The State of the Nation's Health Care:
A Report from America's Internists
on
Opportunities to Improve Medical Care Through

Better Coverage
Less Red Tape
Better Use of Health Information Technology
and
Improved Access to Primary Care Doctors

January 15, 2004

Introduction

The American College of Physicians (ACP) is the nation's largest medical specialty society and second-largest physician organization in the United States, representing over 115,000 doctors of internal medicine and medical students. For the past three years, the College has released an analysis of the state of the nation's health care as a prelude to President Bush's State of the Union address to Congress. The College hopes to influence federal policymakers to address problems and opportunities for improvement in the nation's health care that reflect the perspectives of practicing internists in the front lines of medical care delivery.

The College's 2003 report, titled "The Growing Crisis in Access to Medical Care, Causes and Remedies: A Report from America's Internists on the State of the Nation's Health Care",[i] challenged federal policymakers to address barriers that were making it increasingly difficult for patients to obtain the care they need. The report concluded that access to care was waning due to: declining health insurance coverage (reductions in employer-based coverage and cuts in Medicaid and other "safety net" programs); increased out-of-pocket expenses for patients due to employer cost-shifting; reimbursement cuts to physicians that were limiting the willingness of physicians to take care of new Medicare patients; and increases in the costs of delivering care due to rising medical liability costs and unnecessary paperwork and billing requirements.

Limited Progress, Growing Challenges

Twelve months later, it is apparent that only limited progress has been made in addressing the problems identified in our 2003 report. Unfortunately, the overall state of America's health care has not improved and, by some measures, is worse today:

- The number of Americans without health insurance coverage increased. According to the Census Bureau, the share of the population without health insurance rose in 2002 (the most recent year for which data is available) -- the second consecutive annual increase. An estimated 15.2 percent of the population or 43.6 million people were without health insurance coverage during the entire year in 2002, up from 14.6 percent in 2001, an increase of 2.4 million people. The number and percentage of people covered by employment-based health insurance dropped in 2002, from 62.6 percent to 61.3 percent, driving the overall decrease in health insurance coverage.[ii]

- Millions of low-income Americans were either dropped from public safety net programs or saw their benefits reduced and cost-sharing increased. Thirty-four states, in every region of the country, have adopted cuts that are causing between 1.2 and 1.6 million low-income families and individuals to lose health insurance through Medicaid and S-CHIP. States imposed cuts in eligibility (or reductions in caseloads through other approaches), freezes or reductions in payment rates to health care providers, prescription drug cost containment, reductions in the health services that are covered, and increases in co-payments or other cost-sharing by low-income patients. Almost *half* of those losing health insurance coverage (490,000 to 650,000 people) are children and substantial numbers of low-income parents, seniors, people with disabilities, childless adults and immigrants also are losing coverage. These cuts have occurred despite a temporary increase in federal matching fund payments to state Medicaid programs, which will expire on July 1, 2004.[iii]

- Out-of-pocket expenses for individuals enrolled in employer-based plans have continued to *increase*. Expecting that a significant increase in out-of-pocket costs would moderate use of health care services, employers have raised deductibles and copayments; added copayments to more services; replaced fixed-dollar copayments with coinsurance, where patients pay a percentage of the total bill; and adopted tiered prescription drug benefits. Nationally, employers are estimated to have increased patient cost sharing to buy down—or reduce—average premiums by 2 percent to 3 percent in 2002 and an additional 3 percent in 2003. Meanwhile, health plans are rapidly developing new products incorporating high deductibles and coinsurance. As out-of-pocket costs increase, both the financial and medical consequences for seriously ill and low-income people increase. Nearly half of all personal bankruptcies are due in part to medical expenses. [iv]

- Federal legislation to address access problems caused by escalating medical liability premiums have stalled, leaving more states in crisis even as some state legislatures have acted on their own to address the problem. At least 19 states experienced a medical liability crisis in 2003, with at least another 26 states facing a "near crisis."[v] Although the House of Representatives passed H.R. 5, the Health Act of 2003, which would have adopted the proven medical liability reforms in California as a national standard, similar legislation died in the United States Senate. President Bush has stated that enactment of meaningful medical liability

reform, similar to the provisions in H.R. 5, will be a top legislative priority in 2004.

- On a more positive note, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 temporarily stabilized Medicare payments to physicians, thereby slowing growing access problems for beneficiaries. Specifically, the new law halts scheduled Medicare reimbursement cuts in 2004 and 2005, replacing them with modest updates of 1.5 percent in 2004 and at least that amount in 2005. Earlier in the year, Congress enacted legislation to block a scheduled cut of 4.4% that would have gone into effect on March 1, 2003. Although these actions have stabilized Medicare physician payments, thereby slowing a growing access problem caused by inadequate Medicare payments, *Medicare payments continue to lag behind inflation and in the absences of legislation to permanently fix Medicare's flawed update formula, more cuts will likely occur in 2006 and thereafter.* In addition, *many states reduced Medicaid payments to physicians, posing an additional threat to safety net programs.*

- The administration and Congress have taken important first steps to address the paperwork burdens on physicians resulting from unnecessary Medicare regulations, but such efforts have not been sufficient to slow the avalanche of paper that is being imposed on internal medicine practices. The new Medicare Prescription Drug, Improvement and Modernization Act mandates improvements in Medicare carrier performance, reform of the intrusive Medicare audit process, and the development and testing of alternatives to onerous paperwork documentation requirements. Congress also rightly rejected proposals to mandate that doctors learn and use an entirely new coding system for physician services, and decided that a voluntary approach to encourage the use of electronic prescribing systems would be better than another unfunded mandate to use such technologies. HHS Secretary Tommy Thompson has also taken steps to implement recommendations for regulatory relief that stemmed from a comprehensive review of Medicare regulations that was initiated in 2002. Unfortunately, despite these improvements, the cumulative burden imposed by administrative rules from Medicare and other payers continues to be a major reason that physicians are dissatisfied with medical practice. According to a recent survey, three quarters of physicians expressed dissatisfaction with Medicare paperwork, and half of all physicians hired additional administrative and billing staff to cope with increased paperwork. Eighty percent of physicians stated that they had to increase the training of staff to cope with new paperwork requirements.[vi]

- Over the past four years, there has been a marked decrease in the number of physicians entering internal medicine and other primary care specialties, due in large part to concerns that the overall practice environment is not supportive of primary care practices. This decline is occurring even though demographic trends suggest that more general internists and other primary care physicians will be needed to manage the care of older patients with chronic disease.[vii]

Failure of a Piecemeal Approach

It is evident that despite the limited progress made in some areas, the current federal strategy of dealing with the challenges of decreased coverage, access and quality in a piecemeal manner is not working. A new and comprehensive federal initiative is required to address the marked increase in the number of uninsured Americans, erosion of the publicly funded safety net programs, rising out-of-pocket expenses, and continued decline in the number of physicians entering internal medicine and other primary care specialties (caused in large part by the problems of inadequate reimbursement, escalating medical liability expenses, and rising practice expenses).

Today, the American College of Physicians is calling on President Bush and both Republican and Democratic leaders of Congress to adopt a comprehensive new policy framework that incorporates the following four essential elements.

1. President Bush and Congress should agree to enact legislation consistent with an initial goal of assuring that all Americans with incomes up to 150% of the federal poverty level have access to affordable coverage no later than January 1, 2007. To achieve this goal, Congress should:

    - Provide states with new options and guaranteed federal funding to make existing safety net programs more effective.

    - Provide tax relief subsidies and purchasing arrangements to enable eligible individuals and families to obtain group or individual health insurance coverage.

2. Congress, the administration, and health insurers should institute reforms to drastically reduce the time that physicians now spend on completing paperwork for third party payers, *with the goal of reducing, by half, the average amount of time that physicians spend on paperwork, as of January 1, 2007*.

3. Congress and the administration should provide the resources and support needed to encourage the transition from paper-based health care systems to affordable *patient- and physician-friendly* computer-based systems.

4. The administration and Congress should develop and implement policies to address the need for an adequate supply of physicians in the primary care specialties of internal medicine, family practice, obstetrics/gynecology and pediatrics, with particular attention to assuring that there are enough internists to take care of an aging population with more chronic disease. Such policies should include measures to reduce student debt, improve existing programs to finance the training of primary

care physicians linked to service obligations, and allow for innovation in the way that services are reimbursed to recognize the value of care coordination by primary care physicians.

ACP's Policy Prescriptions

I. Congress should enact legislation to provide all Americans with incomes up to 150% of the federal poverty level with access to affordable care by January 1, 2007.

The College continues to advocate that all Americans be guaranteed coverage under an affordable health plan, but we support the idea of starting with the most vulnerable Americans—those who work in low-wage jobs that do not offer health insurance coverage. Approximately 35% of the uninsured have incomes below the Federal Poverty Level, and another 30% of the uninsured have incomes between 100 and 200% of the FPL.

Lack of health insurance coverage is imposing a huge cost on the United States, measured by lives lost, unnecessary suffering, and higher health care expenditures. One recent study concluded that the United States is spending as much as $98.9 billion annually on the uninsured.[viii]

Reforms should be designed to provide more coverage choices for states, patients and employers, *without eroding existing coverage under existing safety net programs or creating new unfunded federal mandates on financially distressed states.* A pluralistic approach that combines tax credits with improvements in safety net programs is most likely to be effective and to achieve bipartisan support. Specifically:

- *States should be given the option of covering all Americans with incomes up to 100% of the FPL under Medicaid, with the federal government providing the federal dollars to pay the entire additive cost of the increased coverage*. States would also have the option of using lower income levels as the basis for eligibility, but states that opt for lower income levels would get a pro-rated share of the increased federal subsidy.

- *Congress should provide health insurance tax credits, equal in dollar amount to the contribution that the federal government makes to its own employees, to be used by uninsured Americans with incomes up to 150% of the FPL to purchase either individual insurance or group coverage offered through a state purchasing pool arrangement modeled after the Federal Employee Health Benefits Program.*

The above proposed reforms are among the bipartisan provisions included in the Health Coverage, Affordability, Responsibility and Equity Act of 2003, S. 1030/H.R. 2402, which is based in large part on an ACP proposal to provide all Americans with access to affordable health insurance coverage by the end of the decade.[ix] The additional reforms

proposed in the HealthCARE Act of 2003 would gradually expand coverage to the remaining uninsured, so that all Americans would have access to affordable health coverage within seven years.

II. Congress, the administration, and health insurers should institute reforms to drastically reduce the time that physicians now spend on completing paperwork for third party payers, with the goal of reducing, by half, the average amount of time that physicians spend on paperwork as of January 1, 2007.

The College supports efforts made by President Bush and HHS Secretary Thompson to ease unnecessary Medicare regulations. However, we believe that more needs to be done to overcome the cumulative paperwork burden on physicians and to demonstrate that measurable progress has been made. Easing unnecessary rules in a piecemeal fashion can help alleviate specific areas of concern, but such efforts will not succeed in reducing the cumulative burden on physicians without agreement on a measurable goal.

Success in easing paperwork burdens can be measured in several ways: satisfaction or dissatisfaction of physicians and patients with program requirements; numbers of rules generated and eliminated; increases or decreases in the practice expenses required to comply with paperwork requirements, and the time that physicians spend on paperwork instead of patient care. While all such measures should be considered, the College believes that use of time might be the most useful measure, since every minute that physicians spend filling out unnecessary forms is time that cannot be spent in patient care. Increasing numbers of physicians report that they are unable to spend sufficient time with patients, and physicians perceive that they have diminishing control over the management of their time and growing administrative tasks, factors that may be independently related to decreasing physician satisfaction.[x]

Inadequate time with patients can result in lower quality medical care. Reduced time with the patient is important both because of the practical limits it places on what can be accomplished during and outside the encounter, and for the changes that time pressure create in the climate between physician and patient. Time pressure may cause the physician to overlook or pay insufficient attention to the patient's psychosocial concerns. Because of the importance of these concerns, the patient may come to feel from such omissions that the physician is not sufficiently caring. Similarly, time pressure may cause the physician to be overly controlling of the visit and the conversation (with frequent interruption when the patient speaks), ostensibly in an effort to be more efficient. This too, can contribute to patient dissatisfaction. Time pressure can also adversely influence communication between physician and patient, if the physician talks more, talks more rapidly, listens less patiently, or in general interacts less collaboratively.[xi]

Specifically, the College proposes the following:

- *President Bush should direct HHS Secretary Thompson to prepare a report card on the agency's implementation of the recommendations in the 2002 report from*

his task force on regulatory relief. The report card should identify which recommendations have been fully implemented, which have been partially implemented, and which remain to be implemented —with a measurable timeframe for fully implementing the remaining recommendations.

- *President Bush should direct the Department of Health and Human Services to fund an independent study of the time that physicians and their staffs spend on complying with the administrative requirements imposed by Medicare, other federal agencies and private insurers compared to patient care activities and other professional responsibilities and the impact of such time issues on physician and patient satisfaction with medical care, to be completed no later than June 30, 2005.*

- *Following completion of the time study, HHS Secretary Thompson should direct the administrator of the Center for Medicare and Medicaid Services to develop recommendations, in consultation with physician groups, for reducing by half the average amount of time that physicians and their staff spend on Medicare, HIPAA and other administrative requirements for federal health programs, with the goal of implementing the necessary changes by January 1, 2007. Such a reduction should be achieved by eliminating or easing unnecessary documentation and paperwork requirements, standardizing forms and program requirements, developing time-effective alternatives for assuring program accountability, and developing paperless systems for sharing health information and meeting other program requirements.*

- *President Bush should convene a meeting of leaders of the health insurance industry and physician and other health professional organizations to obtain a commitment from industry leaders to develop an action plan to reduce by half the average amount of time that physicians spend in completing third party paperwork, with the goal of implementing such changes by January 1, 2007. Issues to be addressed should include ways to encourage the development of uniform credentialing, re-credentialing, eligibility, claims and enrollment forms as well as time-effective alternative and paperless systems for sharing health information and meeting third party contract requirements.*

III. Congress and the administration should provide the resources and policy framework needed to encourage an expeditious but voluntary transition from paper-based systems to patient- and physician-friendly computer-based information technologies to improve patient care.

Electronic health records, computer provider-order entry systems, e-prescribing, patient registries, and other information technology offer the potential of improving patient care by making medical practices more efficient, increasing productivity, reducing practice expenses, reducing medical errors, allowing for faster communication of clinical care and test results, lowering the costs of documenting care, improving financial management,

decreasing staffing and achieving other practice efficiencies, facilitating physician decision-making and patient access to medical information, and improving and streamlining communication of medical information across communities.[xii, xiii] However, preliminary studies suggest that the savings from such technologies do not accrue to the benefit of physician practices. Although overall costs of health care decline, the savings accrue mainly to hospitals and to payers (health insurance and public sources). Information technology may save money for the system, but these financial benefits do not accrue to the parties that invest the funds.[xiv]

Adoption and receptivity to health information technology lags significantly among physicians in solo and small groups compared with larger physician practices.[xv] Barriers to widespread adoption of information technology include the absence of industry standards for content (how the meanings of medical terms are represented) and how messages are to be sent and received. Security, and thus privacy, has not been assured.[xvi] Physicians and health care facilities are reluctant to invest in information technology because of concern about the ability of different systems to communicate effectively with each other.

Multiple federal agencies—including the Department of Health and Human Services (and within HHS, the Health Information Infrastructure Initiative under the Assistant Secretary for Planning and Evaluation, Center for Medicare and Medicaid Services, the Agency for Health Care Research and Quality, and the National Committee on Vital Health Statistics), the Veterans Administration, and the Department of Defense—are involved in developing policies to develop and support application of health information technology. However, the College believes that the federal government's efforts must be more clearly focused on *addressing the practical barriers to acquisition of information technology at the health care practitioner level*. Such barriers include: the high cost of purchasing electronic health records and of training physicians and staff to use the new technologies, concerns about "interoperability" with other health information systems, the lack of accepted industry standards, the inability of physicians to share in system-wide savings from information technology, and the financial risk of investing in technologies that may soon be obsolete. To address these barriers, the College proposes the following:

- *The Bush administration should provide the necessary resources and commitment to develop and implement an overall policy framework to reduce the barriers to the voluntary acquisition of EHRs and other information technologies by practicing physicians. The policy framework must be specific, practical, measurable and focused on the barriers encountered by the direct intended users (practicing physicians and other health professionals) to acquire such technologies. Specifically, the federal government should provide resources to make it affordable for practitioners to acquire the necessary technologies (including direct payment for physicians' front-end expenses and lost time in operating mixed systems), provide opportunities for physicians to share in the system-wide savings from information technology, and support the development and testing of standards to resolve interoperability and connectivity issues.*

- *Congress should enact authorizing legislation and provide necessary appropriations to implement a policy framework focused on overcoming the practice-level barriers to acquiring health information technology. Provisions included in H.R. 663, the Patient Safety Improvement Act, S. 720, the Patient Safety and Quality Improvement Act, and H.R. 2915, the National Health Information Infrastructure Act, represent a good starting point in developing a legislative framework to encourage the voluntary use of beneficial health information technology.*

- *Acquisition of health information technology should remain strictly voluntary; incentives rather than unfunded mandates should be the core feature of any federal policy framework on health information technology.*

IV. The administration and Congress should develop and implement policies to address the need for an adequate supply of physicians in the primary care specialties of internal medicine, family practice, obstetrics/gynecology and pediatrics, with particular attention to assuring that there are enough internists to take care of an aging population with more chronic disease.

An exit survey of graduating medical school seniors found that choices for General Internal Medicine as a career has dropped precipitously in the past 4 years (12.2 percent in 1999, 10.2 percent in 2000, 6.7 percent in 2001, and 5.9 percent in 2002). Correspondingly, the percentage of students planning careers in other primary care specialties has also been dropping. Family Medicine declined from 13.3 percent in 1999 to 9.1 percent in 2002; Pediatrics dropped from 10.1 percent to 6.5 percent; and OB/GYN decreased from 6.1 percent to 4.9 percent. However, in 1992, student plans for careers in each of these generalist specialties were even lower than they are today. This suggests that any progress that may have been made during the past decade in encouraging students to go into General Internal Medicine and other primary care fields is at risk of being reversed. Meanwhile, medical student interest in Internal Medicine sub-specialty careers has increased from 8.7 to 12.1 percent during the past four years. Specialties like Anesthesiology, Emergency Medicine, and Radiology have also gained progressively in popularity during each of the last four years.[xvii]

An adequate supply of general internists will be required to meet the needs of an aging population with more chronic illnesses. Complications encountered in chronic disease often involve multiple body systems and require physicians with the ability to diagnose and manage the patient comprehensively, a whole patient approach that is a focus of primary care. All internists are prepared with the education, training and skill to provide these services, and the continual, coordinated, and comprehensive care that primary care provides is well-suited to the care of chronic illness. Early detection and treatment of diseases like diabetes, which afflicts over 17 million Americans and is responsible for over 200,000 deaths per year, could prevent many costly and often fatal complications. These complications can include heart disease, stroke, blindness, kidney failure, leg and foot amputations, pregnancy complications, and deaths related to flu and pneumonia Cancer also represents a challenge suited to the multi-system primary care provided by

internists. For example, one study of over 15,000 cases found co-morbidities present in 68.7% of the population (32.6% of these cases had two or more co-morbid conditions). It has been estimated that in 2003 over 1.2 million new cases of cancer will have been diagnosed. Primary care screening services will enable effective treatment to begin at an early stage, reducing the burden from cancer, the second leading cause of death in the United States after heart disease. [xviii]

Current federal policies discourage physicians from entering primary care specialties. Despite a resource-based Medicare payment scale that was intended to reduce disparities in payments between primary care physicians and specialists, specialist physicians typically receive higher aggregate reimbursement for the services that they provide to Medicare patients than do primary care physicians. Medicare "budget neutrality" rules make it impossible to increase per-service and aggregate payments to primary care physicians without lowering payments to other specialties—a "zero sum" game that has limited the expected gains for primary care. Medicare updates also have not kept pace with the rising costs of running a primary care practice. National data indicates that average physician income, after inflation, for primary care doctors dropped 6.4% from 1995-1999—at a time that wages were rising by 3.5% for other professional and technical workers. Specialists' incomes declined by 4%, while the incomes for all physicians declined by 5%. The greater decline in payments to primary care doctors is surprising, given that Medicare adopted policies designed to benefit primary care physicians over surgical specialists. This suggests that the effect of these policies may have been offset by managed care plans' retreat from a broader role for primary care doctors and toward providing enhanced access to specialists.[xix]

Medicare also does not pay for e-mail, telephone consultations, coordination of care and other primary care physician services provided outside the traditional office visit. Programs that encourage physicians to train in primary care specialties have been subjected to budget cuts, such as Title VII funding for health professions training. Federal student loan policies saddle young physicians with high debt and limited flexibility on repayment of the debt, a particular problem for physicians going into primary care since their anticipated earnings during practice years are much lower than for many specialist physicians, with the result that it takes them much longer and a greater proportion of future earnings to pay off their debt.

To address such problems, the College proposes the following:

- *President Bush should direct Secretary Thompson, the Department of Education, the Treasury Department, Department of Labor and other appropriate federal agencies to develop a comprehensive policy framework, in consultation with professional societies representing primary care physicians, to reform federal policies that discourage physicians from practicing in primary care specialties. Such policies should include measures to reduce student debt, assure adequate funding for Title VII health professions programs, improve the effectiveness of the National Health Service Corps and other programs to fund the training of primary care physicians linked to service obligations, provide adequate Medicare*

updates that keep pace with the costs of running a primary care practice, allow for innovation in the way that services are reimbursed to recognize the value of care coordination by primary care physicians, and allow primary care physicians to share in system savings for managing care effectively.

- *As recommended by the Medicare Payment Advisory Commission, Congress should enact a permanent solution to the flawed Medicare fee schedule update formula to prevent additional cuts from occurring in 2006 and subsequent years and to assure adequate annual updates that keep pace with inflation.*

- *Congress should enact the College Loan Assistance Act of 2003, H. R. 2505.* The refinancing provisions in this legislation ease a burden hindering those who have chosen higher education from fully reaping the benefits of their accomplishments; such difficulty is especially apparent in medical student debt (average of $103,000 in 2002). This staggering amount particularly encumbers former medical students who choose to go into badly needed, but less lucrative, primary care specialties, such as Internal Medicine. Difficulty in paying back educational debt is a major deterrent for students to pursue careers in General Internal Medicine, geriatrics and other primary care specialties.

- *The Center for Medicare and Medicaid Services should re-examine the "top down" practice expense methodology, budget-neutrality rules, the adequacy of payments for office visits and other evaluation and management services, and other aspects of the Medicare physician fee schedule methodology that have led to a systematic undervaluation of the services provided by primary care physicians.*

- *Medicare and other payers should provide reimbursement for health-related communication, consultations, and other appropriate services via the Internet, subject to guidelines on the level of work required for the service to be reimbursed as a separate service outside of the usual E/M service.*

- *Congress should enact Medical Liability Reform Legislation that includes the cap on non-economic damages and other key provisions in the H.R. 5, the Health Act of 2003. Although the medical liability crisis affects all physicians, internists and other primary care physicians are particularly vulnerable to the devastating economic impact of skyrocketing medical liability premium costs given low levels of reimbursement for primary care services, lower lifetime earnings compared to other specialties, and the higher practice expenses associated with running a primary care office.* In fact, the cumulative percentage increases in Medical liability premium increases for internists over the past eight years (1974-2002) have been higher than for any other medical specialty.[xx]

Conclusion

During the past twelve months, progress has been made in improving Medicare benefits for prescription drugs and preventive services, easing some red tape, and temporarily stabilizing Medicare physician reimbursement. By other critical measures, however, the state of the nation's health care has declined. More Americans lack health insurance coverage. Out-of-pocket expenses are increasing. Millions of low-income working Americans no longer can count on the safety net offered by Medicaid and the S-CHIP program. Medical liability costs continue to escalate, creating access problems in many states and physician specialties. The cumulative paperwork burden—which diverts valuable physician time from patient care to filling out forms—continues to inundate physician offices. Fewer physicians are going into internal medicine and other primary care specialties, at a time when the demographics of an aging population with more chronic diseases will require a sufficient number of internists to manage their care.

Piecemeal approaches to these problems are not sufficient. The College believes it is imperative that Congress and President Bush commit to a comprehensive policy framework to provide health insurance coverage for all lower-income Americans, as a first step toward providing coverage for all; reduce the amount of time that physicians spend filling out unnecessary forms and meeting other administrative requirements; overcome the practical barriers to the use of health information technology to improve patient care, and provide an environment that is supportive of physicians who decide to train and practice in general internal medicine and other primary care specialties. The proposals in this paper from the American College of Physicians provide the key elements of a new and comprehensive federal policy framework to achieve these goals.

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