



**Expanding Health Coverage:  
Proposals to Provide Affordable Coverage to All Americans  
May 11, 2009**

**Comments of the American Medical Association**

The American Medical Association (AMA) appreciates the opportunity to offer our comments on the Senate Finance Committee's proposal to provide affordable coverage to all Americans. We commend the Committee for its leadership in developing a framework to transform our nation's health care system and for inviting input from diverse groups. The AMA is committed to working with the Finance Committee, Congress, the Administration, and other stakeholders to advance proposals that expand coverage, improve quality, reform government programs, reduce costs, increase focus on wellness and prevention, and provide payment and delivery reforms.

As was evident in its first options paper, it is clear that the Senate Finance Committee views the Medicare program as the foundation for reforms that it proposes for the rest of the health care system. In this paper, the Committee proposes creating a public plan option using Medicare reimbursement rates as a base, mandating physician participation in a Medicare-like public plan option, using a risk-adjustment methodology similar to that used in Medicare Advantage, and expanding Medicare to cover the near-elderly. Medicare cannot lead the way for reforms in the broader health care system when its own foundation is crumbling. The Medicare payment formula needs to be replaced before the program can effectively serve as a proving ground for innovative approaches to payment, delivery, and coverage reform that can be adopted within the rest of the health care system. In fact, unless the sustainable growth rate (SGR) is repealed, many of the proposed laudable initiatives—such as ending health care disparities—are likely to increase the number of physician services provided and so expand the number of years physicians will be facing cuts, making the cost of repeal even greater than it is today.

**Therefore, it is imperative for Congress to repeal the SGR formula for establishing Medicare physician payment updates in order to provide a stable foundation for new payment models, delivery reforms, and expansion of coverage.**

#### **Health Insurance Market Reform**

**We strongly agree that reforms are required to ensure greater accessibility and affordability and to make the health insurance market work better for both patients and physicians. The goal of market reform should be to create a competitive insurance market in which plans compete on price and quality, and patients gain more control over their choice of health coverage and their own care.** The AMA supports the insurance market reforms to create more choice and better access to affordable coverage for both individuals and small businesses.

**We support streamlined, more uniform health insurance market regulation that establishes fair ground rules, while also protecting high-risk patients without driving up health insurance premiums for the rest of the population.** The sheer number and variety of state and federal market regulations make it unnecessarily expensive to provide health insurance in many markets. While remaining supportive of state experimentation, we believe there should be greater national uniformity of market regulation across health insurance markets, regardless of type of submarket (i.e., large group,

small group, individual), geographic location, or type of health plan. Limited state variation in market regulation should be permitted as long as it does not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances (e.g., the Committee's proposed Health Insurance Exchange) or create adverse selection across states.

The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Appropriate regulations and fewer benefit mandates would permit market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing, and premiums. Removal of legislative and regulatory barriers, as well as greater uniformity in regulations, would open up opportunities to buy insurance as part of a group, buy multiyear insurance contracts, and invest in other innovations that would reduce administrative costs and narrow premium differences between high- and low-risk individuals. More flexible regulations could also allow development of specialized coverage for people with chronic conditions, offering better coordination of care, reduction of wasteful services, and quality improvements.

With respect to rating reforms, **strict community rating should be replaced with modified community rating.** By allowing some degree of premium variation based on individual risk factors, but limiting premium differences within specified risk bands, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population. **Some degree of age rating is acceptable, as are lower premiums for nonsmokers and others who make good health choices.**

Currently, the Centers for Medicare & Medicaid Services (CMS) uses risk adjustment in the Medicare Advantage (MA) program. The Committee is looking to the MA risk adjustment process as a model for use by other health insurance plans. While the AMA is generally supportive of using risk adjustment, the implementation in MA has created significant unintended consequences. Some MA plans have imposed extremely burdensome and costly record reviews on physician practices. Care should be taken as the Committee further considers wider use of a risk adjustment methodology to ensure that it does not impose new administrative costs on medical practices and that it does not provide opportunities for inappropriate payment increases to plans or premiums based on risk coding behavior rather than actual medical care needs. We further recommend that the Committee calls for more research on risk adjustment methodologies so that they can factor in more of the variables that affect health care utilization and costs, such as obesity.

**Insured individuals should be protected from losing coverage or being singled out for premium increases due to changes in health status.** Guaranteed renewability rewards people for obtaining and maintaining coverage. In the context of the current market, which does not require everyone to have insurance, guaranteed issue should be replaced with guaranteed renewability. Once everyone has coverage through individual responsibility or an individual mandate, the unintended consequences of guaranteed issue become less of an issue.

**Insurance market reform must include protections for high-risk patients. Explicit, targeted government subsidies should be provided to help high-risk people obtain coverage without paying prohibitively high premiums. Such subsidies could take the form of high-risk pools, reinsurance, and risk adjustment.** Financing risk-based subsidies with general tax revenues rather than through premiums avoids the unintended consequences of driving up premiums and distorting health insurance markets.

We support maintaining the important oversight role of state insurance commissioners with regard to consumer protections, such as grievance procedures, external review, oversight of agent practices and training, and market conduct, as well as physician protections, especially state prompt pay laws, protections against health plan insolvency, and fair market practices.

### **Health Insurance Exchange**

We agree that individuals who currently have coverage and small employers who currently provide insurance to their employees, and who are satisfied with their coverage, should be allowed to keep their coverage. **For those individuals who do not have access to or do not select employer-based insurance, we support establishing a health insurance exchange to increase choice, facilitate plan comparisons, and streamline enrollment that will assist individuals in choosing coverage that best suits their needs.** Insurers should provide understandable and comparable information about their policies, benefits, and administrative costs to empower patients, employers, and other purchasers and consumers to make more informed decisions about plan choice. The Federal Employees Health Benefits Program offers one model for this kind of exchange.

The AMA strongly supports the Committee's recommended functions to be performed by the Secretary of Health and Human Services. We believe that mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, administrative costs, and excluded services.

**Finally, to maintain the public-private balance, as well as avoid access problems, it is critical that the health insurance exchange include plan options that allow physicians to freely negotiate with patients the portion of the claim for medical services that is not covered by the plan.**

### **Benefit Options**

In lieu of mandating insurers to provide standardized benefit packages, we support allowing markets to create the most attractive combinations of plan benefits, patient cost-sharing, and premiums from which consumers can choose. Existing federal guidelines (e.g., Title 26 of the U.S. Tax Code and Federal Employees Health Benefits Program regulations) should be used when considering if a given plan would provide meaningful coverage.

### **Tax Credits**

**We support providing tax credits or subsidies to low-income individuals who need financial assistance to purchase private health insurance.** Subsidies or tax credits are better directed to individuals rather than employers; employment-based insurance minimizes employee choice, provides no portability, and leaves employees subject to discontinuity when employers switch plans.

Currently, the government subsidizes the purchase of health insurance by excluding expenditures on health insurance from an individual's or family's taxable income, but only if insurance is obtained through an employer and usually only on that portion of the premium paid for by the employer. The employee income tax exclusion is inequitable and regressive because it provides a higher subsidy to those with higher incomes and no assistance to those without employee health benefits. Shifting some of this

assistance to tax credits or vouchers for lower-income people would reduce the number of uninsured and improve fairness in the health care system.

**Expanding health insurance coverage through the use of tax credits should be guided by certain principles.** The size of tax credits should be inversely related to income, refundable, and advanceable. The size of the tax credits should also be large enough to ensure that health insurance is affordable for most people. The AMA has modeled tax credits at varying income levels and would welcome the opportunity to share our findings with the Committee. The credits must at least be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories, and at the lowest income levels the credit should approach 100 percent of the premium. In addition, the size of tax credits should vary with family size to mirror the pricing structure of insurance premiums, with premiums for family policies being less than the sum of premiums for individual members. Tax credits should be fixed-dollar amounts for given income and family structure. Moreover, the credits should be capped in any given year.

The AMA supports making tax credits contingent on the purchase of health insurance and making tax credits applicable only for the purchase of health insurance and not for out-of-pocket expenditures. Rather than emphasizing opt out provisions for individuals based on affordability, the AMA suggests that the Committee consider separate and more generous subsidies for those individuals whose health spending is unusually high due to chronic disease or health catastrophe.

With respect to the Committee's suggestion to not allow those enrolled in grandfathered plans to receive tax credits, the AMA has examined the effect of such a policy in simulating its own tax credit proposal. Providing tax credits only to those not covered under an employer-sponsored plan caused a significant increase in the number of the uninsured due to crowd-out. The AMA recommends providing all Americans with tax credits that are inversely related to income and strongly supports maximizing patient choice. Some employees may want to join the Exchange, while others may want to stay with their employer's plan.

### **Individual Responsibility**

**We support requiring individuals and families who can afford coverage to obtain it. The AMA also supports making patients more aware of health care costs so that they can make prudent health care choices.** Those earning more than 500 percent of the federal poverty level should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. Those who cannot afford it and do not qualify for public programs should receive tax credits for the purchase of health insurance. Upon implementation of subsidies or tax credits for those who need financial assistance obtaining coverage, the AMA believes everyone should have the responsibility to obtain health insurance. As previously noted, the AMA has modeled the sufficiency of various tax credit amounts at various income levels to make up a de facto measure of affordability.

Health insurance must also be made more available and affordable for small businesses and the self-employed by eliminating premium volatility and lowering the cost of health insurance premiums. We support encouraging the formation of the HIE and further support exempting insurance plans from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws and physician prompt pay laws.

### **Public Health Insurance Option**

**The AMA does not believe that creating a public health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs across the health care system.** The introduction of a new public plan threatens to restrict patient choice by driving out private insurers, which currently provide coverage for nearly 70 percent of Americans. In an effort to keep public plan costs low, it is likely that a public plan would receive special advantages and government subsidies that would not be available to private insurers. Rather than stimulating competition among insurers and strengthening the health insurance market overall, the competitive advantage of a public plan would be so great that many private insurers would be pushed out of the market entirely. A crowd-out of private insurers and the corresponding surge in public plan participation would likely lead to an explosion of costs that would need to be absorbed by taxpayers.

**Similarly, if the government uses its authority to artificially hold prices below market rates (as it has done in Medicare and Medicaid), the country could see an increase in cost shifting to private carriers and providers. Cost shifting to private carriers leads to higher costs for consumers in private plans. Cost shifting to providers could result in access problems for patients if physicians can't afford to treat patients at the payment rates they receive from third-party insurers.**

The AMA agrees with the Committee that, were a public health insurance option to be pursued, several design details require careful consideration. **The AMA does not support the establishment of a “Medicare-Like Plan” as described in Approach 1.** Significant effort is being put forth by this Committee and others to address the severe flaws in the Medicare program, and there is a growing recognition that the Medicare program in its current form is unsustainable for patients, physicians, and the country. Linking payment rates for a new public plan to Medicare’s rates, even with an enhancement of 0 to 10 percent, is unacceptable given the fact that Congress and the Administration are still seeking solutions to redesign the Medicare Physician Payment system that is producing a downward spiral in physician reimbursement rates.

**Furthermore, the AMA cannot support any plan design that mandates physician participation.** Requiring all physicians and other providers to accept public plan enrollees does not recognize that many physicians and providers may not have the capability to accept the influx of new patients that could result from such a mandate. **This prospect of “overcrowding,” particularly at insufficient Medicare-based payment rates, would drive physicians to stop accepting both Medicare and public plan patients, which would produce serious access problems.** Physicians face more than a 21 percent cut in Medicare payment rates on January 1, 2010, and more steep cuts are scheduled for the coming decade under the SGR payment formula. This presents a looming crisis for Medicare patients’ access to care. Requiring physicians to also accept public plan patients at these inadequate rates would hasten and exacerbate this access crisis.

When physicians decide to accept Medicare patients, they agree to a whole host of federal requirements under that program. Presumably, a public plan would have its own set of requirements. If not, and the public plan simply follows all Medicare program rules and regulations, then it really is an extension of the Medicare program. Physicians (and other providers) ought to have the opportunity to independently decide whether they agree to a separate set of federal requirements under a public plan, rather than automatically being required to accept these requirements simply because they have agreed to accept Medicare program requirements. In addition, federal programs traditionally have never required physician or other provider participation, but rather such participation has been on a voluntary basis. This ensures that the public-private framework, which has always been a cornerstone of our health care

system, remains intact. Mandating participation would shift the balance toward a publicly-run health care system, which the AMA does not support.

The AMA also opposes the idea that a “Medicare-Like Plan” would exempt a public plan from solvency requirements. Private insurers are subject to solvency requirements in order to protect enrollees against plan bankruptcy or fraud, and the requirements serve a critical role in safeguarding patient interests. Exempting a public plan from this costly but important regulatory requirement would place private insurers at a serious competitive disadvantage. Any public plan option that is pursued should ensure that the public plan is subject to the same requirements as private plans operating in the same market.

Approach 2, “Third Party Administrator,” offers improvements over Approach 1, in that it would remove the direct link between Medicare payment rates and those under the public plan, physicians would not be required to serve as part of the provider network, and the public plan would be required to have reserve funds. However, **in the absence of additional details about physician and provider payments, regulatory and administrative requirements, and public plan access to federal funds, the AMA is unable at this time to evaluate whether Approach 2 offers a viable framework for a public plan.** If this approach is adopted, we recommend that physicians be able to negotiate rates with the Third Party Administrator that are sufficient to cover their costs of providing care to the patients enrolled in the program.

Approach 3, “State Run Public Option,” not only would compete with private insurers, but may also duplicate coverage under state Medicaid and CHIP programs. Under Approach 3, the Committee mentions the possible option of allowing individuals to purchase coverage through the state employee plans. **The AMA notes that state employee plans are not public plans; we would support expanding coverage to the uninsured by allowing individuals to “buy in” to state employee purchasing pools (or the Federal Employee Health Benefit Program).**

**The AMA strongly urges the Committee to pursue Option B, which emphasizes improvements in the private health insurance market. In a reformed private insurance market, with a health insurance exchange like the Federal Employees Health Benefits Program that provides a variety of plans from which to choose, a public plan option is unnecessary.** The AMA will work with the Committee to identify regulatory reforms in the health insurance industry that will create an environment where private insurers are able to compete among themselves on the basis of innovative products that meet consumer demand. The goal of stimulating competition should be allowing innovation and choice to flourish, which can best be achieved through the private marketplace.

## **Medicaid Reform**

The safety net provided by public programs needs to be maintained and strengthened. The AMA strongly supports helping low-income individuals obtain health insurance coverage. **There should be greater equity within the Medicaid program through the creation of basic national standards of uniform eligibility for all persons below the poverty line, and the elimination of the existing categorical requirements, which would allow for the coverage of low-income individuals based solely on financial need. With regard to the proposed option, the AMA supports Medicaid eligibility expansions to higher levels of income, but strongly prefers providing these populations with coverage options in the private sector.** The AMA supports financing the medical care portion of the Medicaid program with federally issued tax credits that are refundable, advanceable, inversely related to

income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs available through an exchange, with varying co-pays based on need.

Access to care for Medicaid beneficiaries becomes more limited when physicians cannot afford to accept them as patients. Limited access to care significantly impacts the level, frequency, and location (e.g. emergency room) of care Medicaid recipients receive, potentially resulting in increased costs and poorer health outcomes. **The AMA supports setting Medicaid payment rates at a level that encourages widespread physician participation in the program. Setting a floor at 80 percent of Medicare rates, which themselves are subject to cuts, could have unintended negative effects on access to care for Medicaid beneficiaries.**

**In terms of Options for Medicaid Coverage, we see great promise in providing health insurance through the Exchange to individuals eligible for Medicaid and accordingly oppose Approach 1. We generally support Approach 2.** We support providing the disabled, dual eligibles, and other special needs populations with the opportunity to enroll in a plan of their choice through the Exchange, and believe that their choice of plans should meet their health care needs. Accordingly, we support these populations receiving a larger subsidy to obtain coverage. Overall, individuals eligible for Medicaid need not be restricted to “Low Option” plans in the Exchange. We would oppose allowing states to create Medicaid-only plans to participate in the Health Insurance Exchange, for reasons similar to our concerns regarding the inclusion of a public plan option. We agree that individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive subsidies that are large enough to enable them to purchase coverage in the Exchange with no cost-sharing obligations. Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive a subsidy, tax credit or voucher that is large enough to enable them to purchase coverage with limited cost-sharing. For children eligible for Medicaid, we concur that children’s access to physicians at an early age is essential and strongly support EPSDT coverage in the Medicaid program.

We would also support providing premium assistance to allow individuals eligible for Medicaid to receive coverage through employer-based insurance. Providing premium assistance to these individuals would improve Medicaid’s ability to have a coordinated partnership role with existing private sector health insurance coverage, ease budgetary pressures on the Medicaid program in the process, and avoid crowd-out.

Approach 3 contains elements that are commendable. For example, the AMA supports the provision of federal tax credits to low income individuals who do not qualify for Medicaid and the elimination of categorical eligibility requirements. **The AMA would like to see an option that combines elements of Approaches 2 and 3: increase coverage of eligible individuals through the Exchange and eliminate categorical eligibility requirements.**

### **The Children’s Health Insurance Program (CHIP)**

The AMA strongly supports CHIP, which provides a critical health insurance safety net for children from low income families and has been successful in significantly reducing the number of children without coverage. A key element of CHIP has been longstanding state flexibility to establish income eligibility. While increasing CHIP income eligibility to 275 percent of FPL would provide additional families with coverage, it is questionable if it would offset the number of children who would risk becoming ineligible if income disregards were eliminated. **The AMA strongly supports the intent of the Committee to expand eligibility via the Exchange and diminish reliance on CHIP as a safety net.**

**The AMA strongly agrees that CHIP coverage should include the Medicaid EPSDT benefit.** The provision of EPSDT benefits will provide children with access to physicians and adequate preventive care services at an early age which is essential to their health and well-being.

**We support providing tax credits or vouchers to the CHIP population for the purchase of health insurance on the private market or via the Exchange.** In addition, the amount of financial assistance provided would have to be sufficient enough that coverage would be affordable. The proposed option has the potential to coordinate benefits, streamline administration, and improve access to coverage for this low-income population.

Enhancing the quality of care and patient safety by developing child health quality measures and reporting tools is consistent with the work of the AMA-convened Physician Consortium for Performance Improvement.

### **Other Improvements to Medicaid**

With respect to enrollment and retention simplification, the AMA supports providing additional resources to state Medicaid programs. We support removing Medicaid and CHIP enrollment barriers. Building off of the provisions in the Children's Health Insurance Program Reauthorization Act, **we strongly support the additional requirements proposed by the Committee to simplify the enrollment and retention processes for Medicaid.**

Regarding the proposal to give provider status to podiatrists, optometrists, and free-standing birth centers, optometrist and podiatrist services are widely covered optional services in state Medicaid programs, with most states providing coverage at some level, so this provision appears to be unnecessary. However, we have no objection to Medicaid coverage for services of optometrists, podiatrists, and free-standing birth centers as long as coverage is limited to services these providers are adequately trained and properly licensed or accredited to provide, and patients understand the scope of their providers' training and expertise.

The AMA believes that it is important for state Medicaid agencies to pay for drugs necessary to treat life-threatening and other serious medical conditions. We agree that state Medicaid programs should provide smoking cessation drugs as part of their standard benefit packages and receive federal matching funds to do so.

The AMA would welcome additional transparency in the Medicaid State Plan Amendment (SPA) process. We support mechanisms that provide the opportunity for public comment and legislative oversight prior to the submission of the SPAs to CMS. Increased transparency is especially important in SPAs that would limit benefits.

### **Dual Eligibles**

We support the proposed option to establish a new Medicaid demonstration authority of five years for exploring alternative approaches for coordinating the care of dual eligibles. Fragmentation of care for dual eligible patients does little to promote access and the highest quality of care.

### **Medicare Coverage**



**We applaud the Committee for recognizing the need to reduce the waiting period for Medicare Part A benefits for individuals receiving Social Security Disability Insurance (SSDI) benefits or other title II Social Security or Railroad Retirement benefits on the basis of disability.** We agree that reducing the waiting period to receive SSDI medical benefits is critical so disabled individuals can get the health care they need in a timely manner.

**The AMA does not support extending individuals ages 55 through 64 an option to buy-in to Medicare, even on a temporary basis.** The AMA will work with the Committee to meet the needs of this population as part of overall health system reform, perhaps through an option for purchasing private coverage through the FEHBP. In particular, we believe that the current Medicare program and financing of health care for retirees must undergo a fundamental change in order to ensure efficient and fiscally responsible access to medical services. Expanding this program even temporarily for the 55-64 population, causing a rapid uptick in enrollment as those already enrolled could stay in Medicare, would further add to Medicare's financial instability and exacerbate issues related to Medicare payment levels.

### **Promotion of Prevention and Wellness in Medicare and Medicaid**

**It is imperative that we invest in prevention and wellness to promote a healthy America. We will be unable to achieve the goals of improving quality of care and reducing the rate of growth in health care costs without such investments.** Billions in savings can be achieved through a large-scale national effort of health promotion and disease prevention to reduce the prevalence of chronic disease and poor health status, which leads to unnecessary sickness and higher health costs. Reform should include a specific focus on obesity prevention commensurate with the scale of the problem. These initiatives are crucial to transform health care in America and to achieve our goal of reducing the rate of growth in health costs. **Insurance benefit designs should be aligned with current evidence on disease prevention. Public investments are needed in education, community projects, and other initiatives that promote healthy choices.**

The proposal to expand the array and extent of preventive and wellness promotion services under Medicare and Medicaid is commendable and much needed. The use of the U.S. Preventative Services Task Force (USPSTF) and Advisory Committee on Immunization Practices (ACIP) provide widely respected and utilized guides for designation of recommended preventive services and are often used in both private and public clinical practices. **We support coverage of those preventive services that are rated "A" or "B" by the USPSTF.**

The initial preventive physical examination is a very important Medicare benefit, particularly since the amendments made in 2008 extended the benefit for a year after enrollment and waived the deductible. Combining a health assessment with a personalized plan is commendable. However, the online nature of the health assessment and its separation from a physical examination, and the lengthy gap between the assessment and development of the plan, are problematic.

A web-based or telephonic interview for the health assessment is not optimal for this older population, since they would not feel comfortable with relaying difficult personal health information and would be very suspicious of confidentiality issues. Many patients have low literacy, unfamiliarity with, or lack of access to, computers, and are likely to require assistance in filling out the assessment. Having an assessment on-line also presents numerous issues regarding confidentiality since it is unclear how this

information could be protected yet reviewed, to whom it would be sent, and who would review the information.

We are also concerned that having to wait six months before authorizing payment for a visit to a “qualified health professional” to develop a prevention plan may result in the failure to detect needed clinical intervention in a timely fashion. In addition, without the verification of a physical exam to see which health conditions may be present or not covered in the assessment raises issues regarding the accuracy and utility of the assessment. The literature on computerized health risk assessments also indicate that effective tools provide immediate feedback, assistance and connections to actual people, which is not something that can be done abstractly.

Development and implementation of a plan requires extensive interaction between the clinician and patient and is likely, for effective implementation, to require motivational counseling and ongoing monitoring/assistance. Thus the proposal needs to expand the number of (and allowed frequency of visits to) “Medicare-covered health education and preventive counseling” services and community based programs, with a particular emphasis on primary and secondary preventive services/programs. In addition, such services need to be adequately reimbursed if they are to occur. Prompting and promoting behavior change in patients can be time consuming, requires specific skills and needs to be repetitive over time. As presently structured, there is little financial incentive for primary care physicians to acquire the requisite skills and to provide such services. Evaluation and management services could be provided online and by phone, but although CPT codes have been established for such “non-face-to-face” services, Medicare currently does not cover such services. We urge that this be changed.

Personalized prevention plans should be authorized annually, not once every 5 years. Assessment of modifiable risk factors should focus on behaviors rather than statistics like weight, and include, at a minimum, assessment of tobacco and alcohol use and dietary and physical activity habits, which are the leading underlying causes of mortality and morbidity in the U.S. in adults. Immunizations for those over 65 provide well-documented preventive health benefits. However, the placement of vaccine payment within Medicare Part D—excepting influenza, pneumococcal, and hepatitis B vaccines—creates barriers to immunization. It would be best if all ACIP-recommended vaccines were covered under Medicare Part B.

With regards to immunizations, we recommend utilizing the ACIP recommendations as the standard for coverage rather than those of the USPSTF. Indeed, immunizations are such a proven high value preventive intervention that where appropriate, immunization should be a covered benefit by default. All health plans should cover all ACIP-recommended vaccines and should include first-dollar coverage.

Removal or limiting of cost-sharing for clinical preventive services is a positive step, as is the consideration for incentives to patients to improve their health. Requiring that these be widely available and easily accessible needs to be followed up with sufficient funding to establish and sustain such community programs.

### **Options to Prevent Chronic Disease and Encourage Healthy Behaviors**

**In order to achieve many prevention and wellness promotion objectives, public health and community strategies are also of vital importance and in many cases positively affect larger populations than do clinical services. Therefore, consideration should be given to public health/population level prevention and wellness services, programs, and strategies that can reduce**

**or complement the need for some clinical services.** The Community Guide for Preventive Services, managed by the Centers for Disease Control and Prevention, provides one opportunity to examine this although the Community Guide Task Force (CGTF) is a voluntary, private sector initiative with limited resources. Consideration should be given to strengthening the ability of that task force through the CDC to expand its capacity to identify effective services and to look at how community services may complement clinical services identified by the USPSTF.

The proposed “Prevention and Wellness Innovation Grants” option should encourage states to look at implementing the array of USPSTF recommendations in public health clinical settings supported by public health dollars and implement measures recommended by the CGTF. This should also be part of the identification of best practices and integrated services.

The recommendation to promote team care targets a major gap in preventive services. However, procurement and management of these teams will require reimbursement and payment strategies that allow for an array of types of professional services (medical, non-medical) and a system so that the entire burden for smooth transition from one service to another is not placed primarily on the patient/recipient of services. Since services are likely to combine medical/clinical, community, non-medical services and public health activities/services, states should be encouraged to take a very different approach to planning than is currently the case where public health services are treated completely apart from medical/clinical (and in some cases even community) services. Without a more coordinated superstructure, the burden on any one practitioner could be overly burdensome and result in tremendous duplication of effort. Physicians do not know and usually do not have the time to identify, connect to, and assess the value of a wide array of community services—and vice versa for health departments and community services.

### **Long-Term Care Services and Supports**

The AMA strongly supports reform of long term care services. The Medicaid program should provide services in the most appropriate settings based upon the individual's needs, and provide equal access to community-based attendant services and supports. **The AMA supports the option of allowing states to seek approval for additional services under Section 1915(i).**

We also support the concept of streamlining eligibility criteria for section 1915(c) waivers. However, **the AMA believes that persons with incomes and assets above Medicaid eligibility should be provided with sliding scale subsidies to purchase long-term care coverage.**

The AMA supports the concept of increasing access to Medicaid HCBS for low-income individuals and believes that states should have the ability to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping of federal funds. We support the proposed option to increase the federal match for HCBS, as it would help to ensure that with Medicaid there is a choice for patients to meet their long-term care needs.

### **Health Disparities**

The AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and a barrier to effective medical diagnosis and treatment. Eliminating such disparities is one of our highest priorities. **We support the Committee's proposals to standardize and expand the methods federal health programs use to collect data on race and ethnicity, as well as increased**

**funding for such activities.** We recommend that the Social Security Administration be required to collect information on race.

The AMA is committed to the importance of culturally sensitive health care in eliminating health disparities, including proper communication for limited English proficient patients. However, we believe that requiring physicians to pay for written and oral interpretive services for patients threatens their access to care because often the interpretive services are more expensive than the reimbursement for the physician care provided. This creates a disincentive for a physician to treat such patients. **We urge the Committee to include language interpretive services as a covered benefit for all health plans, rather than having physicians bear the cost of these services.**

We also support increased funding to reduce infant mortality, as well as the proposal to allow states the option of waiving the five-year waiting period for non-pregnant, legal, immigrant adults.