AMERICAN OSTEOPATHIC ASSOCIATION

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The Honorable Charles Rangel
Chairman, Ways & Means Committee
U.S. House of Representatives
102 Longworth House Office Building
Washington, DC 20515

The Honorable Henry Waxman
Chairman, Energy & Commerce Committee
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable George Miller
Chairman, Education & Labor Committee
U.S. House of Representatives
2181 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Rangel, Waxman, and Miller:

With the introduction of the "America's Affordable Health Choices Act" (H.R. 3200), the United States Congress is poised to fundamentally reform our nation's health care system. As President of the American Osteopathic Association (AOA), I am pleased to inform you of our support for numerous provisions included in this historic legislation. We propose several recommendations to improve the legislation. The AOA and the 67,000 osteopathic physicians it represents, shares your desire and commitment to making fundamental and long-term improvements in the way health care is obtained, delivered, and financed.

Our nation's health care system, with a few exceptions, reflects the era of its genesis. While the system has provided quality, timely, and lifesaving care to millions of patients over the past 40 years, it has not self-adjusted to reflect changes in medicine, delivery models, and patient expectations. It has become a patchwork of independent parts versus a seamless system focused on improved of health for patients. We believe that your legislation takes important steps toward enacting reforms that will increase access to health care and physician services specifically, improve the quality of care provided, and improve the efficiency of our health care delivery system.

It is our opinion that "healthcare," at its roots, is the interaction between a patient and a physician. The other issues that are contested in public policy debates are by-products of this core interaction, thus making this the single most important element of any effort to reform the health care system. In our opinion, our country has lost perspective on how valuable and essential this interaction is to the health of the patient and the success of the healthcare system. We believe your legislation, through payment and delivery system reforms, begins the process of restoring value to this core relationship.

We urge you to take advantage of this unprecedented opportunity to make fundamental shifts in how health care is delivered. Simply extending the current broken system to more individuals is not meaningful reform. Instead, Congress should set goals beyond what is easily understood and focus on transforming the health care system for the future. Our current system, based upon single episodes of care, is no longer capable of delivering quality and efficient care. The health care system must take a more longitudinal view, fostering long-term relationships between patients and physicians. We must place a premium on empowering individuals to take a more invested interest in their health. We must eliminate the "patchwork" mentality that plagues our current system. And, we must provide equitable financing for the health care system we desire versus the health care system we have currently.

The AOA is pleased to offer support and recommendations on the following five priority issues included in the America's Affordable Health Choices Act:

1. **Ensure Access to Affordable Health Coverage for all Americans**

The AOA believes that every American should have access to affordable health care coverage. We do not believe that a single approach, applied universally, can meet this goal. The AOA strongly supports policies that will ensure all Americans receive, at a minimum, health care coverage for physician services to ensure their basic medical needs are met.

We support provisions in your legislation that would preserve access to employer-sponsored health care. Since the majority of Americans receive their health care coverage through their employers, we firmly believe that individuals should be allowed to maintain their employer-sponsored coverage. The AOA supports the establishment of an individual mandate as a means of increasing the number of individuals with health insurance. Since a large percentage of the currently uninsured are individuals who have access to health care coverage, we believe that incentives should be created that encourage them to secure such coverage. By expanding the pool of insured individuals, risks are shared by a larger percentage of the population and costs are more effectively contained. We believe that an individual mandate is an essential step toward achieving universal health care coverage.

The AOA has long supported comprehensive reforms of insurance practices that hinder access to obtaining coverage. We support proper regulation of the insurance industry and market. Specifically, we support regulations that foster a competitive marketplace in which insurers must compete on the basis of price, benefits and quality. We support provisions in this bill that would prohibit commercial insurance companies from excluding coverage for pre-existing conditions. Furthermore, we support reforms that would prohibit differential pricing based upon race, gender, or other demographic criteria. Such policies unnecessarily and unfairly limit access to care for those most in need.

The AOA is supportive of provisions in the bill that would establish a health insurance exchange, whereby individuals could purchase insurance for themselves and their families. We also applaud your recognition of the challenges facing the small group market and support the bill's provisions enabling small businesses to participate in the Exchange.

We share the Committees' commitment to ensuring that all insurers provide a broad range of medical services, including prevention and primary care, reflecting the critical importance of these services. We view these standards for coverage as an essential step toward a model of health care delivery that is based on comprehensive, continuous primary care conferred by a physician-directed team. We urge the federal government to use its influence to encourage all health plans, whether public or private, to promote delivery models that place a greater emphasis on prevention and primary care services.

The AOA has not taken a formal position on the establishment of a "public plan option" as a means of providing access to coverage. We support increased competition in the market-place. However, we do believe that a public plan should be subject to all rules applicable to the plans it will be competing against. Competition must be on a level and equitable playing field. We urge the Committees to take appropriate steps to ensure that a potential public plan does not operate under rules and regulations that afford an unfair market advantage.

The AOA continues to believe that a potential public plan should not be based upon or tied to the flawed Medicare program. Physician participation in a potential public plan should not be based upon their Medicare participation. Participation in a potential public plan must be truly voluntary and that the Secretary must be required to form a network of providers. Any provision mandating physician participation in a potential public plan would alter our opinion of the legislation. While we have reservations about the public plan, we do appreciate that the legislation makes physician participation in the public plan optional and that you have taken appropriate steps to ensure that physician payments under the proposal are five percent higher than those paid by the Medicare program. The proposed "opt-out" provision technically makes participation optional, but we continue to be concerned with this provision.

2. **Fundamentally Reform the Delivery System – Begin with Long-Term Reforms of Physician Payment Methodologies**

We applaud the Committees for taking the unprecedented step to enact long-term Medicare physician payment reforms. For the past eight years physician payment policies, specifically the sustainable growth rate (SGR), have eroded physicians' confidence in and acceptance of the Medicare program. In 2010, physicians face a 21 percent reduction in their Medicare payments with additional cuts totaling greater than 40 percent over the next decade.

The AOA and our members are appreciative of efforts by Congress to prevent deep and devastating cuts in payments in recent years. However, the means by which those cuts were prevented have created a policy crisis that is on the brink of realization. Continued reliance upon the current flawed, unstable and inequitable payment methodology threatens access to care for millions of patients and creates an environment whereby the overall quality of care is threatened. Furthermore, it fails to reflect the increase in total Medicare beneficiaries and shifts in care delivery that have occurred over the past 20 years, whereby a larger percentage of care is provided in the ambulatory setting versus the inpatient hospital setting. Advances in science and technology have made life-improving diagnosis and treatment modalities more readily available, and the number of patients with multiple chronic conditions has increased significantly—all of which has led to increases in the overall volume of physician services. We are steadfast in our support for provisions in your legislation that would enact meaningful long-term reforms of the Medicare physician payment formula.

The AOA has long advocated that it is impossible to achieve meaningful health system reforms independent of establishing long-term stability in physician payment methodologies. The approach taken in the legislation whereby the current payment methodology is bifurcated into independent physician service targets is consistent with AOA policies. We are pleased to support its enactment. Under your proposal all evaluation and management services, along with designated preventive care services, would be reimbursed using a methodology that promotes their delivery and provides adequate compensation to physicians.

Additionally, we have urged Congress to implement delivery reforms that place a renewed focus on the importance of primary care and general surgery. We believe, and evidence supports, that an emphasis on patient-centered primary care improves health outcomes and decreases the overall cost of health care. We thank you for including provisions aimed at promoting primary care.

We are pleased that your legislation provides "bonus payments" of five percent to primary care physicians providing designated services and a 10 percent bonus to primary care physicians in health profession shortage areas. We continue to believe that these bonuses should be higher to achieve our joint goals of increasing the supply of primary care physicians. We recommend that the Committee increase bonus payments to primary care physicians to 10 percent, at minimum. Additionally, general surgeons, like their primary care colleagues, face shrinking numbers within their ranks. The AOA strongly supports the extension of bonus payments to general surgeons.

We are strongly supportive of provisions that would expand the patient-centered medical home and implement it fully in the nation's health care delivery system. The AOA strongly supports this move toward a model of health care delivery that is based on an ongoing personal relationship with a physician.

We must raise concerns with provisions that would allow non-physician providers to qualify as medical homes without direct supervision by a physician, however. Also, we are concerned that provisions in your bill providing additional payments for primary care are funded in a way that may require redistribution of payments from other physicians. We encourage the Committees to take into account the overwhelming evidence that producing more primary care physicians will lead to overall costs savings, mostly from Medicare Part A, and to structure medical home payments accordingly.

Finally, the AOA strongly supports provisions that would establish Medicaid payments at 100 percent of Medicare payment rates. We believe that this provision will facilitate greater participation in the Medicaid program. We applaud its inclusion.

3. **Grow the Physician Workforce to Meet Demand and Promote Primary Care and General Surgery**

We are pleased that the legislation includes provisions to reform the nation's graduate medical education system. We salute your decision to include provisions that would remove disincentives that exist regarding training in non-hospital settings. By clarifying in statute the definition of "all or substantially all" as it relates to the training costs of resident physicians in non-hospital settings, your legislation will foster training opportunities in outpatient practice settings and improve the quality of graduate medical education programs – especially for primary care physicians. This has been a priority for the AOA for several years. We are pleased that your legislation would allow teaching

programs to utilize these settings unburdened by onerous regulations. Providing experiences in non-hospital settings for resident physicians, especially those in primary care specialties, increases the likelihood that they will seek practice opportunities in those settings. Additionally, we are supportive of provisions that would allow for the development and evaluation of new training models whereby community health centers and other care delivery sites would be allowed to participate in the training of resident physicians.

Experts across the political spectrum have reached a consensus that the United States will face a shortfall in its physician supply over the next twenty years. However, as you know, the 1997 Balanced Budget Act (BBA) froze the number of residents that a hospital could claim Medicare payment for based on the number of residents that each hospital trained in 1996.

Because it takes 10 years to train a physician, the nation will have a shortage of 85,000 to 200,000 physicians in 2020 unless action is taken soon. While academic and policy experts debate the best approaches to sustain the physician workforce in the long term, the AOA recognizes that we must begin to educate and train a larger cadre of physicians now. For this reason, we urge the Committees to reconsider the inclusion of provisions that would remove the limitation established by the BBA and allow for growth in the graduate medical education system. The AOA strongly supports provisions included in "Resident Physician Shortage Reduction Act of 2009" (S. 973/H.R. 2251).

We also urge the Committees to consider inclusion of provisions that would place a greater emphasis on the training of primary care physicians and general surgeons and provide incentives for non-teaching hospitals to initiate graduate medical education programs. To this end, the AOA believes that the establishment of differential payments in direct medical education payments of 10 percent would create an appropriate incentive to encourage the training of a more robust primary care and general surgery workforce. Furthermore, we urge you to include provisions that would provide interest-free loans to hospitals to establish such teaching programs in rural and suburban areas. This policy is outlined in the "Physician Workforce and Graduate Medical Education Enhancement Act" (H.R. 914). Under this legislation, the Secretary would be directed to establish an interest-free loan program whereby hospitals committed to starting new osteopathic or allopathic residency training programs in underrepresented specialties could secure start-up funding to offset the initial costs of starting such programs.

The AOA applauds your decision to create a National Physician Workforce Commission that would make recommendations on a "national physician workforce strategy." This Commission should include osteopathic and allopathic physicians representing primary care, specialty care, academic, and policy perspectives.

Finally, we urge the Committees to include provisions that would reduce the influence of education debt on medical specialty career choices. A primary deterrent to medical students seeking careers in primary care and general surgery, as well as pursuing practice opportunities in underserved areas, is the heavy burden of educational debt. According to the American Association of Colleges of Osteopathic Medicine (AACOM), the average osteopathic medical school graduate has a debt load of $168,031. The AOA strongly supports provisions in your legislation that would expand the National Health Service Corps. We encourage you to further examine including additional provisions that would provide targeted scholarship, loan deferment and loan forgiveness programs that would allow medical school graduates to pursue training in medical specialties based upon

career interests and talents versus financial obligations. We recommend that the legislation include provisions that would re-establish the "20/220 pathway" as a means of assisting young physicians with management of their educational debt. This policy is outlined in the "Medical Economic Deferment for Students (MEDS) Act" (H.R. 1615)."

4. **Promote Individual Investment in Health Through Prevention, Wellness, and Public Health**

We strongly support provisions in your legislation that would place a greater emphasis on prevention, wellness and public health. According to the Partnership to Fight Chronic Disease (PFCD) 2009 Almanac of Chronic Disease, the total cost burden in 2003 for seven common chronic diseases (stroke, diabetes, pulmonary conditions, heart disease, mental disorders, hypertension, and cancers) accounted for $1 trillion in lost productivity. Additionally, treatment of patients with one or more chronic diseases is responsible for 75 percent of total health spending in the U.S. The PFCD estimates that in 2007 health care costs associated with patients with one or more chronic diseases amounted to approximately $1.7 trillion.

These startling statistics shed light on the long-term issues facing our health care system – patients are sicker and consuming larger amounts of health care services as a result. In an effort to reduce health care costs in the future, we must improve the overall health of our citizens.

The AOA strongly supports efforts to enhance preventive care and wellness. This legislation effectively increases access to preventive care through the elimination of co-pays for these services. Additionally, the authorization of a personalized prevention plan and routine wellness visit will not only encourage individuals to adopt healthier lifestyles, but also reinforces the continuous physician-patient relationship. Primary care physicians play a vital role in interventions to improve nutrition, increase physical activity levels, reduce alcohol intake, and stop tobacco use among their patients.

We encourage you to remain mindful of the costs above and beyond a typical evaluation & management office visit for physicians providing these services. Physician-directed, team-based models of comprehensive patient care such as the patient-centered medical home are central to the AOA's vision for health care delivery system reforms. We strongly support an expansion of these programs and are pleased that your legislation includes such provisions. We recommend that all health coverage programs addressed in your legislation be encouraged to implement the patient centered medical home as a delivery model for primary care and be required to provide services consistent with the prevention measures endorsed by the United States Preventive Services Task Force (USPSTF).

5. **Create an Equitable Health Care Financing Infrastructure**

The AOA has long advocated that Congress begin to evaluate the health care system as a holistic system versus individual components. To this end, we support provisions that allow for the evaluation of health care spending across the entire spectrum of health care, thus enabling savings in one part of health care to finance other parts. Specifically, it is our sincere belief that while necessary investments in primary care, general surgery, prevention, and wellness may incur additional costs at the outset, long-term savings will be realized by reducing the need for spending in other parts of the system. If those savings are achieved, they should be reallocated.

Finally, we encourage the inclusion of medical liability reforms. Costs associated with defensive medicine and the nation's medical tort system are significant and increase the overall cost of health care for all Americans. Some experts suggest that defensive medicine accounts for more than $80 billion per year in our health care system. The AOA believes that any comprehensive health reform legislation must include provisions aimed at decreasing the impact of medical liability. We urge the Committees to reconsider including provisions in the legislation.

We applaud your leadership and commitment to improving the nation's health care system. We recognize the tireless efforts required to produce legislation of this scope and magnitude and we offer our sincere appreciation. We look forward to working with you and your colleagues to implement the policies included in the America's Affordable Health Choices Act as a means of improving access to affordable health care services that will benefit current and future generations.

Sincerely,

Carlo J. DiMarco, DO
President

C: The Honorable Dave Camp, Ranking Member, Ways and Means Committee
Members, Ways and Means Committee
The Honorable Joe Barton, Ranking Member, Energy and Commerce Committee
Members, Energy and Commerce Committee
The Honorable Howard McKeon, Ranking Member, Education and Labor Committee
Members, Education and Labor Committee