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The NPA is a 501c3 organization, founded in 2005. We represent physicians across specialties who, simply put, want to put patient health back at the center of health care. We promote the civic engagement of our members and refuse all funding from pharmaceutical and medical device companies. Our core program areas include: 1) advocacy to ensure affordable, quality health care for all; 2) reducing the influence of pharmaceutical and medical device marketing on medical education and clinical decision making.

The NPA offers the following recommendations in support of the determination of Essential Health Benefits:

- 1. Encourage the delivery of evidence-based care:** In August, 2011, the NPA published the “Top 5 Lists in Primary Care”, in the *Archives of Internal Medicine* (1). These evidence-based lists, developed by practicing physicians, describe tests and treatments that physicians *should avoid*. [By avoiding such](#) overused [tests](#) and treatments that provide no benefit to patients, [patient](#) care is safer and [costs less](#). On October 1st, [the Archives of Internal Medicine published](#) a research letter that conservatively estimates **\$6.7 billion** in annual savings if the recommendations in the Top 5 Lists were followed (2). [We recommend that](#) the Essential Health Benefits determinations strongly discourage [the](#) use of treatments or tests determined to be of no significant benefit to patients. Patients, however, could still elect to pursue marginal treatments at higher levels of cost-sharing.
- 2. A Transparent Decision Making Process:** The decision making process must include meaningful participation by all stakeholders, including consumers and patients. Participants in this process must be free of conflicts-of-interest to the extent possible and all potential conflicts must be fully disclosed.
- 3. Process for Prioritizing Coverage Decisions:** In the absence of infinite resources, coverage decisions will have to be prioritized. The prioritization process should be agreed upon up-front with multi-stakeholder involvement. Such a process will help avert potential discrimination toward sub-populations that may be helped by treatments that are not clinically effective in the broader population. Robust implementation of broad data collection efforts to include race/ethnicity/age/sex etc. will provide critical information to assess potential discrimination.
- 4. Affordability:** The plans, including premiums, co-insurance, and co-pays, must be affordable to individuals and families. Plans should be structured to encourage use of preventive care and other treatments of proven benefit and to discourage care that is of no benefit.

5. Continuous Assessment: A robust mechanism of continuous assessment of the EHB is necessary. This should include review of data from comparative effectiveness research, data on the success or failure of payment reform strategies such as bundled payments and shared savings, and monitoring and sharing of successful strategies from state-based exchanges. Consumers and patients, the ultimate judges of the adequacy of benefits, must have easy and transparent ways to provide meaningful input into this process.

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References:

1. The Good Stewardship Working Group of the National Physicians Alliance. The “Top 5” Lists in Primary Care: Meeting the Responsibility of Professionalism. *Arch Intern Med.* 2011;171(15):1385-1390.
2. “Top 5” Lists Top \$5 Billion. *Arch Intern Med.* <http://archinte.ama-assn.org/cgi/content/full/archinternmed.2011.501>