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Congress of the United States
House of Representatives
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JOINT ECONOMIC COMMITTEE
CONGRESSIONAL HEALTH CARE CAUCUS,
CHAIRMAN

September 16, 2009

President Barack Obama
The White House
1600 Pennsylvania Ave, NW
Washington, DC 20500

Dear Mr. President,

I am once again compelled to write to you to accept your offer to meet with you at the White House to discuss the health care reform proposals currently before us.

I listened intently as you addressed the Joint Session of Congress on September 9, 2009, and you once again extended an olive branch to members of the minority. I want to reiterate that I am completely committed to working in a bipartisan fashion to deliver reforms that all Americans can be comfortable with, increase access to care, lower health care costs for America's families and businesses, and deliver changes to the health system that improve quality.

I thank you for your public commitment to accept innovative ideas from Republicans and hope that you will follow through with your public pledge by reviewing this letter thoroughly. As you stated last week: "I will continue to seek common ground in the weeks ahead. If you come to me with a serious set of proposals, I will be there to listen. My door is always open."

I accept your gracious offer and want you to know that it is not my intention to "kill" health reform. In fact, I stand proudly by my bipartisan work in the U.S. House of Representatives on health care issues. Several of my amendments in the Energy & Commerce Committee were accepted unanimously while others are currently under negotiation with Chairman Waxman for inclusion in a final House product.

That said, I have read the America's Affordable Health Choices Act (H.R. 3200) and I do concede I have many concerns with the approach the bill takes. Many of the items you outlined in your speech do have wide bipartisan support. While we may have disagreements on the policy approaches to address those problems we will never know if we can find common ground if we do not try.

To assist you in identifying measures that could gain wide bipartisan support I am enclosing four pieces of legislation that will make incremental but important reforms to our health system. I believe that, with your leadership, these measures could be passed and signed into law before Thanksgiving. These efforts would show that we can work together to make important reforms that improve

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access to care and protect the doctor/patient relationship.

- **Physician Workforce:** H.R. 914, the *Physician Workforce Enhancement Act*, would establish an interest-free loan program for eligible hospitals to establish residency training programs in certain high-need specialties. Under the program, eligible hospitals could receive up to \$1,000,000 that must be repaid within 3 and half years. H.R. 914 will provide needed resources to smaller and emerging communities so they can attract and retain the medical professionals their communities will rely on in the future. If we do nothing to assist the training of physicians, waiting lines will grow longer, lapses in treatment will occur, and many of our small and rural communities will be at risk of not having physicians to meet their growing needs.

- **Medical Liability Reform:** As you alluded to in your speech, too many doctors are forced to practice defensive medicine and face the constant threat of lawsuits and unsustainable medical liability insurance rates. This results in millions of dollars in unnecessary tests and procedures. Seasoned medical professionals are retiring early because staying in practice is no longer financially feasible, further contributing to our nation's doctor shortage. This is a growing crisis that is pushing affordable health care beyond the grasp of millions of Americans. H.R. 1468, the *Medical Justice Act*, is based on medical liability reform implemented in Texas. The reforms have created a magnet for doctors and provided the funding mechanism to improve access to care and enhance patient safety. To prove the success of Texas' reforms, I'd like to share a few of the statistics, from the Texas Medical Association:
 - Since the 2003 reforms, Texas has licensed 14,496 new physicians. This is a 36 percent increase from pre-reform.
 - Thirty-three rural counties have seen a net gain in ER doctors, including 26 counties that previously had none.
 - After years of decline, the ranks of medical specialists are growing in Texas. In my field of obstetrics, Texas saw a net loss of 14 obstetricians in the two years preceding reform. Since then the state has experienced a net gain of 192 obstetricians, and 26 rural counties have added an obstetrician, including ten counties that previously had none.
 - Charity care rendered by Texas hospitals has increased by 24 percent, resulting in \$594 million in free care to Texas' patients.
 - Texas physicians have saved \$574 million in liability insurance premiums, a significant savings that has allowed more doctors to stay in their practice.

- **Medicare Reform:** Many new Medicare beneficiaries find it difficult to locate a doctor who will accept Medicare. This is because physicians around the country realize that Medicare is an unstable payer, subject to the whims of political will and influence, and are doing what they must to

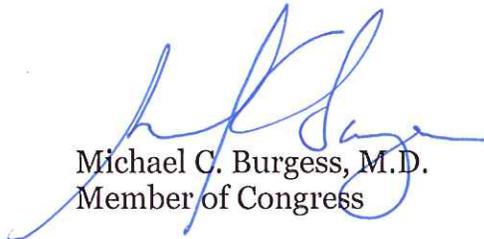
protect their small businesses. Physicians are scheduled to receive a significant reduction in Medicare payments on January 1, 2010. The *Ensuring the Future Physician Workforce Act*, a bill I plan on introducing shortly, will give doctors what they really need – a stable and reasonable predictor of an inflationary reimbursement under Medicare. This will allow seniors to maintain access to their doctor. The legislation also rewards quality reporting of data, further incentivizes the adoption of Health Information Technology, and brings increased transparency on utilization, billing, and funding to the Medicare program.

- **Health Care Price Transparency:** A patient should be able to know what they are paying for and how much they will pay out-of-pocket. H.R. 2249, the *Health Care Price Transparency Promotion Act*, directs states to establish and maintain laws requiring disclosure of information on hospital charges. The legislation requires hospitals and health plans to make this information available to the public, and to provide individuals with information about estimated out-of-pocket costs for health care services. H.R. 2249 aims to make health care more affordable by promoting greater transparency about the cost of health care services for patients seeking care. The legislation sets a national floor for transparency. As someone who has committed his Administration to transparency, this is an important step in helping make health care, and specifically health care costs, more transparent, which empowers the consumer.

As a practicing physician for over 25 years, I believe I bring a unique perspective to the current health care reform debate. I am committed to finding areas of collaboration between the political parties that can deliver meaningful system reforms that will benefit all Americans. I would greatly appreciate the opportunity to review both the efforts outlined above and also my areas of concern with H.R. 3200 so that we may mutually work to bring quality, affordable health care to all Americans.

I look forward to the opportunity to meet with you at your earliest convenience. Should your staff have any questions about any of the attached proposals or would like to arrange a meeting, please contact me or my Legislative Director J.P. Paluskiewicz at my Washington, D.C. office at 202-225-7772.

Sincerely,



Michael C. Burgess, M.D.
Member of Congress

H.R. 914, the Physician Workforce Enhancement

Act of 2009

Summary

1) Establish an interest-free loan program for eligible hospitals to establish residency training programs.

This loan program would begin January 1, 2010 and be administrated by HRSA. Eligible hospitals could receive up to \$1 million. Preference will be given to hospitals in rural and small, urban areas. This program would terminate December 31, 2019 – no loan may be made after this date.

An **eligible hospital** is one that:

- 1) Does not and has not previously operated a residency training program.
- 2) Has secured preliminary accreditation by the ACGME or the AOA.
- 3) Assures HRSA that the loan will be used only for the purposes of establishing and conducting an allopathic or osteopathic residency program in one or more of the following specialties – family medicine, internal medicine, emergency medicine, OB/GYN, preventative medicine, pediatrics, behavior and mental health, and general surgery.
- 4) Agrees to repay the loan.

Permissible uses of loan funds:

- 1) Salaries and benefits for residents.
- 2) Salaries of faculty.
- 3) Any other cost directly attributable to the residency training program.

Repayment of loans – Repayment begins within 18 months. Full repayment is required 2 years after start of repayment. HRSA may not charge or collect interest. If the residency program is canceled before full loan repayment, the loan must be repaid within 45 days of program termination.

2) Report to Congress on the efficacy of the program in achieving its stated goals.

This would occur by January 1, 2014 and annually thereafter.

3) Authorization of \$25 million over 10 years, 2010-2020.

Appropriated funds will remain available until expended. Before the termination date (12/31/2019), any repaid funds will be credited to the loan account. After the termination date, repaid funds will be credited to the general fund in the Treasury.

H.R. 1468, the Medical Justice Act of 2009

Summary

1) Cap non-economic damages against healthcare practitioners and institutions

Limit the amount a person is entitled to for non-economic damages to \$250,000 from a single institution or class of practitioner and \$500,000 from a class of institutions for a total possible non-economic cap of \$750,000 in some cases.

2) Cap on wrongful death awards

Limit the amount a person entitled to damages may receive from a single healthcare practitioner to \$1,400,000 total. This amount includes compensatory, punitive, statutory, and other types of damages. This amount will be adjusted for inflation. The jury is to be instructed not to consider whether or to what extent a limitation on damages applies. Juries will also be instructed that when an individual is injured or dies as a result of health care, liability for negligence may not be based solely on a bad result.

3) Expert Reports Required for Civil Actions

Not later than 120 days after filing, the party filing must present to the other parties a qualified expert report. This report is a written report by a qualified health care expert that includes:

1. a curriculum vitae of the expert
2. a summary of the expert opinion as to the standard of care applicable, how that standard was not met, and the causal relationship between failing to meet the standard and the death or injury of the individual

The report is not to be used during the trial.

4) Expert opinions relating to physicians may only be provided by actively practicing physicians.

The physician must be determined by the court to be qualified on the basis of training and experience. The qualifications include being board-certified or have other substantial training in the area relevant to the opinion.

5) Payment of future damages on a periodic or accrual basis

If the future damages awarded are equal to \$100,000 or more, the practitioner may move to have the court order payment on a periodic or accrual basis of those damages. Future damages are defined as:

3. future costs of medical, health care, or custodial service
4. non-economic damages such as pain or suffering
5. loss of future earnings
6. any other damages incurred after the award is made

6) Unanimous jury required for punitive or exemplary damages

The jury must be unanimous in both the liability of the practitioner and the amount of the award.

7) Proportionate Liability

A practitioner is only liable for the amount of the award that corresponds directly to that person's share of the total responsibility.

8) Defense-initiated settlement process

A defendant may initiate a settlement under this section by serving one or more qualified offers to the person seeking damages. If that person does not accept the offer, that person can submit one or more offers to the defense. A qualified settlement offer is one that specifies it is offered under this section, states the terms of settlement, and states a deadline for acceptance.

Effects of the offer: If the qualified settlement offer is not accepted and the offeree receives a judgment at trial that is significantly less favorable than the offer, the offeree is responsible for the litigation costs of the defendant. Significantly less favorable is defined as less than 80% of the offer if the offeree was the one seeking damages, and more than 120% if the offeree is the one against whom damages are sought.

H.R. 1468, the Medical Justice Act of 2009

Summary

9) Statute of Limitations; Statute of Repose

The Statute of Limitations: when a person is injured or dies as a result of health care, a claim must be brought within 2 years of when the negligence or the health care on which the claim is based occurs. For individuals under age 12, a claim must be brought before the individual reaches age 14. The Statute of Repose: a claim must be brought within 10 years after the act or omission on which the claim is based is completed.

10) Limitations on liability for Good Samaritans providing Emergency Health Care

A health care practitioner that provides emergency health care on a Good Samaritan basis is not liable for damages except for willful or wanton negligence or more culpable misconduct.

Ensuring the Future Physician Workforce Act of 2009

Summary

Payment Reforms to Medicare:

Rebase SGR to 2009 Spending Target for 2010

This provision would keep current statute for 2009 (1.1%) and provide a positive update for 2010.

Eliminate SGR beginning in 2011 - Replace it with MEI

This provision would eliminate SGR in 2011 and produce stable, predictable updates by the use of the Medicare Economic Index (MEI)

3% bonus payments beginning in 2010 & 2011; 1% bonus for quality reporting on the top 10 most expensive disorders covered by Medicare to begin in 2012

Reporting measures play a role in improving quality medical treatment. Because Medicare treats some of the country's sickest patients, it is important that Medicare constantly seek to improve the care it provides. Unfortunately the incentives to report such data are not adequate (2.0 percent for 2009). Starting in 2010 the bonus payment would increase for quality reporting from 2.0 percent to 3 percent and the program would remain in effect through 2011. In 2012, the bonus would decrease to 1 percent and eligible measures would focus on the 10 highest cost disease conditions. By examining the most expensive disorders, we can focus our efforts to improve efficiency and find savings within the system. This approach also provides flexibility; as the most expensive disorders change, the reporting measures will too.

Health IT:

Safe-harbor from anti-kickback laws when implementing HIT

Doctors in private practice contract to be able to admit patients to local hospitals. Hospitals are usually more likely than small practices to have adopted some form of HIT, and it is helpful for the physician and the hospital to have interactive computer systems. However, current anti-kickback law makes it illegal for doctors to accept hardware/software from hospitals under any circumstances. We suggest that the hospital should be allowed to help with HIT implementation, as long as they do not restrict the physician's HIT interoperability, clinical practice, or referral system for their own financial benefit.

Transparency & Reporting:

Confidential reports for physicians on Medicare billing

Physicians often do not know the extent of their billing to Medicare. Each physician would receive a report on their billing practices, compared to those of other area physicians. This is done so they know how they compare to the average and can personally examine areas that may be inappropriately utilized. This is simply an informative measure – it is not meant to be punitive in any way, and is therefore confidential.

Reports to Medicare beneficiaries on utilization

Like physicians, Medicare beneficiaries are often unaware of the cost of their care. Each beneficiary would receive an annual report on the amount of payments made to or on the behalf of the individual (Parts A and B). This is done so they know how they compare to the average and can personally examine their usage.

Collect data on Medicare savings gained by diverting hospital stays with out-patient care

As out-patient care (Part B) has expanded and improved, it seems logical to assume that hospitalizations (Part A) have decreased. Data collection can tell us if this is actually happening.

Create an on-going examination of Medicare funding

Currently, the different parts of Medicare are funded through different mechanisms. However, if it is true that increased spending in Part B has reduced spending in Part A, then Medicare finances are clearly related. By examining Medicare funding, we may discover that there are savings to be found within the system.

Study healthcare disparities

We propose examining the impact of reporting requirements on physician penetration in high-risk health condition areas and minority communities.

H.R. 2249, the Health Care Price Transparency Promotion

Act of 2009

Summary

Why it is needed: We currently have a health care system that is badly in need of reform. However, in the tangled mess of medical bureaucracy, no one has a clear picture of the problem. Physicians and other providers don't get paid enough, patients pay too much, many people don't get any care at all, and everyone claims that someone else needs to change. Before we start changing things, though, it seems prudent to understand the problem fully. Today, I have introduced legislation with that goal in mind. This is a first step toward true price transparency in the health care market.

The Health Care Price Transparency Act of 2009 is a long-term solution to runaway medical costs.

In August 2006, President Bush issued an executive order calling for increased transparency within the federal government's health care agencies. This legislation is an extension of that executive order, giving states the tools to become part of a necessary solution for health care consumers.

What it does: This bill would require states establish health care transparency requirements for hospitals and health plans, as well as conduct a study on what information most useful to consumers.

Hypothetical example: The Texas Hospital Association has created a web-based tool that allows consumers to hospital-to-hospital cost. This assists consumers that are considering non-emergency procedures at area hospitals. Couple this data with hospital quality information, and consumers will be able to truly shop for health services based on quality and cost.

Specifics on HR:

Section 1. Short Title

Section 2. Increasing the Transparency of Information on Hospital Charges and Making Available Information on Estimated Out-of-Pocket Costs for Health Care Services.

The State will establish and maintain laws to require disclosure of information on hospital charges, to make such information available to the public, and to provide individuals with information about estimated out-of-pocket costs for health care services.

Information on Hospital Charges – The laws of a State must:

- 1) Require disclosure, by each hospital located in the State, of information on the charges for certain inpatient and outpatient hospital services (as determined by the State) provided at the hospital.
- 2) Provide for timely access to such information by individuals seeking or requiring such services.

Estimated Out-of-Pocket Costs – The laws of a State must:

- 1) Require that, upon the request of any individual with health insurance coverage, the issuer must provide a statement of the estimated out-of-pocket costs that are likely to be incurred by the individual if he/she receives particular health care items and services within a specified period of time.

Rules of Construction

- 1) The Secretary is not authorized or required to establish uniform standards for State laws.
- 2) States with previously established laws that meet the above requirements are not required to change their laws. Previously established laws that do not meet the above requirements need only change their laws as necessary to meet the requirements.
- 3) States with voluntary disclosure on hospital charges still need to adopt laws.
- 4) It is understood that estimated out-of-pocket charges may well exceed the estimated costs.

H.R. 2249, the Health Care Price Transparency Promotion Act of 2009

Summary

This legislation is to be effective October 1, 2010. In cases where additional State legislation beyond appropriations is required to enact this legislation, an extension until the first calendar quarter after the close of the first regular session of the State legislature is given.

Section 3. Research on Information Valued by Consumers on Charges and Out-Of-Pocket Costs for Health Care Services.

The Agency for Healthcare Research and Quality (AHRQ) shall conduct or support research on:

- 1) The types of cost information that individuals find useful in making decisions regarding healthcare.
- 2) How this useful information varies according to an individual's health insurance coverage, and if so, by what type of coverage they have.
- 3) Ways that information may be distributed in a timely and simple manner.

The AHRQ will report on this study within 18 months after enactment of this legislation.

Such sums as may be necessary are authorized to carry this out.