



AMERICAN COLLEGE OF PHYSICIANS  
INTERNAL MEDICINE | *Doctors for Adults*®

January 15, 2010

The Honorable Harry Reid  
Majority Leader  
United States Senate  
Washington, DC 20510

The Honorable Max Baucus  
Chairman  
Senate Finance Committee  
Washington, DC 20510

The Honorable Tom Harkin  
Chairman  
Senate Health, Education, Labor & Pensions Committee  
Washington, DC 20510

The Honorable Charles Rangel  
Chairman  
House Ways & Means Committee  
Washington, DC 20515

The Honorable Nancy Pelosi  
Speaker  
U.S. House of Representatives  
Washington, DC 20515

The Honorable Henry Waxman  
Chairman  
House Energy & Commerce Committee  
Washington, DC 20515

The Honorable George Miller  
Chairman  
House Education and Labor Committee  
Washington, DC 20515

Dear Majority Leader Reid, Speaker Pelosi and Chairmen Rangel, Waxman, Miller, Baucus, and Harkin:

On behalf of the 129,000 internal medicine physicians and medical student members of the American College of Physicians (ACP), I am writing to urge you to ensure that the final health reform bill **includes policies on coverage for all Americans, payment and delivery system reforms, and meaningful medical liability reform**. The following recommendations are offered to supplement ACP's detailed recommendations for ensuring that the final agreement includes the strongest possible policies to ensure a sufficient supply of primary care physicians, as communicated to you in a January 7 letter [www.acponline.org/advocacy/where\\_we\\_stand/access/1-7letter.pdf](http://www.acponline.org/advocacy/where_we_stand/access/1-7letter.pdf) and one-page [www.acponline.org/advocacy/where\\_we\\_stand/access/1-7rec.pdf](http://www.acponline.org/advocacy/where_we_stand/access/1-7rec.pdf) summary document.

ACP specifically requests that you include the following proposals from H.R. 3962, the Affordable Health Care for America Act, and H.R. 3590, the Patient Protection and Affordable Care Act:

1. **Coverage and affordability.** Both the House and Senate bills would make affordable coverage available to almost all legal residents in the United States by expanding Medicaid to the poor, providing sliding-scale tax credits to help people buy insurance, giving individuals and small businesses access to a wide range of insurers through a purchasing pool (health exchange), reforming insurance practices that allow them to deny coverage or charge excessive rates to people with pre-existing conditions, and requiring the health plans cover essential benefits, including preventive services. The final agreement must ensure that the subsidies are high enough to make coverage truly affordable for middle- and low-income persons. In

addition, the health exchange(s) should be empowered with the ability to negotiate premiums with insurers, spread risk, and facilitate consumer purchase of coverage. Large employers should be required to provide coverage or pay into a pool to fund coverage.

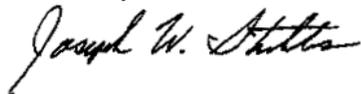
2. **Payment and Delivery System Reform.** ACP supports provisions in both the House and Senate bills make changes to the current payment and delivery system through identification and reapportionment of mis-valued physician fee schedule services (with dedicated funding as proposed by the House); creation of a Center for Innovation; independent research on comparative effectiveness; and reduction of administrative burdens. We support creation of a national strategy for quality through a defined multi-stakeholder collaborative process but recommend that all references in the bills to performance measure development and implementation require consistency with such a collaborative process. We support a study by the Institute of Medicine of geographic variations in quality and cost of care, as proposed by the House, but we do not support the Senate's proposal to adjust payments to physicians based on a value index to be based on an unknown (and therefore) unproven methodology. We support improvements in the Physicians Quality Reporting Initiative but strongly believe that any incentives for participation must be positive and non-punitive. We do not support the current Senate proposal to create an Independent Payment Advisory Board (IPAB) unless it is modified to include safeguards to mandate sufficient public participation, to allow it to make recommendations for all providers and suppliers at the onset; and to give Congress the authority, by a simple majority vote, to determine if the recommendations can go into effect.
3. **Medical liability reform.** Both the House and Senate bills would create a new grant program to fund pilot-testing by states of alternatives to the usual tort system. The College continues to believe additional steps are needed to reduce the costs of defensive medicine, including caps on non-economic damages and design and implementation of new models, such as health courts, to provide alternatives to costly and unpredictable jury trials.

Detailed recommendations regarding each of these provisions that should be included in a final agreement are attached.

Finally, in order for payment and delivery system reforms to be effective, Congress must repeal the flawed Sustainable Growth Rate (SGR) formula and replace it with a new update system that provides stable and positive payments, reflecting increases in practice costs, to all physicians, with higher updates for primary care and preventive services, as contained in H.R. 3961, the Medicare Physician Payment Reform Act of 2009. Although such legislation may be addressed separately from the final agreement on the health reform legislation, it must be enacted in time to prevent a 21% cut on March 1 and to ensure long-term stability in physician payments. ACP will not support another one or two year temporary "patch" that does not result in SGR repeal and creation of the new update system.

Taken together, these recommendations—when combined with the primary care recommendations discussed in our December 12 letter—will help ensure that all Americans will have access to affordable health care and to a primary care physician of their choice. We look forward to Congress advancing these crucial reforms in a final bill produced by Congress and signed into law by President Obama.

Yours truly,



Joseph W. Stubbs, MD, FACP  
President

## Detailed Recommendations for the Final Health Reform Bill on Coverage, Delivery and Medical Liability Reforms

January 15, 2010

### Coverage and Affordability

- Either a national health exchange with a state option to operate an exchange if it meets federal standards, as in the House bill, or state exchanges with a federal back-up, as proposed by the Senate, would be acceptable, but any such exchange, national or state, should be empowered with the ability to negotiate premiums with insurers, spread risk, and facilitate consumer purchase of coverage, as proposed by the House; ensure that sliding scale, advance, refundable tax credits are sufficient to make coverage affordable for eligible persons by adopting the House's higher level of subsidy for persons up to 300% of the Federal Poverty Level and the Senate's higher level for persons between 300 and 400% of FPL. Eligible persons could have access either to a public option, funded by premiums, which pays competitive, negotiated rates, as proposed by the House, or to multi-state plans, including one or more non-profit health plans offered in all 50 states and under contract with the Office of Personnel Management, as proposed by the Senate.
- Convert Medicaid from a categorical program to one that covers the poor and near-poor (up to 133% or 150% of the FPL), as in both bills, and provide sufficient funding to all states on an ongoing basis to maintain such coverage. Medicaid payments to primary care must be increased to equal the Medicare rates, as proposed by the House.
- Prohibit all insurers—including the small and individual insurance market and large group plans offered outside an exchange—from turning down, charging higher rates, or cancelling coverage based on a person's health status or pre-existing condition, implement such reforms by the earlier date of 2013, or 2018 for current employer-sponsored plans, and restrict pre-existing condition exclusions prior to insurance market reforms, as in the House bill.
- Require qualified health plans to cover essential benefits, including preventive services with no cost-sharing, as in both bills; essential covered preventive services should include, at a minimum, those with a rating of A or B by the U.S. Preventive Services Task Force or the Task Force on Clinical Preventive Services, while permitting health plans to offer additional preventive services. Immediately require that health insurers provide coverage with no cost-sharing of evidence-based preventive services with the option to provide additional services, as in the Senate bill.
- Provide consumers with information on medical loss ratios for various health plans, as in the Senate bill.
- Require larger employers either provide coverage or pay into a pool to fund coverage for the uninsured, as in the House bill, and require that individuals have health coverage, as both bills mandate, if sufficient subsidies are provided.

### Payment and Delivery System Reform

- Direct the HHS Secretary to periodically identify physician fee schedule services that are potentially mis-valued and make appropriate adjustments, with a dedicated appropriation of \$20 million annually, as in the House bill.
- Create a Center for Innovation to accelerate selection, testing, and adoption of innovative models, as in both bills.
- Establish positive and non-punitive incentives for participation in the Physicians Quality Reporting Initiative, as in the House bill; create an option for Maintenance of Certification (MOC) to qualify for positive PQRI bonus payments, as in the Senate bill; MOC should not become a requirement of any quality reporting processes.
- Establish an independent research institute on the comparative effectiveness of different treatments to inform clinical decision-making and coverage decisions, as in both bills.

- Reduce the administrative burdens, as in both bills; require the HHS Secretary to adopt a single, binding, uniform interim companion guide for the standards required under version 5010 of the HIPAA transaction rules and to develop specific standards to address uniform claim edits, reason and remark denial codes, first report of injury and electronic fund transfers (EFT), as in the House bill; require the HHS Secretary to adopt and use a single, mandated ICM-9 CM to ICD-10 CM and ICD-10 PS cross walk that is available at no charge to all stakeholders.
- Enact safeguards to mandate sufficient public participation and congressional oversight of any Independent Payment Advisory Board (IPAB) by modifying the language as proposed in the Senate bill, to: require a primary care physician as a Board member; give authority to address payment recommendations for all providers and suppliers at the onset; require that IPAB provide formal opportunities for public comment on policies before they are recommended for adoption; give Congress the authority, by a simple majority vote, to determine if the recommendations can go into effect; and remove any requirement that Congress must pass an alternative plan with equivalent savings. Without such safeguards, ACP cannot support IPAB as proposed by the Senate.
- Establish a national strategy for quality, as proposed in the Senate bill, through a collaborative process such as the National Priorities Partnership and utilize existing multi-stakeholder measurement development and validation processes to identify appropriate existing quality measures and develop measures where such measures do not exist. All references in the bills to performance measures should require consistency with such a collaborative process; the HHS Secretary should not have authority to unilaterally develop and/or implement measures outside of the collaborative process. Public reporting must be based on only on evidence-based measures as defined through such collaboration, be adjusted to reflect differences in the population being treated, and allow for physicians to correct inaccuracy in such reports or to provide additional explanatory information. Physicians should not be subject to duplicative or inconsistent reporting requirements.
- Require a study by the Institute of Medicine of geographic variations in quality and cost of care and methodologies to reduce such variation, as in the House bill, in lieu of the Senate’s requirement that the Secretary develop and implement a “value index” (based on a methodology that has yet be determined and that is beyond the current capabilities of CMS to develop and administer) to adjust payments to physicians based on the outcomes of care provided.
- In order for payment and delivery system reforms to be effective, Congress must repeal the flawed Sustainable Growth Rate (SGR) formula; Replace it with a new update system that provides stable and positive payments, reflecting increases in practice costs, to all physicians, with higher updates for primary care and preventive services, as contained in H.R. 3961, the “Medicare Physician Payment Reform Act of 2009.” Although such legislation may be addressed separately from the final agreement on the health reform legislation, it must be enacted in time to prevent a 21% cut on March 1 and to ensure long-term stability in physician payments. ACP will not support another one or two year temporary “patch” that does not result in SGR repeal and creation of the new update system, as proposed in H.R. 3961.

### **Medical Liability Reform**

- As a first step, fund state programs to improve patient safety and pilot test alternatives to the current medical liability tort system, as in both bills. Additional steps will be needed to reduce the costs of defensive medicine, including caps on non-economic damages and design and implementation of new models, such as health courts, to provide alternatives to costly and unpredictable jury trials.

In a separate document [http://www.acponline.org/advocacy/where\\_we\\_stand/access/1-7rec.pdf](http://www.acponline.org/advocacy/where_we_stand/access/1-7rec.pdf) and letter [http://www.acponline.org/advocacy/where\\_we\\_stand/access/1-7letter.pdf](http://www.acponline.org/advocacy/where_we_stand/access/1-7letter.pdf) to Congress, ACP has also provided detailed recommendations for ensuring that the final agreement includes the strongest possible policies to ensure a sufficient supply of primary care physicians.