ABILITY TO CHOOSE HEALTH PLANS

There have been longstanding concerns that individuals are not equipped to make informed health care plan choices. Indeed, a recent study found that many people lack a basic understanding of even their own managed care plans, e.g., network, cost-sharing, and referral features (Cunningham et al., 2001). On the other hand, individuals rather than employers already make numerous complex decisions regarding education, life insurance, retirement savings, etc. In addition, sophisticated decision-making support regarding health plan choice is available to individuals, with ever-more advanced support forthcoming.

Research on Decision-Making in Health Plan Choice

In recent years, considerable effort has been put into developing information and tools to assist individuals in choosing health plans. Efforts have focused on providing consumers with comparative information on plan benefits, costs, and quality, as well as on providing guidance through the decision-making process. The Health Plan Employer Data and Information Set (HEDIS) and the Consumer Assessment of Health Plan Satisfaction (CAHPS) programs were developed to provide information on relative health plan quality. HEDIS and CAHPS measures of plan quality are already being used to assist some employees in plan choice and to assist Medicare beneficiaries in evaluating Medicare+Choice plans. At the state level, efforts have been made to present HEDIS, CAHPS, and other quality information in standardized format (e.g., the Pacific Business Group on Health, the New York State HMO Report Card, and the Colorado Health Plan Quality Report). A recent study examined the effect on plan choice of providing supplemental information on expected out-of-pocket costs, in addition to quality and other standard plan information (Schoenbaum et al., 2001). All study participants were given information about plan premiums, patient cost-sharing, and gatekeeping features. Half of the study participants were also provided with information about how much alternative plans might actually cost them depending on their patterns of health care consumption. The study found that the additional cost information significantly changed consumers' choice of health plan, mainly by reducing demand for relatively comprehensive and expensive plans by about 20%.

A growing body of research in the field of decision-making theory has refined understanding of how consumers approach health plan choice and how to best provide decision-support for plan choice to a variety of consumers. In addition to content, the presentation of plan information influences whether it is used (Hibbard, 1999). For example, grouping plans into meaningful subcategories such as cost strata is more helpful than providing unordered information. Ongoing research is investigating how presentation format (e.g., data tables vs. graphs, measures of specific quality dimensions vs. summary quality measures) affects consumers' ability to accurately take in and utilize plan information. Research has also shown that patients more readily understand information framed as a potential disadvantage rather than a potential advantage, e.g., a downside of managed care plans is reduced access to specialists (Hibbard et al., 2000). Consumers are also more able to absorb new information when it is linked to familiar information (Harris-Kojetin et al., 2001). Other research indicates the usefulness of navigational aids such as worksheets and graphics, and of breaking down the decision-making process into discrete steps such as narrowing down plan choices, estimating future health costs, systematically comparing several plan options, and finally choosing the best plan.

Relevant AMA Policy

AMA policy supports efforts to assist patients in making informed decisions about health insurance choice and usage (Policies H-165.920[3iii, 10], H-180.961, H-185.971, H-185.973, H-185.984, and H-405.997). Policy H-165.920[10] encourages the development of programs to assist consumers in making informed choices about sources of individual coverage. Policy H-180-961 advocates that all plans use standardized benefit definitions and uniform disclosure formats such as those used by plans participating in the FEHBP. According to Policies H-185.971 and H-185.973, plan literature should explicitly and specifically list exclusions from coverage in order that these are apparent and comparable, as well as explicitly list any limitations in choice of primary care physician or access to specialists.

Support for Plan Selection

Already, a variety of resources exist to assist individuals in evaluating, comparing, and choosing among competing health plans. Consumer-friendly information and support is rapidly becoming more available as health plans cater increasingly to individuals rather than employers. Employers who switch to defined contributions--either with multiple plan choices or by contributing fixed-dollar amounts to individual accounts of "consumer directed" health plans--have continued to play a key role in helping employees make informed choices, in some cases redeploying human resources staff to help employees navigate their choices.

For years, federal employees have obtained comparative information on health plans from health fairs, word-of-mouth, and non-governmental consumer publications geared specifically toward helping them navigate among numerous competing plans. For example, *Checkbook's Guide to Health Insurance Plans for Federal Employees: 2001 Edition*, an inexpensive paperback widely available at Washington DC newsstands and by mail, provides comparative information about every FEHBP plan throughout the country. The impressive array of information about plan costs, special coverage features, and patient satisfaction ratings is made manageable through easy-to-read

tables organized by plan type and geographic region. Information on total premium and out-of-pocket costs is presented according to how many family members are covered and alternative scenarios about health care use. The guide also gives advice about how to narrow down the options, how to read plan brochures, and what to do under special circumstances (e.g., if your spouse's employer offers health benefits or you are eligible for Medicare).

Similarly, Internet software programs can already handle multiple-choice arrangements, assimilate new data, update information instantaneously, display clear price and benefit information, incorporate personal preferences, and compare costs under hypothetical scenarios of health care use. Starting in 1999, members of FEHBP have used an online tool called PlanSmartChoice to help choose plans. PlanSmartChoice asks employees to rate the importance of plan attributes such as cost, access, benefits, and patient satisfaction. Employees are then faced with tradeoffs that force them to choose between plan attributes they have identified as important. On the basis of these answers, the program presents a table of plan details customized to the employee. Eighty-three percent of the more than 250,000 users reported that they were either extremely or very satisfied with the tool. The growing number of Internet-based health insurance marts and many large employers have similar decision-support programs, some for choosing physicians and treatments as well as health plans. The Internet health insurance broker Sageo uses a modeling tool that helps consumers consider what type of plan (HMO, PPO, POS) is right for them and rank plans based on personal preferences. The sophistication of these decision-support tools lies in their ability to filter and synthesize what would otherwise be an overwhelming amount of information.

DISCUSSION

The Council recognizes that the transition to a system of individually selected and owned health insurance will not be entirely smooth. However, the Council believes that transition problems will not be as daunting as some fear. Naturally occurring market responses, some already underway, will go a long way towards addressing the three potential transition issues discussed in this report. Additional measures, some advocated by existing AMA policy, also can be taken to ensure a smoother transition.

With respect to the first issue, the Council believes that a number of factors will mitigate the self-paying individual's price disadvantage. Mitigating factors include increased access by individuals to discounted fees through networks and discount cards; voluntary restraint of physician fees charged to self-paying patients (per Policy H-390.996); increased market pressure to restrain fees as more patients choose MSAs and other arrangements involving out-of-pocket payments; and physician willingness to offer cash discounts to bypass submitting insurance claims.

Regarding the second issue of immediate venues for individuals to purchase health insurance, the Council believes that reasonable options already exist for most individuals to purchase coverage, provided that tax credits are appropriately structured. As advocated by Policy H-165.865, tax credits should be large enough to make insurance affordable for most people, refundable, and inversely related to income. In the view of the Council, there is cause for qualified optimism about the individual market. Recent research indicates that individual-market coverage is not as expensive or inadequate as previously believed. The Council also recognizes that special measures are needed to address the needs of individuals with chronic illness or disability, who might otherwise have difficulty obtaining coverage outside the employment-based system. Extensive AMA policy supports high risk pools, additional direct premium subsidies, risk adjustment, and reinsurance--approaches that both protect special populations and permit insurance markets to function properly.

As for the third issue, individuals' ability to choose health plans, the Council notes that individuals rather than employers already make numerous complex decisions regarding education, life insurance, retirement savings, etc. In fact, it is only through historical accident that employers play the dominant role in choosing individuals' health insurance, and most people would strongly object to the idea of employers or government making such choices for them. The Council believes that the individually based system proposed by the AMA would not only expand individual choices of health insurance, but give patients a stake in understanding the relative costs and value of health care decisions, from choice of plan to health care consumption. People will quickly become accustomed to choosing their health plans, just as they have become accustomed to choosing 401(k) options and long-distance telephone service, particularly since support for making informed health plan choices is becoming ever-more available. Simple, yet powerful decision-making tools regarding health plan choice are already available to individuals, especially via the Internet. Finally, it is worth noting that it is not necessary for all individuals to seek elaborate plan information, hold plans accountable for fulfilling their obligations, or push for quality and service improvements in order for health insurance markets to respond for the benefit of all patients.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association inform individual physicians and group practice administrators why self-paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a significant price disadvantage in purchasing health care services.
2. That our AMA reaffirm Policy H-165.920[10], which supports the development of educational programs to assist consumers in making informed choices as to sources of individual health expense coverage.
3. That our AMA reaffirm Policy H-180.961, which encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market; and supports the enactment of federal and/or state legislation requiring the use by health plans of standardized uniform disclosure formats that have had appropriate input by medical organizations.

(References pertaining to Report 2 of the Council on Medical Service are available from the Division of Socioeconomic Policy Development.)

3. THE EFFECTS OF CLOSING SAFETY-NET HOSPITALS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

At the 2000 Interim Meeting, the House of Delegates adopted Substitute Resolution 425, which calls on the AMA to report on the effects of closing safety-net hospitals, as well as the fate of DC General Hospital and its affiliated community health centers. The Board of Trustees assigned the requested study to the Council on Medical Service for a report back to the House of Delegates at the 2001 Interim Meeting.

This report discusses what constitutes a safety-net hospital; summarizes the current environment facing such hospitals; provides an update on the status of DC General Hospital; discusses the negative effects that result from closing safety-net hospitals; presents possible ways to preserve the public hospital, including pending legislation; and reviews applicable AMA policy.

WHAT IS A SAFETY-NET HOSPITAL?

A safety-net hospital is one that provides a significant level of care to low-income, uninsured, and/or vulnerable populations. Safety-net hospitals are generally distinguished from other health care providers by their commitment to provide care for people with limited or no access to health care because of their financial or insurance status or health condition. The Institute of Medicine (IOM) issued a report in 2000 entitled "America's Health Care Safety Net: Intact but Endangered," which defined "core safety net providers" as having two distinguishing characteristics:

1. By legal mandate or explicitly adopted mission, they maintain an "open door," offering patients access to services regardless of their ability to pay; and
2. A substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients.

Defining "substantial share" is important when trying to identify a safety-net hospital. Whether or not a hospital receives Disproportionate Share Hospital (DSH) payments from the federal government is not helpful in this regard because 40% of all hospitals receive Medicare DSH payments, and in some states, all hospitals are designated as Medicaid DSH hospitals. The IOM study recognized the vital role of public hospitals as "core safety net providers." In particular, the IOM report found that the financial viability of core safety net providers is at risk due to the rising number of uninsured, the impact of Medicaid managed care, and the erosion of major subsidies for safety-net providers.

The nation's public hospitals in more than 100 of the largest metropolitan areas are considered key safety-net hospitals. These hospitals make up only about 2% of all the nation's hospitals, yet they provide more than 20% of all uncompensated care. Safety-net hospitals are not only vital sources of care for the indigent and uninsured, but also important providers of specialty services to the whole community. At least one out of every four safety-net hospitals providing some selected specialty services has a market share exceeding 85% of these services. These hospitals are the primary providers of burn care, pediatric and neonatal intensive care, trauma care, psychiatric inpatient and outpatient care, and alcoholism inpatient treatment in their communities. Compared with other urban hospitals, safety-net hospitals are nearly five times as likely to provide burn care, four times as likely to provide pediatric intensive care, and more than twice as likely to provide neonatal intensive care. Safety-net hospitals are also more likely than other urban hospitals to offer HIV/AIDS services, crisis prevention, psychiatric emergency care, and other specialty care.

THE CURRENT ENVIRONMENT FOR SAFETY-NET HOSPITALS

Financial Position of the Safety-Net Hospital

Safety-net hospitals rely on a variety of funding sources to finance the care they provide. However, to finance the significant portion of uncompensated care, safety-net hospitals rely on local or state government subsidies, Medicaid and Medicare DSH payments, cost shifting, and other programs. In 1993, the average public hospital's charity care was about four times that of the average private hospital as a proportion of revenue. In 1998, the National Association of Public Hospitals and Health Systems (NAPH) reported that 81 of its member hospitals provided almost \$4.5 billion of uncompensated care, which is an average of more than \$55 million per hospital and accounts for 26% of each hospital's total costs. As a group, safety-net hospitals are in a precarious financial position because they are uniquely reliant on governmental sources of financing.

Reductions in Government Funding

The largest single contributor to the strain on the health care safety net are the changes in Medicaid policy over the last several years. Substantial cuts in DSH funding were made under the Balanced Budget Act of 1997 (P.L. 105-33) and were only partially restored for 2001 and 2002 (but remain in place thereafter.) This decline in financial support limits the ability of safety-net hospitals to provide care. Many public hospitals derive 50% or more of their revenues from Medicaid, compared with an average of less than 14% for all U.S. hospitals. Urban public hospitals are highly dependent on Medicaid because they are located in inner-city areas with many welfare and Medicaid recipients. These recipients often alternate between periods on Medicaid and periods without insurance. When patients lack insurance, the public hospital is the only facility that is legally obligated to treat them, regardless of ability to pay. When these patients have Medicaid coverage they could go elsewhere, but often they continue to frequent the institutions where they feel most welcome.

The topic of how safety-net hospitals in certain cities are responding to health care financing changes was recently studied by the Kaiser Family Foundation in an April 2001 report. The report noted that payment reductions by public payors are leading to reduced patient care surpluses that these hospitals have traditionally relied on to subsidize uncompensated care. Further, due to the increasing number of uninsured persons, safety-net hospitals are seeing the demand for and cost of such uncompensated care rapidly increasing.

The Growth of Medicaid Managed Care

By encroaching on the important Medicaid patient base of safety-net hospitals, managed care is endangering one of the primary sources of revenues of such hospitals. Health maintenance organizations (HMOs) send fewer public managed care patients to safety-net hospitals. Further, studies show that increased HMO enrollment is correlated with lower patient volumes for hospitals in minority communities, and that safety-net hospitals are losing the competition for low-risk Medicaid patients. From 1993 to 1994 alone, Medicaid managed care grew nationally by three million enrollees. Tennessee moved 25% of its population (1.2 million people) into TennCare on a single day in 1994. Currently, 48 states and the District of Columbia have some form of Medicaid managed care, and nationally 56% of Medicaid beneficiaries are in managed care plans.

The Medicaid business on which safety-net institutions depend has become increasingly attractive to private sector managed care organizations, especially as payments from other payors have declined. In some markets, the government may be viewed as a more generous payor because discounting and negotiation have driven down private sector payment levels. Rapid enrollment growth and historically high hospital utilization by the Medicaid population also makes Medicaid managed care particularly attractive.

Due to the growth of Medicaid managed care, public hospitals face major threats to their position. One threat is an absolute loss of market share, as managed care payors opt to contract with providers with whom they have prior relationships, who offer more amenities, and who are better equipped to negotiate the complex managed care environment. Waivers granted to states by the federal government to implement Medicaid managed care contain no mandate that the HMOs contract with public or “essential community” providers. Another threat is that adverse risk selection will result if HMOs market their products so as to draw the healthiest Medicaid enrollees to their ranks. For example, many public hospitals historically have maintained large obstetric services for Medicaid recipients, and obstetrics patients are considered desirable by HMOs because they bring young, growing families in which each child is a capitated enrollee. If managed care draws these patients away from public institutions, they will be less able to use Medicaid funds to cross-subsidize their large volume of uncompensated care.

DC GENERAL HOSPITAL

DC General Hospital is illustrative of the problems being encountered by safety-net hospitals. Substitute Resolution 425 (I-00) directed the AMA to send a letter to “the Mayor of Washington, DC, the City Council, the city’s ‘Control Board’ and the city’s congressional oversight committees” to develop the resources needed to sustain DC General Hospital until a new facility could be developed for more cost-effective delivery of health care. This letter was forwarded to the proper parties in December 2000, and noted that the demise of DC General demonstrates a problem of continued access to care for the nation’s underserved population. DC General was the only hospital with the legal obligation to provide care for everyone who lives and works in the DC area, and the letter urged a close examination of the negative affects that its closure would bring to all patients, as well as recommending that adequate funding be ensured so that it remained open to serve as a safety-net for the District.

DC General Hospital had been in dire financial straits for many years, prompting the establishment of the financial Control Board in 1995. In 2000 alone, the hospital lost \$109 million. The mayor of DC and the Control Board felt that persistent management failures and hospital demands on the city budget necessitated private providers be brought in to improve the city’s public health and save taxpayer money. The plan for DC General to close its emergency rooms and trauma-care center and privatize its inpatient services was met with much skepticism. When the Mayor was unable to reach a consensus with the City Council, which favored DC General remaining a full service hospital, city officials crafted a Request for Proposal (RFP) to pay a private company to offer the services provided by DC General. City officials selected Greater Southeast (a for-profit hospital) and an agreement was negotiated to pay this private firm nearly \$90 million per year. Under the city’s proposal, Doctors Community Healthcare Corporation (DCHC), a private physician-owned hospital chain, would purchase the ailing hospital, dismantle it, and convert it to a network of 20 clinics that would work with private physicians. Patients requiring hospitalization or trauma care could go to DCHC-owned Greater Southwest Community Hospital.

Opponents of the city’s plan rallied behind the chief executive of DC General, whose own bid for the contract was rejected, and who maintained that the government should continue operating the hospital rather than transfer the city’s 65,000 uninsured residents to private doctors and hospitals that would “value profit over the needs of the poor.” The Public Benefit Corporation (PBC), the Board that managed DC General, was abolished by the Control Board on April 30, 2001. Despite protests and emotional confrontations, DC General closed its doors on June 25, 2001 and the 1,600 remaining employees of the bankrupt PBC were laid off July 14. In August 2001, a federal judge dismissed a lawsuit by DC Council members who sought to preserve DC General; a decision that affirmed the Control Board’s continuing power to make contracts without Council approval.

POTENTIAL EFFECTS OF CLOSING SAFETY-NET HOSPITALS

A 1996 study published in the *Journal of the American Medical Association (JAMA)* found that “the closing of a public hospital had a significant effect on access to health care and was associated with a decline in health status.” Because of their precarious financial situations, most private hospitals would be placed at enormous risk if the only safety-net hospital in the area is dismantled. Closing a safety-net hospital has the potential to strain every hospital in town.

An example of the potential problems surrounding closing a safety-net hospital already can be seen in Washington, DC. The District's remaining hospital emergency rooms have become immensely overburdened since ambulances stopped taking patients from the city's east side to DC General. City officials have acknowledged that wait times in some hospital emergency rooms, especially at Greater Southeast, have increased dramatically. Overcrowding of emergency departments increasingly has become a problem in many regions of the country. The Council will be studying this issue in detail, along with Emergency Medical Services (EMS) diversions, in a report to the House at the 2002 Annual Meeting.

In addition, many of the services that are disproportionately provided by safety-net hospitals are high-cost and/or unprofitable services. Given the economics of these services, if safety-net hospitals in some areas were to close, other community hospitals might be reluctant or financially unable to broaden the scope of their care. In addition, the supply of public health and specialty services may not continue to meet demand. When safety-net hospitals are the sole provider of a particular service, remaining hospitals may not be able to fill the gap. Access to crucial public health and specialty services can be severely affected when closing a safety-net hospital.

Other hospitals may not be able to handle potentially large increases in patient volume. Where there are multiple safety-net hospitals, the responsibility for providing public health and specialty services is shared. However, if any of these hospitals is forced to downsize or discontinue services, the other safety-net hospitals could be overwhelmed by the subsequent influx of new patients. The likely drain on hospitals' financial resources would result in diminished access for the entire community to one or more services.

Finally, the quality of services may not be comparable at other hospitals. For example, a common debate at the moment is whether to close trauma units in safety-net hospitals, some of which may be the best in their market. Serious consideration has to be given to whether other area hospitals will be able to match its level of quality. The overall patient and service mix at other hospitals may not complement the efficient delivery of trauma care. Further, some trauma units may lack experience in handling patients with multiple injuries, or they may not offer the complex medical services that some patients require.

In contrast to these concerns, a comprehensive January 1999 study by the Kaiser Family Foundation on the privatization of public hospitals found that conversions of public hospitals did not appear to reduce access for populations who traditionally had been served by public hospitals. However, the report also noted that, in most communities, "the jury is still out" on this issue.

PRESERVING THE PUBLIC HOSPITAL SAFETY NET

Governmental Intervention

Although the ability of public hospitals to function effectively in a managed care environment can be improved, it will not be enough to ensure the public sector's ability to compete against national, publicly traded HMOs with substantial capital and sophisticated marketing expertise. However, the government can intervene to protect essential community providers by compelling or offering incentives to health plans to contract with them. The state of Texas passed legislation that requires Medicaid HMOs to include in their networks all providers who have "previously provided care to Medicaid and charity care patients at a significant level as prescribed by the [Texas Health and Human Services] Commission." In defining "significant level" the commission is directed to weigh the extent to which loss of a provider would cause "disruption to existing physician-patient relationships" in addition to the dollar amount of indigent care that provider delivers.

In implementing such protections, the government could require that HMOs contract with public systems for the entire range of services the systems offer. Many HMOs attempt to contract only for services they greatly need, such as primary care, while diverting lucrative inpatient and specialty care to voluntary hospitals. Government can encourage HMOs to include public hospitals in their commercial and Medicare networks. Further, the government could continue to protect public hospitals by preserving their access to the DSH payments they rely on to help defray their costs for uncompensated care. States such as Tennessee, Minnesota, Florida, and Kentucky have diverted all or part of their Medicaid DSH subsidies into managed care premium payments, leaving public providers at the mercy of the HMOs, which may or may not pass the payments on to them. Under such arrangements, private sector providers who enter the Medicaid managed care market may begin receiving DSH dollars even though they have few charity care obligations, while providers under the greatest stress from uncompensated care are deprived of needed revenue.

Pending Legislation

Ensuring that safety-net hospitals remain viable has been a recent focus in Congress, as these hospitals face a significant reduction off in Medicaid DSH funds beginning in fiscal year 2003. In 2001, Reps. Edward Whitfield (R-KY) and Diana DeGette (D-CO) introduced the Medicaid Safety Net Hospital Continued Preservation Act of 2001 (H.R. 854), which would extend Medicaid DSH payments into 2003 and beyond, allowing safety net hospitals the financing necessary to continue providing adequate access to health care for indigent patients. Likewise, the Senate companion bill, the Medicaid Safety Net Hospital Preservation Act of 2001 (S. 572), sponsored by Senators Lincoln Chafee (R-RI), Bob Graham (D-FL), Dianne Feinstein (D-CA), Jesse Helms (R-NC), Kay Bailey Hutchison (R-TX) and Blanche Lincoln (D-AR) would continue the funding levels in the Benefits Improvement and Protection Act (P.L. 106-554) and provide for a growth-rate adjustment to compensate for the increasing costs of providing health care to indigent patients.

AMA POLICY

The AMA has established numerous policies that address safety-net services, public hospitals, and Medicaid managed care. (Policies H-290.979, H-290.986, H-215.976, H-240.964, H-290.985, H-290.998, and H-290.982, AMA Policy Database). In particular, Policy H-215.976 recognizes the public hospital as a component in the public health infrastructure of many communities, as well as a source and base for organized preventive outreach services; and urges the AMA to seek to make public authorities more aware of the public health and the clinical contributions of public hospitals and, therefore, the necessity for adequate financial support during the current health care transition. Policy H-240.964 states that the AMA: (1) recognizes the special mission of public hospitals and supports short-term federal financial assistance for such hospitals until health system reform is implemented; and (2) advocates as part of a national reform initiative that studies be carried out to evaluate whether special consideration for public hospitals is justified in the form of national or state financial assistance, or other reform financing mechanisms, including assistance in privatization and legal restructuring, and if so, it should be implemented.

DISCUSSION

The Council believes that safety-net hospitals are important for both public health and specialty care. Safety-net hospitals demonstrate a higher propensity than other urban hospitals to provide certain public health and specialty services, and are more likely to provide services that attract potentially difficult-to-treat patient populations, including psychiatric care and alcoholism treatment. Frequently, safety-net hospitals are the major providers of public health and specialty services in their communities. The Council believes that ensuring that these hospitals remain viable benefits not only the uninsured, but the larger community as well.

The Council further believes that maintaining community access to safety-net services should be a policy priority. Growth in Medicaid managed care is threatening the availability of some of the services safety-net hospitals provide. Safety-net hospitals depend primarily on Medicaid DSH payments to maintain financial solvency; and the limits placed on DSH payments by the Balanced Budget Act of 1997 are adversely affecting the ability of these hospitals to provide needed services to the community. The Council believes it is important for both federal and state governments to allocate Medicare and Medicaid subsidies (e.g. DSH payments, indirect medical education payments, community grants) to hospitals on the basis of their service to indigent patients. To that end, the Council believes that federal and state governments should establish some type of reporting mechanism to accurately monitor hospitals' provision of indigent care; and to review the effectiveness of federal programs and policies targeted to support the safety net and the populations it serves in meeting their needs. In particular, the Medicaid and Medicare DSH programs need to be reassessed and restructured to insure a greater focus on care to the uninsured and to prevent more closures of safety-net hospitals. The Council believes that legislation such as the Medicaid Safety Net Hospital Preservation Act of 2001 needs to be passed and implemented to provide substantial relief for struggling safety-net hospitals.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy H-215.976, which recognizes the public hospital as a component in the public health infrastructure of many communities; and urges our AMA to make public authorities more aware of the contributions of public hospitals and the necessity for adequate financial support.

2. That our AMA reaffirm Policy H-240.964, which states that our AMA recognizes the special mission of public hospitals and supports federal financial assistance for such hospitals; and advocates that studies be carried out to evaluate whether special consideration for public hospitals is justified in the form of national or state financial assistance, and if so, it should be implemented.
3. That it is the policy of our AMA that Medicare and Medicaid subsidies and contracts related to the care of economically disadvantaged patients should be sufficiently allocated to hospitals on the basis of their service to this population in order to prevent the loss of services provided by these facilities.
4. That it is the policy of our AMA that the current reporting mechanism should be modified to monitor accurately the provision of care by hospitals to economically disadvantaged patients so that policies and programs targeted to support the safety net and the populations these hospitals serve can be reviewed for effectiveness.
5. That our AMA support federal legislation that would extend Medicaid Disproportionate Share Hospital (DSH) payments into 2003 and beyond, thereby contributing to the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients.

4. HOSPITAL MERGER STUDY

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

Council on Medical Service Report 7-I-00 described American Medical Association analyses of hospital mergers, as well as other AMA resources to assist physicians seeking guidance on hospital mergers, and discussed recent trends in hospital transactions. The report presented several recommendations, including that the AMA will “continue to monitor and report on current numbers of mergers and break-ups of mergers of hospitals in this country” and “study the impact on hospital-based physicians as a result of hospital mergers and break-ups.”

This report updates and expands upon the information contained in Council on Medical Service Report 7-I-00 on recent trends in hospital transactions; reviews the available literature on the impact of hospital mergers and the break-up of such mergers on physicians, including hospital-based physicians; summarizes relevant AMA policy; and presents two recommendations.

RECENT TRENDS IN HOSPITAL TRANSACTIONS

In 2000, the number of hospital mergers and acquisitions declined for the third year in a row, with 22% fewer transactions announced than in the previous year, according to Irving Levin Associates, Inc., a health care research and publishing firm. Irving Levin Associates reported that 86 mergers and acquisitions were announced in 2000, compared with 110 in 1999, 139 in 1998, 197 in 1997, and 163 in 1996. The downward trend of merger and acquisition activity is on pace to continue this year. A total of 40 mergers and acquisitions were announced during the first two quarters of 2001, an 18% decrease from the same time last year, according to Irving Levin Associates.

The seventh annual *Modern Healthcare* survey of hospital consolidations, which included mergers, acquisitions, joint ventures, long-term leases, and other partnerships in which a change in control or equity stake occurred, indicated that hospital transactions decreased 9% last year. *Modern Healthcare* reported that 129 transactions, affecting 318 hospitals, occurred in 2000, the fourth straight year in which the number of transactions declined. Last year also marked a tie between those hospitals that converted to for-profit status and those that made a “reverse conversion,” when a not-for-profit took over a for-profit hospital. Seventeen hospitals converted to not-for-profit status, compared with 30 in 1999, according to *Modern Healthcare*. Those 17 hospitals accounted for 5.3% of all of the hospitals involved in transactions last year. Seventeen hospitals converted to for-profit status, compared with 19 in 1999. The remaining 89.4% of hospitals involved in transactions in 2000 did not change their for-profit or not-for-profit status.

The number of recent hospital transactions suggests that hospitals have become more deliberate about their choices than they were several years ago, when mergers were viewed as the best way to achieve financial stability, increase leverage with managed care companies, and build market share. A comparison of merging hospitals with their non-merging rivals by Spang et al. (2001) suggested that merger-related savings might be less than previously estimated.

Some potential partners also have reconsidered their merger plans following the high-profile break-ups of the systems that merged to form Allegheny Health Education and Research Foundation, UCSF Stanford Health Care, Penn State Geisinger Health System, and Baptist St. Vincent's in Florida.

Irving Levin Associates, the American Hospital Association, and the US Department of Health and Human Services Office of the Inspector General, which reports annually on the number of hospital closures, were not aware of any resources that collected information on the number of break-ups of hospital mergers. However, Irving Levin Associates noted that the latest "unmergers"--still relatively uncommon--do not portend a growing trend. The considerable expense and aggravation of separating, including, but not limited to, breaking apart managed care contracts, information systems, clinical protocols, medical staff, patient records, and medical equipment, can deter wary hospitals from merging in the first place, or if the merger has already taken place, may serve as incentives to try and make it work.

A REVIEW OF THE LITERATURE

A review of the literature indicates that a number of studies address the impact that hospital mergers may have on hospital-based physicians and/or have implications for physicians generally. It should be noted that a separate report on the effects of closing safety-net hospitals is before the House of Delegates at this meeting (Council on Medical Service Report 3-I-01). The Council also is preparing a report on overcrowding and hospital emergency medical services (EMS) diversions for the 2002 Annual Meeting.

Ehrhardt et al. (1990) discussed the combining of six hospitals into three in east central Illinois. Each merger involved closing an emergency department located one to three miles from the other emergency department. Attempts were made, sometimes successfully, to combine the emergency physician staffs. The authors observed that finances are not necessarily the principal problem in combining emergency department staffs. Contract issues, working conditions, uncertainty regarding the future, and the treatment of physicians by the administration are at least equally relevant and important issues. They also concluded that the sooner in the merger announcement timetable that emergency department physician staffs are combined, the better and smoother the combination of emergency services occurs.

In documenting physician support for a hospital merger, Tremonti et al. (1983) found that physicians from private practice, the medical specialty of anesthesiology, and those least satisfied with the hospital administration were the least supportive of the analyzed merger. Formal involvement in the merger process, via task force membership, did relatively little to increase physician support for the merger. However, a significant correlation between perceived input into the merger process and support for the merger indicates positive aspects of involvement, even though this may not have occurred through the formal structure of task forces.

The authors concluded that providing physician input, in an informal or formal task group, is a must. Any forum provided should be meaningful and engender in the professional a sense of identity and ownership, not merely assignment. The maintenance of credibility by the administration also is crucial to the development of support for a merger. Of particular concern are those hospital-based physicians who are salaried or on contracts, and the uncertainty surrounding a new organization and that physician group's relationship with that organization. The authors determined that special attention should be paid to establishing open communication and involvement of those individuals in the planning process. Riffer (1986) noted physicians' concern regarding the potential loss of special considerations that they received at one facility because of long-term tenure in the wake of a hospital merger.

Bogue et al. (1995) presented the results of a survey on what happened to hospitals after mergers occurring between 1983 and 1988. The survey indicated that acquired hospitals continued to be used for acute services after 42% of the mergers. Conversion from general acute to non-acute inpatient uses (e.g., psychiatric and substance abuse services, rehabilitation, and long-term care) occurred 41% of the time, whereas acquired hospitals were closed in 17% of the mergers. In mergers in which both hospitals retained acute services, the acquired and the acquirer had greater similarity in service mix, full-time equivalents per bed, and occupancy rates, compared with mergers in which one hospital eliminated acute care. Greater distance (measured in miles) also existed between those hospitals that merged but retained both physical plants for acute services.

Maynard et al. (1995) interviewed senior administrators in 22 Midwestern medical institutions that merged between 1987 and 1990 on the problems they had encountered during the consolidations of medical staffs. Many of the problems centered on difficulties adjusting to change. Respondents described changing loyalties, internal politics, power struggles, ownership, and leverage issues as disturbing to medical staffs, engendering in physicians fears of loss of individuality and ownership, and consequently perceived loss of power. The administrators recommended that increased attention be paid to specific local issues, and that there be active involvement and communication between the medical staff and administrators at all phases of the consolidation process.

Council on Medical Service Report 7-I-00 highlighted the results of a 1996 survey initiated by the AMA Organized Medical Staff Section on the effects of hospital mergers on medical staff organizations and the practices of individual members of the medical staff. The survey included in-depth telephone interviews with chiefs of staff in 30 hospitals across the United States that merged between 1993 and 1995. The chiefs of staff identified several benefits of mergers, including: an increase in the number of specialty departments; physicians' exposure to different points of view and methods; a more positive financial outlook; increased attractiveness to managed care programs; greater efficiency of operations; and improved quality of services.

However, most chiefs of staff also reported drawbacks. For example, in the few hospitals where the mergers were announced only after they were completed, some staff members were concerned that physicians and hospital administrators were placed in adversarial roles. Medical staffs were less likely to trust administrators if mergers were done in secrecy or if layoffs were involved. Physical distance between campuses also caused some communication and logistical problems. In addition, consolidation of services meant or could mean the deterioration of the physician/patient ratio, and physicians had lost or were likely to lose leverage with and have their practices more closely controlled by the hospital. Moreover, some physicians had been or could be shut out entirely if one hospital became "the only game in town."

The medical staffs were consolidated in 17 of the 21 mergers. In 11 cases, the new medical staff included all of the members of the former hospitals' staffs. In four situations, the staffs were merged, but physicians who did not have clinical privileges at both hospitals had to apply for those privileges at the newly merged hospitals, in some cases working under a new credentialing process. In one hospital, the new medical staff bylaws required that all physicians reapply, and all were accepted onto the medical staff. In another instance, where four hospitals merged, a new medical staff organization was created. This staff consolidation resulted in the elimination of some members of the medical staff. In four of the mergers, the medical staffs were not consolidated, and all of the physicians retained their clinical privileges.

Most of the respondents reported that some clinical departments were consolidated and/or closed as a result of the merger. Of the 15 respondents who reported closings and/or consolidations of clinical departments, most felt that these situations had or would have very little or no effect on referring physicians. Three reported situations where physicians were inconvenienced, two noted positive effects on physicians, and one was as yet uncertain about the effects. However, nine chiefs of staff saw some effects of closings and/or consolidations on specialists. Some specialists left the hospitals and others were inconvenienced by changes in location. In three instances, physicians working for a professional corporation with an exclusive contract were not necessarily offered a position at the newly merged hospital but, in all cases, this situation was discussed with the physicians prior to the merger.

An assessment of the early impact of hospital mergers in St. Louis and Philadelphia by Wicks et al. (1998) found that mergers had not yet caused fundamental changes in terms of the consolidation of specialized services. However, some of the hospital systems were making efforts to "integrate cultures," that is, to promote discussions among physicians, paving the way to integrating services in the future. There was some development of system-wide medical information systems, and some efforts to develop medical protocols and guidelines to improve the quality of care. One Philadelphia hospital system had closed two hospitals that were deemed inefficient and redundant to capacity elsewhere in their system. This system had consolidated several types of health services previously provided in three major hospitals--including obstetrics, behavioral health, and psychiatry--into one of these hospitals. Some consolidation of these services also was occurring in St. Louis. There were plans within various systems to consolidate some clinical services in other areas such as cardiology. However, a number of the hospital system leaders interviewed indicated that this type of consolidation, while desirable in theory, is very difficult to achieve in practice, particularly among senior medical staff.

In discussing trends in health care sector consolidations, Magel (1999) observed that for many physicians, consolidation contributes to the ongoing erosion of autonomy and control that has accompanied the growth of managed care. The economic incentives that drive some managed care companies to discourage physicians from performing certain costly services and encourage them to perform “higher margin” services also exist for health care conglomerates. If the mix of services offered and the resources invested for growth gravitate toward those areas of patient care that are most profitable for the consolidated system, physicians will likely experience an erosion in their clinical autonomy. In addition, services and service delivery policies may become more standardized through the implementation of “best practices” guidelines as consolidated systems seek to ensure quality of care, reduce costs, streamline production, and gain more control. In terms of professional development and patient care, larger delivery systems can, according to Magel, provide increased access to the latest technologies, consultative services, and continuing medical education.

Weil et al. (1998) noted that with mergers and capitated payment that includes selected panels of doctors, some physician eventually will be virtually excluded from obtaining sufficient patient revenues within a specific community. However, in examining the impact of a proposed merger between the only two hospitals in the greater Lafayette, Indiana, area on a multi-specialty clinic, Brown et al. (1998) asserted that hospital mergers can benefit group practices. They found that most physicians in the community had come to view the merger as promoting Lafayette as a regional medical center, leading to a broadened patient base with its associated greater challenges and enhanced job security. Well-trained young physicians in primary care and in the subspecialties also were increasingly drawn to Lafayette as a regional health center. The authors concluded that while some had voiced concerns over the change from a two- to a one-hospital system, particularly in the area of patient and physician choice, the majority had embraced the change as the best way to ensure the maximum of choice in the long-term.

While, ideally, members of the medical staff are involved and representing physicians’ interests as hospitals determine the most prudent course for their survival, Johnson (1997) provided the following suggestions for individual physicians to maximize their position in the event of a hospital merger:

- Learn all you can about the hospital’s strategic planning process. High levels of stress and anxiety may be rampant among hospital employees, and this can breed a lot of misinformation. Get your information directly from the people in a position to know what is going on, then evaluate how the plans will affect you directly. After you have the facts about decisions made versus options under consideration, make your position known in a rational, constructive way.
- Review all of your contractual and legal obligations with the hospital. For example, does your contract include a “no compete” clause? Assess the possible consequences of merger or affiliation activity to your practice, and how much bargaining power you have. Enlist the aid of your attorney and your county and state medical societies.
- Make your practice as efficient as it can possibly be. Get expert help to evaluate where you and your staff can improve options.
- Keep up to date with developments in your field. Make sure your curriculae vitae is current, including the one on file in the medical staff office.
- Keep a record of your services to the hospital and the community. Know the contributions you have made that go beyond your technical competence. Make sure you personally know some of the key community leaders and hospital board members.
- Give serious thought about where you want to be five years from now. Based on what you know about the changing market, does it make sense to bring on another partner?
- If possible, become actively involved in at least one key issue within the hospital. Although the last thing you need is more meetings to attend, the only way to influence change is to be involved. So pick your issue and committee carefully--know which one provides real opportunity for you to have a positive impact on something which concerns you personally.

- Hone your management skills by learning effective techniques for negotiating, resolving conflicts, and running effective meetings--skills you may need if you find yourself in a hospital merger or affiliation situation.
- Learn about the economies of managed care so that you can help guide your practice and hospital through these murky waters.

In addition, Blumenthal et al. (2000) detected no measurable adverse effects of change in ownership on the teaching, research, and indigent care at three academic health center hospitals.

While no studies were found on the impact of hospital break-ups on hospital-based physicians or otherwise, Kastor (2001) and Drazen et al. (1998) identified some of the factors that may contribute to the dissolution of hospital systems. Kastor analyzed three mergers of teaching hospitals--the Massachusetts General and Brigham and Women's hospitals in Boston; the Presbyterian and New York hospitals in New York City; and the teaching hospitals of the University of California, San Francisco and Stanford University. As previously mentioned, UCSF Stanford broke apart just 23 months after coming together in 1997. Kastor concluded that as much money can be spent as can be saved in combining hospital functions; domination of managed care remains an unproven accomplishment supported only by anecdotal data; and combining clinical services for the most part is an unrealized goal. He cited the peculiar character of the institutions he studied as one possible reason why they experienced such problems, why one failed, and why so many of the chief executive officers associated with the mergers lost their jobs. The many constituencies and purposes of academic medical centers make them exceedingly difficult to manage.

Drazen et al. observed that reasons for failed mergers in the healthcare industry can be found in four critical dimensions of integration: structural, operational, clinical, and informational. To achieve structural integration, for example, which involves integrating governance and organizational strategies, the authors advised proceeding with the merger slowly and involving constituencies from both organizations in early planning processes. In the event that the merger does fail, they noted that measures taken prior to the merger, such as including an escape clause in the merger contract, could help avoid problems in dividing operational assets, physician practices, and information assets. However, it should be noted that some consultants and senior hospital administrators caution against leaving a "trap door" in hospital transactions. They assert that if a hospital has doubts about whether or not a merger is the right step to take, neither institution should proceed with the transaction in the first place.

Finally, in preparing this report, the Council sought information on the impact of hospital mergers and the break-up of such mergers on physicians from a number of national medical specialty societies. However, only the College of American Pathologists (CAP) had more than anecdotal information from its members specifically regarding this issue. In particular, data from the CAP Year 2000 Practice Characteristics Survey Report indicated that the single most important reason for a merger with other pathology or multi-specialty groups was the merger of a hospital. Among pathologists involved in a group merger between 1998 and 2000, 48% reported that a hospital merger was the single most important reason for the merger, compared with 41% in 1998, 50% in 1996, and 31% in 1994. However, there has been a significant decrease in the number of pathologists reporting practice mergers--8% in 2000, 13% in 1998, 12% in 1996, and 4% in 1994.

AMA POLICY

The AMA has established several policies related to hospital mergers and hospital-based physicians (Policies H-220.937, H-235.991, H-420.959, H-295.885, H-383.997, H-215.979, and H-225.997, AMA Policy Database). In particular, Policy H-220.937 states that hospital medical staffs should be actively involved in at least the following activities at the onset of and during a merger: (a) defining the role and structure of the medical staff(s), (b) development and approval of medical staff bylaws, rules, policies, and regulations, (c) defining and approving credentialing processes, (d) quality improvement, peer and utilization review activities, (e) decisions regarding clinical services to be offered by the institutions, and (f) all decisions pertaining to the delivery of and access to medical services. Policy H-235.991 affirms that medical staff bylaws should contain a successor-in-interest provision to protect medical staffs from a hospital ignoring the medical staff bylaws and establishing new bylaws to apply post-merger. Policy H-383.997 outlines principles for agreements between hospitals and hospital-based physicians.

DISCUSSION

The hospital “merger mania” of the mid- to late-1990s appears to have run its course, and the break-ups of several high-profile mergers likely played a role in this waning enthusiasm. As detailed in this report, a review of the literature indicates that hospital mergers can impact physicians both positively and negatively. In particular, the consolidation and closure of clinical departments and the termination of contracts following a merger can profoundly affect physicians, both clinically and financially. While every merger situation is unique, how mergers impact physicians may depend at least in part on when and to what degree physicians become involved in the merger process; the relationship between the medical staff and hospital administrators; and the degree of similarity and physical distance between the merging entities. The literature also suggests that, despite the difficulties in doing so, varying degrees of clinical consolidation have been attained as a result of hospital mergers.

Consistent with the literature and AMA policy, the Council strongly believes that physicians should play a significant role at the onset of and during the merger process. As a result, the Council believes that there is merit in augmenting current AMA policy with new policy. Specifically, in the event of a hospital merger, the Council believes that a joint committee with merging medical staffs should be established to resolve any differences regarding organizational structure, medical staff bylaws, credentialing processes, quality improvement, utilization and peer review activities, and other medical staff functions. The Council also notes that hospital administrators should pay special attention to establishing open communication and involvement of hospital-based physicians, who may be particularly vulnerable to change as a result of a merger. In addition, the Council believes that individual physicians should follow the steps previously outlined in this report to maximize their position in the event of a merger. Finally, the Council believes that the numerous AMA resources regarding hospital mergers and break-ups, including this and Council on Medical Service Report 7-I-00, as well as the other AMA resources highlighted in the latter report, should be made available in one location on the AMA web site to assist physicians seeking guidance on this issue.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That it is the policy of our American Medical Association that, in the event of a hospital merger, acquisition, consolidation, or affiliation, a joint committee with merging medical staffs should be established to resolve at least the following issues: (a) medical staff representation on the board of directors; (b) clinical services to be offered by the institutions; (c) process for approving and amending medical staff bylaws; (d) selection of the medical staff officers, medical executive committee, and clinical department chairs; (e) credentialing and recredentialing of physicians and limited licensed providers; (f) quality improvement; (g) utilization and peer review activities; (h) presence of exclusive contracts for physician services and their impact on physicians’ clinical privileges; (i) conflict resolution mechanisms; and (j) the role, if any, of medical directors and physicians in joint ventures; (k) control of medical staff funds; (l) successor-in-interest rights; and (m) that the medical staff bylaws be viewed as binding contracts between the medical staffs and the hospitals.
2. That AMA resources regarding hospital mergers, acquisitions, consolidations, affiliations, and break-ups be made available in one location on the AMA web site to assist physicians seeking guidance on this issue.

(References pertaining to Report 4 of the Council on Medical Service are available from the AMA Division of Socioeconomic Policy Development.)

5. CRITERIA FOR LEVEL OF CARE STATUS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED

At the 2000 Interim Meeting, the House of Delegates adopted Resolution 707 as amended, which called for the AMA to study “the problem of variation in designation of level of care status (ambulatory, observation versus inpatient), by insurance companies, managed care companies, and the Health Care Financing Administration” (now the Centers for Medicare and Medicaid Services); as well as “the feasibility of working with appropriate

associations and agencies to develop a uniform, evidence-based, clinical criteria for designation of level of care status.” The Board of Trustees transmitted amended Resolution 707 (I-00) to the Council on Medical Service for study and report back to the House at the 2001 Interim Meeting.

In order to ascertain the scope and nature of the problem caused by variation in level of care status, and to better determine whether there currently exist criteria that physicians would likely support, the Council reviewed comments provided by the original author of Resolution 707 (I-00), Stephen House, MD. In addition, the Council considered the comments received from members of the Physician Consortium for Performance Improvement in response to several questions relating to level of care status. The Consortium is a physician-led initiative convened by the AMA that includes representatives from more than 50 national medical specialty societies and 15 clinical and methodological experts for the purpose of developing performance measures and measurement resources for physicians. The Council greatly appreciates the input of Dr. House and the Consortium members who responded to questions on this issue.

The following report provides an overview of the scope of the problem, highlights relevant AMA policy, summarizes proprietary level of care criteria that are currently in use, and provides several policy recommendations.

SCOPE OF THE PROBLEM

Variation in level of care status can be problematic for physicians because assigning a level of care that varies from that of the patient’s health plan must subsequently be defended on grounds that the chosen level of care was medically necessary. In addition, with many health plans using various proprietary “black box” criteria for level of care status, physicians may be unaware that there may be administrative reasons for selecting another level of care, which may be justifiable and appropriate under the clinical circumstances. As such, some physicians have reportedly been subjected to reprimands from hospital administrators for assigning levels of care that are subsequently disputed by health plans.

However, based on comments received by members of the Physician Consortium for Performance Improvement, the Council believes it is difficult to determine the actual scope of the problem. For example, among the comments received by Consortium members were at least two references to the lack of concern about level of care. One member from a large physician specialty organization stated that concern about level of care status has not been “on our radar screen at all, we haven’t heard from a single member that it’s a concern.” Similarly, another Consortium member reported that in nine years as a health plan administrator, there had been no more than four inquiries regarding level of care status. Furthermore, at least three Consortium members, who otherwise did not respond, merely commented that they did not understand the concern reflected in the survey.

Nonetheless, although the frequency of level of care challenges may be low, the Council is concerned that when such challenges do occur, they have the potential to disrupt the patient-physician relationship, and they require physicians to engage in an effort to retrospectively justify their medical judgment.

AMA POLICY

Because variation in level of care status can result in the medical necessity decisions made by physicians being questioned and undermined, the Council believes the AMA definition of medical necessity (Policy H-320.953, AMA Policy Database) is particularly relevant. The AMA defines medical necessity as “health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is: (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and (c) not primarily for the convenience of the patient, physician, or other health care provider.” Consistent with this definition, the Council believes that physicians must continue to abide by their own medical judgement regardless of the health plan’s notion of appropriate level of care.

Although AMA policy lacks specific references to criteria for determining level of care status, there is relevant policy with regard to medical review that addresses many of the underlying concerns expressed by Resolution 707 (I-00). For example, Policy H-320.948 states that when a health plan or utilization review organization makes a determination to retrospectively deny payment for a medical service, or down-code such a service, the physician rendering the service, as well as the patient who received the service, shall receive written notification in a timely manner that includes: (1) the principal reason(s) for the determination; (2) the clinical rationale used in making the determination; and (3) a statement describing the process for appeal.

In addition, long-standing AMA Policy 320.968[2] supports efforts to increase payor accountability in the use of medical review criteria, including requiring private review entities and payors to disclose to physicians on request the screening criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed; requiring that any physician who recommends a denial as to the medical necessity of services be of the same specialty as the practitioner who provided the services; and requiring that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed.

EXISTING LEVEL OF CARE CRITERIA

The preamble of Resolution 707 (I-00) implies a preference for the level of care criteria developed by InterQual, which is used to process Medicare claims. The preamble further suggests that the level of care criteria used by Medicare carriers could be adopted as an all-payor standard, thus decreasing confusion and hassle factors, while assuring “appropriate reimbursement for rendered covered services.” According to information available on InterQual’s Web site, InterQual criteria are used not only for Medicare claims, but also by more than 900 licensed health plans, and major indemnity insurers, including Blue Cross and Blue Shield plans, self-insured organizations, state funds, the Department of Defense, and the Department of Veterans Affairs.

InterQual reports that its criteria are developed with input from a national panel of generalist and specialist physicians from academic and community-based practice, working both within and outside the managed care industry. InterQual staff physicians and nurses develop initial drafts of the criteria, which are then reviewed and revised by physicians and other health care professionals with expertise relevant to the particular subject. Currently, InterQual offers the following proprietary criteria for levels of care:

- Acute Level of Care Adult & Pediatric
- Rehabilitation Levels of Care Adult
- Subacute & Skilled Nursing Facility Levels of Care Adult
- Home Care Adult & Pediatric
- Behavioral Health Level of Care

“Milliman & Robertson (M&R) Care Guidelines” contain proprietary criteria for the assessment of health care delivery, although the level of care criteria are embedded in more general guidelines, such as the “Pediatric Care” or “Inpatient and Surgical Care” guidelines. Consistent with AMA Policy H-320.948[1, 2] regarding the principal reason and clinical rationale for health plan denials, M&R’s publications specifically state that “when the M&R Care Guidelines are cited to the provider in the context of a denial notice, that notice must contain reasons for denial, including an easily understood summary of the applicable utilization management decision criteria from the Guideline used. It must also include how the guideline cited is applied to the specific patient’s condition. When a payor adopts this approach, both the provider and the patient are able to understand fully the rationale for the healthcare organization’s decision.” M&R documents go on to state that “anyone who uses the Guidelines as the sole basis for denying authorization for treatment without proper consideration of the unique characteristics of each patient or as the sole basis for denying payment for treatment received is using our Guidelines inappropriately.” In fact, current AMA policy states that the AMA formally rejects the M&R guidelines as a clinical standard of care (Policy H-410.963).

Furthermore, the Council believes guidelines such as those developed by InterQual and M&R must explicitly allow for physician autonomy in making responsible medical decisions. The assessment of information found in a claim, or even the medical record, after the fact, regardless of the expertise and training of the reviewer, can never capture the exact circumstances faced by the treating physician.

DEVELOPMENT OF UNIFORM CRITERIA FOR LEVEL OF CARE STATUS

Regardless of an implied preference for InterQual criteria relative to other proprietary options, Resolution 707 (I-00) calls for the AMA to “study the feasibility of working with appropriate associations and agencies to develop a single, evidence-based, clinical national standard for designation of level of care status,” suggesting that the ideal criteria would be developed with significant input from the AMA. The Council believes that an undertaking on the scale of developing level of care criteria would be very expensive for the AMA. In addition, the Council believes that even if all health plans used one standard for level of care status, and even if that one standard were to be developed by the AMA, physicians would still be obligated to assign the level of care they thought was indicated for a given patient under a given set of conditions, and physicians’ designations of level of care might frequently vary from the standard designation. Therefore, the Council believes that regardless of the standard, reasonable minds may disagree on the appropriate designation of level of care.

The Consortium members were asked to assess the importance of third party payors using uniform standards for the designation of level of care status, and whether there are clinical implications of such variation. The majority felt uniformity in level of care designation is desirable. One respondent said that most payors probably think they are operating under a uniform system currently, and another noted under a different question that there are essentially two sets of standards: InterQual or M&R.

The Consortium members shared a complex and rich understanding of whether there are valid clinical reasons for variation in the level of care status within disease or condition categories. For example, one Consortium member stated that level of care guidelines “should incorporate sensitive, specific, reliable and valid risk adjustment methods, to tie an individual patient’s severity of illness to ‘standard’ intensity of services.” In addition, Consortium members generally felt there were not valid clinical reasons for variation in the level of care status between various third party payors. It was noted that there are conditions, unrelated to a given patient’s coverage, which would vary level of care status, such as age, geographic region, and comorbidities.

Regarding the likelihood of third party payors agreeing to uniform clinical criteria for designation of level of care status, the Consortium members were less in agreement. Some felt payors would embrace uniformity, as they have done with review criteria. Others felt that payors were unlikely to work toward uniformity due to the proprietary nature of standards usage. Regardless of whether they support the development or use of uniform standards for level of care, those Consortium members who spoke to the feasibility of developing such standards concurred with the assessment that such an undertaking would consume enormous financial and human resources.

DISCUSSION

Given the potentially prohibitive resource demands that would be involved in developing a single national standard for level of care status, combined with the apparent low frequency of instances where level of care designation disputes are unresolved, the Council does not believe the AMA should undertake the goal of developing such standards.

Nevertheless, in order to reduce instances when physician judgement is challenged by health plan administrators, the Council believes there is merit in advocating policy to support the development and use of level of care status criteria that are consistent with the underlying concerns of Resolution 707 (I-00). Accordingly, consistent with AMA policy related to medical review generally, the Council supports several recommendations with regard to level of care status, some of which incorporate comments expressed by members of the Consortium and the author of Resolution 707 (I-00).

The Council also believes that private sector accrediting organizations should be encouraged to adopt accreditation standards that are consistent with the AMA criteria for the development and use of level of care guidelines. In addition, the Council believes that hospitals should strive to maintain a uniform standard regarding level of care status in all their various third party payor contracts.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association support the development and use of level of care guidelines that meet the following criteria:
 - (a) Level of care guidelines should function as guidelines only, and should not be used as requirements for all instances and cases. That is, level of care guidelines must allow for appropriate physician autonomy in making responsible medical decisions.
 - (b) Level of care guidelines should acknowledge the complexity of care for each patient under the particular set of clinical circumstances.
 - (c) Level of care guidelines should apply to all facility support systems so that patients are not assigned a level of care that slows or stalls their treatment.
 - (d) Level of care guidelines should be developed under the direction of actively practicing physicians.
 - (e) Level of care guidelines should be developed based on individual patient severity of illness and intensity of service.
 - (f) Level of care guidelines should be validated through standard data quality control checks and professional advisory consensus.
 - (g) Level of care guidelines should be reviewed and updated periodically.
 - (h) Level of care guidelines should allow for a timely appeal process.
2. That it is the policy of our AMA that private sector accrediting organizations, where applicable, should adopt standards that are consistent with AMA criteria for the development and use of level of care status guidelines.
3. That our AMA urge the American Hospital Association to encourage hospitals to work with the medical staff toward the use of a uniform standard for level of care status in all their payor contracts.
4. That our AMA work with the Centers for Medicare and Medicaid Services to eliminate the use of "inpatient only" criteria, which is currently a part of the Ambulatory Payment Classification (APC) implementation of the Outpatient Prospective Payment System (OPPS).

6. INAPPROPRIATE BUNDLING OF MEDICAL SERVICES BY THIRD PARTY PAYORS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

At the 2000 Interim Meeting, the House of Delegates adopted Resolution 813, which calls for the AMA to study the problems associated with inappropriate bundling of medical services, including the bundling of preoperative assessment in making the decision for surgery with the procedure, and to present a report with potential solutions, including an analysis of legislative, judicial, and regulatory remedies.

The Council believes it bears acknowledging that the issue of third party payor bundling has been identified as a high priority issue for the AMA by both member and non-member physicians. The 2001 AMA Initiatives Survey, which was completed by 730 practicing physicians who were representative of the physician population, asked respondents to rank the importance of 20 policy development and advocacy initiatives. The results of the survey indicate that the issue of downcoding and bundling of claims ranked second only to the issue of payment delays and

denials in terms of its impact on physicians and their practices, impact on the perception that the AMA addresses issues on which it is best suited to lead, and impact on the decision whether to become or remain a member of the AMA. The 2001 AMA Initiatives Survey, the third such annual survey, was conducted between May and July 2001.

The following report summarizes several recent reports of the Board of Trustees and Council on Medical Service on issues related to inappropriate third party treatment of claims for payment of medical services; highlights AMA policy; summarizes the results of a Member Connect survey regarding the incidence of inappropriate bundling; identifies numerous solutions that can be taken by the AMA, state medical associations, and individual physicians; and presents several proactive advocacy-oriented recommendations.

BACKGROUND

The preponderance of testimony at the 2000 Interim Meeting regarding Resolution 813 indicated problems with particular payors not recognizing modifiers or inappropriately bundling preoperative assessment of the decision for surgery with the surgical procedure. The Council notes that Board of Trustees Report 6-A-01 discussed the policy developed by the Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Administration) to address the practice of some Medicare carriers not paying for preoperative screening examinations based on the erroneous view that such examinations constitute uncovered “screening” exams. Although the new preoperative screening policy pertains to Medicare payment practices specifically, it is quite possible that other payors will follow suit.

Testimony on Resolution 813 (I-00) also noted the AMA’s success in having Current Procedural Terminology (CPT) named as the code set under the Health Insurance Portability and Accountability Act (HIPAA), but that the CPT guidelines were not adopted as a part of HIPAA. These facts were addressed in Council on Medical Service Report 2-A-01, which reviewed existing standards for coding and payment of multiple and bilateral services; discussed CPT coding guidelines; examined Medicare and private payor policies on multiple and bilateral services; and reviewed related AMA private sector advocacy efforts. In addition, Council on Medical Service Report 5-I-00 studied managed care retrospective payment denials or down-coding of claims, and summarized the results of an AMA online survey, which showed that 43% of the physicians surveyed had more than 10% of their claims retrospectively denied, and 39% reported they had more than 10% of their claims down-coded.

AMA POLICY

AMA policy on inappropriate bundling is clear and unequivocal. Policy H-70.949 (AMA Policy Database), which the House of Delegates reaffirmed at the 2001 Annual Meeting, calls on the AMA to take steps to ensure that public and private payors do not bundle services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines.

Additionally, Policy H-70.937 calls for the AMA to (1) vigorously oppose unilateral, arbitrary recoding and/or bundling by all payors; (2) make it a priority to establish national standards for the appropriate use of CPT codes, guidelines, and modifiers and to advocate the adoption of these standards; (3) formulate a national policy for intervention with carriers or payors who use unreasonable business practices to unilaterally recode or inappropriately bundle physician services; and (4) support legislation to accomplish this; and along with medical specialty societies, calls on its members to identify to the AMA specific CPT code bundling problems by payors in their area and that the AMA develop a mechanism for assisting our members in dealing with these problems with payors.

PROBLEMS ASSOCIATED WITH INAPPROPRIATE BUNDLING

In order to elicit a broader array of possible problems associated with third party payor bundling, the Council assisted in the design of an AMA “Member Connect” online survey to address this issue. In April 2001, the survey was e-mailed to approximately 1,750 Member Connect registrants, all of whom are AMA members, and generated 605 responses. The survey responses provided a rich enumeration of problems associated with inappropriate bundling, as well as a chronicle of suggested solutions to bundling.

Respondents were asked what percentage of claims were bundled, in the 12 months preceding the survey (April 2000-April 2001), for each of the following five key modifiers:

- Modifier -25, which indicates an evaluation and management service was performed on the same date as a procedure or other service;
- Modifier -51, which indicates multiple surgical procedures performed during the same session by the same physician;
- Modifier -50, which indicates a bilateral procedure performed during one operative session;
- Modifier -57, which indicates an evaluation and management visit that leads to a decision to perform surgery; and
- Modifier -59, which indicates a procedure or service performed on the same date as another procedure or service with which it is not normally reported, but was appropriate under the clinical circumstances.

During the 12 months preceding the survey, half of physicians had 10% or more of their submitted claims bundled by an insurer, with a third of those physicians having 20% or more bundled for an evaluation and management service performed on the same date as a surgical procedure or for multiple surgical procedures performed in the same session by the same physician. Also in the year prior to the survey, almost two-fifths of physicians had 10% or more of their submitted claims bundled by an insurer, with one-fifth or more of those physicians having 20% or more bundled for a bilateral procedure performed during one operative session, for an evaluation and management visit that led to a decision to perform surgery, or for a procedure or service performed on the same date as another procedure or service to which it is not normally reported, but was appropriate under the clinical circumstances.

Physicians also were asked about the incidence of Medicare and/or Medicaid bundling claims for the five services or procedures represented by the Modifiers -25, -50, -51, -57, and -59. Approximately two-thirds of physicians indicated that Medicare, and more than half of physicians reported that Medicaid, bundles claims for evaluation and management services performed on the same date as a surgical procedure or for multiple surgical procedures performed in the same session by the same physician. More than half of physicians indicated that Medicare, and more than two-fifths of physicians indicated that Medicaid, bundles claims for a bilateral procedure performed during one operative session, for an evaluation and management visit that led to a decision to perform surgery, or for a procedure or service performed on the same date as another procedure or service with which it is not normally reported, but was appropriate under the clinical circumstances.

The Member Connect survey also asked about the success of appealing a third party payor's decision to bundle claims. During the 12 months preceding the survey, of the claims that were bundled, a fourth of physicians indicated that they were unable to receive appropriate payment by appealing claims, half indicated that they have been able to receive appropriate payment for 1-19% of bundled claims, and a fourth indicated that they have been able to receive appropriate payment for 20% or more of bundled claims.

According to the survey, payors are not forthright in communicating their payment policies. Only 1% of respondents said that all payors inform them of their practices for bundling or provide them an explanation of their policies, while 45% said that some payors do so, and 54% reported that payors do not make their policies known.

The Council is particularly troubled by results indicating that many physicians have simply given up on trying to bill for the medical services they provide. A majority (58%) of physicians indicated that there are services or procedures that they no longer submit claims for because they know they will not receive payment. In a follow-up question to those who said they have stopped submitting claims, respondents indicated that they no longer submit claims for the following services and procedures: any second abdominal surgery code that would require a modifier; any visit while a patient is pregnant; any excision of skin lesions done during an E&M visit; allergy injections at the same time as an office visit; chondroplasty; and meniscal debridement.

The responses indicated that the reluctance to submit claims that are likely to be denied has an adverse impact on patients. Several respondents noted that they simply try not to provide more than one service in one day, even if doing so would be prudent, because of the high rate of denial when using the appropriate modifiers.

POTENTIAL SOLUTIONS

The Member Connect survey asked respondents to note any remedies or solutions they have found to be effective to address the problem of inappropriate bundling. Some of the responses indicate truly advisable solutions, while other responses can only be thought of as ways in which physicians have learned to cope with relentless abuse. The Council would include the following as “coping mechanisms” identified by physicians: avoiding seeing patients covered by insurers who inappropriately bundle; requiring patients to come back on a different date to perform a surgery; requiring patients to come back on separate days to perform each single injection; and forgoing payment. Such coping mechanisms inconvenience patients as well as the physicians who practice them, and should be avoided in favor solutions that empower physicians and strengthen the patient/physician relationship.

Among the empowering solutions to bundling that the Member Connect respondents identified are the following: coding properly, including correct use of modifiers; receiving training on how to code; appealing every claim that has been inappropriately bundled, sometimes with additional documentation; being persistent; consulting an attorney; contacting the state insurance commissioner; and participating in state medical society class action lawsuits. A description of correct coding, appeals, the AMA Model Managed Care Contract, state medical society class action lawsuits, and other legal and legislative remedies are discussed below.

Correct Coding

Correct coding is critical to the determination of whether third party payor bundling is inappropriate. Only when claims are submitted correctly and CPT guidelines are followed, can bundling by third party payors be considered inappropriate, and become an advocacy issue. The AMA CPT Department provides a number of resources to assist with correct coding. CPT Information Service provides four free coding consultations for AMA members, and is also available by subscription. Information on this service is available by calling (800) 634-6922.

In addition, the following publications are available to help physicians ensure that their claims are coded correctly, and can be purchased by calling AMA Press at (800) 621-8335:

- *CPT Assistant*, a newsletter that provides monthly coding advice, including questions and answers;
- *CPT Changes 2001: An Insider’s View*, which is updated annually and provides an in-depth discussion of each year’s coding changes; and
- *Principles of CPT Coding*, which is a textbook on correct CPT coding.

Appeals

One strategy that the Council finds particularly regrettable, and unacceptable, is evident in the responses of several physicians to the Member Connect survey that indicated that they have grown to accept the lost income for certain services. One such respondent noted that it is poor quality care to not provide the necessary services, so physicians provide the services and simply lose their revenue. Regarding appeals, several respondents to the Member Connect survey noted the expense of filing appeals. As one survey respondent noted, it costs very little for insurers to bundle claims, particularly if such bundling can be accomplished through proprietary software containing so called “black box” edits, which are known only to the insurers who use them. Nevertheless, the Council urges physicians to persist in their efforts to be paid appropriately.

Information Clearinghouse

At the 2001 Annual Meeting, the House of Delegates adopted as amended Resolution 701, which called for the AMA to establish an “information clearinghouse” for physicians to report information about administrative disputes with third party payors. The AMA Private Sector Advocacy Group (PSA) was charged with administering and coordinating this information clearinghouse to guarantee that information would be collected and shared on a regular basis with the Federation in order to identify trends better and to facilitate effective, legally appropriate action by physicians and their representative organizations.

PSA is currently in the process of designing information clearinghouse so physicians will be able to provide detailed information by completing a Health Plan Complaint Form available through the PSA web site. The Council is aware that an increasing number of state medical associations are collecting information on the administrative and other hassles facing physicians by health plans. In fact, a recent PSA survey suggests that nearly 70% of state medical associations have developed data collection devices to collect detailed information on the problems that physicians are facing with private and public payors.

It is anticipated that the PSA site will allow physicians to complete the form online or download and submit it via fax. The Health Plan Complaint Form will include questions related to health plan coding and reimbursement policies, including downcoding and bundling practices, as well as their acceptance of CPT modifiers, and other administrative and payment hassles associated with particular third party payors. Once this information has been collected, the AMA will be able to target health plan practices and work with health insurers to address the seriousness of these issues and secure meaningful changes. PSA also will be able to use the information gathered from the clearinghouse in its continuing efforts to assist the Federation in collecting data on physicians' administrative and payment problems with health plans. Relevant information from the clearinghouse will be posted on the AMA web site on a quarterly basis, as appropriate.

In addition, PSA has developed a document that provides a comprehensive overview of downcoding and bundling of claims, as well as recommended strategies. As noted in the document, PSA is available to help medical associations develop strategies to combat inappropriate bundling. The paper is available on the PSA web site at www.ama-assn.org/ama/pub/category/4354.html. In particular, the document identifies correct coding and claims submission as the most important first step to address inappropriate bundling. The PSA document also describes how PSA can help physicians fight bundling by documenting a pattern of such inappropriate practices in a particular locale with a particular insurer, and by developing the clinical and policy-based reasons to counter the insurers' justification for bundling or downcoding.

AMA Model Managed Care Contract

The AMA's model contract, which physicians can use in their review of health plan agreements, addresses downcoding and bundling of claims, and contains a supplementary section describing how to address these unfair practices. Both the model contract and the supplement are available on the AMA web site at www.ama-assn.org/ama/upload/mm/38/mmcmsa.pdf. The model contract contains language requiring managed care organizations to attach their fee schedules to their agreements with physicians, and provides for a financial obligation of third party payors engaged in bundling. The pertinent section of the model contract, section 3.6, reads as follows:

Section 3.6 Coding for Bills Submitted. Company hereby agrees that claims submitted for services rendered by Medical Services Entity shall be presumed to be coded correctly. Company or Payor may rebut such presumption with evidence that a claim fails to satisfy the standards set forth in Exhibit C. Exhibit C shall include a detailed description of Company's coding standards and requirements, including, but not limited to, the rules on modifiers, multiple surgeries, evaluation and management, and bundling policies such as edits, including correct coding initiatives. Company and Payor shall not adjust the billing codes submitted by Medical Services Entity on a claim without first requesting additional documentation to satisfy the coding standards described in Exhibit C. Company or Payor must provide adequate notice if it wishes to adjust a code and must allow sufficient time for Medical Services Entity to submit additional documentation or explanation. Medical Services Entity shall have the right to appeal any adverse decision regarding the payment of claims based upon the level of coding with rights and duties as set forth in this Agreement. If Company or a Payor reduces payment of a claim in contravention of this section, such party shall be obligated to reimburse Medical Services Entity for the full amount of billed charges for the claim.

The supplement to the model contract recommends several steps physicians should take if they suspect a third party payor is bundling their claims. First, physicians should obtain the appropriate fee schedule information for that payor, and routinely compare the actual payment received with the payment owed according to the fee schedule. The second step recommended in the supplementary model contract document is to ensure that claims are filed correctly. The Council reiterates that all instances of inappropriate bundling should be appealed.

State Medical Association Class Action Lawsuits

Class action lawsuits initiated by state medical associations are becoming increasingly common as physicians grow weary of sustained and often escalating health plan infringements into the arena of medical practice. In February 2001, the Connecticut State Medical Society (CSMS) filed separate class action lawsuits against Aetna, Cigna, Oxford, ConnectiCare, Anthem Blue Cross/Blue Shield and Physicians Health Services, the six largest insurers in Connecticut, and recently added United HealthCare. In August 2001, the Medical Society of the State of New York (MSSNY) also filed six class action lawsuits against Aetna, Cigna, Empire Blue Cross/Blue Shield, Excellus, Oxford and United HealthCare. The class action lawsuits brought by both CSMS and MSSNY allege a number of abuses, including the inappropriate bundling of claims. The AMA has been supportive of the physicians in these state class action lawsuits, including the immediate release of favorable statements to the press, and the involvement of the AMA/State Medical Society Litigation Center as a supportive resource.

Other Legal Remedies

The AMA/State Medical Society Litigation Center also is currently helping plaintiff physicians in the case of *Kaiser v. CIGNA* (Madison County, IL, Cir. Ct). This class action lawsuit alleges that, through the use of ClaimCheck Software, CIGNA improperly bundled and downcoded CPT procedures in order to reduce its payments to physicians. To assist the plaintiffs at the class certification hearing, the AMA's CPT Department submitted an affidavit, which explained to the court that the AMA interpreted CIGNA's software edits differently from the way that CIGNA represented that those edits should be interpreted. The Litigation Center and the plaintiffs' attorneys are discussing how they can optimally collaborate in this and possibly similar lawsuits.

Legislation

The Council notes that existing remedies, including class action lawsuits, though strong and promising actions, require the existence of laws prohibiting inappropriate bundling. As such, the Council believes that model state legislation should be developed to assure that all states have the opportunity to enact appropriate laws.

DISCUSSION

Due to the clarity of existing AMA policy on bundling of claims, combined with the results of the 2001 AMA Initiatives Survey, which indicated that physicians view the issue of downcoding and bundling as very important to their practices and to their perception of the AMA, the Council believes a strong advocacy response is warranted. As such, the Council recommends that AMA activities related to inappropriate bundling be continued, promoted, and amplified. In particular, the Council believes the activities of the Private Sector Advocacy Group, especially those regarding the information clearinghouse, be undertaken with interested state medical associations and national medical specialty societies to secure meaningful change in third party payor coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment.

The Private Sector Advocacy Group should serve as a repository of information and possible actions on behalf of individual physicians. The Council also believes that the AMA should continue to monitor state medical association class action lawsuits, and provide supportive legal and CPT technical resources, as appropriate. Consistent with Policy H-70.949, the Council urges the development of model state legislation, and the enactment of such language in state legislatures.

Physicians who suspect inappropriate bundling should first review their coding and claims submission processes. Very often, simple and correctable coding errors can result in reduced payments. The Council is greatly concerned that the results of the Member Connect survey indicate that many physicians simply forgo billing for services provided because they know they will not be paid. The Council is optimistic that strengthened AMA advocacy, similar to the AMA's ongoing prompt payment campaign, can bring relief to those physicians who continue to serve their patients regardless of whether they believe they will be paid, and to those who are coding correctly but have their claims inappropriately bundled.

Because of its great importance to physicians, AMA activities on inappropriate bundling should be highlighted on the AMA web site and other communication vehicles to assure that physicians are aware of the AMA's advocacy achievements, in addition to providing physicians a means to become involved.

Finally, the Council urges all members to register as participants in Member Connect. This tool allows members to voice their opinions on pertinent issues. In addition to surveying members on inappropriate bundling, Member Connect has solicited member opinion on such issues as Medicare paperwork and hassles, Medicare audits, downcoding of claims and patient protection legislation. Responses to Member Connect surveys can be particularly useful in guiding the development of advocacy initiatives, as well as in highlighting areas where additional policy consideration is required. Only AMA members are able to register for Member Connect, and they may do so simply by calling (800) 337-1599.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association continue to promote its Private Sector Advocacy activities and initiatives associated with the collection of information on third party payor modifier acceptance and inappropriate bundling practices.
2. That our AMA use the data collected as part of its Private Sector Advocacy information clearinghouse to work, in a legally appropriate manner, with interested state medical associations and national medical specialty societies to identify and address inappropriate third party payor coding and reimbursement practices, including inappropriate bundling of services, rejection of CPT modifiers, and denial and delay of payment.
3. That our AMA continue to monitor the class action lawsuits of state medical associations, and provide supportive legal and technical resources, as appropriate.
4. That our AMA develop model state legislation to prohibit third party payors from bundling services inappropriately by encompassing individually coded services under other separately coded services unless specifically addressed in CPT guidelines, or unless a physician has been specifically advised of such bundling practices at the time of entering into a contractual agreement with the physician.
5. That our AMA urge state medical associations to advocate the introduction and enactment of AMA model state legislation on claims bundling by their state legislatures.
6. That our AMA urge physicians who are experiencing problems with health plans to complete the Health Plan Complaint Form available on the AMA Private Sector Advocacy web site.
7. That our AMA highlight its Private Sector Advocacy document on bundling and downcoding, the related section of the AMA Model Managed Care Contract, and its advocacy initiatives on its web site and other communications measures to assure that physicians are aware of the AMA's advocacy on this issue.
8. That our AMA encourage all members to register for participation in AMA Member Connect surveys, in order to voice their concerns on matters of importance to physicians, by calling (800) 337-1599.

7. MEDICARE REVIEW ACTIVITIES

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Since 1997, the Council on Medical Service has presented periodic reports to the House of Delegates on Medicare review activities. These reports have addressed a broad scope of Medicare review activities and updated the House on emergent activities. At the 2000 Interim Meeting, the House adopted the recommendations in Council on Medical Service Report 10, which included an update on the Peer Review Organization (PRO) program, the error-rate and provider education programs conducted by Medicare Integrity Program (MIP) contractors, and the revised Medical Review Progressive Corrective Action procedures for pre- and post-payment audit processes.

The following report includes an update of the PRO program, including the beneficiary complaint process; the Coordination of Benefits (COB) contract under MIP; the Comprehensive Error Rate Testing Program (CERT) program; the Medicare Education and Regulatory Fairness Act (MERFA); and other relevant Medicare review activities.

PEER REVIEW ORGANIZATION PROGRAM

The Centers for Medicare and Medicaid Services (CMS, formerly the Health Care Financing Organization) administers the Peer Review Organization (PRO) program which is designed to monitor and improve utilization and quality of care for Medicare beneficiaries. The program consists of a national network of 53 PROs (also known as Quality Improvement Organizations) responsible for each US state, territory, and the District of Columbia. Each PRO maintains a staff of multi-disciplinary experts whose mission is to ensure the quality, effectiveness, efficiency, and economy of health care services provided to Medicare beneficiaries.

With respect to the Medicare PRO program, CMS plans to award 3-year Seventh cycle PRO contracts beginning in August 2002. CMS expects the goals of the Seventh Statement of Work (SoW) to be similar to the current contracts (Sixth SoW), but there may be changes in the way some PRO work is completed, as well as room for new quality improvement topics. CMS plans to expand the performance measure for acute myocardial infarction; expand the current stroke project to include reducing complications of carotid endarterectomy; and initiate a project on prevention of surgical site infections. In addition, a patient safety monitoring system to identify risk factors and adverse effects of errors will be included in the Seventh contract cycle.

The Beneficiary Complaint Process

The Office of the Inspector General (OIG) issued a report in August 2001 entitled, "The Medicare Beneficiary Complaint Process: A Rusty Safety Valve," which was aimed to assess the beneficiary complaint process. According to the OIG, the process is currently flawed due to its length and confidentiality limitations. CMS previously considered improving the process in 1996 when it convened a Beneficiary Complaint Task Force, which included representatives from the American Medical Association, the American Hospital Association (AHA), various PROs, CMS and the OIG. Current AMA Policy H-340.900 (AMA Policy Database), established by Council on Medical Service Report 1-A-97, urges implementation of a Medicare beneficiary complaint process that meets the information needs of patients, offers appropriate due process for physicians, and maintains confidentiality of review findings. The AMA has long supported efforts to improve the beneficiary complaint process, but has real concerns about the regulatory and punitive overtones in the OIG's report. The report suggests more of a "police-type" role for PROs in the future, and suggests a need to attribute blame and responsibility rather than take the necessary steps to assure that quality issues are properly identified and resolved.

According to the American Health Quality Association (AHQA), the trade association for the PRO industry, PROs investigate thousands of complaints annually, the vast majority of which (approximately 90%) are not substantiated. This means that in the overwhelming majority of cases, a PRO response to a beneficiary complaint indicates that the care provided met professionally recognized standards. When PROs do validate a complaint, most beneficiaries want to know that the problems they encountered have been identified and remedied, and not establish blame. With respect to PRO investigation of beneficiary complaints, the AMA has advocated that PROs adhere to the following principles: (1) physicians should be provided with the fundamental principles of fairness and due process throughout PRO proceedings; (2) all appeal mechanisms available to physicians should be exhausted before PROs disclose their decisions to beneficiaries; (3) the language used in PRO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and (4) PROs should be required to receive affirmative physician consent before patients are notified of PRO review determinations (Policy H-340.901).

In response to a suit filed by consumer advocacy group Public Citizen on behalf of a consumer who wished to learn the complete results of an investigation, a federal court ruled in July 2001 that the findings of such investigations could be open to Medicare patients and their families. US District Judge Ellen Huvelle ordered Medicare officials to disclose the results of all cases in which a patient or family member has complained of medical mistakes or poor care. The ruling overturned a policy that for more than two decades has prevented Medicare beneficiaries from obtaining data on physicians. Previously, the Clinton and Bush administrations have defended the policy, saying confidentiality was essential to the peer review process by which physicians evaluate one another. Judge Huvelle rejected that argument, finding it was contrary to the intent of federal Medicare statute.

When a Medicare patient complains of substandard care, the complaint is investigated by a PRO, which acts as an agent for the government. Federal rules allow treating physicians who are the subject of such complaints to block the disclosure of information that would identify them. The government maintains that the reviewing doctors must be free to evaluate their peers honestly, “without fear that the proceedings might later be used” in a malpractice suit against the treating physician.

Judge Huvelle ruled that the regulations and the corresponding PRO manual were “contrary to law.” Under federal Medicare law, she stated that a beneficiary who files a complaint is entitled to know the “final disposition,” regardless of whether physicians give their consent. The judge ordered the Department of Health and Human Services (HHS) to send a letter to PROs within 20 days, informing them they must disclose the results of investigations to beneficiaries who file complaints. CMS initial request to stay the judge’s order was denied, but granted on appeal in September 2001. At the time this report was written, CMS was deciding whether to appeal the underlying decision, which could take as long as a year to file.

Industry Response

Since the District Court ruling, the AHQA, AHA, and AMA have each issued statements raising concerns with the court ruling. AHQA stated that the Medicare complaint program should be “made more responsive and accountable to beneficiaries,” and that CMS must strike a new balance if the court order goes into effect. AHQA feels PROs must provide greater disclosure to a complainant when quality falls below the level of professionally recognized care, while simultaneously working cooperatively with physicians to constantly improve quality for all beneficiaries. AHQA noted the value of collaborative clinical improvement projects undertaken over the past several years by hospitals, physicians, and PROs, in part due to the trust between PROs and physicians. AHQA remarked that this trust “can potentially suffer” as a result of Judge Huvelle’s ruling, which serves to increase the tension “between the interest of individuals who seek full disclosure of complaint investigation findings” and the public’s interest in encouraging physicians “to provide confidential data about quality problems.”

The AHA expressed serious concern that release of PRO information would adversely affect the integrity and effectiveness of the PRO process. The AHA noted that the peer review process only works if physicians are willing to “review individual practitioner behavior, engage in discussions aimed at uncovering safety or quality issues, and work together to craft corrective action plans and prospective policies to improve quality and patient safety.” Therefore, it is essential that physicians are in a position to engage in “completely frank and candid exchanges.” Without the protection of a medical review privilege, the AHA argued that “physicians are unlikely to participate in meaningful peer review, or worse, may participate in a manner that is ineffective in promoting quality, or that hinders substantially the ability to weed out incompetent practitioners.” The AHA believes that this interest outweighs any countervailing interest of any individual in access to the information.

The AMA also expressed apprehension that the ruling could compromise efforts to get at health care problems. An important key to improving the quality of care is to create an environment in which physicians feel comfortable discussing incidents of substandard care and the reasons behind them. The AMA expressed its concern that full disclosure from peer review investigations “jeopardizes current efforts aimed at improving the quality of care.”

MEDICARE INTEGRITY PROGRAM

In another step designed to further its campaign against Medicare waste, fraud, and abuse under the Medicare Integrity Program (MIP), CMS awarded a Coordination of Benefits (COB) contract to GHI Medicare of New York. The COB contract is intended to consolidate the activities that support the collection, management, and reporting of insurance coverage of beneficiaries. All Medicare Secondary Payer (MSP) claims investigations will be initiated from, and researched at, the COB contractor and will no longer be a function of local Medicare carriers or fiscal intermediaries. The goals for implementing this single-source development approach is to greatly reduce the amount of duplicate MSP investigations. This will offer a centralized one-stop customer service approach for all MSP-related inquiries, including those seeking general MSP information, but not those related to specific claims or recoveries that serve to protect the Medicare Trust Fund. GHI Medicare will provide customer service to all callers from any source, including beneficiaries, employers, insurers, providers, suppliers, and attorneys or other beneficiary representatives.

The term “Medicare Secondary Payer” generally refers to when Medicare is not responsible for paying a claim first. The COB contractor will use a variety of methods and programs to identify situations in which beneficiaries have other health insurance that is primary to Medicare, including an initial enrollment questionnaire, a MSP claims investigation, and a voluntary MSP data match. In such situations, the other health plan has the legal obligation to meet the beneficiary’s expenses before Medicare. The goal of MSP information gathering and investigation is to identify MSP situations quickly and accurately, thus ensuring correct payments by the responsible party. Physicians may well benefit from lower administrative claims costs, and through enhanced customer service to their patients. In addition, the COB contractor will be the sole authority in ensuring the accuracy and integrity of the MSP information contained in CMS’ database (i.e., Common Working File).

COMPREHENSIVE ERROR RATE TESTING PROGRAM

In order to improve the processing and medical decision making involved with payment of Medicare claims, CMS began a new program in 2000 called the Comprehensive Error Rate Testing Program (CERT). Under CERT, an independent contractor (DynCorp of Virginia) selects a random sample of claims processed by each Medicare contractor. DynCorp’s medical review staff will then verify the contractor’s decisions regarding the claims were accurate and based on sound policy. CMS will use the DynCorp findings to determine the underlying reasons for errors in claims payments or denials, and to implement appropriate corrective actions aimed toward improvements in the accuracy of claims and systems of claims processing.

Eventually, all Medicare contractors will undergo CERT review by DynCorp. DynCorp will request a small sample of claims (approximately 200) on a monthly basis as they are entered into their system. DynCorp will follow the claims until they are adjudicated, and then compare the contractor’s final claims decision with its own. Identified cases of incorrect processing (e.g., due to questions of medical necessity, inappropriate application of medical review policy) become targets for correction or improvement. Providers and suppliers of the sampled claims will be asked to provide additional information (e.g., medical records, certificates of medical necessity) for DynCorp staff to verify that the services billed were delivered, were medically necessary, and the claims processing procedures were appropriate. According to CMS, the intent of CERT is to improve claims accuracy and payment processes and, therefore, protect the integrity of the Medicare Trust Fund.

SENIOR MEDICARE PATROL PROJECT

In June 2001, HHS awarded \$9.3 million for Senior Medicare Patrol projects to pay retirees to identify and report fraud and abuse. The 52 Senior Medicare Patrol Project grants administered by the Administration on Aging include four new projects in Kentucky, New Jersey, Tennessee, and West Virginia, and 48 renewed grants distributed in 43 states plus the District of Columbia and Puerto Rico. Senior volunteers undergo several days of training reviewing health care benefit statements and outlining the steps seniors can take to protect themselves. Volunteers work in local senior centers and other places where older persons gather teaching beneficiaries such skills as how to treat their Medicare number as they would their credit cards, how to use journals to keep track of their medical services and health care instructions, how to read their Medicare notices, and how to get answers to billing questions they may have.

MEDICARE ADMINISTRATIVE AND PAPERWORK REQUIREMENTS

In January and February 2001, the AMA’s Division of Market Research and Analysis conducted a survey of physicians to determine their experiences and opinions of Medicare requirements. The survey results indicated that Medicare’s administrative and paperwork requirements are a serious problem for most medical practices, and that they interfere with patient care services. Three out of four (76%) physicians reported that they and their staff spend, in an average week, more than 5 hours completing Medicare forms and administrative requirements, with 30% of these physicians indicating they and their staff spend more than 20 hours completing Medicare forms and administrative requirements in an average week. More than one-third (38%) of physicians reported spending, in an average week, one hour completing Medicare forms and administrative requirements for every 1-4 hours of patient care.

The majority (81%) of physicians reported that Medicare’s paperwork requirements take time away from patient care, and over half (52%) indicated that Medicare’s rules and requirements decrease their willingness to see Medicare patients. Four out of five (80%) physicians felt that carriers do not give them clear guidance as to which Medicare rules and requirements must be followed.

The Medicare Education and Regulatory Fairness Act (MERFA)

As long-standing AMA policy indicates (Policies H-180.973 and H-180.976), and as the AMA survey results confirmed, the piles of paperwork and amount of red tape physicians encounter when treating Medicare patients is a cause for serious concern. Therefore, the AMA has been tirelessly advocating for the passage of the Medicare Education and Regulatory Fairness Act (MERFA) (H.R. 868/S. 452) to reform and correct several of the most onerous Medicare hassles. The Act, sponsored by Sens. Frank Murkowski (R-AK) and John Kerry (D-MA) and Reps. Patrick J. Toomey (R-PA) and Shelley Berkley (D-NV), currently has more than 218 cosponsors in the House and 34 cosponsors in the Senate. More than 50 medical and specialty organizations also support this legislation.

Complex federal regulations equate to countless hours of paperwork for physicians, who must comply with numerous federal mandates to complete claim forms and advance beneficiary notices, certify medical necessity, file enrollment forms, and comply with code documentation guidelines. Failure of a physician to follow Medicare's needlessly complex rules, or even just a perception of such failure, can result in an audit of a physician's billing records, withholding of payments, and a complete crippling of a physician's practice.

MERFA would reform the Medicare post-payment audit process and provide greater physician education on CMS rules in an effort to reduce the regulatory burden on providers. One of the more comprehensive elements of MERFA would prohibit CMS from offsetting future Medicare payments to a provider charged with accepting overpayments until any appeals of the accusation can be completed. In addition, the legislation would mandate the use of a set percentage of funds in CMS' budget for the implementation of provider education programs aimed at reducing the occurrence of inadvertent Medicare billing errors.

MERFA would provide modest reform of Medicare audit practices by guaranteeing physicians certain due process rights, including an equitable right of appeal. MERFA better targets current Medicare education dollars to provide needed outreach and education to physicians and health care providers, especially those in rural communities, on the complexities of Medicare billing. Specifically, MERFA would:

- *Curtail Use of Extrapolation:* When a carrier identifies an alleged physician billing error, it can extrapolate the single identified error to the physician's other claims, resulting in an allegation that the physician has been overpaid by tens of thousands of dollars. MERFA would end this unfair practice for first-time audits.
- *Prohibit Payment Demands Until Fair Determination:* CMS requires that alleged overpayments to physicians be repaid within 60 days, even if a physician appeals. Many alleged overpayment amounts are substantially reduced on appeal. Under MERFA, if a physician chooses to appeal, payment would not be demanded until after the appeal is heard and the arbitrator actually deems that the physician owes CMS money.
- *Provide Meaningful Options for Appeals:* When assessed an overpayment, the only way physicians can appeal is to subject their practices to what is known as a "statistically valid random sample." Statistical sample audits can essentially shut down a physician's practice, preventing physicians from treating patients. Physicians are often forced to settle with CMS rather than be subjected to such unfair scrutiny. MERFA would provide a fair appeal right for physicians without harming their practice or their patients.
- *Protect Health Professionals from Unfunded Mandates:* MERFA would protect health care professionals from future unfunded mandates by requiring that Medicare payment rates better reflect the costs of mandates imposed on physicians and other providers. An example of such an unfunded mandate is the requirement that physician practices incur, at their own expense, the cost of hiring trained clinical interpreters to assist patients who have limited English proficiency.

The Physicians' Regulatory Issues Team

The Physicians' Regulatory Issues Team (PRIT) was created by CMS to improve responsiveness to the daily concerns of practicing physicians, specifically understanding and complying with an extraordinary number of pages of Medicare regulations. The PRIT has been invaluable to CMS in amplifying the voice of practicing physicians. The PRIT is responsible for new initiatives that support agency policy staff and leadership, providing them with new ways to add the input of practicing physicians onto the decisions and products of CMS. Some of these initiatives include (1) a Physicians' Issues Project that targets specific Medicare requirements that adversely affect physicians

day-to-day experiences with Medicare; (2) a mechanism to collect the many physician questions, comments, and issues into an ongoing set of Frequently Asked Questions (FAQs); (3) the creation of a new web site architecture that takes existing information and organizes navigation through the web site to be both easy and intuitive to the physician user; and (4) the development of a system to query a broad cross-section of diverse types of physician offices across the country, in order to view the daily impact of Medicare rules and regulations, and to receive ongoing feedback on how to improve the agency's support of the clinical relationship.

DISCUSSION

With respect to the PRO beneficiary compliant process, the Council believes that there are significant reasons for the AMA to continue to support current policy requiring PROs to obtain consent from the physician who provided the care in question before they can share review results with beneficiaries. First, any approach to quality improvement and ensuring patient safety can only occur in an environment where information is shared, and needs to avoid focusing on individual components in an isolated or punitive way. Disclosing physicians' names without their consent would further the tendency of providers to avoid discussing adverse events. While the Council feels that the process of providing information to beneficiaries in the complaint process certainly needs to be improved, obtaining physicians' consent before the release of information to patients must continue to be part of that process or the goal of quality improvement in the Medicare program will be greatly compromised.

Secondly, the Council agrees with AHQA, the association of PROs, that trust is an essential component for quality improvement and that practitioners must trust a PRO to candidly share their assessment of quality problems. As the early years of the PRO program demonstrated, if trust is eradicated due to complaints identifying physicians, opportunities for quality improvement will be lost.

With respect to Medicare administrative and paperwork requirements, the Council has long felt that regulatory relief for physicians is sorely needed. To address the complex situations these regulations give rise to, and to avoid the inconsistent interpretation of Medicare rules and regulations by carriers, the passage of a bill like MERFA is essential. This type of bill would send a clear message to CMS contractors that they should focus on educating physicians about how to bill correctly rather than to conduct heavy-handed audits of already-submitted claims. Such an approach would be a much-needed paradigm shift for Medicare contractors, whose focus has been punitive rather than preventive. Regulatory relief also would provide physicians with greatly sought after due process rights in post-payment audit situations, and would address problems with CMS documentation requirements. Simply put, a bill such as MERFA would provide immediate relief to physicians who are extremely frustrated with Medicare while helping to ensure that patients continue to have access to a wide range of physicians in the Medicare program in the future.

Finally, the Council believes it is worth noting that testimony presented before Congress in July 2001 by General Accounting Office Director William Scanlon specifically cited the shortcomings in how Medicare contractors provide information to physicians and respond to their questions. After reviewing several information sources (i.e., bulletins, telephone call centers, web sites) from selected carriers, Scanlon testified as to the carriers' "disappointing performance record." At the time this report was written, the GAO planned to issue a Fall 2001 report that identifies the actions CMS can take to ensure that carriers improve the "consistency and accuracy" of their communications with providers. As a result, the Council believes that any allocation of federal money for program integrity purposes would be better spent educating physicians about Medicare rules to prevent billing errors, rather than on poorly conceived projects such as the Senior Medicare Patrol Project.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association reaffirm Policy H-340.901, which states that our AMA strongly urges the requirement that Medicare Peer Review Organizations (PROs) adhere to the following principles: (a) physicians should be provided with the fundamental principles of fairness and due process throughout PRO proceedings; (b) all appeal mechanisms available to physicians should be exhausted before PROs disclose their decisions to beneficiaries; (c) the language used in PRO correspondence with beneficiaries should be properly worded to ensure that the patient/physician relationship is not jeopardized; and (d) PROs should be required to receive affirmative physician consent before patients are notified of PRO review determinations.

2. That our AMA continue its strong support and advocacy efforts towards passage of a regulatory relief bill for physicians that includes written advice from Medicare contractors, limits on extrapolation, and stronger due process rights.
3. That it is the policy of our AMA that a substantial portion of federal dollars allocated for identifying, policing, and deterring fraud and abuse under the Medicare Part B program would be best spent on educating physicians and other health care providers about Medicare rules to prevent billing errors.

8. THE POTENTIAL IMPACT OF GENETIC-BASED BIOTECHNOLOGY ON THE FUTURE PRACTICE OF MEDICINE

HOUSE ACTION: FILED

Council on Medical Service Report 14-I-98 assessed the rate and potential impact of technological change on the practice of medicine, and examined some of the implications for physicians, patients, and the health care system. In adopting the recommendations in the report, the House of Delegates asked the Council on Medical Service to continue to study and report on the impact of technological developments on the practice of medicine, the patient-physician relationship, and the physician workforce.

During the past three years, substantial advances have been made in many fields such as robotics, biofeedback, and genetic biotechnology. While recognizing that developments in many fields have the potential to profoundly influence medical practice in the future, the Council on Medical Service focuses in this report on developments in genetic biotechnology and the potential to transform the treatment of a broad spectrum of diseases.

In a 1901 article summarizing medical progress in the 19th Century, Sir William Osler wrote, "...bacteriology opened unheard of possibilities for the prevention of disease." Now, as we enter the 21st Century, the same can be said of the potential for genetics and biotechnology. The first project to map the human genome began in 1989. In September 2000, two competing efforts published "rough drafts" of the genome. In 2001, many billions of dollars are being invested in basic science, research and development, and clinical studies to exploit the exploding universe of genome and genome-related information becoming available. These investments range from development of special-purpose supercomputers to process the huge volumes of data to clinical trials of DNA-replacement techniques.

In this report, which is presented for the information of the House, the Council on Medical Service describes some of the forecasts that have been made for the potential of genetic-based biotechnology (a partial list of sources of forecasts is contained in the Appendix). Based on these forecasts, the Council describes how potential developments may have profound impacts on the demand for medical care and the medical service delivered by the physician workforce.

ANTICIPATED PACE OF GENETIC BIOTECHNOLOGY DISCOVERY AND DEVELOPMENT

Many researchers and industry analysts have speculated about the pace at which genetic biotechnology discovery and development will bring forth useful diagnostic and therapeutic applications. An amalgam of several forecasts is outlined below:

Through 2010:

- Rapid identification of genes responsible for the more common diseases.
- Progress in understanding the molecular mechanisms for some of those diseases leading to rationally designed drugs to treat them.
- Sequencing genomes of many pathogenic microorganisms and understanding of their disease-causing mechanisms.

Through 2020:

- Understanding of the mechanisms of diseases caused by the more complex interactions of multiple genes and environmental factors.
- Routine use of DNA-based diagnostics.
- Rapid increase in the number of rationally designed drugs and therapies based on knowledge of disease mechanisms.
- Maturation of techniques such as artificial tissue generation and cloning of animals to provide organs for xenotransplantation.
- Gene therapy for single-gene diseases; several hundred diseases may be curable.

Beyond 2020:

- Early detection and prevention will eliminate genetic disorders before symptoms arise.
- Many of the diseases caused by known viruses and microorganisms will be prevented or quickly treated.

Some anticipate more rapid progress than that outlined above. One event in our recent history gives a hint of what to anticipate from the biotechnology boom. After President John F. Kennedy announced the goal of landing men on the moon within 10 years of May 25, 1961, reporters related that NASA officials they interviewed “didn’t have a clue” about how to go to the moon. The United States had only primitive computers and rockets, and many thought that every scientist and engineer in the nation would have to be drafted into the effort. Based on their current state of technical knowledge, many scientists and engineers were highly skeptical about reaching the goal in twice the time.

Today, many of those in the scientific and medical communities today seem to have equal difficulty imagining that technology we do not yet know about, rather than developments based on our current knowledge, will produce the breakthroughs and products that we all hope biotechnology will yield. Presidents Kennedy and Lyndon B. Johnson achieved their goal by managing the budget appropriations process to secure all the funding that NASA requested. Similarly, the key to realizing quick results from the biotechnology industry lies in the capital market; adequate supplies of capital to fund private genetic research and development will assure the fastest results possible. Unlike the government’s program to send men to the moon, private sector genetic research and development efforts are aiming at tangible payoffs, can take significantly greater risks, and can field multiple approaches to discovery and product development.

TRANSFORMATION TO GENETIC MEDICINE

It is widely believed that, as more tests for genetic susceptibility to diseases become available, the practice of medicine will evolve from a therapeutic model to a preventive one based on genetics. The new tests will enable detection of common diseases long before patients develop symptoms.

It is estimated that there are approximately 4,000 gene disorders. Thousands of tests will likely become available for specific gene disorders and for polygenic predisposition to developing diseases through environmental and behavioral interactions. The availability of tests and possibilities for prevention will stimulate a great patient demand for genetic screening and treatment.

Because the predicted demand for genetic testing and counseling is so large, it is thought that genetic medicine must become a large component of medical practice. To meet the growing demand for genetic medicine, all physicians will need to closely monitor the rapidly advancing knowledge of gene-disease relationships, and to become skilled in conveying that information to patients. Similarly, our systems of undergraduate, graduate, and continuing medical education will be challenged to produce a new genre of physicians to serve the growing demand for genetic medicine services.

Related developments (e.g., “pharmacogenomics”) in genetic medicine will some day enable physicians to tailor drug treatment to each patient’s specific genetic makeup to maximize the effectiveness of drug therapy for each patient as well as avoid adverse reactions. Many biopharmaceutical firms are concentrating on finding the small differences in gene sequences (e.g., single nucleotide polymorphisms, or SNPs) between individuals that potentially affect disease progression and an individual’s response to therapy. A recent study by Genaissance Pharmaceuticals of 82 individuals found an average of 14 sequence versions for each gene in the human genome.

A pharmacogenomic product exemplifying SNPs is Genentech’s Herceptin monoclonal antibody against the Her2 protein. In clinical trials against breast cancer, Herceptin only performed well in a subgroup of patients (about 30%) whose cancer cells were found to over-express Her2. As a result, breast cancer patients are now screened to determine whether their tumor cells over-express Her2, because Herceptin is not effective otherwise. Thus, some patients can be given a drug targeted at their particular variant of breast cancer, while the others will not waste time receiving an ineffective drug. As more “personalized” drugs become available, genetic testing of patients for their responses to the drugs will likely become a routine part of prescribing pharmaceuticals in medical practice.

DECLINE OF HOSPITALIZATIONS AND PROCEDURES?

Throughout the 20th Century, the distribution of health care expenditures has been remarkably stable. It has been characterized by an extreme concentration of annual expenditures within a small fraction of the population. Throughout the century, only 30% of the population has accounted for 90% of annual expenditures on health care. Further, about 12% of Americans are hospitalized each year, but they spend 40% of health care dollars. Less than one-half of the non-institutionalized population have one or more chronic conditions, but they account for 76% of medical care costs. Persons with chronic conditions account for 69% of hospital admissions and 80% of hospital days.

This historically stable distribution of health expenditures could change significantly in the near future if, through advances in biotechnology, we are able to prevent or reduce the incidence of some chronic diseases. For example, some researchers and industry analysts suggest that the following scenarios are possible:

- Annual expenditures on diseases of the circulatory system comprise about 17% of total national health care expenditures. In 1996, 20.7 million Americans had a heart condition (excluding hypertension), and 6.34 million heart-related procedures were performed. Discovery of the genetic origins of susceptibility to heart disease and development of preventive measures for hypertension, atherosclerosis and congestive heart failure may significantly reduce related hospitalizations and procedures such as revascularization.
- Annual expenditures on diseases of the musculoskeletal system comprise about 6% of total national health care expenditures. In 1996, 33.6 million Americans had arthritis and almost 400,000 total knee and hip replacements were performed. Advances in genetic medicine could virtually eliminate the need for surgery in these patients after 2025.
- Lung disease accounts for approximately 7.3% of health expenditures in the United States. About 15 million Americans are affected by asthma; they generate more than 1.5 million emergency room episodes and 500,000 hospitalizations each year. Because asthma is related to known gene mutations, it is possible that further developments could lead to targeted treatment and prevention by 2025.
- The expanding prevalence of diabetes in the United States has been described as epidemic, expected to reach 23 million in ten years from about 16 million in 2001. Complications of diabetes, including cardiovascular disease and stroke, diabetic retinopathy and kidney disease, and amputation of limbs account for 10% of annual health expenditures, including 25% of Medicare expenditures. Type 2 diabetes is a polygenic disorder and accounts for 90% to 95% of all diabetes cases. Type 2 diabetes could be preventable within the next 25 years as the disease-causing interactions between genetic predispositions and environmental factors such as obesity and lifestyle are elucidated.

As the predicted advances in DNA-based disease prevention and genetic medical therapies become available over the next quarter-century, a number of procedures in common use today will likely be phased out, as well as the hospitalizations associated with them. An actual experience that may give insight into the potential impacts of advances in genetic biotechnology is that of the impact of public water supply fluoridation on the demand for dental

services and consequent changes in the practice of dentistry. Public water supply fluoridation was initiated in the 1950s to prevent tooth decay in cohorts exposed to it during tooth development, and now reaches almost two-thirds of the American population.

The nationwide prevalence of dental caries, the dental disease that historically consumed the most resources to treat, declined 65% in children between 1971 and 1994. The nationwide prevalence of dental caries also has begun to decline in American adults. The composition of services provided by dentists has changed in response to the changing disease pattern. Between 1959 and 1990:

- The percentage of patients receiving a 1-surface amalgam or an extraction fell from 20.1% to 5.3%, and from 13% to 4.9%, respectively;
- The percentage of U.S. dental patients receiving an oral examination increased from 20.1% to 42.8%; and
- The percentage of patients receiving a prophylaxis increased from 19.9% to 38.6%.

The decline in the incidence of dental caries resulted in a significant reduction in operative procedures, but preventive services increased to take their place. As noted above, the same pattern could unfold in medical practice as genetic biotechnology provides the means to reduce the incidence and prevalence of genetic-based chronic disease.

CONCLUSION

The American public will quickly learn of advances in preventive and therapeutic capability, and will likely demand genetic medical services such as screening for disease predisposition and preventive measures. The measured prevalence of many diseases will rise above current levels because of early detection. The historically concentrated expenditure at the high-cost tail of the distribution of health care spending may dissipate as high-cost episodes of hospitalization and consumption of high cost procedures are displaced by broad-based screening, early detection, and prevention.

Health expenditures will likely be distributed over a larger proportion of the population as the ability to detect predisposition to chronic disease advances and more disease is prevented or is attenuated in severity. In fact, the number of elderly (age 65 or greater) becoming chronically disabled has been declining since the late 1980s. This was manifested, for example, in the number of nursing home residents declining by 200,000 during the 1990s. A number of factors are thought to underlie this trend, including fewer people smoking, new drugs for heart conditions and other illnesses, healthier lifestyles, and advances in medical technology. As discussed in this report, advances in genetic biotechnology predicted to occur over the next 25 years could accelerate this trend.

In addition, the Council foresees a shift in the paradigm of medical practice from treatment to prevention based on rapidly increasing capabilities of genetic medicine that will significantly change demands on physicians over the next 25 years. However, the exact pace of change is uncertain at this time. It could proceed much faster than some predict. The Council will continue to study and report on the impact of technological developments on the practice of medicine, the patient-physician relationship, and the physician workforce.

APPENDIX - SELECTED SOURCES OF FORECASTS FOR GENETIC MEDICINE

Matthew J. Elrod-Erickson and William F. Ford, "Economic Implications of the Human Genome Project," *Business Economics*, October 2000, pp. 57-60.

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