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RESOLUTION 16-501

(Referred to Reference Committee E)

Subject: Practicing Physician Declining Membership Analysis

Introduced by: Michael DellaVecchia, MD, on behalf of the Philadelphia County Medical Society

Author: Kurt Miceli, MD, Philadelphia County Medical Society

WHEREAS, The total number of U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) increased from 741,495 in December 2010 to 797,645 in December 2015; and

WHEREAS, The total number of non-AMA U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) increased from 622,991 in December 2010 to 685,784 in December 2015; and

WHEREAS, U.S. physicians in Life Stage categories “Mature” and “Senior” (based on the AMA Physician Masterfile) represent the majority of practicing physicians (specifically 63.29% of all U.S. physicians and medical students); and

WHEREAS, The American Medical Association’s (“AMA’s”) membership for physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) declined from 118,504 in December 2010 to 111,860 in December 2015; and

WHEREAS, The percentage of total U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) who were members of the AMA in December 2010 was 15.98%; and

WHEREAS, The percentage of total U.S. physicians 40 years and older (Life Stage categories “Mature” and “Senior,” based on the AMA Physician Masterfile) who were members of the AMA in December 2015 declined to 14.02%; and

WHEREAS, Membership dues for the AMA from 2014 to 2015 decreased from $40.4 million to $39.5 million; and

WHEREAS, The AMA states that it advocates on behalf of physicians and aims to be the voice of physicians; and

WHEREAS, The AMA has as its mission to “promote the art and science of medicine and the betterment of public health”; and

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4 http://www.ama-assn.org/ama
6 http://www.ama-assn.org/ama/pub/about-ama.page
WHEREAS, The AMA has supported physician membership drive campaigns in the past noting that “Together We are Stronger;” and

WHEREAS, A clear discrepancy exists between declines in AMA membership for the majority of practicing physicians and the AMA’s intent to be the voice of physicians; and

WHEREAS, Reasons for this discrepancy need to be understood and acted upon so that membership declines in practicing physicians can be reversed for the strength and financial health of the organization as well as the larger voice of physicians in the country; and

WHEREAS, It is in the interest of any membership organization to represent a substantial proportion of the individuals it claims to represent; therefore, be it

RESOLVED, That the Pennsylvania Medical Society petition the AMA to study the reasons for membership decline among practicing physicians in Life Stage categories “Mature” and “Senior” by proportionally surveying both members and non-members in these categories as to the reasons why or why not individuals are members; and be it further

RESOLVED, That any such survey examine a variety of concerns physicians may have with regard to the AMA, its attention to its mission, its adequacy in advocating for physicians, any political bias which may be dissuading individuals from remaining or becoming members, and possible solutions for the foregoing concerns; and be it further

RESOLVED, that this survey be undertaken immediately by an independent consulting company with expertise in membership engagement and reported to the AMA House of Delegates at the 2017 Annual Meeting and made available to the AMA membership at large at that time.

Fiscal Note: $2000

Relevance to Strategic Plan

501
RESOLUTION 16-502

(Referred to Reference Committee E)

Subject: Participation of Physicians on Healthcare Organization Boards

Introduced by: Mukul Parikh, MD, Dauphin County Medical Society

Author: Jaan E. Sidorov, MD

WHEREAS, The Pennsylvania Medical Society advances quality patient care, advocates for patients and promotes physician leadership; and

WHEREAS, Not-for-profit and for-profit healthcare corporations, organizations and other entities provide medical services, insurance, information technology services, devices, pharmaceutical products and other products and services that contribute close to 20% of the United States Gross Domestic Product; and

WHEREAS, Health organization governance boards are comprised of leaders who are ultimately responsible to establish the policies, make the strategy and oversee the activities and the performance that determine healthcare value; and

WHEREAS, Health organization boards select the Chief Executive Officer and monitor his or her progress; and

WHEREAS, There is significant evidence that the participation of physicians in the governance of many healthcare organizations is associated with higher business performance, clinical quality and social outcomes; and

WHEREAS, Physicians have special expertise with complex clinical outcomes data, can add to a board’s cognitive diversity, have a reputation for altruism and can offer special competitive insights; therefore, be it

RESOLVED, That the Pennsylvania Medical Society advocate for and promote the membership of physicians on the boards of healthcare organizations including, but not limited to, acute care providers, insurance entities, medical device manufacturers, health technology service organizations; and be it further

RESOLVED, That the Pennsylvania Medical Society promote educational programs that prepare and enable physicians to participate on health organization boards; and be it further

RESOLVED, That the Pennsylvania Medical Society provide existing healthcare boards with resources that increase their awareness of the value of physician participation in governance matters; and be it further

RESOLVED, That the Pennsylvania Delegation to the AMA take this issue forward to the American Medical Association at the next feasible opportunity.

References


**Fiscal Note:**

**Relevance to Strategic Plan**

502
RESOLUTION 16-503

(Referred to Reference Committee E)

Subject: Analysis of American Board of Internal Medicine (ABIM) Finances

Introduced by: Jennifer Lorine, DO, on behalf of the Montgomery County Medical Society

Author: Jennifer Lorine, DO, Montgomery County Medical Society

WHEREAS, The American Board of Internal Medicine (ABIM), a 501-C3 organization, used $56 million of diplomats’ money to form another 501(c)(3) corporation known as the ABIM Foundation; and

WHEREAS, The ABIM Foundation uses the income of the $56 million for internal salaries, dubious research which consistently publishes data in support of MOC, and approximately $500,000 a year for high-end retreats at the county’s most expensive resorts; and

WHEREAS, The ABIM paid its President $2,774,000 for her final 30 months of employment (an annualized salary of $1.1 million dollars); and

WHEREAS, The ABIM President gave her First Assistant a raise of $103,000/year in 2011, $83,000/year in 2014, and a bonus of $313,000 in 2011 for total earnings well in excess of $500,000; and

WHEREAS, The ABIM purchased a condominium for $2.3 million and sold it for $1.7 million losing $600,000 in cash along with real estate sales and transfer fees adding another loss of approximately $200,000, and chose to house its out-of-town guests in the most expensive per square foot real estate in the city of Philadelphia as well as provide a chauffeur-driven limousine for their use; and

WHEREAS, The top employees at the ABIM are receiving retirement contributions of 18 percent per year (fully funded by the ABIM with no employee contributions) in contrast to the industry average of 5 percent; and

WHEREAS, There may well be many more undiscovered excessive expenses at the ABIM; therefore, be it

RESOLVED, That the Pennsylvania Medical Society (PAMED) petition the American Medical Association (AMA), through its delegation to the AMA, to analyze the finances of the American Board of Internal Medicine (ABIM) and its Foundation; and be it further

RESOLVED, that PAMED request the results of this analysis be shared with our AMA House of Delegates and our membership at large.

Fiscal Note:

Relevance to Strategic Plan

503
RESOLUTION 16-504

(Referred to Reference Committee E)

Subject: Endorse National Board of Physicians and Surgeons (NBPAS) for Recertification

Introduced by: Amelia A. Paré, MD, Chair, and Sharon L. Goldstein, MD, Vice Chair, on behalf of the Allegheny County Medical Society

Author: Coleen A. Carignan, MD

WHEREAS, Maintenance of Certification (MOC) is a highly controversial and onerous program established and administered by the American Board of Medical Subspecialties (ABMS) and affiliated subspecialty boards and sold at great cost to previously Board certified physicians; and

WHEREAS, MOC is costly in time and money and is estimated to cost physicians between $16,725 to $40,495 over a 10-year period and 32.7 million physician hours over a 10-year period (Ann. Inter. Med. 2015;163(6):401-408; and

WHEREAS, There is no scientific evidence to show that MOC improves the quality of patient care (JAMA 2014, 312 (22);2348-57); and

WHEREAS, The current MOC process is opposed by numerous medical societies and legislative bodies including the Pennsylvania Medical Society (PAMED), the American Association of Physicians and Surgeons (AAPS), the American Association of Clinical Endocrinologists (AACE), American Society of Nephrology (ASN), the American College of Cardiology (ACP), American Gastroenterological Association (AGA), the Oklahoma State Legislature and the State of Kentucky; and

WHEREAS, Finances of the American Board of Internal Medicine (ABIM) and the salaries of its officers, the majority of which come directly from physicians through MOC fees, has been called into question (Eichenwald, Kurt. (2015, June 5) “Medical Mystery Making Sense of ABIMS Financial Report,” Newsweek); and

WHEREAS, PAMED does not desire to support such dubious practices; and

WHEREAS, PAMED wishes to support the continuing medical education and recertification of our fellow physicians in a manner that is not onerous, prohibitive to their practice of medicine, and preserves its integrity; and

WHEREAS, The National Board of Physicians and Surgeon (NBPAS) was created by physicians from prominent academic centers and medical societies (www.NBPAS.org); and

WHEREAS, The NBPAS is a newly formed organization which provides a viable, cost and time effective alternative for Board recertification; and

WHEREAS, The NBPAS supports initial certification through ABMS and its affiliated subspecialty boards and requires its participants to be previously board certified; and

WHEREAS, NBPAS recertification is based on attaining CME provided by a recognized provider of ACCME and the CME must be related to the specialty in which the candidate is applying; and
WHEREAS, The NBPAS is now supported by 30 medical centers and numerous medical societies such as the AACE, the West Virginia State Medical Society (WVSMS), and the Washington State Medical Society (WSMS); therefore, be it

RESOLVED, That the Pennsylvania Medical Society recognizes and supports recertification by the NBPAS as a viable alternative to recertification through the ABMS/AOA; and be it further

RESOLVED, That the Pennsylvania Medical Society supports the position that NBPAS equally fulfills all requirements by insurance companies, hospital bylaws and employment contracts that require MOC for participation; and be it further

RESOLVED, That the Pennsylvania Medical Society also be willing to review alternative boards for recertification; and be it further

RESOLVED, That the Pennsylvania Medical Society Delegation to the AMA bring this resolution to the AMA for consideration at its next scheduled meeting.

Fiscal Note:

Relevance to Strategic Plan

504
RESOLUTION 16-505

(Referred to Reference Committee E)

Subject: Support Reform of the Maintenance of Certification (MOC) Process and Adopt a Position Favoring Acknowledgment of an Alternative Board, the National Board of Physicians and Surgeons (NBPAS), for Certification of Physicians Pursuing Lifelong Education

Introduced by: Anthony Dippolito, MD, MBA, on behalf of the Northampton County Medical Society

Author: Anthony Dippolito, MD, MBA, Northampton County Medical Society

WHEREAS, The American Board of Internal Medicine (ABIM) has violated the confidence entrusted to that organization as evidenced by the American Medical Association (AMA) and Pennsylvania Medical Society (PAMED) votes of no confidence for financial irregularities; and

WHEREAS, The MOC examination has not been shown to improve the quality of patient care; and

WHEREAS, No exam can guarantee practitioner competency and improve the delivery of healthcare; and

WHEREAS, The ABMS & ABIM have had no oversight and have allowed groups like the AHA to sit on any Board associated with physician certification; therefore, be it

RESOLVED, That the NBPAS be accepted as an alternative certifying organization; and be it further

RESOLVED, That no hospital or insurance company use MOC examination to exclude physicians from participating in their organizations; and be it further

RESOLVED, That no organization with “Conflict of Interest” as presented in the PAMED “Conflict of Interest and Disclosure Policy” be allowed to sit on any board associated with Physician certification; and be it further

RESOLVED, That PAMED seek endorsement through the PAMED Delegation to the AMA for physician certification through the NBPAS.

Fiscal Note:

Relevance to Strategic Plan

505
RESOLUTION 16-506

(Referred to Reference Committee E)

Subject: Support Physician-Driven, Free Market-Based Healthcare Payment Model Creation and the Restoration of the Patient-Physician Relationship through Innovative Consumer-Driven Healthcare Financing and Delivery Solutions

Introduced by: Anthony Dippolito, MD, MBA, on behalf of the Northampton County Medical Society Board of Directors

Authors: Arvind Cavale, MD, Bucks County Medical Society; Herb Kunkle, MD and Winslow Murdoch, MD, Chester County Medical Society; Anthony Dippolito, MD, MBA, Northampton County Medical Society; Jim Thomas, MD, Montgomery County Medical Society; Ahmed Haasan, MD, Carbon County Medical Society; and Oscar Morphi, MD, Lehigh County Medical Society

WHEREAS, The intrusion of multiple counterproductive intermediaries into the healthcare equation has injured the patient-physician relationship; and

WHEREAS, Artificial regulatory constructs have added excessive waste into the healthcare equation; and

WHEREAS, This has caused soaring costs which make healthcare less affordable and unsustainable for our patients; and

WHEREAS, Value to our patients can be restored via innovative free market healthcare solutions; and

WHEREAS, Healthcare reform solutions are being proposed through a collaborative patient-physician-business healthcare network; and

WHEREAS, A new delivery system that will restore the healthcare promise of physicians to their patients by providing affordable coverage with high-quality care through a new patient coverage paradigm is urgently needed; and

WHEREAS, This proposed coverage plan will not be devoted to the rules, regulations, and policies that do not provide value to the patient-physician relationship; and

WHEREAS, The mission of the Pennsylvania Medical Society (PAMED) is synergistic with creating such a coverage plan as patient advocates striving to provide value to the patient-physician relationship; and

WHEREAS, PAMED, by supporting such a coverage plan, will benefit and strengthen its membership and mission by supporting the physicians and patients in Pennsylvania; therefore, be it

Resolved, That the Pennsylvania Medical Society endeavor to aid in the creation of, and partner with, a stand-alone comprehensive and innovative healthcare initiative; further, ask the Board of Trustees to create a loan that may be released incrementally up to $5 million for a stand-alone comprehensive and innovative healthcare initiative; and be it further
Resolved, That the Pennsylvania Medical Society anticipate that this endeavor be marketed and promulgated through the county medical societies throughout the state of Pennsylvania; and be it further

Resolved, That the Pennsylvania Medical Society partner with and provide administrative, secretarial and county resources to this innovative physician-led plan and support physician-developed processes to manage quality, utilization and cost through a patient- and physician-driven, free market-based healthcare system; and be it further

Resolved, That the Pennsylvania Medical Society support patient centric and physician facilitated, free market-based healthcare reform as an alternative to government or commercial insurance-devised payment models.


Fiscal Note:

Relevance to Strategic Plan

506
Mission Statement:

The Healthcare Alliance is a consortium of Physicians with an Innovative Concierge Insurance Model who will seek contractual relationships for its patients with a Panel of Healthcare Providers, Laboratories, Radiology Labs, Pharmacies, Urgent Care Centers, Surgical Centers and hospitals in a given geographical area.

The purpose of The Healthcare Alliance is to provide high quality patient care through a simplified physician controlled delivery system. The Healthcare Alliance brings a unique model of healthcare to the marketplace that endeavors to correct the current imbalance between cost and delivery.

The Healthcare Alliance plans to incorporate a PANEL of primary care physicians and specialists to form the core of the entity and to unite individual patients and families already in their practices around and in their geographic area. In addition local small businesses will also be encouraged to adopt an employer-sponsored self-insurance model. In doing so, both patients and local businesses will receive a significant cost benefit without the loss of quality care. Similarly, The Healthcare Alliance will seek to restore the patient – physician relationship that has been continually eroding with the ever expanding top down healthcare models.

The Healthcare Alliance (THA) seeks to engage in free market Healthcare Reform in pursuit of Decrease Cost, Increase Quality, and Improved Access. THA will restore the Physician Patient Relationship that has been significantly challenged in recent years. It has long been apparent that much of the waste, unnecessary regulations and mandates resulting in clinically useless activity has contributed to soaring costs resulting in an economically unsustainable healthcare system.

Within this healthcare crisis, however, there are opportunities. Opportunities to restore the patient physician relationship. THA as a new delivery system will restore the healthcare promise of physicians to their patients by providing affordable coverage with high quality care. THA, a collaborative consortium of physicians and businessmen, believe in the Free Market approach to healthcare reform. THA will replace the current mechanism of healthcare delivery with a whole new paradigm. Unlike an IPA, THA will not be strangled by the whims of insurance companies like IBC, Capital Blue Cross, Highmark, United, or Aetna. Unlike an ACO, THA will not be burdened with federal regulations mandating unfavorable onerous obstacles preventing private practice physicians from banding together. As a Concierge Insurance, THA can be selective with whom (patients) it allows to participate. Physicians will thus be better prepared to overcome the regulations & price fixing promulgated by the back room dealings of the insurance companies and government bureaucratic engineers whose aim is to annihilate private practice.

THA construct will consist of Panels of Primary Care and Specialist Physicians. THA will be Physician owned and operated.

Understanding the major drivers of Healthcare, THA will create Value by:

- Directly managing utilization, quality, costs, and risks.
- Keeping the middlemen (insurance companies, government, and hospitals) and their perverse incentives far from the Patient Physician relationship.
- Creating an impact through a physician-business healthcare collaborative group in the PA/ Philly/ NJ region.
ABSTRACT Accountable care organizations are intended to improve the quality and lower the cost of health care through several mechanisms, such as disease management programs, care coordination, and aligning financial incentives for hospitals and physicians. Providers employed several of these mechanisms in forming the integrated delivery networks of the 1990s. The networks failed, however, because of heavy financial losses stemming from hospitals’ purchase of physician practices and their inability to align incentives, garner capitated contracts, and develop the infrastructure to manage risk. Although the current mechanisms underlying accountable care organizations continue to evolve, whether and how they will have an impact on quality and costs remains open to question. Care coordination and information technology are proving more complicated and expensive to implement than anticipated, providers may lack the ability to implement these mechanisms, and primary care providers are in short supply. As in the 1990s, success depends on targeting specific populations, such as people with multiple chronic conditions who need and may benefit from coordinated care.
cians as well as disease management programs and capitated risk contracts. The networks lacked a large, salaried multispecialty group of physicians, an insurance vehicle, and experience in managing risk-based contracts. Thus, they were less tightly bound together than staff and group model health maintenance organizations, such as Kaiser and Group Health. Although there were some exceptions, the integrated delivery networks were generally regarded as unsuccessful at improving quality or lowering cost.

There is enthusiasm this time that reforms along comparable lines will work. Much of the enthusiasm stems from the following two assumptions about accountable care organizations: that better care coordination will improve quality at any given cost, and that the organizations will lower Medicare’s rate of spending growth. However, the parallels with the disappointing 1990s seem quite strong to us, raising our concern that the fate of the organizations may resemble that of the earlier integrated delivery networks.

Accountable care organizations face daunting challenges. First, it is unclear what capabilities they possess to affect quality and cost. Second, even if these capabilities exist in theory, it is unclear whether provider organizations that excel at them will actually emerge.

In this article we ask how the current proposals differ from the earlier failed models and whether any of the differences are large enough to yield better results this time. First, we review the similarities and differences between integrated delivery networks and accountable care organizations. Next, we describe the capabilities that the organizations need to deliver on quality and cost, and we review the evidence on their chances of succeeding. We then consider whether providers can make the necessary changes, given their record of strategic change. We conclude by discussing the Achilles’ heels of accountable care organizations and what the future is likely to hold.

**Boldly Charging Into The Past?**

Today’s accountable care organizations strongly resemble the integrated delivery networks of the 1990s. For example, both models create a care continuum and involve horizontal consolidation of hospitals; both may also create vertical integration of hospitals, physicians, and providers of postacute care (Exhibit 1). Accountable care organizations and the older integrated delivery networks both had support from federal legislation to pursue what is now called the “Triple Aim” of improved quality of care, improved population health, and reduced cost.

The Clinton administration’s health plan called for the creation of purchasing cooperatives where people without large-group insurance could buy coverage. Through local insurer-provider collaborations, health plans and providers were to form “accountable health partnerships,” which would integrate the financing and provision of health care. Despite the failure of the Clinton plan to become law, the plan spurred the formation of integrated delivery networks for the population with commercial insurance.

The integrated delivery networks of the 1990s did not deliver on their promises for a variety of reasons. They lacked the information technology, such as electronic health records and data on claims, needed to manage risk contracts; they overpaid physicians for their practices; they acquired hospitals without achieving economies of scale; and they failed to coordinate care for the population most in need, the chronically ill.

They also entered capitated contracts on a piecemeal basis with a few private insurers, rather than with payers that covered a large portion of their patients. As a result, newer risk-based payment methods were few and variable. This variation led to mixed or conflicting incentives for providers: Although some payments were based on capitation (global or partial), most remained fee-for-service.

Finally, although they were labeled integrated delivery systems as well as networks, most of the organizations did not really take a systems approach that involved integrated organizational planning for everything from hiring and other
personnel matters to physician culture. Instead, they bolted together various providers, such as doctors and hospitals, and mechanisms, such as disease management and population health management, hoping the combinations would work.

Accountable care organizations differ from integrated delivery networks in some important ways (Exhibit 2). For example, unlike the networks, accountable care organizations rely heavily on health information technology, data analytics, and decision support systems. They foster alternative payment methods, including bundled payments and shared savings—although it should be noted that most of these methods were present in, or at least contemplated for inclusion in, integrated delivery networks.

Finally, there is new management language that focuses on disruptive innovation, described below, and chronic care management. And there is an interest in process improvement such as “Lean manufacturing,” which emphasizes removing waste from the system.

Perhaps the biggest difference, however, is the impetus from the demand rather than the supply side. Private-sector providers and payers have developed commercial pilot accountable care organizations based on existing managed care models—for example, health maintenance organizations—in markets where such models already predominate, such as California, and increasingly in markets where they don’t, such as Illinois, Massachusetts, and northern Virginia.

Private-sector approaches, however, are not the main focus of the Affordable Care Act. The imprimatur for accountable care organizations comes from the Centers for Medicare and Medicaid Services (CMS), which—following the provisions of the Affordable Care Act—encourages such organizations of providers to serve the Medicare population. CMS is patron and protector of the current restructuring effort, seeking to bring costs down to help alleviate the federal deficit. This gives the accountable care organization movement a greater sense of urgency and political approbation.

Another difference this time around is the lack of consensus over what should be the new entities’ organizational core—a hospital system, physician group practice, or some wholly new type of organization—and over what the new entities should do, or stop doing, to reduce spending and how they should control out-of-network utilization. In contrast, in the 1990s there was some consensus that capitated contracting between insurers and integrated delivery networks (or between payers and health maintenance organizations) would cut costs by reducing hospital admissions and inpatient days, and by restricting out-of-network utilization.

**Needed For Success: Provider Capabilities**

The Brookings Institution has enumerated several principles for both Medicare and private-sector accountable care organizations, including patient focus, provider accountability, transparency of performance, and payment reform. Brookings suggests that pursuing these principles will help providers to improve quality, control spending, and manage risk.

To comply with these principles, accountable care organizations must develop new infrastructure and capabilities; Exhibit 3 provides one list of potentially important resources. For example, the organizations need to invest in information technology, develop new governance structures and organizational processes, and institute cultural changes.

**Which Capabilities Make a Difference?**

Some of the capabilities listed in Exhibit 3 have been shown to be necessary for cost-effective care, but the importance and effectiveness of others is unknown or questionable. Moreover, effective implementation requires a systems approach in which the needed capabilities are com-

### Exhibit 2

**Features Of Accountable Care Organizations That Integrated Delivery Networks Lacked**

<table>
<thead>
<tr>
<th>Type of feature</th>
<th>Specific features</th>
</tr>
</thead>
</table>
| Care management tools and practices | Clinical decision-making support  
Quality measurement and management  
Chronic care management  
Clinical integration and disease registries  
Patient engagement  
Evidence-based medicine  
Many new employees  
Disruptive innovation  
Lean manufacturing and process flow improvements |
| Information technology | Health information technology and data analytics  
Public stimulus for information technology investments  
Health information exchanges and data sharing |
| Payment               | Performance risk (not insurance risk)  
Pay-for-performance in meeting quality and cost targets  
Focus on cost-effective treatment of disease  
Shared savings and bundled payments (not capitation)  
Provider investments in innovation research |
| Regulation and oversight | Broad governance  
Accountability and value  
Demand-side impetus for change from CMS  
Explicit encouragement from the public sector, including CMS  
Government emphasis on demonstration projects |

**Source:** Authors’ analysis. **Note:** CMS is Centers for Medicare and Medicaid Services.
**Infrastructure Features And Capabilities For Successful Accountable Care Organizations**

<table>
<thead>
<tr>
<th>Type of resource</th>
<th>Specific resources</th>
</tr>
</thead>
</table>
| Concrete assets  | Delivery system expansion  
|                  | Health information technology infrastructure and electronic health record system  
|                  | Health information exchange for all providers  
|                  | Clinical decision-making support |
| Managerial and financial systems | Methods of accountable care organization payment from payers  
|                                | Prospective budgets and resource planning  
|                                | Method to disburse shared savings  
|                                | Utilization measurement and management on a per member per month basis  
|                                | Measures of provider performance  
|                                | Analytics for episodes of care to manage cost per service or case  
|                                | Clinical microsystems comprising front-line providers working in small, interdependent groups to provide care for specific groups of patients  
|                                | Real-time data and performance measures  
|                                | Disease registries  
|                                | Management services organizations that provide back-office assistance to physicians  
|                                | Governance structure |
| New organizational processes | Coordinated care across service settings  
|                                | Coordination of managerial and clinical silos  
|                                | Alignment of providers  
|                                | Continual learning to improve care processes  
|                                | Management of out-of-network utilization  
|                                | Patient engagement  
|                                | Clinical integration to facilitate the coordination of patient care across conditions, providers, settings, and time  
|                                | Lean manufacturing and clinical redesign  
|                                | Patient behavioral change  
|                                | Care teams |
| Cultural changes | Accountability for the “Triple Aim” (see Note 3 in text)  
|                  | Focus on value  
|                  | Focus on primary care physicians  
|                  | Focus on wellness and prevention |

**Source** Authors’ analysis of Accountable Care Organization Learning Network’s Toolkit (see Note 8 in text).

(accountable care organizations) have not promoted cooperation, improved quality, contained costs, or integrated clinical care. The history of hospital-physician relationships reveals conflicting goals, clinicians’ preference for remaining independent, and increasing physical separation between hospital practice sites and physician practice sites. Nevertheless, some organizational models, such as large medical groups that align physicians in different specialties, and some financial models, such as bundled payments that align the financial incentives of different providers, show promise of quality improvement and cost containment.11

**Care Coordination** Coordination among multiple providers has long remained an elusive goal. In 2002 CMS funded fifteen demonstrations of care coordination for Medicare populations under the Medicare Coordinated Care Demonstration. Only three sites reduced patient costs and admissions, and even in those sites, there were no net savings to Medicare after factoring in fees for care coordination. Moreover, only one site—Health Quality Partners—is still operating under the demonstration and continues to be evaluated by CMS.

Evaluators concluded that care coordination alone “holds little promise of reducing total Medicare expenditures for beneficiaries with chronic illness.”12 Researchers studying another multicenter trial of care coordination similarly found little impact on utilization.13

These demonstrations offer several lessons. First, the programs demonstrated positive but modest impacts only for Medicare beneficiaries with multiple treatable chronic conditions and very serious illness; they were not effective for the broader low-risk Medicare population. Second, successful sites shared certain characteristics, including explicit transitional care models; timely information on acute episodes; patient self-management education; nurse coordinators; and intensive interactions among patients, physicians, and coordinators. The generalizability of any feature associated with the one continuing program has not been demonstrated.

At the same time, care coordination for Medicare patients poses some daunting challenges for integrated delivery networks that are not as established and dominant as Geisinger Health System, Intermountain Healthcare, and Advocate Health Care, and thus have not had the time and resources to develop these capabilities. For example, Medicare fee-for-service beneficiaries see an average of two primary care providers and five specialists across four sites of care annually.14 A physician treating 257 Medicare patients would have to deal with up to 229 other physicians practicing in 117 care sites.15

Care is thus dispersed across multiple practi-
tioners in multiple specialties practicing in multiple sites. To paraphrase the saying popularized by Hillary Clinton, “it takes a village” to coordinate care. However, it may not be easy to coordinate such a large village.

Patients with multiple chronic conditions use an even larger number of providers and have lower percentages of visits to their assigned primary care physicians than other patients do. Physicians will be challenged to coordinate care for such patients unless accountable care organizations can drastically reduce the number of providers patients can choose among. This is important because, at any one time, a small number of chronic patients account for most of Medicare’s spending.16

DISEASE MANAGEMENT Providers have long experimented with disease management programs that identify patients with chronic conditions and then monitor and educate those patients to better manage their conditions. Despite two decades of efforts, net program benefits—in terms of health or money—have remained elusive. The Congressional Budget Office found insufficient evidence that disease management programs for Medicare can even pay for themselves, concluding that any reduction in the cost of care is tempered by implementation costs.27 Such programs sometimes improve patients’ functional status but do not save money.28

Researchers summarized the experience of nine demonstration projects, many of them disease management demonstration programs, that have been funded by CMS and its predecessor agency since 1999.29 There was a net increase in costs in most programs, no widespread evidence of improved compliance with evidence-based care, and no evidence of behavioral change by patients. CMS concluded that how a program is implemented and its willingness to undergo continual refinement are critical to overcoming operating problems in these programs.30

Thomas Bodenheimer and Rachel Berry-Millett reached similar conclusions in their review of care management programs for patients with multiple chronic conditions.20 Such programs may improve quality, but they have at best mixed impacts on cost and utilization.

Supporters of disease management argue that the results of good programs are not published in scholarly journals. Major insurers continue to experiment and believe that they have achieved success. Often, however, patient sample sizes in their experiments are too small or the research designs are too informal to qualify as publishable evidence. Other studies suggest that disease management can sometimes control spending for beneficiaries who fully participate over long periods of time.21 These findings, however, do not fully account for program costs and selection effects.

PATIENT-CENTERED MEDICAL HOMES The accountable care organization is designed to work in tandem with a patient-centered medical home, in which a team led by a primary care physician provides comprehensive patient services. According to advocates, the patient-centered medical home works best when treating patients who have high-risk chronic conditions and when using face-to-face interactions among patients, physicians, and care coordinators.

Evidence suggests that patient-centered medical homes improve certain aspects of quality, such as prevention and chronic disease management; improve the patient’s experience; and reduce the utilization of the emergency department.22 By achieving these results, the homes bend the cost trend for a while and address the “Triple Aim” of improving care for individuals and populations and bringing costs under control.3 Much of this evidence comes from dominant, well-established care networks.23 Evidence from Seattle-based Group Health, for instance, indicates that realizing these improvements may require large staffs, strong institutional management, and the capacity to manage change.24

Demonstration projects suggest that any improvements rest on long-term practice transformation, an internal capability for organizational learning, development by physicians of a willingness to collaborate and function as a part of a care team, and a multiyear commitment to change. Most interventions to redesign physician practices do not meet such expectations.25

HEALTH INFORMATION TECHNOLOGY Perhaps no single element of accountable care organizations has received as much attention, funding, and enthusiasm as information technology. Recent reports have tempered expectations, however.

Research conducted on decision support systems; computerized physician order entry; and electronic health records, in which the prior two components are embedded, reveals mixed effects on cost and quality.26 Overall, the evidence suggests that information technology is necessary but insufficient to improve outcomes.

CLINICAL DECISION SUPPORT SYSTEMS: Decision support systems might increase quality by improving physician decision making, reducing medication errors, and facilitating the prevention and use of evidence-based recommended therapy.27 System effects are stronger for increasing preventive care than reducing utilization.28 Evidence on the benefits of diagnostic assistance offered by electronic systems is mixed, partly
because physicians often ignore the systems’ advice.27

Theoretically, decision support systems can reduce adverse drug events and thereby reduce costs, but evidence of the effects on costs, testing, and clinicians’ time is again mixed.27 The Agency for Healthcare Research and Quality concluded that “it is unlikely that there will be any major improvements in the quality and cost of care from the use of health [information technology] without proper implementation and use of [clinical decision support systems],” which itself is a challenge.27

▸COMPUTERIZED PHYSICIAN ORDER ENTRY: Computerized physician order entry can reduce costs and improve quality by reducing medication error rates,29 but evidence of this often comes from self-selected advanced integrated delivery networks with customized systems. Literature reviews30 report mixed success of the technology in averting adverse drug events, increasing adherence to guidelines, and prescribing efficiency.

▸ELECTRONIC HEALTH RECORDS: Evidence on electronic health records and their impact on quality and cost is also mixed.31 A 2006 review reported that favorable evidence came from advanced integrated delivery networks whose histories and capabilities differ markedly from those of other providers and whose results may not be generalizable.32 A more recent review reports positive or mixed results from studies since 2007.33 There continues to be little evidence of the records’ cost-effectiveness or their ability to support such components of the accountable care organization as the patient-centered medical home.

Research suggests that provider organizations implementing electronic health records need to make a series of concomitant changes to realize the benefits of the records and avoid undesired consequences.34 The new technology must be blended into the social system, workflow, and physician culture of the organization. Achieving this involves a heavy emphasis on the implementation of parallel changes in people and work processes, and on the interoperability of information systems across care settings.35

▸PAY-FOR-PERFORMANCE AND SHARED SAVINGS

The shared savings approach of accountable care organizations parallels that of the 2005–10 Medicare Physician Group Practice Demonstration.36 Although all ten participating groups reached prespecified benchmarks on most quality measures, only five generated any savings, and only two generated enough savings to qualify for bonuses in all five years. There is also some debate as to whether the project caused the favorable results.37

Previous reviews of pay-for-performance programs suggest at best mixed results. Data from a large health maintenance organization contracting with physician groups in California38 show no improvement in outcomes and no transformation of care. Data from a large medical foundation39 likewise show no quality improvement. A RAND analysis40 finds inconclusive evidence for any impact on patient outcomes, and a recent analysis of the Premier Hospital Quality Improvement Demonstration finds no long-term effect.41

SUMMARY

The evidence reviewed above suggests that components of accountable care organizations have limited and uncertain impact, especially on cost savings, and thus provide little support for the two postulates mentioned above: that better care coordination will improve quality at any given cost, and that the organizations will lower Medicare’s rate of spending growth. If the organizations increase “value” (quality or outcome divided by cost), at best they raise the numerator but do not lower the denominator.

The Lens Of Change Management

The Brookings Institution acknowledges that accountable care organizations face “a multitude of technical, legal, and analytic changes”42 to develop the capabilities listed in Exhibit 3. The list should give developing accountable care organizations and their advocates pause for reflection on several points.

First, from the perspective of strategic implementation, there is no guidebook to help providers develop a coherent system of these capabilities and implement them effectively.

Second, implementing all of the changes will require considerable money and time. Accountable care organizations will incur steep development costs—and lack revenues needed to finance the changes, because revenue may decline together with the volume of inpatient care while the organizations focus on implementing those changes. At the same time, CMS wants the organizations, within a three-year period, to assume upside risk via shared savings and downside risk by voluntarily repaying the agency for exceeding cost thresholds. In contrast, research on organizational change suggests a more realistic window is five to seven years.12

Third, the changes will require hiring new types of personnel such as care coordinators and information technology staff, as well as nurse practitioners and other health professionals who can provide care in collaboration with physicians. We have seen no model of a “flat” accountable care organization—one requiring no increase in numbers or layers of staffing.
Fourth, the organizations will need to ensure that all changes are internally congruent. Changes in the organizations’ infrastructure (adding the infrastructure features and capabilities in Exhibit 3) must be congruent with each another and matched by changes in people’s behavior and attitudes. In this way, the organizations are akin to a sociotechnical system that recognizes the complex interaction among the tasks people perform, the social groups they belong to, and the technology they use. Unfortunately, many organizations do not make the congruent set of changes needed to achieve superior performance when they undertake strategic initiatives.\textsuperscript{43}

Providers’ ability to develop the needed capabilities is also uncertain because of their mediocre track record with strategic change.\textsuperscript{44} Some promising models of change, such as the application of Lean manufacturing techniques, still await peer-reviewed validation. Perhaps Lean approaches are akin to diet programs: They are good for you but hard to sustain, and the participants who succeed are not a random sample.

The Achilles’ Heels Of ACOs

**FOCUS ON PRIMARY CARE PHYSICIANS** Accountable care organizations rest on a foundation of primary care physicians who can coordinate all medical care for high-risk patients in addition to supplying their own services. Primary care providers need to function as gatekeepers for Medicare patients to curb utilization because the organizations are at financial risk.

Because advocates of accountable care organizations assume that primary care will play a critical role, they need to acknowledge the shortage and uneven geographic distribution of primary care providers nationwide. The percentage of primary care providers who accept new patients falls as one moves from the commercially insured population (84 percent) to the Medicare (61 percent) and Medicaid populations (42 percent).\textsuperscript{45}

Physician shortfalls might be alleviated by the use of nonphysician providers, such as registered nurses and nurse practitioners.\textsuperscript{46} Although there is research supporting such concepts as nurse-led patient-centered medical homes, it is also true that systematic reviews of such substitution for physicians sometimes reveal negative results, including reductions in productivity, patient volume, and practice income.\textsuperscript{47}

One concern is whether asking primary care doctors to coordinate care will require them to reduce the time they spend on direct patient care. A recent study suggested that physicians in the patient-centered medical home would need to work an additional 3.2 weeks per year to coordinate care for patients treated by specialists for seven chronic conditions.\textsuperscript{48} Another study showed that Swiss primary care providers wanted additional compensation in exchange for the decreased autonomy that they would experience if they collaborated more frequently with office staff and worked with other physicians in patient referrals.\textsuperscript{49} Another concern is whether primary care providers can accurately identify complex patients in need of coordinated care.\textsuperscript{50}

**PHYSICIAN PRACTICE ORGANIZATION** Larger physician groups deliver care that is higher quality and more efficient, although the causal pathway is not well established.\textsuperscript{41,51} In contrast, smaller groups are less likely to utilize patient-centered medical home features such as chronic disease registries and nurse case managers.\textsuperscript{52}

Unfortunately, the spread of large multispecialty groups has occurred at a glacial pace and been limited to certain states or regions. California is one of those areas.

The number of physician groups has remained stagnant for decades, as has the percentage of nonfederal physicians in the groups.\textsuperscript{53} Moreover, at least through 2006, the average size of a physician group practice has increased slowly. But the percentage of doctors in groups with a hundred or more members has remained at 1 percent since the late 1980s.\textsuperscript{53} Quick change is unlikely.

**OUT-OF-NETWORK UTILIZATION** Under the provisions of the Affordable Care Act, accountable care organizations will assign (“attribute”) patients to primary care providers based on which provider is expected to account for the majority of patients’ evaluation and management visits, according to data on prior utilization. This differs from the integrated delivery network contracting model, in which patients would explicitly be assigned to a physician gatekeeper. However, some patients with chronic conditions receive most of their care from specialists, who may not be accustomed to coordinating care.

This poses a problem for accountable care organizations. The roughly 20 percent of Medicare beneficiaries who have at least five chronic conditions usually seek care from and refer themselves to specialists.\textsuperscript{55} The opportunity for a primary care physician or a patient-centered medical home to coordinate care may thus be lost. If so, this factor will limit the ability of accountable care organizations to affect a huge portion of Medicare spending. In contrast to the older model, the primary care provider cannot directly control patient use of out-of-network providers but instead must rely on persuasion.

**DISRUPTIVE INNOVATION** Policy makers now...
put a good deal of reliance on “disruptive innovation,” such as retail clinics, to solve health care’s problems. Disruptive innovation offers products that cost much less than, but are more simplified and less technically capable versions of, the products they replace. The evidence is mixed as to whether they provide comparable quality in some dimensions at lower cost. Accountable care organizations may be considered the new disruptor on the block, but it is not clear that they offer a more simplified and lower-cost alternative to traditional models of delivering acute care that consumers would prefer.

Future Directions
What is to be done? First, it is important to realize that the path to knowledge begins with having realistic expectations. In the 1990s the ability of integrated delivery networks to achieve economies of scale and a seamless continuum of care was oversold. Today policy makers need to realistically assess and periodically revisit the promises and premises of accountable care organizations. We suspect that the organizations are not the magic solution (“silver bullet”), but perhaps they can be part of a wider array of efforts (“bronze buckshot”) to tackle the Triple Aim.

We ought to have realistic expectations about our ability to deliver on the Triple Aim. Prior to the publication of an article by Donald Berwick and coauthors in this journal, economists and others commonly referred to inevitable trade-offs between cost, quality, and access—what was then labeled the “iron triangle.” There is still no firm evidence that anyone knows how to achieve the Triple Aim. Recent evidence illustrates one crucial point: Improving quality for some conditions often increases costs.

Second, just like the 1990s networks, accountable care organizations need to target specific population segments that would benefit most from coordinated care.

Third, much of the evidence shows that strategic change needs to be carefully implemented. Unfortunately, implementation and execution are poorly understood processes. Providers may need to put greater effort into change management going forward.

Medicare’s need to slow the growth of its payments will surely influence its conduct of the accountable care organization program. We suspect that Medicare will move toward providing what is effectively a budget-determined capitation payment, either explicitly or as an end-of-year adjustment to accumulated fee-for-service payments.

What does that imply for the emergence, performance, and success of accountable care organizations? It requires a reconsideration of our earlier conjecture that the organizations will be more likely to improve quality than to lower costs. With intense financial pressure from Medicare generated by lower Medicare payments, the organizations may be forced to limit costs—and, if they cannot do so by ridding their systems of waste, perhaps to do so by achieving fewer quality improvements.

More generally, Medicare may wish to use accountable care organizations to contain costs. In effect, the organizations will be told, “Here is how much money you will get per patient, and you are not allowed to charge any more; do the best you can with that.”

This draconian incentive system will truly constitute a test of how much waste there is in the system.

The findings in this article were presented at the Malcolm MacEachern Symposium at Northwestern University, in Evanston, Illinois, May 11, 2011. The authors thank John Glaser and Dennis Cortese for their comments on the initial draft of this article, and Jonathan Bor, Sarah Dine, Larry Wheeler, and two anonymous reviewers for their comments on subsequent drafts.

NOTES
2009;301(6):613.
13 See Boult et al. 2011 in the online Appendix, as in Note 10.
18 See Galbreath et al. 2004 in the online Appendix, as in Note 10.
21 See Atherly and Thorpe 2011; Rula et al. 2011 in the online Appendix, as in Note 10.
22 See Cooley et al. 2009; Grumbach and Grundy 2010 in the online Appendix, as in Note 10.
23 See Grumbach and Grundy 2010 in the online Appendix, as in Note 10.
25 See Crabtree et al. 2011; Nutting et al. 2011 in the online Appendix, as in Note 10.
26 See President’s Council of Advisors on Science and Technology 2010; Lee et al. unpublished; McCullough et al. unpublished in the online Appendix, as in Note 10.
28 See Chaudhry et al. 2006 in the online Appendix, as in Note 10.
29 See Kaushal et al. 2003 and 2006 in the online Appendix, as in Note 10.
30 See, for example, Esiami et al. 2007 in the online Appendix, as in Note 10.
31 See Moreno et al. 2010; Buntin et al. 2011 in the online Appendix, as in Note 10.
33 See Buntin et al. 2011 in the online Appendix, as in Note 10.
35 See Shekelle et al. 2006; Fleming et al. 2011 in the online Appendix, as in Note 10.
37 See Iglehart 2010 in the online Appendix, as in Note 10.
38 See Mullen et al. 2010 in the online Appendix, as in Note 10.
39 See Chung et al. 2010 in the online Appendix, as in Note 10.
40 See Damberg et al. 2007 in the online Appendix, as in Note 10.
42 See Kastor 2001; Ulrich et al. 2001 in the online Appendix, as in Note 10.
47 See Morgan et al. 2008; Laurant et al. 2009 in the online Appendix, as in Note 10.
50 See Grant et al. 2011 in the online Appendix, as in Note 10.
51 See Weeks et al. 2010 in the online Appendix, as in Note 10.
52 See Rittenhouse et al. 2011 in the online Appendix, as in Note 10.
53 See Burns 2006 in the online Appendix, as in Note 10.
54 See Carey et al. 2008; Parente and Town unpublished in the online Appendix, as in Note 10.
56 See Schreyogg and Stargardt 2010; Joynt et al. 2011 in the online Appendix, as in Note 10.
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Lawton R. Burns is chair of the Health Care Management Department at the Wharton School of the University of Pennsylvania, where he is also the James Joo-Jin Kim Professor of Health Care Management. In addition, he directs the Wharton Center for Health Management and Economics.

Burns teaches courses on health care strategy, strategic change, organization and management, managed care, and integrated delivery systems, and he has published papers on the structure and performance of physician networks and the economics of group practices and investor-owned networks.

From 1998 to 2002, Burns was a visiting professor in the Department of Preventive Medicine at the University of Wisconsin School of Medicine, where he taught corporate strategy to physicians. He has also taught at the Graduate School of Business at the University of Chicago and the Graduate School of Business Administration at the University of Arizona. He received a doctorate in sociology and an MBA, with a focus on health administration, from the University of Chicago.

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Pauly has made important contributions to the fields of medical economics and health insurance, and he wrote a classic study on the economics of moral hazard that was the first to point out how medical insurance can drive patients’ use of medical services. He has examined national health care reform, the individual insurance market, the effects of poor health on worker productivity, and the market for voluntary health insurance in developing countries. He received a doctorate in economics from the University of Virginia.

In this month’s Health Affairs, Lawton Burns and Mark Pauly offer an analysis and commentary suggesting that today’s accountable care organizations may encounter the same failures that doomed many integrated delivery networks in the 1990s. They sift the evidence and conclude that accountable care organizations will have difficulties similar to those encountered by earlier organizations in such areas as aligning incentives among providers and managing risk.

The authors are also dubious that accountable care organizations will be able to muster enough primary care providers in many parts of the country, and skeptical that doctors will cede authority to others. And although features such as care coordination and information technology may help improve the quality of care provided, the authors see little likelihood that they will lower costs.

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Dear Doctor:

Larry Downs, CEO of the Medical Society of New Jersey, testified on behalf of MSNJ at the first meeting of the Assembly Insurance Committee 2016-2017 session. The committee invited MSNJ to discuss the status of the health insurance industry.

Below is a copy of his testimony.

February 4, 2016

Dear Chairman Coughlin and members of the Assembly Financial Institutions and Insurance Committee:

Thank you for the opportunity to discuss the health insurance industry as it relates to physicians who provide care and patients who benefit from it. In no other industry does the service provider rely on a third party for payment and then have to fight to receive it. Physicians are at the mercy of insurance companies to raise revenue so they can run their practices, when their sole focus should be on providing patient care. To improve care quality and reduce costs, insurers must reduce administrative burdens and provide fair payments and contracts to physicians who dedicate their lives to serving their patients. The Legislature should aim to balance the scales and ensure coverage that lives up to the premiums that patients and their employers pay. Below, we will address business practices that improve the health of the insurance industry at the price of consumer choice and coverage.

INSURANCE COMPANIES ARE DOING WELL

"With the rise of managed care between 1970 and 1989, health care administrators increased almost sixfold while the number of physicians only doubled. An industry report by the Sherlock Company indicates that the percentage of premium revenue allocated to administrative costs and profit ranges from 16.5 to 27.1 per cent....The extent to which health care revenues are actually shifting from clinicians to managers is not clear, but there is no doubt that conflict rages between the advocates of professionalism versus commercialism." The Rise of Managed Care in the United States: Lessons for French Health Policy. Victor G. Rodwin, Health Policy Reform, National Schemes and Globalization. 1997

The national average base salary for all insurance industry CEOs: $544,100 (not including bonuses and stock options). Compare this to the national family-practice physician average salary: $165,300

Who Makes What

http://www.nytimes.com/interactive/2014/05/17/sunday-review/1000000002886175.embedded.htmlhttp://r20.rs6.net/tn.jsp?f=001QYLptlQbjAfa22gb0s8H5KetZpzqOgh3mV-2QiGiExfm-ce377liCZ9bjTMVICuE6l8Yfxzdqt_NdPdRR3e9Tbx9ZotWLHC0Evj-56sD0eICzdAbxzVOuLbXVt1seXMEDUkw5A8gndoKtH6f0DqrdLDd-5JJ42AT7JeihksCW33UnWBDVI-SwEoL1FYfWmUqj_TmPSq2CtpiVtyEvic4daQUL6BTQB_3Uxq4HIVEdn_YpbttnASWBhELZrw4BAu4Td9X8AgfCU0pwio8z3g1Q==&c=sZ8xsC0KmIRUpxy8deCZziFhpXz1Uu8mjmax12IUVeP8UUG3VndbQ==&ch=lds
"And those numbers almost certainly understate the payment gap, since top executives frequently earn the bulk of their income in non-salary compensation...the chief executive of Aetna, earned a salary of about $977,000 in 2012 but a total compensation package of over $36 million, the bulk of it from stocks vested and options he exercised that year."

Medicine's Top Earners Are Not the M.D.s
http://www.nytimes.com/2014/05/18/sunday-review/doctors-salaries-are-not-the-big-cost.html?_r=0
http://r20.rs6.net/tn.jsp?f=001QYLptlQbjAfAa22gb0s8H5KetZpqzQgh3mV--2QiCiExfm-ce377liCZ9bjTMVCuEija-Q5o9FpxG36zspULUASh1N11ZLm5sGnGcfa9W2ulzyw--6P8OF5WTP6nWzmCqzdog1TqyptlSstgKn-Cn6wXJ01JBEbEEnPv--ya3jDM7TWRsGLQYfeX27VU9sIHMiLuA7h8zUlIeepfQKdT2zw0EKxFlTvbo9Mc6nMmQIhepK42ak6P9bUbA lrnxmdppzOsYqUeQle3_Fx5mjej2L--e8c=--Z8xsC0KmlRUPxy8deCZZiFhpXz1UuBmjmax12IUVeP8UUUG3VnadbQ=&ch=Ids7AVsbZRRJ65cjims jxVs8ZAsQY6zz--K_udY_1C7OJo9LOpNzQ===

In New Jersey "the CEO of Horizon drew a salary of nearly $935,000 and bonuses of $7.8 million in 2009. Pay and bonuses to the company’s nine highest-paid executives that year totaled $24.3 million, up from $15.1 million the previous year."

Blue Cross executive pay scrutinized
http://www.northjersey.com/news/blue-cross-executive-pay-scrutinized-1.285927%20http://r20.rs6.net/tn.jsp?f=001QYLptlQbjAfAa22gb0s8H5KetZpqzQgh3mV--2QiCiExfm-ce377liCZ9bjTMVCuEUZl--wRYT39MU02hbUeEUvXCqvCozUkkvWx92jDfzjAE34JE1VHbGUbJE5hnUyTyhWS8Y1UIJmo9s94Jbh0K--BB8em9iqKZpkMNqhvEEjtWvxDFoMyrhuvhkgv3pmoqzf_iddHkrFJJbWKNY06LSlyLkgoQWnp3jcc2glvAuZjQ7qkL0w5cRx--qajn&c=sZ8xsC0KmlRUPxy8deCZZiFhpXz1UuBmjmax12IUVeP8UUUG3VnadbQ==&ch=Ids7AAVsbZRRJ65cjims jxVs8ZAsQY6zz--K_udY_1C7OJo9LOpNzQ===

Profit and salaries are going up. "Profit jumped almost 29% year over year in the first quarter, totaling more than $1.4 billion. UnitedHealth's revenue increased 13% to $35.8 billion."

UnitedHealth books another profitable quarter, raises 2015 outlook
http://www.modernhealthcare.com/article/20150416/NEWS/304169977http://r20.rs6.net/tn.jsp?f=001QYLptlQbjAfAa22gb0s8H5KetZpqzQgh3mV--2QiCiExfm-ce377liCZ9bjTMVCuEUZl--wRYT39MU02hbUeEUvXCqvCozUkkvWx92jDfzjAE34JE1VHbGUbJE5hnUyTyhWS8Y1UIJmo9s94Jbh0K--BB8em9iqKZpkMNqhvEEjtWvxDFoMyrhuvhkgv3pmoqzf_iddHkrFJJbWKNY06LSlyLkgoQWnp3jcc2glvAuZjQ7qkL0w5cRx--qajn&c=sZ8xsC0KmlRUPxy8deCZZiFhpXz1UuBmjmax12IUVeP8UUUG3VnadbQ==&ch=Ids7AAVsbZRRJ65cjims jxVs8ZAsQY6zz--K_udY_1C7OJo9LOpNzQ===

"Cigna’s fourth-quarter net income was $467 million, compared with $361 million in the same period of 2013. Profit on the year increased 42% to $2.1 billion."

Cigna closes 2014 with profitable quarter
http://www.modernhealthcare.com/article/20150205/NEWS/150209968
"Aetna recorded more than $2 billion in profit in fiscal 2014, the highest level in the company's history and a signal that healthcare reform continues to treat the health insurance industry well."

Aetna closes 2014 with record profit, up 6.6% for the year

http://www.modernhealthcare.com/article/20150203/NEWS/302039967

"Simply put, greater access to health insurance has led to more customers for the insurance giants. And UnitedHealth is not the only company to benefit. The other four members of the so-called Big Five health insurers -- Aetna (AET), Cigna (CI), Humana (HUM), and Anthem (ANTM) (formerly WellPoint) -- have all beaten the S&P 500 over the past five years or so as well."

Thanks, Obamacare! Health insurer stocks soar


PATIENTS ARE NOT PRIORITIZED

Carriers are doing very well and have very large reserves of money, even the non-profits. Insurers have developed a range of interventionist strategies and tools to reduce their cost and increase revenue, "such as selective contracting with networks of providers (PPOs or IPAs); utilization review - for example, prior authorization of non-emergent hospital admissions and aggressive review of lengths of hospital stay; pharmaceutical benefits management; introduction of practice guidelines and physician profiling; and outright acquisition or formation of health maintenance organizations (HMOs) and point-of-service plans (POS)." The Rise of Managed Care in the United States: Lessons for French Health Policy. Victor G. Rodwin, Health Policy Reform, National Schemes and Globalization. 1997

Carriers control cost by shifting payment responsibilities to patients. Rather than covering care with the dollars received from individual and employer premiums, more and more plans require patient to pay for care upfront in the form of deductibles - 1 in 5 Americans have high deductible plans and the number is growing. This is a huge transition creating a situation in which patients do not understand their responsibilities and are often unable to pay the deductibles. In addition, physicians often go UNPAID for
their work when seeing patients with these plans, since insurers pay physicians NOTHING for any treatments or procedures until patient deductibles are fully paid (often thousands of dollars).

Carriers also control cost by including too few physicians in network. Insurance carriers fail to comply with laws that require them to have the right amount of physicians - INCLUDING CRITICALLY NEEDED SPECIALISTS AND SUBSPECIALISTS - in their networks. We need to enforce network adequacy rules.

Carriers also control cost by denying coverage. Access to insurance does not equal access to care. In addition to facing a shortage of network physicians, patients are regularly denied coverage for treatments, procedures and medications, even when they see IN NETWORK physicians. For example, in 2014, Horizon denied 8,496 claims JUST in Medicaid JUST for prescriptions.

NJDURB February 2015 meeting materials

The coverage hurdles are dangerous for patient health and result in increased long term patient costs, but more importantly, they negatively impact patient access to quality care. Most primary care physicians in private practice spend 10 or more hours a week on paperwork, mostly to get insurance coverage for patient care. Medscape Physician Compensation Report 2015


COMPETITION

MSNJ is greatly concerned by the lack of competition in the health insurance market. "We find that the majority of U.S. commercial health insurance markets are highly concentrated. These markets are ripe for the exercise of health insurer market power, which harms consumers and providers of care." 2014 Competition in health insurance: A comprehensive study of U.S. markets, American Medical Association

Two federal mergers are underway: Anthem and Cigna and Aetna and Humana. These mergers have garnered national attention from physicians and policy experts. "The mergers will result in higher health insurance premiums and patient costs. A growing body of peer-reviewed literature suggests that greater health insurer consolidation leads to price increases, as opposed to greater efficiency or lower health care costs. Recent studies also suggest premiums for employer sponsored fully insured health benefit plans are rising more quickly in areas where insurance market concentration is increasing. These findings should not be surprising-when insurers face little if any competition in the sale of health insurance coverage, they lack the incentive to pass along cost savings to patients. On the other hand, research is finding that competition among insurers is associated with lower premiums." American Medical Association

In New Jersey, there is little competition. For example, excluding co-ops, only three large companies sell products on the exchange: Horizon Blue Cross Blue Shield of New Jersey, the state's largest insurer; AmeriHealth of New Jersey, and UnitedHealthcare, the nation’s largest insurer.
MEDICAL LOSS RATIO
New Jersey had medical loss ratio requirements before the Affordable Care Act. But, medical loss ratio requirements will not control health insurance premium increases due to reduced competition. Medical loss ratio (MLR) regulations require large health insurers to devote at least 85 percent of premium revenues to paying claims and quality improvement. But, MLR requirements do not address the level of the premium increase, only the percentage used for claims and quality activities; and they do not directly address non-price dimensions of health insurer competition such as product design, provider networks, and customer service.

"Quality improvement activities" (QAI) are exempt from the formula, but in a list of activities that insurers may already be counting as QIA, there are many that are of questionable validity. This includes: claiming QIA expenses for undefined activities such as “services provided by sources outside the company;” "prior authorization;" "overhead allocation;" “Explanation of Benefit notices;” undefined “internationalization review of all new services;” "utilization management;" "prescriber detailing;" "high performance network designation;" and other activities that may or may not qualify, but the lack of specificity limits the ability for regulators to reject them.

PHYSICIAN CONTRACTS
Aside from concerns about the lack of consumer choice and cost controls, we hear daily from our physicians about the difficulty faced when dealing with insurers, whether in or out of network. Network contracts are unilateral; they are contracts of adhesion. This is the main reason physicians are out of network.

Insurance companies directly affect the viability and well-being of New Jersey’s physicians. “The vast majority of New Jersey physicians (95.31%, up from 89.89% in 2014) believe that the changing healthcare environment has negatively impacted their role as a physician...According to the 2015 New Jersey Health Care Monitor, of those, more than 39% said that they felt an increased administrative burden as a result of the changing environment, while 26.5% said reduced reimbursement and 15.6% reported reduced time spent with patients were among the most prevalent ways in which their practice had be negatively impacted.” 2015 New Jersey Health Care Monitor, Brach Eichler

Below are examples of unfair business practices:

All Products Clauses: Physicians who become providers in one of an insurer’s health plans, e.g., a PPO, are sometimes forced to participate in its other less attractive products. Conversely, a physician who wants to terminate participation in one product is automatically out of all of the insurer’s other products. This is now an acute problem with new plans purchased by consumers through the federal healthcare exchange created pursuant to the Affordable Care Act. Exchange products offer low payments to physicians and high deductibles for patients, who often cannot afford them. Many physicians are treating patients with exchange plans as patients without insurance, since the coverage is so weak.

Contract amendments and contracts that permit “incorporation by reference” to new payment policies, rules, etc. are very loosely regulated. Though notice is required for changes, the physician has no control over the changes and no recourse except to terminate the entire agreement. Between the two tactics of all products clauses and unilateral amendments, we believe Horizon was able to place certain physician in
Tier 2 of Omnia without their knowledge or approval.

Ratings and rankings: Carriers use secret methods to rate physicians and, in turn, terminate contracts or reduce contract benefits. This is exemplified in the Horizon Omnia network, in which Tier 2 physicians do not know why they are ranked as such. Further, physicians suffer great administrative burden with each new quality metric imposed by government programs and insurance companies; they are inconsistent, administrative burdens.

Place of Service Restraints and Payment Disparities: We are concerned that carriers are making decisions that will determine whether physicians may practice independently of a hospital. For example, one carrier’s policy on “Allowable Practice Locations for Pathologists” disallows payment to pathologists for office-based services, so that only hospital-based pathologists are included. We believe that this is anti-competitive and an unfair business practice. We also believe that it is not in the best interests of patients who are accustomed to receiving these services on site, such as at a large dermatological practice or an ambulatory care facility. In addition to a carrier’s ability to restrict the place at which a physician may practice, we are concerned that many services may be safely rendered in an office or ambulatory care setting at a lower fee than when hospital-based. If we are to bend the cost curve for healthcare, then we must ensure that services are being rendered in the most appropriate setting at the most reasonable cost.

Lack of fee increases: Many physicians suffer flat payments despite increased costs. Without competition, carriers pay as little as possible, demoralizing our best physicians and leading them to leave the state. In fact, carriers have illegally and artificially kept payments low, as was done with the Ingenix database; it took the act of a State Attorney General to finally end the practice.

http://www.nytimes.com/2012/04/24/nyregion/health-insurers-switch-baseline-for-out-of-network-charges.html?_r=0%20<http://r20.rs6.net/tn.jsp?f=001QYLptlQbjAfa22gb0s8H5KetZpqQoh3mV-2QiCIfxmf-ce377iCZ9bjTMVICuEQVVIJbmjMivMkRW4fERxg8cqV7Rc9tAKrDS0JwHJnbP9h66hdaiffWZa9nH4UxK7An6YGL5VWKW3eJNbfBdCjVMkej_oA15au8wAkzCW-zFg9xywUCGx5vTyniOh6mpRz-NzfWnn0Ahq9ho7tlcoDvsLXYNULucGuipLMw6tx19KTzkar05-6LbrnQAF-eMAbWCwKY1kUz8sq-t4zogpsz257IXprRsRzw8yDtwTpYM7fuFuDSoTdRx5qzjze&c=sZ8xsCOmRUPxy8deCZZifhpXz1UuBmjmax12IVeP8UUG3VnadbQ==&ch=Ids7AAVsbZRRJ65cjimsjxVs8ZAsQY6zz-K_udY_1C70Jso9LOpNzQ==>

REGULATION
We are concerned that the New Jersey Department of Banking and Insurance (DOBI) may not have enough resources to regulate carriers. We know the resources to enforce network adequacy are inadequate. In 2013, when responding to comments on proposed regulations, DOBI acknowledged its stated goal of “protecting consumers while promoting the growth, financial stability and efficiency of the insurance industry.” We believe that, in order to protect consumers, growth must be defined as competition, rather than consolidation. As shown above, revenue is growing, but competition and oversight are not.

In order to truly help consumers, we urge policymakers to improve their health literacy. Physicians should be able to focus on care, but instead spend countless hours fighting with insurers for payments and bear the brunt of patient frustration when insurers do not provide the coverage expected or promised. The physician-patient relationship was once sacred, but today it is marred by mutual frustration towards a
third party payer. Insurance companies must be more transparent with physicians and patients about their contracts, products and services.

CONCLUSION
Our economic impact study is attached for your reference. Physicians are a major economic force, yet there is little support for those who directly provide care under increasing financial pressure and increasing government mandates.

Thank you again for hearing our observations and concerns about the health insurance industry. There are several bills that will increase transparency, competition, network adequacy, contracting and coverage to help physicians and their patients focus on quality and personalized care. A few of these bills are listed below for your review.

Current session:
? A886 Establishes certain network adequacy and standard application requirements for health insurance carriers; requires determination of hospital diversity for tiered networks.
? A887 Requires carriers to disclose selection standards for placement of health care providers in tiered health benefits plan network; establishes oversight monitor to review compliance.
? A1906 Requires Commissioner of Banking and Insurance to develop standard prior authorization form for prescription drug benefits for use by network providers.
? A2284 Concerns the delivery and oversight of coverage under certain health benefits plans; establishes Health Care Patient Ombudsperson in the Division of Consumer Affairs.
? A2298 Requires certain health benefits plans to provide treatment for behavioral health care services when determined medically necessary.
? A2328 Requires health insurance carriers to comply with certain network adequacy requirements.

Last session:
? A2872 Regulates physician profiling programs used by managed care networks.

Sincerely,

Lawrence Downs, Esq., CEO
Medical Society of New Jersey

MOMS
PO Box 549
Howell, NJ 07731
Resolution 15-503: The Education of Pennsylvania Physicians, Fellows, Residents, and Students to the Legislative Processes of Pennsylvania and How to Participate Therein – Resolution 15-503, introduced at the 2015 annual meeting and referred for study to the Board of Trustees, called on the Society to establish a readily available multimedia presentation educating Pennsylvania physicians on the legislative process.

The Pennsylvania Medical Society (PAMED) has increased its communication to Pennsylvania physicians — in a variety of formats and mediums — regarding the legislative process, as well as the Society’s advocacy efforts.

When a bill is introduced that may impact Pennsylvania physicians, PAMED communicates this with members via several communications channels, such as the all-member email, mobile app, social media, blogs, etc. Our regular communications walk Pennsylvania physicians through the bill’s movement in the Pennsylvania General Assembly.

Part of educating physicians on the legislative process is also increasing awareness of PAMED’s advocacy efforts. This has included:

- **Quick Consult** documents on new laws and programs, such as the state’s medical marijuana law and new prescription drug monitoring program (PDMP).
- **Increased advocacy-related content in PAMED’s all-member email, mobile app, and other communications.** PAMED’s new mobile app, launched in May 2016, focuses on the latest news and advocacy, giving Pennsylvania physicians the ability to easily connect with their legislators on important issues.
- **Increased awareness of PAMED’s advocacy efforts** — In May 2016, PAMED launched a new print publication — **Physician Advocate** — designed to help keep members up to date on PAMED’s advocacy efforts, the legislative process, and how new laws and regulations may impact them.
- **Media call-ins** when awareness/education is needed on particular issues, such as medical marijuana.
- **Voter Voice calls to action** — When legislators need to hear the physician voice on a particular issue, such as streamlining physician credentialing and prior authorization reform, PAMED sends a call to action to ALL Pennsylvania physicians explaining the issue and providing talking points. For example, in May/June 2016, Pennsylvania physicians received three calls to action from PAMED to take action and contact their legislators in opposition to the CRNP bill.
- **Online education** — When new laws or regulations become a reality, PAMED ensures that members have the resources to understand and comply. For example, one of the modules in our multi-part opioids CME series focuses on the state’s PDMP, provider and dispenser reporting requirements, and user access. We’ve also broken down the 962-page MACRA proposed rule into three Quick Consults and are working on an online video series which breaks the rule down into bite-sized, easily-digestible segments.
- **Magazine issues focused on advocacy** — In the fall of 2014, PAMED’s quarterly magazine, **Pennsylvania Physician**, sent to all Pennsylvania physicians (as well as legislators and media), focused on advocacy, and the fall 2016 issue will have a similar theme. All issues have advocacy-related content, such as a legislative affairs spotlight column, which are written by internal subject matter experts. We’ve also featured state officials — such as Physician General Rachel Levine, MD, and Secretary of Drug and Alcohol Programs Gary
Tennis – and legislator Q&As with Sen. Jake Corman and Rep. Gene DiGirolamo, that
provide insight into how physicians can get involved in the legislative process and physician
advocacy.

- **New customizable website** — PAMED launched a new website in April 2016. It features the
ability for users to customize the content they see by article type (blog, article, etc.), bills we
support, oppose, or have no position on, etc. We also have the ability to highlight key stories
on the homepage, including a banner when there is a call to action on an important advocacy
issue. The homepage also features a social media feed and latest news, which often contain
advocacy updates.

In development for 2017 are a webinar and informational sheet on how legislation moves through the
state legislature, real-time bill tracking on PAMED’s website, and more interactivity on PAMED’s
website and mobile app regarding advocacy.

**RECOMMENDATION**

1. The Board of Trustees recommends that this report be adopted in lieu of Resolution 15-503.

David A. Talenti, MD
Chair
Policy Sunset - Resolution 89-9, Ten Year Sunset Provision for PMS Policy, directed that all Society policies adopted prior to 1981 be reviewed and presented to the House of Delegates for readoption; in subsequent years, all policies adopted by the Society be reviewed and presented to the House for similar action on the tenth anniversary of their adoption. All policies reviewed but not readopted automatically expire at the conclusion of that House of Delegates meeting. The Board implements this resolution by overseeing the sunset process and bringing a report with recommendations to the House each year.

The process employed is as follows: Once identified, the policy actions subject to sunset are sent to the relevant unit of the Society for review and a decision on whether the policy should be retained, rescinded, or retained in part. In instances where the recommendation is to rescind or retain in part, the reviewing unit is directed to indicate the reason for that decision. In addition, Society legal counsel reviews all policies for anti-trust ramifications. Policies are then submitted to the Board for recommendation to the House for action.

This year, this procedure was followed for policies for 1966, 1976, 1986, 1996, and 2006. The Board acted on these at its August meeting. These policies are now presented to the House for its consideration and action. Each item has a recommendation approved by the Board.

RECOMMENDATION:

1. The Board of Trustees recommends that the action indicated be adopted for each policy item.

David A. Talenti, MD
Chair

Attachment
## 2016 PENNSYLVANIA MEDICAL SOCIETY SUNSET POLICY REVIEW

<table>
<thead>
<tr>
<th>Policy Number &amp; Title</th>
<th>Retain</th>
<th>Retain in Part</th>
<th>Rescind</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.999-Testifying Before State Legislature (Res. 7, H-82; revised, Res. 210, H-96)</td>
<td>X</td>
<td></td>
<td></td>
<td>The Pennsylvania law that removed the requirement that motorcyclists wear protective head gear has been in effect since September 2003. While PAMED should maintain its public endorsement that motorcycle helmets reduce or eliminate the severity of potential injuries, repealing the law as a “high priority” should be abandoned given the lack of any legislative interest in doing so.</td>
</tr>
<tr>
<td>10.997-Motorcycle Helmet Law (Res. 404, H-2006)</td>
<td></td>
<td>X</td>
<td></td>
<td>Manadatory seat belt laws have been on the books in Pennsylvania for some time. While the penalty for not using vehicular seatbelts is considered a secondary offense, the law requires adults and children to be belted. Unless PAMED wants to pursue elevating the penalty to a “primary” offense, this policy should be rescinded.</td>
</tr>
<tr>
<td>15.996-Mandatory Use of Seat Belts (Res. 23, H-86)</td>
<td></td>
<td></td>
<td>X</td>
<td>This has been part of the Vehicle Code and in effect for over ten (10) years. There is not enough support in the legislature to repeal this provision. Because this is law, regulations and judicial means are not possible methods for rescinding.</td>
</tr>
<tr>
<td>35.987-Advertising by Non-Physician Health Care Providers . (Res. 412, H-2006)</td>
<td>X</td>
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<tr>
<td>35.988-Department of Transportation Physical Examinations by Chiropractors (Res. 401, H-2006)</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>35.999-Direct Reimbursement of Nurse Anesthetists (Res. 40, H-86)</td>
<td>X</td>
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<tr>
<td>70.999-Uniform Disease and Procedural Coding (Res. 53, H-86)</td>
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<td>X</td>
<td>This is being accomplished through ICD-10 for uniform disease coding and CPT for procedural coding.</td>
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<td>Bill Number</td>
<td>Title</td>
<td>X</td>
<td>Notes</td>
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<tr>
<td>115.997</td>
<td>Prescription Drug Expiration Dates (Res. 409, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>135.999</td>
<td>Air Pollution (Res. 10, H-66)</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>140.994</td>
<td>Physician Advertising (Res. 504, H-2006)</td>
<td>X</td>
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<tr>
<td>140.998</td>
<td>Restrictive Covenants in Medicine (Report 6, Board of Trustees, H-96)</td>
<td>X</td>
<td></td>
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<tr>
<td>145.999</td>
<td>Health Consequences of Firearms (Res. 50, H-86)</td>
<td>X</td>
<td></td>
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<tr>
<td>160.982</td>
<td>Health Care Services to the Underserved (Report 6, Board of Trustees, H-2006)</td>
<td>X</td>
<td>Even with passage of the Affordable Care Act and the development of marketplaces and the expansion of Medicaid as well as mental health parity, there continue to be individuals in the commonwealth that are underserved including the LGBT population</td>
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<tr>
<td>160.983</td>
<td>Access to Health Care (Res. 403, H-2006)</td>
<td>X</td>
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<tr>
<td>160.988</td>
<td>Access to Quality Medical Care (Res. 508, H-96)</td>
<td>X</td>
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<tr>
<td>160.989</td>
<td>Health Care Delivery Models (Report 3, Board of Trustees, H-96)</td>
<td>X</td>
<td>PAMED is very engaged in the new value-based health care delivery models and are making efforts to educate physicians on these as well as business opportunities to further assist physicians in succeeding in these new models.</td>
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</tr>
<tr>
<td>180.988</td>
<td>Reimbursement for Services Related to Obesity Diagnosis (Res. 306, H-2006)</td>
<td>X</td>
<td>Most, if not all, insurance companies reimburse for services related to obesity. This is an important public health issue and needs continued support from PAMED.</td>
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<tr>
<td>180.989</td>
<td>Reimbursement for Services Related to Tobacco Abuse Diagnosis (Res. 305, H-2006)</td>
<td>X</td>
<td>Most, if not all, insurance companies reimburse for services related to smoking cessation and other services related to tobacco-related diseases. This is an important public health issue and needs continued support from PAMED.</td>
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<tr>
<td>185.975</td>
<td>Reimbursement for HPV Vaccination (Res. 309, H-2006)</td>
<td>X</td>
<td>Most, if not all, insurance companies reimburse for the HPV vaccine. This is an important public health issue and needs continued support from PAMED.</td>
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<td>Code</td>
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<tr>
<td>185.977</td>
<td>Physician Phone Appeals for Denied Procedures (Res. 303, H-2005; reaffirmed, H-2006)</td>
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<tr>
<td>185.992</td>
<td>Denial of Care (Res. 510, H-96)</td>
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<tr>
<td>185.993</td>
<td>Emergency Room Precertification (Res. 403, H-96)</td>
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<tr>
<td>230.993</td>
<td>Linkage of Academic Privileges and Hospital Privileges (Res. 402, H-96; revised, H-2006)</td>
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<td>230.994</td>
<td>Effect of Changes in Hospital Character Upon Medical Staff Credentialing (Res. 616, H-96)</td>
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<td>230.999</td>
<td>Exclusive Contracts (Hospital Medical Staff Section Report, H-86)</td>
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<td>255.999</td>
<td>Clinical Clerkships (Res. 18, H-86)</td>
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<td>260.996</td>
<td>Specimen Handling Fee (Res. 6, H-86)</td>
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<td>260.999</td>
<td>Alpha Fetoprotein Testing (Report H, Board of Trustees, H-86; policy retained in part, H-96)</td>
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<tr>
<td>280.998</td>
<td>Mandated Laboratory Testing of Nursing Home Patients (Res. 507, H-96)</td>
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<tr>
<td>285.986</td>
<td>Managed Care Organization Reimbursement Formulas (Res. 304, H-96)</td>
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<tr>
<td>285.987</td>
<td>Managed Care Organization Termination of Participation (Res. 306, H-96)</td>
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</table>

PAMED continues to advocate for reforms in the pre-authorization process and has introduced legislation to remediate various aspects of pre-authorization process.

This is an ongoing issue to seek a “reasonable” drawing and handling fee as operating costs continue to increase for the physician practice.

Pennsylvania Medicaid reimburses for this service.

Federal and state regulations for laboratory testing of nursing home patients continues to evolve, so it is important to continue to monitor.

Severity of illness adjustments especially as it pertains to risk are being used in the new value-based payment methodologies.

Network adequacy has become a major discussion item at the federal and state level. Increased scrutiny has been applied by regulators as evidence show many provider directories contain incorrect information regarding their participating providers.
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<tr>
<th>Code</th>
<th>Description</th>
<th>Status</th>
<th>Notes</th>
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</thead>
<tbody>
<tr>
<td>290.995</td>
<td>Parity Between Outpatient Departments and Physicians’ Offices (Res. 4, H-76)</td>
<td>X</td>
<td>Activity is occurring at the Federal level to create parity between physician offices and outpatient departments.</td>
</tr>
<tr>
<td>290.996</td>
<td>Low Physician Fee Schedule Deters Physician Participation (Res. 22, H-76; revised, H-2006)</td>
<td>X</td>
<td>Although most of Medicaid is now delivered through managed care where fee schedules are negotiable, the starting point is generally the fee-for-service fee schedule. Increasing fees could help in the negotiation process.</td>
</tr>
<tr>
<td>310.996</td>
<td>Parity for International Medical Graduates (Res. 203, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>350.996</td>
<td>Statement of Principles for Cultural Competency (Report 8, Board of Trustees, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>385.965</td>
<td>Reimbursement for Immunizations (Res. 314, H-2005; reaffirmed, H-2006)</td>
<td>X</td>
<td>Adequate reimbursement for immunizations is important as costs to purchase, store, and administer the immunizations continue to increase. Immunizations are a major public health concern so patients need access to providers providing them.</td>
</tr>
<tr>
<td>385.986</td>
<td>Third Party Reimbursement for Services Rendered by Physician (Report 25, Board of Trustees, H-96)</td>
<td>X</td>
<td>The importance of this policy cannot be understated. We just experienced a scenario where Highmark unilaterally cut ACA marketplace reimbursement by 4.5%.</td>
</tr>
<tr>
<td>405.996</td>
<td>Protecting Patient’s Right to Know Who is Treating Them (Res. 410, H-2006)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>435.969</td>
<td>Delinkage of Medical Liability Insurance to Physician Licensure (Res. 407, H-2006)</td>
<td>X</td>
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<tr>
<td>435.990</td>
<td>Tort Reform/CAT Fund Reform 10-Point Action Plan (Report 27, Board of Trustees, H-96)</td>
<td>X</td>
<td>The action plan articulated in the policy is outdated and should be updated. House should consider developing updated policy.</td>
</tr>
<tr>
<td>435.991</td>
<td>CAT Fund Premium and Surcharge (Res. 408, H-96)</td>
<td>X</td>
<td>CAT Fund no longer in existence; now Mcare. Policy should be updated to reflect current state of affairs.</td>
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<tr>
<td>Code</td>
<td>Title</td>
<td>Action</td>
<td>Details</td>
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<tr>
<td>440.975</td>
<td>Safe Treatment of Head Lice Infestation (Res. 204, H-2006)</td>
<td>X</td>
<td>This was accomplished by submission of a resolution to the AMA Annual meeting in June 2007 (Res 432-A-07). However, Resolution 432 was not adopted by the AMA House of Delegates.</td>
</tr>
<tr>
<td>440.976</td>
<td>Air Pollution Caused by Diesel Trucks (Res. 201, H-2006)</td>
<td>X</td>
<td>In 2008, the general assembly approved legislation limiting diesel truck idling to 5 minutes. As a result, PAMED’s policy to reduce diesel-related air pollution should be rescinded.</td>
</tr>
<tr>
<td>440.977</td>
<td>Health Impact of High Fructose Syrup (Report 2, Board of Trustees, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>440.978</td>
<td>Healthy Choices in Hospital Cafeterias . (Res. 207, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>440.979</td>
<td>Promotion of HPV Vaccine (Res. 309, H-2006)</td>
<td>X</td>
<td></td>
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<tr>
<td>440.993</td>
<td>Standards for Blood Donors (Report 18, Board of Trustees, H-96)</td>
<td>X</td>
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<tr>
<td>440.994</td>
<td>Antibiotic Resistance Surveillance Network (Res. 216, H-96)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>445.999</td>
<td>Community Committees (Address of the President, H-86)</td>
<td>X</td>
<td>This policy remains pertinent and enables CMS’ to further define their role within the community as a voice of physicians.</td>
</tr>
<tr>
<td>480.999</td>
<td>Telem medicine (Report 29, Board of Trustees, H-96)</td>
<td>X</td>
<td>In our recently introduced telemedicine legislation, this is a very important component of the legislative language.</td>
</tr>
<tr>
<td>490.998</td>
<td>Ban on Smoking in Hospitals (Res. 24, H-86)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>490.999</td>
<td>Ban Distribution of Cigarettes and Smokeless Tobacco (Res. 25, H-86)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>530.995</td>
<td>Forums (Report of Ad Hoc Committee on House Representation)</td>
<td>X</td>
<td>These forums are no longer utilized.</td>
</tr>
<tr>
<td>530.996</td>
<td>Mainstreaming Underrepresented Physician Groups (Report of Ad Hoc Committee on House Representation, H-96)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>545.995</td>
<td>Time of House of Delegates Meeting (Report 14, Board of Trustees)</td>
<td>X</td>
<td></td>
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<tr>
<td>545.996</td>
<td>Appendixes to Resolutions (Res. 96-609)</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>555.995</td>
<td>Medical Student Dues (Ad Hoc Committee on House Representation, 11-96; revised, H-2006)</td>
<td>X</td>
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</table>