



Board of Directors Report O to the 2009 Congress of Delegates

Health Care Reform

(1) This supplemental report provides an overview of current activities on health system reform (current as of October 10, 2009) for the information of the Congress of Delegates.

AAFP Advocacy Guidelines (Principles) for Health System Reform

(2) The following guidelines have been approved by the AAFP Board of Directors to guide our advocacy efforts during the final efforts to achieve meaningful health system reform in 2009. Such guidelines are subject to change and compromise in these negotiations with the Administration and the Congress subject to approval as determined by the Board chair.

- 1) Any reform legislation should be consistent with current AAFP policy.
- 2) Expanded health care coverage should be accomplished by this legislation in a meaningful manner.
- 3) Reform of the private insurance market should be fundamental to such legislation including guaranteed issue of insurance and the elimination of pre-existing illness exclusions.
- 4) Such reform legislation must fundamentally begin to recognize and place value upon the role of family medicine and primary care as essential in a reformed health care system. The Academy will work to achieve the following goals in this regard:
 - a) GME reform favorable to family medicine and primary care training to assure an improved workforce
 - b) A permanent fix to the current SGR formula should be included in the overall effort for health system reform – either inclusive of the reform legislation or other legislation achieving this goal for 2009
 - c) A primary care bonus of at least 10% will be a strategic goal in lobbying for such reform legislation. The AAFP however believes that such a bonus should actually be 25% cumulative over the next 5 years.
 - d) Health reform legislation should expand the ability of Medicare and Medicaid to move forward rapidly with the implementation of the PCMH model of care, including a blended model of payment. This must include all Medicare beneficiaries and not just those with certain chronic disease conditions.
- 5) The AAFP supports a public plan that includes the following principles:
 - The administrators of the public plan must be accountable to an entity other than the one identified to govern the marketplace.
 - The public plan cannot be Medicare.
 - The new 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.
 - The insurance market rules and regulations governing the public plan should 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 will presumably be eligible for subsidies in the new marketplace.
 - Public and private insurers should be required to adhere to the same rules regarding reserve funds.

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- 1 • The public plan would also need to contribute to value-based initiatives that benefit
2 all payers.
- 3 6) The AAFP can support the creation of an independent commission to oversee the quality
4 and cost of the Medicare and Medicaid programs. Legislation creating such a commission
5 must assure the following:
- 6 a) The commission membership should be broadly based and be inclusive of primary
7 care physician representation as well as consumers, employers, and other major
8 stakeholders. It must not be dominated by full time government employees.
- 9 b) Final commission recommendations should be subject to Congressional override by
10 a defined mechanism.
- 11 c) The commission should follow the current procedure of a public comment period for
12 any of its recommendations before final promulgation and approval of such
13 recommendations.
- 14 d) The commission should have oversight of all providers in the Medicare program
15 (physicians, hospitals, home health agencies, etc.) in exerting its authority to
16 address quality and cost issues with Medicare and Medicaid. If this commission is
17 only given jurisdiction over Medicare Part B in its work, there must be a clear,
18 transparent, and enforceable alternative process to address and control the quality
19 and cost of the other parts of Medicare and those provider sectors. And this
20 process must assure coordination with the above noted commission in making its
21 recommendations.
- 22 7) The AAFP does not believe that health reform legislation should include a penalty for
23 certain physicians deemed by some mechanism to be 'cost outliers' as it is very uncertain
24 as to the validity of such cost data within the Medicare program.
- 25 8) It would be preferable for the current PQRI program in Medicare to maintain or increase the
26 2% annual bonus and it should remain a voluntary program.
- 27
- 28 9) Reform of the medical liability system should be included in health reform legislation and
29 should include the following provisions:
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- 31 a) Impose a hard cap on non-economic damages;
- 32 b) Limit attorneys' contingency fees;
- 33 c) Inform juries of prior insurance payments to patients and reduce awards
34 by the amount of compensation from collateral sources;
- 35 d) Replace joint and several liability with proportionate liability, so each party
36 would pay a share of a malpractice award based on the proportion for
37 which he is liable;
- 38 e) Allow periodic payment of future damages at a defined award limit;
- 39 f) Provide for Alternative Dispute Resolution Systems, and
- 40 g) Require an expert witness who possesses knowledge and expertise and
41 practices in the same medical specialty as the defendant.
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BACKGROUND

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47 (3) Shortly after the federal elections of 2008, in which the Democratic Senator from Illinois, Barack
48 Obama, was elected President, and in which reforming the way health care in this country was paid for
49 and delivered became a major campaign discussion, the chairman of the Senate Finance Committee,
50 Senator Max Baucus (D-MT), released a white paper on health reform proposals. Thus began a debate

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1 that has engaged Congress and the American public in an evaluation of a complex health care system
2 that is mixed with public and private payers and providers. The focus of the debate has shifted between
3 finding ways of assuring health care coverage for those without insurance to “bending down the curve” of
4 rising health care costs for individuals, employers and the government.

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6 (4) The AAFP has been deeply involved in this debate from the beginning. Sen. Baucus, for example,
7 sought the AAFP’s advice on how to improve payment for primary care physicians and how to build up the
8 supply of family physicians as more people receive health care coverage. The House Ways and Means
9 Committee and the Energy and Commerce Committee both invited public testimony from AAFP on how to
10 better provide health care based on primary care. Officials from the Department of Health and Human
11 Services (HHS) and the White House policy staff solicited family medicine’s views on various proposals for
12 implementing the Patient Centered Medical Home (PCMH), which will give primary care physicians
13 considerable help in delivering care to their patients.

14
15 (5) AAFP developed and perfected several tools for amplifying family medicine’s message of health
16 reform built on primary care and investments in the education and training of family physicians. One
17 important tool is the AAFP’s federal political action committee (FamMedPAC), which raised nearly
18 \$750,000 in the 2007-2008 election cycle and has raised \$250,000 since the beginning of 2009. These
19 funds have been used to contribute to campaigns of legislators who support many or all of family
20 medicine’s Congressional priorities. The PAC has orchestrated meetings with legislators, in Washington
21 and in the home districts that have allowed family physicians to engage in serious and useful discussions
22 about health reform.

23
24 (6) The AAFP also initiated the Connect for Reform program, which provides AAFP members who
25 choose to sign on to the service frequent updates on the progress of health reform in Congress and alerts
26 for opportunities to weigh in with legislators at appropriate times. It has also included a blog to which
27 members can post their ideas, suggestions and information, providing members with an unusual
28 opportunity to exchange opinions with fellow family physicians around the country.

29
30 (7) The grassroots program actively encouraged members and chapters to participate in the town hall
31 meetings that legislators regularly use to stay in touch with their constituents, especially during the month-
32 long August break. Members and chapters were provided with talking points, background information and
33 summaries of the issues, sample op-ed and letters to the editor and information about scheduled town
34 halls. Members who attended sent in reports on the discussions and often found themselves to be the
35 only physicians who addressed the issues, making them valued advisors for the legislator and staff.

36
37 (8) As the debate on health care reform escalated, AAFP flew in to Washington several family
38 physicians who had relationships with particular legislators who were key to an upcoming debate or vote.
39 These family physicians met with the legislator and staff to help make the case that the legislator’s actions
40 were being observed by their constituents.

41
42 (9) The AAFP Board’s Executive Committee met every Monday by conference call to review the past
43 week’s actions of Congress and consider what they needed to do for the week ahead. They flew in to
44 Washington to testify before Congressional Committees, to meet with key legislators, to participate in a
45 Congressional press conference, to attend a White House summit on health care reform and to meet with
46 the President in the Oval Office and participate with him in a Rose Garden event.

47
48 (10) At the annual Family Medicine Congressional Conference, the Senate’s Deputy Majority Leader,
49 Senator Dick Durbin (D-IL), received the AAFP Award for National Leadership in Government Service. In
50 addition, Ways and Means Committee member, Rep. Xavier Becerra (D-CA), addressed the conference
51 participants at a FamMedPAC/Grassroots Advocacy reception. Over 200 AAFP and academic family

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1 medicine organization members attended this year's conference, which provided participants with the tools
2 they needed to take the message of family medicine and health reform to their legislators and the
3 opportunity to meet with other family physicians who were equally engaged in the debate.
4

5 (11) The Government Relations staff also met continuously with Congressional legislators and staff
6 during the months that they were planning and deliberating on health reform proposals. The AAFP
7 produced statements and sent detailed letters to Congress at each stage in the process, making sure that
8 Congress had the input of family medicine.
9

10 (12) To amplify that message, AAFP participated in several coalitions of stakeholders in health care
11 reform. AAFP is part of the Health Care for America Now (HCAN) coalition, which supports broad health
12 care coverage; the Herndon Alliance, which is led by Bob Crittenden, MD, a family physician from Seattle
13 and which is involved in developing the most effective messaging for health reform; the National Coalition
14 on Health Care, which is a several decades-old coalition of business and labor organizations that support
15 health care for all; and most recently, Americans for Stable Quality Care, which is supported by the AMA,
16 Families USA, pharmaceutical companies.
17

18 (13) Five committees debated health care reform and produced legislation of more than a thousand
19 pages. As the AAFP Congress of Delegates meets in Boston, both the House of Representatives and the
20 Senate are preparing to take their bills to the floor. After each chamber votes on a bill, both measures will
21 be considered by a conference committee for a final bill, probably by the end of the year. A more detailed
22 summary of how the issue of health reform has been debated and discussed follows.
23

24 THE WHITE HOUSE

25 (14) On September 9, President Barack Obama told a rare joint session of Congress that he was not
26 the first President to pursue health reform but that he was determined to be the last. The President
27 described the problem that plagues the health care system as not just a problem for the uninsured and
28 urged legislators to act as quickly as possible.

29 (15) Drs. Jim King, Ted Epperly and Lori Heim, AAFP's Board Chair, President and President-elect, met
30 with President Obama in the Oval Office then participated in the event at the White House Rose Garden
31 on October 5. The White House had invited doctors from across the country including representatives
32 from the American Medical Association, the National Medical Association, the Family Physicians, and the
33 American College of Physicians, the Doctors for America, American Academy of Pediatrics, and the
34 American College of Cardiology.

35 (16) At the Rose Garden event, President Obama reiterated his core principles for health care reform
36 and acknowledged the important role doctors play in this debate by saying, "You are the people who know
37 this system best. You are the experts. Nobody has more credibility with the American people on this issue
38 than you do."

39 Patient-Centered Medicare Demonstration Pilot

40 (17) AAFP was invited by the White House to a patient-centered medical home event on September
41 16. Nancy-Ann DeParle, Director of the White House Office of Health Reform, HHS Secretary Kathleen
42 Sebelius, Governor Jim Douglas (R-VT) jointly announced an important demonstration pilot to promote
43 "Advanced Primary Care."

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1 (18) Secretary Sebelius credited Governor Douglas with having “a good idea” which won the approval
2 of HHS to allow Medicare to join Medicaid and other providers to implement integrated, patient-centered
3 care. Under what Governor Douglas described as the “Blueprint” primary care physicians will be paid
4 higher fees for providing quality care rather than paying more for increased volume.

5 (19) They also took the opportunity to promote the President’s health reform effort. The Secretary
6 quoted President Reagan’s statement that status quo “is Latin for the mess we’re in” and called for prompt
7 action on health reform. She noted, as an indication that Congress must act on health reform that the
8 Kaiser Family Kaiser Family Foundation announced that health care premiums will increase next year
9 along with co-pays and deductibles.

10 HHS Grants to Improve Patient Safety, Cut Defensive Medicine

11 (20) In his address to the joint session of Congress, President Obama said that he would immediately
12 address medical liability by allowing states to make decisions on how to deal with the issue with financial
13 help from the federal government. Following up on that pledge, the Secretary of HHS, Kathleen Sebelius,
14 announced the availability of grants to states for experiments in reducing medical malpractice and the
15 resulting lawsuits. HHS will give out \$25 million in grants to states and hospital systems for projects to
16 improve patient safety and reduce frivolous lawsuits against physicians. Additional information is available
17 at: <http://www.healthreform.gov/newsroom/factsheet/medcalliability.html>
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20 THE HOUSE OF REPRESENTATIVES

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22 (21) During July, the House Energy and Commerce debated its health reform bill (HR 3200) in fits and
23 starts as Committee Chair Rep. Henry Waxman (D-CA) and House Speaker Rep. Nancy Pelosi (D-CA)
24 tried to bridge the divide between the concerns of the fiscally conservative Blue Dog Democrats and the
25 liberal Progressive Caucus. After a number of false alarms, Chairman Waxman announced that he, the
26 Blue Dogs and more liberal members had come to an agreement. The proposal would assuage Blue Dog
27 concerns about cost but allow liberal Democrats to fund subsidies for families to purchase insurance. One
28 major change that AAFP requested was the public plan option was separated from Medicare payment
29 schedule and the Centers for Medicare and Medicaid Services (CMS) will be able to negotiate rates from
30 the beginning of the public plan. This will assure additional bargaining leverage for physicians, since they
31 will not be locked into Medicare rates, as originally proposed.

32 (22) The Energy and Commerce Committee met on September 23 to complete work on amendments to
33 the health care reform bill that had not been voted on prior to the August recess. After a one-day session,
34 the Committee passed a series of amendments, by a vote of 28-22, which had been agreed to by
35 Chairman Henry Waxman (D-CA) and the senior Republican, Rep. Joe Barton (R-TX). This additional set
36 of amendments now goes to the House Rules Committee to be combined with the previously approved
37 health reform bills.

38 (23) House Speaker Nancy Pelosi (D-CA) has said the bills from the House Energy and Commerce,
39 Ways and Means, and Education and Labor committees likely will be merged sometime in October and
40 presented to the full House for debate. However, differences remain around the precise structure of the
41 public plan option to be contained in the merged bill. Among other issues, payment rates to providers
42 differ: the Ways and Means measure would link payments to Medicare, while the Energy and Commerce
43 committee would mandate that the public plan negotiate with providers for rates.

44 (24) Some commonalities in the three versions of the House bill include:

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- 1 ○ an end to the Medicare formula known as the Sustainable Growth Rate (SGR)
- 2 ○ separate expenditure targets for primary care and all other medical services with a larger
- 3 target for primary care
- 4 ○ pilot testing of the Patient-Centered Medical Home
- 5 ○ 5-percent bonus Medicare payments to primary care physicians
- 6 ○ Medicaid reimbursement at parity with Medicare
- 7 ○ extension of the voluntary Physician Quality Reporting Initiative (PQRI)
- 8 ○ several provisions designed to increase primary care workforce

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10 (25) After the bills have been combined, the resulting legislation will go to the Congressional Budget
11 Office to determine how much the bill will cost, which should take approximately 10 days. After receiving
12 the bill's cost, House leaders will determine when to put the legislation on the floor for a vote. Due to the
13 high political stakes associated with this bill, House leadership has taken a key role in determining the
14 contents of a final bill.

15 (26) Of particular interest to family physicians, prior to the end of the Energy and Commerce debate,
16 Rep. Diana DeGette (D-CO) had a formal discussion with Health Subcommittee Chairman Frank Pallone
17 (D-NJ) regarding reauthorization of Title VII Health Professions Grants. Rep. DeGette highlighted the
18 importance of reauthorizing the primary care workforce training provisions that were improved by the
19 health care reform bill, but also wanted to ensure that the committee approved the provisions of the Title
20 VII programs that fell outside the pending health reform legislation. Chairman Pallone acknowledged that
21 the health reform bill targeted primary care training to facilitate access for all Americans and pledged to
22 work with Rep. DeGette to reauthorize Title VII.

23 (27) AAFP Board Chair, Jim King, along with the President of the Patient Centered Primary Care
24 Collaborative (PCPCC) Paul Grundy, MD and Larry Wickless, DO, the President of the American
25 Osteopathic Association were on Capitol Hill on July 29 to meet with the fiscally conservative Blue Dog
26 Democrats on health care reform. AAFP sought to highlight the need for increased support for primary
27 care and the Patient Centered Medical Home.

28 (28) Rep. Zack Space (D-OH) was one of the Energy and Commerce Committee Blue Dogs who made
29 a deal to wrap up the committee consideration of the bill before the recess and produce a budget neutral
30 measure with a voluntary public plan which does not use Medicare payment rates.

31 (29) The legislative health aide to Rep. Allen Boyd (D-FL) acknowledged the value of PCMH and
32 described the need to bend the health care cost curve. Dr. Grundy told him about the IBM experience and
33 other PCMH models finding lower costs in primary care based systems.

34 (30) Staff to Rep. Parker Griffith, MD (D-AL) said that the Representative was opposed to any public
35 plan in the bill. When asked about how he might view the exchange or co-op alternatives, she reiterated
36 that he opposed a public plan. Rep. Griffith feels strongly that medicine will be well served by a
37 competitive insurance market so that physicians are not limited as they are by Medicare.

38 (31) The legislative director to Rep. Collin Peterson (D-MN) noted that the Representative is "skeptical
39 about PCMH." She thinks it is too costly and will impose a government bureaucracy to determine who is
40 eligible. She thinks that adding a payment code for care management would be better and said that hiring
41 a nurse "health coach" would be even better. She recognizes that there are physician shortages and
42 thinks that we should support scholarships and loans and a fair payment structures.

43 (32) The legislative aide to Rep. Harry Mitchell (D-AZ) was receptive to the group on primary care
44 access and workforce issues. She indicated that the Representative asked to be briefed on the "medical

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1 home” concept a few weeks ago and has been a strong supporter ever since. He is concerned that if
2 health reform is enacted that there will not be enough primary care physicians to care for the population.

3 (33) The staff to Rep. Marion Berry (D-AR) indicated he likes the House bill because it helps
4 underserved areas, but he is sensitive to workforce issues and wants an increase in residency slots. He
5 does not want to risk “coverage” without “care.” He would like to reduce or eliminate the geographic
6 payment disparity under Medicare.

7 (34) Rep. Dennis Cardoza (D-CA) sits on the Rules committee which will be the next stop for the House
8 bill after it clears Energy and Commerce. Rep. Cardoza said his wife, Kathleen McLoughlin, is a family
9 physician and AAFP member. He emphasized the importance of “bending the cost curve” as a goal for
10 any viable legislation. GME funding issues have plagued at least one residency program in his district, and
11 there are plans to open in the district a medical school emphasizing primary care.
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15 SENATE HEALTH, EDUCATION, LABOR AND PENSIONS (HELP) COMMITTEE

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17 (35) On June 9, Senator Edward Kennedy (D-MA), Chairman of the Health, Education, Labor, and
18 Pensions (HELP) Committee, presented his draft health reform legislation, the *Affordable Health Choices*
19 *Act*. This comprehensive health care reform bill would require everyone to be insured, reorganize the
20 insurance industry and help make health care more accessible for low-income U.S. residents. Because of
21 jurisdictional issues, it did not propose any changes to Medicare or Medicaid, since that is within the
22 purview of the Finance Committee. In a letter dated June 15, the Congressional Budget Office (CBO)
23 projected that this bill would cover about 39 million individuals of the currently 47 million uninsured. On
24 June 17, the Committee began considering hundreds of amendments to be offered to the draft bill.
25 Committee Republicans used the debate to highlight the projected cost of the bill.
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27 (36) After four weeks of debate, on July 15 the committee voted 13-10 on party lines to approve its
28 \$611 billion health care reform legislation.
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31 SENATE FINANCE COMMITTEE

32 (37) On September 16, Senator Max Baucus (D-MT), who chairs the Senate Finance Committee,
33 released a draft of his health reform bill, the *America’s Healthy Future Act*. In spite of the Senator’s efforts
34 to win bipartisan support, Republicans unanimously rejected it.

35 (38) The bill would mandate that all Americans have health insurance and prohibit insurers from
36 denying coverage based on pre-existing conditions. The bill calls for nonprofit, member-owned
37 cooperatives instead of a government-run insurance plan to compete with private carriers. The
38 Congressional Budget Office’s preliminary estimate projected that the health reform bill would result in
39 coverage for 94 percent of all non-elderly U.S. residents and cost \$774 billion over a decade.

40 Physician Payment

41 (39) The Senate Finance bill carries a provision that would result in a 10-percent bonus for primary care
42 services provided by primary care physicians. Half of this bonus would be paid for by reductions in
43 payments for other physician-provided services, resulting in a payment decrease of 0.5 percent for non-
44 primary care physicians.

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1 (40) Like the House bill, the Baucus draft bill would extend the PQRI, but this legislation would impose a
2 2-percent penalty for failure to participate. However, physicians who complete a Maintenance of
3 Certification program would be considered participating.

4 (41) The bill would avert for one year the scheduled 21 percent cut in the conversion factor for the
5 Medicare Physician Fee Schedule and replace it with a 0.5 percent increase for calendar year 2010. The
6 existing SGR formula would be applied again in 2011 and a 25 percent decrease in the conversion factor is
7 projected. Unlike the House bills, Medicaid payment rates would not be affected in the Senate legislation.

8 **Physician Workforce**

9 (42) The Baucus draft bill also has several provisions designed to increase the primary care workforce
10 including redistribution of unused residency slots with a priority toward primary care, increased flexibility in
11 laws and regulations governing graduate medical education funding in the Medicare program,
12 development of a national health care workforce strategy, and demonstration grants to address needs in
13 the health professions workforce

14 (43) The draft bill would seek to increase training and improve access to primary care services.
15 Qualified teaching health centers would be eligible for payments for direct graduate medical education
16 expenses and other indirect expenses associated with operating approved graduate medical residency
17 training programs.

18 (44) The AAFP issued a statement acknowledging that the *America's Healthy Future Act* seeks to
19 provide Americans with access to affordable care and to establish a solid foundation of primary care. The
20 statement indicates that AAFP "looks forward to working with the Senate on these and additional features
21 of health system reform — such as finding a permanent solution to the formula by which Medicare pays
22 physicians and permitting additional medical liability reforms — as this legislation moves forward."

23 **Medicare Commission**

24 (45) The draft bill included a provision that would create an independent Medicare Commission to
25 submit proposals for reducing excess growth in Medicare costs by targeted amounts. The commission
26 would operate under procedures that would require the implementation of its cost-reduction
27 recommendations unless Congress overrides the recommendations and offers a substitute measure that
28 would reduce Medicare costs by a similar amount. The committee revealed during its deliberations that
29 these cost-cutting measures would not affect Part A payments, since the hospitals and hospices had
30 agreed to a separate multi-billion dollar reduction in their Medicare payments.

31 (46) In late September, the committee began meeting for 2 weeks to consider amendments to the draft
32 bill. These are the major issues of debate:

33 **Public Plan Option**

34 (47) The committee voted 15-8 against an amendment by Sen. Jay Rockefeller (D-WV) to add a public
35 insurance option to the \$900 billion health care reform package. The Consumer Choice Health Plan
36 (CCHP) would be available to all individuals and businesses purchasing health insurance through the
37 national health insurance exchange. It would use Medicare payment rates for at least 2 years and
38 physicians who participated in Medicare would be considered participating in the CCHP unless they
39 specifically opted out. Five committee Democrats joined all 10 Republicans in voting no. The Democrats

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1 voting against the Rockefeller amendment included Baucus and Senators Tom Carper (DE), Kent Conrad
2 (ND), Blanche Lincoln (AR) and Bill Nelson (FL).

3 (48) The panel immediately moved to consider a second public insurance option amendment offered by
4 Senator Charles Schumer (D-NY). Although largely similar to the Rockefeller measure, Schumer's
5 amendment would require a government-run insurance option, within an exchange, but with
6 reimbursement rates negotiated between plan administrators and providers. Under this amendment,
7 physicians and hospitals would be able to voluntarily opt in to participate in the public option plan. This
8 amendment was defeated by a vote of 10 to 13. All committee Republicans voted in opposition and were
9 joined by Democrats Baucus, Conrad, and Lincoln.

10 (49) On the final day of committee debate, Senator Maria Cantwell (D-WA) offered an amendment that
11 would allow states to create a basic health plan to cover residents who earned between 133 and 200
12 percent of the federal poverty level. If a state chose to create such a plan, it would be allowed to use the
13 low-income subsidies designated for this population to purchase health coverage on behalf of these lower-
14 income residents. Senator Jon Kyl (R-AZ) expressed concern about whether such a state-based option
15 would affect the general risk pool, effectively increasing premiums for those with higher incomes. The
16 amendment passed on a largely party-line vote of 12 to 11, with Sen. Lincoln voting with the committee
17 Republicans.

18 **Quality Modifier**

19 (50) Senator Cantwell also offered and the committee agreed to accept an amendment that would
20 direct the HHS Secretary to develop and implement an additional modifier to the Medicare Physician Fee
21 Schedule that would be based on quality. The yet-to-be-identified indicators are intended to mitigate
22 geographic variation in physician payments.

23 **Comparative Effectiveness Research**

24 (51) The committee also defeated two amendments that would have limited the federal government's
25 use of information produced by comparative effectiveness research (CER). Senators Pat Roberts (R-KS)
26 and Kyl offered amendments that would ensure that federal government entities could not use CER data
27 to make coverage decisions and ultimately ration the delivery of health care services. Sen. Baucus
28 insisted that the focus of the language in his draft bill was only on clinical outcomes, not on treatment cost
29 issues. The Kyl amendment was defeated along party lines, but Senator Olympia Snowe (R-ME) voted
30 with Democrats to defeat the Roberts amendment.

31 **Geographic Disparities**

32 (52) Senator Charles Grassley (R-IA) offered an amendment that would authorize the HHS Secretary to
33 correct geographic disparities in Medicare provider payments that was approved by a vote of 23 to 0.
34 Current Medicare payment policies negatively impact providers practicing in rural areas. The amendment
35 would increase rural providers' payments but not at the expense of providers in urban and suburban
36 areas.

37 **Abortion Funding**

38 (53) Senator Orrin Hatch (R-UT) offered an amendment that would codify the Hyde amendment and
39 would prohibit authorized or appropriated federal funds under the Mark from being used for elective
40 abortions and plans that covered such provisions. Chairman Baucus stated that the draft bill already
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1 prohibited federal funding to be used for abortions and that private funds to cover abortions must be
2 separated from federal funds. Sen. Hatch reported that many pro-choice advocates agree that tax money
3 should not be used for abortions. The amendment failed on a roll call vote of 13-10.

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5 (54) Sen. Hatch also offered an amendment that would protect providers who object to abortion and
6 respect their right of conscience. He pointed out that this amendment was adopted in the House
7 Committee on Energy and Commerce by a voice vote. Chairman Baucus explained that the bill already
8 extends the conscience clause to private insurers. The amendment failed by a vote of 10-13.

9 **Patient Identification**

10 (55) Sen. Grassley offered an amendment that would require individuals to present a photo ID in order
11 to apply for Medicaid benefits. Senator Robert Menendez (D-NJ) stated that this amendment created new
12 barriers for children and low-income individuals who were seeking Medicaid coverage. The amendment
13 failed on a vote of 10-13.

14 **Deductibility of Medical Care**

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16 (56) Sen. Nelson offered an amendment that to prevent a taxation of retiree health benefits. The
17 amendment would allow individuals 65 and older to claim Section 213 deductions if their medical
18 expenses exceeded 7.5 percent of the adjusted gross income (AGI). The revenue offset is closing
19 corporate tax loopholes and also would make non-deductible the free rider for employees. Sen. Grassley
20 agreed that seniors should be protected; however, he did not want this tax to fall on the middle class. The
21 amendment was agreed to by a vote of 14-9.

22 (57) Sen. Kyl offered an amendment to expand the deduction for catastrophic medical expenses. Under
23 current law, individuals may itemize catastrophic medical expenses if they exceed 7.5 percent of AGI. This
24 amendment would reduce that threshold to 5 percent. The offset would be tied to the tax credit for the
25 lowest cost plan. Chairman Baucus stated that the offset would take money from low-income individuals
26 and give it to the middle class. The amendment failed on a vote of 9 to 13.

27 **Fee on Health Insurance Providers**

28 (58) Sen. Grassley offered an amendment to prevent fees being imposed on the health insurance
29 industry from being passed onto health care consumers in the form of higher insurance premiums. Title VI
30 of the draft bill imposes a fee, in the form of a nondeductible excise tax, of \$60 billion on health insurance
31 providers that sell health insurance policies to individuals and employees. The fee would be apportioned
32 among all health insurance providers subject to the fee based on the market share of that provider. This
33 amendment would strike the fee on health insurance providers contained in the Chairman's draft. This
34 amendment would be fully offset by a corresponding reduction in unspent and unallocated mandatory
35 spending that falls within the jurisdiction of the Senate Committee on Finance from the *American Recovery*
36 *and Reinvestment Act*. The amendment failed 10 -13.

37 **Medicare Commission**

38 (59) Senator John Cornyn (R-TX) offered an amendment that would prohibit the Medicare Commission
39 from presenting proposals that would result in reduced payments to primary care practitioners. The
40 amendment failed on a roll call vote of 9 to 14.

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1 (60) Sen. Rockefeller offered an amendment that attempted to include hospitals under the Medicare
2 Commission; however, decisions made to reduce costs in that industry would be non-binding, unlike with
3 other groups. The amendment was adopted on a party-line vote.

4 **Wellness Programs**

5 (61) Sens. Ensign and Carper offered an amendment to enhance existing regulations to encourage
6 individuals to adopt healthy behaviors through voluntary participation in programs of health promotion and
7 disease prevention. The amendment modified the sections of the draft bill relating to rating rules in the
8 individual market and small group markets by allowing group health plans and health insurance issuers
9 offering coverage in these markets to vary insurance premiums based on an individual or an employee's
10 participation in wellness programs. The language defines programs of health promotion of disease
11 prevention to meet certain requirements and to assure that none of the conditions are based on health
12 status factors. Sen. Ensign argued that behaviors, such as obesity and smoking, could be addressed in
13 this manner. The amendment was agreed to by a vote of 18 to 4.

14 **Medicaid Personal Responsibility Agreement**

15 (62) Sen. Cornyn offered an amendment that would encourage personal responsibility for all
16 Americans. The draft bill exempts Medicaid beneficiaries from the personal responsibility requirement.
17 This amendment would require certain non-elderly, non-pregnant Medicaid beneficiaries to sign a state-
18 designed personal responsibility or "member" agreement. Sen. Bingaman opposed the amendment and
19 described it as demeaning to Medicaid beneficiaries. The amendment failed by a vote of 9 to 14.
20

21 **Teaching Health Centers**

22 (63) Senator Michael Enzi (R-WY) offered an amendment to strike the provisions in Sen. Bingaman's
23 amendment on "Teaching Health Centers" because it was under the HELP Committee's jurisdiction.
24 Chairman Baucus explained that they had gotten the approval from the HELP Chairman to add this
25 language. The amendment was withdrawn.

26 **Resource Outlier Penalty**

27 (64) Sen. Kyl offered an amendment that would strike the following provision related to the Physician
28 Feedback Program: "Beginning in 2015, payment would be reduced by five percent if an aggregation of
29 the physician's resource use is at or above the 90th percentile of national utilization. After five years, the
30 Secretary would have the authority to convert the 90th percentile threshold for payment reductions to a
31 standard measure of utilization, such as deviation from the national mean." The amendment failed by a
32 vote of 10 to 13.

33 **Affordability**

34 (65) Sens. Schumer and Snowe offered an amendment that would exempt individuals from the
35 mandate if their insurance costs would be greater than 8 percent of their annual income. The original bill
36 specified 10 percent. The amendment also phased in the penalties over time. The amendment passed by
37 a vote of 22-1, with only Sen. Kyl voting "no."

38 **AAFP GRASSROOTS**

39
40

BOARD OF DIRECTORS REPORT O, continued

1 (66) The AAFP has provided information to members and to chapters to keep them informed and
2 engaged in the advocacy health care reform provisions consistent with AAFP policy. In late summer the
3 AAFP conducted three “tele-town hall” meetings – one with chapter leaders and two for the general
4 membership – during which AAFP officers provided background information on health care reform
5 legislation and answered questions from AAFP members from all over the country.

6 7 **Congressional August Recess**

8
9 (67) Beginning in mid-July, the AAFP encouraged members to meet with their legislators over the
10 August recess period. This could have been in the form of a town hall meeting, district office meeting, or
11 site visit. To date, AAFP grassroots staff has collected reports from key contacts, chapters, and connect
12 for reform members who attended 45 town hall and in-district meetings over the August recess. If you met
13 with one or more of your legislators during August, we want to hear how it went! Please send your meeting
14 report via email to grassroots@aafp.org.

15 (68) Also in August, the AAFP encouraged chapters and connect for reform members to submit
16 comments on the proposed 2010 Medicare Physician Fee Schedule. Members were provided a template
17 letter to CMS and asked to submit comments directly to CMS by August 31 using regulations.gov.

18 **In Washington, DC**

19 (69) Drs. Pat Connolly and David Howe of Maine traveled to Washington to meet with Republican
20 Senators Olympia Snowe and Susan Collins. Dr. Jim King, the AAFP Board Chair, joined them. In her
21 meeting, Sen. Collins noted the need for primary care and expressed a good deal of interest in changing
22 the reimbursement structure; acknowledged the value of coordinated and integrated care. In Sen.
23 Snowe’s office, they met with senior legislative staff, who acknowledged the problems with payment,
24 workforce and specifically mentioned the problems with overvalued services. Sen. Snowe’s staff expressly
25 requested that family physicians be more vocal about the need to build the primary care workforce and
26 that one of the ways is to begin now to improve the payment for primary care services to send a signal to
27 the market encouraging more medical students to enter primary care.

28 (70) Drs. King and Patrick McCarville were in DC on Thursday, September 17 for Congressional visits
29 on health reform. They discussed health reform with Dr. McCarville’s U.S. Representative, Rep. Lee Terry
30 (R-NE), and pointed out the importance of health reform which supports primary care and they stressed
31 the need to increase primary care payment in order to expand the workforce. Rep. Terry agreed that
32 Americans should have coverage but opposed any mandates or increased government spending.

33 (71) In their meeting with Sen. Ben Nelson (D-NE), the Senator acknowledged the need for more
34 primary care physicians and pointed to his bill to expand federal tax relief for medical student debt
35 repayment.

36 (72) Drs. King and McCarville also met with the health legislative aides to both of the Republican
37 Senators from Tennessee, Bob Corker and Lamar Alexander. The aides identified several major obstacles
38 contained in the Senate Finance Committee Chairman’s bill including: taxes on businesses; fiscal effects
39 on states of Medicaid expansion; Medicare cuts funding a new entitlement (e.g., insurance subsidies); and
40 mandates on individuals to purchase health insurance. The senators believe the SGR should be dealt
41 with more thoroughly in the bill.

42 (73) Dr. King met the health legislative assistant to Rep. Bart Gordon (D-TN), to thank him for
43 successfully including a provision on medical liability in the Energy and Commerce Committee’s bill. He
44 noted the President’s announcement which reflects his amendment and encouraged that the Baucus bill

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1 would give private insurance reform a central role and cover 94 percent of the population. Rep. Gordon
2 would prefer co-ops be regional or national so that CBO will count them as savings to the federal budget.

3 (74) He also met with Rep. Rick Boucher (D-VA) who posed a number of thoughtful questions. He
4 wondered if the nation will have sufficient primary care workforce to care for the uninsured if they are
5 provided coverage. Rep. Boucher expressed his opposition to the public option, which he sees as a threat
6 to private insurers that will lead to a single-payer system. He also is concerned about reductions in
7 Medicare because he does not believe it possible to cut \$500 billion from the program without rationing.

8 (75) Lastly, he was interested in the PCMH. He is not convinced that it can work. Dr. King shared
9 examples of its effectiveness including the initiatives cited in the summary produced by Dr. Grumbach for
10 the Primary Care Patient Centered Collaborative.

11 **FamMedPAC**

12 (76) The PAC has solicited donations from AAFP members all year, and is conducting a phone
13 campaign targeting prior donors who have not yet given in 2009. FamMedPAC also did a joint mailing
14 with the New York Chapter to solicit contributions to both PACs. Thus far in 2009, the FamMedPAC has
15 received just over \$250,000 in contributions from almost 900 AAFP members. Since the beginning of
16 2009, the PAC has contributed \$270,500 to 88 congressional candidates and party campaign
17 committees.

18 (77) FamMedPAC participated in a joint Government Relations booth at the National Conference of
19 Family Medicine Students and Residents in Kansas City at the end of July.

20 (78) Government Relations staff and AAFP members have been able to attend a number of events
21 sponsored by FamMedPAC. Each event allows for an in-depth discussion of AAFP's key issues. At many
22 of these events, AAFP is the only primary care group in attendance. The PAC has participated in more
23 than 85 events this year, including for the following:

- 24 • **Senator Kay Hagan (D-NC)**
- 25 • **Rep. Xavier Becerra (D-CA)**, who serves on the Health Subcommittee of the Ways and
26 Means Committee and is the Democratic Caucus Vice Chair.
- 27 • **Rep. Bill Shuster (R-PA)**
- 28 • **Rep. Nathan Deal (R-GA)**, a member of the Health Subcommittee of the House Energy and
29 Commerce Committee.
- 30 • **Sen. Max Baucus (D-MT)**, the Chair of the Senate Finance Committee and a leader in the
31 healthcare reform debate.
- 32 • **Rep. Mike Thompson (D-CA)**, who serves on the Health Subcommittee of the House Ways
33 and Means Committee.
- 34 • **The Tuesday Group**, comprised of centrist Republican members of the House.
- 35 • **Rep. Charles Boustany (R-LA)**, a cardio-thoracic surgeon. Rep. Boustany is a new member
36 of the House Ways and Means Committee.
- 37 • **Rep. Walt Minnick (D-ID)**
- 38 • **Rep. John Shimkus (R-IL)**, a new member of the House Energy and Commerce Health
39 Subcommittee.
- 40 • **Rep. Joe Crowley (D-NY)**, a member of the House Ways & Means Committee, Chief Deputy
41 Whip and Vice Chairman of Finance for the Democratic Congressional Campaign Committee.
- 42 • **Rep. Diana DeGette (D-CO)**, who is on the Health Subcommittee of the Energy and
43 Commerce.
- 44 • **Rep. Charlie Rangel (D-NY)**, Chairman of House Ways and Means Committee.

BOARD OF DIRECTORS REPORT O, continued

- 1 • **Sen. Tom Harkin (D-IA)**, who serves on both the Appropriations and HELP Committees.
- 2 • **Sen. Chris Dodd (D-CT)** who serves on the HELP Committee and is Chair of the Banking
- 3 Committee.
- 4 • **House Majority Leader, Rep. Steny Hoyer (D-MD)**.
- 5 • **Senate Minority Leader Mitch McConnell (R-KY)**.
- 6 • **Sen. Chuck Schumer (D-NY)**, who serves on the Senate Finance Committee.
- 7 • **Rep. George Miller (D-CA)**, who chairs the House Education and Labor Committee and is a
- 8 close ally of Speaker Pelosi.
- 9 • **Rep. Mike Ross (D-AR)**, who is on the Health Subcommittee of the House Energy and
- 10 Commerce Committee and is the Chair of the Blue Dog (moderate Democrats) Health Care
- 11 Task Force.
- 12 • **Rep. Allen Boyd (D-FL)**, who serves on the House Appropriations Committee and is a
- 13 member of the Blue Dogs (moderate Democratic) Caucus.
- 14 • **Rep. Tim Murphy (R-PA)**, a psychologist and a member of the Health Subcommittee of the
- 15 House Energy and Commerce Committee.
- 16 • **Rep. Dave Obey (D-WI)**, Chairman of House Appropriations Committee.
- 17 • **Rep. Earl Pomeroy (D-ND)**, a member of the House Ways and Means Health Subcommittee
- 18 • **House Speaker Nancy Pelosi (D-CA)**
- 19 • **Sen. Arlen Specter (D-PA)**, a member of the Senate Appropriations Committee
- 20 • **Rep. Pete Stark (D-CA)**, Ways and Means Health Subcommittee Chairmen
- 21 • **Rep. Peter Welch (D-VT)**, a new member of the Energy and Commerce Committee.
- 22 • **Rep. Anna Eshoo (D-CA)**, who is a member of the House Energy and Commerce Health
- 23 Subcommittee.
- 24 • **Rep. Bruce Braley (D-IA)**, a new member of the Energy and Commerce Health Care
- 25 Subcommittee.
- 26 • **Senator Harry Reid (D-NV)**, the Senate Majority Leader.
- 27 • **Rep. John Shadegg (R-AZ)**, a member of the House Energy and Commerce Health
- 28 Subcommittee and the Republican Health Care Task Force.
- 29 • **Rep. Bill Pascrell, (D-NJ)** a member of the Ways and Means Health Subcommittee.
- 30 • **Rep. Eric Cantor (R-VA)**, the House Republican Whip.
- 31 • **Sen. Mike Enzi (R-WY)**, a member of both the Senate Finance and HELP Committees. Sen.
- 32 Enzi is the Republican lead negotiator on health care reform legislation in the Senate.
- 33 • **Rep. Debbie Wasserman Schultz (D-FL)**, who serves on the House Appropriations
- 34 Committee.
- 35 • **Rep. Charlie Gonzalez (D-TX)**, who serves on the Health Subcommittee of the House Energy
- 36 and Commerce Committee.
- 37 • **Blue Dog Democrats**, a coalition of moderate to conservative Democratic Representatives,
- 38 that includes, among others, **Reps. Walt Minnick (ID), Barron Hill (IN), Travis Childers**
- 39 **(MS), Earl Pomeroy (ND), Leonard Boswell (IA), and Allen Boyd (FL)**.
- 40 • **Rep. John Barrow (D-GA)**, a Blue Dog and member of the Health Subcommittee of the
- 41 House Energy and Commerce Committee. AAFP Board Chair Jim King attended the
- 42 fundraising lunch.
- 43 • **Rep. Patrick Kennedy (D-RI)**, who serves on the Labor-HHS Appropriations Subcommittee.
- 44 • **Del. Donna Christensen (D-VI)**, who serves on the Energy and Commerce Health
- 45 Subcommittee and is a family physician. AAFP Board Chair Dr. Jim King attended the event.
- 46 • **Rep. Frank Pallone (D-NJ)**, the Chair of the Health Subcommittee of the Energy and
- 47 Commerce.
- 48 • **Rep. Rosa DeLauro (D-CT)**, who chairs the Agriculture Appropriations Subcommittee with
- 49 jurisdiction over FDA funding and serves on the Labor, HHS, Education Appropriations
- 50 Subcommittee and Budget Committee.
- 51 • **Rep. Lois Capps (D-CA)**, who is on the Health Subcommittee of Energy and Commerce.

BOARD OF DIRECTORS REPORT O, continued

- 1 • The **New Democrat Coalition**, including **Reps. Allyson Schwartz (PA), Frank Kratovil**
2 **(MD), John Barrow (GA), Bill Foster (IL), Adam Smith (WA), Dan Maffei (NY), Parker**
3 **Griffith (AL), Debbie Halvorsen (IL)** and staffers for **Mike McMahon (NY) and Ron Kind**
4 **(WI)**.
- 5 • **Rep. Pat Tiberi (R-OH)**, who is a member of the Ways and Means Committee.

6 7 **THE PATH AHEAD**

8 (79) With committee actions essentially completed, the focus now is on the leadership of the House and
9 the Senate. The Senate's Majority Leader, Sen. Harry Reid (D-NV), has notified Senators that he
10 proposes to bring the combined Finance Committee and HELP Committee bill to the Senate in the next
11 few weeks. Given the procedural hurdles the lie ahead, most estimates are that it will take at least 3
12 weeks of debate to reach a final vote. Meanwhile, the Speaker of the House anticipates finishing work on
13 combining their three bills and producing a bill for debate around the same time. The procedures in the
14 House are more expedited, and so the House will spend about a week on the bill.

15 (80) After both chambers pass their bills, the very complex job of negotiating a bill that would satisfy
16 both chambers will begin. This could be the most difficult part of the process, since the constituencies of
17 both bodies are so different. The best guess at this point is that this negotiating process will produce a bill
18 by early to mid-December for a final vote before the end of the year.

19 (81) Meanwhile, discussions between the White House and Congress and between the House and the
20 Senate are on-going in an attempt to accelerate the process. The AAFP will continue to make sure that
21 family medicine is part of these discussions and that all parties now of the importance of providing
22 everyone with health care based on primary care, which will require improved payment for family
23 physicians, broader authority for implementing the patient centered medical home and greater investment
24 in the education and training of primary care physicians so that the newly insured will be able to find a
25 family physician to take care of them.