

# AMA vision for health system reform

Earlier this year, the American Medical Association put forward our vision for health system reform consisting of a number of key objectives reflecting AMA policy. Throughout the current debate we have consistently recommended that any proposals to replace portions of current law should pay special attention to ensure that individuals currently covered do not become uninsured.

Proposals should maintain key insurance market reforms, such as coverage for pre-existing conditions, guaranteed issue, and parental coverage for young adults; stabilize and strengthen the individual insurance market; ensure that low- and moderate-income patients are able to secure affordable and meaningful coverage; and guarantee that Medicaid, the Children's Health Insurance Program (CHIP), and other safety net programs are adequately funded. Moreover, we believe that the health care system can be further strengthened by reducing regulatory burdens that detract from patient care and increase costs and by providing greater cost transparency throughout the health care system.

## Take steps forward in covering all Americans

The AMA has long advocated for health insurance coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice, and universal access for patients. According to the Office of the Assistant Secretary for Planning and Evaluation (ASPE) of the U.S. Department of Health and Human Services (HHS), 20 million nonelderly adults gained health insurance coverage because of the Affordable Care Act (ACA) as of early 2016. Various strategies are needed to target the remaining uninsured. While some uninsured fall into a coverage gap due to states not expanding Medicaid, others are eligible for Medicaid, CHIP or tax credits to purchase coverage but have not enrolled. For individuals who are eligible for Medicaid, CHIP or tax credits but remain uninsured, renewed attention to outreach, education and enrollment assistance is needed to improve perceptions about the cost of

coverage, awareness of financial assistance available and clarity about eligibility rules.

Realizing the impact of expanding Medicaid on state uninsured rates, the AMA, at the invitation of state medical associations, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL) as authorized by the ACA.

Some of the uninsured remain ineligible for tax credits because of an offer of affordable employer-sponsored insurance (ESI). To make strides in insuring this population, the AMA supports legislation or regulation to fix the ACA's "family glitch," which denies premium and cost-sharing subsidies to purchase coverage on health insurance exchanges to families facing high-cost ESI when one family member has access to affordable employee-only coverage, irrespective of the cost of family coverage. In addition, AMA policy supports allowing workers and their families to be eligible for subsidized marketplace coverage if their employer coverage has premiums high enough to make them exempt from the individual mandate.

Individuals also have remained uninsured because they do not qualify for premium tax credits to purchase marketplace coverage, while premiums for some individuals already eligible for premium tax credits still may be too high to incentivize them to get covered. AMA policy supports using 500 percent of the FPL as a threshold above which individuals should be required to have health insurance without any financial assistance being provided. As such, the AMA would support providing premium tax credits to eligible individuals with incomes up to 500 percent FPL. In addition, to make premiums more affordable, the AMA supports lowering the cap on premiums for the second-lowest cost silver plan for the highest incomes eligible for premium tax credits (for example, from 9.69 to 8.5 percent of household income), and lower premium caps for lower incomes accordingly. To increase the

coverage rates of young adults, the AMA could support providing young adults (ages 19–30) with enhanced tax credits—e.g., \$50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio. Smaller amounts also could be provided to individuals between ages 30–35.

## **Maintain key insurance market reforms**

### **Guaranteed issue and guaranteed renewability**

Prior to the passage of the ACA, individuals with pre-existing conditions were routinely denied coverage and/or priced out of coverage. The AMA supports the elimination of denials of health insurance coverage due to patients having pre-existing conditions by requiring health insurers to provide guaranteed issue and guaranteed renewability. AMA support for guaranteed issue is contingent upon an individual responsibility requirement being in place. Without individual responsibility, eliminating health insurance denials due to pre-existing conditions is not feasible because individuals would be able to forego coverage until they become ill or injured. As a result, their care would be costly, driving up premiums for everyone. In addition, guaranteed issue without individual responsibility can flood the market with individuals who have costly high health risks and price out those individuals with low health risks.

### **Modified community rating**

AMA policy supports modified community rating, risk bands and risk corridors. Although some degree of age rating is acceptable, the AMA stresses that an individual's genetic information should not be used to determine his or her premium. In addition, the AMA supports the concept of health insurance contracts with lower premiums for nonsmokers.

### **Dependent coverage up to age 26**

The AMA supports including young adults to age 28 under extended family health insurance coverage. According to ASPE, from 2010 to 2016, 6.1 million young adults (ages 19 to 25) gained health insurance coverage because of the ACA, including 2.3 million young adults who gained coverage from 2010 through the start of open enrollment in October 2013 due to the provision that allows young adults to stay on a parent's plan until age 26.

## **Stabilize and strengthen the individual market**

### **Continue to fund cost-sharing reductions**

Uncertainty about continued funding for cost-sharing

reductions (CSRs) and enforcement of the individual mandate is contributing significantly to market uncertainty and volatility. Nearly 60 percent of all individuals who enrolled in and paid for marketplace coverage as of February 2017 receive assistance to reduce deductibles, co-payments, and/or out-of-pocket limits through CSR payments. AMA policy states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. Accordingly, the AMA believes cost-sharing subsidies are necessary not only to make health care services affordable for individuals with low-incomes, but to stabilize the health insurance marketplace. If cost-sharing reductions are not funded, the Congressional Budget Office estimates that premiums for silver plans offered through the marketplaces would be 20 percent higher in 2018 and 25 percent higher by 2020. Consequently, there would be an increase in federal resources dedicated to premium tax credits larger than the amount saved by ending payments for cost-sharing reductions, causing an increase in the federal deficit.

### **Enforce the individual mandate**

AMA policy supports a requirement that individuals and families who can afford health insurance coverage be required to obtain it, using the tax structure to achieve compliance. The AMA is concerned with any relaxation in enforcement of the individual responsibility provision of the ACA, as the provision has contributed not only to coverage gains, but also to promoting a balanced risk pool between those who are sick and those who are healthy. The AMA continues to believe that an individual mandate remains the best way to maximize coverage gains, as well as help ensure healthy individuals enroll in coverage and stay covered. If the individual responsibility provision is not enforced, fewer young, healthy people will enroll in health insurance coverage, as the provision encourages individuals to get health insurance coverage to avoid paying a penalty.

### **Invest in risk adjustment and reinsurance**

The AMA believes that an effective approach to stabilize the individual market is to create risk adjustment and reinsurance programs to account for high-risk/high cost patients enrolled in marketplace plans to protect against premium increases. AMA policy supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as risk adjustment and reinsurance. Risk adjustment and reinsurance are efficient uses of government funds to advance

affordability and coverage goals. For example, to fund the ACA's transitional reinsurance program, insurers and third party administrators paid \$63 per enrollee per year in 2014, \$44 in 2015 and \$27 in 2016. These investments in reinsurance yielded premium reductions. In 2014, the \$10 billion reinsurance fund, the result of the \$63 per enrollee per year contributions, was estimated to reduce premiums by 10–14 percent. Importantly, reinsurance enables high-risk enrollees to remain in the same individual market risk pool and enjoy the same protections and choices as healthy plan enrollees.

### **Increase the number of younger and healthier people enrolled in marketplace coverage**

Additional actions are necessary to increase the number of younger and healthier consumers purchasing plans through the marketplaces, in order to help balance the individual market risk pools. AMA policy supports legislation or regulation to fix the ACA's "family glitch," which could increase the number of younger and healthier people in marketplace coverage, as a significant percentage of affected employees and their families are under the age of 35.

AMA policy calls for tax credits to be refundable, advanceable, inversely related to income, and large enough to purchase quality, meaningful coverage. The AMA recognizes that additional financial support may need to be directed toward young adults to improve insurance take-up rates and help balance the market risk pool. As such, the AMA could support providing young adults (ages 19–30) with enhanced tax credits—e.g., \$50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio. Smaller amounts could be provided to individuals between ages 30–35.

### **Improve health insurance affordability**

Most individuals with marketplace coverage—84 percent—receive a tax credit to lower their premium. Given that the size of the premium tax credit for which an individual or family is eligible is tied to a cap on the percentage of income an individual or family must spend on their monthly premiums if they enroll in a "benchmark" plan (second-lowest cost silver plan available), premium tax credit recipients are largely shielded from premium increases. However, individuals and families with incomes over 400 percent FPL have to pay the full cost of their premiums. Many individuals, including those with incomes that qualify for little or no premium subsidization, have difficulty affording their

coverage, and premiums for some individuals already eligible for premium tax credits still may be too high to incentivize them to get coverage. Moreover, the AMA remains concerned that patients enrolled in plans with high deductibles may have difficulty affording the care they need, which can result in them avoiding or delaying needed care.

AMA policy supports numerous options for improving health insurance affordability, several of which have been previously addressed in this document:

- Fund cost-sharing reductions.
- Expand eligibility for premium tax credits up to 500 percent FPL.
- Lower the cap on premiums for the second-lowest cost silver plan for the highest incomes eligible for premium tax credits, and lower premium caps for lower incomes accordingly.
- Provide young adults with enhanced tax credits.
- Fix the ACA's "family glitch."
- Modestly fund health savings accounts (HSAs) to help individuals with incomes above 250 percent FPL afford the cost-sharing requirements of the plans in which they have enrolled.
- Create demonstration projects to allow individuals eligible for cost-sharing subsidies—who forego these subsidies by enrolling in a bronze plan—to have access to a pre-funded HSA in an amount determined to be equivalent to the cost-sharing subsidy they would have received had they enrolled in a silver plan.
- Allow individuals eligible for employer-sponsored insurance to receive subsidies to purchase exchange coverage if their ESI is expensive enough to make them exempt from the individual mandate.
- Support innovative benefit designs, which could allow certain physician services and prescription drugs to be provided pre-deductible.

### **Protect Medicaid and CHIP**

Millions of Americans have gained coverage through the Medicaid expansion under the ACA, many for the first time. Without access to Medicaid, these individuals would be uninsured. Medicaid expansion has provided access to critical services, including mental health and substance abuse treatment related to the ongoing opioid misuse and addiction crisis. AMA policy states that the AMA, at the invitation of state medical associations, will work with state and specialty medical societies in advocating at the state level to

expand Medicaid eligibility to 133 percent of the FPL as authorized by the ACA.

Beyond expansion, the underlying structure of existing Medicaid financing ensures that states are able to react to economically driven changes in enrollment, as well as increased health care needs driven by external factors, including natural disasters, epidemics, or breakthrough treatments for serious medical conditions, such as hepatitis C. The AMA has long supported state flexibility in the Medicaid programs so that states may pursue innovations that improve care for patients with low incomes in ways that best meet each state's unique needs. However, the AMA opposes caps on federal Medicaid funding. Going forward, the AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors and other stakeholders during the process of developing federal legislation, regulations and guidelines on Medicaid funding.

Addressing the future of CHIP, the AMA strongly supports CHIP reauthorization and will lobby toward this end. In particular, AMA policy supports providing performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through CHIP with an enhanced federal match. The AMA believes it is essential to ensure predictable funding of CHIP in the future. AMA policy supports providing additional funding for CHIP to ensure adequate funding of the CHIP program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate.

### **Reduce regulatory burdens**

The AMA believes that it is imperative to reduce regulatory burdens that detract from patient care and increase costs. The AMA has urged the Centers for Medicare & Medicaid Services (CMS) to further reduce the requirements of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for all physicians' practices to provide additional flexibility, and reduce reporting burdens as well as administrative hassles and costs. The AMA supports effective quality management programs in health system reform that are streamlined, less intrusive, and result in real reduced administrative burdens for physicians and patients. Addressing electronic health records, the AMA has worked with the federal government and HHS to improve the electronic health records incentive program requirements to

maximize physician participation. Finally, the AMA is continuing its advocacy efforts to reduce the number of physicians subjected to prior authorization, as well as the overall volume of prior authorization that may adversely affect patient access to timely and medically necessary care.

### **Provide greater cost transparency**

The AMA supports efforts to provide greater cost transparency throughout the health care system. Physicians, hospitals, health plans, pharmaceutical companies and pharmacy benefit managers all have a role in ensuring patients have access to the information they need to make sound decisions that reflect their health care needs and budgetary realities. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among health plans regarding covered services, formularies, provider networks, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.

### **Incorporate common-sense medical liability reforms**

The AMA is committed to working with Congress, the administration, and other stakeholders to achieve enactment of health system reforms that include implementation of medical liability reforms to reduce the cost of defensive medicine. The AMA has been a strong advocate for passage of federal medical liability reform (MLR) legislation, based on existing laws in California and Texas, including H.R. 1215, the Protecting Access to Care Act of 2017 (PACA), which passed the U.S. House of Representatives in June. The AMA supports a range of federal legislative initiatives to implement medical liability reforms, including a limitation of \$250,000 or lower on recovery of non-economic damages; the mandatory offset of collateral sources of plaintiff compensation; decreasing sliding scale regulation of attorney contingency fees; and periodic payment for future awards of damages. The AMA will not support federal legislation if it would undermine effective tort reform provisions already in place in the states. Federal preemptive legislation that endangers state-based legislation will be actively opposed.

In addition, the AMA supports the implementation and evaluation of innovative reforms to see if they are able to improve the nation's medical liability climate. The AMA has called for federal funding for pilot projects to test such concepts as health courts, liability safe harbors for the practice of evidence-based medicine, early disclosure and compensation models, expert

witness guidelines and affidavits of merit—to gauge whether these concepts will improve the nation’s flawed medical liability system. These reforms could either complement traditional MLR provisions, such as caps, or they may be able to improve the liability climate in a state that is not able to enact traditional MLR provisions for political or judicial reasons. Implementation and evaluation of these innovative reforms are needed to determine their effectiveness.

### **Continue advancement of delivery reforms and new physician-led payment reform models**

The AMA supports promoting physician-led payment reform programs that serve as models for others working to improve patient care and lower costs. The AMA has promulgated goals for physician-focused alternative payment models (APMs), as well as guidelines for medical societies and physicians to begin identifying and developing APMs. The AMA has encouraged CMS and private payers to support assistance to physician practices working to implement APMs, and advocated for APMs to be developed in concert with specialty and state medical organizations.