

AHC Health Reform Working Group

Introduction

Successful health care reform must assure all citizens of high quality care at an affordable cost. We, the leaders of some of America's Academic Health Centers (AHCs) believe our institutions can play an essential role in reforming the American health care system.

BJC HealthCare

*Brigham and
Women's Hospital*

Emory University

*Johns Hopkins
Medicine*

*Mount Sinai Medical
Center*

*NewYork-
Presbyterian
Hospital*

*UCSF Medical
Center*

*University of
Pennsylvania*

*University of
Washington
Medicine*

AHCs consist of a medical school, one or more affiliated teaching hospitals, and one or more health professions schools. Many of our AHCs also include Assisted Living facilities, Nursing homes, Hospice Care Units and Sub-acute Nursing Facilities. AHCs are centers of life-long learning. They provide both the "seed corn" and the bedrock of our health care system. Each year, millions of Americans visit our teaching hospitals for primary care, advanced specialized care, and safety-net and emergency services not available in all hospital settings. We also train future physicians, nurses, and other health care professionals, work to develop the next generation of life-saving medical treatments and technology, and engage in innovative research. Our AHCs serve as economic anchors in our communities by providing jobs that not only support families, but also help drive the economies of our regions.

AHCs are an important part of America's safety net. While representing only 6 percent of all hospitals, teaching hospitals provide more than 40 percent of the care for our nation's uninsured and underinsured people.

Every change in health care spending and policy has important consequences. Given the critical role AHCs play in our nation's health, it is crucial that Congress carefully consider the impact of health care reform proposals on such institutions so as to support and strengthen their commitment to excellence in education, research and patient care delivery. There are five areas that are of critical concern to AHCs.

Graduate Medical Education and Indirect Medical Education

In recognition of vital and interrelated roles (teaching, research and patient care) that AHCs play, the federal government provides additional payments – through Medicare graduate medical education (GME) and indirect medical education (IME) - for teaching hospitals to recognize the greater costs incurred in providing services. These payment adjustments support society's expectation of high quality health care, superior medical education, cutting-edge biomedical research and innovation that are the hallmarks of teaching hospitals.

Without GME and IME, current reimbursement mechanisms in both the private and public sector are not sufficient to maintain these critical activities. Compared to other hospitals, academic medical centers have higher costs because they treat sicker patients and provide comprehensive physician training programs and specialized services that are not widely available at other hospitals. Our patients tend to be sicker and have comorbidities that require more complex medical care. Teaching hospitals provide a

disproportionate amount of intensive and specialized care in areas such as obstetrics and neonatal care, trauma, burn, and surgical transplant services. Academic health centers also provide care to a large portion of the uninsured population – providing approximately 40% of all charity care in this country. The nation relies on teaching hospitals in good times and in times of national crisis, including an important role in the SARS outbreak and the H1N1 pandemic.

Thanks in large part to Medicare support for Graduate Medical Education, teaching hospitals have been able to provide this patient care and professional training while operating on aggregate financial margins that are below the margins of non-teaching hospitals. We encourage Congress to ensure dedicated and stable financial support for teaching hospitals throughout the health care reform debate so that we can continue our commitment to educating the nation's future health care professionals and providing the specialized services so invaluable to our nation's health care system.

Geographic Variation

Data contained in the Dartmouth Atlas reveals variations in Medicare spending among various regions of the nation. While Dartmouth attributes this to over prescription of service by physicians and hospitals, recent publications demonstrate that the major drivers of such variation have nothing to do with over utilization. Surprisingly, data from the Dartmouth Atlas data does not adjust for area wages, a factor which is beyond the control of a hospital and reflects the area's cost of living. We all understand that it costs more to hire a nurse in Boston, New York, Chicago, San Francisco or Philadelphia than it does in other parts of the country. Medicare correctly recognizes this fact and as such makes the necessary adjustments through its area wage index. Before making any policy changes based on variation in Medicare spending, at the very least the data should be appropriately adjusted to reflect the local area wages, otherwise hospitals in areas with high cost of living will be unfairly penalized.

Policy priorities such as payments to compensate for Medicaid and Medicare shortfalls or medical education account for some of the differential. The most significant cause of variation is the poverty level of the patient base served by hospitals in high cost areas. Patients who have long been uninsured and who become eligible for Medicare will have historic medical problems and a higher level of severity of illness. Recent editorials in the Los Angeles Times¹ and in Roll Call² document the effect that poverty has on the rate of Medicare admissions and days in a hospital (low income leads to more frequent and longer inpatient stays).

MedPAC studies show that the wage factor, along with the distribution of GME/IME and DSH payment add-ons, which are long established in Medicare payment policy, explain almost all of geographic variation in payments. Variation is thus tied not to inappropriate payments, but to established policy directions that reflect Medicare's commitment to equity.

There is insufficient evidence to draw firm conclusions about the relationship between variations in spending and quality of care or associated patient outcomes. A deliberative approach to geographic variations in Medicare spending calls for addressing root causes. We strongly endorse an IOM study of the causes of geographic variations in care and urge Congress and the President to wait until these causes are fully understood before enacting policies in this area.

¹ <http://www.latimes.com/features/health/medicine/la-oe-stobo27-2009jul27,0,1720166.story>

² <http://www.rollcall.com/news/37230-1.html>

Independent Medicare Commission

We believe that an Independent Medicare Commission is ill-advised. Congress should not relinquish its important role in oversight of public health insurance programs, as well as its prerogative to expand current public health insurance programs, and even create new ones. The taxpayers provide the funding for Medicare, and it should remain the taxpayers right to representation to voice opinion and provide input as to how Medicare monies are deployed. Delegation of this responsibility to a select few, responsible only to the Executive Branch, will eliminate the people's right to representation in this area of public policy.

Congress' continued involvement is critical because of the enormous diversity of situations and vital interests in communities across the nation; situations and interests whose needs are unlikely to be protected by a small, unelected group. Since Congress has affirmatively determined that it should support these social issues, it behooves the legislative branch to protect its intent by maintaining oversight.

Medicare has never been solely an insurance program. It is also a social program that appropriates resources that support not only health care for seniors, but also vital services that provide the underpinning of the entire American health care system.

MedPac, which some consider to be a precursor to the IMC, was not established to be, nor has it ever functioned as a substitute body for representative government of the people, by the people, and for the people. It is advisory to Congress, and should remain advisory for the very reason that it is not representative of the American people, and their varied and diverse interests.

Administrative Simplification and Medical Liability Insurance

Reducing the cost of doing business is an essential aspect of reducing overall hospital and health care costs. Relieving administrative and liability insurance expenses are two potential areas of savings. A recent article in Health Affairs showed that it costs a physician practice about 68 thousand dollars a year for each physician to interact with insurance companies. If you add the malpractice insurance expenses to those, these two expenses are significant cost to the health care system particularly when you consider there are over 800,000 doctors practicing medicine in the USA. (Health Affairs Web Exclusive 533)

To reduce the administrative burden, the insurance industry and others have proposed: standardization and simplification of preauthorization and claims submission policies, data elements in electronic transactions, appeals processes, and increased use of electronic transactions. America's Health Insurance Plans (AHIP) suggests that simplification could save hundreds of billions of dollars. The current House bill (H.R. 3200) gives the HHS Secretary the authority to implement standardization rules, and the Senate Bill is expected to address the issue as well. We support these provisions and hope Congress will seek additional ways to reduce administrative costs.

Addressing the financial burden of medical liability insurance is equally important to driving down costs. A McKinsey study³ estimated that defensive medicine adds as much as \$190 billion each year to health care costs. We believe Congress should include provisions to mitigate the burdens of excess litigation in

³ "Accounting for the Cost of US Health Care: A New Look at Why Americans Spend More," McKinsey & Company, Dec. 2008

the health care arena. Potential areas to explore include: improved dispute resolution systems; federal health courts, mediation and arbitration; clinical practice guidelines; alternative compensation systems for neurologically impaired newborns; and disclosure, apology, and early offers of compensation. Hospitals in New York State alone spent \$1.4 billion on malpractice coverage in 2006, which represented 8% of their non-labor operating costs . Clearly these resources could be put to better use by expanding access for the uninsured and underinsured populations.

Comparative Effectiveness/Clinical Guidelines

Research, with an eye toward establishing standards for clinical practice, is critical to improving quality and reducing unnecessary spending. AHCs are well-positioned to engage in this type of research. We support comparative effectiveness research that considers both outcomes and costs in a way that serves the needs of our patients.

Conclusion

We applaud Congress for the enormous effort it is expending to achieve meaningful health care system reform. As AHCs, with our interlocking programs of education, research and patient care delivery, we hope to continue both during and after health care reform to play a key part in the improvement of health in the United States and in the advancement of the understanding of human health in the world.