

**Framework for Implementation of the Patient Protection and Affordable Coverage Act  
June 4, 2010**

The South Dakota State Medical Association (SDSMA) takes this opportunity to offer our comments on the Patient Protection and Affordable Coverage Act. We commend President Obama and members of Congress for their leadership in developing proposals to transform our nation's health care system and for inviting input from diverse groups. We are committed to working with our state's Governor, members of Congress, the administration, and other stakeholders to implement proposals that expand coverage, improve quality, reform government programs, reduce costs, increase focus on wellness and prevention, and provide payment and delivery reforms.

As advocates for patients and physicians of South Dakota, the SDSMA believes in a health care system that:

- Provides the greatest possible access to basic quality care that is affordable for all by:
  - Using a shared public/private effort to provide access to and financing for services and allowing individuals/employers to purchase additional services or insurance;
  - Promoting a robust private health insurance market;
  - Helping people who can't afford it purchase private health insurance coverage through tax credits and vouchers;
  - Allowing families and individuals to choose their health plan; and
  - Allowing patients to be able to retain the ability to choose their own doctor and be permitted to enter into private contracting arrangements with their physicians.
- Protects individuals and families from losing their health insurance coverage or financial ruin by:
  - Making available affordable plans for catastrophic health care coverage;
  - Ensuring sustainable public programs for vulnerable populations;
  - Allowing patients to own their health insurance even if it's financed through their employer, so if they leave that job, the insurance isn't lost; and
  - Providing sufficient public funding for public health and other essential medical services, including disaster medicine and trauma care.
- Meets the highest standards of care while addressing prevention, wellness, and public health by:
  - Increasing our investment in prevention and wellness;
  - Ensuring that everyone takes responsibility for their own health, insurance protection for their family, and choosing a personal physician;
  - Eliminating racial, ethnic, and gender disparities;
  - Implementing adequately tested and proven payment reforms that are based on quality – not quantity – by promoting medical homes and rewarding care coordination of chronic diseases; and
  - Offering incentives or reductions in premiums for enrollees who utilize preventative services and make appropriate lifestyle decisions.
- Provides effective, efficient, and appropriate health care by:
  - Reducing or eliminating administrative barriers and unreasonable overhead costs;
  - Implementing cost management strategies for all stakeholders – patients, providers, and payers; and

- Enacting medical liability reforms – thus, reducing the costs associated with the practice of defensive medicine.

### Valuable Components

The SDSMA supports:

- Improving access to health care coverage by:
  - Eliminating restrictions on pre-existing conditions so no one is denied health insurance; and
  - Requiring individuals to have insurance coverage or pay a penalty based on premium cost;
- Increasing payments for physician primary care specialties while not finding those funds by reduction of other specialty reimbursement;
- Reducing inappropriate health spending variations, but only if based on sound evidence and not just fiscal objectives;
- Improving the efficiency and quality of health care by investing in EHRs;
- Using evidence-based quality measures (however, measures should be developed by the Physician Consortium for Performance Improvement (PCPI) and used for point of care information, as well as performance reporting);
- Making greater investments in wellness and prevention;
- Improving care coordination by promoting medical homes; and
- Addressing doctor shortages, especially in rural areas, by providing more support for medical education and residency training programs.

### Concerns

The SDSMA is concerned with:

- Plans for creating a temporary high-risk pool with subsidized premiums –reimbursement must be adequate and physicians should not be required to participate;
- The formation of state-based, state-administered health insurance exchanges and interstate compacts – the SDSMA does not believe a new public health insurance plan is essential to ensuring competition in a reformed insurance market;
- The granting of federal tax dollars for the creation of Consumer Operated and Oriented Plans (CO-OPs) – CO-OPs must meet the requirements placed on all qualified health benefit plans within the state of South Dakota, and should not be given federal assistance in terms of grants or subsidies to compete in the market place;
- The proposed requirement to mandate that all physicians who order Medicare-covered items or services be required to enroll in Medicare;
- The proposed imposition of a Medicare provider enrollment fee on physicians;
- Expansion of the current Medicare and Medicaid programs – currently many physicians provide care to Medicare and Medicaid enrollees at a loss. Any expansion to these programs will be detrimental to the provider community and may lead to serious access to care problems for those in the rural communities;
- The requirement for employers with more than 50 full-time employees to provide health care coverage or pay a penalty;
- The proposed tax penalties for those who elect to not have health coverage. The SDSMA supports mandates for individual coverage; however, the SDSMA believes the current tax penalties proposed for those who elect not to have coverage are not substantial enough to encourage compliance;
- A provision that would empower an independent commission to mandate payment cuts for physicians who are already subject to an expenditure target and other potential payment reductions under the Medicare physician payment system;
- Imposing penalties for physicians who fail to meet the meaningful use requirements by 2015;
- The public reporting of physician quality and efficiency measurements that are not scientifically valid, verifiable and accurate;

- Redistributing Medicare payments among providers based on outcomes, quality, and risk adjustment methods that too are not scientifically valid, verifiable and accurate;
- Using untested payment methodologies such as “bundling” or “accountable care organizations” as the method for reimbursing for provider services until such time as they have been proven to improve care and reduce costs; and
- The proposal to eliminate physician hospital investment and ownership via the Stark self-referral law.

#### Issues for Further Consideration:

The SDSMA supports reforms that are consistent with the principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. We offer the following health system reform issues for further consideration:

- Expand Access - Access to coverage does not guarantee access to health care services. Payment systems for physicians must be stable and adequate to preserve access to care. In particular, the current Medicare physician payment system, which produces steep annual payment reductions that require repeated Congressional intervention, needs immediate reform in order for annual adjustments in payments to keep pace with rising practice costs.
- Reform Government Programs - Repeal the Medicare SGR payment formula and provide adequate Medicare and Medicaid reimbursement based on the cost of providing care and adjusted annually for medical inflation, with equitable reimbursement for geographic areas that are currently penalized for providing lower-cost care.
- Reduce Costs - Enact medical liability reforms that will lead to a reduction in defensive medicine and ultimately the cost of health care. Streamline insurance claims processing.
- Improve Quality - Improve the quality and efficiency of care by providing data to physicians at the point of care and using evidence-based measurement as a tool to reduce unnecessary utilization. Quality measurement programs that are simply designed to identify and penalize physicians whose results are below the top level of performance will not yield the system-wide improvements needed to assure access to high-quality health care for all. Quality improvement programs need to focus on improving care through education rather than reporting or ranking systems.