

# Federal Health Policy Hall of Shame and AAPS Advocacy Hall of Fame

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The last 75 years have seen exponential growth in government interference in American medicine. The result has been soaring costs and decreased quality and access. AAPS was founded to help fight back, and has unceasingly done so. Our members have helped win big battles along the way, and even the losses have given the opportunity to shine a light on real solutions that respect the American tradition of freedom. To help commemorate our first 75 years, we've created this timeline of notable policy battles and AAPS efforts to keep the flame of liberty in medicine alive:

**1942:** Wartime wage controls enabled widespread growth of employer-sponsored third-party payment for medical services by providing fringe benefits to workers, distancing the patient from the cost of medical care. IRS rulings clarified, and Congress later legislated, that employees were not required to pay tax on the dollar value of these employer-paid group health-insurance premiums.<sup>1</sup> AAPS has steadfastly advocated for tax fairness: "Individually owned policies should receive the same tax treatment as employer-owned policies... Out-of-pocket payments should receive the same treatment as insurance premiums."<sup>2</sup>

**1943:** The Emergency Maternal and Infant Care program (EMIC) for the families of low-ranking servicemen was the largest expansion of public health programs to date. AAPS warned that this "temporary war measure... provided an entering wedge for federal control,"<sup>3</sup> and recommended that "doctors as individuals should accept the responsibility of caring for families of servicemen and on terms acceptable to the patients... as your just share of the burden in the defense of Freedom."<sup>4</sup>

**1943:** The Wagner-Murray-Dingell bill was first introduced, providing for comprehensive health insurance under Social Security. AAPS was founded in the same year, with a founding objective of "the decisive defeat of the Wagner-Murray-Dingell Bill."<sup>5</sup> Congress took no action on the bill — which was introduced in 14 sessions.

**1944:** President Franklin Roosevelt's State of the Union message outlines an "economic bill of rights," including "the right to adequate medical care and the opportunity to achieve and enjoy good health." AAPS has consistently taught that medical care is not a right, and about the consequences of pretending it is.<sup>6</sup>

**1946:** The Hill-Burton Act, a "one grant" postwar emergency measure "perpetuated by successive Congresses" provided government subsidies to construction of hospitals, laying the groundwork for decades of government-granted special favors for these institutions, to the detriment of less expensive independent office-based care.<sup>7</sup>

**1954:** Hill-Burton was expanded to establish and subsidize hospital diagnostic-treatment clinics. "[A]nother form of socialized medicine whereby the hospital, financed by the government, will assume the dominant role in diagnosing and treating illnesses," predicted AAPS.<sup>8</sup>

**1954:** Disability benefits were included in the Social Security Act. AAPS foreshadowed further expansion: "If permitted to remain in the law, the provisions will place physicians who certify to the medical disability of workers covered by Social Security in the unsavory position of government-paid and controlled practitioners."<sup>9</sup>

**1960:** The Kerr-Mills bill (Medical Assistance for the Aged) enacted "federal subsidies to states which institute their own programs to help aged persons meet medical expenses," reported AAPS as it warned against "passage of any type of federal medical care bill that provides unconstitutionally for more federal interference with the states."<sup>10</sup> AAPS further noted that while the bill, H.R. 12580, "is less objectionable than other measures to provide more expensive medical and hospital care for the aged under the actuarially unsound system of Social Security, we cannot in good conscience support [it]. To do so would be an attempt to compromise principles. The provision of medical care at the federal level is constitutionally and morally wrong."<sup>11</sup>

**1965:** Medicare and Medicaid were enacted along with the "promise," in Section 1801, that government would not interfere in practice of Medicine. True to its principles, AAPS launched a campaign to encourage "non-participation" by the nation's 200,000 practicing physicians—"a plan to save quality medical care for patients and to save medical freedom for both patients and physicians."<sup>12</sup>

**1969:** IRS removed the requirement that nonprofit hospitals offer a portion of care without charge or at rates below cost. The "Community Benefit Standard" gave a further competitive advantage to hospitals that was not available to independent physicians.<sup>13</sup>

**1972:** Professional Standards Review Organizations (PSROs) were established in the Social Security Amendments of 1972 as the "first national quality-assurance system administered as a part of Medicare itself."<sup>14</sup> AAPS warned that PSROs, "would force physicians to justify their medical decisions to federal employees and conform to governmentally dictated standard... without regard to the uniqueness of each individual."<sup>15</sup> *AAPS v. Weinberger* challenged the constitutionality of the act creating PSRO. A three-judge panel in the U.S. District Court for the Northern District of Illinois upheld its constitutionality, and the

Supreme Court denied further review.<sup>16</sup> The AMA was complicit: "Under one million-dollar contract, AMA will develop standards of diagnosis and treatment and...also split \$2.8 million with other organizations to train PSRO personnel."<sup>17</sup>

**1972:** Medicare eligibility was extended to 2 million individuals under age 65 with long-term disabilities (after a 24-month wait) and to individuals with end-stage renal disease (ESRD). Medicare was given the authority to conduct demonstration programs, including capitation payments for services covered under Parts A and B to "Health Maintenance Organizations."<sup>18</sup> AAPS warned, "One of the effects of this language is to prefer HMOs over regular fee-for-practice and permit them to keep a percentage of the 'profits' by short-changing unsuspecting members."<sup>19</sup>

**1973:** The Health Maintenance Organization Act of 1973 subsidized the growth of HMOs and enacted other policies to increase adoption of this flawed model, including mandating employers who offer insurance to include an HMO. AAPS noted that this Act would "make discrimination against private medicine public policy of the federal government.... Enormous opportunities will open up for the unscrupulous to set up HMOs with premeditated intent to harvest huge profits by giving the least service possible at the highest capitation fees the traffic will bear."<sup>20</sup>

**1976:** Medicare launched the HMO demonstration projects authorized by the Social Security Amendments of 1972.<sup>21</sup>

**1977:** The Health Care Financing Administration (HCFA, later rebranded the Center for Medicare and Medicaid Services or CMS) was created. The expansion of the federal health-related bureaucracy necessitated this new branch of the Department of Health, Education, and Welfare (HEW) to administer the Medicare and Medicaid Programs separately from the Social Security Administration.

**1979:** The Department of Education Organization Act created a separate Department of Education. The Department of Health, Education, and Welfare (HEW) became the Department of Health and Human Services (HHS) on May 4, 1980.

**1980:** Federal oversight begins for Medicare private supplemental insurance ("Medigap"). In the early 1980s, Medicare eligibility was expanded to federal employees, nonprofit organization employees, and the self-employed.

**1981:** Disproportionate Share Hospitals (DSH) payments were created by the Omnibus Budget Reconciliation Act of 1981 (OBRA 81). OBRA 81 repealed a requirement that states pay Medicare hospital payment rates, and allowed states to make additional payments to hospitals serving a disproportionately large share of Medicaid and low-income patients. Although the first "Omnibus" amalgamation of appropriation measures passed in 1950, the use of behemoth budget and appropriations bills as a means to sneak through sweeping legislation accelerated in the 1980s.<sup>22</sup> This practice facilitates "suspension of the usual procedural boundaries," "gaudy earmarks and tailor-made rule-changes benefiting favored interests."<sup>23</sup>

**1981:** Medicaid Managed Care was expanded by OBRA 81. Before the waivers that were allowed under this statute, less than one percent of the Medicaid care population was enrolled in managed care. From 1999 to 2012, the share of Medicaid beneficiaries enrolled in managed care grew from 64 to 89 percent.<sup>24</sup> In a letter to AAPS, Utah Republican Sen. Orrin Hatch touted: "We have just completed the budget reconciliation process and have legislatively directed many changes in the handling of major health programs. These changes include block granting of 15 categorical programs to enable states to better target and administer their health resources." Sen. Hatch continued: "My plans in the upcoming legislative agenda include exploring avenues for encouraging competition within the health care community to reduce health costs. I plan on holding hearings to discuss and debate ways of infusing greater market competition in our nation's health care system."<sup>25</sup>

**1982:** Medicare Price Caps and Controls were legislated. Following double-digit average growth in Medicare hospital spending during the 1960s and 1970s, the Tax Equity and Fiscal Responsibility Act (TEFRA) was enacted. "Many of the cost caps and restrictions on providers will only serve to aggravate the already severe problem of cost shifting to private patients," predicted AAPS. TEFRA also brought other unwelcome changes, such as expanded use of HMO agreements, reduced ability for individuals to deduct medical care, and curtailing of drugs the government determines are "ineffective." "In whole or in part, this is a dumb, dumb bill," concluded AAPS.<sup>26</sup>

**1982:** The Peer Review Improvement Act of 1982 (rolled into TEFRA) rebranded Medicare's PSRO "quality assurance" structure by deleting the "S" [Standards] and creating "Peer Review Organizations (PROs)" that would review medical necessity issues and appropriateness of care, and conduct physician office site reviews. "The same as PSRO with a different name," reported AAPS News. AAPS member Rep. Ron Paul, M.D., (R-Texas) testified against the bill, saying: "Proponents of S. 2142 have claimed that it is designed to help deregulate PSROs, by allowing the government to contract the PSRO function out to the private sector. However, I believe this is a distinction without a real difference. After all, what real difference does it make whether the federal government contracts out the enforcement of harmful regulations, or undertakes the enforcement on its own? The taxpayers are still stuck with the bill, physicians must still comply with government edicts or face sanctions, and all enforcement decisions still reside with the Secretary of Health and Human Services."<sup>27</sup>

**1983:** Price controls on Medicare hospital services were expanded. The Social Security Amendments of 1983 extended controls on hospital payment launched by TEFRA to all hospital Medicare patients. "In so doing, the system of payment to hospitals was changed from a cost-related payment system to a prospective payment system (PPS)," based on diagnosis (Diagnosis Related Groups or DRGs), reported AAPS. Because payments are irrespective of the intensity of the actual service provided, the PPS provided incentives to reduce the kinds or amounts of services provided, or patient length of stay. AAPS attorney Kent Masterson Brown concluded: "Therefore, AAPS's long-standing position that hospitals should not take

assignments under Medicare, but bill the patient directly was obviously good advice for hospitals, as those direct billing hospitals may now be able to be exempted from the DRG payment system.”<sup>28</sup>

**1983:** The American Medical Association entered an agreement with HCFA for AMA Current Procedural Terminology (CPT) codes to become the sole code set for Medicare and Medicaid physician services.<sup>29</sup> It is estimated that AMA’s royalty revenue outpaced dues by more than \$200 million from 2008 to 2015.<sup>30</sup>

**1984:** Information was standardized. HCFA required providers to use the HCFA-1500 to submit Medicare claims. The HCFA Common Procedure Coding System (HCPCS) (now called Health Care Procedure Coding System) was created, which included CPT.

**1984:** A “temporary” Medicare physician fee freeze was enacted. To control years of double-digit growth in Medicare Part B expenditures, Congress imposed a “two-year” freeze on Medicare physician fees. The temporary freeze was succeeded by a permanent price-control scheme based on the concept of a relative value scale (RVS). AAPS members, Atlanta surgeons Douglass Whitney, M.D., and W. Daniel Jordan, M.D., launched a lawsuit, *Whitney v. Heckler*, challenging the constitutionality of the law. The U.S. Court of Appeals for the Eleventh Circuit did not find the fee freeze unconstitutional, but noted that physicians are not required to choose between complying and violating the policy in order to obtain judicial review.<sup>5</sup>

**1986:** The Emergency Medical Treatment and Active Labor Act (EMTALA), passed as part of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (signed in 1986), required hospitals participating in Medicare that operated active emergency rooms to provide appropriate medical screenings and stabilizing treatments, without ascertaining the existence of a source of payment. *AAPS News* reported: “This statute, better known as the ‘patient dumping’ statute...authorizes civil suits against hospitals by patients alleging violation of the statute and harm due to the alleged violation. It also authorizes HHS to terminate hospitals’ participation in Medicare and to assess civil monetary penalties against physicians and hospitals that violate the statute.”<sup>31</sup>

**1986:** States are now required to cover treatment of emergency medical conditions for certain illegal immigrants, another provision tucked into COBRA. “As the smoke cleared over Congressional budget reconciliation skirmishes, a final count showed that COBRA had made more than 50 changes in provisions of the Medicare law,” including extension of the physician payment freeze, reported AAPS.<sup>32</sup>

**1986:** The Group Purchasing Organization (GPO) Anti-Kickback Statute exception (“safe harbor”) was enacted as part of the Omnibus Reconciliation Act of 1986, paving the way for abuse of rebates paid to GPOs by manufacturers of medical supplies and drugs. The safe harbor was strengthened by the “Medicare and Medicaid Patient and Program Protection Act of 1987” and corresponding federal regulation.<sup>33</sup> AAPS is advocating for repeal of this measure (see below).

**1986:** The Health Care Quality Improvement Act (HCQIA) gave significant legal immunity to peer review processes, facilitating retaliation against physician whistleblowers. “Nearly 30 years later, the immunity provided by HCQIA has resulted in rampant and widespread abuse of the peer review process for purposes having nothing to do with professional competence or conduct,” warned Lawrence Huntoon, M.D., Ph.D. in 2015.<sup>34</sup> The National Practitioner Data Bank (NPDB) was created in the same bill.

**1988:** The Medicare Catastrophic Coverage Act (MCCA) expanded hospital, home health, skilled nursing facility, outpatient drug benefits, and other new “catastrophic coverage” for the elderly, to be funded by higher Part B premiums. AAPS opined: “As is usually the case, the political pressures are to confer small benefits on large numbers of people rather than to meet the genuine need of a few.” AAPS also explored innovative alternatives: “The Health IRA concept is being increasingly seen by health care policy analysts as a promising approach to providing catastrophic illness coverage for the elderly.”<sup>35</sup> After massive complaints about higher premiums, the law was largely repealed in 1989;<sup>36</sup> provisions requiring states to cover Medicare cost-sharing for Medicaid enrollees remained.

**1988:** The Clinical Laboratory Improvement Act (CLIA) was enacted. Congress did this “in response to public furor about one or more deaths attributed to false-negative Pap smear readings,” AAPS reported.<sup>37</sup> AAPS President Albert Fisher, M.D., urged Congress in 2018 to consider repeal because “access to timely, high quality care for millions of Americans has been compromised by decreased access to clinical laboratories in doctors’ offices.”<sup>38</sup>

**1989:** International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) reporting was mandated. Medicare began requiring physician offices to submit ICD-9-CM codes with each claim. After initially being rejected, the provision reappeared in the final version of the MCCA, through a “back door” process,” reported AAPS. The codes “would be available for immediate use for utilization review of physician services...and could be used in the future to facilitate drug utilization review.”<sup>39</sup>

**1989:** The Omnibus Reconciliation Act of 1989 (OBRA 89) required states to cover services provided by federally qualified health centers (FQHCs) and made generous startup grants of \$650,000 per clinic. AAPS past-president, Alieta Eck, M.D., reports that “their Form 990s tell a story of profligate spending, of highly paid executives and well-endowed bank accounts used for travel, ‘recruitment,’ and consultants.... One such clinic takes in \$14 million in taxpayer funds and spends \$160-\$280 per patient visit—for charity care.”<sup>40</sup> In comparison, Dr. Eck’s true charity clinic sees patients at a cost of \$15 per patient.

**1989:** HEDIS, the HMO Employer Data and Information Set, was developed by the National Committee for Quality Assurance (NCQA). Later rebranded as the Healthcare Effectiveness Data and Information Set, HEDIS created standards to assess managed-care systems using data elements that are collected,

evaluated, and published. The burden of collecting and submitting the data fell to physicians and would later be used to as a “pay for performance” measure to reward or penalize doctors for scores tied to HEDIS metrics.<sup>41</sup>

**1990:** The Stark I law, enacted in the Omnibus Budget Reconciliation Act of 1990 (OBRA 90), placed limits on physicians’ referring Medicare patients to clinical laboratories in which their physicians, or physicians’ family members, have a financial interest. At our annual meeting in 1990, AAPS nominated Rep. Pete Stark (D-Calif.) for “Bureaucrat of the Year” for progress in bringing all physicians under federal control.<sup>42</sup>

**1990:** OBRA 90 required states to pay Medicare premiums for Medicare beneficiaries with incomes between 100 and 120 percent of the Federal Poverty Level (FPL), called special low-income Medicare beneficiaries (SLMBs). Regulation of Medigap plans was also increased.

**1990:** The Mandatory Medicare Claims Filing Requirement required physicians to submit claims and further removed patients from involvement in payment for care. This provision was passed in OBRA 89. To this day, there remains ambiguity as to “whether a physician becomes subject to the mandatory claims filing requirement simply by serving a patient who is enrolled in Medicare,” whether or not Medicare payment is sought. AAPS remains one of the only organizations advocating for the rights of patients and doctors to work together outside of federal oversight.<sup>43</sup>

**1991:** The 27 percent annual spending growth in Medicaid in 2 years prompted the Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991, limiting the federal funds matching of revenues from provider donations and provider taxes as the state share of Medicaid expenditures. It also placed a national ceiling on Medicaid special payments to DSH hospitals. However, incentives remain for states to “game the Medicaid system.”

**1992:** Medicare implemented the Resource-Based Relative Value Scale (RBRVS) in OBRA 90 to set price controls on physicians’ services. The charge-based system of “usual and customary” fees was replaced with a scale based on physician work, practice expense, and malpractice insurance expense, as determined by government in conjunction with the AMA’s RVS Update Committee (RUC). The RBRVS “considers only the producer and completely neglects the consumer,” AAPS said. “Nowhere does the calculation of ‘relative value’ consider the most important factor: the benefit to the person who purchases the goods or services. The RBRVS schedules, if used at all, should only be used to determine reimbursement, not to dictate what physicians may charge. The proper fee in all cases is the one that physician and patient agree is just and reasonable.”<sup>44</sup> Medicare also set a physician balance billing limit for nonparticipating physicians at 15 percent above the new RBRVS-set fee schedule, as authorized by provisions enacted in OBRA 89. AAPS physicians fought back, bringing a lawsuit led by AAPS past-president Lois Copeland, *Stewart v. Sullivan*, in which she and her patients sued to protect their rights to physician care on mutually agreeable terms.<sup>45</sup>

**1992:** Medicare’s Health Care Quality Improvement Initiative (HCQII) was the next iteration of the PRO. “The HCQII moved from concentrating on individual clinical errors to analyzing patterns of care and outcomes as the means toward monitoring and improving mainstream health care.”<sup>14</sup> HCQII helped increase the growth of clinical practice guidelines, “quality-improvement projects,” and “the evolution of new data systems.”<sup>14</sup>

**1993:** The Clinton Health Care Task Force was formed. It culminated in the generation of the Health Security Act, a bill that “demands the forfeiture of our freedom, and subjugation of patients and physicians to the dictatorship of a National Health Board.”<sup>46</sup> AAPS challenged the secrecy of the task force composition and meetings in a federal suit, *AAPS v. Clinton*. U.S. District Judge Royce Lamberth ordered that the Task Force must comply with Federal Advisory Committee Act (FACA) rules. Eventually 250 boxes<sup>47</sup> of records were released and AAPS “engaged in a complete review of the documents” that uncovered, for example, a memorandum to White House Health Care Task Force member Walter Zelman of the California Department of Insurance from Douglas Letter, Appellate Litigation Counsel in the Civil Division of the U.S. Department of Justice.<sup>48</sup> The “Zelman memorandum” outlines strategies for the use of public-private partnerships in circumventing constitutional challenges to government medical rationing.<sup>49</sup> The sunshine that AAPS helped shine on the Clinton Plan was instrumental in stopping this attempt at a federal takeover of medicine.

**1993:** The “Stark II” amendments to the Omnibus Reconciliation Act of 1993 (OBRA 93) were enacted. AAPS reported: “The law expands the Stark I ban on Medicare referrals to clinical laboratories in which physicians have a financial interest to many other services, including physical and occupational therapy, durable medical equipment, and inpatient and outpatient hospital services. Any misunderstanding of the law could lead to significant penalties. There are no proposed regulations for Stark II and no final regulations for Stark I. After thousands of hours of scrutiny of the law and the legislative history, many physicians have been unable to determine how or whether the law applies to them.” AAPS advised physicians to ask their congressional representatives, though the House or Senate member would probably not know the answer.<sup>50</sup>

**1993:** Medicaid “estate recovery” mandates were placed on states by OBRA 93. Following the all-Democrat passage of the Patient Protection and Affordable Care Act (PPACA or ACA), AAPS noted that these provisions are particularly problematic in light of the ability to mandate enrollment in Medicaid. Even the capitation fee paid to Medicaid managed care contractors may be subject to estate recovery, AAPS reported.<sup>51</sup>

**1993:** Medicaid’s Section 1115 waiver program exploded, thanks to liberalization of the approval process and rules. Oregon’s waiver (the first statewide waiver approved in more than 10 years) expanded coverage to all uninsured residents up to 100 percent of the FPL, moved almost all non-disabled enrollees into managed care, and set up a prioritized list of services to define the program’s benefit package. The level of covered services was determined based on the state’s budgetary resources (aka

rationing). Oregon led the nationwide growth trend: “In 1983, 750,000 beneficiaries (3%) were enrolled in managed care.” In 1994 the number grew to 7.8 million beneficiaries (23%). “The most significant growth occurred between 1993 and 1994.”<sup>52</sup>

**1996:** The Health Insurance Portability and Accountability Act (HIPAA) was enacted. While it was claimed to protect patient privacy, AAPS reported the truth in action alerts that shut down the HHS email server: “Masquerading as ‘medical privacy protection,’ HIPAA is largely carried over from Hillary’s Health Care Task Force and the failed ClintonCare plan for government control of medicine and medical records.”<sup>53</sup> HIPAA set in motion the events that would lead to electronic health records (EHRs) becoming the counterproductive time sink they are today, instead of a tool to benefit the patient-physician relationship. Draconian “fraud and abuse” penalties were also a centerpiece of the HIPAA law and greatly increased the risk in being a physician. (AAPS leads the way in standing up for physician victims of overzealous government prosecution, such as ophthalmologist Jeffrey Rutgard, M.D.)<sup>54</sup>

**1995:** AMA and HCFA implemented major revisions to CPT and released the “guidelines” for Evaluation and Management (E&M) CPT codes, which describe office visits of varying levels of complexity. “The art and science of medicine, through a collaborative effort by the AMA and HCFA, is to be reduced to the production of voluminous documents by the new ‘E&M’ ‘guidelines,’” reported AAPS. AAPS organized opposition to the increasingly onerous 1997 guidelines that culminated in an “AMA-fly-in” in Chicago in April 1998. At the fly-in, AAPS distributed the results of a physician survey that found: of AAPS members, 83 percent thought the E&M documentation guidelines were “unlawful and unconstitutional,” as did 71 percent of non-members. Sample open-ended comments described the guidelines as “a first-year medical student exercise,” “a political tool to destroy private medicine,” a “complete waste of time and effort,” and “an invasion of privacy.”<sup>55</sup>

**1997:** The Medicare Sustained Growth Rate (SGR) was created by the Balanced Budget Act (BBA) of 1997 in an attempt to constrain Medicaid and Medicare spending, which had increased from 25.7 percent of total health spending in 1983 to 32.5 percent in 1997. As usual with central planning, things didn’t go as expected: “Every year there is a battle in Congress to stave off the automatic Clinton-Gingrich ‘sustained growth rate’ (SGR) cut in Medicare physicians’ fees that was enacted in 1997. Each year, Congress has delayed it, meaning that the following year’s cut, according to the formula, is more draconian. The 2014 cut under SGR would be 24.4%.” AAPS used the crises as an opportunity to call for true reform: “What Congress should do is repeal the price controls. Then patients, not an AMA committee and Medicare bureaucrats, could decide what a service is worth. Medicare’s job is to decide what to reimburse—not what the doctor charges.”<sup>56</sup>

**1997:** The State Children’s Health Insurance Program (SCHIP, now CHIP) was also born of the BBA of 1997. Purportedly about increasing access to care, SCHIP was yet another “bipartisan” bill inspired by the plans from the Clinton Health Care Task Force. It strengthened the hold of managed care on low-

income patients and foreshadowed ACA Medicaid Expansion, especially as SCHIP “covered” larger swaths of patients. A 2007 AAPS Action Alert quoted Rep. Tom Price’s (R-Ga.) warning that Congress has “proposed to take control of healthcare away from families and doctors, by expansions of SCHIP to income groups in which two-thirds already have private coverage.” This is called “crowd out” of the private sector.<sup>57</sup>

**1997:** The BBA of 1997 pushed more low-income patients into managed care by permitting states to require most Medicaid beneficiaries to enroll in managed-care plans without going through the section 1915(b) waiver process. In 1996, about 40 percent of Medicaid beneficiaries nationwide were enrolled in managed care; by 2003, the figure had climbed to more than 59 percent.<sup>58</sup> Medicaid Managed Care was beginning to become a “cash cow” for the insurance cartel.<sup>59</sup>

**1997:** Medicare+Choice (Medicare Part C, now called Medicare Advantage), managed care for Medicare, was formalized by the BBA of 1997. In 2017, 20 years later, payments to Medicare Advantage plans totaled \$210 billion (up from \$78 billion in 2007), 30 percent of total Medicare spending.<sup>60</sup> As the 1995 AAPS White Paper on Medical Financing states, there is “no evidence that managed care has ever reduced the cost per equivalent service rendered.”<sup>61</sup> Prospective Payment Systems (another rationing tool) were also pushed onto five more Medicare services: inpatient rehabilitation hospital or unit services, skilled nursing facility (SNF) services, home health services, hospital outpatient department services, and outpatient rehabilitation services. These mandated payment reductions for home health care contributed to a large number (approximately 3,500) of agencies closing, merging, or withdrawing from the Medicare program.

**1997:** Medicare private contracting, the goal of litigation in *Stewart v. Sullivan*, was recognized by statute, but despite AAPS efforts was on an all-or-none, rather than case-by-case basis. Section 4507 of the BBA opened a wedge of freedom for Medicare patients and physicians through provisions allowing “use of private contracts by Medicare beneficiaries.”<sup>62</sup> AAPS has become the top resource for physicians seeking information on opting out of Medicare as provided by this law.

**1999:** The Balanced Budget Refinement Act of 1999 (BBRA) was passed in response to concerns that some of the cuts of the BBA of 1997 were too severe in conjunction with expanding federal budget surpluses. The BBRA halted or delayed some of the payment reductions that were part of the BBA and increased payments for some Medicare providers. AAPS noted at the time that it also created “another 133 provisions requiring HCFA regulation on top of the 335 provisions in the Balanced Budget Act of 1997.” Further: “HCFA was essentially overwhelmed in its efforts to handle the number and complexity of BBA requirements.... So the point to remember is that when Congress complains about HCFA, Congress is really complaining about itself.”<sup>64</sup>

**2000:** In the Benefits Improvement and Protection Act of 2000 (BIPA), “Congress is still trying to rectify the problem [fee cuts made by BBA of 1997] in a way that will probably have the effect

of making Medicare's longer-term financial problems worse," AAPS reported. The Medicare + Choice program would get \$11 billion in new payments over 5 years; hospitals would get more than \$11 billion; nursing homes and home health agencies would get \$3.2 billion.<sup>65</sup>

**2000:** The Hospital Outpatient Prospective Payment System was implemented and perpetuated "facility fees." Seventeen years of this experiment demonstrate that, while purportedly implemented to control costs, it in fact increases spending for services that are provided at lower cost at office-based physician practices. For example, AAPS pointed out: "Medicare payments for chemotherapy administered in hospital outpatient settings have more than tripled since 2005 (from \$90 million to \$300 million) while payments to physician community cancer clinics decreased by 14.5 percent."<sup>66</sup>

**2001:** The Health Care Financing Administration was re-named the Centers for Medicare & Medicaid Services (CMS) by Secretary Tommy Thompson. Rebranding by CMS seems to be a strategy used to reinvent failed ideas. One AAPS member, looking into improper Medicare fines and penalties that destroyed a private practice, commented following the name change: "Changing the name of the skunk to 'pretty little kitty with the white stripe,' doesn't change the smell."<sup>67</sup>

**2002:** Quality Improvement Organizations (QIOs) replaced PROs and used EHRs to track "key quality indicators." But as AAPS reported in 2006, QIOs, which receive \$300 million annually to investigate complaints of poor care and to improve quality of care rendered by physicians, hospitals, and nursing homes, are themselves in need of supervision. The *Washington Post* reported that the groups rarely looked into patient complaints, that some executives receive lavish pay and perks, and that conferences are frequently held at posh resorts.<sup>68</sup>

**2003:** Medicare Part D, the Medicare prescription drug benefit and "largest single expansion in the history of the Medicare program," was created by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA). Congress had promised market-based reform to the program, but "instead of fixing the foundation, Congress has just remodeled and added a second and third story" to the edifice, AAPS stated in a call for implementation delay.<sup>69</sup> The program also increased prior-authorization red tape and unleashed other forms of third-party interference into prescription drug decision-making. The legislation specifically forbids the government from negotiating drug prices with manufacturers, but empowers use of Pharmacy Benefit Managers (PBMs). And predictably: "the copay for most generics on Part D plans is two to three times what [patients] would pay without insurance," reported AAPS in 2006.<sup>70</sup>

**2003:** The Recovery Audit Contractors (RACs) "demonstration project" created by the MMA was the next iteration of CMS attempts to recover Medicare payments. RAC's "sole revenue is a contingency fee from recoveries based on mis-coding, unnecessary services, or incorrect payment amounts," reported AAPS. In addition, "although purportedly designed to detect improper payments, both overpayments and underpayments,

the RAC program was heavily biased toward finding only overpayments."<sup>71</sup>

**2003:** The MMA also rebranded claims processing. "Medicare Administrative Contractors" (MACs) replaced Medicare carriers, DMERCs (DME regional carriers), and fiscal intermediaries. The name change, alas, did not change the bureaucracy's "insatiable appetite for physician time and one which obstructs, impedes, and interferes with every aspect of the practice of medicine today." Prior to opting out of Medicare, Lawrence Huntoon, M.D., Ph.D. reported that he spend "well over 50% of my time doing nothing but fighting this HCFA/Medicare bureaucracy. In fact, in our office we have Frankenstein's son, 'Little Frank,' which stands 6' 10" tall and weighs 168 pounds. 'Little Frank' consists of approximately 20,000 pages of correspondence that I have had with the HCFA/Medicare bureaucracy regarding problems created by the bureaucracy."<sup>72</sup>

**2003:** Pharmacy Benefits Managers were granted use of the GPO Anti-Kickback Statute safe harbor through HHS Inspector General guidance, just in time for the rebates (aka kickbacks) that would flow in from Part D prescribing.<sup>73</sup> "Physicians Against Drug Shortages calculates that such 'corrupt practices have driven up the prices of drugs sold by PBMs to individual consumers by at least \$100 billion annually,'" AAPS told the Senate Finance Committee in June 2018.<sup>74</sup>

**2003:** HIPAA's electronic transmission standards, under which all covered entities must submit Medicare claims electronically, began, as did mandatory compliance with the HIPAA "Privacy Rule" and other aspects of HIPAA "administrative simplification." AAPS through its 2002 lawsuit challenging HIPAA, *AAPS v. HHS*, established the "country doctor exemption" from the over-regulation, freeing third-party-free physicians who do not transmit information related to "covered transactions" electronically.<sup>75</sup>

**2005:** The Deficit Reduction Act of 2005 created the Medicaid Integrity Program (MIP) to aid in detecting fraud and abuse. A 2018 report initiated by Sen. Ron Johnson (R-Wis.) describes oversight by the Centers for Medicare and Medicaid Services (CMS) to be "poor," and the amount of fraud, "stunning." The report also noted that "the cost of Medicaid, initially \$222 per user, has soared to \$7,973, an increase of nearly 3,500 percent. The overall cost to the taxpayers is \$554 billion/year, up from \$299 billion in FY 2014."<sup>76</sup>

**2006:** The Physician Quality Reporting System (PQRS), enacted in the Tax Relief and Health Care Act of 2006 (TRHCA), paid incentives for reporting "quality" data to CMS. The AMA helped implement the program, reported AAPS: An AMA-led consortium "authored 56 percent of the measures adopted by CMS in its 2010 PQRS program."<sup>77</sup> Maintenance of Certification (MOC) was also ingrained: According to the American Board of Medical Specialists (ABMS), "Physicians who successfully meet the criteria for PQRS reporting in 2014 will receive an incentive payment equal to 0.5% of their total estimated Medicare Part B Physician Fee Schedule allowed charges for covered professional services furnished during the reporting period." Also, "PQRS offers eligible physicians who are certified by an

ABMS Member Board and have satisfactorily submitted data under PQRS the opportunity to earn an additional incentive of 0.5% for participating in a CMS-qualified Maintenance of Certification program 'more frequently' than is required to qualify or maintain board certification."<sup>78</sup>

**2006:** Recovery Audit Contractors (RACs), Medicare bounty hunters created by the 2003 MMA, are made permanent by the TRHCA of 2006. AAPS wrote: "The perverse incentive the government is creating by ramping up attacks against physicians who provide care to complex sick patients is to not take on too many complex sick patients lest they face financial hardship due to coerced down-coding or financial ruin due to a government attack."<sup>79</sup>

**2009:** The Health Information Technology for Economic and Clinical Health Act (HITECH), part of the 2009 stimulus package, was passed. "In brief," explained Hermann W. Børg in these pages, "HITECH appropriated billions of dollars for bribes to physicians who would meet Meaningful Use (MU) criteria. Physicians who would not adopt an MU-certified EHR by 2015 were to be penalized. Legislators believed that such bribes and penalties should increase demand for EHR. This plan did not work. MU requirements have ironically slowed technological advancements since EHR developers concentrated on MU compliance instead of improvements."<sup>80</sup>

**2010:** This year brought the Obama Administration's Patient Protection and Affordable Care Act (ACA). Its failures are too numerous to mention here but are well known to most readers of this journal, as are the efforts of AAPS to combat ACA's intrusions into the patient-physician relationship. Here's one shocking fact that demonstrates magnitude of the policy debacle: "The federal government spent \$341 billion from 2014 through 2016 to increase private coverage by just 1.7 million people.... That's \$200,000 per person."<sup>81</sup> The only physician-written review of the entire law we are aware of was published in this journal.<sup>82</sup> AAPS was the only physician group to directly challenge the law in court. *AAPS v. Sebelius*<sup>83</sup> was filed three days after ACA was signed into law, and *AAPS v. Koskinen*<sup>84</sup> challenged changes the Obama Administration made to the law without approval by Congress. AAPS also filed more than 10 *amicus curiae* briefs in support of other challenges. In 2017, when the Congress and the White House appeared willing to repeal ACA, AAPS offered solutions, as in our White Paper on Repeal/Replacement of the Affordable Care Act."<sup>2</sup>

**2014:** IRS Commissioner John Koskinen ruled that patients paying a monthly fee for Direct Primary Care (DPC) are ineligible to contribute to a Health Savings Account (HSA) and cannot use HSA funds to pay the fee. AAPS continues efforts to reverse this misguided and harmful policy, and sent to Congress a letter in support of a legislative fix, co-signed by 1,125 physicians and patients.<sup>85</sup>

**2015:** ICD-10 requirements for Medicare go into effect after at least three delays (the transition was mandated by HIPAA passed in 1996). "With its 68,000 codes—five times the current number, ICD-10 is a giant counterproductive leap in the wrong direction that will increase costs and harm patient care," AAPS told Congress in a Capitol Hill briefing that also

featured examples of how physicians "who practice outside of government and insurance company control are lowering costs for patients while providing higher-quality medical care."<sup>86</sup>

**2015:** The Medicare and CHIP Reauthorization Act (MACRA) was enacted. "MACRA replaces threatened SGR pay cuts," which were postponed 17 times by Congress, "with certain pay cuts for those who put patients ahead of system satisfaction," for instance by using too many resources or not putting patient data in government-overseen EHRs, AAPS reported.<sup>87</sup> Our efforts helped generate more than 4,000 comments to CMS in opposition to MACRA regulation. Policymakers, including the Medicare Payment Advisory Commission (MedPAC), are realizing that the unwieldy program needs to be repealed.<sup>88</sup>

**2018:** CMS once again rebrands Meaningful Use, this time as "Promoting Interoperability." Earlier, while implementing MACRA, CMS changed MU to "Advancing Care Information." The latest name change is purportedly to emphasize the need for data sharing. In comments to CMS, AAPS stated: "We urge great caution with any such requirements, especially given the problems inherent in the current implementation of Health Information Technology as influenced by flawed federal policy."<sup>89</sup>

**2018:** Medicare and Medicaid penalties were increased by the "Bipartisan Budget Act of 2017." Beginning Feb 9, 2018, Civil Monetary Penalties (CMP) will at least double with the highest fine set at \$100,000 per violation. Felonies involving fraud and abuse, previously punishable by not more than 5 years imprisonment, may now result in sentences of up to 10 years.<sup>90</sup> Soon after the increased penalties went into effect, the Department of Justice announced the "largest health care fraud enforcement action in department history." AAPS wrote: "There is no excuse for intentionally defrauding the taxpayer, but many physicians have had their lives ruined because of inadvertent violations of complex billing rules while they were working very hard, caring for patients.... Physicians feel that they are not only being blamed, but hunted."<sup>91</sup>

**2018:** In response to the opiate abuse epidemic, Congress has put forth almost 60 bills,<sup>92</sup> most of which improperly regulate prescribing but don't address the prime contributor to the surge in opioid deaths, the illicit use of drugs like fentanyl.<sup>93</sup>

**2018:** The Trump Administration increases options outside of ACA-controlled plans by reducing regulation of Association Health Plans (AHPs) and Short Term Plans. To bolster these new options, AAPS calls for AHPs to cut out the insurance company bureaucracy and for increased flexibility for the use of Health Savings Accounts by all Americans.<sup>94</sup>

**2018:** AAPS completed its 27th Thrive, Not Just Survive workshop on third-party-free practice, to help ensure independent physicians are available outside of government and insurance company control. Approximately 2,500 physicians have attended AAPS "Thrive" workshops, and many thousands more have watched the training sessions online.

As we close this time-line, the old becomes new again as HHS is hinting at yet another name change, adding back

the word “welfare” to the department’s title, as it had as the Department of Health, Education, and Welfare, from 1953 to 1979. The rebranded Department of Health and Public Welfare (DHPW) would bring “nutrition assistance programs” under the department’s control and house a Council on Public Assistance with statutory authorities and responsibilities.<sup>95</sup> Predictably, Medicare Advantage and Medicaid managed care plans are already figuring out how to profit from the coming change that push more services under HHS control.<sup>96</sup>

The AAPS Diamond Anniversary will be commemorated at our 75th Annual Meeting, Oct. 3-6, 2018 in Indianapolis, Ind. It will not only be a celebration; the battle to save American Medicine continues and there is much work to be done.

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