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SECOND THOUGHTS

What the ACA Should Have Included—Physician Perspectives at the University of Pennsylvania

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Many feel that the United States health care system is unstable, unsustainable, and broken in numerous ways. The largest health care overhaul in decades, the Patient Protection and Affordable Care Act (ACA) was passed and implemented in 2010 [1]. Professional medical organizations have come out in support of the act, but the degree to which organizations other than the American Medical Association (AMA) were consulted in crafting the bill is murky at best [2]. And what about doctors themselves? The vast majority of physicians feel that the AMA doesn't effectively represent them [3]. A Physician's Foundation survey in 2012 found over 82 percent of doctors agreed that "physicians have little influence on the direction of health care and have little ability to affect change" [4]. Physicians whose lives and practices are profoundly affected by health reform policy do not feel they have a say about which issues are important and how best to solve them. It's time for them to be a part of the debate.

To begin elucidating physicians' point of view on health care reform, researchers in the University of Pennsylvania hospital system polled medical school faculty over the past several months, asking the following question: "If you could spend the next year solving a problem in the US health care system, what would it be and why?" The open-ended question allowed physicians to select the problems they thought most pressing, and the concrete time frame encouraged responses that were relevant and timely from a policy perspective.

Survey Respondents

A total of 460 medical school faculty members (out of a faculty body of 2,192) at the University of Pennsylvania (UPenn) who had interacted with preclinical medical students over the prior 16 months were polled. The response rate among physician faculty members was 53 percent (244). Of the respondents, 3 percent were primary care physicians (internal medicine, pediatrics, family medicine), 10.8 percent were in surgical specialties, and the rest were in other specialties, with more than 50 specialties represented. The faculty status of physician respondents is displayed in table 1.

Survey Results

The top problem areas identified by respondents to the survey are shown in figure 1.

Table 1. Faculty status of physician respondents

Faculty status	Percentage
Assistant professor	31.3
Professor	29.7
Associate professor	22.6
Instructor	3.7
Adjunct professor	1.9
Other	10.8

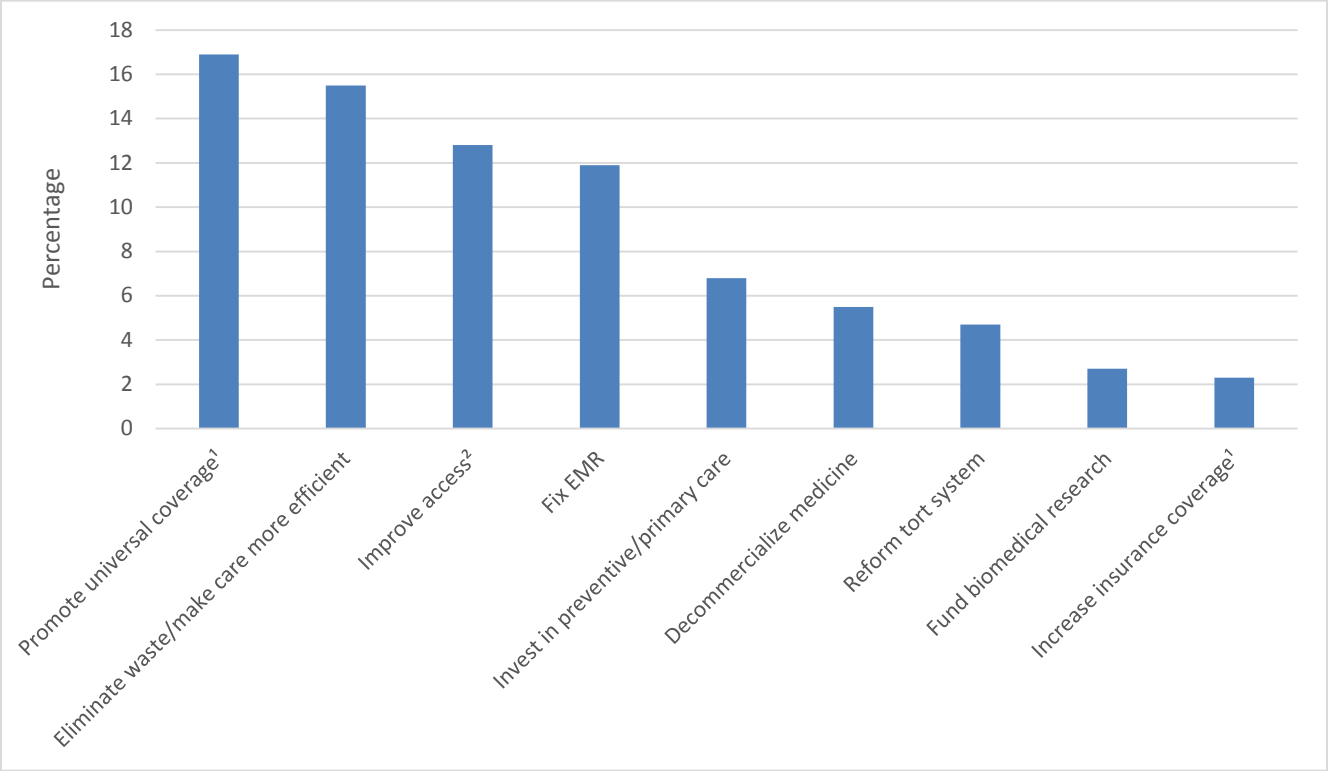

Figure 1. Top health care problem areas identified in the UPenn physician survey.
Notes: [1]coverage refers to financial affordability as defined by WHO [5]; [2]access is defined as the availability of resources and physical accessibility.

A comprehensive list of the UPenn physicians' goals for health care reform was created by this author from the survey responses and appears in table 2.

Table 2. The UPenn physician action list

Increase access to care for patients—specifically low-income, disadvantaged, and elderly patients
Focus on preventive medicine and increasing primary care availability.
Improve patient education about preventive lifestyle measures and the complexity of the medical system.

Make major changes to insurance structure Decouple insurance from employment. Investigate moving to a single-payer system. Educate the public about the economics of insurance and the need for everyone to pay a share of the costs. Increase coverage, most prominently for mental health services. Hold insurance companies accountable for paying for treatments that work. Simplify the bureaucracy so doctors don't spend so much time dealing with insurance companies.
Fix the EMR (electronic medical record) Enable EMRs used in various institutions to communicate with one another. Create an EMR that won't curtail physician-patient interaction or place a burden on physician time.
Remove third-party control over patient care Prohibit requiring pre-approval from insurance companies for most treatments so that they are no longer an obstacle to care. Eliminate counterproductive government regulations. Mitigate commercial and political influence over the practice of medicine.
Fundamentally change the way we treat physicians Reward value, not volume. Stop the practice of "speed medicine"—give clinicians more time with their patients. Ensure government policymakers and hospital administrators value and respect physicians.
Abolish the culture of defensive medicine Reform the tort system to allow physicians to practice medicine without fear of frivolous litigation.
Make costs transparent Elucidate costs and standardize reimbursements. Simplify insurance reimbursement structure because understanding costs and insurance requires more time than physicians believe they have. Educate physicians about simplified reimbursements. Require that physicians factor costs into treatment plans.
Eliminate waste Eliminate unnecessary care/change the culture of defensive medicine. Use evidence-based standards to identify the best available interventions and treatments. Become better stewards of scarce resources. Spend more money on research to innovate and replace costly and inefficient technologies. Elucidate patient goals better, especially end-of-life care goals.

It's worth noting that most of the responses to this survey aren't new ideas. The plurality of responses concerned increased or universal insurance, which is the main goal of the ACA. But if just these physicians had been involved in framing health care policy, the ACA's other important goals and the subsequent public response to their implementation might have looked very different.

Below are three specific examples of proposals, based on survey responses, for tackling issues physicians felt were poorly addressed by the ACA.

Consider Both Quality and Cost in Treatment Guidelines

Analysis. Use of evidence-based medicine and research into costs of treatment were favored by 16.8 percent of respondents. Physicians indicated that information about quality and outcomes (as determined by comparative-effectiveness research) ought to be used when deciding treatment regimens but that cost was also a necessary factor. Essentially, rather than pure cost effectiveness research or comparative effectiveness research, physicians recommended research into value: the integration of the two.

Cost and comparative effectiveness solutions are an integral part of the future of health care, given their ability to provide insight into evidence-based medicine that better applies our existing resources and limits use of unnecessary treatments [6, 7]. The ACA did include measures to promote comparative effectiveness research but forbade the consideration of cost in Medicare payment considerations [8]. It also went a step further and prevented the Patient-Centered Outcomes Research Institute (PCORI) from doing any cost effectiveness research at all [9]. Politically, cost effectiveness research has been linked to the unpopular idea of rationing care and has therefore become unpopular itself [9]. However, the doctors polled in this survey felt that eliminating cost from the equation would not curb rationing, which would still happen through unequal distribution of resources—favoring overprescription of low-value treatments for those who have means and access at the cost of providing health care to those who do not.

Proposal. The surveyed physicians' responses indicate that collecting evidence about the value of health care interventions to improve the delivery of care should be prioritized. PCORI should be allowed to be cognizant of costs and to publish them in recommendations for treatments of comparable safety and efficacy. Standards to prove comparable efficacy should be rigid, but the costs of treatments that meet them should not be ignored. Translating these findings into reimbursement policies is a complicated step to come later, but at the very least research organizations ought to investigate costs (as opposed to what patients are *charged* or billed) and publish that information. Physicians could help explain the benefit of value-based medicine to politicians and the public, which could make the idea as palatable as comparative effectiveness research has become with physician endorsement [9].

Analysis. Of survey respondents, 10.9 percent would have spent the next year fixing the Medicare EMR incentive program. The ACA provided incentives to physicians for engaging in the "meaningful use" of electronic health records—i.e., using them to record and transmit patient information, track treatments and outcomes, and support clinician decision making—before 2015. The meaningful use program sets baseline requirements for EMR systems, including compliance with HIPAA (the Health Insurance Portability and Accountability Act) and the ability to extract data for research and quality improvement purposes, among others. Clinicians who do not participate in or fail to meet standards will receive reductions in Medicare payments starting in 2015 [10].

By promoting early adoption of improperly designed existing EMR systems, policymakers emphasized speed over sustainability and usefulness; trying to implement changes to an already inefficient EMR system is much harder than starting with an efficient EMR system (which is why many hospitals that are due to meet meaningful use Stage 2 standards have applied for hardship exemptions and why so few have met those standards today [11]). Respondents to the survey would have preferred adopting a better-designed EMR, even at the cost of a delay.

Of the physicians who wanted to fix the EMR, 83 percent reported having problems using the in-house EMR to communicate with external EMR systems. Printing, scanning, and then emailing a note to be placed in a patient record in another system (as physicians do daily at UPenn) satisfies meaningful use Stage 1 standards, clearly showing that meaningful use can be achieved with subpar systems [12]. But merely satisfying meaningful use Stage 1 standards could, according to all survey respondents, lead to duplicate tests because of time constraints or inadequate patient hand-offs between clinicians due to poor communication.

Most importantly, meeting these meaningful use standards is tied to Medicare payouts, with hospitals possibly seeing up to a 5 percent reduction in payments for failing to participate or meet the standards [9]. Hospitals and doctors have a short time to make their software compatible with the standards and may succeed at the risk of increasing costs and reducing quality. Concurrently, EMR companies are reaping billions in profit from health information technology laws [13].

Proposal. Meaningful use standards should be delayed by two to three years, and EMR manufacturers should be tasked with creating a superior product, a major requirement of which would be the capacity for universal exchange of information across EMR systems. A failure to create such a product should result in exclusion from the program and thus falling profits. These consequences would give EMR manufacturers a compelling incentive to conduct thorough market research and ensure systems are adopted with appropriate goals in mind.

Minimize Counterproductive Regulations

Analysis. Of survey respondents, 12.7 percent favored removing the influence of third parties, most commonly insurance companies and regulation related to insurance policies. An example is provided below.

The Hospital Readmission Reduction Program (HRRP) reduces Medicare payments for each patient readmission within 30 days that exceeds the national average for five conditions—heart failure, heart attack, pneumonia, chronic lung problems, and elective hip and knee replacements [14]. The idea was to encourage hospitals to increase follow-up and coordination of care to avoid preventable readmissions [15], certainly a noble goal.

The ACA also contains the "two-midnight rule," which redefines how a patient is classified as an inpatient (someone whose condition is expected to require two nights in the hospital), a status with higher reimbursement rates than those for outpatients [16]. The Centers for Medicare and Medicaid Services (CMS) implemented policies that would allow auditors to deny payment for hospitalization if they disagreed with the hospital's classification of an inpatient [17]. These policies, when combined, allow insurers to avoid a significant number of payments, and a coalition of hospitals and the American Hospital Association are suing the Secretary of Health and Human Services (HHS) on the basis that this avoidance violates the Administrative Procedure Act [18]. Although asking physicians to justify their classification of patients as "inpatient" is also a noble goal, it's unclear if this rule's effects achieve the desired outcomes.

Insurance companies' unwillingness to pay the higher inpatient rates has influenced the way in which the surveyed physicians practice; 62.5 percent of survey respondents who favored removing the influence of third parties identified insurance companies as one such unwelcome influence. This could get in the way of the thorough admission care HRRP intends. Based on the procedures CMS has implemented and the fact that insurance companies can retroactively rescind payments, it is reasonable to suppose that the burden on physicians to fight insurance companies will only increase. The lawsuit shows that many hospitals have already found these regulations unfair and unwelcome.

Proposal. A concerted effort should be made to understand the consequences of policy implementation on care delivery and workflow and avoid unintended consequences by involving physicians in decision making. In this particular case, physician input should be used to replace the two-midnight rule with a more productive policy, given the conflicts in testimony about its effectiveness and the lack of evidence backing its implementation [19] as well as its harmful effects on the HRRP program. Physicians' input would also help in determining metrics that significantly impact readmission rates, unlike the

current measures [20]. If improperly implemented, the HRRP program could increase defensive medicine practices and unnecessary tests on first admission. If properly implemented, the HRRP program could be a powerful force for improved outcomes and reduction of unnecessary care.

Looking Toward the Future

This paper has shown that physician input can generate actionable policy recommendations and add to national discourse in a substantial way.

This survey of UPenn physicians is clearly not representative of the nation, but we do not yet know whether or how UPenn deviates from the national workforce. First, how do academic physicians' opinions about health care reform differ from those of private practice physicians and hospitalists? Given that physicians who advise on research and policy tend to be concentrated in academic medical centers, it's important to understand how their point of view differs from that of the majority of physicians. Second, how do specialists differ from primary care doctors? Third, how do regional differences affect preferences for reform? Finally, how do political affiliations drive opinions on health care delivery? Answering these questions can help inform state Medicare and Medicaid policies as well as drive understanding of the practical implications of national policy implementation.

Nevertheless, this survey is a necessary first step in determining what reforms physicians want to undertake, for two reasons. First, although listening to the individual opinions of the more than 800,000 professionally active physicians in the US [21] is not possible, sampling different groups of physicians on major health care issues creates an opportunity for physicians to proactively inform regional and national health policy. Secondly, although the issues raised by the UPenn physicians are not new—in fact, the ACA touched on many of these, like cost transparency, cost control, and boosting the primary care workforce—it is unclear whether or not these problems were *appropriately* addressed by the ACA. As in the case of EMRs, solutions created without physician input can be suboptimal. It behooves the federal government to consult physicians so that its resources are used in the most practical way.

Despite UPenn's position as a hospital system at the forefront of policy recommendations and research with an Innovation Center dedicated to involving physicians, many of those polled communicated that this was the first time they had been asked to think about what *they* wanted to change about health care. In such a high-stakes debate, the lack of input by physicians at such an institution is troubling. First, the government and the AMA should systematically and comprehensively investigate how US physicians in different regions, specialties, and practices across the nation feel about a variety of important health care issues. Second, policymakers should make a concerted effort to proactively work with physicians to craft bills that successfully solve issues they

identify as important. The cost of health care is a massive drain on our economy and our families—not taking into account or understanding the views of such a main player in the industry significantly hinders progress and needs to change.

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