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HEALTH CARE REFORM 2009

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[AAFP Letter Regarding America's Affordable Health Choices Act \(H.R. 3200\)](#) (*PDF file)

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Health Care Reform: FAQ's

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Why would family physicians support the bills in Congress?

The legislation in the House of Representatives contains numerous provisions that are designed to support primary care physicians. There is a bonus payment to primary care physicians of 5 percent (10 percent if the practice is in a physician shortage area – usually rural areas). The SGR is eliminated (which is good for all physician practices) and the replacement system has higher conversion factors for E/M and preventive care services, which are the ones that most family physicians provide. Primary care services in Medicaid are paid at least at the Medicare rate, which is a substantial increase in some states. The legislation invests in a broader pilot-testing of the medical home practice model. And payments to departments of family medicine and to family medicine residencies are increased, and there is increased tuition assistance for medical students who choose family medicine (or other primary care specialties). The legislation is the first major investment in primary care that the federal government has made in years. Finally, the bill is consistent with our long-term policy of supporting health care coverage for all – and this legislation is a step in that direction.

Many of my elderly patients are concerned that Medicare is going away. What should I tell them?

There is nothing in the current bills that would take away Medicare. Please tell your patients that Medicare will still be there for them – even if health care legislation passes Congress. The legislation does not eliminate the program, nor does it eliminate benefits.

Why is the AAFP supporting a so-called "public plan?" I think that will lead to a single-payer system or socialized medicine.

The legislation preserves the private insurance market, so medicine will not be socialized. But what it is intended to do is to provide some competition for insurance companies, especially in areas where one company is dominant or a monopoly, which are often rural and where many of our members have no leverage in negotiating with the major plans. Members have been asking for years to find some method to give them some bargaining power with the major plans. While this is not the best mechanism, it is



a start.

In addition, it is not at all clear whether or not a public plan will be part of any final bill. Many Members of Congress – particularly in the Senate – are discussing the idea of a “co-op,” which would be a non-profit entity run by the members at the state or national level.

However, the AAFP Board of Directors discussed public plans at length, since this option has been part of the discussion for quite some time. The Board came up with principles on a public plan option, consistent with those set forth in the New America Foundation document “[A Modest Proposal for a Competing Public Health Plan](#)” (12-page PDF file: [About PDFs](#)).

These principles are:

- administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace -- in other words, the authority overseeing the marketplace and responsible for enforcing its rules should not have an incentive to favor a public plan compared with private plans;
- the public plan cannot be Medicare;
- the public plan must be actuarially sound;
- the public plan cannot leverage Medicare or any other public program to force providers to participate;
- the public plan should not be required to use Medicare payment rates;
- insurance market rules and regulations governing the public plan must be the same as those governing private plans;
- the public plan cannot be granted an unfair advantage in enrolling the uninsured or low-income individuals, who presumably will be eligible for subsidies in the new marketplace;
- public and private insurers should be required to adhere to the same rules regarding reserve funds; and
- the public plan would need to contribute to value-based initiatives that benefit all payers.

We have used these principles as a yardstick to measure the public plans in the House and Senate bills. We have found that the bills are consistent with our policy. The bills do not force providers or patients to participate and plans will negotiate rates with providers.

Do these bills change how I will get paid?

The House bill includes language that replaces the current SGR formula with another volume-control payment method. This includes better payment rates for cognitive services, like office visits and preventive health services, than for procedural services. The new formula is GDP + 2 percent for E/M and preventive services and GDP + 1 percent for all other services.

This does not benefit primary care physicians exclusively, since most physicians provide at least some cognitive health care services. It encourages the effective use of a physician's training and skills. Whether it is sufficient is always an open question until the data is in. Our early review of the revised payment structure suggests that it is a step in the right direction for our members and is a good down payment for better enhancement for primary care.

And, without the House bill, physicians get a 21 percent cut in Medicare next year and cuts in the 5 percent range annually for the foreseeable future. This bill is a major step forward out of a failed Medicare formula that has plagued us since 2001.

The Senate Finance committee has not yet released their legislation so we cannot review it at this time.

Why is my Academy supporting bills that will increase the deficit?

The cost of health care reform may be significant, but part of the reason is that we have postponed dealing with the problem. As significant as the cost is now, it will only get higher if we continue to put off the necessary decisions. Paying for health reform will require a combination of measures like tax increases, reductions of tax benefits, and efficiencies in the health delivery system.

The goal of the legislation is not to increase the deficit. Specifically, while the House legislation would rebase the SGR, and this money would be added to the deficit, members of Congress continue to seek various means to pay for the reform legislation.

Won't the comparative effectiveness research give federal bureaucrats the power to make medical decisions for your patients and force rationing of health care?

We do not believe that more knowledge about how various treatments, procedures, and products compare with each other will lead to rationing. Instead, we believe that the more objective information physicians and patients have about health care issues the better their choices will be. It is valuable to have a respected agency like the Agency for Health Care Research and Quality as a disinterested moderator of this information.

How come I'm not hearing anything about medical liability in these bills? Wouldn't medical liability reform cut costs?

There are clearly additional costs due to defensive medicine. The AAFP's policy has called for a cap on non-economic damages, and we have signed a letter to Congress, along with several other physician groups that calls for medical liability reform. There are many alternatives that Congress has considered from time to time. For example, we have supported bills that would give some states authority and resources to try out alternative methods of dispute resolution and liability settlements.

Right now, the bills do not contain medical liability reforms, but we know that many Members of Congress are interested in including different reforms. We are advocating that these reforms be added later as the legislation works its way through the process.

What about nurse practitioners? I heard they now will be treated the same way as physicians.

No. Members of Congress are keenly aware of the differences in training between physicians and nurse practitioners. Nevertheless, in an effort to help provide health care access to some rural areas, the House bill does make some changes.

While nurse practitioners are potentially able to head primary care medical homes, this is only in pilot programs and only in states where they have independent authority to practice. In addition, their payment rates under Medicaid – like physicians' – are increased, but the differential between NPs and physicians is maintained. Finally, both physicians and nurse practitioners are eligible for Medicare payment incentives – 5 percent for selected primary care services. This language is part of the House bill's overall goal of providing more funding for primary care.

Why won't employers simply "dump" their employees into any public plan?

In the House bill, employers are prohibited from selecting the public plan for their employees. They are required to provide coverage or pay a payroll tax. Specifically, their options are to continue to buy a group policy as they do today; set up a self-funded plan, or make a defined contribution so that their employees may purchase a plan through the Exchange.

In the HELP bill, there is a requirement that if someone is offered employer sponsored coverage they cannot enter the gateway and thus the community health insurance option unless that offer is unaffordable to them (using a rigorous test). CBO has estimated no net loss of employer-sponsored coverage.

Isn't the Patient-Centered Medical Home just another version of the failed "gatekeeper" model run by the HMOs many years ago?

Good question and here's the difference. The medical home model is on which patient care is an integrated team with the primary care physician at the center.

Patients are active participants in their own health and well-being. They are cared for by a physician who leads the medical team that coordinates all aspects of preventive, acute and chronic needs of patients using the best available evidence, appropriate technology, and referrals to sub-specialists when needed.

But, aren't you taking away the individual's freedom of choice through a Patient-Centered Medical Home?

The short answer is no. In the medical home model, the primary care physician and the patient decide together which path to take. If they decide that the patient would benefit from a particular treatment provided only by a subspecialist, then the primary care physician would work with the patient to make that happen. Importantly, however, the primary care physician would stay involved, i.e., after a particular treatment, both physicians would discuss next steps, in conjunction with the patient.

What about sub-specialists? What financial incentive is there for them to participate if all money goes to primary care?

As physicians who all have taken the Hippocratic Oath, we clearly believe that our sub-specialist colleagues will continue to see patients, even under a reformed health care system that places more emphasis on primary care. In addition, our sub-specialist colleagues will be able to treat those extraordinarily complex cases, in conjunction with the primary care physicians, for which they have been trained.

Nevertheless, there is no simple way to predict how physicians – or the market – will react. Our goal in supporting health care reform simply is to establish the best system that provides the right kind of care for the patient at the right time.

I've heard a lot of about "insurance reforms." What sort of reforms are in the health reform bills?

- Protects patient choice
- Prohibits pre-existing condition exclusions
- Requires guaranteed issue and renewal for insured plans
- Requires parity in mental health and substance abuse disorder benefits consistent with AAFP policy
- Ensures adequacy of provider networks.
- Ensures value and lower premiums
- Requires coverage of essential benefits package including prevention
- Requires fair marketing practices by health insurers
- Requires fair grievance and appeals mechanisms
- Requires information transparency and plan disclosure
- Requires timely payment of claims
- Requires administrative simplification
- Closes the Medicare Part D donut hole is also big for our patients.
- Eliminates annual and lifetime caps on losses.

How do these bills help family physicians, like me?

The AAFP is strongly committed to health care reform legislation that will increase the number of family doctors and boost your Medicare payments.

The House bill offers strong support for primary care in a variety of ways, including medical home demonstration projects, improving Medicare payment for primary care physicians, expanding scholarships and loan programs for those who choose careers in primary care, and reforms the way that Medicare updates physician pay rates that recognized the value of primary care.

The bill that was passed by the Senate HELP committee also includes a number of primary care provisions. While the committee does not have jurisdiction over Medicare – that is handled by the Senate Finance committee -- the HELP bill supports training for family medicine; gives priority to programs that educate students in team-based approaches to care, including the patient-centered medical home; Increases the supply of qualified health care workers by providing low-interest student loans and loan repayment programs and creates a Primary Care Extension Program to provide assistance to primary care providers about evidence-based therapies, preventive medicine, health promotion, chronic disease management, and mental health.

It also funds Community Health Teams to support the development of medical homes and to ensure a patient's care is coordinate by a team that includes primary care providers.

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