REPORTS OF COUNCIL ON MEDICAL SERVICE

The following reports, 1-16, were presented by Eugene Ogrod, MD, Chair:

1. UNIVERSAL EXPLANATION OF MEDICAL BENEFITS FORMS

HOUSE ACTION: FILED

At the 1998 Interim Meeting, the House of Delegates adopted Substitute Resolution 106, which calls for the AMA through its participation in the National Uniform Claim Committee (NUCC), to develop standard explanation of medical benefits (EOMB) forms that are consistent with existing policy, and further, to encourage third-party payors—including the Health Care Financing Administration (HCFA)—to use the standard EOMB forms. A report back to the House of Delegates was requested on the AMA's progress in contacting health insurance companies about adoption of such standard EOMB forms.

This report, which is presented for the information of the House, summarizes the current activities of the NUCC, including its discussion of the possible development of a standard EOMB form; describes HCFA's development and implementation of its Medicare Summary Notice, which has replaced earlier Medicare EOMB forms; and summarizes relevant AMA policy on the use of EOMB forms.

DISCUSSION BY THE NATIONAL UNIFORM CLAIM COMMITTEE

Since its inception in 1995, the NUCC has gained recognition as the national public and private sector committee responsible for developing a uniform data set for use by the non-institutional health care community (e.g., physicians, medical equipment suppliers) to transmit related claim and encounter information to and from all third party payors. The AMA chairs the NUCC, which is comprised of representatives from HCFA, key provider and payor organizations, and standards setting groups.

The NUCC was designated in the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 (PL 104-191) as one of the organizations to be consulted by standards development organizations and the Secretary of the Department of Health and Human Services (HHS). These provisions specifically call for the Secretary of HHS to adopt standards for the following administrative and financial electronic health care transactions: health claims or equivalent encounter information; health claims attachments; enrollment and disenrollment in a health plan; eligibility for a health plan; health care payment and remittance advice; health plan premium payments; first report of injury; health claim status; and referral certification and authorization.

In recent reports to the House of Delegates (CMS Reports 13, A-99, and 7, I-98), the Council on Medical Service has reported extensively on the status of the implementation of the administrative simplification provisions, specifically with respect to the development of several proposed rules. Current policy supports the AMA maintaining a leadership role in the NUCC and advocates use of its standard claims/encounters data set for implementation of the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996 (Policies H-190.980, H-190.978[5], and H-190.974, AMA Policy Compendium).

An agenda item at the February 1999 meeting of the NUCC addressed the possible development of a standard EOMB form by the NUCC. A key part of the discussion on this issue involved a presentation by HCFA staff regarding HCFA's implementation of its Medicare Summary Notice (MSN) which has replaced the previous Medicare EOMB forms. The initial development of the MSN by HCFA began in late 1993, and involved the use of a management consulting firm that conducted surveys and focus groups to gain the perspectives of Medicare beneficiaries on the MSN format. Following pilot-testing of the MSN by the Medicare carriers in Florida and Texas in 1996 and 1997, HCFA initiated national implementation of the MSN in 1998. At the time this report was written, approximately 80% of Medicare carriers were using the MSN, with the remaining 20% scheduled to begin following the completion of final Year 2000 (Y2K) computer activities.

HCFA believes that the MSN is superior to the old Medicare EOMB because it has a standard format, uses clear and concise messages, contains customer service information and deductible information, and provides beneficiaries with the ability to file an appeal easily using the MSN. HCFA claims that Medicare beneficiaries have been pleased with the MSN, and that it has reduced beneficiary paperwork.

Although the NUCC discussed the feasibility of standardizing the data elements and messages for EOMBs, most of its members expressed little interest in undertaking such an initiative. In contrast, most members believe that the NUCC needs to continue to concentrate its efforts on providing input to the development of national health data standards as mandated by the administrative simplification provisions of the Health Insurance Portability and Accountability Act of 1996.

RELEVANT AMA POLICY

Long-standing AMA policy has urged the health insurance industry to develop and utilize explanation of medical benefits (EOMB) language that is less misleading or inflammatory (Policy H-190.994[2]). Similarly, as a result of Policy H-390.870, the AMA has urged HCFA to instruct Medicare carriers not to use wording on the Medicare EOMB that is inflammatory and misleading (e.g., "this service may not have been medically necessary") but rather, to use language that accurately reflects the reason for the denial (e.g., "this service may be necessary but it is not paid for by Medicare...or is beyond the scope of Medicare coverage").

In addition, Policy H-390.865 favors the use of a standardized, easy-to-understand EOMB form, whether in print or electronic form, by all public and private third-party payors. Furthermore, the AMA has advocated that the standardized form should clearly state information such as the patient's name, the insured's name, the date of service, the CPT code submitted, the amount charged, the amount allowed, the amount discounted, the amount of the co-payment, the deductible amount, the withhold amount, and the payment to the physician.

DISCUSSION

The Council on Medical Service believes that AMA leadership in the National Uniform Claim Committee (NUCC) has been evident both in the Committee's development of a uniform data set for electronic claims transmission to public and private payors, and in its input to HHS in the development of a number of proposed rules for administrative and financial electronic health care transactions standards. Given its current commitment to this latter activity, however, it does not appear that the NUCC will be undertaking the development of a standard EOMB anytime in the near future.

In reviewing the Medicare Summary Notice (MSN) developed and implemented by HCFA, the Council believes that it has been streamlined considerably from earlier Medicare EOMB forms, and appears to contain clearer, more concise language that is not offensive in the manner that earlier Medicare EOMB forms were. For example, consistent with Policy H-390.870, the MSN does not use language that was common in earlier Medicare EOMB forms that simply stated that services were denied because they were "not medically necessary."

Nonetheless, while the Council believes that the MSN is an improvement over previous Medicare EOMB forms, it appears that additional changes to the MSN are warranted. In a June 1999 letter to HCFA Administrator Nancy-Ann Deparle, the AMA raised concerns with a statement in the MSN that instructs Medicare beneficiaries to "report Medicare fraud by calling the Office of the Inspector General's (OIG) Fraud Hotline." The AMA had been led to believe that beneficiaries would be instructed to follow a three-step process for reporting matters to the OIG Fraud Hotline. First, beneficiaries would be urged to call their physician or other health care provider. Second, they would be instructed to consult with their Medicare carrier. Third, beneficiaries would be advised to call the OIG Fraud Hotline only if they had taken these earlier steps and believed a Medicare fraud issue still existed. In a July 1999 meeting with AMA staff, HCFA staff agreed to change the "fraud statement" in the MSN, but indicated that it likely would not be implemented until all Medicare carriers had completed their final Y2K computer changes (i.e., after January 1, 2000).

In conclusion, although the NUCC will not be undertaking the development of a standard EOMB at the present time, the Council is encouraged that HCFA has continued to make progress in the development of its MSN which is an improvement over previous EOMBs. The Council also believes that the intent of Substitute Resolution 106 (I-98) continues to be well-addressed by Policies H-190.994(2) and H-390.865.

2. INSURANCE COVERAGE FOR ADULTS WITH CONGENITAL AND/OR CHILDHOOD DISEASES (RESOLUTION 121, I-98)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 121 (I-98) AND REMAINDER OF REPORT FILED

At the 1998 Interim Meeting, the House of Delegates referred Resolution 121 to the Board of Trustees. Introduced by the American College of Cardiology, American Society of Hematology, American Society of Anesthesiologists, American Urological Association, American Academy of Family Physicians, American Association of Neurological Surgeons, Congress of Neurological Surgeons, American Academy of Neurology, American Society of Clinical Oncology, American Medical Group Association, American Society of Plastic and Reconstructive Surgeons, American Academy of Dermatology, The Society for Investigative Dermatology, Inc., American Society of Dermatologic Surgery, American College of Emergency Physicians, and American Association of Plastic Surgeons, the resolution calls for the AMA "in collaboration with other state and national medical societies and other interested parties, in the absences of universal health care insurance coverage, to work to pursue an appropriate mechanism for ensuring affordable health insurance coverage for adults with congenital and/or childhood diseases." The Board referred Resolution 121 (I-98) to the Council on Medical Service for a report back to the House at the 1999 Interim Meeting.

This report discusses the prevalence of congenital and/or childhood diseases using the highly visible conditions more precisely identified as birth defects and disabilities; presents available information on the costs of treatment and level of health insurance coverage for this population; summarizes federal laws and pending legislation that have the potential to increase access to health insurance for this population of adults; describes relevant AMA policy; and presents several recommendations.

PREVALENCE OF BIRTH DEFECTS AND DISABILITIES

It is difficult to categorize or classify congenital and/or childhood diseases as separate identifiable and distinct groups of conditions. Often, congenital and/or childhood diseases are grouped with or beneath the larger category of birth defects. In other instances, congenital and/or childhood diseases may be a viewed as a subset of early onset chronic conditions or disabilities affecting individuals throughout their life. This ambiguity also makes identification of insurance access and coverage for this potentially vulnerable population problematic.

Birth defects are one of the major causes of childhood and adult disability. There are between 3,000 and 5,000 different medical conditions recognized as birth defects. Annually, there are more than 150,000 infants born with birth defects in the United States. Birth defects are currently the leading cause of infant mortality and a major cause of disability in children and young adults accounting for approximately 1 out of every 5 infant deaths. Although 20% of all infant deaths are currently related to birth defects, the rate was cut by more than 50% between 1960 and 1994.

Congenital heart defects are the most common major birth defect, occurring in approximately 8 in 1,000 live births in the United States. This amounts to approximately 30,000 infants born with heart defects each year in the United States. Nearly 25,000 of these infants will require some kind of surgical intervention, including valve repair or prosthetic device implantation, to correct their congenital heart defects. The majority of these infants will survive surgery and, with the appropriate care, reach adulthood. In fact, more than 85% of infants born with congenital heart disease can expect to survive to adulthood. In 1991, it was estimated that there were between 400,000 and 500,000 adults over the age of 21 in the United States with congenital heart disease. Fewer than 10% of these individuals were believed to be disabled and the remaining adults were viewed as capable of working. However, despite the recent advances in medical technology associated with surgical repair of congenital heart defects in infants and children, many will encounter complications later in life that may require surgical intervention.

In the United States, there are approximately 250,000 individuals with Down syndrome. Although the percentage of children born with Down syndrome has not changed significantly over the last few decades, the number of children with Down syndrome surviving childhood has improved dramatically due to recent medical advances in treatment of the major health problems associated with Down syndrome such as heart disease. In the 1930s, the estimated life expectancy for a child with Down syndrome was only nine years. Today, a majority of individuals with Down

Syndrome live at home or in semi-independent living facilities and work part-time. At present, life expectancy among individuals with Down Syndrome has reached about 55 years of age.

Cystic fibrosis currently affects approximately 30,000 children and young adults in the United States. In 1995, 35% of the cystic fibrosis population consisted of adults, compared to 8% in 1970. Today, patients with cystic fibrosis have a median survival age of 31 years, and it is estimated that nearly 50% of all patients affected with cystic fibrosis will be adults in the next 10 years. The increased life expectancy can be attributed largely to new drug therapies and improved regimens of care.

COSTS OF TREATMENT AND LEVEL OF INSURANCE COVERAGE

Based on a review of the literature, there appears to be limited, recent data available on the aggregate cost of congenital and/or childhood diseases in the United States, as well as on the level of insurance coverage for patients with such diseases. According to a 1994 article, the estimated lifetime costs for infants born with birth defects in the United States totaled $8 billion in 1992. In accordance with this estimate, the lifetime costs for some of the more significant and long-term birth defects, such as cerebral palsy and Down syndrome, are often in excess of $450,000 per individual.

Now that individuals with congenital heart defects and other congenital anomalies are surviving into adulthood, insurability increasingly becomes an important issue. A 1991 study estimated that only 22% of those individuals with the most severe cardiac defects had health insurance. However, another 1991 study reported that only 10% of adult patients with major or complex congenital cardiac defects were uninsured. It also was estimated, in 1991, that the actual cost of congenital heart disease for the age period of 22 to 40 years was roughly $18,773 per case, or roughly $1000 per case per year.

The Cystic Fibrosis Foundation estimated that the total cost in 1995, to treat cystic fibrosis was more than $900 million, representing a cost of approximately $39,166 per person. According to the Cystic Fibrosis Foundation's estimates in 1995, more than 34% of people with cystic fibrosis have some type of secondary coverage such as Medicare, Medicaid, SSDI, COBRA, or other programs in addition to their primary coverage. However, individuals with cystic fibrosis may have difficulty in obtaining the type of specialized care they require or may have limited access to the latest medications used to combat the disease.

Approximately one-sixth of adult, non-elderly Americans with disabilities currently have no health insurance. For the majority of Americans, health insurance is tied to their employment status. Having a severe disability has a large effect on the chances of being employed. According to United States Census data, in 1994-1995, 29 million working age adults (ages 22 to 64) had a disability, while 14 million working age adults had "severe" disabilities. At the same time, 77% of adults with disabilities were employed, compared to 82% of those with no disability, while only 26% of adults with severe disabilities worked.

It has been estimated that over 550,000 severely disabled individuals who are presently employed are uninsured. People with disabilities are less likely to have private health insurance coverage and more likely to have government coverage than people with no disabilities. In general, individuals with non-severe disabilities have insurance coverage patterns similar to those with no disability (expect for a slightly higher percentage of uninsured). However, the mix of public and private insurance coverage as well as the cost of health care is significantly different for disabled individuals, especially severely disabled individuals. In 1994-95, almost 44% of individuals age 22 to 64 with severe disabilities had private health insurance, compared to 80% for people of this age group without disabilities. In addition, close to 40% of the people age 22 to 64 with severe disabilities had government coverage, compared to only 3% for people of this age group without disabilities. In 1994, the average Medicaid payment for an adult with a disability was $8,654, compared to $2,118 for adults without disabilities. In 1995, the average Medicare payment for an under age 65 adult with a disability was $5,283, compared to $4,808 for beneficiaries over age 65.

AMERICANS WITH DISABILITIES ACT

The Equal Employment Opportunity Commission (EEOC) has enforcement authority to address the portion of the Americans with Disabilities Act (ADA) that specifically prohibits employment discrimination. The ADA prohibits employers with more than 15 employees from discrimination in employment against any qualified individual with a disability. Specifically, a decision regarding employment may not be motivated by concerns about the impact of an

employee's or a prospective employee's disability on the employer's health plan. In addition, an employer may not deny an individual with a disability equal access to health insurance, or require such an individual to have terms and conditions of health insurance different from those of employees without disabilities. However, the equal access requirement does not prevent the employer from offering a health policy that has coverage limitations, such as restricting the number of services and treatment options, and exclusions of certain kinds of coverage that are not "disability-based," including pre-existing conditions. These health plan limitations and pre-existing condition clauses may have a greater adverse impact on the health and well being of certain employees with disabilities, though these restrictions are permissible under the ADA as long as the employer is not using them as a means of evading responsibility under the ADA. Furthermore, the ADA does not require employers to provide health insurance. However, if an employer chooses to offer health insurance to employees, the ADA requirements apply.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996

The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) also provides health insurance coverage protection to adults with congenital and/or childhood diseases. Specifically, the Act increases portability of health insurance through restrictions on limitations or exclusions of benefits related to a condition that was present before the date of enrollment for health insurance coverage by group health plans and health insurance issuers offering group health insurance coverage. This restriction on pre-existing condition exclusions allows pre-existing condition limitations in only certain circumstances, and these exclusions are bound by time and coverage constraints. Group health plans or health insurance issuers may exclude certain health benefits and coverage only for conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 6 months prior to enrollment. This exclusion cannot extend beyond 12 months after the enrollment date and the exclusion period may be reduced based on creditable coverage applicable to the participant or beneficiary as of the enrollment date. If an individual with a specific condition had health insurance coverage immediately prior to the enrollment date, that period of coverage is counted against the pre-existing condition exclusionary period.

FEDERAL AND STATE GOVERNMENT ACTIVITIES

The Health Care Financing Administration (HCFA) Center for Medicaid and State Operations released the final version of its guide entitled "Key Approaches to the Use of Managed Care System for Persons with Special Health Care Needs" in October 1998. The document provides a framework for states to consider when designing and implementing quality strategies for persons with special health care needs. The guide applies to states planning Medicaid managed care programs for persons with special health care needs under section 1115 and 1915(b) waivers. The document is intended to assist states in identifying and resolving potential problems associated with providing adequate access to quality medical services, assuring an adequate provider network for these populations and addressing social and support needs. States are not mandated, however, to adhere to any of the recommendations of the guide.

The Balanced Budget Act of 1997 (P.L. 105-33) mandated the Secretary of Health and Human Services to evaluate the safeguards needed to protect individuals with chronic health care needs enrolled in Medicaid managed care. HCFA is presently working on a report that outlines the safeguards needed to protect individuals with special health care needs enrolled in Medicaid managed care programs. It is anticipated that this report will be presented to Congress by the end of 1999.

In June 1999, the United States Senate voted 99-0 to approve the Work Incentives Improvement Act of 1999 (S.331) that is designed to permit disabled Americans to join the workforce without risking the loss of their federal health benefits. Under current law, if disabled individuals reach a specified level of income, they lose disability benefits and any health insurance that they may have received through Medicaid or Medicare. Without these health benefits, many disabled individuals are unable or unwilling to work. It has been estimated that the proposed bill could help some of the approximately 7.5 million Americans with disabilities join the workforce by discontinuing the practice of eliminating their Medicaid or other federal health insurance benefits. The bill creates several options for states and workers with disabilities, including continuation of Medicare coverage for individuals with disabilities who have returned to work, Medicaid-Buy-In for individuals who become disqualified because of earning limits or because of improvements in their medical conditions, and authorization for state demonstration projects that make available Medicaid benefits to workers who are not presently disabled, but have a specific physical or mental impairment that is "reasonably expected" to become a severe disability. At the time this report was written, the House version of the bill (H.R. 1180) was awaiting mark-up by the Ways and Means Committee Health Subcommittee.

CURRENT AMA POLICY

The AMA has established comprehensive policy that, to a large extent, addresses many of the health care access and coverage needs for adults with congenital and/or childhood onset diseases. A number of AMA policies address the issue of insurance portability, pre-existing conditions, and guaranteed renewability (Policies H-165.960, H-165.950, H-165.951, H-165.991, H-185.967 and H-165.920, AMA Policy Compendium). Moreover, Policy H-185.989 opposes any attempt by health insurers to "cancel, reduce, refuse to renew, or increase an individual's premium for coverage...based on an illness occurring during the time insurance is in force."

Policy H-165.920 advocates for individually selected and owned health insurance that could enable people with specialized health care needs, such as individuals with congenital and/or childhood diseases, to choose appropriate health plans that provide access to these specialized and necessary services. This policy further encourages employers to consider the merits of risk adjusting their defined contributions so that higher risk employees would receive a larger contribution, while the lower risk employees would receive a lower contribution. Under this approach, useful risk adjustment measures such as age, sex and family status would be used to provide higher risk employees with a larger contribution.

The AMA continues to support community rating bands that allow premiums to vary by rating factors such as age, gender, claims experience, and health status, but limit the allowable range in variation from the average premium charged as a realistic and balanced position for ensuring that insurance policies are not priced beyond the means of those who need it most (Policies H-165.920 and H-165.882). The AMA also continues to advocate for the establishment of state risk pools to provide adequate health insurance coverage to those individuals unable to obtain insurance elsewhere because of medical considerations or lack of access to group coverage (Policies H-165.915, H-165.995, H-165.920, H-165.991, and H-165.992). Policy H-185.985 "calls upon all third party payors and appropriate federal regulatory agencies to make all guidelines related to patient coverage a matter of public information and easily obtainable by both patients and physicians." In addition, Policy H-180.964 encourages the health insurance industry to extend parent's family health coverage to young adults up to the age of 28 who do not otherwise have health insurance coverage.

Policy H-185.967 states that "treatment of a minor child's congenital or developmental deformity or disorder due to trauma or malignant disease should be covered by all insurers and that such coverage shall include treatment which, in the opinion of the treating physician, is medically necessary to return the patient to a more normal appearance (even if the procedure does not materially affect the function of the body part being treated)." Finally, Policy H-475.992 advocates for the definition of reconstructive surgery that includes surgery that is "generally performed to improve function, but may also be done to approximate a normal appearance" and is "performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease."

DISCUSSION

Through medical and technological advances, many children are now surviving childhood diseases that were previously fatal. For example, survival for childhood leukemia/lymphoma has approached 70%. However, these children and, later, these adults, often require ongoing medical care and resources for their complex medical needs.

It is possible that many adults with congenital and/or childhood diseases are facing the common difficulty of obtaining health insurance coverage. In some cases, even if health insurance is obtained, it may not cover certain conditions that develop later because they may be viewed as pre-existing or not "medically necessary" to the health and well-being of the individual. In fact, health insurers have increasingly drawn a line between payment for medical procedures that are "medically necessary" and allow people to function, and services that provide for increased freedom of function or the ability to live a more productive life.

Continued improvements in the early diagnosis and management of patients with congenital and/or childhood diseases, as well as advances in medical technology, will likely result in the sustained growth in the number of adults with congenital and/or childhood diseases. A review of the current literature, however, reveals that it is extremely difficult to identify accurately the number of individuals with congenital and/or childhood diseases, let alone what percent of this population is insured, underinsured, has access to appropriate and necessary health care services, or has reached their lifetime caps on coverage. In addition, repeated requests for additional information

from the 17 co-sponsors of Resolution 121 (I-98) produced little additional data on the size of this population, their specific health insurance needs, or the current status of their health insurance coverage.

Given the fact that there are no definitive data to verify the perceived lack of health insurance coverage for this potentially vulnerable population, the Council believes that it is necessary to advocate for a study by the federal government of the present insurability of this population and the potential costs associated with enhancing such coverage. At the same time, the Council believes that the AMA's existing policies related to individually selected and owned health insurance, portability, pre-existing conditions, guaranteed renewability, state risk pools, and community rating bands continue to serve as vehicles to increase awareness of the health care needs of adults with congenital and/or childhood diseases, as well as effectively promote greater health care access and quality for this potentially vulnerable population.

An increasing percentage of health care services for adults with congenital and/or childhood disease is being provided in community care and home settings, with the family playing an ever-increasing role in care planning and care giving. However, the out-of-pocket expenses for families who care for adults with congenital and/or childhood diseases are not well documented. The Council is concerned that the cost burden associated with the health care of adults with congenital and/or childhood diseases could be shifted more profoundly to the individual or family if insurance coverage that provides adequate access to needed health care services, including ancillary and support services, supplies and prescription drugs, is not available. The Council also believes that while the family should play a large role in the development of a care plan, it should not bear the full burden of the costs associated with the health care regimen.

The unspecified magnitude of this population, their specialized health care needs, and their seeming disproportionate use of resources may necessitate a change in treatment regimens and a reformation in health insurance coverage policies. Individually-selected and owned health insurance may, in fact, provide the best option. The Council on Medical Service believes that continuity of care can only be achieved for this population through health insurance coverage that permits and encourages access to health care services and health care professionals specialized in the care of children and adults with congenital and/or childhood diseases. The Council also believes that health insurance coverage for adults with congenital and/or childhood diseases must be able to respond to both the routine and the unique medical needs of this apparently sizeable and exceedingly diverse population.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 121, (I-98), and the remainder of the report filed:

1. That the AMA work with the Federation and other interested parties to encourage federal and state governmental agencies to develop a comprehensive population profile of adults with congenital and/or childhood diseases, their health care service needs, and their level of health insurance coverage.

2. That the AMA work with the Federation and other interested parties to encourage federal and state governmental agencies to identify adults with congenital and/or childhood diseases and identify any barriers of access to primary and specialty health care services.

3. That the AMA urge public and private third-party payors to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population.

4. That the AMA emphasize that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population.

3. ON-CALL PHYSICIANS
(RESOLUTIONS 124, I-98 AND 713, A-99)

HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTIONS 124 (I-98) AND 713 (A-99), REMAINDER OF REPORT FILED AND FOLLOWING RECOMMENDATION ADOPTED:
That the AMA establish and participate in a task force with the American Hospital Association, American College of Emergency Physicians, other appropriate medical specialty societies, medical staff representatives and other interested parties to delineate: (a) the responsibilities of thos physicians on-call to the emergency department, (b) mechanisms for payment for care provided by an on-call physician to the emergency department, and (c) options for medical staff on-call coverage to ensure appropriate medical care for all emergency department patients in light of EMTALA requirements, and that the AMA report back at the 2000 Annual Meeting with a status report of the activities of the task force.

At the 1998 Interim Meeting, the House of Delegates referred Resolution 124 to the Board of Trustees. Sponsored by the American College of Emergency Physicians (ACEP), the resolution calls on the AMA to "work with the Federation, the American Hospital Association (AHA), ACEP, and other interested state medical and specialty societies to report recent trends in the reimbursement, responsibilities and availability of on-call physicians and the impact of these trends on the timely delivery of emergency services." The Board referred Resolution 124 (I-98) to the Council on Medical Service for a report back to the House at the 1999 Interim Meeting.

At the 1999 Annual Meeting, the House of Delegates referred Resolution 713 to the Board of Trustees for decision. Introduced by the California delegation, the resolution calls for the AMA to adopt nine detailed recommendations including "policy that: (1) the decision to provide or discontinue emergency services should be made jointly between the medical staff and the hospital; (2) medical staffs should determine and adopt protocols for appropriate, fair, and responsible specialty back-up coverage where medical staffs and hospitals have jointly decided to maintain emergency services; (3) hospitals should maintain the ultimate responsibility for provisions of emergency on-call coverage; (4) in hospitals providing emergency services, the hospital and its medical staff share an ethical responsibility for the provision of emergency services; that the AMA not support universal mandatory emergency room coverage as a requisite of medical staff membership as the principal solution to the difficulties in providing emergency specialty backup services; that the AMA continue to seek enforcement of laws and regulations which require physicians to be appropriately reimbursed for emergency on-call services; that the AMA urge regulators to enforce the law which requires physicians under contract by managed care plans to be compensated for services provided to the health plans' enrollees; that the AMA consider supporting legislation which requires health plans to pay non-contracted physicians usual and customary rates for physician services provided on an emergency basis to their enrollees, and that enrollees should not suffer additional costs because of the failure of the health plan or delegated entity to arrange in advance for adequate panels of specialists to care for their patients; that the AMA consider sponsoring legislation and/or regulations stipulating that health plans that do not pay properly submitted bills for the provision of emergency on-call services by contracted or non-contracting physicians be required to pay interest and penalties; that the AMA, AHA, and other interested organizations continue to seek additional funding sources or increases in indigent funding for emergency on-call services provided to the uninsured; that the AMA advocate for EMS policy to ensure the appropriate utilization of emergency departments based on specialty capability; that the AMA to work with the AHA, ACEP, and other interested parties to determine the scope and potential impact of the emergency care back-up problem and recommend balanced solutions and, if necessary, legislative remedies which meet the needs of the public and of health care providers."

At its October 1999 meeting, the Board agreed that this report should be presented to the House in response to the issues raised in both Resolution 124 (I-98) and Resolution 713 (A-99). The report specifically focuses on issues pertaining to physician reimbursement, reasons for on-call staffing insufficiencies, Emergency Medical Treatment and Active Labor Act (EMTALA) problems, and examines several potential solutions to the on-call coverage shortage in emergency departments.

BACKGROUND

In the vast majority of communities, the hospital on-call system works well. It is largely invisible to the public, but is one of the foundations of quality hospital care. Physicians respond day and night, taking time away from their families and other personal commitments, to care for critical patients who are brought into their community hospitals. On-call duties often come with the privilege of practicing in a hospital and can serve as a covenant between physician and hospital as part of their mutual responsibility to all patients who come to the hospital door. However, with the tremendous growth of managed care over the past decade, physicians' loyalty and linkage to hospital institutions has been significantly altered.

Widely-read newspapers such as USA Today and the Los Angeles Times recently reported on the growing number of specialists who are refusing to come to the hospital when called to care for emergency room patients. The newspaper articles alleged that specialized treatment sometimes is not available because physicians will not come in when called, will not volunteer to be on-call in the first place, or simply are not available. While these cases currently appear to be isolated on a regional basis, they are at the core of the public's confidence in what hospitals do and are part of a larger concern about physicians both caring for and being accountable to the care of patients in their communities.

In late 1998, the California chapter of ACEP, the California Medical Association, and the California Healthcare Association formed an "On-call Task Force." The task force surveyed key constituents regarding the on-call coverage problems in their own hospitals. A four-page survey was mailed to Emergency Department (ED) Medical Directors, Medical Staff Chiefs (MSC), and Hospital Administrators (HA) at all of California's 420 hospitals. According to the Task Force, the overall response was "outstanding," with 123 ED Directors, 111 MSCs, and 130 HAs responding. Overall, 18% of the respondents considered the lack of on-call physician backup to be a "very serious problem" and 42% considered it a "somewhat serious problem." Among the reasons listed for the on-call problem: physicians do not equate hospital privileges with a duty to assist their hospital in fulfilling its public service responsibilities; lack of adequate payment or no payment for such services under managed care; and difficulty enforcing any mandatory medical staff requirement to serve on-call. The majority of respondents (52%) stated that on-call coverage is provided for the ED through a mandatory condition of medical staff membership. Twenty-two percent of the hospitals provide daily stipends ranging from $100 to $1000, with trauma surgeons, neurosurgeons, and obstetricians being at the high end. Despite subtle differences, the survey suggested that a majority of California hospitals have serious problems with their ED on-call system.

EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT

Under the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1986 (42 U.S.C. §§1317 *et seq.*), hospitals that receive Medicare and Medicaid funding cannot transfer emergency department (ED) patients to another facility until the patient is first screened and stabilized. Patients who are not stabilized can only be signed over to another facility if the risks of not transferring the patient outweigh the risks of such a transfer, and only if the receiving facility is able to accept the patient. Hospitals with specialized capabilities are thus required to receive emergency patients in transfer from facilities which lack these capabilities. Delays and deficiencies in care constitute EMTALA violations, which can subject hospitals to civil penalties of up to $50,000 per violation, as well as potential loss of license and exclusion from federal health programs, such as Medicare and Medicaid. Although federal regulators rarely target physicians for EMTALA violations, focusing more often on institutions, the law states that physicians responsible for inappropriately transferring patients can face a penalty of up to $50,000 per violation as well.

The Office of the Inspector General (OIG) has noted that EMTALA addresses the quality of care of all patients, not just patients who may be most vulnerable to inappropriate transfers because they lack health care coverage and cannot pay for services. Recently, at a forum on EMTALA sponsored by the Emergency Department Practice Management Association, a representative of the OIG stated that many of the cases she handles concern patients who were transferred for non-monetary reasons, and particularly cited a case in which an on-call physician refused to come to the hospital to treat a patient.

EMTALA is intended to ensure that all patients who come into the ED receive appropriate care regardless of their insurance or ability to pay, but such treatment still should meet minimum health care quality standards. In other words, the government wants not just fair treatment, but quality care in EDs. To protect against an EMTALA violation:

- Hospitals must maintain a list of physicians, including specialists and sub-specialists, who are on-call to evaluate and treat patients in the emergency room.

- Hospitals are responsible for ensuring that on-call physicians respond within a reasonable period of time.

- The medical staff bylaws or policies and procedures must define the responsibility of on-call physicians to respond, examine, and treat patients with emergency medical conditions.

- Although physicians are not required to be on-call at all times, hospitals must have policies and procedures that are followed when a particular specialty is not available or on-call physicians cannot respond because of situations beyond their control (e.g., if the physician is performing another surgery).

- In most cases, on-call physicians must come to the hospital to examine the patient when a request is made for their services. If, however, their offices are located in a hospital-owned facility on adjacent land or on the hospital campus, the patient may be seen in the physician's office.
- If a hospital transfers a patient to another facility because an on-call physician fails or refuses to appear, it must give the on-call physician's name and address to the receiving hospital. Failure to provide this information would violate EMTALA.

PAYMENT OF ON-CALL PHYSICIANS

EMTALA is creating dilemmas in states with high managed care penetration for a wide variety of reasons, including the on-call issue. If a managed care plan member shows up at the ED of an out-of-plan hospital and needs to be admitted, the admission must be done by a member of that hospital's medical staff. If the patient's primary care physician is not on the medical staff, that means an on-call physician must admit the patient. Some on-call physicians apparently are reluctant to do this because they are having considerable trouble getting paid by the managed care plan, which is already paying a monthly capitation fee to the patient's primary care physician.

The majority of states have laws that require third-party payors, including health maintenance organizations (HMOs), health insurers, and preferred provider organizations, to pay for medically necessary emergency care, pursuant to the health plan policy. These payors must generally pay for the reasonable charges of the hospital and treating physician for the emergency services provided, with the exception of non-covered services, deductibles or copayments.

However, on-call physicians may not be paid at all, or may not be paid adequately for emergency care, even though fair payment by HMOs is a legal requirement. In addition, physicians generally are not paid for "standby" services (i.e. staying in the area, wearing a beeper, and being ready to respond in case emergency services are necessary).

Although managed care plans are required in many states to pay contracting and non-contracting physicians who provide emergency care in the ED, many plans find loopholes to avoid compliance with such laws. Disputes between physicians and payors regarding lack of payment for ED services are frequent. Moreover, HMO contractual arrangements with physicians do not require payment for the standby component. HMOs generally rely on the hospitals to ensure specialist availability and expect the specialists to be available for their patients when needed. However, these same HMOs expect hospitals or physicians to absorb the cost of providing this care. The low reimbursement rates that physicians often receive from HMOs is also apparently one of the contributory reasons why on-call coverage is being affected.

Another issue is that HMO contracts with specialists may not include on-call services as part of the contractual arrangement. Such physician specialists are reluctant to provide non-authorized or non-contracted services for ED patients, as they may not be paid for such services. Also, many HMO contracts with specialists require a referral from the primary care physician (PCP), in order for the specialist to be paid. When the ED physician calls in a consultant, there generally is no referral from the PCP and payment for the consultant's services are often denied.

Another point physicians are disputing is what constitutes "fair and reasonable" payment under the varying state laws. Often a health plan pays the on-call physician the contracted rate regardless of whether the physician has contracted with that plan. Physicians in these circumstances are protesting that they should be paid their "usual and customary" rate by the plan. However, in these circumstances, the physician's only practicable option is to attempt

to balance bill the patient for the difference between the contracted rate they get paid and his or her usual and customary fee.

OTHER REASONS FOR ON-CALL COVERAGE PROBLEMS

Medical Staff Affiliations

Among the reasons for the apparent difficulty in finding physicians to provide ED on-call coverage is that many physicians no longer have multiple medical staff affiliations, or are dropping all medical staff affiliations. This reduces the total number of physicians available in each hospital to take call in a particular specialty. Such reductions are exacerbated by specific medical group/ hospital affiliations, as well as managed care contractual affiliations.

Not Necessary to Build Practice

In years past, the hospital was the foundation for developing a thriving private practice. Physicians were willing to make personal sacrifices in order to serve in the ED as a way of building their practice population. Today, with managed care affiliations, patient populations are already defined for the physician and such services are not nearly as relevant to practice growth.

Practice Productivity

A primary problem with managed care often cited by physicians is the pressure to see more patients in less time. Calls to the ED during office hours can infringe on physicians' office productivity. A physician who is up all night in the ED and then must return to his or her office all day to see many patients can run the risk of exhaustion, which may affect quality of care.

Behavioral/Culture Changes

A primary reason cited for the on-call staffing problem is that both younger and older physicians are desiring to devote more time to their families and personal lives, and additional trips to the ED can take up valuable time. This time not only could be devoted to personal activities, but also to care for patients for whom physicians have long-standing relationships. This conflict may have far-reaching implications, as the emergency system is a "carefully pieced together network" that relies on relationships and the cultural history of the practice of medicine as much as high-tech equipment and hospitals.

Liability and Accountability Considerations

The ED is clearly a high-risk environment due to the seriousness of cases brought in and the lack of a pre-existing patient-physician relationship. The challenge of complying with EMTALA and other state laws regulating emergency care creates additional risks and liability concerns. These risks extend to physicians who respond or refuse to respond in an on-call capacity. Moreover, at least one malpractice liability carrier has refused coverage for ED on-call services. In addition, the traditional values of physicians tending to the health of the community at large has, to some extent, been replaced by the managed care ethic of accountability only for populations under contract.

POTENTIAL SOLUTIONS TO ON-CALL COVERAGE PROBLEMS

Mandatory On-Call Coverage

Mandatory call required by medical staff by-laws has been used by some hospital and medical staffs to address the issue of how to get physicians to be on-call for the ED. This is certainly an attractive solution for the hospital, which generally will not have to pay physicians for services under this approach. Such mandates would appear to work best when there are an adequate number of physicians to share the mandated call, the mandate is reasonable (e.g. no more than two weekends a month), managed care plans are diligently paying for services provided, and there are not a large number of uninsured patients. In Montana, for example, nearly every hospital requires on-call coverage without additional compensation as part of staff privileges. The mandated approach can fail, however, due to the inability of some hospitals and hospital medical staff to enforce such a bylaw requirement. Such requirements often are not enforced because physicians faced with such unfunded mandates simply leave the medical staff, or

give up their active staff privileges in favor of courtesy privileges to which mandatory call requirements often do not pertain. In addition, some hospital medical staff bylaws have "grandfather" clauses which exempt physicians of a certain age from being on-call or exempt physicians who have provided ED on-call services for a certain number of years.

Contracting Out for On-Call Services

A hospital may contract with an outside medical group in order to staff ED backup. Typically, professional medical corporations that enter into such contracts to provide physician backup services to EDs run like model independent practice associations. Hospitals sign up with the corporation and pay certain rates for services, and physicians each independently accept or decline each hospital proposal.

This approach assures a wide spectrum of specialists are available for emergency patients needing consultative services. Moreover, physicians are motivated to provide services because payments to physicians in this situation tend to be more fair. However, this approach can be extremely costly for the hospital, which must pay the physicians the difference between the collected amount and the contracted fee schedule. Also, antitrust concerns could be triggered if competing hospitals begin agreeing upon the price to be paid to physicians or if the hospital and physician are considered direct competitors. Also, the corporate practice of medicine doctrine and/or fraud and abuse issues (i.e. potential anti-kickback or fee-splitting) are also potentially problematic.

Paying Stipends to Physicians

Some hospitals ensure specialist availability in the ED by paying certain specialists fees or stipends, anywhere from $100 to $1000 per day. This solution recognizes the opportunity cost of serving on an on-call basis and that any professional should be paid for being available and ready for service.

This method also ensures specialist availability to patients in need of an emergency consultation. The advantage to the hospital is that such costs are fixed, and such a payment mechanism is easy to execute. Paying stipends may work best for for-profit hospitals when there is an inadequate number of specialists in the community, as well as low ED patient volume. However, it would probably be financially prohibitive for most hospitals to pay such stipends to physicians. In addition, if stipends are applied unevenly, it may create a great deal of resentment among specialties. Physician acrimony may result not only if some specialists receive higher stipend amounts than others, but if some specialties get little or no support for equal or greater volumes of work.

Legislative or Regulatory Actions

It has been suggested that all managed care plans and insurance companies could be required by law to contribute to a state fund to be used to provide safety net compensation, which may include stipends, to physicians covering EDs. Contributions could be proportionate to the payor's percentage of insured patients in each county covered by that payor. Insurers claim, however, that if they are required to pay into an on-call stipend pool, they would raise premiums for everyone.

Another legislative option is that hospitals be required to pay on-call physicians in a manner that would result in enough physicians in the on-call pool. HMOs would be required to pay an incremental increase in the hospital's capitation rate, in order to subsidize necessary on-call services. Lastly, some policy experts suggest emergency care should be considered similar to fire and police protection, and should be paid for by the general public through a special tax.

CURRENT AMA POLICY

The AMA has established a number of current policies that address issues related to on-call physicians and emergency services (Policies H-130.970, H-130.978, H-130.975, H-130.960, H-130.964, H-240.969, H-285.954, AMA Policy Compendium). In particular, Policy H-130.970(2), which was developed by the Council on Medical Service, supports the principle that all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. Furthermore, Policy H-130.970(5) states that all health plans should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., EMTALA).

Policy H-130.978 encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided. In addition, Policy H-130.960 urges physicians and component medical associations to collect and submit to the AMA reports on physician willingness to serve on ED on-call panels.

DISCUSSION

The Council recognizes that emergency services are vital to all communities and that a lack of adequate on-call physicians is becoming an increasingly serious concern in some regions of the country. Furthermore, the Council feels strongly that it is the fundamental responsibility of every physician to treat patients in need.

There are no definitive national data available pertaining to the scope of on-call physician coverage problems. Thus far, California is the only state to have done a formal survey of its hospitals and medical staff. Most reports are anecdotal in nature or based on individual experiences, but are not verified through formal surveys or other collection efforts. In addition, the on-call situation appears to be particularly market driven, with different specialties encountering different obstacles in different regions of the country. Clearly, it is more of a problem in those states most entrenched in the managed care environment.

The Council recognizes that there are numerous potential available solutions to the problem of on-call coverage in EDs, some of which may eventually require legislative or regulatory change. The Council does not see the merit, however, in supporting only one solution that would universally apply to every situation and every market, but rather, believes in promoting different solutions for different communities. In addition, while legislative action may be a viable and necessary option in the future, the Council believes that due to the variety of state law requirements, it does not see the value in endorsing a comprehensive legislative solution to every state-specific situation. Nonetheless, the Council believes any effective solution should combine a sincere commitment by physicians to provide on-call coverage with fair and adequate payment to physicians providing such on-call services. The Council recognizes the complexity of all of the elements involved in the on-call problem and believes it is important to recognize that the on-call issue is in transition. As such, the Council will continue to look for solutions to this increasingly prevalent problem. The Council feels that real solutions can only come though the collaboration of all the stakeholders involved. Thus, state and specialty societies, as well as hospitals, need to share successful models for on-call coverage, and where deficiencies and failures develop, these should likewise be shared.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 124 (I-98) and Resolution 713 (A-99), and the remainder of the report be filed:

1. That the AMA reaffirm Policy H-130.970(2) which states that all physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay.

2. That the AMA reaffirm Policy H-130.970(5) which states that all health plans should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act.

3. That the AMA advocate that physician on-call coverage for emergency departments be guided by the following principles:

   (a) The hospital and physicians should jointly share the responsibility for the provision of care of emergency department patients.

   (b) Every hospital that provides emergency services should maintain policies to ensure appropriate on-call coverage of the emergency department by medical staff specialists that are available for consultation and treatment of patients.

   (c) The organization and function of on-call services should be determined through hospital policy and medical staff by-laws, and include methods for monitoring and assuring appropriate on-call performance.

(d) Hospital medical staff by-laws and emergency department policies regarding on-call physicians responsibilities must be consistent with Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

(e) Medical staffs should determine and adopt protocols for appropriate, fair, and responsible medical staff on-call coverage.

(f) Hospitals with specialized emergency care capabilities need to have a means to ensure medical staff responsibility for patient transfer acceptance and care.

(g) Hospitals that lack the staff to provide on-call coverage for a particular specialty should have a plan that specifies how such care will be obtained.

(h) The decision to operate or close an emergency department should be made jointly by the hospital and medical staff.

4. That the AMA support the enforcement of existing laws and regulations that require physicians under contract with health plans to be adequately compensated for emergency services provided to the health plans' enrollees.

5. That the AMA support the enactment of legislation that would require health plans to adequately compensate out-of-plan physicians for emergency services provided to the health plans' enrollees.

4. GEOGRAPHIC DIFFERENCES IN PAYMENT RATES TO MEDICARE+CHOICE PLANS (RESOLUTION 703, I-98)

HOUSE ACTION: RECOMMENDATION ADOPTED IN LIEU OF RESOLUTION 703 (I-98) AND REMAINDER OF REPORT FILED

At the 1998 Interim Meeting, the House of Delegates referred Resolution 703 to the Board of Trustees. Introduced by the Arizona delegation, the resolution calls for the AMA to "petition Congress to require statewide coverage coupled with statewide shared risk in order for any managed care entity to be eligible to provide coverage in Medicare managed care markets." The Board of Trustees referred the resolution to the Council on Medical Service for a report back to the House at the 1999 Interim Meeting. In correspondence with the Council, the author of the resolution indicated that the main concerns underlying it were inadequate capitation payments to Medicare managed care plans in rural counties and the resulting withdrawal of Medicare health plans from rural areas.

This report summarizes provisions of the Balanced Budget Act (BBA) of 1997 that address regional inequities of payment rates; discusses reasons behind the withdrawals of Medicare health plans from rural areas; presents relevant existing AMA policy on this issue; and discusses the implications and possible unintended consequences of requiring statewide participation by Medicare managed care plans.

BALANCED BUDGET ACT CHANGES IN PAYMENTS TO MEDICARE+CHOICE PLANS

Prior to the passage of the BBA, Congress set the capitated payment paid to Medicare managed care plans at 95% of the county's average Medicare fee-for-service per capita payment cost adjusted for each enrollee's characteristics. By setting the payment rate at 95%, Congress intended to share in the efficiencies of capitated plans and to save money for the Medicare program. The payment to a capitated plan for a specific enrollee was the adjusted average per capita cost (AAPCC) rate multiplied by a demographic cost factor for that beneficiary.

Changes in Variation in Payments

There were several perceived problems with the AAPCC payment methodology First, the wide variation in AAPCC rates was viewed as not reflecting the true underlying disparity in costs. Second, the large disparity in AAPCC rates may have led to few, if any, capitated plans in low-cost areas. Third, studies have shown that capitated plans attract relatively healthier Medicare enrollees; and, for that reason, plans were overpaid by 5% or more. In addition, widely

disparate payment rates across geographic areas contributed to variability in access and to sizable differences in supplemental benefits.

Prior to passage of the BBA, there was substantial variation in Medicare's basic payments to managed care risk plans within states. In 1997, in New York, for example, plans in the lowest-paid county would have received $303 per patient per month compared to $767 in the highest-paid county. The range in payments in New York was 112% of the average payment. Only in the smaller states was variation in payments less of a problem for any plan that might want to contemplate a statewide operation. In Rhode Island, for example, the monthly difference between the highest-paid and lowest-paid plans in 1997 was only $46. Thus, plans in the lowest-paid county in Rhode Island still received 95% of the average across that state.

The BBA introduced numerous changes in capitated payments to Medicare managed care plans (more recently referred to as Medicare+Choice [M+C] plans) including payment floors, minimum percentage increases, and risk adjustment. A major anticipated effect of these changes is to reduce geographic disparities, particularly rural-urban disparities, in payment rates that are not based on differences in local health care costs.

Reducing Geographic Variation

M+C plans must offer uniform benefits, premiums, and co-payments to all Medicare beneficiaries residing in the service area of the M+C plan. The BBA caps the capitation rate in higher-cost counties and increases the capitation rate in lower-cost counties. In 1997, there was nearly a five-fold difference between the highest and lowest AAPCC rates in the U.S. This variation reflected differences in wages, supply of physicians, hospital beds, and practice styles across counties as well as other factors.

As of 1998, capitation payments received by Medicare managed care plans were no longer tied solely to local costs for traditional fee-for-service Medicare patients. Under the new approach, payments to plans are the greater of one of the following three options:

- A minimum payment amount or "floor" rate ($367 per member per month in 1998);
- A minimum percentage increase of 2%; or
- A "blended" capitation rate, which combines a local rate with a national rate, then adjusts for input prices and a budget neutrality factor.

For each succeeding year, the minimum payment amount or "floor" rate is the minimum amount rate for the preceding year, increased by the national per capita growth percentage for the year. The national per capita growth percentage for a year is HCFA's estimate of the rate of growth in per capita expenditures, reduced by a defined number of percentage points in the year. For the years 1999 through 2002, the reduction is 0.5 percentage points.

The blended amount is based on a mix of the county's area-specific rate and a price-adjusted national average area-specific rate. The national average input-price adjusted amount (NAIPAA) is the weighted national average of all area-specific amounts adjusted by each county's wage index and physician cost index. In 1998, the blend was 90% of the county's area-specific rate and 10% of the NAIPAA. For 2000, the blend will be 74% of the county's area-specific rate and 26% of the NAIPAA. Each year thereafter, the BBA decreases the proportion based on the area-specific amount and increases the proportion based on the NAIPAA until 2003 when it will supposedly reach a 50/50 split.

The blended amount is intended to move capitation rates in all counties closer to the national average. The minimum payment amount is designed to increase capitation rates mainly for rural counties with the intention of luring capitated plans into these underserved markets. The minimum percentage increase is designed to counteract the capitation rates to higher cost counties. These three options were designed to alter capitation rates. Overall spending should not increase, however, since total payments are subject to budget neutrality. The national floor on payments in any county established by the BBA was a way to address the lack of plan offerings in rural counties. To balance this increase, county payment levels for plans not at the floor were guaranteed a 2% minimum increase each year, which is the amount that payment levels have increased in those counties every year since that time. Basically the lowest levels were increased and the highest levels were constrained. As a result, variation in payment levels was reduced in every state.

In terms of the top to bottom range relative to the state average, each of the 50 states exhibited a decline from 1997, the last year prior to the change, to 2000. The maximum relative range (in New York, both years) fell from 112% to 88%. The minimum relative range fell from 10% in Rhode Island in 1997 to 6% in Vermont in 2000. Prior to passage of the BBA, rural counties received as little as 54% of the state average (Ohio) and as much as 95% (Rhode Island) in 1997. For the year 2000, rural counties receive no less than 77% of the state average (Florida) and as much as 99.3% (Nebraska).

While payment levels in some of the rural counties have increased substantially, many high-payment (i.e., high-cost) areas will see a cumulative increase of 6.1% from 1997 to 2000. If the pre-BBA levels characterized the cost of purchasing health care in those areas in 1997, there should be opportunities for expanding into rural counties, but "statewideness" may still be elusive. In Ohio, for example, the lowest monthly rate increased $176 from $225 to $401. The highest rate, however, increased by just $35 from $570 to $605. The attached table, prepared by staff from the AMA Center for Health Policy Research utilizing data from the Health Care Financing Administration (HCFA), lists the minimum, maximum, and average Medicare risk plan monthly payments across counties by state in 1997 and 2000.

Starting as early as the year 2000, HCFA intends to use diagnostic information to risk-adjust capitation payments to M+C plans. Under risk-adjustment, plans will be paid more for patients whose health care costs are expected to be high and less for relatively healthy patients. By aligning capitated payments to plans with expected costs of enrollees, plans are expected to have less incentive to select low-risk enrollees and avoid the chronically ill. Initially, payments to M+C plans will be risk-adjusted using hospital inpatient data. More complete risk-adjustment based on both hospital inpatient and ambulatory care data is to be introduced in 2002 or later.

HCFA plans to phase in the new interim risk-adjustment system slowly. In 2000, only 10% of health plans' payments will be adjusted using the new method. This proportion will be increased each year until 2003, when 80% of plans' payments will be adjusted using the interim system. In 2004, HCFA intends to implement a more finely tuned risk-adjuster that uses medical data from physician offices, skilled nursing facilities, home health agencies, and other health care settings and providers.

MEDICARE+CHOICE PLANS WITHDRAWALS

As of July 1999, more than 17% of the nearly 40 million Medicare beneficiaries were enrolled in a M+C plan. Shortly before the M+C program was implemented, 45 plans announced they would not renew their Medicare contracts, and 54 others announced they would reduce the geographic areas in which they provided services. In July 1999, 41 plans announced their intent to leave the M+C program, and 58 said they would reduce their services. Their actions will affect a total of about 327,000 beneficiaries.

The plans cite, among their reasons for leaving the Medicare market, the payment limits imposed by the BBA, overly burdensome regulations, and their opposition to the new risk-adjustment formula. According to a June 1999 General Accounting Office report, plan withdrawals cannot be traced to a single cause. Rather, a variety of factors appear to be associated with plans' withdrawal decisions. While payment level is certainly one factor that influences where plans choose to offer services, withdrawals were not limited to counties with low payments. In fact, 91% of high-payment-rate counties experienced a plan withdrawal compared with 34% of low-payment-rate counties. Also, 10 of the 11 counties with the highest payment rates were affected by the withdrawals. A portion of the pullouts may have been the result of plans deciding they were not strong enough to effectively compete in certain markets.

The current movement of plans in and out of the M+C program is likely to be a normal reaction to market competition and conditions. While new payment rates were certain to have been considered in plans' decisions to withdraw from certain geographic areas, factors such as recent entry into the market, low enrollment, trouble establishing adequate provider networks, and high levels of competition, played contributing roles as well.

Moreover, although an unusually large number of managed care plans left the Medicare program in 1999, a number of new plans have applied to either enter the program or expand their participation. HCFA reports various plans either have approved or pending applications to participate in the program. Furthermore, slightly more beneficiaries have access to M+C plans in 1999 than in 1998 before the withdrawals occurred. It is likely that many M+C plans could be blaming lower payments, when in fact they are simply clearing out of money-losing markets to boost their profits.

Although for some localities withdrawals have meant significantly diminished or no access, only 1% of previously covered managed care enrollees were left without any M+C plan option. In addition, beneficiary access to Medicare managed care plans increased slightly in 1999.

RELEVANT AMA POLICY

The AMA has established several policies that are relevant to the issues raised in Resolution 703 (I-98). Existing AMA policy calls for the promotion of access to health care in rural areas (Policies H-465.994 and H-465.985, AMA Policy Compendium) and for the elimination of geographic payment inequities not based on cost or utilization differences (Policies H-465.985 and H-400.955). Perhaps of most relevance to Resolution 703 (I-98) is Policy H-400.955 which states the following:

(1) The AMA believes geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjusters that include demographic factors, health status, and other useful and cost-effective predictors of health care use.

(2) The AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care.

(3) The AMA will seek modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations.

(4) The AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow for equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts.

Policy H-400-950 also supports Medicare risk payment methodology that would set equitable payment levels across geographic regions and allow for "equitable payment rates" in areas with low utilization due to cost containment efforts. In addition, Policy H-400.950 supports changing the current geographic unit from the county to a larger geographic area such as the state.

IMPLICATIONS OF REQUIRING STATEWIDE PARTICIPATION

In considering the actions called for in Resolution 703 (I-98), the Council believes that requiring statewide participation by Medicare managed care plans is not only politically unfeasible, but has several possible unintended consequences as well. The proposed solution also would be difficult to implement in a number of states, particularly those with large rural areas.

Medicare managed care plans, as a requirement for Medicare participation, offered more generous benefits, such as coverage for prescription drugs, routine dental care, and hearing exams, that those available in the fee-for-service program. Although the extent of extra benefits varies by plan, they are more commonly offered in high-payment counties. If plans are forced to share risk statewide, the additional benefits offered by plans, which make them an attractive option for Medicare enrollees, may be significantly reduced. In addition, there is a strong possibility that statewide shared risk would lead to additional plan pullouts, resulting in less choice and access for beneficiaries in both rural and urban areas. Statewide coverage, coupled with shared risk, could result in plans reducing services and/or coverage for their members. This, in turn, has implications for all organizations that provide care to those members, including hospitals, physicians, long-term care facilities, and pharmacies.

Some Wall Street analysts warn that Medicare managed care plans will lose their attraction to beneficiaries and eventually drop out of the program altogether if they are forced to scale back all of the extra benefits they are able to provide now. Indeed, many M+C plans already have started moving in this direction. PacifiCare, has suggested, for example, that nearly all Medicare members will see some combination of member-paid premium increases, increased copayments, or reductions in benefits.

DISCUSSION

Large variation in county Medicare managed care plan payment rates was one of the motivating factors behind some of the changes enacted in the BBA. The imposition of a floor rate has removed some of the greatest variation. The combination of the low national growth percentage and the budget neutrality rule, however, delayed the application of the blended-rule rate. When county rates are more heavily based on the national component of the blend, more of the county variation will be reduced.

HCFA has announced rates that implement the blend in 2000 and as such, substantial numbers of counties will finally be eligible for a blend rate starting in 2000. At that point, there will be a narrowing of the current range of variation across counties and regions, one of the policy objectives of the BBA. The methodology in the BBA ensures that this narrowing will remain modest, beyond the impact of raising rates in the lowest-paid counties to the floor.

In August 1999, the Director of HCFA's Center for Health Plans and Providers stated that, "payment is rising in all counties this coming year by an average of 5%, and will rise by as much as 18% in some areas. . . BBA payment reforms were designed to increase payment in counties that had the lowest rates and therefore the fewest number of plans."

The outlook for managed care plans in low-cost counties is favorable. Although fewer enrollees live in these low-cost counties, capitated plans will have strong incentives to move into these areas, because capitation rates are improving. As a result, the Council believes it would be premature to conclude that the BBA methodology needs to be radically revised to ensure the success of Medicare+Choice plans. In addition, the Council recognizes that one of the difficulties in establishing plans in rural areas involves the lack of adequate provider networks.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 703 (I-98), and that the remainder of this report be filed:

1. That the AMA reaffirm Policy H-400.955 which states that geographic payment differences in Medicare capitation rates should reflect demonstrable variations in practice costs and utilization, be adjusted at the individual level with improved risk adjusters, and be set at levels that establish and maintain access to quality care; and that the AMA supports a Medicare risk payment methodology that would set equitable payment levels across geographic regions.

TABLE

Minimum, Maximum, and Average Medicare Risk Plan Monthly Payment Rates,
Across Counties by State in 1997 and 2000

	1997			2000		
State	Minimum	Maximum	Average	Minimum	Maximum	Average
Alabama	345.49	646.93	446.98	401.61	686.53	484.19
Alaska	270.20	579.11	420.49	401.61	623.98	494.81
Arizona	308.73	519.91	413.52	401.61	551.74	464.79
Arkansas	268.57	496.35	377.92	401.61	526.74	429.76
California	372.96	622.55	464.23	438.04	660.65	518.65
Colorado	241.47	568.75	383.63	401.61	603.55	445.57
Connecticut	423.69	500.69	465.00	482.64	546.20	516.75
Delaware	395.18	515.64	452.21	450.67	547.20	495.35
Florida	327.70	748.23	480.62	401.61	794.02	520.84
Georgia	306.92	647.08	450.52	401.61	686.68	490.61
Hawaii	313.64	384.25	351.37	401.61	453.39	427.46
Idaho	259.99	419.40	328.08	401.61	464.16	409.83

	1997			2000		
State	Minimum	Maximum	Average	Minimum	Maximum	Average
Illinois	290.12	559.27	370.49	401.61	593.51	427.98
Indiana	278.90	532.25	392.51	401.61	564.82	444.44
Iowa	252.12	410.93	322.24	401.61	458.62	405.96
Kansas	265.19	519.09	390.47	401.61	550.86	441.01
Kentucky	289.32	535.60	405.73	401.61	568.38	452.76
Louisiana	370.01	727.72	501.70	421.89	772.26	539.79
Maine	312.71	383.79	345.30	401.61	434.55	411.33
Maryland	356.64	632.70	477.48	413.12	671.43	519.12
Massachusetts	403.88	637.29	510.01	462.21	676.30	552.80
Michigan	299.75	638.68	423.22	401.61	677.77	473.85
Minnesota	227.30	422.41	304.32	401.61	470.65	407.00
Mississippi	290.72	594.00	409.58	401.61	630.36	453.92
Missouri	257.06	541.99	378.91	401.61	575.17	431.62
Montana	239.38	409.85	339.39	401.61	455.25	414.50
Nebraska	220.92	432.72	292.05	401.61	471.42	404.26
Nevada	297.46	509.46	406.37	401.61	554.90	468.13
New Hampshire	350.25	421.12	383.84	417.34	479.31	444.95
New Jersey	438.91	559.24	513.31	491.08	593.47	554.22
New Mexico	231.67	435.44	333.77	401.61	474.73	409.90
New York	303.28	767.35	412.59	401.61	814.32	466.72
North Carolina	299.52	499.09	371.93	401.61	529.63	426.47
North Dakota	256.67	423.64	336.03	401.61	460.82	409.08
Ohio	225.01	570.12	414.36	401.61	605.01	461.79
Oklahoma	278.68	488.59	379.68	401.61	518.50	430.58
Oregon	283.08	441.66	344.74	401.61	487.34	419.52
Pennsylvania	334.51	704.25	459.96	401.61	747.35	499.68
Rhode Island	431.12	477.43	453.86	473.50	519.29	497.85
South Carolina	268.14	459.60	361.09	401.61	496.35	424.67
South Dakota	233.06	421.71	314.15	401.61	470.91	405.52
Tennessee	345.27	649.73	467.62	401.61	689.49	504.88
Texas	229.70	677.79	420.86	401.61	719.28	467.32
Utah	272.36	517.15	366.17	401.61	548.80	428.15
Vermont	324.23	385.32	349.43	401.61	424.33	407.48
Virginia	255.60	607.49	398.71	401.61	644.67	449.91
Washington	317.12	431.39	375.20	401.61	486.29	440.14
West Virginia	281.93	641.67	410.34	401.61	680.94	455.93
Wisconsin	250.30	434.75	318.97	401.61	470.57	406.49
Wyoming	274.07	452.30	373.92	401.61	488.82	433.45

Source: AMA tabulation of data from the Health Care Financing Administration

5. STATUS REPORT ON THE MEDICAID PROGRAM

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

At the 1997 Interim Meeting, the House of Delegates adopted the 21 recommendations contained in Board of Trustees Report 31 related to Medicaid financing (Policy H-290.982, AMA Policy Compendium). Board Report 31 (I-97) presented the findings of the AMA Inter-Council Medicaid Task Force, which advocated that the Medicaid program be viewed and treated as three separate programs because the needs and attendant costs of one group of beneficiaries may overwhelm those of another group of beneficiaries. In particular, the Task Force noted the intensive use of both long-term and acute care services among the elderly, blind, and disabled, although these populations account for a minority of the Medicaid beneficiary population.

In its ongoing study of mechanisms for increasing health care coverage for the uninsured, the Council on Medical Service believes these issues must be addressed with a comprehensive understanding of the Medicaid program and its beneficiaries. The Council presents this report in its effort to evaluate and present information related to the future viability of the Medicaid program.

THE MEDICAID PROGRAM

Medicaid was authorized in 1965 by Title XIX of the federal Social Security Act as a federal-state matching entitlement program that pays the medical care for certain vulnerable and needy individuals and families with low income and assets. Medicaid is the largest source of health care funding for the country's poorest people.

States are given broad discretion in determining eligibility standards, payment rates, and scope of services. There is no requirement that all low-income individuals be eligible for Medicaid. The federal government does, however, require that states cover certain low-income population groups that are considered "categorically needy." These include pregnant women and children under the age of six who are in families at or below 133% of the federal poverty level; children under the age of 19 who were born after September 30, 1983, and whose family income is at or below 100% of the federal poverty level; recipients of federal adoption or foster assistance; the aged, blind and disabled who receive benefits under the Supplemental Security Income Program (SSI); individuals who meet what on July 16, 1996 had been the income and related standards of Aid to Families with Dependent Children (AFDC, the former cash benefit program); special protected groups, such as those who lost cash assistance due to earnings income or increased Social Security benefits), and certain Medicare beneficiaries who have low incomes and limited resources.

In addition to the "categorically needy," states have the option of providing Medicaid coverage for other groups that share some characteristics of the mandatory groups, but with more liberally defined eligibility criteria. For example, states may choose to cover infants up to age one and pregnant women whose family income is at or below 185% of the federal poverty level; as well as individuals who would be eligible if institutionalized, but who are receiving care under home or community-based services. A significant optional coverage group includes "medically needy" persons who would be eligible for Medicaid under one of the categorical or optional groups, except that they exceeded the income or asset limits. In order to qualify for Medicaid coverage, this group of individuals must "spend down" by incurring medical expenses that reduce their income and assets to or below their state's level.

Some states have used their discretionary eligibility authority to address the problem of the uninsured by developing programs to expand Medicaid coverage to low-income (up to 150% of the federal poverty level) and non-elderly adults, who are not disabled and who have no children. In the absence of private sector reforms that would enable persons with low-incomes to purchase insurance, the Council supports such Medicaid expansion efforts to provide coverage to the otherwise uninsured.

THE BENEFICIARY TRIAD

The Medicaid program is often thought of as providing medical coverage for three distinct beneficiary groups: children, the blind and disabled, and the elderly. The common thread among all Medicaid beneficiaries is that they are in families with very low incomes. Table 1 summarizes the 1997 Medicaid beneficiary population.

Table 1: Medicaid Enrollees and Expenditures by Group, 1997

	Enrollees		Direct Expenditures	
	Thousands (or 000)	% of Total	$ Millions (or 000,000)	% of Total
All Enrollees	40,570	100.0	145,282	100.0
Nondisabled Children	21,019	51.8	24,301	16.7
Nondisabled Adults	8,604	21.2	16,122	11.1
Aged	4,114	10.1	44,450	30.6
Blind and Disabled	6,833	16.8	60,409	41.6

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports, 1999. Data are provided in cooperation with the Kaiser Commission on Medicaid and the Uninsured.

Notes: Data are for federal fiscal year 1997. Does not include $15.9 billion in disproportionate share hospital payments, administrative costs, accounting adjustments, or expenditures in the U.S. territories; total expenditures with all of these inclusions are $165.9 billion. Enrollees are defined as individuals who sign up for the Medicaid program for any length of time during the federal fiscal year–these people may never actually use medical services.

In addition, to beneficiary groups included in the triad, nondisabled, low-income pregnant women and other adults with children receiving cash assistance account for roughly a fifth of Medicaid recipients. Although the elderly and disabled account for less than a third of Medicaid recipients, 60% of total program expenditures go to these groups. Prior to the enactment of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193, the "Welfare Reform Act"), people who received cash assistance were automatically enrolled in Medicaid. As reported in CMS Report 2 (A-99), the Welfare Reform Act administratively disconnected the link between receiving cash assistance and Medicaid enrollment so that an additional effort must now be made to enroll those in families receiving cash benefits. In addition, although the Welfare Reform Act of 1996 was specifically intended to allow those who left the welfare rolls for work to keep their Medicaid coverage, several thousand Medicaid-eligible low-income workers have lost their coverage. Because many former welfare recipients took low-wage jobs that offer no health benefits, the result has been an increase in the number of people without health insurance.

Children and the elderly are characterized in the Medicaid beneficiary population by virtue of their age. Table 2 summarizes the age of Medicaid beneficiaries in 1997. According to unpublished 1997 data provided by HCFA, 66% of Medicaid recipients in the 45 to 64 age group were disabled.

Table 2: Medicaid Enrollees by Age, 1997

	Enrollees	% of Total
Total enrollees	40,344,493	100.0
under 1 year old	2,112,346	5.2
1-5 years old	7,531,010	18.7
6-14 years old	9,108,943	22.6
15-20 years old	3,977,133	9.9
21-44 years old	9,486,692	23.5
45-64 years old	3,308,820	8.2
65-74 years old	1,964,608	4.9
75-84 years old	1,603,379	4.0
85 years old and over	1,143,560	2.8
Age unknown	92,568	0.2

(Source: HCFA-2082 Report, Table 28)

The Disabled

In 1997, approximately 73% of disabled Medicaid recipients were nonelderly adults aged 21 to 64 years old. The disabled accounted for 16.8% of Medicaid beneficiaries and 41.6% of direct Medicaid expenditures, making the disabled the most costly beneficiary group. The relatively high expenditures for the disabled reflects their substantial health care needs and the very nature of their Medicaid eligibility. Of total Medicaid expenditures for care of the disabled, 41.3% went to finance long-term care (see Table 4). With the discussion of long-term care to follow, it is relevant to note that in 1995, only 10.9% of nursing facility residents were under age 65, which indicates that the disabled are underrepresented in the nursing home population relative to the elderly—the other significant nursing

home population. In 1997, long-term care expenses for the disabled consisted of 36.6% for care in an intermediate care facilities for the mentally retarded, 36.7% for home health care, and 23.5% for care in skilled nursing facilities.

The Elderly

In 1997, the elderly accounted for 10.1% of the Medicaid population and 30.6% of direct Medicaid expenditures. Medicaid beneficiaries over the age of 65 are also eligible for coverage under the Medicare program, making them "dual eligibles." Long-term care costs for the elderly accounted for 74.1% of total Medicaid expenditures for the elderly. Within long-term care, 82.1% of expenditures for the elderly were for care in nursing facilities. Like the disabled, the high costs associated with elderly Medicaid beneficiaries represent the substantial health care needs of this group.

Children

In 1997, 51.8% of Medicaid beneficiaries were nondisabled children, who accounted for 16.7% of direct program expenditures. Thus, children comprise the largest category of Medicaid beneficiaries, but receive a relatively small portion of Medicaid resources. The great medical and social value of ensuring access for children is fortuitously combined with the relatively low cost of their health care. The Council continues to strongly support Policy H-165.882(1), which places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for children.

CMS Report 2 (A-99) provided an overview of the State Children's Health Insurance Program, commonly referred to as CHIP, which was authorized by the Balanced Budget Act of 1997
(P.L. 105-33, "BBA"). All states and six U.S. territories have approved CHIP programs, which provide health insurance coverage to low-income children who are ineligible for Medicaid. Although CHIP programs can be structured as either Medicaid expansions or as separate programs, eligibility criteria for CHIP can be characterized as including an income cap that is higher than that allowed for Medicaid eligibility.

As of June 1999, 1.3 million children were enrolled in state CHIP programs. In May 1999, two comprehensive reports were issued that provide updates on CHIP: one by the U.S. General Accounting Office (GAO) and the other by the Department of Health and Human Services Office of the Inspector General (OIG). The GAO reported that a growing number of states are exploring statutory options under CHIP for including family coverage and subsidizing employer-sponsored coverage. Such innovations are consistent with Policy H-165.882[8], which calls for alternative sources of financing premium subsidies for children's private coverage. The 15 states included in the GAO's analysis had all developed innovative outreach strategies. The OIG report focused on enrollment processes and recommended shorter and multi-lingual enrollment applications, which are consistent with the recommendations in CMS Report 2 (A-99) (Policy H-290.982[17 and 18]).

On October 12, 1999, President Clinton announced a multi-agency plan to increase federal efforts to enroll more children in Medicaid and CHIP. The plan will attempt to reach children through school-based programs and through their grandparents by informing seniors about the programs
in Social Security notices. In addition, the plan includes private sector initiatives such as placing enrollment information on grocery bags. Furthermore, HCFA has awarded a five-year, $4.2 million contract to Mathematica Policy Research, Inc. to conduct a five-year study of CHIP success toward expanding access to health insurance to children in low-income families.

RELEVANT AMA POLICY

The AMA has established comprehensive policy concerning the financing of Medicaid, which includes policy on long-term care financing and improving access to health care coverage for the otherwise uninsured. In addition, AMA policy on the uninsured favors private over public coverage as a means of increasing access, and provides a detailed policy for achieving privately and individually owned insurance (Policy H-165.920).

Policy H-290.982(1) advocates that Medicaid reform not be undertaken in isolation, but rather in conjunction with Medicare reform, in order to ensure that the delivery and financing of care through both programs result in appropriate access and level of services for patients; (2) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and

other approaches; (3) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs; (4) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care; (5) urges states to administer their Medicaid and SCHIP programs through a single state agency; (6) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs; (7) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of tax credits; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children; (8) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services; (9) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals; (10) calls for HCFA to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care; (11) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income; (12) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care; (13) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs; (14) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance; (15) supports efforts to assess the needs of mentally retarded individuals and, as appropriate, shift them from institutional care in the direction of community living; (16) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments; (17) urges HCFA to require states to use its simplified four-page combination Medicaid/CHIP application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and (18) urges HCFA to ensure that Medicaid and CHIP outreach efforts are appropriately bilingual and culturally sensitive in states or localities with large uninsured ethnic populations.

Policy H-280.991 establishes guidelines for long-term care financing proposals. Among the comprehensive list of principles in this policy are the following key recommendations: (7) provide sliding scale subsidies for the purchase of long-term care insurance coverage for individuals with incomes between 100-200 percent of the poverty level; (8) encourage private sector coverage through an asset protection program; equivalent to the amount of private coverage purchased; (9) create tax incentives to allow individuals to deduct the cost of coverage from income tax, encourage employers to offer such policies as a part of employee benefit packages and otherwise treat employer-provided coverage in the same fashion as health insurance coverage, and allow tax-free withdrawals from IRAs and Employee Trusts for payment of long-term care insurance premiums and expenses; (10) authorize a tax deduction or credit to encourage family care giving; and (10,a) provide an environment that permits states to develop innovative financing and delivery arrangements.

Policy H-165.920(7) strongly supports legislation promoting the establishment and use of medical savings accounts and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.

Policies H-165.882 and Policy H-165.920(2) related to improving access for the uninsured, recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access. The former policy includes 11 recommendations for increasing access for children including a recommendation to place particular emphasis on expanding insurance coverage to uninsured children and placing a preference on enabling children to obtain private insurance rather than being placed in Medicaid (Policy H-165.882[1]). In addition, Policy H-165.882[8] advocates other sources of financing premium subsidies for children's private coverage.

MEDICAID FINANCING

The HCFA Office of the Actuary estimates that 1999 federal and state Medicaid expenditures will total $181 billion, covering 34.9 million individuals, or about 13 percent of the United States population. For 2000, budgeted projections estimate that 35.4 million individuals will be covered at a cost of $192 billion. State Medicaid programs operate by making "vendor" payments, with vendors being physicians and other health care practitioners as well as health care facilities. Table 3 includes a summary of overall 1997 Medicaid expenditures as expressed in terms of vendor payments.

Table 3: Medicaid Vendor Payments, 1997

Vendor Type	Dollar Amount	% of Payments
General and mental inpatient hospital	$25 billion	20.2%
Outpatient hospital	$6.2 billion	5.0%
Clinic services	$4.3 billion	3.5%
Lab and X-ray services	$1 billion	0.8%
Nursing facility services	$30.5 billion	24.7%
Home health services	$12 billion	9.7%
Intermediate care facilities	$9.8 billion	7.9%
Physician services	$7 billion	5.7%
Dental services	$1 billion	0.8%
Other practitioner services	$979 million	0.8%
Prescription drugs	$12 billion	9.7%
Family planning	$400 million	0.3%
EPSDT	$1.6 billion	1.3%
Rural health	$308 million	0.2%
Other care	$11 billion	8.9%
Service unknown	$2 million	0.0%

(Source: HCFA-2082 Report, Table 10)

States may pay vendors directly or pay for Medicaid services through various prepayment strategies. The BBA cleared the way for states to require Medicaid beneficiaries to enroll in managed care plans. The AMA expressed strong opposition to the mandatory enrollment procedure, citing the difficulties of Medicare+Choice implementation as evidence of an unstable market and the subsequent threat to the public health safety net. The Council also developed a comprehensive series of principles to guide the development and implementation of Medicaid managed care plans (Policy H-290.985). As of July 1999, Medicaid managed care programs were operating in 38 states. Consistent with the AMA's expressed concern with the precedence of Medicare+Choice, some Medicaid managed care plans have withdrawn, reduced services, or limited enrollment of Medicaid beneficiaries in their plans, citing low payment rates and a high degree of administrative requirements.

The BBA eliminated the requirement that Medicaid managed care plans maintain a minimum of 25% private sector enrollees, which served as an indirect quality assurance measure based on the presumption that plans with private sector enrollees would maintain a competitive quality standard. Following the enactment of the BBA, states may now enroll beneficiaries established solely to serve the Medicaid population. With the elimination of the private sector in managed care plans enrollee requirement, HCFA has identified numerous quality and patient protection

measures that plans must meet. In addition, a June 1999 OIG report found that Medicaid managed care plans lack guidelines to detect fraud and abuse. The report specifically found that Medicaid managed care plans were particularly susceptible to fraudulent enrollment processes and withholding covered services from beneficiaries.

It is too early to know whether the savings to the Medicaid program with mandatory managed care enrollment will be substantial. There is reason to believe, however, that any savings will be diminished because Medicaid fee-for-service payment rates were already very low. In addition, the beneficiaries enrolled in the managed care plans tend to be generally healthy adults and children who have accounted for a minority of Medicaid expenditures. Moreover, managed care can be a risky option for the disabled and others with significant health care needs. Inadequate panels of specialists and other measures that trim services that may be infrequently used for the general population, can have a profound impact on meeting the needs of persons with disabilities.

LONG-TERM CARE FINANCING

In 1997, nursing facility services accounted for 76.5% of Medicaid's long-term care expenses. At the same time that demand for long-term care increases, the nation is seeing what may become a shortage of services. Nursing homes, in particular, are under intense scrutiny following well-publicized cases of patient negligence as well as fraud and abuse. In 1998, expenses for nursing facility residents were principally covered by Medicaid (67.6%). Private insurance paid for 23.2% of nursing facility expenses and Medicare covered 9.3%. Although Medicare does not cover "long-term care," it does cover acute care services that may be provided in settings where long-term care is provided, such as skilled nursing facilities, for up to 100 days.

Table 4 summarizes Medicaid expenditures in long-term care by beneficiary group. Costs incurred by the elderly for care in nursing facilities are significant. The disabled are more likely to be represented in alternatives to nursing facility care, such as in home health and intermediate care facilities for the mentally retarded.

Table 4: Medicaid Expenditures on Long-Term Care by Enrollee Group and Type of Service
(Millions of Dollars or 000,000)

		Long Term Care				
	All Services	Total LTC (% of all svcs)	Nursing Facilities (% of LTC)	ICF-MR (% of LTC)	Mental Health (% of LTC)	Home Health (% of LTC)
Total	145,282	59,621 (41.0)	32,944 (55.3)	9,732 (16.3)	2,798 (4.7)	14,148 (23.7)
Nondisabled Children	24,301	1,487 (6.1)	46 (3.1)	37 (2.5)	1,028 (69.1)	376 (25.3)
Nondisabled Adults	16,122	243 (1.5)	25 (10.3)	4 (1.6)	82 (33.7)	132 (54.3)
Aged	44,450	32,922 (74.1)	7,017 (82.1)	551 (1.7)	877 (2.7)	4,477 (13.6)
Blind and Disabled	60,409	24,969 (41.3)	5,856 (23.5)	9,141 (36.6)	810 (3.2)	9,162 (36.7)

Source: Urban Institute estimates based on data from HCFA-2082 and HCFA-64 reports, 1999. Data are provided in cooperation with the Kaiser Commission on Medicaid and the Uninsured.

Notes: Data are for federal fiscal year 1997. Does not include administrative costs, accounting, adjustments, or the U.S. territories; total expenditures with these inclusions are $165.9 billion. ICF-MR refers to intermediate care facilities for the mentally retarded.

Whereas the long-term care expenses for the disabled can be presumed to remain relatively stable, similar expenses for the elderly are expected to soar in the coming decades. The U.S. population is aging, with mortality and fertility rates both declining, and the baby boom generation beginning to reach age 65 in 2011. In 1999, 14% of the U.S. population is age 65 or older, and long-term care accounts for one-tenth of total health care spending. By 2030, 20% of the population will be 65 or older. In March 1999, the Congressional Budget Office estimated that national

expenditures for long-term care services for people aged 65 and older would grow each year through 2040. Because of the strain on public financing sources, 1999 has seen considerable federal debate on financing long-term care.

Costs of Nursing Care

The average annual charge for nursing home care is nearly $50,000 and patient choice of nursing homes is sharply curtailed under Medicaid. Many residents pay out-of-pocket for their nursing home costs, at least for the initial few months of residency. Some nursing homes restrict the number of new residents covered by Medicaid, or require proof that new residents will be able to pay out-of-pocket for a specified time, such as one year.

In a study of innovative long-term care alternatives, the American Association of Retired Persons found that most states regulated the growth of nursing home beds either through a certificate of need process, a moratorium, or both; and many states restricted rate reimbursement increases and controlled access to nursing home care. Policy H-290.982(12) encourages the development of alternative long-term care options.

MSAs and Long-Term Care

AMA policy on individual health insurance (H-165.920) strongly supports legislation promoting the establishment and use of medical savings accounts (MSAs). The policy supports the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as essential for expanding coverage and increasing patient choice of health insurance. However, the current tax code limits the use of MSAs to the self-employed and individuals who work for companies with 50 or less employees. CMS Report 10 (I-99), which is before the House of Delegates at this meeting, discusses AMA advocacy of MSA expansion efforts.

Long-term care insurance premiums are considered an acceptable MSA expense so that for those eligible to invest in MSAs, the purchase of long-term care insurance is a prudent option. However, it would not be an optimal choice to accumulate a large MSA balance in anticipation of long-term care costs because unspent MSA balances are subject to taxation if the beneficiary of the MSA is anyone other than the spouse of the policy holder. Insurance is usually the best way to plan for a contingency that has a relatively small likelihood of realization but a very high potential cost, such as the need for long-term care.

Private Long-Term Care Insurance

AMA policy H-280.991 supports a variety of alternatives for privatizing responsibility for long-term care needs. There has been considerable public debate on how best to encourage individuals to purchase private long-term care coverage. In recent years, the availability of insurance for long-term care has greatly increased so that a variety of products are available. Because Medicaid eligibility is income and asset dependent, those who need long-term care, but who lack long-term care insurance, often find that they must “spend down” their assets in order to qualify for Medicaid coverage. The Robert Wood Johnson Foundation has developed demonstration projects linking Medicaid to private long-term care insurance. The demonstrations allow those who purchase private long-term care insurance to protect some or all of their assets from eligibility consideration in the event they exhaust their long-term care insurance and need to apply for Medicaid coverage.

Long-term care proposals that were generally consistent with AMA policy were discussed during the 1999 session of Congress. One bill would have provided a refundable tax credit to cover long-term care expenses, consistent with Policy H-280.991(10). A separate proposal would have made long-term care insurance premiums fully deductible, consistent with Policy H-280.991(9).

CONCLUSION

As suggested by the AMA Inter-Council Medicaid Task Force in Board Report 31 (I-97), the Council on Medical Service considered both the positive and negative implications of treating the Medicaid program as three separate programs with separate beneficiary needs. For purposes of better understanding the financial strains of the Medicaid program, however, the Council believes that the most useful initial step is to look at the expenditures associated with the various beneficiary groups relative to the overall program costs. At this time, the Council believes that any effort to separate the program for purposes other than analyzing its components could inadvertently harm those groups for which such a separation would intend to protect. For example, the health care access interests of children

may be better served by their remaining in the same entitlement program as elderly people who have a stronger political base.

Nonetheless, the Council is greatly concerned about the impending surge in long-term care expenditures and is encouraged that some federal legislators are responding for the need to address this issue. The Council believes that AMA policy on Medicaid and long-term care financing continues to be pertinent to ongoing advocacy efforts. The Council notes that long-term care insurance should receive the same tax treatment as health insurance, because it is used to cover expenses related to maintaining health. Whereas AMA Policy H-165.920(20) supports a tax credit for the purchase of individual health insurance, and Policy H-280.991(9) supports a tax deduction for the purchase of long-term care insurance, the Council recommends that advocacy for individually owned insurance apply also to long-term care insurance so that a tax credit would be provided for the purchase of long-term care insurance.

Furthermore, the Council believes that improving health care access for the poor, regardless of age or disability, is a key national priority, and the most appropriate framework for improving access was developed in Council Report 9, A-98 (Policy H-165.920), which supports a refundable tax credit for the purchase of individually owned insurance. Under the current insurance market, however, the disabled would have difficulty obtaining affordable individually owned insurance and the Council recognizes the critical role of Medicaid as a safety net for the poorest elderly and disabled who have enormous health care needs. Therefore, in the absence of private sector reforms to enable the poor and uninsured to purchase coverage, the Council would support eligibility expansions in Medicaid and CHIP.

RECOMMENDATIONS

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

1. That the AMA reaffirm Policy H-165.882(1), which places particular emphasis on advocating policies and proposals designed to expand coverage for uninsured children and recommends that the funding for this coverage should preferably be used for the selection of private insurance rather than placement in the Medicaid program.

2. That, in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, the AMA support eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups.

3. That the AMA reaffirm Policy H-165.920(12), which encourages the replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with a tax credit for individuals equal to a percentage of the total amount spent for health expense coverage by the individual's employer.

4. That the AMA advocate that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance.

5. That the AMA urge Congress and the Administration to develop proposals and enact solutions to address the pending growth of long-term care needs of the American population.

6. That the AMA continue to advocate for appropriate payment to physicians under the Medicaid program.

6. PHYSICIAN PERFORMANCE PRODUCTIVITY MEASUREMENT

HOUSE ACTION: FILED

The Council on Medical Service (CMS) previously examined the issue of physician performance measurement in CMS Report J (A-93). That report summarized the potential applications of physician profiling, discussed current issues and experiences in profiling, and established a series of principles to guide the development and use of physician profiles (Policies H-406.993 and H-406.994, AMA Policy Compendium). The Council also studied the issue of financial incentives utilized in the management of medical care in CMS Report 3 (I-96). That report described the primary types of financial incentives, presented recent data on the prevalence of such incentives, summarized relevant AMA policy, and established a series of principles to guide the use of financial incentives in

the management of medical care (Policy H-285.951). In addition, CMS Report 8 (I-99), which is before the House of Delegates at this meeting, examines the impact of physician assumption of financial risk.

The potential applications of physician productivity measures have expanded in recent years. A 1997 survey by the American Medical Group Association (AMGA) revealed that 84% of clinics surveyed used productivity as part of their physician compensation program. Survey data from the Medical Group Management Association (MGMA) also reveal that the percentage of medical groups that base between 50% and 100% of established physicians' incomes on productivity has increased from 47% of medical practices in 1993 to 51% of practices in 1997. Moreover, according to survey data from Medical Economics, productivity formulas account for a higher percentage of doctors' earnings in western states because the significant managed care presence in those states has resulted in an increased emphasis on physician productivity and efficiency.

In addition to serving as a method of compensating physicians, productivity measures have been used for physician profiles by practices and health plans to attempt to determine the cost and quality of care, to establish group or individual productivity targets, to balance workloads, to assign over-head expenses, and for cost accounting and resource planning purposes. Whereas productivity at one time meant gross billings based on a standard fee schedule, irrespective of payer, it now has several different meanings in terms of how physician performance is measured.

This report, which is presented for the information of the House, reviews the available literature on the current status of physician performance productivity measurement, highlights relevant AMA policy, and discusses several factors that should be considered when evaluating the various physician productivity measures available.

CURRENT STATUS OF PHYSICIAN PERFORMANCE PRODUCTIVTY MEASUREMENT

Over time, physicians' clinical productivity has been measured in a number of ways. Before managed care became the driving force in medicine, many physicians measured their productivity by how much they earned. Today, however, capitation -- where a physician or a group of physicians agree to provide medical care to a group of patients for a rate negotiated in advance -- often undermines the link between payment and productivity. Measuring productivity based on earnings also tended to favor procedural over cognitive services and reflected the influence of local fee structures and the effectiveness of collections staff.

Charges and Collections

According to 1997 MGMA survey data, 28% of responding medical practices used gross charges to measure physician productivity in their physician compensation methodologies. Critics of this method maintain that most groups will not be able to afford to base physicians' incomes on billings based on non-discounted fee schedules because, in most markets, payers routinely disregard these schedules. They contend that groups that continue to pay physicians on dollars billed, but for which they have little chance of collecting, run the risk of creating financial problems for their practices. Alternatively, according to the 1997 MGMA survey data, 19% of responding medical practices used net or adjusted charges -- gross billings minus all adjustments, such as amounts that insurers "disallow" and discounts that physicians have agreed to accept -- to measure physician productivity in their physician compensation methodologies. To achieve payer neutrality, and thereby discourage the "cherry picking" of cases, medical groups that base physician productivity on net charges may determine billings by using a uniform fee schedule. However, using net charges as a physician productivity measure fails to credit physicians for uncovered services that they have performed.

Sixty-two percent of medical practices responding to the MGMA survey reported using net collections -- usually defined as actual collections for professional services plus all other group revenues minus expenses -- to measure physician productivity in their physician compensation methodologies in 1997. Physician productivity can be measured using gross collections as well. Some groups opt for a collections-based structure, viewing collections as "money in the door" and the best measure of the group's financial picture. However, like net charges, using collections to measure physician productivity fails to credit physicians for uncovered services that they have performed. Collections are also, by definition, not payer-neutral. The amount collected from insurance companies can vary greatly based on different fee schedules or the plan's covered services. Therefore, the collections-based structure can cause competition among physicians for the patients with health plans paying the most in order to increase productivity. Another potential disadvantage associated with collections as a productivity measure is that collections may vary based on the effectiveness of collections staff.

Measuring physician productivity using either charges or collections does not necessarily place additional data collection burdens on physicians or other staff. Charges and collections are already compiled for basic business purposes. However, critics maintain that basing physician productivity on charges or collections may encourage overutilization that could eventually jeopardize the group's standing with managed care organizations. Charges and collections also may reflect the influence of local fee structures, impeding comparisons across practices.

Number and Duration of Patient Encounters

Ten percent of the medical practices responding to the MGMA survey reported using patient encounter data to measure physician productivity in their physician compensation methodologies in 1997. Unlike charges and collections, number of patient encounters is a payer-neutral measure of productivity. Moreover, office staff can easily track this type of information. However, a clear benefit exists for having many healthy patients to keep volume high. If one physician in a group captures the majority of healthy patients, that individual has a distinct advantage over his or her colleagues. Basing physician productivity on the number of patient encounters also may encourage limiting the amount of time spent with any one patient in order to maximize the total number of patients seen. To avoid this, others have suggested using the duration of patient encounters to measure physicians' productivity. They argue that the duration of the face-to-face encounter with the patient or family is strongly predictive of the total amount of physician work. Like the number of patient encounters, the duration of such encounters is a payer neutral productivity measure. However, this measure may result in overutilization. Moreover, while most hours are easy to count once timesheets are collected, physicians may or may not keep accurate, detailed or consistent time allocation records for direct patient care specifically.

Patient Panel Size

According to the 1997 MGMA survey data, 2% of responding medical practices reported using patient panel size to measure physician productivity in their physician compensation methodologies. Medical groups that derive a large share of their incomes from capitation payments may wish to reward physicians based on how many capitated patients they have. While this type of information may be relatively easy to collect, patient panel size alone does not account for services performed, thereby potentially penalizing physicians who may have sicker patients. Moreover, this measure is clearly not payer-neutral in that physicians do not receive credit for their fee-for-service patients. However, this can be overcome by basing physician productivity on total number of patients.

Relative Value Units

Fifteen percent of medical practices responding to the MGMA survey used total relative value units (RVUs) to measure physician productivity in their physician compensation methodologies in 1997. In 1992, Medicare significantly changed the way it pays for physicians' services. Instead of basing payments on charges, the federal government established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS). The total RVU, which consists of physician work, practice expense, and professional liability insurance, is multiplied by a monetary conversion factor to calculate Medicare payments. The physician work component accounts, on average, for 55% of the total relative value for each service. The factors used to determine physician work include: the time it takes to perform the service, the technical skill and physical effort involved, the required mental effort and judgement, and stress due to the potential risk to the patient.

Work RVUs are updated annually to account for changes in medical practice. The legislation enacting the RBRVS also requires the Health Care Financing Administration (HCFA) to review the entire scale every five years. Annual updates to work RVUs are based on recommendations from a committee involving the AMA and national medical specialty societies. The AMA/Specialty Society RVS Update Committee (RUC) represents the medical profession, with 23 of its 29 members appointed by national medical specialty societies, including those recognized by the American Board of Medical Specialties, those with a large percentage of physicians in patient care, and those that account for high percentages of Medicare expenditures. HCFA also sought assistance from the RUC in the first five-year review of the RBRVS.

The results of the 1998 AMGA survey demonstrate a strong trend toward medical group use of work RVUs to measure physician productivity. In 1996, a little more than 21% of the responding groups reported using work RVUs, while 34% of the responding groups reported using this measure in 1997. Unlike total RVUs, work RVUs focus exclusively on direct physician-patient care, thereby making this a more accurate gauge of physician work. Work RVUs exist only for codes that have a direct physician-patient care component. Ancillary procedures carry a

work RVU of zero. Since becoming resource-based in 1992, work RVUs are generally stable, while total RVUs have fluctuated from year to year, thereby making it more difficult to budget and analyze trends. However, total RVUs will stabilize once both the practice expense and professional liability insurance components of the relative value system are resource-based. HCFA plans to complete the phase-in of the resource-based practice expense and professional liability insurance components by 2002. The RUC, through its Practice Expense Advisory Committee, is developing a work plan to recommend requirements to the newly implemented practice expense rules.

Total and work RVUs as a measure of physician productivity may lead to overutilization because RVUs increase with the number of procedures and the level of procedural intensity. RVUs also necessitate accurate coding to effectively measure productivity. Despite these potential drawbacks, there are a number of potential advantages associated with using RVUs as a measure of physician work. First, the system itself has a certain amount of risk stratification built into it: sicker patients require more evaluation, which correlates with higher evaluation and management codes. Second, RVUs are payer-neutral, which means that there is no incentive to see patients from one health plan over another. Third, RVUs provide a useful metric that allows for the measurement and comparison of provider utilization and productivity across physicians performing a varied mix of services. Fourth, using RVUs as a productivity measure does not necessarily place additional data collection burdens on physicians or other staff because many practices already use the RBRVS for billing purposes. Fifth, RVU data may assist practices in detecting differences in practice patterns, checking for coding errors, improving cost accounting, determining whether it is efficient to provide certain services, and defending against health plans' profiles of doctors. Plans often base physician bonuses, payment rates, and deselections on data gleaned from the doctor's claims and, up until now, most groups have had to take the plan's information on faith.

Finally, some have proposed using RVUs-to-office-visits as a physician productivity measure. It is argued that this method allows practice managers to learn about their physicians' coding patterns and detect extremes in these patterns. For example, a very low RVU-to-visit ratio could point to lost revenues resulting from a physician who regularly refers patients elsewhere for treatments and procedures. Likewise, a higher ratio might suggest a case mix with more Medicare patients and hospital cases.

RELEVANT AMA POLICY

As previously noted, Policy H-285.951 states that, within a physician group, individual physician financial incentives may be related to quality of care, productivity, utilization of services, and overall performance of the physician group. Policy H-285.982, which provides ethical guidelines on issues in managed care, states that financial incentives are permissible only if they promote the cost-effective delivery of health care and not the withholding of medically necessary care. The AMA also has established a number of policies related to physician performance measurement and profiling. Policy H-450.994 maintains that accountability should represent a part of every health care delivery system. Policies H-406.994 and H-406.997 outline the principles that should guide the development of physician profiles, while Policies H-406.993 and H-406.996 guide the development, use, and release of physician-specific health care data.

DISCUSSION

A review of the literature on the current status of physician performance productivity measurement suggests that there is not one "best" way to measure physicians' work. Rather, the appropriate method or methods may be determined by a number of factors, including, but not limited to, medical group size, the methods insurers use to base payments to practices, and the goals of an organization. However, the Council believes there are some general principles that should be considered when evaluating various physician productivity measures. First, physicians should view the method or methods used to assess their productivity as being fair-handed in order for the measurement system to succeed. To that end, physicians should play a primary role in the development, adoption, and use of any system designed to measure their productivity. Second, the measurement system should encourage the provision of the appropriate level of care. Efforts to increase physician production should never be at the expense of quality medical treatment. Third, the measurement system should attempt to address both the clinical and non-clinical aspects of physicians' work. None of the production measures cited in this report account for the non-clinical work physicians may perform, including teaching, conducting research, and participating in professional associations.

In addition, the ease of collecting and counting production units should be considered before adopting any physician productivity measurement system. No system should be implemented that is so complex that physicians do not understand it or so cumbersome that production cannot be measured accurately. The more complicated the measurement system, the more difficult it may be to motivate physicians to comply with and support this system. A well-defined system also can alleviate suspicions about unfair allocations of practice income because it is usually more easily communicated and understood. A primary objective of any physician productivity measurement system should be to educate the physicians being measured. Physician productivity data have the potential to increase the quality and control the costs of medical care by modifying physician behavior. However, such data should be limited to internal use because physician work is defined differently across practices and each definition has its owns set of consequences associated with it. Specifically, physician productivity data should be used internally to provide physicians with frequent and thoughtful productivity performance feedback. Finally, considerable care should be taken when attempting to measure physicians' work. Such work is, by its very nature, complex, thereby making it difficult to accurately quantify, and doing so may result in unintended consequences, many of which are outlined in this report.

7. SOCIOECONOMIC FACTORS INFLUENCING THE PATIENT-PHYSICIAN RELATIONSHIP

HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

The current environment in which health care services are provided is changing rapidly and there are tremendous pressures on the patient-physician relationship. Health care delivery is increasingly characterized by efforts to integrate services through the growing use of hospitalists, demand management, case management, and utilization management. As part of its ongoing mission to study the socioeconomic factors impacting the practice of medicine, the Council on Medical Service has on numerous occasions expressed concern about threats to the patient-physician relationship. References to the patient-physician relationship are a pervasive element of AMA policy and advocacy efforts.

Because of the various possible ways in which socioeconomic factors impact the patient-physician relationship, the Council has focused the scope of this report on Policy H-140.975 (AMA Policy Compendium), which highlights the following rights of patients as key elements of the patient-physician relationship:

- the right to information for and guidance in making treatment decisions;
- the right to respectful, responsive and timely treatment;
- the right to confidentiality;
- the right to continuity of care; and
- the basic right to adequate health care.

The current health care market challenges physicians as they struggle to uphold these rights. In light of the strength, pervasiveness, and persistence of concerns about the patient-physician relationship, the Council presents this report to document some of the factors influencing the patient-physician relationship, and to discuss AMA advocacy on behalf of patients and physicians. The socioeconomic factors discussed may affect more than one element of the patient-physician relationship. For example, demand management clearly impacts access to information and guidance in making treatment decisions, but the Council discusses it as a factor impacting continuity of care. By the integrated nature of managed care techniques, they affect many areas of the patient-physician relationship so that the discussion of them under a single element of that relationship is done for purposes of illustration.

ORIGIN OF THE PROBLEM

Underlying the significant changes in health care delivery systems, and thus the forces affecting the patient-physician relationship, is the current U.S. health care financing system. In particular, the Council believes that employer-sponsored coverage and the growth of managed care have brought about significant changes in the patient-physician relationship. The Council believes that pressures to reduce health care spending, such as through managed care techniques, can largely be attributed to the fact that private insurance has largely been controlled by employers rather than individual patients.

Only since World War II have tax and social policy encouraged employers to provide employees with health care benefits. The tremendous rise in health care costs was not anticipated until decades after employer-sponsored health insurance had become entrenched as an entitled expectation. Relative to the Gross Domestic Product, national health care expenditures have increased from 5.1% in 1960, to 8.9% in 1980, and 13.5% in 1997. Inflation in health care costs throughout the latter half of the century has encouraged employers, as well as public sector payors, to seek ways to control costs and managed care was embraced as a means of doing so.

INFORMATION FOR AND GUIDANCE IN MAKING TREATMENT DECISIONS

Among the strategies that are or have been used by managed care organizations to control the cost of health care is the management of information and treatment decisions through the use of financial incentives and gag clauses. CMS Report 8 (I-99), which is before the House of Delegates at this meeting, discusses the impact of physician assumption of financial risk.

AMA Policy

Policy H-140.941 provides detailed guidelines for physician acceptance of financial incentives, with the first consideration being the physician's primary duty to the patient. Policy H-285.951[a] states that patient advocacy is a fundamental element of the physician-patient relationship that should not be altered by the health care system in which physicians practice, or the methods by which they are compensated. The policy calls on physicians to disclose any financial incentives or contractual agreements that may tend to limit the diagnostic and therapeutic alternatives that are offered to patients, or that may tend to restrict referral or treatment options, with physicians being able to satisfy their disclosure obligations by assuring that the plan makes adequate disclosure to enrollees (Policies H-140.978[4, 5] and H-285.982[2,f]). Gag clauses are opposed in Policy H-285.963[2], which advocates that contracts exclude any provisions that prohibit physicians from discussing any issue with patients or other health professionals that may have a bearing on patient health, including the consequences of payment decisions by a third-party payor; and Policy H-285.959, which calls for a legislative ban on gag clauses.

AMA Advocacy

The AMA initially developed a comprehensive Patient Protection Act (PPA) in 1994 and has continued to aggressively advocate its principles during the 1999 federal debate of patients' bill of rights legislation. The AMA has advocated that any plan using financial incentives to ensure that they are free of any inducement to reduce or limit medically necessary services. The PPA contains draft requirements concerning the use of physician incentives, such as the requirement that plans provide adequate stop-loss protection. Furthermore, the AMA has advocated for plans to disclose financial incentives to patients. Twenty-five states have enacted laws to ban the use of financial incentives that compensate physicians or other health care professionals for ordering or providing less care than is medically necessary. Contracts containing gag clauses received considerable negative publicity in the early 1990s. The AMA strongly advocated for the elimination of gag clauses, including the development of model legislation for use by states. As of June 1999, 48 states had enacted legislation or adopted regulations to ban the use of gag clauses.

RESPECTFUL, RESPONSIVE AND TIMELY TREATMENT

The right to respectful, responsive and timely treatment has been challenged by onerous preauthorization practices and inadequate access to physicians caused by restrictive referral practices. In July 1999, the Kaiser Family Foundation and the Harvard School of Public Health released the findings of a survey of 1,053 physicians and 768 nurses, that found that 87% of physicians reported that their patients had experienced a health plan coverage denial over the previous two years, with the most frequent denial being for prescriptions. Two-thirds of physicians reported that they often or sometimes intervened with plans on behalf of their patients, with plans responding to intervention favorably 42% of the time or with a compromise 21% of the time.

Denials of specialist referrals were reported by 29% of the physicians in the Kaiser/Harvard survey as occurring weekly or monthly. A study sponsored by the Agency for Health Care Policy and Research, that also was published in July 1999, indicated that nearly 25% of patients felt that their primary care doctor limited their access to specialists. Restrictions on referrals, whether real or perceived, may lead patients to distrust their physicians if patients believe they are the source of restrictions on access to specialists. A study reported in the July 21, 1999 issue of JAMA found that 94% of patients highly valued their primary care physician as the source of first contact

and 89% valued their primary care physician's role as a coordinator of referrals. However, physician or medical group interference with seeing specialists was perceived by 23% of patients, who were more likely to report low trust and satisfaction with their primary care physicians.

AMA Policy

The AMA has extensive policy on utilization management, most recently augmented by CMS Report 13 (I-98), which provided a definition of medical necessity that consciously excluded any consideration of cost. In addition, that report recommended that physicians carefully review their managed care contracts to ensure that they do not contain definitions of medical necessity that emphasize cost and resource utilization above quality and clinical effectiveness (Policy H-320.953[5]). Long-standing AMA policy states that medical necessity denials should only be made by a physician of the same specialty who is licensed to practice medicine and actively practicing in the same jurisdiction as the physician under review (H-285.998 [5], H-165.951[3,e4], and H-320.968[2,d]). Policy further supports that health plans (H-285.945, H-285.998[5] and 320.968[3]) and plan medical directors (H-285.939) be held subject to legal action for decisions to deny payment for medically necessary care. Policy H-320.968[2,c] calls for review entities to establish independent appeal mechanisms, while Policy H-320.952 provides detailed components that all health plans should incorporate into their external review procedures.

In addition, Policy H-140.978[3] calls on physicians to assure that their contractual agreements restricting referral or treatment options are disclosed to patients. Policy H-160.952 calls for the development of referral guidelines for access to specialty care and Policy H-165.908[1] calls for plans to provide an optional and affordable "point-of-service" feature so that patients who choose such plans may elect to self-refer to physicians outside of the plan at additional cost to themselves.

AMA Advocacy

In addition to being prominently advocated in the PPA and during the AMA's aggressive advocacy in 1999 for patients' rights legislation, the need for scrutiny of utilization management is also reflected in model state legislation concerning the conduct of review, qualifications of reviewers and medical directors, disclosure of screening criteria, and the availability of independent appeals. On July 28, 1999, the AMA participated in a press conference on the release on the Kaiser/Harvard survey results, and expressed gratitude to the survey authors for their work and to underscore the importance of the findings. The AMA used the timing and findings of the report to reiterate its strong support for meaningful patients' rights legislation.

In ongoing advocacy, the AMA in 1991 became a corporate member of the Utilization Review Accreditation Commission (URAC) now known as the American Accreditation HealthCare Commission/URAC. Through AAHCC/URAC, the AMA participates in the development of accreditation standards that are consistent with and often incorporate significant AMA policy. In fact, most firms conducting utilization management are accredited by AAHCC/URAC and thus accreditation is mandated or deemed sufficient to satisfy state regulations in many states.

CONFIDENTIALITY

The right to confidentiality is addressed in numerous policies and efforts to ensure confidentiality of patient-specific information is gaining momentum, with the 106th Congress considering measures to protect medical record information. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191) mandated that medical record privacy legislation be enacted by August 21, 1999, or the decision would revert to the Department of Health and Human Services. At the time this report was written, the HIPAA deadline had passed and Congress had not yet reached consensus.

AMA Policy

AMA policy on patient privacy and confidentiality is comprehensive and fully patient-centered. Policy H-315.983 provides extensive principles for the evaluation of proposals regarding patient privacy and the confidentiality of medical information, addresses the inappropriate use of medical information by employers and insurers, provides guidelines for assuring the security of patient medical information, and contains principles for the breach of confidentiality for purposes of public health and safety or law enforcement. Policies H-315.989 and H-315.990 stress the importance of protecting the confidentiality of computerized patient records, Policy H-315.986 opposes

insurers using claims as blanket waivers of confidentiality rights, and Policy H-315.987 calls for access to medical record information to be limited on a need-to-know basis.

AMA Advocacy

Because of the HIPAA deadline, there was considerable legislative activity in 1999 on patient privacy and confidentiality. In its advocacy, the AMA convened a Board/Council Task Force on Confidentiality, which presented interim confidentiality recommendations at the 1999 Annual Meeting in Board of Trustees Report 36 (A-99). Throughout the year, AMA advocacy on this issue has included testifying numerous times before Congressional subcommittees, sending letters to members of Congress, and providing talking points on its web site for use by physicians. All AMA advocacy efforts on this issue have stressed the importance of confidentiality in protecting the patient-physician relationship.

CONTINUITY OF CARE

The right to continuity of care is an increasing challenge for physicians and patients with the emergence of hospitalists, disease and demand management, and case management. Such processes seek to reduce costs by streamlining the management of services provided. Though such techniques can provide physicians with valuable information and often prove fiscally efficient, these procedures can overlook the continuity of care needed by patients, who may be overwhelmed by numerous situation-specific relationships. In addition, a cornerstone of continuity in the patient-physician relationship is its endurance. For some specialists, the relationship may span the duration of an illness or course of treatment. For others, particularly the primary care specialists, the relationship may last a lifetime. Children are particularly adversely affected by a system that discourages continuity of care, with infants and young children having preventive medical needs that must be well documented and coordinated. For example, a lack of continuous care can result in duplicated or missed vaccinations.

Throughout the 1990s, there have been well-publicized cases of health care organizations—health plans, hospitals, and IPAs—that have failed. Many times, failures resulting from poor organizational management have required that patients choose new physicians. Perhaps the greatest challenge to continuity of care is a direct result of employer-based coverage. The endurance of the patient-physician relationship, irrespective of current course of treatment, is jeopardized by the artifact of employer-sponsored coverage whereby patients can be forced to change health plans when they change jobs or when their employers change the health plan options of employees. One study found that, in a three-year period, nearly 50% of patients had a change in health plan, with 75% doing so involuntarily.

AMA Policy

AMA policy development has responded to the evolving processes that mark managed care's trend toward integration of health care delivery. The emerging use of hospitalists is addressed in Policy H-285.964, which opposes any hospitalist model that disrupts the patient-physician relationship or the continuity of patient care. Detailed principles for the conduct of disease and demand management procedures are provided in Policy H-285.944, which encourages disease management programs to involve the patient's physician as much as possible, and to minimize arrangements that may impair the continuity of a patient's care across different settings. The policy also provides detailed principles to guide the development of disease and demand management systems. Case management is addressed in Policy H-285.998[4], which states that health plans should not use arrangements that impair the continuity of patient care across different treatment settings, and which affirms that the primary goal of high-cost case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; with cost containment being a legitimate but secondary objective.

AMA Advocacy

In 1998 and 1999, the AMA participated in AAHCC/URAC's development of 24-hour telephone triage and case management standards for the accreditation of entities conducting these elements of a highly integrated health system. Both sets of standards built on previous accomplishments gained in URAC's utilization management standards and incorporated many of the utilization management principles and policies previously cited.

THE BASIC RIGHT TO ADEQUATE HEALTH CARE

The final patient right cited in Policy H-140.975 is a basic right to health care. An analysis of the historical role of Blue Cross and Blue Shield plans that appeared in the June 17, 1998 issue of JAMA, indicated that many plans originally relied on community rating and served as "insurers of last resort," by making coverage affordable to those who would otherwise be uninsured. Market forces such as competition from commercial insurers, financial losses and managed care caused them to revise their identity as a social good. A study published on March 24/31, 1999 in JAMA indicated that regions with the greatest managed care penetration have the lowest levels of physicians providing charity care. The study also found that physicians with a greater ratio of managed care, contracts were the least likely to provide charity care.

AMA Policy

The Council believes the systemic nature of the problems faced by patients and physicians is most fundamentally addressed in Policy H-165.920, which outlines an extensive AMA proposal for making individual selection, purchase and ownership of health insurance viable. The AMA plan would provide a refundable tax credit for the purchase of health insurance, which would be particularly beneficial to the uninsured whose incomes are too high to qualify for Medicaid, but
too low to purchase insurance without also sacrificing other needs. More importantly, individual ownership of insurance would empower patients to control decisions about their health care.

In addition, the pervasive problem of the uninsured is addressed in extensive AMA policy supporting universal coverage of health care services (H-165.904 [3]), and incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access (H-165.882 and H-165.920[2]). Policy H-160.961 states that each physician has an obligation to share in providing care to the indigent, depending on community characteristics, geographic location, the nature of the physician's practice or specialty, and other conditions. A number of policies support voluntarism in free clinics (H-165.940,
H-165.953, and H-165.965).

AMA Advocacy

At its 1999 Annual Meeting, the AMA unveiled a major communications initiative entitled "Is it Good Medicine?" and linked it to increasing access and expanding coverage. In July 1999, the AMA issued a Joint Statement of Principle with the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American College of Physicians-American Society of Internal Medicine, and the American College of Surgeons. The statement challenged the 106th Congress and declared 2000 presidential candidates to make the critical issues of health insurance coverage and access a top priority.

In addition, the AMA has persistently warned Congress that cuts in Medicare payments would harm beneficiaries. In order to assess the degree to which reductions in Medicare physician payment would harm beneficiary access to care, in 1998 the AMA began collecting detailed information on physician responses to changes in Medicare payments through its Socioeconomic Monitoring System (SMS). Using the new measures, the SMS data indicate that physicians are profoundly affected by Medicare payment policy. Physicians reported reducing office staff (31%), curtailing salary increases (36%), forgoing equipment updates or renewals (35%), changing their practice type (19%), and retiring early (30%) as strategies they have used to cope with reduced Medicare payments. Although physicians continue to see their Medicare patients, the services they receive are changing as physicians are forced to adjust to the payment reductions. The AMA will conduct additional analysis of these measures using data collected in 1999.

CONCLUSION

Although nearly two-thirds of Americans have some level of employer-sponsored health insurance coverage, the Council believes that this system of health care financing is largely responsible for the cost-sensitive factors that have encouraged some of the more onerous aspects of managed care and the current move toward ever more efficient integration of health care delivery, with an emphasis on cost savings rather than patient satisfaction. In adopting the recommendations of CMS Report 9 (A-98), the House completed a comprehensive policy shift from

advocating employer-sponsored insurance coverage to individually selected and owned insurance as the preferred option.

The Council continues to believe that viable individually owned insurance is necessary to allow patients to assert their will in how care is delivered. In fact, some insurers and health plans may have an adverse response to the AMA proposal for individually owned insurance, in part because it will encourage a stronger bond between physicians and patients than between plans and patients. Because patients are more likely than employers to change plans due to dissatisfaction with plan performance, plans will have to try harder to remain competitive. Under individually owned insurance, many patients may switch plans if a service recommended by their physician is denied by the plan, and plans may find it harder to enforce practices that interfere with the patient-physician relationship.

RECOMMENDATIONS

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

1. That, as a method for strengthening the patient-physician relationship, the AMA reaffirm Policy H-165.920, which advocates the viability of individually owned insurance.

2. That the AMA reaffirm and strongly advocate the principles of Policy H-140.975, which stresses the fundamental elements of the patient-physician relationship, in its advocacy for patient rights legislation.

3. That the AMA continue to monitor infringements on the patient-physician relationship and respond with policy development and advocacy initiatives that are both timely and appropriate.

4. That the AMA report on the impact that Medicare payment policies have had on the ability of physicians to provide patient care and the resulting effect on the patient-physician relationship.

8. IMPACT OF PHYSICIAN ASSUMPTION OF FINANCIAL RISK

HOUSE ACTION: FILED

Council on Medical Service Report 3 (I-96) established a set of 13 principles to guide the use of financial incentives in the management of medical care. Since the development of that report, the Council has continued to monitor the use of financial incentives. This report, which is presented for the information of the House of Delegates, describes the principal types of financial incentives, presents recent data on the prevalence of such incentives, and summarizes the scientific literature that examines their impact on physician behavior.

TYPES OF FINANCIAL INCENTIVES

It is useful to separate financial incentives, or compensation methods, into three groups: those used by insurers to pay physicians; those used by insurers to pay group practices; and those used by group practices to pay practice members. Although physicians in group practice may receive payments directly from insurers, insurers usually make payments to group practices. The groups themselves reimburse owners and employees in the practice. Solo practitioners, of course, continue to receive payments directly from insurers.

Presently, there are three elemental methods by which physicians and practices are compensated – capitation, fee-for-service (FFS), and salary. Frequently these methods are used in combination with one another. As this report will demonstrate, "managed care" does not imply a particular payment method.

A capitated payment, sometimes referred to as a per-member-per-month payment (PMPM), is a fixed-dollar amount paid to cover a specific range of medical services. As discussed below, practices rarely use capitation to compensate physicians. Capitated payments are generally prepaid.

FFS compensation is based on productivity measures such as charges and collections, number and duration of patient encounters, patient panel size, and relative value units. This method remains a common payment mechanism between insurer and practice, insurer and physician, and practice and physician. CMS Report 6 (I-99), which is before the House of Delegates at this meeting, examines the various productivity measures practices and insurers use to compensate physicians. The FFS revenues of physicians and practices are affected by the number and type of services that they provide.

Capitated payments transfer actuarial risk from the payer to the payee, for example from an insurer to a practice or a practice to a physician. When total costs for services exceed the total PMPM payment the recipient of the capitated payments is, from a financial perspective, adversely affected. Even in cases where the PMPM equals or exceeds the expected cost of services included in the contract, a few high-cost cases over a short period of time may impose financial duress on physicians, particularly those in small practices which are less likely to have capital reserves with which to smooth losses from one year to the next.

Critics argue that physicians' decisions of which treatment methods to use may themselves be affected by capitation. Others insist that capitation gives the physician, rather than the insurer, control over medical decisionmaking. However, this is true only if capitation is coupled with fewer requirements for preauthorization and utilization review. A recent review of the literature noted that there is little empirical evidence to date on the association between physician payment method and utilization management. If PMPM rates are adequate, capitation may give physicians and practices incentive to increase their patient base in order to increase revenue.

Individual physicians are generally not paid on a capitated basis from their group even if the group receives capitated revenue. However, capitation at the practice level affects physician behavior indirectly – it places a ceiling on practice revenue available for distribution, by salary or FFS payments, to physicians in that practice. Finally, the incentives present in any compensation method are themselves affected by how expenses are shared within the practice and the number of physicians in the practice.

Salary is rarely used as a payment mechanism between insurer and physician except in the case of the two percent of physicians employed by staff-model health maintenance organizations (HMOs). A physician's salary is not affected by the productivity measures that affect FFS payments. Salary can be viewed as a "middle ground" between the incentives of capitation and FFS payments.

Bonuses can be used in conjunction with each of the three elemental methods of compensation. Some bonuses are themselves a form of financial incentive. For example, productivity-based bonuses may be used in conjunction with salary to attenuate the fact that salary does not provide physicians an incentive to maximize their productivity because their revenue is not affected by the number of hours they work or the number of patients they see, as long as they meet their contractual obligations. Other bonuses are based on quality of care measures such as patient satisfaction and movement toward quality improvement targets.

Withholds are also used in conjunction with capitation, FFS, and salary. The withhold amount is subtracted from a practice's or physician's payment by the insurer. The insurer allocates the withheld amount to a risk pool, or over several risk pools, designed to cover the cost of a particular group of services when the cost is larger than the insurer expects. With regard to capitated contracts, a risk pool may be created to cover the cost of referrals from primary care to non-primary care physicians if such referrals are not included in the capitated contracts of primary care physicians. When the cost of such services is equal to or less than expected, physicians get back the withheld amount in entirety.

PREVALENCE OF FINANCIAL INCENTIVES

The AMA Socioeconomic Monitoring System (SMS), a program of surveys of non-federal post-residency patient care physicians, contains several questions regarding the nature of financial risk that practices and physicians bear. At the practice level the SMS tracks whether the practice has capitated contracts, the percent of practice revenue from such contracts, and the percent of practice revenue subject to a risk pool withhold. Table 1 summarizes this information for 1998. Thirty-eight percent of physicians were in practices with at least one capitated managed care contract. Capitated revenue share among practices with contracts was 24%. Therefore, in spite of almost universal participation in managed care, 94%, the majority of practice revenue is still earned under FFS or discounted FFS arrangements. General/family practitioners and pediatricians were most likely to have capitated contracts, 58% and 68%, respectively. Capitation continues to be most prevalent in the Pacific census division where 50% of all

physicians had a contract and, among those physicians, 37% of their practice revenue came from capitated sources. The extent of capitated revenue was relatively constant, 22%, across practices with 24 or fewer physicians but was much larger, 30%, for practices with 25 or more physicians.

Forty-five percent of physicians were in practices whose revenues were subject to withholds and, among those physicians, 19% of their practice revenues were subject to withholds. Withholds were most common among primary care physicians although they were also prevalent among surgeons and radiologists. Primary care physicians had the largest amount of revenue at risk ranging between 21% for internists to 29% for obstetricians/gynecologists. The use of withholds varied greatly across census division. In New England more than 60% of physicians were in practices with revenues subject to a withhold while in the Middle Atlantic states only 35% of physicians were. Withholds were more prevalent among large practices than small. Finally, withholds are used in a variety of contract arrangements. In fact, 36% of physicians in practices with no capitated contracts had practice revenues subject to a withhold. The prevalence of both capitation and withholds has remained constant since the AMA began tracking these incentive mechanisms in the mid-1990s.

The 1998 SMS survey also collected information on financial risk at the physician level. Few physicians are paid by their practices on a capitated basis even when their practices receive capitated payments from insurers. Nevertheless, physicians are aware of and may be affected by practice level capitation. Practice level capitation affects the revenues available to pay for the cost of services provided to patients covered by capitated contracts and available for distribution, by FFS, salary, or bonus, to physicians. The magnitude of the impact of practice level capitation on an individual physician is, in theory, affected by its importance in terms of total practice business and the number of physicians in the practice.

Table 2 presents the 1997 distribution of physicians according to whether they receive a salary or bonus. Seventy-two percent of physicians received a salary and 29% were exclusively salaried. Salary was most common among physicians in staff-model HMOs, 91%, followed by institutional employees and employees of group practices, 86% and 80% respectively. Close to half of employees regardless of employer were paid exclusively on a salaried basis while less than 25% of owners and independent contractors were.

Seventy-three percent of physicians with ownership interest in group practices and 52% of solo practitioners indicated they were paid a salary. Salary statistics among owners, however, can be deceptive when trying to assess the financial incentives that may affect physician practice style. For example, even if 100% of a practice's contracts were FFS, owners could "pay themselves" a portion of practice revenue less expenses and label the payments salary or label them FFS. Despite which labels are given to such payments, owners are subject to the incentives inherent in their payments from insurers.

Primary care and non-primary care physicians were equally likely to receive a salary. Primary care physicians were, however, more likely than non-primary care physicians to be exclusively salaried, particularly among physicians who were owners of group practices and among employees of staff-model HMOs.

Twenty-eight percent of physicians received a bonus. Bonuses were most commonly received by owners of group practices and HMO employees, 41% and 40%, respectively followed by, employees of group practices, institutional employees, independent contractors, and solo practitioners. Twenty-five percent of primary care and 31% of non-primary care physicians received a bonus. Few physicians received more than half of net income from a bonus.

Some capitated contracts include coverage for the following ancillary services: laboratory tests, diagnostic services or radiological services; inpatient or outpatient hospital services; referrals to other physicians; prescription drugs; or non-physician services. While broad contracts do not necessarily imply greater risk for the practice than narrow contracts, they bear watching because the costs of ancillary services are generally more variable than other services. Small practices are particularly vulnerable. 1998 SMS data show that hospital services were most commonly included in capitated contracts, 43%, followed by test costs and referrals, 41% and 34%, respectively. Primary care physicians and physicians in large practices had broader contracts than other physicians.

Stop-loss provisions and reinsurance contracts protect practices and physicians who receive capitated payments from expenses that greatly exceed the capitated payment. Stop-loss and reinsurance contracts may be written with regard to an individual claim, a single patient, a treatment method for an individual patient or a group of patients, and may be written directly into a capitated contract or purchased from an outside insurer. In 1998, 79% of physicians indicated their practice had insured against at least some of the risk associated with its capitated contracts. This

marked an increase from the prior year especially among solo practitioners for whom the lack of protection had been particularly distressing.

IMPACT OF FINANCIAL INCENTIVES

Four recent review articles effectively summarize the empirical literature on the effects of financial risk. The first, a 1996 review article by Hellinger, is the most comprehensive review of the literature that examines the impact of financial incentives used by managed care plans on physician behavior. He describes three potential sources of bias in comparisons of utilization in managed care and FFS insurance: patient selection of health plan; physician selection of health plan (or health plan selection of physician); and missing information on financial and non-financial plan characteristics. For example, healthy patients may join HMOs while patients with chronic conditions may prefer traditional plans with more open access to non-primary care physicians. Similarly, physicians with conservative practice styles may gravitate toward HMOs while more aggressive physicians may hesitate to subject their treatment decisions to utilization management techniques used by HMOs. If this were the case, inadequate controls for patient and physician characteristics would cause the effect of capitation on utilization to be overstated. If capitation were paired with less invasive utilization management requirements (but the utilization management requirements were unmeasured), then estimates of the impact of capitation on physicians' behavior would understate the true negative impact. If, on the other hand, capitation were paired with a large degree of utilization management, estimates would overstate the negative impact. All but one of the articles he reviews compares capitation to FFS. The other article compares salary to FFS.

All the studies Hellinger reviews find that capitation is associated with fewer hospital stays and fewer expensive procedures, tests, or treatments and he concludes "financial incentives are a key element in explaining the success of managed care plans in reducing the utilization of health services." The article that compares salaried physicians to FFS physicians reaches a similar conclusion. Hellinger limits his review to empirical research that corrects for at least one of the potential sources of bias discussed above.

The other review articles (Kane, 1998, Dudley, et al, 1998, and Seidman et al, 1998) find no consistent difference in quality of care in managed care plans and FFS settings. These articles do not contradict the Hellinger article, rather, they differ from it in a crucial way. They summarize studies that do not, in general, isolate the impact of financial incentives in managed care from the impact of other non-financial control mechanisms (e.g., prior authorization) that managed care organizations (MCOs) use. Instead, the articles estimate the impact of managed care as a whole, including techniques both financial and non-financial. However, the dearth of studies where practice or physician compensation method from MCOs is known often makes such review articles the most frequently cited source of information on how physician behavior is affected by financial risk.

CONCLUSION

In this report, the Council reviews the types of financial incentives used by insurers, summarizes their prevalence, and summarized the scientific literature that examines their impact on physician behavior. The report also describes how physicians in group practice are compensated, a topic not addressed when the Council previously addressed this topic in CMS Report 3 (I-96). While close to 40% of physicians are in practices with capitated contracts, more than 75% of revenue in those practices is still earned on a FFS basis. Forty-five percent of physicians are in practices whose revenues are subject to withholds. Nineteen percent of their practice revenues are subject to withholds. More than one-third of physicians in practices with no capitated contracts have practice revenues that are subject to a withhold. Neither capitation nor withholds have increased in prevalence since the AMA began tracking these incentive mechanisms in the mid-1990s.

Capitated payments from insurers to group practices are almost universally distributed by the practice to practice members through FFS or salary, not capitation. Although practice members are not paid by capitation they are aware of and may be affected by practice level capitation. However, the extent to which practice level capitation affects physician behavior is unknown.

Seventy-three percent of physicians with ownership interest in group practices received a salary in 1997, indicating that "salaried" is not synonymous with "employee." Bonuses are most commonly received by owners of group practices and physicians in staff-model HMOs although even among these physicians it accounts for a smaller percent of net income than other compensation mechanisms.

The scientific literature suggests that capitated payments affect the nature of services that physicians provide. However, the literature does not generally speak to the issue of whether capitation affects patient outcomes. The literature does address the impact of managed care as a whole on quality of care (including outcome measures) and finds no consistent differences between managed care and FFS insurance. Managed care plans use a variety of compensation methods. Capitation accounts for only a small portion of practices' managed care revenues. Furthermore, utilization management techniques vary across managed care plans and are also used by traditional FFS insurers. Therefore, where quality differences between managed care plans and FFS insurers are found, the differences can not generally be attributed to differential financial incentives.

The Council on Medical Service will continue to monitor the use of financial incentives used to compensate practices and physicians, as well as the scientific literature that examines their impact on physician behavior and on patient outcomes.

References for this report are available from the AMA Division of Health Policy Studies.

Table 1

Physician Experience with Capitation and Withholds in 1998

	Percentage of Physicians in Practices with Capitated Contracts	Percentage of Practice Revenues Capitated[a]	Percentage of Physicians in Practices with Revenues Subject to a Withhold	Percentage of Practice Revenues Subject to a Withhold[b]
All	38%	24%	45%	19%
Specialty				
General/Family Practice	58	25	47	22
General Internal Medicine	51	26	49	21
Internal Medicine Subspecialties	37	23	48	15
General Surgery	24	–	50	15
Surgical Subspecialties	23	20	49	15
Pediatrics	68	29	56	24
Obstetrics/Gynecology	25	23	51	29
Radiology	38	19	50	13
Psychiatry	16	31	20	19
Anesthesiology	29	23	40	14
Pathology	38	–	30	–
Emergency Medicine	27	10	31	13
Other Specialties	16	21	33	15
Census Region				
New England	40	21	62	25
Middle Atlantic	31	27	35	21
East North Central	45	19	54	17
West North Central	33	19	55	18
South Atlantic	35	19	36	16
East South Central	29	16	50	17
West South Central	33	23	37	12
Mountain	41	21	44	18
Pacific	50	37	50	24

Practice Size				
1 Physician	29	22	40	21
2-4 Physicians	33	23	49	20
5-9 Physicians	37	22	50	15
10-24 Physicians	40	21	56	13
25 or More Physicians	62	30	56	21

[a] Among physicians with capitated contracts.
[b] Among physicians with practice revenues subject to withholds.
– Indicates fewer than 25 observations.
Source: 1998 Socioeconomic Monitoring System Survey.

Table 2

Compensation Methods of Physicians in 1997

	Any Salary	Exclusively Salaried	Any Bonus
All Physicians	72	29	28
Practice Arrangement			
Solo Practitioners	52	21	9
Owners of Group Practices	73	18	41
Employees of Group Practices	80	44	32
HMO Employees	91	50	40
Institutional Employees[a]	86	45	26
Independent Contractors	49	23	20
Specialty			
Primary Care[b]	72	34	25
Non-Primary Care	72	26	31

[a] Institutional employees include employees of emergency centers, hospitals, medical schools, universities, and state and local governments.
[b] Primary care specialties include family/general practice, general internal medicine, pediatrics, and obstetrics/gynecology.
Source: 1998 Socioeconomic Monitoring System Survey.

9. COSTS AND BENEFITS OF PHARMACEUTICAL USE IN THE UNITED STATES

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

During the past several years, there have been increasing concerns raised regarding the rapid growth in pharmaceutical use in the United States. These concerns have been primarily based on the perception that pharmaceutical expenditures are spiraling out of control relative to other health care expenditures. Additional concerns have been raised regarding the pricing strategies of generic drug manufacturers. Resolution 522 (A-99), in part, asked the AMA to review the foreign and domestic pricing of proprietary and generic pharmaceuticals.

This report summarizes current data on national health expenditures; documents recent increases in pharmaceutical spending that have potential to accelerate total national health care spending; describes recent trends in generic drug prices; presents international comparisons; and summarizes some of the commonly identified benefits of pharmaceutical use.

NATIONAL HEALTH EXPENDITURES

National health expenditures (NHE) increased 4.8% in 1997, the lowest rate in over 30 years. The slow down in the growth of NHE has been attributed, at least in part, to managed care which is not expected to have as large of an impact on future expenditures. NHE, which reached $1.09 trillion in 1997, is predicted to increase to $1.59 trillion in 2003 (see Figure 1). As a share of Gross Domestic Product (GDP), the Health Care Financing Administration (HCFA) expects NHE to increase from 13.5% in 1997 to 15.2% in 2003.

A 1998 September/October Health Affairs article authored by Sheila Smith and others indicate that rising expenditures in the private sector are expected to be the driving force behind the projected growth in national health spending. Slow growth of private health insurance premiums, from 4.0% in 1996 to 3.2% in 1997, is attributed to consumers continuing to switch from traditional fee-for-service plans to managed care plans. However, because most consumers are now enrolled in managed care plans, growth is expected to accelerate. Abt Associates estimate that enrollment in managed care plans increased from 41 million in 1985 to 154 million in 1993. Interstudy data, showing an 11.4% increase in HMO premiums between 1996-1997, indicate that managed care plans may not be able to control expenditure increases in the future.

Spending for physician services is expected to increase at a faster rate over the next four years. Annual increases are expected to climb from a low of 2.9% for 1996 to 7.3% for 2000. This acceleration is expected for both public and private-sector spending. Private-sector physician spending is projected to increase at an average of 4.7% for 1997-1999, up from 1.6% for 1994-1996. Factors contributing to this acceleration include consumers' demand for increased access to specialists, a wider choice of out-of-network options, and an acceleration in medical price inflation. Still, physician expenditures are projected to remain at about the same level relative to total spending. Physician expenditures accounted for 19.9% of total health spending in 1997 and are projected to comprise 19.5% of total spending in 2003.

Another factor responsible for increasing health care expenditures is the advent and use of new technology. Managed care may have a small long-term effect on expenditures if the rate of diffusion of new technologies can be slowed. Slower rates of diffusion could be expected to restrain growth in health care costs.

PRESCRIPTION DRUG EXPENDITURES: UTILIZATION AND PRICE GROWTH

The growth rate in prescription drug expenditures has accelerated, increasing 14% in 1997, even as the growth of total health care expenditures has slowed. The rise in prescription drug expenditures may accelerate total health care expenditures in the future. Prescription drug expenditures comprised 7.2% of NHE in 1997 and based on HCFA projections, drugs will make up 9.6% of total expenditures in 2003 (see Figure 2). If 1997's growth rate of 14% per year were to continue, however, prescription drug expenditures would account for 16% of NHE in 2003.

It has been stated that drug expenditures now equal hospitalization expenditures for many health plans. However, on a national level, hospital expenditures are almost five times greater than prescription drug expenditures. Hospital expenditures are projected to decline as a percentage of total expenditures, from 34.0% in 1997 to 31.6% in 2003. However, these expenditures will still far exceed prescription drug expenditures. Furthermore, it is possible that increases in prescription drug expenditures contribute to declining hospital expenditures. Examples of how prescription drugs have reduced hospital and other health care expenditures are presented later in this report.

The 1997 expenditure increase of 14% was mostly due to non-price factors such as utilization and case mix. For example, Express Scripts, a pharmacy benefit management company, reports that utilization of common drugs among its members (22 million members from 10,000 health plans) grew 4.5 percent in 1997. This increase is 2.2 times the rate of increase between 1995 and 1996, and 60 percent higher than the annual rates of increase between 1993 and 1994, and 1994 and 1995.

Mehl and Santell (American Journal of Health-System Pharmacists, January 1999) list the following factors as being responsible for increased prescription drug expenditures:

- Continued declines in out-of-pocket payments for drugs. In 1989, 51% of payments for prescription drugs were out-of-pocket. In 1997 just 29% of prescription drug payments were out-of-pocket.

- A decrease in drug approval time. The Food and Drug Administration (FDA) has decreased the time necessary to approve new drugs under the Prescription Drug User Fee Act of 1992 and is expected to decrease the time even further under the FDA Modernization Act of 1997.

- Growth in the financial return to the industry. Patent protection has been extended for an additional three years, providing 20 years of exclusivity.

Direct-To-Consumer Advertising

Another factor contributing to the increased demand for prescription drugs is direct-to-consumer (DTC) advertising. According to IMS Health, total promotional spending directed toward physicians and consumers by the pharmaceutical industry totaled $6.14 billion for the 12-month period that ended in March 1999. DTC advertising accounted for $1.53 billion of this amount, representing a 16% increase from the previous year. As a point of comparison, the pharmaceutical industry reportedly spent more than $17 billion on research and development in the US in 1998.

The top 10 DTC spending brands are allocating the majority of their promotional dollars to reach consumers, not physicians. For example, Schering-Plough and Glaxo Wellcome spent more than 90% of their total promotional budget for Claritin and Zyban. For the 12-month period that ended in March 1999, the top 10 brands comprised slightly less than half of the $1.53 billion DTC expenditure. Sales for these 10 drugs totaled $9.3 billion in sales in 1998.

Data from a 1998 survey by Prevention magazine, conducted with the assistance of the FDA, show that 53 million consumers talked to their physicians about a medicine they saw advertised. DTC also encouraged 21.2 million consumers to talk with their physician about a medical condition or illness. About 12.1 million consumers received a prescribed drug as a result of seeing a DTC advertisement. While DTC may encourage patients to visit their physician, the increased business impacts upon those physicians who receive capitated payments for their services provided.

Generic Drug Pricing

According to the FDA, a generic is a version of a drug that is equivalent to the brand-name drug and is not marketed until the patent exclusivity of the brand-name drug has expired. An average of about 10 brand-name drugs lose patent protection annually. DTC advertising is, at least, in part, a response to the influx of generic drugs. DTC advertising represents an effort by the brand-name companies to distinguish their products on the basis of quality. In contrast, generic drugs compete solely on the basis of price and, therefore, they will almost always be priced lower than private-brand drugs. Sales data for generic drugs reflect the lower prices. IMS Health reports that in 1998 generic drugs accounted for just 8% of all prescription drug sales while comprising 47% of units dispensed.

The Consumer Price Index (CPI) shows that prescription drug price inflation steadily declined during the period 1990 to 1997 (See Figure 3). As noted previously, the main factors responsible for the jump in drug expenditures were non-price factors such as utilization and case mix. Price increases were not a major factor. The availability and use of generic drugs was a primary reason for past overall low drug price inflation. However, recent data from IMS Health reported increases in the price of both brand name and generic drugs in the first quarter of 1999. The increase in generic drug prices reverses a seven-year trend. Brand and generic prescription drug prices in the retail sector, which accounts for a majority of prescription sales, rose 4.7 % compared to the first quarter of 1998. Brand-name prescription drug prices increased 4.7% over 1998 first quarter levels. Generic prescription drug prices increased 5.0% over the 1998 first quarter levels.

Twenty-nine out of the top 100 generic drugs showed a price increase from the first quarter of 1998 to the first quarter of 1999. In general, these increases came from a wide range of generic manufacturers. Because generic drug companies compete on the basis of price, it is unlikely that generic drug prices will rise to the level of their

brand-name counterparts. However, because of rising prices, generic drugs will not be as helpful, as in the past, in limiting overall drug prices.

Recently, the Federal Trade Commission (FTC) charged Mylan Laboratories with conspiring to create a monopoly for two anti-anxiety agents—clorazepate and lorazepam—by negotiating exclusive long-term contracts for the specialty chemicals used to make the compounds. In particular, it has been alleged that Mylan was seeking to extract unfair profits through price increases in excess of 3000%. In January 1998, the price of clorazepate increased from $11.36 to $377 per 500-tablet bottle. In March 1998, the wholesale price of a 500-pill bottle of lorazepam increased from $7.30 to $190. Mylan argued that, even after these price increases, brand-name versions of these drugs were still more expensive, and they would have had to stop producing them if they did not raise prices. They also argued that the long-term contracts for the specialty chemicals assured them of a reliable stream of raw material and left competitors free to make the drugs with alternative ingredients. To date, Mylan appears to be an isolated incident. However, some members of Congress have asked the FTC to launch a much broader probe of the generic drug industry. Specifically, the FTC was asked to investigate whether generic manufacturers tie their prices to those of brand-name firms to keep some drugs off the generic menus.

Managed Care and Pharmaceuticals

Managed care organizations accounted for $24.8 billion of the $48 billion reimbursed for prescription drugs from all sources in 1997. Increases of 10-12% or more in managed health care coverage rates were being predicted for 1999, with even larger increases expected for fee-for-service plans. Managed care organizations point to prescription drug coverage as a major reason for their rate increases. The prescription drug expenditures are rising faster than any other component of their health care costs (Mehl and Santell, January 1999). As a result, managed care companies have responded by:

- Holding physicians financially accountable for health costs by implementing drug risk pools. The percentage of health maintenance organizations placing physicians at risk for pharmacy benefits was 27.3% in 1996 – a figure some have estimated may have doubled over the past two years (CMS Report 12, I-99, which is before the House of Delegates at this meeting, addresses the issue of pharmacy benefit risk-sharing by physicians);

- Directing patients to specific pharmacies and mail-order discount programs;

- Obtaining agreements from physicians and patients to switch patients from prescribed drugs not covered by the plan to drugs that are covered;

- Using of formularies (lists of approved drugs) including closed formularies (drugs not on the list are not reimbursed);

- Using practice guidelines to influence prescribing; and

- Using "step therapy," in which the drug with the highest benefit to loss ratio is tried first.

INTERNATIONAL COMPARISONS

As a point of reference to US expenditures, IMS Health data show that the total worldwide market for pharmaceuticals is $302 billion. Novartis, Merck, and Glaxo Wellcome are the top three pharmaceutical companies in terms of global sales. Within the total audited world market, the leading 20 pharmaceutical companies account for 57.3% of all sales. The leading 10 companies account for 36% of total sales. The top 10 worldwide markets represent 84% of all global audited pharmaceutical sales. The US, which is the largest market (40% of the worldwide market), grew 11% to $99.5 billion in 1998. Japan experienced negative growth rates of 1% in 1997 and 1998 because of government efforts to restrain prices. However, at $38.8 billion, Japan is still the second largest market. Within the top five European markets, Germany is highest, achieving sales of $18.2 billion 1998. The fastest growing Western European markets in 1998 were Spain (11% growth over 1997) and Italy (9%).

According to 1996 data from the Organization for Economic Co-operation and Development, there are large differences between countries' health care spending and the amount spent on pharmaceuticals. The US spends about 1.1% of its GDP on pharmaceuticals. Among Western European countries, spending ranges from a high of 1.6% of GDP in France to 0.7% in Denmark and Norway. Japan spends about 1.5% on pharmaceuticals. As a share of total

health spending, pharmaceutical spending ranges from 20% in Spain to 9% in Norway among Western European countries. The United Kingdom's (UK) share is 17.3% and France's share is 16.7%. The US's share is 7.8% and Japan's share is 20%. Between 1990 and 1997, the compound annual growth rate in prescription spending per capita in the US was 3.9% compared with 6.4% in the UK, 4.7% in Spain, and 4.3% in the Netherlands.

An independent analysis commissioned by Warner-Lambert (an over-the-counter drug manufacturer) and prepared by the Boston Consulting Group, outlined the methods used by several countries to limit pharmaceutical expenditures. For example, the UK Pharmaceutical Price Regulation Scheme attempts to limit overall spending to a given proportion of the capital invested by pharmaceutical companies in the UK. The French government negotiates revenue limits on a bilateral basis with each pharmaceutical company. Germany instituted drug budgets in 1993. Countries employing more interventions (France, Spain, and Japan) did not have lower spending levels than countries with fewer interventions (Switzerland, the UK, and the US).

The Boston Consulting Group analysis also details how a country's pharmaceutical policies impact the generic drug market in that country. For example, the ulcer drugs known as H2 antagonists illustrate the impact of different policies. With government-mandated prices, the prices of these ulcer drugs in France remained at patented prices, after they went off-patent. Germany encourages the use of generic drugs. Between 1986 and 1997, the entry of generic manufacturers drove the average price of H2 antagonists down by 75% in real terms. Spain has more H2 antagonist suppliers than the US, but most of them are branded local licensees or copy products introduced before the adoption of patent protection in 1992. With little competition from generics, the prices of these branded drugs have not fallen in Spain. In the US, on the other hand, as a direct result of an influx of generic competition in 1994, the average real price for a day's therapy with H2 antagonists fell by 35% in real terms between 1994 and 1996.

The pharmaceutical industry argues that prices for pharmaceuticals vary widely from country to country for many reasons, including differences in living standards, income, willingness to pay, medical practice, product volume, exchange rates, the level of competitive medical service, product prices, patent terms and expiration dates, the length of time and cost of drug marketing approval, and government-imposed reimbursement and price controls. According to the Pharmaceutical Research and Manufacturers Association (PhRMA), a common methodological flaw in most comparisons is that manufacturers' list prices of drugs in the US are compared with list prices in other countries. This practice leads to significant overestimates of US prices because, unlike the situation in most other countries, the actual transaction price in the US is significantly less than the list price.

BENEFITS OF PHARMACEUTICAL USE

The pharmaceutical industry asserts that several studies demonstrate the cost savings derived from using prescription drugs. However, there is no comprehensive cost/benefit analysis or assessment of prescription drugs. In general, the studies cited by the pharmaceutical industry show the impact of individual drugs. Some results of particular studies highlighted by PhRMA include:

- A 1998 study sponsored by the National Institute of Health found that treating stroke patients promptly with a clot-busting drug not only reduces disability it also saves health care costs. The study showed that while it initially costs more to treat patients with the drug, the expense is more than offset by reduced rehabilitation and nursing home costs (savings could amount to over $100 million per year).

- A study released by the Agency for Health Care Policy and Research in September 1995 concluded that increased use of a blood-thinning drug would prevent 40,000 strokes a year, saving $600 million.

- A 1991 study published in the New England Journal of Medicine (Volume 325, No. 5) by the SOLVD Investigators, showed that patients on ACE inhibitors for congestive failure avoided nearly $9000 each in hospitalization costs over a three-year period—and that the drug reduced deaths by 16 percent.

- A drug for schizophrenia has helped many patients to be treated outside the hospital, in less costly settings, according to a 1990 study. The annual cost of the drug therapy was $4,500, compared to more than $73,000 a year for treatment in a state mental institution. Between 133,000 and 189,000 schizophrenia patients could potentially be helped by schizophrenia therapy (Hospital and Community Psychiatry, 1990).

PhRMA reported that its member companies anticipated investing more than $24 billion on research and development in 1999. Research and development as a percent of sales was estimated to reach 20.8%. PhRMA reported that between 1997-1998, new medicines were in development for cancer (316), drugs and vaccines for children (146), AIDS and AIDS-related diseases (124), heart disease and stroke (96), rheumatoid arthritis (24), diabetes (21), and Alzheimer's disease (17).

RELEVANT AMA POLICY

The AMA has established considerable policy related to the costs and benefits of pharmaceutical use. Policies H-110.995, H-110.996, and H-110.998, AMA Policy Compendium, urge the pharmaceutical industry to exercise reasonable constraint in the pricing of drugs, and to explore ways of reducing the costs of brand name drugs. Policy H-110.997, supports programs whose purpose is to contain the rising cost of prescription drugs provided that several key criteria are met, including physicians having significant input into the development and maintenance of such programs, and the freedom to prescribe the most appropriate drugs and method of delivery for the individual patient. Policy H-125.991 addresses drug formularies and therapeutic interchange, while Policy H-285.965 contains a series of statements on managed care cost containment involving prescription drugs. This latter policy specifically states that limits should be placed on the extent to which managed care plans use incentives or pressures to lower prescription drug costs; that physicians are ethically required to advocate for additions to the formulary when they think patients would benefit materially; and that research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare. Policy H-285.954 states that certain professional decisions critical to high quality patient care should always be the ultimate responsibility of the physician practicing in a health plan, either unilaterally or with consultation from the plan. Seventeen specific decisions are cited, including use of out-of-formulary medications (Policy H-285.9549[1][j]).

At the 1999 Annual Meeting, the House of Delegates also refined AMA policy on DTC advertising of prescription drugs. Policy H-105.988 states that the AMA considers acceptable those product-specific DTC advertisements that follow the guidelines for such advertisements that were developed by the AMA, in consultation with the FDA, in 1993. The guidelines are as follows:

- The advertisement should be disease-specific and enhance consumer education.
- The ad should convey a clear, accurate and responsible health education message (i.e., information on the prevention or treatment of a disease, disorder, or condition).
- In all cases, the ad should refer patients to their physicians for more information.
- The ad should not encourage self-diagnosis and self-treatment, but should identify the consumer population at risk.
- Discussion of the use of the drug product for the disease, disorder, or condition should exhibit fair balance.
- Warnings, precautions, and potential adverse reactions associated with the drug product should be clearly explained so as to facilitate communication between physician and patient.
- No comparative claims can be made for the product. In the interest of fair balance, alternative non-drug management options for the disease, disorder, or condition can be included.
- The brief summary information should be presented in language that can be understood by the consumer.
- The advertisement must comply with applicable FDA rules, regulations, policies and guidelines as provided by their Division of Drug Marketing, Advertising and Communications.
- The ad should be part of a manufacturer's education program that would include collateral materials to educate both physician and consumer.
- The manufacturer should not run concurrent incentive programs for physician prescribing and pharmacist dispensing.

Policy H-105.988(2) also opposes product-specific DTC advertisements, regardless of medium, that do not follow the above AMA guidelines. Furthermore, the AMA encourages the FDA, other appropriate federal agencies, and the pharmaceutical industry to conduct or fund research on the effect of DTC advertising, focusing on its impact on the patient-physician relationship, as well as overall health outcomes and cost-benefit analyses (Policy H-105.988[3]).

DISCUSSION

As discussed earlier in this report, pharmaceutical expenditures increased 14% in 1997. If costs continue to grow at this rate, it has been suggested that pharmaceuticals could reach 16% of total national health expenditures by 2003. The most recent projections from HCFA suggest, however, that pharmaceuticals will comprise less than 10% of total health spending in 2003. Nonetheless, even this degree of growth represents a significant increase from just over 7% in 1997. Furthermore, the increase is coming at a time when total health care spending has slowed. Hospital expenditures are projected to decline slightly as a percentage of total spending in 2003, while the physician share is expected to remain constant.

While prescription drug prices have remained steady throughout the past decade, it appears that a combination of other factors have contributed to the recent growth in pharmaceutical expenditures. Insurance plan coverage of prescription drugs has continued to rise, while patient out-of-pocket payments have declined. The amount of time it takes for a new drug to receive approval from the FDA has decreased, while the patent protection for such drugs has been extended. In addition, there has been a significant increase in DTC pharmaceutical advertising—the impact of which has the potential to increase the volume of new prescriptions, as well as a corresponding number of physician office visits.

The increased availability of generic drugs has helped to keep drug prices from increasing at more rapid rates, especially over the last few years. However, recent data indicate that the ability of generic drugs to continue to keep overall pharmaceutical prices down may be waning. Although the Mylan case appears to be an isolated event, it has raised serious concerns regarding the generic pricing strategies of some manufacturers. The Council believes, therefore, that continued monitoring of the quality and pricing of generic drugs by appropriate federal agencies, such as the FDA and the FTC, may be warranted.

An international comparison of pharmaceutical expenditures among a number of countries indicates that the US does not spend much more, and in many cases spends less, than other countries. Between 1990 and 1997, the rate of growth in pharmaceutical spending per capita was 3.9% in the US. By comparison, the growth rate for this same period was 6.4% in the UK, 4.7% in Spain, and 4.3% in the Netherlands. In addition, for those policymakers for whom price controls have been viewed as a possible method of slowing growth in pharmaceutical expenditures, it should be noted that those countries with the most pricing interventions (i.e., France, Spain, and Japan) did not have lower pharmaceutical spending levels than those countries with fewer interventions (i.e., Switzerland, the UK, and the US).

Although there is no definitive analysis or assessment of the net benefits of prescription drug use, the cost/benefit studies cited in this report indicate that use of drugs for specific illnesses and conditions resulted in reductions in surgeries, hospitalizations, and other health-related expenses. Accordingly, any stringent new efforts that are proposed to contain pharmaceutical costs will need to be carefully considered due to the possible effect of increasing health care expenditures in other areas.

Finally, while acknowledging the role that various managed care techniques have played in containing pharmaceutical expenses, the Council believes that an appropriate balance needs to be maintained. As physicians continue to confront drug utilization management programs, pharmacy benefit risk-sharing arrangements, and constant pressure to comply with specific formularies and switch patient prescriptions, their principal role as patient advocate in prescribing the most appropriate drugs for their patients must continue.

RECOMMENDATIONS

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

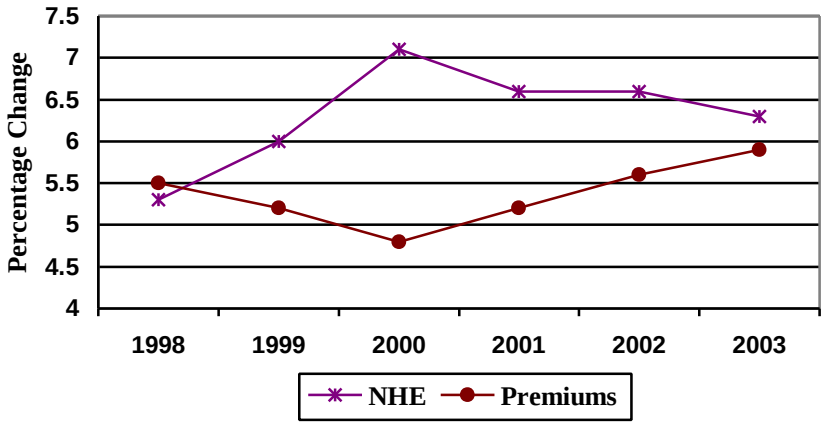
1. That the AMA reaffirm Policy H-110.997, which supports programs whose purpose is to contain the rising cost of prescription drugs provided that several key criteria are met, including physicians having both significant input into the development and maintenance of such programs, and the freedom to prescribe the most appropriate drugs and method of delivery for the individual patient.

2. That the AMA reaffirm Policy H-105.988(2), which opposes product-specific direct-to-consumer pharmaceutical advertisements, regardless of medium, that do not adhere to AMA guidelines (Policy H-105.988[1]).

3. That the AMA encourage the Food and Drug Administration to carefully monitor the manufacturing quality, bioavailability and efficacy, and the Federatl Trade Commission, to carefully monitor the pricing of generic pharmaceuticals within the United States.

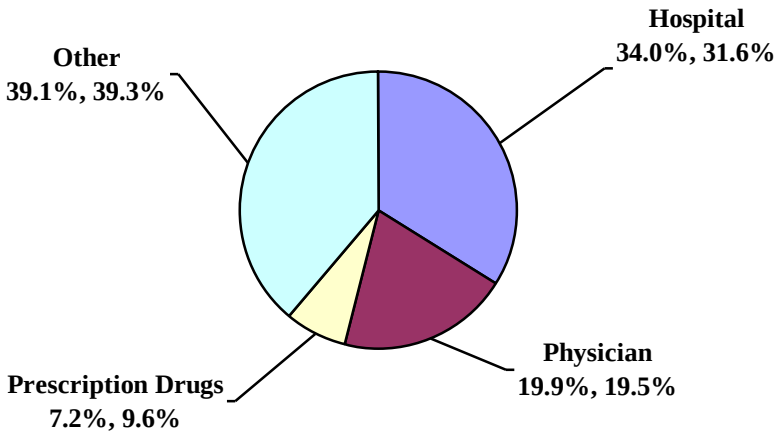
References used in this report are available upon request from the AMA Division of Medical Practice Information and Products.

Figure 1. **Projected Annual Changes in National Health Expenditures (NHE) and Private Health Insurance Premiums**



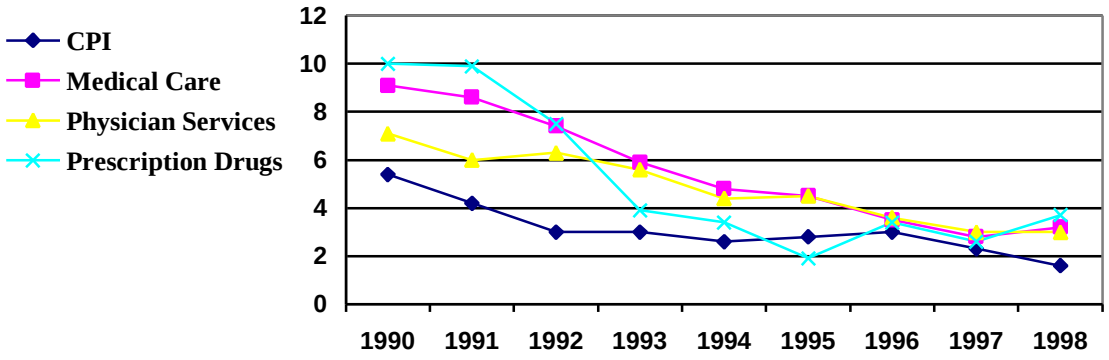
Source: Congressional Budget Office (Premiums), Health Care Financing Administration (NHE).

Figure 2. **Distribution of National Health Expenditures, 1997, 2003**



Source: Health Care Financing Administration.

Figure 3. **Annual Percentage Changes in the Consumer Price Index (CPI) and Selected Medical Components**



Source: Bureau of Labor Statistics.

10. CRITICAL EXPANSION OF MEDICAL SAVINGS ACCOUNTS

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTIONS 108 AND 109 AND REMAINDER OF REPORT FILED

Longstanding AMA policy supports Medical Savings Accounts (MSAs) as a health insurance option (Policies H-165.895[2] and H-165.920[7], AMA Policy Compendium). MSAs are a market approach, rather than a regulatory approach, to our health system problems, particularly the rising cost of medical care, "job lock" associated with traditional employer-based health benefits, and restrictions on choice imposed by most employer-based plans. MSAs allow individuals to determine the value of health care by spending their own money rather than what they perceive as someone else's money when they have traditional pre-paid coverage. MSAs encourage patient access to a wider range of services, such as preventive services, long-term care, prescription drugs, optical services, infertility treatment, and other benefits often not covered by conventional plans. Most important, MSAs allow the individual, not a third party, to choose their physician, plan, treatment, and range of services that best meet his or her needs.

This report reviews the current status of MSAs, including the reasons for disappointing sales of MSA products; reviews bills pending before Congress to repeal restrictions on MSA availability; discusses current MSA marketing and product development activities; and highlights key AMA policy.

CURRENT STATUS OF MSAs

The AMA, and many physicians individually and in small groups, devoted significant resources to advocating MSAs before federal legislation was passed in 1996 authorizing a limited number of MSAs for specific segments of the population. This legislation, The Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), established a demonstration of MSAs in which a maximum of 750,000 MSA accounts could be opened. Contrary to initial expectations, MSA sales proceeded slowly. On September 30, 1999, the Internal Revenue Service reported that a total of 42,477 tax returns reporting contributions to MSAs were filed for 1998. Surprisingly, 10,106 or 24% of those returns were from tax payers who were previously uninsured.

A number of reasons have been cited for the poor sales of MSAs:

- Eligibility is restricted to the population that is least likely to be insured.
- Rigid restrictions on product design imposed by the legislation do not permit products to be tailored to consumer demand.
- Brokers and agents are not well trained to sell MSAs because of the complexity of their tax effects.
- Commissions are generally lower for the high-deductible products sold with MSAs than for more comprehensive products.
- Brokers often receive little or no commission for selling the savings component of the MSA.
- The general public has difficulty understanding the complexity of MSAs. Brokers and agents must spend more time selling MSAs than when selling other health insurance products that often pay higher commissions.

RECENT CONGRESSIONAL ACTIVITY

There is considerable sympathy in Congress for removing the restrictions on MSAs. A number of almost identical MSA "expansion" bills have been introduced in the 106th Congress by Sen. Trent Lott (S.300); Sen. James Inhofe (S.657); Sen. Charles Grassley (S.1350); Rep. Michael Bilirakis (H.R. 448); Rep. Bill Archer (H.R. 614); and Rep. Charles Norwood (H.R. 1136). All of the bills contain provisions to:

- Repeal the limitation on the number of MSAs;
- Expand eligibility to employees of any size employer;

- Increase the income tax deduction for the contribution to the MSA to 100%;

- Allow both employees and employers to contribute to MSAs (except S.300, which retains the current limitation);

- Reduce the permitted annual minimum deductibles; and

- Allow MSAs to be offered in cafeteria plans provided by employers.

MSA MARKETING AND PRODUCT DEVELOPMENT ACTIVITIES

Companies with a financial interest in MSAs are proceeding to develop, package, and market innovative products built around MSAs on the assumption that lobbying for MSA expansion through their MSA advocacy organization, the Council for Affordable Health Insurance, will be successful. Some of these path breaking products combine a PPO, investment services, a debit card, and software, hardware and electronic networks connecting insurers, MSA account administrators, and physicians to facilitate real-time processing of transactions.

KEY AMA POLICY

Current AMA policy addresses MSA expansion as well as promoting MSAs to the public and physicians. For example, Policy H-165.879 directs the AMA to work for the immediate offering of MSAs to all individuals without restrictions with regard to company size or the total number of MSA enrollees; to encourage consumers to obtain their MSAs from a wide variety of sources; and to encourage employees with dual coverage through a spouse's health plan to consider the establishment of MSAs. Policy H-180.957 directs the AMA to pursue activities to inform physicians and the public about the value and availability of MSAs, including using the AMA Web Site as a key information medium for this purpose. Accordingly, the AMA Web Site contains pages that describe why the AMA supports MSAs, describe MSA eligibility rules, and provide a listing of companies offering MSAs.

DISCUSSION

Development and advocacy of the MSA concept has almost completed the transit from the policy development and advocacy stage to the business implementation stage. With the exception of "expansion" legislation, further development of MSAs will proceed in the market place where they will be subject to the market test. This test includes not only whether they offer intrinsic value to consumers, but also whether vendors can package and market them to expand consumer demand. Aside from fundamental insurance market reform, which could substantially change the environment for MSAs, there is little additional policy development and advocacy work to be done by the AMA. Nonetheless, the Council believes that the AMA should continue to actively include the advocacy of MSAs, and MSA expansion legislation in its ongoing campaign for health insurance market reform.

The Council believes that opportunity remains to develop approaches for expanding the availability and applicability of MSAs to children. For example, under the current estate tax treatment of MSAs, an MSA ceases to be an MSA except in a bequest to a surviving spouse beneficiary. Consequently, individuals who might wish to pass their MSA on to a child or grandchild can not do so. Similarly, individuals who might wish to establish independent health expense protection through an MSA for a child or grandchild cannot do so under current law. The Council will continue to assess potential ways to adapt MSAs and the laws and regulations governing their design to the health insurance needs of children.

RECOMMENDATIONS

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

1. That the AMA continue to incorporate advocacy of Medical Savings Accounts (MSAs) prominently in its campaign for health insurance market reform.

2. That the AMA should enhance activities to educate patients about the advantages and opportunities of MSAs.

3. That the AMA continue to advocate repeal of the current restrictions on Medical Savings Accounts by:

   (a) Permanently repealing the limit on the number of MSAs and removing the demonstration status of the project;

   (b) Expanding eligibility to employees of any size employer and to any individual;

   (c) Increasing the income tax deduction for the contribution to the MSA to 100%;

   (d) Allowing both employees and employers to contribute to MSAs;

   (e) Reducing the permitted annual minimum deductibles and allowing unlimited annual maximum deductibles;

   (f) Allowing MSAs to be offered in cafeteria plans provided by employers;

   (g) Allowing individuals with pre-existing medical conditions, who have been covered by medical insurance during the previous 12 months, to participate in an MSA without penalty; and

   (h) Allowing those covered by MSAs to collectively form a group purchasing arrangement for pharmaceuticals and other services.

4. That the AMA should continue to monitor and encourage the efforts by companies to develop, package, and market innovative products built around MSAs.

5. That the AMA explore the formation of an MSA, to be offered to AMA physicians through its own medical insurance programs.

11. NON-PHYSICIAN PRESCRIBING (RESOLUTION 511, I-98)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 511 (I-98) AND REMAINDER OF REPORT FILED

At the 1998 Annual Meeting, the House of Delegates referred Resolution 511 to the Board of Trustees. Introduced by the Colorado Medical Society, the resolution calls for the AMA, in collaboration with medical specialty and state societies, to "study and report on the impact of non-physician prescribing on the health of America and make recommendations regarding additional proactive initiatives that might be considered, including the possibility of model legislation." The Board referred Resolution 511 (A-98) to the Council on Medical Service for study and a report back to the House of Delegates.

This report reviews the current status of non-physician prescribing, including analyses of relevant statutes and regulations in each state; describes AMA policy and model state legislation related to non-physician prescribing; discusses the concerns of the Council regarding non-physician prescribing; describes the current Advocacy Resource Center (ARC) campaign on non-physician scope of practice issues; summarizes the available literature on the impact of non-physician prescribing on the quality of health care; and presents several policy recommendations.

STATUS OF NON-PHYSICIAN PRESCRIBING

A review of the literature reveals that existing state-by-state analyses differ regarding the prevalence of non-physician prescribing. Consequently, the AMA's Division of State Legislation analyzed the relevant statutes and regulations in each state to determine the number of states that either prohibit or restrict the ability of advanced practice nurses, optometrists, physician assistants (PAs), and pharmacists to prescribe. According to these analyses, 46 states and the District of Columbia currently require advanced practice nurses to enter into a collaborative practice arrangement or adhere to a protocol with a physician to prescribe. Alaska, Oregon, and Washington are the only states that do not require advanced practice nurses to collaborate with a physician or adhere to a protocol

between themselves and a physician to prescribe. Georgia currently prohibits advanced practice nurses from prescribing and 36 states currently require advanced practice nurses to receive specific education or training to prescribe.

In addition, with some exceptions, 26 states currently prohibit advanced practice nurses from prescribing Schedule II drugs, which include substances that have been approved for medical use, but have a high potential for abuse, such as morphine. In various ways, 18 states currently prohibit advanced practice nurses from prescribing Schedules III and IV drugs, which include substances that are less likely to be abused, and 18 states currently prohibit advanced practice nurses from prescribing Schedule V drugs, which include substances sold over-the-counter. Fourteen states permit advanced practice nurses to prescribe only non-controlled substances.

Analyses of the prescribing authority of optometrists by the AMA's Division of State Legislation reveal that all 50 states and the District of Columbia currently permit optometrists to prescribe diagnostic and therapeutic pharmaceutical agents. However, with some exceptions, nine states and the District of Columbia currently prohibit optometrists from prescribing topical pharmaceutical agents, 26 states and the District of Columbia currently prohibit them from prescribing oral pharmaceutical agents, 37 states and the District of Columbia currently prohibit them from treating glaucoma, and 31 states and the District of Columbia currently prohibit optometrists from removing superficial foreign bodies. Thirty-nine states and the District of Columbia also require optometrists to undergo specific education or training to prescribe.

Information on the prescribing authority of PAs, compiled by the AMA's Division of State Legislation, indicates that three states -- Indiana, Louisiana, and Mississippi -- currently prohibit PAs from prescribing. However, the scope of practice of PAs ensures that they work under the supervision of a physician, including when PAs prescribe medications. In various ways, 34 states and the District of Columbia currently prohibit PAs from prescribing Schedule II drugs, 13 states and the District of Columbia currently prohibit them from prescribing Schedules III and IV drugs, and 12 states and the District of Columbia currently prohibit PAs from prescribing Schedule V drugs. Eight states and the District of Columbia currently permit PAs to prescribe only non-controlled substances. In Arkansas and Maryland, PAs are permitted to prescribe Schedules III through V drugs and Schedules II through V drugs respectively; however, implementation of this authority is currently pending promulgation of the relevant regulations in both states.

Analyses of the prescribing authority of pharmacists by the AMA's Division of State Legislation reveal that 35 states and the District of Columbia currently prohibit pharmacists from prescribing. However, the 15 states that grant pharmacists prescribing authority also require them to enter into a collaborative practice arrangement or adhere to a protocol with a physician to initiate or modify drug treatment. Detailed information on the prescribing authority of pharmacists, as well as of advanced practice nurses, optometrists, and PAs in each state is available from the AMA's Division of State Legislation.

The National Association of Boards of Pharmacy (NABP) compiles information on the prescribing authority of several types of non-physicians, including, but not limited to, doctors of homeopathy, midwives, and naturopathic doctors. According to the NABP, with some exceptions, 46 states and the District of Columbia currently prohibit doctors of homeopathy from prescribing, 42 states currently prohibit lay midwives from prescribing, and 42 states and the District of Columbia currently prohibit naturopathic doctors from prescribing. Doctors of chiropractic and psychologists have no prescribing authority in any state.

RELEVANT AMA POLICY AND MODEL LEGISLATION

The AMA has adopted several policies that address non-physician prescribing, as well as others that advocate for proactive public education initiatives on this issue. Policy H-120.959, AMA Policy Compendium, states that the AMA will continue to pursue appropriate regulatory, legislative, and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications. Policy H-120.996 opposes the prescribing of medications by optometrists, Policy H-345.989 opposes the prescribing of medications by psychologists, and Policy H-160.928 opposes pharmacists being given the authority to initiate or modify prescription drug treatment except on a case-by-case basis at the specific direction of a physician. Policy H-35.989 opposes legislation or proposed regulations authorizing PAs to make independent medical judgements as to the drug of choice for individual patients. Policy H-360.987, on the supervision of medical care delivered by advanced practice nurses in integrated practices, says that exercising independent medical judgment in selecting the drug of choice for patients must continue to be a physician's responsibility.

Policies H-160.949, H-275.943, and H-450.955 state that the AMA will educate the public and legislators about the differences in education and professional standards between physicians and non-physicians. Policy H-125.999 supports efforts to inform the public and the profession of the potential problems and risks should a physician's choice of therapeutic agents be delegated to a non-physician.

The AMA has developed model state legislation granting prescribing authority under limited circumstances to nurse practitioners (NPs) and regulating such prescription practices. The AMA model bill provides that "in collaboration with a delegating physician, a [NP] may perform the medical function of prescribing drugs which are specified in an approved formulary, pursuant to protocol and agreement with the delegating physician." The model bill also provides for disciplinary action against NPs who fail to comply with the Act or to follow approved protocols. In addition, the model bill includes a disclaimer stating that the AMA is "not encouraging states to enact, or endorsing, legislation allowing [NP] prescribing. This model bill suggests that, when such legislation is considered and enacted, it is critical that it be allowed only with these conditions and limitations, in order to best protect the health and safety of patients."

The AMA also has developed model state legislation concerning the diagnosis and treatment of glaucoma by optometrists. The AMA model bill provides that "if during the course of examining a patient, an optometrist determines signs of disease, the optometrists shall refer the patient to a medical doctor or doctor of osteopathy" and that "no optometrist licensed in this state shall be permitted to treat glaucoma." In addition, the AMA has developed model state legislation to provide for appropriate generic drug and therapeutic substitution. The AMA model bill prohibits a pharmacist from substituting a "generically equivalent or therapeutically alternative drug for a brand name drug without prior consultation with and authorization from the prescriber."

DISCUSSION

The Council believes that physicians' unique training, experience, broad knowledge base, standards of care, ability, and expertise make them best suited to determine the drug of choice for individual patients, as well as the most capable of detecting and treating adverse reactions that may arise from taking prescribed medications. The Council also believes that the extensive training of physicians -- four years each of undergraduate and medical education, three to six years of residency training, and two or more years of additional training in a subspecialty for some physicians -- allows them to make judicious decisions regarding the care of patients, including knowing when medical intervention is and is not appropriate. The Council believes it is worth the AMA re-emphasizing to the public these benefits of receiving care and treatment from a physician. Such an approach is consistent with the Advocacy Resource Center's (ARC's) campaign addressing the scope of practice of non-physicians.

In 1999, the ARC launched a Scope of Practice Initiative to make more effective organized medicine's efforts on scope of practice issues, including non-physician prescribing. As part of this initiative, the ARC serves as the central repository for a broad spectrum of information on scope of practice issues and has developed a communications campaign for use at the state level that focuses on the unique attributes of physicians and their ability to lead the health care team. In the near future, the ARC also will launch its own web site, a major focus of which will be the Scope of Practice Initiative. The site will include a "virtual" scope of practice support center representing the work of the ARC as well as materials and information shared by specialty organizations, state medical societies, and organizations outside of organized medicine. The support center will include informational documents, statutory summaries, and communication tools. The Council believes that the AMA should encourage state medical associations and other interested physician organizations to proactively use the advocacy campaign materials on scope of practice developed by the ARC.

The Council also believes that the authority to prescribe medications is a serious one and, as such, should include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. Prescribing drugs necessitates providing patients with the appropriate follow-up care. When a patient suffers an adverse reaction to a prescribed medication, his or her only recourse should not be going to the emergency room, which may not be the most cost-effective means of seeking treatment. In addition, the Council believes that those who make medical decisions should be held accountable for those decisions. Similarly, those with the authority to prescribe medications should be liable for such actions.

Finally, much of the research that has been conducted in the area of non-physician prescribing lacks acceptable conceptual definitions and measurement variables or fails to use the appropriate methodological controls necessary for valid conclusions. This lack of definitive evidence may result in part from the fact that many of the challenges to

accurately gauging performance among physicians also apply when comparing the performance of physicians and non-physicians. For example, physicians tend to treat sicker patients than non-physicians, complicating comparisons of their outcomes. Groups or individuals that have an interest in showing favorable outcomes for non-physicians also have typically undertaken the research conducted in this area. However, given the growing trend of non-physician prescribing and the current lack of definitive evidence on this issue, the Council believes that further methodologically valid research on the relative impact of non-physician prescribing on the quality of health care is warranted.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 511 (A-98), and that the remainder of the report be filed:

1. That the AMA, in collaboration with specialty societies, immediately develop programs to educate the public about the differences in education and professional standards between physicians and non-physician health care providers.

2. That the AMA encourage state medical associations and other interested physician organizations to proactively use the advocacy campaign materials on scope of practice developed by the Advocacy Resource Center.

3. That the AMA advocate that prescriptive authority include the responsibility to monitor the effects of the medication and to attend to problems associated with the use of the medication. This responsibility includes the liability for such actions.

4. That the AMA support the development of methodologically valid research on the relative impact of non-physician prescribing on the quality of health care.

5. That the AMA reaffirm Policy H-120.959, which states that the AMA will continue to pursue appropriate regulatory, legislative and legal means to oppose any efforts to permit non-physician health care professionals to prescribe medications.

Detailed information on the prescribing authority of non-physicians is available from the AMA Division of State Legislation.

12. PHARMACY BENEFIT RISK-SHARING BY PHYSICIANS (RESOLUTION 241, A-99)

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 241 (A-99) AND REMAINDER OF REPORT FILED AND FOLLOWING RECOMMENDATION ADOPTED: That the AMA ask the Council on Ethical and Judicial Affairs to consider developing an ethical opinion on pharmacy benefit risk-sharing by physicians.

At the 1999 Annual Meeting, the House of Delegates referred Resolution 241 to the Board of Trustees. Introduced by the Organized Medical Staff Section, the resolution calls for the AMA "to oppose the practice of the health plans' mandatory shift of pharmacy risk-bearing to physicians and medical groups; to determine the impact this issue has on the quality of medical care that physicians provide to their patients; and to introduce legislation to prohibit the mandatory shift of pharmacy risk-bearing to physicians and medical group, and/or develop model legislation to assist states that are fighting this problem." The Board of Trustees referred Resolution 241 (A-99) to the Council on Medical Service for a report back to the House of Delegates at the 1999 Interim Meeting.

This report describes the prevalence of pharmacy benefit risk-sharing by physicians; discusses the potential benefits and challenges of such risk-sharing, summarizes relevant AMA policy that conceptually is related to this issue; and presents several policy recommendations.

PREVALENCE OF PHARMACY BENEFIT RISK-SHARING BY PHYSICIANS

Although pharmacy benefit risk-sharing has been viewed as a relatively new development, some physicians and physician groups have been accepting partial risk for pharmacy costs since hospital and other cost-related withholds were introduced in the 1980s. Within the last few years, however, the practice has become more prevalent. According to 1996 data from a survey of 765 HMOs conducted by the SMG Marketing Group, 27.3% of all HMOs used risk pools or withholds for pharmaceuticals—a figure that some have estimated may have doubled over the past two years. Furthermore, approximately 24.6 million Americans were enrolled in HMOs during 1996 that shared pharmacy risk with physicians and other health care providers.

POTENTIAL BENEFITS AND CHALLENGES OF PHARMACY BENEFIT RISK-SHARING

As more physicians and physician groups have gained experience with risk-based contracts, such as capitation, their willingness to accept or share risk for pharmacy benefits has grown. Those who have been involved in pharmacy benefit risk-sharing list a number of potential benefits, such as ownership of the formulary and drug distribution system; receipt of full or partial rebates from pharmaceutical manufacturers; and, if planned and implemented correctly, increased profitability. Physician groups that have accepted risk for prescription drugs as part of a global capitation contract also suggest that it provides the group with the ability to shift potential excess drug expenses to group budgets for other health care services.

Yet, many physicians and physician groups lack the necessary data, policies, and infrastructure to successfully accept pharmacy benefit risk without adversely affecting the financial stability of their practices, as well the potential quality of care of their patients. Furthermore, physicians usually have little or no control over health insurance underwriting practices, pharmaceutical manufacturer pricing, health plan benefit design, health plan enrollment processes and marketing practices, and the evolution of new technology and drugs. For example, physicians sharing pharmacy benefit risk can be significantly affected if they are not allowed to renegotiate contract changes due to mid-year health plan benefit design changes such as increased coverage for pharmaceuticals, formulary additions, or reductions in patient copayment amounts.

Perhaps the greatest challenge for physicians accepting pharmacy benefit risk, however, is attempting to adequately project the impact of direct-to-consumer (DTC) advertising. During 1998, DTC advertising expenses were expected to rise to $1.3 billion, an approximate 50% increase over 1997 expenditures. This level of spending not only fuels a "public appetite" for the newest drugs, but also potentially increases the overall volume of physician office visits as patients seek prescriptions for these drugs. A separate report before the House of Delegates at this meeting (CMS Report 9, I-99) addresses the costs and benefits of pharmaceutical use in the United States.

RELEVANT AMA POLICY

AMA policy traditionally has supported pluralism and has opposed patients and physicians being subjected to mandatory practice arrangements or contract provisions. For example, Policy H-285.989 (AMA Policy Compendium) opposes tying a physician's participation in one managed care panel (e.g. a PPO) to that physician's participation in another managed care panel (e.g. an HMO). Policy H-285.964 advocates that participation in "hospitalist" programs should be at the voluntary discretion of the patient and the patient's physician. Policy H-195.994 opposes the mandatory enrollment of employees in HMOs. Policy H-285.944 advocates for voluntary patient participation in disease management programs.

Perhaps of most relevance to Resolution 241 (A-99), current policy on managed care cost containment involving prescription drugs (Policy H-285.965[3]) specifically states:

> Physicians must not be made to feel that they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are necessary for their patients but that may also be costly. There should be limits on the magnitude of financial incentives, incentives should be calculated according to the practices of a sizable group of physicians rather than on an individual basis, and incentives based on quality of care rather than cost of care should be used. Physician penalties for non-compliance with a managed care formulary in the form of deductions from withholds or direct charges are inappropriate and unduly coercive.

At the same time, the AMA has had long-standing support for the right of physicians to enter into whatever contractual arrangements with health care systems they deem desirable and necessary (Policy H-285.951[b]).

DISCUSSION

During the past several years, concerns have been raised regarding the accelerated growth in prescription drug expenditures. For example, according to the Health Care Financing Administration, prescription drug expenditures rose 14% in 1997. As a result, health plans and other third-party payors have implemented a number of strategies in an attempt to curtail rising drug expenditures, such as directing patients to specific pharmacies and mail-order programs, implementing specific drug formularies, utilizing prescribing guidelines, contracting with pharmacy benefit management companies, and implementing drug utilization management programs. As discussed in this report, health plans increasingly have been attempting to shift risk for pharmaceutical use to physicians and physician groups, as well.

At the 1999 Annual Meeting, one of the concerns raised among those who testified on Resolution 241 was that physicians and physician groups who choose voluntarily to assume pharmacy risk should not be precluded from doing so. The Council agrees with this view and, consistent with Policy H-285.951(b), believes that physicians should continue to have the right to enter voluntarily into whatever contractual arrangements with health plans that they view as appropriate.

At the same time, the Council believes that physicians need to exercise extreme caution before entering into any contractual arrangement to fully accept or even share pharmacy risk. As previously discussed, there are a multitude of factors that impact on prescription drug utilization, many of which physicians have little control over. Prior to entering into any potential agreement to accept pharmacy risk, the Council believes that physicians should seek considerable actuarial, contracting, and legal advice.

Consistent with the both the intent of Resolution 241 (A-99) and long-standing AMA policy on pluralism, the Council is strongly opposed to any mandatory imposition of pharmacy risk on physicians or physician groups by health plans and other third-party payors. Physicians should not be coerced into signing written services agreements that contain contract provisions that are not within their best interests or that of their patients. In particular, the Council believes that the AMA "Model Managed Care Services Agreement" should be modified to include a provision that prohibits the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third-party payors.

Furthermore, due to its concern over this issue, the Council believes that the development of AMA state model legislation that would prohibit the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third-party payors, is warranted.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 241 (A-99), and the remainder of the report be filed:

1. That the AMA oppose the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third-party payors.

2. That the AMA modify its "Model Managed Care Services Agreement" to include a provision that prohibits the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third-party payors.

3. That the AMA develop model state legislation that prohibits the imposition of mandatory pharmacy benefit risk-sharing on physicians and physician groups by health plans and other third-party payors.

4. That the AMA urge physicians and physician groups to seek actuarial, contracting, and legal advice prior to entering into any voluntary agreement to accept or share pharmacy risk.

5. That the AMA reaffirm Policy H-285.951(b), which states that physicians should have the right to enter into whatever contractual arrangements with health care systems they deem desirable and necessary, but they should be aware of the potential for some types of systems to create conflicts of interest, due to the use of financial incentives in the management of medical care.

13. DEFINITION OF "MEDICAL NECESSITY"

HOUSE ACTION: FILED

At the 1999 Annual Meeting, the House of Delegates referred Resolution 724 to the Board of Trustees for decision. Introduced by the American Academy of Neurology and the American Academy of Physical Medicine and Rehabilitation, the resolution called for the AMA to adopt the following definition of "medical necessity":

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations in a manner that is: (1) in accordance with generally accepted standards of medical practice; (2) clinically appropriate in terms of type, frequency, extent, site and duration; and (3) not primarily for the convenience of the patient, physician, or other health care provider.

In reviewing this issue, the Board sought the input of the Council on Medical Service. This report, which is presented for the information of the House, describes the development and impact of the current AMA definition of "medical necessity"; summarizes additional information received from the sponsors of the resolution; and discusses why both the Council and the Board believe that the current AMA definition should not be modified at this time.

DEVELOPMENT AND IMPACT OF THE AMA DEFINITION OF "MEDICAL NECESSITY"

Following considerable discussion at the 1998 Interim Meeting, the House of Delegates established the following AMA definition of "medical necessity" (Policy H-320.953[3], AMA Policy Compendium):

> 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.

The definition was adopted from a report of the Council on Medical Service (CMS Report 13, I-98) that was prepared primarily to address the growing problem of some health plans attempting to insert egregious definitions of medical necessity into managed care contracts. A number of these definitions included "lowest cost criteria" that often would define medical necessity in the context of the shortest, least expensive or least intense level of treatment, care or service provided. The House also adopted several other policy recommendations to augment the AMA's comprehensive policy base on medical review, such as advocating that determinations of medical necessity should be based only on information that is available at the time that health care services and products are provided (Policy H-320.953[7]).

The current AMA definition of medical necessity has had a significant impact on public policy debates regarding who should ultimately make medical necessity determinations. This issue, which has continued to be one of the key factors in the ongoing congressional debate over federal patients' bill of rights legislation, moved into prominence following the AMA House of Delegates reaching consensus on a definition of medical necessity in December 1998. As a result, the AMA definition of medical necessity has had an equally significant effect on a number of debates over state patients' bill of rights legislation. Related policy from CMS Report 13 (I-98) has influenced other activities in the private sector as well. For example, consistent with Policy H-320.953(6), the American Accreditation HealthCare Commission/URAC revised its health plan standards, in April 1999, to prohibit health plans seeking accreditation from using definitions of medical necessity that emphasize cost and resource issues above clinical effectiveness.

DISCUSSION

The definition proposed in Resolution 724 (A-99) would have modified the current AMA definition of "medical necessity" (Policy H-320.953[3]) by addition and deletion to read as follows:

> Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing, ~~or~~ treating or rehabilitating an illness, injury, disease or its associated symptoms, impairments or functional limitations 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.

In considering these proposed changes, the Council invited the co-sponsors of Resolution 724 (A-99) to submit additional comments and information. In particular, the Council raised three main concerns with the proposed changes to the definition: (1) the term "rehabilitating" already appears to adequately fall under the terms "preventing, diagnosing or treating"; (2) the terms "impairments or functional limitations" already appear to adequately fall under the terms "illness, injury, disease or its symptoms"; and (3) a change in the AMA's definition of medical necessity could have an adverse impact on pending federal and state debates on patients' bill of rights legislation.

The Council also re-reviewed the language in the 10 state laws that define medical necessity that it previously reviewed in the development of CMS Report 13 (I-98). None of the 10 state definitions of medical necessity specifically reference "rehabilitating" or "impairments or functional limitations."

In July 1999, the co-sponsors of Resolution 724 (A-99) submitted identical letters to the Council in response to these concerns. With respect to the potential addition of the term "rehabilitating," the co-sponsors indicated that the term has its own specific meaning, and that "while rehabilitation may seem to fall under the rubric of treatment, because it does have its own very specific identity, to not refer to it in a definition of medical necessity could carry the implication that it is not a focus of medical necessity determinations." The co-sponsors also stated that impairments and functional limitations still may require rehabilitation because they may persist after a disease or illness is no longer active. As a result, "not referring to rehabilitating and impairments or functional limitations in a definition of medical necessity will provide payors with the opportunity to narrowly construe the meaning of medical necessity." Finally, the co-sponsors indicated that they recognized the "confusion and possible detriment of introducing a revised definition of medical necessity into the current patients' bill of rights discussion," and stated that they had no intention of approaching legislators with an expanded definition.

While sympathetic to the additional views expressed by the co-sponsors of Resolution 724 (A-99), the Council does not believe that a change in the AMA's definition of "medical necessity" is warranted. The original goal of the Council in developing a definition was to provide a sufficient level of detail to clarify what are the most important factors for making medical necessity determinations. The Council believes that the current definition continues to meet this intent and has as much relevance for a physician providing rehabilitative services as for a physician providing any other kind of service. In particular, the Council believes that the term "rehabilitating" adequately falls under the terms "preventing, diagnosing or treating," and the terms "impairments or functional limitations" adequately fall under the terms "illness, injury, disease or its symptoms."

The Council also has significant concerns regarding the precedent that would be set with the addition of what would be viewed by many throughout organized medicine as "specialty-specific" language. Such a precedent could potentially open up the current definition of medical necessity to ongoing requests for additional references to specific types of services. In addition, the Council believes it should be emphasized that issues related to medical necessity determinations are often quite different than issues related to coverage determinations. While a health care service or product provided by a physician may be medically necessary, it may not be covered under a specific health benefit plan.

Furthermore, while the Council appreciates the willingness of the co-sponsors to not approach legislators with an expanded or revised definition of medical necessity during critical federal debates over patients' bill of rights legislation, a change in the AMA's definition of medical necessity would require the AMA to do just that—advocate for use of the revised definition.

At the time that this issue was reviewed and discussed by the Council, it did not believe that the changes sought in Resolution 724 (A-98) merited jeopardizing the outcome of the high-level debate that was being pursued by many members of the Federation.

CONCLUSION

At its October 1999 meeting, the Board of Trustees agreed with the Council on Medical Service that the current AMA definition of "medical necessity" (Policy H-320.953[3]) remains appropriate, and that the changes proposed in Resolution 724 (A-99) should not be implemented. The Board also supported the development of an informational report to the House of Delegates on this issue for the 1999 Interim Meeting.

14. STATUS REPORT ON MEDICARE REVIEW ACTIVITIES

HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED AND POLICIES H-340.899[2], H-340.898[2,5], AND H-340.918 REAFFIRMED

Since 1997, the Council on Medical Service has presented periodic reports to the House of Delegates on Medicare review activities. At the 1999 Annual Meeting, the House of Delegates adopted the recommendations in Council on Medical Service Report 11, which summarized current Medicare review activities, including the status of the Medicare Integrity Program, the Peer Review Organization (PRO) Sixth Scope of Work, developments in Medicare carrier post-payment audit review processes, and the national initiative entitled, "Who Pays? You Pay," launched by the Department of Health and Human Services (HHS), the Justice Department, and the American Association of Retired Persons.

On June 11, 1999, the Department of Health and Human Services Office of Inspector General (OIG) announced savings of $6.8 billion from health care fraud and abuse and other related activities during the first half of fiscal year 1999. The savings included $6.4 million from enacted suggestions and other measures to better use funds, $140.5 million in audit disallowances, and $175.8 million in investigative receivables.

Since CMS Report 11 (A-99) was prepared, there have been a number of new developments involving Medicare review programs. The following report updates current Medicare review activities, including the Medicare Integrity Program task orders and contracts, an update of the implementation process of the PRO Sixth Scope of Work, and the recent expansion of the Senior Medicare Patrol Project.

MEDICARE INTEGRITY PROGRAM

Private Medicare contractors, commonly known as intermediaries and carriers, have worked with the Health Care Financing Administration (HCFA) since the Medicare program began in 1965. They are charged with paying hospitals, physicians and other health care providers for services provided under Medicare as well as with handling routine questions from beneficiaries, physicians, and other health care providers about the program. They also are responsible for safeguarding the integrity of claims processing in the Medicare program.

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 (PL 104-191) created the Medicare Integrity Program (MIP), which provided HCFA with $107 million for payment safeguard activities, as well as new authority to contract with private entities to perform specific payment safeguard functions. The aim of MIP is to reduce the cost of administering Medicare by consolidating the payment safeguard functions of the current intermediaries and carriers. MIP creates a framework for contracting out program integrity functions to entities that are not required to be insurance companies, as contractors had been previously.

Under MIP, HCFA created Payment Safeguard Contractors (PSC). On May 19, 1999, HCFA announced the 12 private companies it will hire as PSCs. These contractors will supplement and support program integrity work already being done by Medicare carriers and intermediaries. PSC's scope will not be national, but rather regionally based.

On that same date, HCFA also announced the first series of MIP task orders. The MIP task orders identify six projects on which the 12 selected contractors may bid. The MIP draft task orders include: (1) conducting cost-report audits for large health-care chains; (2) preventing possible Year 2000 threats to program integrity; (3) conducting on-site reviews of community mental health centers; (4) identifying effective areas to target for national provider education; (5) performing data analysis and other activities to support the Affiliated Contractor fraud units that detect and prevent Medicare fraud and abuse in New England; and (6) ensuring providers comply with the corporate settlement agreements of the OIG.

The first round of contracts will not entail any substitution of additional participants for existing contractors, since the functions they will be asked to perform will be complimentary and supporting of existing claims review activities, and will not result in termination of existing arrangements. Eleven of the twelve groups of contractors include Blue Cross and Blue Shield plans, so the aim of increasing competitiveness in the contracting business has not yet begun.

HCFA has stated it needs to "carefully consider the incentives, types of contracting arrangements, and evaluation criteria" that are established through the task orders and develop approaches to "quantify contractor effectiveness and program savings." HCFA defined a successful performance measurement program as one that will measure and evaluate the PSC's performance in administering the MIP, assess customer satisfaction with the services that PSCs provides, and compare PSCs' performance to the performance achieved by traditional Medicare contractors.

At the time this report was written, the system for compensation to MIP contractors had yet to be established. The Council would like to see compensation based on the proper repayment of claims and not based on any type of bounty system for "turning in" physicians and others or for dollars recovered.

PRO SIXTH SCOPE OF WORK UPDATE

As previously reported by the Council, the Sixth Scope of Work indicates that the following percentages approximate the relative level of effort by PROs: 60% Quality Improvement Projects (75% National, 25% Local); 30% Payment Error Prevention Program (PEPP), and 10% Beneficiary Rights/Outreach/Statutorily Mandated Review Activities. HCFA changed the role of PROs by modifying the Sixth Scope of Work from a quality and educational oriented program to one focused on billing errors through its new PEPP program. The AMA strongly opposed the different direction of the PRO program and recommended that it be revised to direct PROs to focus on quality improvement activities, rather than on alleged fraud and abuse, and advocated for the complete elimination of the PEPP. However, HCFA has remained adamant that PEPP can and will work. The goal of the PEPP program is to reduce payment errors on Medicare bills to hospitals by 50% by 2002.
HCFA continues to suggest that the PROs will be rewarded with "bounties" when describing how PROs will be paid for administering the PEPP program. The Sixth Scope initially labeled these "bounties" as "incentives," and a later revision simply renamed them "award fees." Particularly aggressive language in the section entitled "Award Fee Plan" states that "a 40% relative reduction in the baseline payment error rate…will result in the PRO receiving the maximum award…" In addition, there is nothing in the Sixth Scope that specifically defines when referrals to the OIG should result.

HCFA held an open "town hall meeting" on July 19, 1999, to discuss the role of Medicare PROs, including the controversial PEPP. It is anticipated that the implementation of the Sixth Scope of Work will take place from August 1999 through February 2000. At the meeting, HCFA officials indicated that when a PRO finds "substantial reason" to suspect persistent fraud or abuse after conducting an educational effort, the PRO will refer the situation to the OIG. HCFA also mentioned that guidelines for these referrals will be written and publicly available when they are completed.

Also discussed at the meeting was the use of standardized quality indicators by PROs to identify the best opportunities to improve the care of beneficiaries, as well as PEPP's "modified" review activities that aim to curb fraud, waste, and abuse in the Medicare billing process. At the meeting, it was specifically noted that PEPP's emphasis was on two types of provider billing errors: unnecessary admissions and miscoded diagnosis-related group assignments. In a question and answer sheet distributed at the meeting, HCFA claimed that the PEPP program will affect physicians "very little" since PROs will be examining only hospital bills and "will not examine physician bills." The Council is extremely skeptical of this assertion.

Finally, HCFA specifically instructs in the Sixth Scope that PROs will be responsible for pursuing and following up on written beneficiary complaints that may come in about the quality of care provided in physician offices under the Medicare fee-for-service program. PROs will be expected to be following up if and when beneficiaries complain.

SENIOR MEDICARE PATROL PROJECT

It was announced by HHS, on June 17, 1999, that a Medicare "fraud-busting" program that uses seniors to uncover billing problems had been expanded with $7 million in grants to 39 states. The anti-fraud initiative, known as the Senior Medicare Patrol Project, began two years ago with $2 million in grants to 12 states. The project uses retired

accountants, physicians, lawyers, teachers and nurses to teach beneficiaries to spot billing and benefit problems. According to HHS, over the past 18 months, 6,000 volunteers have educated 70,000 beneficiaries. The expansion will fund training for 15,000 volunteers, who will educate up to 250,000 Medicare enrollees. Volunteers work in their own communities and in local senior centers to help identify deceptive health care practices, such as overbilling, overcharging, or providing unnecessary or inappropriate services. Senior volunteers undergo several days of training reviewing health care benefit statements and outlining the steps seniors can take to protect themselves.

The projects involve numerous types of anti-fraud activities, including 386 public service announcements that reached an estimated 44 million individuals in the first year of the program. The projects identified a total of 657 allegations of fraud, waste, or abuse that were referred to Medicare contractors or investigative agencies. Eighty-eight were identified as potential overpayments. Four state projects estimated that as much as $1.16 million in Medicare funds may be recouped while the remaining eight projects were not able to identify any potential Medicare savings.

AMA POLICY

The AMA has established comprehensive policy relating to Medicare review activities. (Policies H-340.899, H-340.901, H-340.902, H-340.910, H-340.918, H-340.968, H-340.898, H-335.968, H-335.977 and H-330.921, AMA Policy Compendium). Policy H-340.899 states in part that the AMA will strongly urge HCFA to provide for more involvement from the AMA, other physician organizations, and hospital and organized medical staffs in refining and implementing the PRO Sixth Scope of Work. Policy H-340.898 states, in part, that the AMA will continue to oppose any type of "bounty" system for compensation to any Medicare contractor, including those in the Medicare Integrity Program, and instead urge HCFA to base compensation on the proper repayment of claims, rather than the numbers of resulting referrals to law enforcement agencies. Policy H-340.898 states, in part, that the AMA should urge HCFA to clarify in the PRO Sixth Scope of Work that referrals to the OIG should not occur unless a hospital does not respond to intervention or when significant evidence of fraud exists.

DISCUSSION

As discussed throughout this report, HHS and HCFA have initiated a number of programs targeting the physician community and directed toward combating fraud and abuse. More recently, however, Medicare contractors themselves have been implicated in fraud and abuses against a backdrop of highly uneven performance in fraud control activities. At a July 14, 1999, hearing of the House Commerce Committee's Subcommittee on Oversight and Investigations, lawmakers heard from numerous government officials and other witnesses who stressed that Medicare contractor fraud and abuse is rampant, largely because of weak oversight from HCFA, and that the federal government currently has only a tip-of-the-iceberg knowledge about the extent of such fraud. A General Accounting Office study released at the hearing determined that HCFA is responsible for many of the problems that have resulted in a high payment error rate and the rash of recent breakdowns in the contractors' own integrity, enabling the firms to routinely waste funds and even cheat the program out of billions of dollars each year without detection.

The Council continues to believe that the federal government's current efforts to pursue potential fraud and abuse have gone too far. In particular, the government's aggressive tactics treat physicians as criminals, and policymakers with little knowledge of the practice of medicine are losing sight of the volumes of regulations with which a physician must comply. For the long-term good of the Medicare program and its beneficiaries, the Council feels strongly that something must be done to change this dynamic.

The Council continues to be concerned that the MIP will create an environment in which MIP contractors will strive to "turn in" the most physicians and recoup the most money for Medicare. As previously noted, Policy H-340.898 categorically opposes any system for compensation based on "bounties" or "incentives" and believes compensation should be based on the proper repayment of claims, rather than the numbers of resulting referrals to law enforcement agencies. A bounty system would skew the motives of the MIP away from recovering improper payments and toward making them a subsidiary of the OIG.

In addition, the Council feels the conflict of interest provisions set forth by HCFA are wholly inadequate and must be strengthened to ensure that MIP contractors remain unbiased in their activities. MIP contractors should have to identify and monitor, and perhaps forbid, their employees' interest in entities for which the contractor performs MIP

activities to ensure that the employees are unbiased in performing their duties. In addition, the Council hopes that HCFA has improved the protections surrounding patient records that are in the possession of MIP contractors. Strict obligations should be imposed on MIP contractors to restrict the disclosure or use for commercial purposes of patient specific information. Most importantly, the Council considers it imperative that there continues to be a sincere working dialogue between the AMA and HCFA regarding the MIP contracts. In light of recent reports regarding contractor fraud and abuse, the Council feels strongly that an appropriate accountability system for MIP contractors is essential.

The Council continues to believe that the PEPP program in the PRO Sixth Scope of Work does not clearly emphasize the importance of education, clinical improvements, and interventions aimed at the physician who may have made an error. The Council also firmly believes that the AMA must closely monitor the implementation the PEPP to ensure that it sufficiently protects physicians from possible erroneous referrals to the OIG. The AMA should have significant opportunity to review and comment on the referral guidelines HCFA is drafting. Referrals should not occur unless a hospital does not respond to intervention or when significant evidence of fraud exists.

In conclusion, the Council continues to have serious concerns with a number of the previously discussed Medicare review activities and the hostile environment it seeks to create. Simplification and better education about Medicare rules should be the priority for HCFA.

RECOMMENDATIONS

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

That the AMA continue to diligently advocate to the Health Care Financing Administration for the active participation of physician organizations in: (a) the implementation process of the Medicare Peer Review Organization Sixth Scope of Work, especially the Payment Error Prevention Program; and (b) the development and issuance of the PRO proposed guidelines regarding referrals to the Office of the Inspector General.

15. MEDICARE PHYSICIAN ENROLLMENT PROCESS

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

The Health Care Financing Administration (HCFA) has announced its intention to issue a proposed rule in the summer of 2000 which will dramatically impact the Medicare Provider/Supplier application process. HCFA is considering codifying 15 mandatory and discretionary criteria physicians and other health care providers must meet to enter the Medicare program and to continue providing services to beneficiaries.

On June 8, 1999, HCFA held a "town hall" meeting concerning Form 855 and the existing enrollment process. Proper submission of Form 855 is required as a condition of receiving a "provider" identification number for the Medicare program. The proposals set forth by HCFA at its June 1999 meeting regarding provider enrollment have raised numerous issues and concerns. Accordingly, the following report reviews the proposed new Medicare physician enrollment process, describes the Council's suggestions for streamlining the existing process, and presents several policy recommendations.

FORM 855 ENROLLMENT APPLICATION

Form 855, currently 17 pages long, is used by physicians to enroll in the Medicare program. HCFA hopes to begin using the revised form sometime after January 1, 2000. Regarding its proposed regulation on enrollment, HCFA recently stated, "we will review providers and suppliers periodically and re-enroll them every three years based on their performance. Providers and suppliers that do not meet Medicare standards will not be re-enrolled." Although HCFA's policy on enrollment and re-enrollment is still unfolding, it views enrollment as a cornerstone of the agency's fraud and abuse strategy. Clearly, a proposed regulation in this area will have major implications for physicians. As it is, Form 855 is extremely difficult to complete, and many carriers have delayed issuing provider numbers.

New Enrollment Process

The AMA has expressed considerable concern with HCFA's suggestion that it may require virtually all physicians to submit enrollment forms to HCFA. These physicians would have to submit practice or billing information changes to HCFA contractors in order to maintain billing privileges. The new enrollment process would require physicians who have not completed Form 855 to submit an enrollment form to HCFA. This new procedure would apply to hundreds of thousands of physicians who were caring for Medicare beneficiaries prior to the 1996 debut of Form 855. Physicians who have not opened a new practice location or switched practices prior to this time have never submitted a Form 855 to HCFA. Currently, physicians inform HCFA of major changes in their practices by completing Form 855.

Mandatory Denial or Revocation of Enrollment

HCFA also has proposed that physicians should be subject to mandatory enrollment denial or enrollment revocation if the physician: (1) is excluded from participation in a federal program;
(2) has committed a felony in the last five years; (3) has, for the purpose of obtaining or maintaining enrollment, failed to disclose information that would have otherwise denied or revoked enrollment; (4) has failed to submit required cost reports if enrolled previously; (5) does not meet requirements for provider/supplier type; or (6) has ceased business activities as evidenced by a lack of claims submission for one year.

Denial or revocation of a provider number has the same practical effect as excluding a physician from receiving payments from Medicare. The Council believes that the above enumeration of triggering events for mandatory revocations and denials exceeds HCFA's statutory authority for mandatory exclusions from the Medicare program under the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191). HIPAA sets forth only the following offenses as bases for mandatory exclusions from the Medicare program: (1) conviction of program-related crimes; (2) felony conviction relating to health care fraud (indicating fraud, theft, embezzlement, breach of fiduciary duty, or other financial misconduct); and (3) felony conviction related to unlawful manufacture, distribution, prescription or dispensing of a controlled substance. These proposed, new revocation or denial standards would cover management issues that fall outside the conditions set forth under the statute for mandatory physician, supplier and provider exclusion.

Permissive Denial or Revocation

The permissive denial or revocation provisions HCFA has proposed would give the agency broad discretion in revoking or denying provider identification numbers to physicians. Under the proposal being discussed, HCFA could deny or revoke the enrollment of a physician who: (1) has committed a felony more than five years earlier; (2) provided any false or misleading information on Form 855; (3) is currently under payment suspension associated with another provider; (4) is currently under indictment for felonies which would serve as the basis for denial or revocation; (5) has previously left the program with outstanding debts; (6) has history of or currently having a high error rate for claims; (7) has not been able to obtain or lost license; (8) fails onsite visits because of unqualified technicians conducting tests, required physician supervision not present, personnel working outside the scope of their licensure, conditions that may cause harm to beneficiaries; or (9) fails to provide the records needed for payment or records needed for establishing Medicare eligibility.

In contrast, HIPAA states that the Secretary of the Department of Health and Human Services (HHS) has permissive exclusionary authority to exclude individuals and entities from participation in any federal health care program if the person or entity has been convicted of any of the following: (1) a criminal offense consisting of a misdemeanor relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct in connection with the delivery of a health care item or service or with respect to any act or omission in a health care program; (2) a criminal offense relating to fraud, theft, embezzlement, breach of fiduciary responsibility, or other financial misconduct with respect to any act or omission in a program operated by or financed by a federal, state, or local government; (3) obstruction of an investigation into any of the criminal offenses listed under mandatory exclusions; or (4) a misdemeanor relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance.

Again, the Council believes HCFA is attempting, without statutory authority, to fold difficult program management issues, such as high error rates or not properly supervising staff, into this initiative. It is likely that HCFA would have difficulty distinguishing accurate physician error rates, as denial rates vary by carrier, are often due to carrier

error, and may be unrelated to physician errors. In other instances, physicians submit claims even though they are aware that payments will not be made, in order to receive payments from secondary coverage. If HCFA attempts to use these somewhat obscure areas to exclude less desirable business partners from the Medicare program, physicians could unfairly become entangled in the process. In addition, the new system could severely limit the physicians available to serve Medicare patients.

Suggestions for Streamlining the Existing Process

HCFA plans to work with its carriers to expedite the approval of provider enrollment. Carriers have repeatedly returned applications because certain information is missing that is not critical to whether the physician should be given a Medicare number. Some carriers have rejected applications if the physician did not include a copy of her or his original Social Security card. Other carriers have rejected applications because, even though the physician listed several prior practice locations, he or she did not list every practice location since beginning to practice medicine. Still, other carriers require physicians to submit employment proof such as confidential employment or independent contractor agreements and copies of the physician's payroll withholding stub.

In many states, physicians have been waiting for months to receive enrollment approval. During this time, non-enrolled physicians cannot receive Medicare payment. This is especially difficult for physicians who are just beginning to practice medicine, and for the practice that a new physician may be joining. In fact, physicians who have just completed their residency training must spend several months assembling their documentation for state licensure, which often includes records from high school through residency. Once the correct documents are submitted, licensure normally occurs within six weeks. Physicians must wait until they are licensed to apply for hospital privileges, which generally takes three months to obtain. Only then can physicians submit their Form 855 to HCFA to obtain provider identification numbers. It is not uncommon for the carriers then to take more than six months to process Form 855 before enrolling physicians in the Medicare program.

The Council believes that HCFA and its Medicare carriers need to shorten the length of enrollment times. One way to accomplish this would be to permit physicians to enroll via an online version of Form 855, while mailing relevant attachments to HCFA. In addition, HCFA should prohibit carriers from sending incomplete or incorrectly completed Form 855s back to physicians and restarting the approval process. The Medicare Carriers Manual states that carriers should process enrollment applications within 45 calendar days, absent extenuating circumstances. However, many carriers have very low rates of meeting this 45-day approval time. Others bypass the deadline by waiting until the end of the 45-day period, and then returning the application to the physician citing minor information that is missing.

The Council also believes that HCFA should institute temporary provider numbers for physicians during the enrollment application period. By the time a new physician submits Form 855, he or she has already undergone tremendous scrutiny to become licensed in a state. In certain instances, licensed physicians could be paid for the services they are providing while they are waiting for HCFA to process their permanent provider identification number. Identifying and reserving a limited number of temporary provider numbers would help facilitate a smooth transition for patients, physicians, and practices during the enrollment process.

AMA POLICY

The AMA has not established policy on the Medicare enrollment process. Nonetheless, Policy H-390.881 (AMA Policy Compendium) states, in part, that the AMA will continue to oppose Medicare regulations which increase the administrative burdens on physicians.

DISCUSSION

The Council believes that HCFA's proposal to mandate a new method of enrollment in the Medicare program would be an enormous new regulatory burden for physicians, who are still trying to understand and cope with other confusing Medicare regulations. This proposal would require many hours of physicians' time, and would subject them to possible discretionary punitive measures such as revocation or denial of their provider number. The Council believes that HCFA must adhere to its narrow statutory authority and must refrain from subjecting physicians to additional regulatory hassles and from creating new harmful consequences for those who fail to abide by these new burdensome requirements.

The Council believes it is extremely important to streamline the Medicare physician enrollment process. To do this, the carrier could contact the applicant, preferably by telephone, to gather the missing information without restarting the approval process. Only during this period when the carrier is waiting to receive these materials in the mail should there be a delay in the approval process. In addition, HCFA should institute an on-line enrollment process as soon as possible, which would allow the applicant to send in original source information, including signature pages and attachments via regular mail.

The Council also believes that HCFA should be urged to create an option through the Medicare enrollment process in which physicians could set up electronic billing and payment. As the system currently operates, the physician or group practice must first go through the enrollment process, obtain their provider number, and then separately apply for an electronic billing number and electronic remittance address. Consolidating the process would also provide incentives for physicians to electronically bill Medicare, as they would not have to submit two different sets of forms.

Finally, as recent Congressional testimony indicated, HCFA has numerous process problems with its Medicare contractors and its current enrollment process. The Council strongly believes that these problems need to be fixed before HCFA expands its use of additional program integrity tools.

RECOMMENDATIONS

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

1. That the AMA insist that the Health Care Financing Administration (HCFA) not exceed its statutory authority in the development of proposals relating to Form 855 and physicians' enrollment in the Medicare program, and consider pursuing litigation should HCFA do so.

2. That the AMA insist that HCFA refrain from subjecting physicians to additional administrative burdens in the Medicare enrollment process.

3. That the AMA strongly urge HCFA to create an option during the Medicare enrollment process that will allow physicians to apply for and set up electronic billing and payment.

4. That the AMA strongly urge HCFA to institute temporary provider numbers for physicians during the Medicare enrollment application period.

16. TAX CREDIT SIMULATION PROJECT

HOUSE ACTION: FILED

The general principle of the tax credit proposal contained in AMA policy on individually selected and owned health insurance is to replace the present exemption from employees' taxable income of employer-based health benefits with a "refundable" tax credit equal to a percentage of total spending on health expense coverage by individuals and their employers (Policy H-165.920[12], AMA Policy Compendium). As described in Council on Medical Service Report 9 (A-98), the Council continues to believe that a tax credit, rather than the current individual tax exemption, is a more equitable approach to obtaining health insurance.

In preparing CMS Report 9 (A-98), the Council developed recommendations that would establish a basic policy agenda for change that could be advocated by the AMA. The Council specifically wanted to avoid the development of a detailed "all or nothing" agenda that would be inflexible and perceived as a return to the massively complicated health system reform proposal debated and rejected by Congress and the public in 1993. As a result, details of the tax credit proposal, as well as the sequence for transition to the system outlined in CMS Report 9 (A-98), were left unspecified. For example, the report did not address guidance on the size of a tax credit or a specific formula for calculating the tax credit.

During the past year, several legislative proposals have been introduced that share conceptual elements with the AMA's tax credit proposal. As this issue continues to "ripen" and emerge as significant legislation, in terms of Congressional leadership support or committee recognition, the Council believes that the AMA will need to be in an

optimal position to be an active participant in directing the debate, and in evaluating the estimated impact of the specific elements in the proposals under consideration.

In cooperation with the Council on Medical Service, the AMA Center for Health Policy Research has initiated a Tax Credit Simulation Project in order to develop economic modeling and simulation capabilities for assessing the impact of alternative tax-credit options and proposals. The key components to be examined in the simulation model include the following:

- change the deduction from taxable income for health expense coverage in the current tax structure to a refundable tax credit which reduces tax liability;

- provide tax equity between employer-provided and individually purchased health coverage;

- implement a refundable tax credit with sufficient incentive for consumers to purchase an adequate level of coverage/benefits, with a defined employer contribution to partially offset the premium for the chosen plan;
- target larger health insurance refundable tax credits toward low-wage employees and low-income families as opposed to the current system that gives the largest health insurance tax benefits to the highest-income families;

- implement uniform employer defined contributions across plans, but allow direct contributions to vary by employee based on the individual's health risk;

- extend refundable tax credit for all spending on coverage, whether contributed by employee or employer;

- maintain the current aggregate compensation levels when employer contributions are eliminated; and

- exempt employee and employer contributions from FICA and unemployment taxes.

This report, which is presented for the information of the House of Delegates, presents a preliminary examination of the economic issues in evaluating alternative proposals for providing individuals with a tax credit for the purchase of health insurance. Specifically, the report summarizes existing research, outlines an analytical framework for examining alternative tax credit proposals, describes the current employer-based health insurance system, and presents estimates from the first stage of the simulation model.

EXISTING RESEARCH

Including employer contributions for health insurance coverage in employees' taxable income changes the after-tax price of health insurance relative to the prices of wage benefits and retirement benefits, regardless of whether or not the firm contributes to employees' health insurance coverage as part of total compensation. Increases in the after-tax price of health insurance coverage tend to reduce the demand for health insurance as workers substitute other forms of compensation for health insurance. The change in the after-tax price of health insurance will depend upon the federal and state marginal tax rates and the pay-roll tax rate. Providing a refundable tax credit for the purchase of insurance creates a counter-balancing effect that influences the demands for each of the benefits in a worker's compensation package. The refundable tax credit is much like a tax rebate and is expected to increase the demand for coverage.

For those with employer-based coverage, the net-effect of treating employer contributions for the purchase of health insurance as taxable income and providing a refundable tax credit on the demand for coverage is unclear. For a given level tax credit, higher-income families may receive a lower tax subsidy than under current law. Lower-income families will see increased benefits or receive a tax credit. For those currently without coverage, the positive effect of the refundable tax credit on income is expected to increase the amount of coverage purchased. The amount of insurance that could be purchased with the credit will vary across small-employer and individual insurance markets (Chernew, Frick and McLaughlin, 1997; Liu and Christianson, 1996; Feldman, Dowd, Leitz and Blewett, 1997; and Marquis and Long, 1995).

The existing research suggests that changing the tax-favored status of employer contributions for health insurance and other fringe benefits not only affects household income, but also changes the incentives employers have to offer benefit coverage and influences the contribution levels, mix of benefits, and possibly total compensation. Estimates of the impact of a tax credit on employer costs, however, are mixed. Lewin-VHI (March 1994) estimated that the

refundable tax credit described below would increase employer costs by 4.6%. Woodbury and Huang (1991) estimated that taxing health insurance contributions would reduce real expenditures on health insurance by 13.9%, during the 1969-1982 time period, and would reduce real expenditures on health insurance by nearly 9% (annually) under the 1986 tax reform.

Woodbury and Huang also account for the substitutions among wages, health benefits and pension benefits. Real expenditures on wages and retirement benefits also were found to decline when health insurance contributions are included in taxable income. The trade-off among the components of total compensation has not been addressed in any other research identified. The impact of changing the tax provisions of employer contributions for health insurance coverage on each of these components of compensation will be of primary interest to the stakeholders in the system. The changes also will play an important part in developing specific elements of the defined contribution principles outlined in Policy H-165.920.

METHODS

The unit of observation in the analysis of health insurance coverage can vary from individual coverage, family coverage, or some "health insurance unit." The last two units for analysis are typically composed of the policyholder, his or her spouse, and the children in specified age categories. Nationally representative samples of the U.S. population are available in the March Current Population Survey (CPS) and the Medical Expenditure Panel Survey (MEPS). Data from the CPS and MEPS can be used to identify the populations eligible for the health expense tax credit, and estimate the number and distribution of persons by health insurance status broken out by household characteristics (e.g., income category) and employment characteristics.

The mathematical representation of the proposed changes in the income tax structure and the behavioral relationships among the key components of Policy H-165.920 will be developed in stages. The first stage of the simulation will be performed using data from the CPS and other sources which have been aggregated to income category or bracket averages. The parameters measuring the relationships among the variables in the model will be derived from published sources. The outcome variables from this stage of modeling include changes in the distribution of tax-credit from employer-based coverage. In the later stages, the simulation project will examine the relation between benefit levels and the tax liability as influenced by a variety of economic and demographic variables.

By nature, the aggregate level analysis from the first stage of the project does not provide a means to rigorously identify the economic and demographic characteristics that affect the decision to obtain health insurance coverage. For example, important factors include wages, family size and age distribution, health insurance premium, employee share of premium, tax rate, benefit level and mix, and other employment characteristics. This is the kind of detailed information needed to develop a specific tax-credit reform proposal with components targeted to corresponding subsets of the population. From this analysis it is possible to examine various breakouts (e.g., by population sub-group, state and region, and industry) of the insured and uninsured populations.

Future stages of the Tax Credit Simulation Project will focus on developing empirical economic models of individual and family health insurance coverage decisions. The results of the modeling procedures will be used to simulate the impact of alternative tax credit reforms on insurance coverage and the other outcome variables (e.g., tax revenues, and fringe benefit compensation shares). The AMA Center for Health Policy Research is working with a consulting firm to construct a database from the CPS for estimating these models. The database will be expanded by linking the CPS database to health care expenditure and health insurance premium data from MEPS and other sources.

EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE

Table 1 presents the distribution of nonelderly persons covered by employer-based health insurance, the percentage of persons in each income category with employer-based coverage, and the average premium for health insurance by family income, in 1997. The percentage of nonelderly in each category covered by employer-based coverage increases with income. While 12% of individuals in families with income no greater than $10,000 have coverage, 90% of individuals in families with income of $200,000 or more have coverage from employers. The health insurance premium also rises with income. For families with income of $10,000 or less, the average premium is $1,861. The average premium for employer-based coverage is over $7,000 for families with income of $200,000 or more.

SUBSIDY FROM EMPLOYMENT-BASED HEALTH INSURANCE COVERAGE

Exempting health benefits (i.e., premiums, flexible spending accounts, out-of-pocket expenditures in excess of 7.5% of adjusted gross income, etc.) from taxes has been estimated to cost the federal government as much as $111.2 billion (Sheils and Hogan, 1999). The portion of that federal revenue foregone or "tax subsidy" from employer-based health insurance is determined by the effective average tax rate (CBO, 1998a), the premium for health insurance, and the share of the premium paid by the employer (Rice, et. al., 1998). Multiplying the average value for each of the variables in an income category would give the average subsidy per family in that income category.

Table 2 presents the distribution of the federal tax subsidy from employer-based health insurance coverage, by family income. Under current law the tax subsidy rises with income (see Exhibit 1). The subsidy rises from $169 per family with income of $10,000 or less, to $2,024 for families in the $200,000 or more income category. This is because tax rates, premiums and employer contributions are generally higher among higher income families. The largest share of the total tax subsidy, 25% or over $16 billion, is received by families with incomes between $50,000 and $75,000 (see Exhibit 2).

EMPLOYMENT–BASED HEALTH INSURANCE TAX CREDIT REFORMS

Several reform schemes to treat employer contributions to health insurance as taxable income and provide a tax credit for the purchase of health insurance have been proposed. There is little agreement, however, on the rule or formula for calculating the dollar value of the tax credit. One approach would be to propose a level or flat credit. For example, the value of the credit could be set at the average tax subsidy received by those currently with employer-based coverage. The National Center for Policy Analysis estimates this to be $500 per person (National Center for Policy Analysis, 1997.) Alternative credits, $800 per person, have been proposed by the Council for Affordable Health Insurance. The formula also could be specified so that the credit varies inversely with gross income. For example, if health coverage expenses were either below 10% of gross income, between 10% and 20% of gross income, or over 20% of gross income, the percent reimbursed or credited would be 25%, 50%, and 75%, respectively (Lewin-VHI, 1994). A means test based on family income as a percentage of the poverty guidelines also could be used (CBO, 1998b).

To illustrate the impact of changing the tax-exempt status of employer contributions to health insurance, two simple tax-credit proposals can be compared. Both would treat employer contributions for health insurance as taxable income and provide a level credit (i.e., the credit does not vary with income). The first proposal provides a $750 credit for the policyholder and an additional $250 credit for each dependent. A second proposal would provide a $250 tax credit per covered person. Table 3 presents the average tax subsidy, the change in tax subsidy and the change in federal tax revenues under the two proposals. Compared to current law, the $750/$250 credit proposal increases the tax subsidy $89 per family on average, and reduces federal tax revenues by $5.6 billion. This $89 represents an increase in after tax income for the average family. The $250 credit proposal decreases the tax subsidy $411 per family on average, and increases federal revenues by more than $25.5 billion.

The tax subsidies from the two tax-credit proposals also are presented in Exhibit 3. The distribution of the subsidy from either proposal is more uniform than under current law as presented in Exhibit 1. As illustrated in Exhibit 4, the largest increases in subsidies come at the low end of the income distribution and the largest decreases in subsidies come at the high end of the income distribution. Relative to current law, families in the lower income categories would receive larger subsidies, while families in the higher income categories would see their subsidies fall. In fact, families with income of $75,000 or greater would have their after-tax income fall if the $750/$250 tax credit proposal became law. Under the $250 credit proposal, after-tax income would fall for all families with income of at least $20,000.

EXPANDING TAX CREDIT TO UNINSURED

The tax credits for the purchase of health insurance outlined also would be available to those without health insurance coverage. Table 4 presents the number of uninsured persons, by percent of federal poverty level, potentially impacted by tax credit legislation. The last two columns of Table 4 contain estimates of the impact on federal tax revenues of implementing the $750/$250 tax credit and the $250 tax credit proposals, respectively. If all households currently without coverage were to purchase insurance, the $750/$250 proposal would result in a revenue loss or cost of $22.8 billion. Combined with the $5.6 billion subsidy to the insured, the cost of the $750/$250 proposal would total $28.4 billion. In contrast, expanding the $250 tax credit would cost $10.7 billion,

but the additional $25.7 billion taxes paid by those with employer-based coverage under that proposal would more than offset the cost of expanding the tax credit to the uninsured. On net, the $250 tax credit proposal would increase federal tax revenue $15 billion ($25.7 billion in additional revenue minus $10.7 billion to cover the uninsured).

One means to assess the ability of the uninsured to pay for health insurance, even when the purchase is subsidized with a tax credit, is to examine the share of income needed to purchase a typical plan. For simplicity, it could be assumed that a "typical" plan has a $1,800 premium for a single individual and a $4,800 premium for family coverage. The tax credit proposal considered has eligibility tied to household income relative to the federal poverty level, and is similar to that offered in the bill sponsored by Sen. Jim Jeffords (R-VT). It allows those without employer-based coverage to purchase health insurance and receive a tax credit of $1,200 per adult and $600 for children. Because the tax credit and health insurance premiums differ significantly between single individuals and joint and head-of-households, the two categories of tax filers are compared.

Income levels and the after-tax premiums as a share of income, by percent of federal poverty level, under this type of proposal are presented in Table 5. The last two columns show the percentage of income a single filer, and a joint or head-of-household filer, respectively, would have to allocate to the purchase of health insurance. For single filers, the after-tax premium would represent between 4% and 7% of income. The after-tax premium for joint and head-of-household filers would be between 12% and 28% of income. Existing research suggests that people generally do not purchase health insurance if the premium is more than 5% to 8% of income. Thus, tax credits of $1,200 per policy holder and $600 per dependent may not reduce the after-tax premium enough or create a large enough incentive to get substantial numbers of low-income families currently without health insurance to buy coverage.

CONCLUSION

The Council on Medical Service continues to believe that the AMA's proposal to reform the health insurance system by replacing the present exemption from employees' taxable income of employment-based health benefits with a refundable tax credit, and shifting toward individually selected and owned health insurance, is in the best interests of all Americans. As the information in this report indicates, however, additional study and policy refinements will be needed to provide policymakers with the necessary guidance to turn this proposal into reality.

The aggregate level estimates presented in this report provide benchmarks for beginning to evaluate the impact of alternative proposals to reform the tax treatment of employer contributions for the purchase of health insurance. There is a need, however, to develop individual level models of the policyholder and family decision to obtain health insurance coverage. Those models are well suited to account for the offer or access to health insurance, as well as household and labor market characteristics. For example, offer rates and take-up rates have been found to vary by wage rates and firm size (Cooper and Schone, 1997; and Rice, et. al., 1998) and are important factors to be accounted for in the individual level simulation models. In addition, the cost and coverage impacts of specific characteristics of households as they relate to eligibility (e.g., state and small group reform initiatives, CHIP eligibility, Medicaid eligibility and expansion, and federal poverty level eligibility triggers) can only be accurately assessed using more micro level analysis.

The Council will continue to work with the AMA Center for Health Policy Research on the Tax Credit Simulation Project. It is the Council's intent to present a follow-up report to the House of Delegates at the 2000 Annual Meeting that contains "guiding" policy principles to better evaluate emerging legislative tax credit proposals.

References and a description of the data sources used in this report are available from the AMA Division of Health Policy Studies.

Table 1. Employment-Based Health Insurance Coverage[a] and Health Insurance Premiums[b], 1997

Family Income ($)	Nonelderly Persons with Employment-based Coverage (Millions)	Share with Employment-based Coverage	Average Health Insurance Premium
0 to 10,000	2.9	12%	$1,861
10,000 to 20,000	9.0	31%	$2,410
20,000 to 30,000	15.6	54%	$3,132
30,000 to 40,000	19.4	69%	$3,712
40,000 to 50,000	19.3	75%	$4,444
50,000 to 75,000	41.4	82%	$5,166
75,000 to 100,000	21.6	87%	$6,112
100,000 to 200,000	17.1	88%	$6,519
200,000 or More	4.7	90%	$7,013
All Incomes	151.0		$4,383

Source: [a] Fronstin, 1998; [b] derived from CBO 1994 and Various KPMG Peat Marwick surveys, see Rice, et. al., 1998.

Table 2. Employment-Based Health Insurance Tax Subsidy

Family Income ($)	Average Tax Subsidy	Average Tax Subsidy per Family Member	Total Tax Subsidy (Millions)	Share of Total Tax Subsidy
0 to 10,000	$169	$72	$209	0.3%
10,000 to 20,000	$399	$276	$2,488	4%
20,000 to 30,000	$710	$429	$6,686	11%
30,000 to 40,000	$798	$418	$8,103	13%
40,000 to 50,000	$967	$437	$8,431	13%
50,000 to 75,000	$1,171	$389	$16,134	25%
75,000 to 100,000	$1,543	$470	$10,139	16%
100,000 to 200,000	$1,694	$503	$8,594	14%
200,000 or More	$2,024	$564	$2,630	4%
All Incomes	$1,015	$420	$63,414	

Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

Table 3. Average Tax Subsidy and Changes in Tax Subsidy for Alternative Tax Credit Proposals

	$750/$250 Tax Credit Proposal			$250 Tax Credit Proposal		
Family Income ($)	Average Tax Subsidy	Change in Average Tax Subsidy	Change in Federal Tax Revenues (Millions)	Average Tax Subsidy	Change in Average Tax Subsidy	Change in Federal Tax Revenues (Millions)
0 to 10,000	$1,085	$917		$585	$417	
10,000 to 20,000	$861	$462		$361	-$38	
20,000 to 30,000	$914	$204		$414	-$296	
30,000 to 40,000	$978	$180		$478	-$320	
40,000 to 50,000	$1,053	$87		$553	-$413	
50,000 to 75,000	$1,252	$81		$752	-$419	
75,000 to 100,000	$1,321	-$222		$821	-$722	
100,000 to 200,000	$1,341	-$353		$841	-$853	
200,000 or More	$1,397	-$627		$897	-$1,127	
All Incomes	$1,104	$89	-$5,572	$604	-$411	$25,675

Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

Table 4. Expanding the Tax Credit to the Uninsured

Income as a Percent of Poverty	Uninsured Nonelderly Population (Millions)	Uninsured Children (Millions)	Uninsured Nonelderly, Single Filers (Millions)	Uninsured Nonelderly, Joint and H-of-H Filers (Millions)	Cost to Expand $750/$250 Tax Credit Proposal (Millions)	Cost to Expand $250 Tax Credit Proposal (Millions)
< 150%	19.1	5.3	9.1	10.0	$10,893	$4,775
150% - 199%	7.7	1.9	3.0	4.7	$4,172	$1,925
200% - 399%	16.2	2.7	4.3	11.9	$7,743	$4,049
> 399%	0.4	0.8	0.0	0.4	$169	$101
Total	43.4	10.7	16.3	27.1	$22,808	$10,749

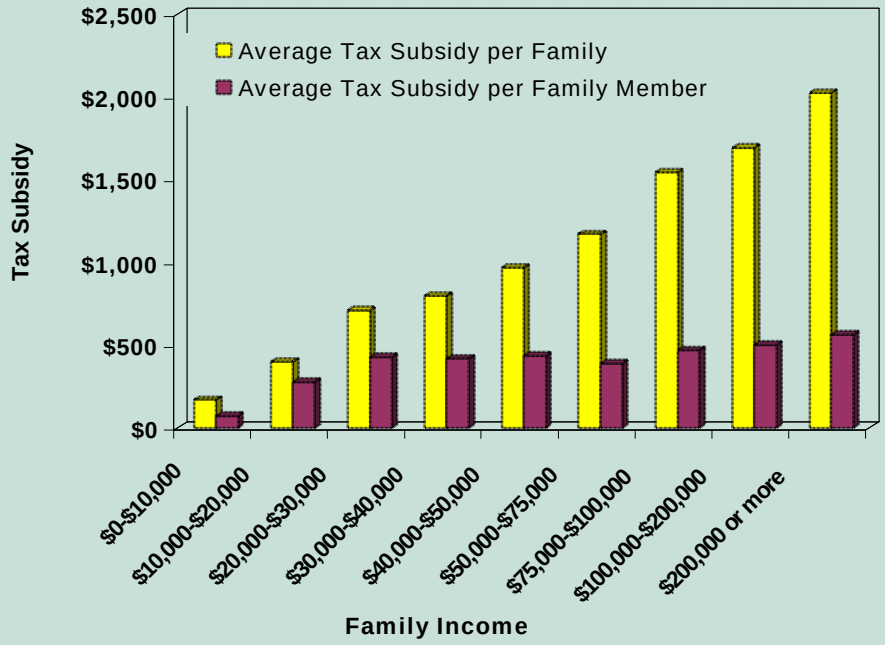
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999; estimates of the number of uninsured are derived from Government Accounting Office, 1998, and Thorpe 1999.

Table 5. Expanding Coverage - After Tax Premium Income Shares

			Jeffords-like Proposal	
Income as a Percent of Poverty	Income - Single Filer	Income – Joint and Head of Household Filers	After Tax Premium as Share of Income – Single Filer	After Tax Premium as Share of Income - Joint and Head of Household Filers
100%	$8,240	$10,827	7%	28%
150%	$12,360	$17,164	5%	17%
200%	$16,480	$23,845	4%	12%

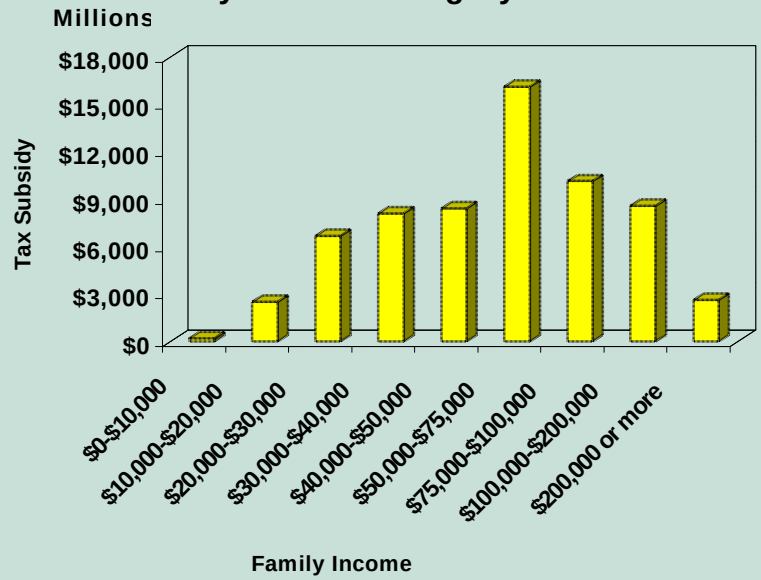
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

Exhibit 1: Average Tax Subsidy Under Current Law, by Income Category



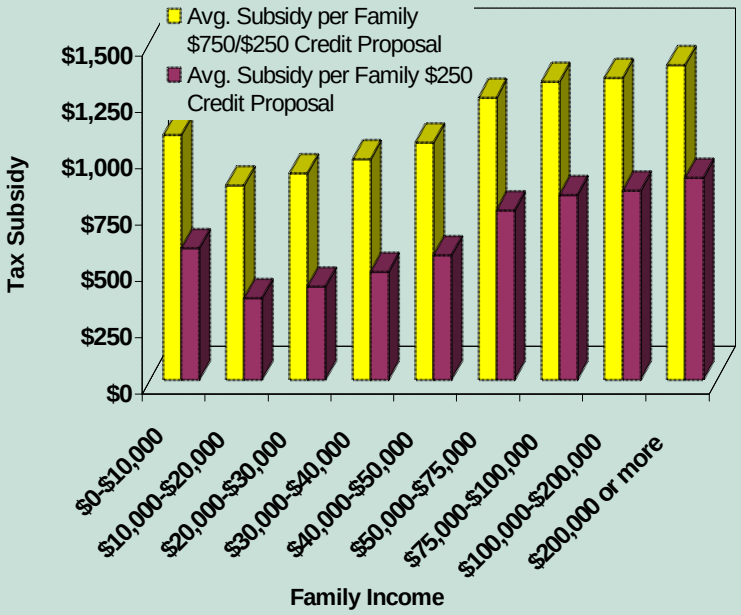
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

Exhibit 2: Total Tax Subsidy Under Current Law, by Income Category



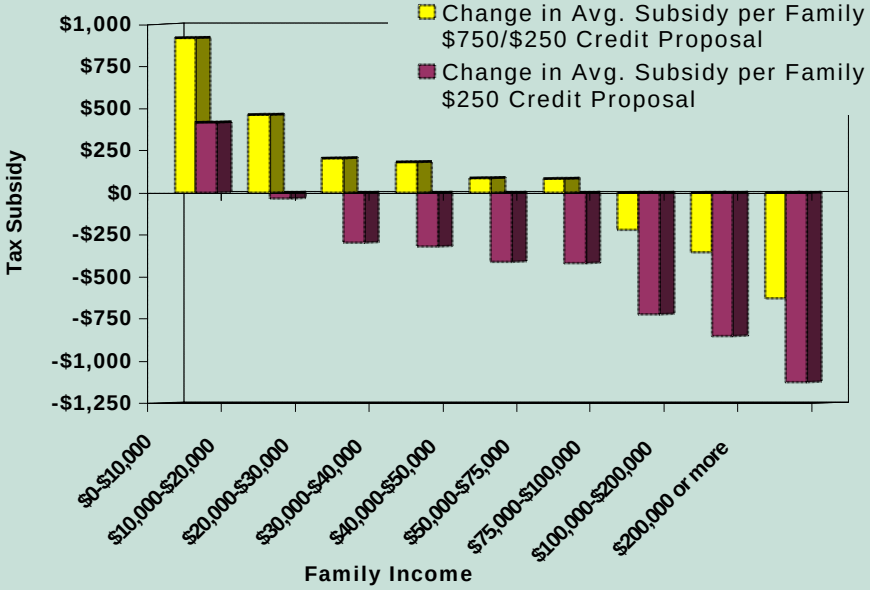
Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

Exhibit 3: Average Tax Subsidy - $750/$250 and $250 Credit Proposals, by Income Category



Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.

Exhibit 4: Change in Average Tax Subsidy - $750/$250 and $250 Credit Proposals by Income Category



Source: Preliminary estimates, American Medical Association, Center for Health Policy Research, August 1999.