



October 23, 2009

Letter to the West Virginia Congressional Delegation:

On behalf of the West Virginia State Medical Association (“WVSMA”), with over 2,500 Allopathic and Osteopathic physicians, Medical Resident and Medical Student members, we are writing to share our comments on the health system reform efforts being considered in the United States Congress.

We are on the front lines caring for patients in The Mountain State and know that the status quo is not acceptable. We proudly provide appropriate, high quality care to those in need, including millions of dollars in uncompensated care each year to the thousands of people who have inadequate or no health insurance coverage. We also know that West Virginia citizens have some of the nation’s highest rates of chronic conditions such as diabetes, obesity, heart disease, and cancer thus placing an even greater importance on having a health care system that ensures the right care is provided at the right time in the right setting.

As physicians, we believe a failed healthcare financing structure; inefficient and inappropriate overregulation, and a litigious environment that drains limited resources due to high-cost defensive medicine are primarily responsible for the weaknesses of our current healthcare system. The time for action is now and we support action by Congress and the White House that is appropriate to tackle these specific problems.

The WVSMA firmly believes health system reform must keep at the forefront guiding principles that:

- protect the sacred relationship between patients and their physicians in making healthcare decisions without interference from insurance companies or the government;
- promote affordable health insurance coverage for all through a choice of plans that guarantees portability and eliminates denials for pre-existing conditions;
- encourage greater personal responsibility for prevention and wellness on the part of all citizens;
- repeal the broken Medicare physician payment system that harms seniors' access to care;
- address the crushing weight of medical liability exposure; and
- eliminate unnecessary governmental and insurance company bureaucracy.

West Virginia State Medical Association
4307 MacCorkle Avenue, SE
P.O. Box 4106 • Charleston, West Virginia 25364
Phone: 304-925-0342 • Toll Free: 800-257-4747 • Fax: 304-925-0345
www.wvsma.com

Over the past few months, physicians and patients have found common ground with policymakers on several critically needed health system improvements but significant work remains.

The WVSMA supports the expanded availability of affordable health insurance coverage that is portable and has no pre-existing condition exclusions. Considerable attention and public debate has centered on the issue of whether a public-option should be included in a newly established health insurance exchange that offers a mix of insurance coverage options from which the public may choose. The WVSMA has very serious concerns over the inclusion of a public option. Many proponents of this concept readily admit that the current proposal is a calculated step in the overall goal of achieving a single-payor health care system. This would have a devastating impact on those aspects of our health care system we proudly cherish such as timely access to high-quality health care; protecting the strong physician patient relationship; and encouraging cutting edge medical innovation.

The WVSMA believes the co-op proposal that promotes the creation of policyholder owned, non-profit mutual insurance programs is far superior. Our State's own experience in the area of government run public-option medical liability and workers' compensation insurance programs clearly demonstrate the short comings of this approach. In both cases a failed public-option was replaced by co-op mutual programs that have proven successful at fulfilling the goals of controlling cost, reducing premium, enhancing competition and promoting quality.

Any solution must include the right of patients to privately contract with physicians; to choose their own health plan; and the ability of physicians to collectively negotiate with health plans. We also encourage the inclusion of health savings accounts as qualified health benefits plans that may be offered through any established health insurance exchange.

We support legislation that would encourage greater adoption of health information technology through incentives to e-prescribe and implement and maintain electronic medical records, without penalty for non-adoption of these systems.

We support a focus on preventive health and wellness initiatives that promote a healthier population as well as the funding of patient-centered medical home projects that are physician-led and provide the necessary incentives to appropriately compensate for increased care coordination. West Virginia, with our size, close knit healthcare community and poor health status is well oriented for such initiatives. We support a strong focus on strengthening primary care by increasing Medicaid and Medicare reimbursement. This additional investment, however, must not be funded through cuts that fall on the backs of other physician specialties.

We support the effort to increase training of primary care physicians and the recognition that medical school debt relief is critically needed. The majority of West Virginia is already officially designated by the federal government as a Health Professional Shortage Area (HPSA) and Medically Underserved (MU) and is experiencing the negative consequences this has on access to care.

A permanent fix to the fatally flawed Sustainable Growth Rate (SGR) formula is critical to any reform. Without this, any reform legislation would be irresponsible and unworkable. We applaud the House for including a permanent fix in HR 3200 and are deeply concerned with the Senate's failure to advance S. 1776. Such a fix would promote improved patient access to high quality care; must be designed with input from the physician community; ensure payment rates cover the full cost of care; include participation options for all physicians; and ensure an appropriate level of physician decision-making authority over any shared-savings distributions.

If Congress is truly serious about reducing healthcare costs, it must adopt substantive medical liability reform measures to reduce the high cost of defensive medicine. Our own state's legislative achievements are nationally recognized and should serve as a workable and effective medical liability reform model. Key elements include caps on non-economic damages, elimination of joint liability, pre-filing certificate of merit, prescriber immunity, and requiring full collateral source offset. The direct and measurable results of these reforms have clearly shown that meritless lawsuits are down, medical liability insurance coverage has expanded, premium costs have declined and access to care has improved with more physicians seeking licensure to practice medicine in our State's improved practice environment. We are also committed to finding new and innovative solutions to resolving legitimate medical disputes in a quick and fair manner through alternative dispute resolution programs such as health courts which provide a forum where medical liability actions can be heard by judges specially trained in medical liability matters. Any federal liability reforms however, must not supersede stronger state laws.

Many health system reform proposals include a significant expansion of federal bureaucracy and funding for comparative-effectiveness research and expansion of evidence based and preventive medicine programs; however, proponents present little hard evidence of projected savings, nor do they offer sufficient analysis regarding how existing organizational and community factors might influence the need for, and effectiveness of, such proposed measures in different communities, including such basic questions as how local communities would afford certain health personnel proposed to be trained.

We oppose restrictions that curtail physician-owned hospitals. Reports by the Government Accounting Office (GAO), Medicare Payment Advisory Commission (MedPAC), and Centers for Medicare and Medicaid Services (CMS) confirm that general hospitals are largely unaffected by competition from specialty hospitals. Reports do not show that physicians who have an ownership interest in a specialty hospital inappropriately refer patients to that hospital or cause increased utilization. In our own capitol city of Charleston, the Charleston Surgical Hospital (formerly the Eye and Ear Clinic), a physician-owned hospital, is an example of the excellent care that can be provided under this business model. Any restrictions on physician-owned hospitals should be rejected.

We do not support the establishment of an Independent Medicare Commission whose recommendations would automatically take effect if Congress fails to act on the Commission's

proposals each year. As proposed, the Commission's recommendations would create a double-jeopardy situation for physicians and non-physicians practitioners who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system. Another serious objection is that the payment rate reductions recommended by the Commission would not be applied in an equitable way to all sectors of the Medicare program. This initiative must be substantially redesigned to ensure fairness and equity, and to avoid unintended consequences for Medicare patients.

We do not support punitive provisions that target government calculated resource use outliers. This effort is premature in that critical safeguards still need to be developed and accurately adjusted for differences in patient mix. New risk-adjustment tools are also needed and issues of attrition have not yet been resolved.

We appreciate your kind consideration of the priorities and viewpoints outlined in this letter and wish to reiterate that the WVSMA, its membership and physician leadership stand ready to assist you in your efforts.

Respectfully yours,

A handwritten signature in cursive script, appearing to read "Carlos C. Jimenez".

Carlos C. Jimenez, MD
President

A handwritten signature in cursive script, appearing to read "Stephen L. Sebert, M.D.". The signature includes the letters "M.D." at the end.

Stephen L. Sebert, MD
Council Chairman