Frequently Asked Questions about The Patient Protection and Affordable Care Act

Does the legislation fulfill the AMA's essential elements for health system reform?

Five of the seven American Medical Association (AMA) essential elements for health system reform are substantially achieved in the legislation. Health insurance coverage is significantly expanded; pre-existing condition limitations are removed and other health insurance market reforms are implemented; the patient-physician relationship is protected; investments and incentives are provided for quality improvement, prevention and wellness initiatives; and insurance claims processing is streamlined and standardized to eliminate unnecessary costs and administrative burdens. The Administration and congressional leaders remain committed to permanent repeal of the Medicare Sustainable Growth Rate (SGR) formula. In addition, the Administration already has initiated a medical liability reform alternative grant program.

Will the legislation truly expand health insurance coverage to the uninsured?

According to the Congressional Budget Office (CBO), the legislation expands coverage to an additional 32 million persons by 2019, a 59 percent reduction in the number of uninsured. Independent estimates from RAND and The Lewin Group also forecast a similarly sized reduction. Expanding Medicaid eligibility to all individuals under age 65 (including childless adults) up to 133 percent of the federal poverty level (FPL), and providing refundable and advanceable "premium" credits to individuals and families up to 400 percent of FPL ($88,200 per year for a family of four) for the purchase of private health insurance are the two key factors that allow for this expansion. CBO estimates that employer-provided coverage will decrease by only 4 million, or 2 percent. RAND's estimate for employer-provided coverage is a 6 million increase. The legislation also would provide dependent coverage for children up to age 26 under all individual and group policies. Long-standing AMA policy supports providing low-income individuals and families with refundable and advanceable tax credits for the purchase of health insurance, creating national standards of uniform Medicaid eligibility for all persons below the poverty level, and extending coverage for dependent adult children on their family policies.

Will Medicaid expansion place further financial burden on the states and on physician practices?

Many state governments are struggling to balance their budgets due to the lingering effects of the recession. However, the legislation provides 100 percent federal funding for the expansion of Medicaid coverage to all individuals under age 65 with incomes up to 133 percent of FPL from 2014 to 2016, 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent thereafter. The AMA has long supported the creation of national standards of uniform

Continued on page 2

eligibility for all persons below the poverty level. CBO projects that 16 million currently uninsured Americans will become covered under Medicaid and the Children's Health Insurance Program by 2019, as a result of the legislation. In addition, the legislation requires that Medicaid payment rates to primary care physicians providing primary care services be no less than 100 percent of Medicare payment rates for 2013 and 2014, and provides 100 percent federal funding for the incremental costs to states of meeting this requirement.

Will Americans be required to have health insurance under the legislation?

Americans who have affordable options for health care coverage but who choose to remain uninsured are required to pay a penalty to offset the cost of their health care. The penalty is a flat tax in the amount of $95 in 2014, $325 in 2015, and $695 in 2016, or as an alternative, as a percent of income in the amount of 1 percent in 2014, 2 percent in 2015, and 2.5 percent for 2016. After 2016, the penalty will increase annually by the cost-of-living adjustment. As previously noted, affordability is addressed by providing tax credits for the purchase of health insurance for individuals and families earning up to 400 percent of FPL. There are important exemptions to the "individual responsibility" requirement for dependents, non-citizens and those who express objections on religious grounds. These provisions are consistent with long-standing AMA policy on the issue of greater individual responsibility. The AMA supports a requirement that individuals and families earning more than 500 percent of FPL ($110,250 per year for a family of four) obtain coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. The AMA supports a similar requirement for those earning less than 500 percent of FPL, upon enactment of premium subsidies such as those in the legislation, that make coverage affordable at lower income levels.

How does the legislation help those who are uninsured and have been unable to obtain health insurance coverage because of their health or because of affordability?

The legislation contains key provisions to ensure that people who have had trouble getting health insurance coverage in the past—either by being priced out of the market or because they are "uninsurable" at any price—have more health insurance options. Consistent with AMA policy opposing pre-existing condition exclusions, and supporting modified community rating and guaranteed issue in the context of an individual mandate, insurance companies will no longer be able to deny coverage based on pre-existing conditions, and premiums will no longer be allowed to be based on gender and health status. The affordability of health insurance coverage is addressed in a manner that is consistent with AMA policy: Individuals and families with incomes up to 400 percent of FPL would be eligible for assistance in the form of refundable, advanceable, and sliding-scale premium credits, as well as cost-sharing subsidies.

How does the legislation help insured Americans keep their health insurance coverage?

The health insurance coverage of individuals and families who are already insured will also be protected. Insurers will no longer be able to drop coverage if policyholders actually get sick, and once insured, individuals and families will be guaranteed renewal of their health insurance policies, which is consistent with AMA policies supporting guaranteed renewability and ending the arbitrary rescission of health insurance policies.

Continued on page 3

Will health insurance premiums rise due to the legislation?

Health insurance premiums will not rise for most people. CBO predicts that premiums in the large group market (nearly 70 percent of the non-elderly covered population) would fall 0 to 3 percent in 2019 compared to current law. Premiums in the small group market (13 percent of those with insurance coverage) may fall—CBO predicts a change from -2 percent to + 1 percent compared to current law. Only premiums in the nongroup market (17 percent of those with insurance coverage) are expected to rise compared to current law. CBO predicts that premiums in the nongroup market will increase 10 to 13 percent. It should be noted, however, that while premiums will likely rise modestly in the nongroup market, those purchasing such policies will be gaining richer benefits. CBO also has indicated that 57 percent of the nongroup enrollees will likely receive a subsidy that would make their actual contribution 56 to 59 percent lower than what they would pay under current law.

Does the legislation expand the role of government into the practice of medicine with respect to implementing payment changes, determining quality and dictating standards of care?

Physicians will continue to exercise considerable control over the practice of medicine and the care that they provide to their patients. Nonetheless, several provisions in the legislation remain troubling, such as value index adjustments to individual physician payments based on cost and quality outcomes, potential penalties on physicians who do not successfully participate in the Physician Quality Reporting Initiative (PQRI), and public reporting of physician claims data to develop performance reports. The legislation contains some safeguards related to these provisions and the AMA will work aggressively for additional safeguards in subsequent correction bills. PQRI penalties for physicians that do not meet reporting criteria, and the value index adjustments to individual physician payment are not scheduled to be implemented until 2015. The legislation also calls for improving payment accuracy by identifying and addressing misvaluations within the Medicare physician payment schedule. The language clearly allows the Secretary of Health and Human Services (HHS) to rely on existing processes to address coding revisions and relative valuation of physician services, leaving the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC) in place to represent organized medicine. Representatives of the Centers for Medicare and Medicaid Services have stated clearly that the agency has no intention of creating a separate committee or review panel.

What is the impact of creating an Independent Payment Advisory Board (IPAB)?

The legislation will establish a target for overall Medicare spending growth and an Independent Payment Advisory Board (IPAB) that would develop proposals to cut Medicare spending if the target rate of growth is exceeded. The Secretary of HHS will be required to implement the IPAB's proposals unless the statutory process is overridden by new legislation. CBO projects that IPAB cuts would total $13 billion over 10 years. The AMA strongly opposes any provisions that would empower an independent commission to mandate payment cuts for physicians, who are already subject to an expenditure target, and any other payment reductions under the Medicare physician payment system. The Administration and congressional leaders have reaffirmed their commitment to address AMA issues of "double jeopardy," projection errors and appropriate spending increases (e.g., H1N1) in subsequent correction bills.

Continued on page 4

Does the legislation ban physician-owned hospitals?

The legislation would ban new physician-owned hospitals and restrict existing facilities, unless they were the primary provider of Medicaid services. The AMA strenuously opposed this provision in the legislation and repeatedly advocated that physician-owned hospitals have achieved the highest quality scores in some markets and have been shown to provide more net community benefits through uncompensated care and taxes than not-for-profit competitors as a share of total revenues.

Does the legislation include proven medical liability reforms?

The legislation establishes a competitive grant program for states to develop, implement and evaluate innovative medical malpractice reforms. This is in addition to the $25 million medical liability reform alternative grant program that the Administration initiated in September 2009, which is being implemented by the Agency for Healthcare Research and Quality (AHRQ). The AMA will continue to advocate for proven liability reforms at the federal level, such as a cap on non-economic damages. The AMA worked aggressively to ensure that liability reform provisions were included in health system reform legislation, and the Administration's effort to stimulate innovation at the state level represents tremendous progress in an area where previous administrations have failed to propose even incremental changes.

Is antitrust relief for physicians included in the legislation?

Antitrust relief for physicians is not included in the legislation. Nonetheless, there appears to be growing recognition that antitrust relief is needed to enable physicians and other health care professionals to effectively negotiate with health plans without fear of violating antitrust laws. Physicians should be allowed to negotiate contract terms that increase patient choice and improve quality of care. Patients and their physicians should make informed decisions about their health care needs, not insurers. The AMA is advancing this objective through dialogue with the Federal Trade Commission and the Department of Justice to modify enforcement policies through regulatory processes.

How will the legislation benefit physicians and their practices?

The legislation contains a number of provisions that, in combination, clearly benefit physicians and their practices. Recent AMA estimates suggest that physicians provided $24 billion in charity care in 2008, much of it to their uninsured patients. The financial impact this has on physicians' practices is particularly acute when private and public payments are declining or flat, and physicians are less able to cover the cost of treating uninsured patients with revenue from insured patients. Expanded health insurance coverage to the uninsured, which the CBO has estimated will increase to 32 million more insured Americans by 2019, would help with the problem of uncompensated care. In addition, the time and cost burden of physicians' interactions with health plans remains large. Estimates from 2006 suggest that physicians spend three hours per week, their nursing staff spend 19 hours and their administrative staff spend 36 hours per week interacting with health plans. In total, the annual time cost of these activities is more than $68,000 per physician. Many of the administrative simplification provisions in the legislation would reduce these costs. ■