



Frequently Asked Questions about H.R. 3962, the Affordable Health Care for America Act November 5, 2009

Below you will find a series of questions and answers addressing H.R. 3962, the Affordable Health Care for America Act, which was introduced in the House on Oct. 29, 2009. This legislation reflects the melding of the House Energy & Commerce, Ways & Means and Education and Labor Committees' health reform proposals. This document also provides answers to general policy questions raised in the context of overall health care reform.

This document is organized in terms of ACP's priorities for health reform and how the current proposals reflect these priorities. ACP's priorities include:

- Providing all Americans with access to *affordable* health insurance;
- Creating incentives to reverse a growing and catastrophic shortage of general internists and other primary care physicians;
- Ending the annual cycle of Medicare physician payment cuts; and,
- Reforming the medical liability system

Provide all Americans with access to an affordable health insurance plan

1. What is ACP's position on coverage for all Americans?

One of ACP's long-standing policy objectives is affordable coverage for all. ACP believes that all Americans should have access to an affordable health insurance plan that does not exclude or discriminate against those with pre-existing conditions. People who cannot afford coverage should be provided with help, in the form of tax credits, to buy coverage. We believe the public should have a wide choice of health plans and those plans should compete based on innovations to improve patient care, not on cherry-picking out the young and healthy; and all insurers should cover preventive services and other essential benefits. We support the creation of insurance exchanges to enable small businesses and those who do not have access to employer-based coverage or Medicare, Medicaid, and CHIP to purchase qualified coverage through the exchanges. We support expansion of Medicaid to low-income persons. We also believe that once affordable coverage options are available, individuals should be required to purchase coverage with appropriate hardship exemptions.

We are committed to doing all that we can to get legislation enacted this year to ensure that all Americans will have access to affordable coverage and to a general internist or other primary care physician. Change creates risk, but we do not believe that the status quo is in the best interests of ACP members and patients.

2. What does the College think of coverage provisions that are included in H.R. 3962?

The bill is generally consistent with ACP on the issue of expanding health coverage. We are pleased that it would provide people with a wide choice of health plans, including the option of maintaining their current health plan. ACP supports the bill's proposals to reform the insurance industry so that coverage no longer is out of reach for people who have pre-existing conditions or who develop an illness while insured. We support sliding scale tax

credits, coverage of evidence-based preventive services with no cost-sharing, and expansion of the applicability of Medicaid to lower income populations. ACP believes that a public plan could appropriately be offered if physician and patient participation is voluntary and if the plan is funded through premiums—as H.R. 3962 requires. We also believe that the public plan should be able to use innovative payment models to support patient-centered primary care, and appreciate the reference in the bill to medical homes as being among the new payment and delivery models that the public plan should consider adopting.

We are pleased that under H.R. 3962, the Secretary of Health and Human Services would have the authority to negotiate payment rates under the public plan, as opposed to basing them on Medicare rates. We believe that payments to physicians under the public plan should be competitive with those of other insurers and not replicate flaws, such as the undervaluation of primary care, in existing payment models.

The College also strongly supports the establishment of a health insurance exchange to assist individuals and small businesses in finding affordable, high quality health coverage, as included in H.R. 3962. Ensuring access to preventive and primary care is crucial to reducing the rates of chronic disease and improving health and well-being for all. ACP is particularly encouraged that the House bill would require all insurance plans to provide a core set of benefits that include preventive and primary care services.

3. Does ACP support allowing uninsured individuals the option of obtaining insurance through a public plan administered by the federal government?

This is an issue that has elicited strong but divided opinion among ACP members. Some internists have expressed practical and philosophical concerns about the public plan, while others have said that they believe a public plan is essential.

ACP's Board of Regents adopted guidelines for evaluating proposals that would include a combination of public and qualified private health plans based on the degree to which they would advance important policy objectives, including reforming payments to support patient-centered primary care, promoting fair competition between plans on a level playing field, redesigning benefits to support prevention and wellness, ensuring adequate access to physicians within each plan, and ensuring that both patients and physicians can voluntarily choose the plans in which they participate. ACP believes that a public plan that meets these and other important policy objectives could appropriately be among the options offered to the public. ACP is committed to providing Congress and the White House with its perspectives on how to design private and public health insurance options to best meet the needs of patients.

With that in mind, ACP has worked diligently in urging the House committees to change the provision in an earlier version of the legislation that called for the public plan to use Medicare rates (Medicare plus 5 percent for physicians who accept both Medicare and the public plan) for its first three years. After that, the public plan would set its own rates. The College believes that the public plan should instead be required to pay competitively with private insurers.

We are pleased that this provision was changed in the newly released House health reform bill, H.R. 3962. This legislation gives the Secretary authority to negotiate rates under the public plan, instead of basing them on Medicare. Physicians participating in the public plan are permitted to balance bill (as long as the charges do not exceed the sum of the in-network cost-sharing plus 15 percent of the total payment for each item and service), but will receive a reduced negotiated payment rate. Physicians accepting the public plan negotiated rate as full payment will be deemed “preferred physicians.”

Under H.R. 3962, physician and patient participation in the public plan would be *voluntary*. The public plan would have to pay for itself through premiums collected, rather than being funded from the U.S. Treasury, to help place it on a level playing field with private insurers.

4. Could the public plan included in H.R. 3962 lead to rationing, or eliminate private insurance?

Generally speaking, ACP does not believe that a public plan, if designed appropriately, will lead to rationing of care or elimination of private insurance. Many of those who are concerned that a public plan will lead to rationing of care believe that this will be the case if the public plan eventually crowds out all private insurers, giving the federal government sole authority over benefits paid under such a plan (i.e. a single payer system). The idea that the public plan would destroy private insurance is not supported by expert analysis.

H.R. 3962 does not give the public plan or the federal government any authority to ration or set explicit limits on care based on cost or other criteria. Like private health plan options, the public plan would be required to cover essential benefits, as recommended by an expert commission that would have representation from practicing physicians. As is the case with private health insurance plans, a public plan would have the authority to review the medical necessity and appropriateness of care provided by physicians and other clinicians. Unlike private insurers, however, publicly funded plans are generally required to be “transparent” in the medical review criteria that they use.

In examining the plan originally proposed by H.R. 3200 and now included in H.R. 3962, the Congressional Budget Office notes that because physician participation in the public plan is voluntary, and payments are likely to be the same or lower than payments under private insurance plans, it is difficult to estimate how many people would enroll in the public plan. The CBO suggests that enrollment in a public plan, at full implementation, could be as many as 6 million people out of the estimated 30 million who would get coverage through the exchange, many of whom though are currently uninsured, but even so, this would mean that most people in the exchange would be covered under private insurance. CBO also estimates that the vast majority of persons—168 million, an increase of six million persons compared to current law—would be covered by their employers.

H.R. 3962 also includes a requirement that the proposed public plan would negotiate reimbursement rates with physicians instead of basing them on the Medicare rates. In addition, the bill prohibits the public plan from accessing the U.S. Treasury to protect against insolvency. H.R. 3962 would effectively eliminate market dominance by a single insurer currently seen in parts of the country, by providing eligible individuals and small businesses a broad choice of qualified health plans, private and public.

5. Does H.R. 3962 prohibit private contracting?

No. We have found nothing that takes away existing rights for physicians and patients to enter into voluntary contracts. Because participation is voluntary, no physician would be mandated to accept the public plan and its rates, just like no physician is required to accept the fee schedules offered by a private insurer, unless they voluntarily elect to participate with that insurer. Many private insurers also require, as a contractual condition of participation, that physicians accept the plan’s payment schedule as full payment.

Because participation in the public plan is voluntary, no physician will be required to accept patients enrolled in the public plan if they do not wish to accept its payment scale. However, physicians who treat Medicare patients will be deemed as participants in the public plan unless they choose to opt-out of this option. Physicians who choose to opt out of the public plan may do so beginning one year prior to the public plan’s first year of operation. Nationwide, only a relatively small number of persons—6 million, according to the CBO—are likely to be enrolled in the public plan.

6. Does H.R. 3962 prohibit private insurance?

No. Persons and small businesses that are eligible to purchase coverage through a health exchange would be able to choose from a wide variety of health plans, all of which would be provided by private insurance plans, with the addition of a public plan option and potentially, a member-run non-profit health insurance cooperative. As noted above, the independent Congressional Budget Office estimates that under H.R. 3962, the vast majority of Americans will be covered under private insurance, with only a relatively small number enrolled in the public plan.

H.R. 3962 will require that all insurers, whether offered through an exchange or outside it, comply with insurance market reforms, including prohibitions on excluding persons with pre-existing conditions, guaranteed renewability, and modified community rating. ACP policy has long favored such reforms. Individual insurance companies will eventually have to comply with such requirements. The legislation provides for a “grandfather” period, though, where people can elect to keep their current individual coverage even if it doesn’t meet the new requirements.

Create incentives to reverse a growing and catastrophic shortage of general internists and other primary care physicians

7. How will H.R. 3962 help primary care?

H.R. 3962 provides for an additional 5 percent increase, beginning in 2011, for designated evaluation and management services by general internists and other primary care physicians. The primary care bonus is increased to 10 percent for designated services in Health Professional Shortage Areas. H.R. 3962 also would increase Medicaid payments for primary care in all states to be equivalent to Medicare. ACP continues to believe that a larger primary care bonus is needed and has asked for a 10 percent bonus in all areas of the country. Even so, ACP believes that the recognition of the need to increase payments for primary care is an important step forward. The bill has extensive provisions to increase the supply and improve the training of primary care physicians. H.R. 3962 includes the following additional provisions to support primary care:

- Medicaid payments for primary care will be increased to equal the Medicare rates.
- Pilot testing of the Patient-Centered Medical Home, which will pay primary care physicians in a qualified medical home for care coordination services not covered in the regular office visit fee.
- Creating a national advisory council to recommend workforce goals and develop metrics to assess workforce policies.
- Increasing funding for National Health Services Corps and increasing award amounts from \$35,000/year to \$50,000/year. Also establishes a new program to allow half-time service in the NHSC.
- Increasing award amount for Faculty Loan Repayment Program from \$20,000/year to \$35,000/year.
- Establishing new loan repayment program to primary care physicians in areas of the country with an insufficient supply and high need for primary care.
- Eliminating barriers to training in non-hospital based settings to allow primary care residents to have increased exposure to ambulatory care settings.
- Distributing Graduate Medical Education training positions to primary care programs – would redistribute unused residency positions to training programs that would like to create or expand their primary care training programs.
- Providing grants to address health care disparities, and to develop interdisciplinary models of team-based care.
- Establishing a program for the training of primary care medical residents in community-based settings.

Based on estimates from the Congressional Budget Office, ACP calculates that the combined investment in primary care from the above provisions is approximately \$64 billion over the next ten years. Altogether, primary care gets the single largest investment of funds of any health care sector.

The bipartisan Preserving Patient Access to Primary Care Act (PPAPCA), H.R. 2530, introduced by Rep. Allyson Schwartz includes additional provisions that would complement those H.R. 3962 to comprehensively address recruitment and retention issues in primary care. PPAPCA was based directly on ACP's proposals to avert the primary care access crisis.

8. ACP has called on the federal government to establish a health care workforce policy to provide specific targets for increasing primary care capacity, including training and retaining more primary care physicians whose training is appropriate for the present and anticipated health care needs of the nation. How does this compare to what has been proposed in H.R. 3962?

H.R. 3962 establishes an Advisory Committee on Health Workforce Evaluation and Assessment to assess, evaluate and advise on the appropriateness of the nation's health workforce and make recommendations on policies to ensure that such workforce is meeting the nation's needs. The Advisory Committee will consist of 15 members with representatives of the health care workforce and health professionals, employers, third-party payers, and labor unions.

The Advisory Committee is charged with making recommendations regarding standardized methodology and procedures to enumerate the health care workforce. It would also review current and projected supply and demand, and make recommendations concerning priorities, goals, and performance outcome measures for Federal workforce programs.

ACP has proposed that at least one primary care physician be a member of the committee, specifically to address the current primary care physician shortage.

9. Does ACP agree that nurses can fulfill many of the duties of primary care physicians? Do the health reform proposals put nurses on an equal footing with physicians? Will an adequate number of nurses relieve some of the strain on primary care practices?

Physicians and nurses complete training with different levels of knowledge, skills, and abilities that while not equivalent, are often complementary. As trained health care professionals, physicians and nurses share a commitment to providing high quality care. However, physicians are often the most appropriate health care professional for many patients. Nurse practitioners play a role in meeting the current and growing demand for primary care, especially in underserved areas.

Workforce policies should ensure adequate supplies of primary care physicians and nurse practitioners to improve access to quality care and to avert anticipated shortages of primary care clinicians for adults. Workforce policies should recognize that training more nurse practitioners does not eliminate the need, nor does it substitute, for increasing the numbers of general internists and family physicians trained to provide primary care.

H.R. 3962 pilots would allow PCMHs led by advanced practice nurses to participate in the pilots, within the scope of practice of their state licenses. ACP believes that in the PCMH model, care for patients is best served by a multi-disciplinary team where the clinical team is led by a physician. However, given the call for testing different models of the PCMH, ACP believes that PCMH demonstration projects and pilots that include evaluation of physician-led PCMHs could also test the effectiveness of nurse practitioner-led PCMH practices in accord with existing state practice acts and subject to the same standards of evaluation for physician-led PCMH practices, as H.R. 3962 would require.

H.R. 3962 would define nurse-practitioners as primary care providers in order to also qualify for some of the primary care training and scholarship programs. Nothing in the bill, however, would allow NPs to provide care that is beyond their state license.

10. Will the bonus payment included in H.R. 3962 for primary care services be sufficient to recruit and retain additional primary care physicians?

ACP appreciates the House's efforts to provide an increase for primary care services but believes that the proposed bonus, by itself, is insufficient. H.R. 3962 calls for a 5 percent bonus for designated services by primary care physicians in 2011 (10 percent bonus for the same services in health professional shortage areas). At the urging of ACP, H.R. 3962 expanded the definition of primary care services under the bonus as it includes all E/M and Medicare-covered preventive services including hospital visits. This increases the number of services on which the 5% bonus (10% in HPSAs) would be paid and it enables most general internists to qualify. This is an improvement over an earlier improvement of the bill, which would have defined primary care services as only a limited set of outpatient-focused services and would have excluded hospital visits from the bonus. The Congressional Budget Office estimates that approximately \$5 billion in new money out of the federal budget will be spent on primary care bonus payments over the ten-year period 2010-2019. While the Congressional Budget Office estimate is over a ten-year window, the bonus payment would be a permanent part of the Medicare payment system.

ACP recommends that Congress provide a 10 percent increase in total Medicare payments for primary care physicians beginning in 2010. All reforms aimed at improving primary care are important but making significant progress to reduce the compensation gap is needed to send a strong signal to physicians-in-training, and in practice, that primary care is a valued and viable option. ACP's goal continues to be to raise payments to primary care physicians to be competitive with other specialties, through a combination of improvements in the fee-for-service system and other reforms to support the value of patient-centered primary care. Given pay-as-you-go rules, ACP does not believe, though, that it will be possible to get Congress to increase Medicare fee-for-service rates to be fully competitive within five years, as we have repeatedly urged.

Although the amount of the bonus payment in H.R. 3962 is significant yet suboptimal, it is important to look at the bonus in the broader context of what the bill would do to address the primary care workforce crisis. As noted above, the legislation includes restructuring federally-funded workforce programs and GME to increase the numbers of primary care physicians. It includes more than \$1.8 billion to pilot test the Patient-Centered Medical Home on a national basis, as described below. PCMHs led by primary care physicians will be eligible for monthly risk-adjusted care coordination payments for qualified patients, which if designed correctly will substantially increase payments to internists in qualified PCMHs. The legislation also raises Medicaid payments for primary care physicians over the next four years until they are no less than the comparable Medicare rates (in most states, Medicaid pays primary care doctors substantially less than Medicare). This provision results in an additional \$57 billion in payments to primary care physicians over the next four years. It improves the accuracy of the physician work and practice expense relative values, distributing any "savings" from such adjustment back to all other physician services, including undervalued evaluation and management services.

In sum, H.R. 3962 has the right mix of policies to support primary care, but ACP will continue to pursue a higher bonus payment.

11. How will H.R. 3962 improve the accuracy and appropriateness of Medicare relative value units (RVU)?

Inaccurate and mis-valued relative value units under the Medicare fee schedule contribute to the under-valuation of primary care services and may create incentives for increased and unwarranted volume. ACP supports that

H.R. 3962 provides the Secretary with authority, direction and funding to identify mis-valued codes through such means as:

- Accepting recommendations through the existing processes—e.g. through recommendations from the American Medical Association’s Relative Value Scale Update Committee;
- Conducting surveys, data collection, and other analytics; or
- Using contractors to identify and adjust values.

The College also appreciates that H.R. 3962 addresses the low assumed use of expensive equipment, such as MRI and CT machines, that results in higher than warranted payments.

While ACP appreciates that the proposal highlights the importance of making corrections to mis-valued services and takes some important steps to do so, the College continues to recommend the following specific reforms to improve the accuracy and appropriateness of Medicare RVUs including:

- Establishing an expert process to identify potentially overvalued or mis-valued services for further review.
- Requiring that the Secretary study the processes it uses to obtain expert advice on relative value units, and specifically, the adequacy of representation of primary care and other physicians who have expertise in the work associated with treating patients with chronic illnesses.

12. Does ACP support the H.R. 3962 provision to create a national pilot for the PCMH?

Yes, but we continue to work with Congress to ensure that the pilots are designed to include enough patients and practices to truly show the potential value of the model. ACP strongly supports a provision in H.R. 3962 that would direct the Secretary to establish two national, well-funded medical home pilot programs to provide patient centered care to Medicare beneficiaries. The legislation provides almost two billion dollars to fund the pilots. The new pilots provide the Secretary with substantial leeway to expand the components of the pilot program that are beneficial to the Medicare program, including regulations to implement on a permanent basis. The pilots evaluate both an Independent Patient Centered Medical Home (payment to the independent practice) and a Community Based Medical Home (payments made both to the independent practice and a non-profit community (state) entity that provides medical home services in coordination with the independent practice model. ACP would like to see the patient participation requirements under the Independent Practice to include a broader group of patients. More specifically, to replace the patient eligibility threshold that includes the sickest 50 percent of patients with the more inclusive threshold of “one or more chronic conditions” or all patients.

While the legislation repeals the current Medical Home demonstration project previously approved under the Tax Relief and Healthcare Act of 2006, it maintains the elements important to the College that were to be part of the repealed project, i.e. strong primary care emphasis; encouraging small-medium size practice participation; bundled, risk-adjusted payment for care coordination and other activities not currently covered under the current fee schedule; and recognition of different levels of medical home practices. Given that the Independent practice model aspect of the pilot is scheduled to take place within six months of enactment, it is likely that much of the design, implementation and evaluation work used for the Medical Home project currently approved by Congress will be employed in this new pilot. The College does believe it very important that Medicare initiate testing of the PCMH in an expeditious manner.

The bill also provides authority for the Secretary of Health and Human Services to establish a Medicaid medical home pilot program.

13. How does ACP feel about the establishing of a Payment Innovation Center, which is contained in H.R. 3962?

The College strongly supports the establishment of a Center within the Centers for Medicare and Medicaid Services (CMS) that would allow the agency to test innovative payment models and expand those that demonstrate the ability to increase quality and/or decrease aggregate program costs.

We appreciate that H.R. 3962 dedicates significant funding for the Center's operations and enables it to select models that may not be initially cost neutral as it is appropriate to enable investment in promising approaches with an assessment of cost in the context of program-wide spending. We support the bill's direction that CMS would receive input from individuals with expertise in medicine and health care management. We do, however, recommend that this be modified to establish a technical advisory panel of experts, which includes a slot for a primary care physician. In addition, we urge clarification as to how the Center would relate to demonstration/pilot projects CMS is currently conducting and would conduct as a result of other sections in H.R. 3962—including to test the Patient Centered Medical Home. Our intent is that experience with all models is assessed and acted on in a cohesive and prompt manner. The current payment system is broken and unsustainable. As there are no alternatives that have demonstrated success to the extent that wide-spread implementation is warranted, the ability to test, evaluate, and expand promising models on a fast-track is imperative.

14. Does H.R. 3962 establish a demonstration program that tests a model aimed at improving care of patients in the home setting?

Yes. H.R. 3962 establishes a Medicare demonstration project, the Independence at Home Demonstration Program, that tests a payment incentive and delivery model that aims to reduce expenditures and improve outcomes for severely ill beneficiaries that benefit from receiving care in their home. CMS would enter into agreements with "Independence at Home" practices, which are lead by a physician and include other clinical staff, such as nurses, pharmacists, or social workers. These practices can be lead by a nurse practitioner but the nurse practitioner must be practicing consistent with state scope of practice law. High-risk beneficiaries with multiple chronic conditions who need assistance with activities of daily living would be eligible and beneficiary participation would be voluntary. Practices would receive a percentage of savings generated under the model above a 5 percent savings threshold. Practices would be paid for comprehensive geriatric assessment and monthly care coordination services during the project but CMS could recoup these fees if a practice fails to generate the minimum threshold of savings. This demonstration project is essentially self-funded. ACP policy supports testing innovative models and expanding those that work. The College intends to ensure that "Independence at Home" practices coordinate with physicians who also care for participating beneficiaries to avoid fragmentation.

15. Will the administrative simplification provisions included in H.R. 3962 save money and allow physicians to spend more time with their patients?

According to a recent article in *Health Affairs*, physicians reported spending almost a half-hour each day, three hours each week, and three weeks per year interacting with health plans. The study estimated that the value of the time practices spent interacting with health plans is \$23 billion to \$31 billion each year. For primary care practices, this translates to an average cost of \$64,859 annually per physician, or nearly one-third of the income plus benefits of the average primary care physician, regardless of the size of the practice. Significant administrative relief is needed to allow doctors to spend more time with their patients and to reduce the costs of health care.

ACP is pleased that H.R. 3962 heads this call. The bill establishes standards for financial and administrative transactions that: facilitate use of patient-specific machine-readable cards that indicate patient eligibility for service and payment responsibility consistent with health plan coverage; enable, where feasible, real-time

adjudication of claims that would provide immediate electronic payment for services rendered; provide acknowledgement and status of electronic submissions; and ensure that all information, e.g. description of explanation of benefits, is in straightforward, unambiguous terms. Another positive is the requirement that health plans have a claims adjudication system that allows timely payments and has a denial management system that has uniform claims edit packages, uniform explanation of benefits/remittance advice, and appeals process. HHS is required to ensure that the standards are clear and unambiguous, requiring little need for interpretation and/or supplemental guidance. HHS is required to put these rules in place within two years and have a plan to update them periodically as needed. HHS can identify other standards in consultation with stakeholders.

The bill includes a mix of specific and general directives to HHS. ACP supports H.R. 3962 initiatives, which include a mix of specific and general directives to HHS, to simplify administrative requirements. ACP would work with HHS and other appropriate entities to establish the details pertaining to the implementation of standards for these directives.

End the annual cycle of Medicare doctor payment cuts

16. How does ACP feel about the efforts to reform the physician payment formula known as the Sustainable Growth Rate (SGR)?

H.R. 3962 does not address the flawed SGR formula because it is being addressed in a separate bill, the “Medicare Physician Payment Reform Act of 2009” (H.R. 3961), in tandem with H.R. 3962. House leaders have indicated a commitment to moving this stand-alone SGR fix bill in conjunction with the House’s comprehensive health reform bill.

H.R. 3961 would eliminate the SGR accumulated debt, remove expenditures on physician-administered drugs from the SGR calculation, use a MEI-based update for 2010, and have higher growth allowance for evaluation and management services going forward. Accounting for the funds to eliminate the accumulated debt is a huge step forward, because the hundreds of billions of dollars in accumulated budget costs associated with providing physicians with positive updates has been the single greatest obstacle to a permanent solution to the SGR problem. H.R. 3961 also provides a higher overall physician spending target than the current SGR formula—GDP plus two percent for all evaluation and management and preventive services, GDP plus one percent for all other services. The current SGR formula limits growth for all services only to GDP. H.R. 3961 also removes physician-administered drugs from the new formula, a longstanding goal of ACP, because inclusion of such drugs has been a major contributing factor to spending exceeding the SGR target.

Although a huge improvement over the current SGR, the College is concerned, though, that even with these changes, the continued reliance on GDP (even with the additional growth factors) could result in payments not keeping pace with physicians’ practice expenses, especially for services that are not included in the evaluation and management service/preventive services category. ACP’s goal continues to be to replace the SGR with a new update system that provides fair, predictable, and stable updates for physicians. ACP continues to explore how this new payment formula would impact future updates, and resulting revenue impact, that would result from the changes.

17. Does ACP support separate SGR targets as a way to control growth in Medicare Part B spending?

ACP prefers that Congress refrain from expenditure targets that determine payment updates. The College’s preference would be to implement payment reforms that encourage more efficient and effective care, e.g. the PCMH, and to only use expenditure targets if those efforts fail to control rising costs. The H.R. 3961 inclusion of expenditure targets indicates the belief that they are needed while reforms are identified and implemented. Faced with continued expenditure targets, ACP supports the higher expenditure target growth allowance for evaluation

and management services and preventive services that is provided in H.R. 3961. That being said, the College also wants to ensure that services provided by internists, including subspecialists, in the non-E/M service/preventive service category receive adequate updates.

Reform the medical liability system

18. President Obama noted in an address to the AMA earlier this year that he is not advocating for caps on damages in professional liability cases but that he is open to considering other reforms to reduce “defensive medicine.” Where does ACP stand on this issue?

ACP believes that reform of medical liability system is essential. The College supports professional liability reform that:

- Limits awards for noneconomic damages at \$250,000;
- Eliminates punitive damages;
- Eliminates the collateral source rule (eliminates double compensation to plaintiffs for certain items);
- Allows for periodic payment of future damages and structured settlements; and
- Provides for attorney fee regulation in personal injury and medical malpractice cases.

ACP also supports the testing of alternative solutions, such as health courts, which would have medical liability cases heard by an expert panel of judges instead of a lay jury, and other proposals developed by the AMA/Specialty Society Medical Liability Project.

19. Does H.R. 3962 address medical liability reform?

H.R. 3962 encourages states to explore alternatives to the costly liability system through reforms that ensure court cases have merit and that allow providers to quickly compensate patients without litigation by providing financial incentives to states that enact certificate of merit and/or early offers programs in medical liability cases. The bill unfortunately does not include a cap on non-economic damages. Realistically, though, caps on non-economic damages would not get the majority of votes in the House of Representatives and the 60 votes needed in the Senate for it to become law. The lack of support in Congress for caps is unfortunate, but this has been the case for decades, no matter which political party has had control of Congress or the White House. Accordingly, progress on medical liability reform is more likely to occur at a state level, with financial support from the federal government. Related, the Agency for Healthcare Quality and Research is soliciting proposals for “planning grants from States and health care systems for patient safety and medical liability innovations that put patient safety first and work to reduce preventable injuries; foster better communication between doctors and their patients; ensure that patients are compensated in a fair and timely manner for medical injuries, while also reducing the incidence of frivolous lawsuits; and reduce liability premiums.” More information can be found at: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HS-10-022.html>.

As the health reform proposals continue to undergo changes throughout the legislative process, ACP will continue to advocate for reforms to support innovative models, such as health courts, to reduce the costs of defensive medicine.

20. What does ACP think of the Republican alternative to H.R. 3962?

The House Republican leadership has developed a bill that it has offered as an alternative to H.R. 3962. The GOP alternative would create state risk pools, allow insurance to be sold across state lines, and prohibit insurers from rescinding coverage, but it does not provide any real financial support to help people buy coverage. Although the bill has some policies that ACP supports, like caps on non-economic damages in medical liability lawsuits, it does

not address ACP's priorities of ensuring that all Americans will have access to affordable coverage or reforming physician payments to support primary care. The Congressional Budget Office has estimated that the bill would reduce the number of nonelderly people without health insurance by about 3 million in 2019 and leaving about 52 million nonelderly residents uninsured. The share of legal nonelderly residents with insurance coverage in 2019-83 percent-would be roughly in line with the current share.

Other Health Reform Topics

21. Does ACP support the Comparative Effectiveness provisions of H.R. 3962?

The comparative effectiveness provisions are broadly consistent with ACP policy, which emphasizes the importance of the increased availability of comparative effectiveness information to assist patients and their personal physicians in choosing the most safe and effective treatment. ACP policy emphasizes that this comparative effectiveness information be the result of scientifically valid research from a trusted source, that there is multi-stakeholder input as part of a transparent process to develop this comparative effectiveness information and that this information be disseminated in a comprehensible manner for use by all relevant parties including patients, providers and healthcare payers.

H.R. 3962 facilitates the development of increased comparative effectiveness information through expanding the role of the Agency for Healthcare Research and Quality. The Agency has a successful history of comparative effectiveness information development under the restraints of meager Congressional financing. The bill also provides adequate protection from undue political influence by establishing a funding stream primarily independent of the Congressional authorization process.

22. How can the federal government possibly pay for comprehensive health care reform? Won't this bankrupt the country?

ACP believes that health reform should be funded in a way that is sustainable over the long term and does not contribute to the deficit. The Congressional Budget Office estimates that "enacting H.R. 3962 would result in a net reduction in federal budget deficits of \$104 billion over the 2010–2019 period. In the subsequent decade, the collective effect of its provisions would probably be slight reductions in federal budget deficits."

23. What happens if health care reform fails entirely?

ACP is committed to doing all that it can to get legislation enacted this year to ensure that all Americans will have access to affordable coverage and to a general internist or other primary care physician. ACP believes that the current health care system is not sustainable and reform is essential. In the absence of reform:

- Medicare Part A, which covers elderly inpatient visits, will run out of money by 2017, <http://www.ssa.gov/OACT/TRSUM/index.html>
- Also by 2017, an average middle-income family will spend four out of every 10 dollars they earn on health care alone, putting it out of reach for most. Economist Uwe Reinhardt, <http://economix.blogs.nytimes.com/2008/11/07/the-health-care-challenge-sailing-into-a-perfect-storm>
- By 2020, the number of uninsured is expected to climb from 46 million to 60 million, which is about one in five of our population, <http://www.census.gov/hhes/www/hlthins/hlthin07/hlth07asc.html>

- Even those with insurance will not be able to find a primary care doctor because of a pending primary care physician shortage of tens of thousands, http://www.medpac.gov/documents/20080916_Sen_Fin_testimony_final.pdf
- And although we rightly take pride in having some of the highest quality care in the world, at least some of the time, such care will increasingly become out of reach to many because of the cost.

On the other hand, we have within reach enactment of legislation that would:

- Expand coverage to 96-97% of all legal residents;
- Ensure that no one would be turned down, charged exorbitant rates, or have their insurance cancelled because they are sick;
- Ensure that no one would go bankrupt because of health care;
- Ensure that insurers would compete by offering better value rather than cherry-picking;
- Ensure that everyone would have access to essential services, including prevention; and,
- Create workforce policies and payment reforms that would begin to address the primary care workforce crisis.

The U.S. health care system is a train wreck in waiting, and the current health reform effort is our best and perhaps only chance to put it on a safer track. The U.S. has within its grasp the chance to enact legislation to provide affordable coverage to most Americans, to make the cost affordable and sustainable for families and businesses, and to begin to rebuild the primary care physician workforce. It is understandable why so many internists are unhappy with the way things are, and yet distrustful of the changes being proposed to make things better. But there will be far more reasons for internists to be discontented if health care reform is allowed to fail.