



THE AMERICAN CONGRESS
OF OBSTETRICIANS
AND GYNECOLOGISTS

Office of the President

Gerald F. Joseph, Jr., MD, FACOG
39288 Magnolia Trace
Ponchatoula, LA 70454-6922

March 20, 2010

Honorable Nancy Pelosi
Speaker
House of Representatives

Honorable Steny Hoyer
Majority Leader
House of Representatives

The Honorable George Miller
Chair
Education & Labor Committee

The Honorable Sander Levin
Chair
Ways & Means Committee

The Honorable Henry Waxman
Chair
Energy & Commerce Committee

Honorable Robert Andrews
Chair
E&L Health Subcommittee

Honorable Pete Stark
Chair
W&M Health Subcommittee

Honorable Frank Pallone
Chair
E&C Health Subcommittee

Honorable John Dingell
Chair Emeritus
E&C Committee

Dear Representatives Pelosi, Hoyer, Miller, Levin, Waxman, Andrews, Stark, Pallone and Dingell,

On behalf of the American Congress of Obstetricians and Gynecologists (ACOG), representing over 53,000 physicians and partners in women's health, thank you for your tremendous leadership and commitment to health reform.

ACOG has a long and strong history of supporting health reform. As ob-gyns, we see first-hand the devastating effect a lack of insurance or underinsurance can have on our patients. ACOG is privileged to have worked with you and many Members of the House in this effort, including Representative Schakowsky who introduced H.Con.Res.48, which set the marker for women's health in health reform. We have been committed to working with you on enacting comprehensive health reform which addresses the needs of all women and their physicians through many worthwhile provisions in the current bill. ACOG however regrets to inform you that we reluctantly must oppose the current health reform bill (H.R.3590 and H.R.4872) due to several provisions we believe undermine health reform's great promise.

We greatly appreciate and support the following elements in the bill:

- Minimum benefits standards, including maternity coverage and preventive services coverage with cost-sharing protections;
- Medical home demonstration projects which address the unique health needs of women and which recognize ob-gyns as principal care physicians in women's health care delivery;
- Health insurance market reforms which end the harmful practices of pre-existing condition exclusions, coverage rescissions, annual and lifetime benefit caps, and reforms that guarantee renewability and availability of coverage;
- Requiring health insurers to allow individuals through age 26 to remain on their parents' health insurance;
- A requirement for individuals to purchase coverage with subsidies for lower-income individuals;
- Ensuring a public safety net by converting Medicaid into a categorical program to cover all of poor and near-poor individuals and increasing the federal medical assistance percentage (FMAP) to support states in coverage of newly eligible individuals;
- Protecting ob-gyn ultrasound from any changes to imaging reimbursement;
- Ensuring direct access for women to ob-gyns;
- Restoring payment for DXA services;
- Providing Medicaid coverage for tobacco cessation counseling and pharmacotherapy to pregnant women;

- Prohibiting cost-sharing for Indians enrolled in a qualified health benefit plan in the individual market;
- Medicare coverage with no co-payment or deductible for an annual wellness visit;
- Giving States the option to expand coverage of family planning services for low-income women;
- Providing support services to women suffering from postpartum depression and psychosis and research into the causes, diagnoses and treatments;
- Creating an appeals and feedback process for physicians participating in the Physician Quality Reporting Initiative (PQRI) and establishing a participation pathway for physicians completing a qualified Maintenance of Certification program with their specialty board of medicine;
- Development of Medicaid quality measures with multi-stakeholder input;
- Well-designed clinical comparative effectiveness research, which is conducted through an independent institute and is not used to make coverage and payment decisions;
- Establishing grant programs to support new or expanded primary care residency programs at teaching health centers, which recognize obstetrics and gynecology as primary care;
- Establishing a Prevention and Public Health Investment Fund;
- Requiring employers to provide break time and a place at work for breast-feeding women to express milk; and
- Funding for comprehensive sex-education.

These important changes to our health care system however will only work if coupled with meaningful medical liability reform and a permanent repeal of the Sustainable Growth Rate (SGR) formula, replaced with a sensible and reliable method of Medicare physician payment.

In 2002, the Institute of Medicine (IOM) found that “the current liability system hampers efforts to identify and learn from errors, and likely encourages ‘defensive medicine’...changes in the liability system are a critical component of health care system redesign.” The Congressional Budget Office also recently found \$54 billion in savings from eliminating defensive medicine. ACOG supports caps on non-economic damages and other reforms like those in California and Texas laws. While we’re working toward that goal, we support meaningful alternative reforms such as Health Care Courts, I’m Sorry Programs, Medical Review Panels, Medical Screening and Mediation, Voluntary Alternative Dispute Resolution, Expert Witness Qualifications and Defined Catastrophic Injury Systems. This bill does not support testing the full range of these alternatives.

We are also concerned that SGR repeal is not part of this bill. Health care reform cannot be built on a broken payment system, which affects ob-gyns and other physicians far beyond the Medicare program.

The following provisions in the bill are also of great concern:

- Establishment of an Independent Medicare Advisory Board whose recommendations on controlling cost growth and care delivery could become law without congressional action;
- Mandatory participation in a still flawed PQRI program with penalties for non-participation;
- Medicare payment increases to primary care physicians and rural general surgeons, at the expense of other providers;
- The establishment of a shadow RUC, giving the HHS Secretary authority to negate conclusions of AMA/Specialty Society Relative Value Update Committee (RUC), the entity through which medical services are valued. The AMA RUC is a functioning and dynamic process, which recommends appropriate data driven increases *and decreases* in the value of codes reimbursed under the Medicare Physician Fee Schedule;
- Creation of a budget-neutral value-based payment modifier which CMS does not have the capability to implement and placing the provision on an unrealistic and unachievable timeline;
- Failure to address in the long-term the low reimbursement levels in the Medicaid program and only applying increases to a subset of providers, despite an overall increase in the Medicaid-eligible population;
- Inclusion of catastrophic-only health plans for individuals under 30, which may burden women with unaffordable out-of-pocket costs, especially in cases of an unplanned pregnancy;

- Prohibiting undocumented immigrants from purchasing unsubsidized insurance products with their own money through new exchanges and failure to lift the 5-year Medicaid waiting period for lawfully residing immigrants;
- ACOG believes that health reform should not be a vehicle to address divisive abortion politics. The original compromise Capps-DeGette language achieves the goal of maintaining the Hyde amendment, while protecting physicians and other health providers in their choice of practice. Consistent with our long-standing policy, the College cannot support the bill language that places additional burdens and restrictions on abortion coverage and access.
- \$50 million in funding for ineffective abstinence-only education; and
- Expanding reimbursement for services provided by Certified Professional Midwives (CPMs) in free-standing birth centers. While we support reimbursement for facility fees of accredited birth centers, ACOG opposes any attempt to recognize CPMs as covered practitioners for the purpose of providing services to Medicare or Medicaid beneficiaries. Only certified nurse-midwives (CNMs) or certified midwives (CMs), both certified by the American Midwifery Certification Board (AMCB), should be eligible to receive reimbursement. While some CPMs have completed formal academic programs, others have completed apprentice programs with no minimum educational requirement or qualified faculty oversight. Even CPMs that have formal schooling have not completed the rigorous curriculum and exam requirements required by the AMCB. Serious complications can arise, even in seemingly low-risk pregnancy and delivery. In some of these instances, expert intervention is all that stands between a healthy mother and baby, and tragedy.

Again, thank you for your commitment to improving America's health system. We are committed to continuing to work with you to see comprehensive and meaningful health care reform enacted.

Sincerely,



Gerald F. Joseph, Jr., MD, FACOG
President