

REPORT 9 OF THE COUNCIL ON MEDICAL SERVICE (A-14)  
Improving the Affordable Care Act  
(Resolution 204-I-13)  
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2013 Interim Meeting, the House of Delegates referred Resolution 204, “Improving the Affordable Care Act,” which was sponsored by the Indiana Delegation. Resolution 204-I-13 asked that the American Medical Association (AMA) consider 20 recommendations related to the Affordable Care Act (ACA). The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2014 Annual Meeting.

As outlined in the appendix, the Council conducted a thorough analysis of each recommendation of Resolution 204-I-13, and compared each recommendation to AMA policy. Some recommendations of Resolution 204-I-13 are consistent with and already addressed by AMA policy; however, other recommendations are inconsistent with AMA policy. The Council notes there is not policy specifically relevant to five recommendations of the resolution. As outlined in the appendix, the Council believes that establishing policy addressing these recommendations would have unintended consequences or be inconsistent with long-standing AMA policy.

The Council has actively monitored the implementation of the ACA since its enactment in 2010. With the implementation of health insurance exchanges, the Medicaid expansion and other provisions of the law, issues have emerged that have the potential to impact patient access to care, physicians and their practices, and the patient-physician relationship. As such, the Council highlights the following key issues for the House of Delegates, which include AMA policy and advocacy relevant to each issue:

- Narrow networks;
- Physician payment levels in exchange plans and Medicaid;
- Affordability of exchange plan coverage;
- Balance of enrollees in state exchange risk pools, and
- The uninsured in states that do not expand Medicaid.

At this juncture, the Council believes that AMA policy is sufficient to respond to these emerging issues, and urges continued federal and state advocacy efforts to carry out AMA policy. Overall, the Council believes that foundational policies of the AMA in support of covering the uninsured and expanding choice continue to be sound, and therefore recommends the reaffirmation of policies addressing individually selected and owned health insurance; health insurance tax credits and other subsidies; health savings accounts; coverage of high risk patients; health insurance market regulation; and individual responsibility. Nevertheless, significant provisions of the ACA still need to be addressed to promote and protect the interests of physicians and patients, including those pertaining to the Independent Payment Advisory Board, the Value-Based Payment Modifier program, and the non-physician provider non-discrimination provision. In addition, the Council recognizes that the ACA did not address other critical issues, including medical liability and antitrust reform, as well as replacing the SGR. As such, the Council recommends the reaffirmation of policies in support of continued AMA advocacy to modify portions of the ACA, as well as policies addressing critical issues that the ACA did not address.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-14

Subject: Improving the Affordable Care Act  
(Resolution 204-I-13)

Presented by: Charles F. Willson, MD, Chair

Referred to: Reference Committee A  
(Gary L. Bryant, MD, Chair)

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1 At the 2013 Interim Meeting, the House of Delegates referred Resolution 204, “Improving the  
2 Affordable Care Act”, which was sponsored by the Indiana Delegation. Resolution 204-I-13 asked  
3 that the American Medical Association (AMA) consider 20 recommendations related to the  
4 Affordable Care Act (ACA). The Board of Trustees assigned this item to the Council on Medical  
5 Service for a report back to the House of Delegates at the 2014 Annual Meeting.

6  
7 This report provides an overview of ACA implementation, highlights emerging issues with ACA  
8 implementation, and presents policy recommendations. The appendix to this report includes a chart  
9 that compares each recommendation of Resolution 204-I-13 to AMA policy and offers additional  
10 Council analysis.

### 11 12 BACKGROUND

13  
14 In 2013, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT)  
15 estimated that the combined coverage provisions in the ACA would expand coverage by 25 million  
16 over ten years. Therefore, in 2023, 89 percent of all residents of the United States are estimated to  
17 be insured, with 11 percent (31 million individuals) remaining uninsured. For 2014 in particular,  
18 CBO and JCT projected that 7 million individuals would enroll in coverage through health  
19 insurance exchanges, and there would be 9 million new enrollees in Medicaid and the Children’s  
20 Health Insurance Program (CHIP). The projection also showed that 2 million fewer individuals  
21 would have non-group and other health insurance coverage in 2014, with an estimated 14 million  
22 fewer Americans uninsured in 2014.<sup>1</sup>

23  
24 The CBO and JCT coverage projections for 2014 were predicated on a fully functional  
25 healthcare.gov website, which launched October 1, 2013, to enable individuals to sign up for  
26 coverage through new health insurance exchanges. In the early stages of the launch, the website  
27 experienced difficulties that impacted the site’s ability to provide information about the health  
28 plans available in each state; estimate the cost of the insurance and whether an individual or family  
29 qualifies for subsidies to lower their health insurance premium or out-of-pocket costs; enroll  
30 individuals in coverage through health insurance exchanges; and transmit enrollment data to health  
31 insurance issuers. In addition, the technical issues of healthcare.gov in some cases affected its  
32 ability to determine site visitor eligibility for Medicaid and CHIP coverage.

33  
34 In addition, during the fall of 2013, some individuals enrolled in coverage sold in the individual  
35 and small group markets received cancellation notices stating that their health plans would not be  
36 offered in 2014 due to not meeting the health plan standards outlined in the ACA. Estimates vary  
37 widely—from 2.6 million<sup>2</sup> to 4.7 million<sup>3</sup>—regarding the number of cancellations sent out

1 specifically due to noncompliance with the ACA. The Council notes that the methodologies used to  
 2 create such estimates account for the variation. Health plans in existence at the time the ACA was  
 3 enacted into law (March 23, 2010) had the option to receive “grandfathered” status and therefore  
 4 not comply with all of the new rules if the health insurers did not substantially change the plan’s  
 5 benefits and costs. Plans that did not receive “grandfathered” status, therefore, have to meet ACA’s  
 6 essential health benefit standards, offer first-dollar coverage of preventive services, guarantee  
 7 patient appellate rights and undergo rate review for premium increases deemed to be excessive. In  
 8 addition, non-grandfathered plans in the individual market have to abide by ACA provisions that  
 9 prevent denials due to pre-existing conditions and end annual limits on coverage.

10  
 11 Resulting from implementation issues, CBO and JCT released a new projection in February 2014,  
 12 which estimated one million fewer individuals enrolling in coverage through health insurance  
 13 exchanges in 2014, as well as one million fewer new enrollees in Medicaid and CHIP. The CBO  
 14 and JCT again released a projection in April 2014, which estimated one million fewer new  
 15 enrollees in Medicaid and CHIP, and a smaller decrease in non-group and other coverage. The  
 16 April projection showed that there would be 12 million fewer Americans uninsured in 2014, a  
 17 reduction from both the 2013 and February 2014 projection. However, in 2023, it projected that 26  
 18 million fewer US residents would be uninsured, one million more than the 2013 projection.<sup>4</sup>

**Snapshot of Coverage: 2014**

<b>CBO Coverage Projections for 2014</b>	<b>May 2013</b>	<b>February 2014</b>	<b>April 2014</b>
Health Insurance Exchanges	7 million	6 million	6 million
Medicaid and CHIP New Enrollees	9 million	8 million	7 million
Non-Group and Other Coverage	-2 million	-2 million	-1 million
Reduction in Uninsured	14 million	13 million	12 million
<b>Actual Coverage Figures</b>			
Enrollment in Exchanges (as of 4/19/14)	8 million		
Determined Eligible for Medicaid & CHIP (as of 3/31/14)	14.7 million*		
Health Insurance Policy Cancellations	2.6 - 4.7 million		
Off-Exchange Enrollment	Not yet known		
Reduction in Uninsured	Not yet known		

\*Includes those newly eligible under the ACA, those eligible under prior law and, for some states, renewals. Eligibility determinations made solely by federally-facilitated exchanges, without any assistance by state agencies, are not included. Data reported are as of March 31, 2014.

19 As outlined in the table, as of April 19, 2014, approximately eight million individuals selected  
 20 plans through health insurance exchanges. Of these exchange enrollees, 2.6 million signed up in  
 21 state-based health insurance exchanges, and 5.4 million signed up in federally-facilitated  
 22 exchanges.<sup>5</sup> It is not clear at this time how many people signed up for individual coverage directly  
 23 with a health insurer, off of the exchanges. Some large health insurers have reported that 20 to 30  
 24 percent of their new enrollees signed up for coverage off of the exchanges.<sup>6</sup> RAND Corporation  
 25 found that approximately 7.8 million individuals purchased plans directly from health insurers, off  
 26 of the exchanges, through March 2014.<sup>7</sup> The Council notes that individuals who qualify for special  
 27 enrollment periods are able to sign up for exchange coverage after the March 31 deadline, such as  
 28 individuals who lose employer-sponsored coverage and those who get married. In addition, from  
 29 October 1, 2013, to March 31, 2014, more than 14.7 million individuals were determined eligible  
 30 for Medicaid and CHIP coverage by state agencies, which include those newly eligible under the

1 ACA, those eligible under prior law and, for some states, renewals. This figure does not include  
2 eligibility determinations solely made by federally-facilitated exchanges, without any assistance  
3 from state agencies.<sup>8</sup> Overall, 1.96 million individuals were determined or assessed eligible for  
4 Medicaid or CHIP by federally-facilitated exchanges, which includes determinations made with  
5 and without state assistance.<sup>5</sup>

6  
7 The Council expects data to be released later this year that show the impact of the ACA on  
8 reducing the number of uninsured Americans. The Council is aware of concerns raised to date  
9 pertaining to the percentage of exchange enrollees who previously were insured, versus being  
10 uninsured. There is no nationwide tracking of the previous insurance status of exchange enrollees,  
11 but a few state exchanges included a question about insurance status during the exchange  
12 application process. In New York, of the nearly 343,000 individuals that have enrolled in exchange  
13 coverage as of mid-March, 59 percent were uninsured at the time of application.<sup>9</sup> In Kentucky, of  
14 the 65,000 individuals that have enrolled in exchange coverage as of mid-March, 75 percent were  
15 uninsured at the time of application.<sup>10</sup> RAND Corporation estimated that 36 percent of individuals  
16 enrolled in the exchanges through March were previously uninsured.<sup>7</sup> McKinsey & Company  
17 conducted a national survey mid-February 2014 of individuals eligible to purchase coverage on the  
18 individual market (either on or off the exchanges), which showed that 27 percent of respondents  
19 were previously uninsured. As some of the survey respondents purchased coverage off of the  
20 exchanges, the survey results cannot be directly compared to the number of individuals enrolled in  
21 exchanges.<sup>11</sup>

22  
23 There is also plan-to-plan and state-to-state variation to date in the percentage of exchange plan  
24 enrollees who have paid the first premium for their policies. Factors impacting these numbers  
25 include the effective start dates of the plans patients enroll in, as well as issues with health plan  
26 billing. Approximately 80 to 85 percent of individuals who signed up for Blue Cross Blue Shield  
27 Association health plans—offered in the exchanges in all states but Iowa, Mississippi and South  
28 Dakota—paid their premiums as of February 1.<sup>12</sup> Likewise, 85 percent of individuals who signed up  
29 for Wellpoint coverage, and 80 percent of individuals who signed up for Aetna coverage, through  
30 the exchanges had paid their premiums through February.<sup>13</sup>

31  
32 The states that have released applicable data to date show a range in the percentage of enrollees  
33 that have paid their first premium. For example, 54 percent of Maryland exchange enrollees have  
34 paid their first premium as of March 1.<sup>14</sup> In Vermont, 64 percent of exchange enrollees have paid  
35 their first premium as of March 17. Of this number, 94 percent of enrollees whose policy started in  
36 January have paid their premiums, 93 percent of enrollees whose policy started in February, and 82  
37 percent whose policy started in March.<sup>15</sup> In California, approximately 85 percent of enrollees have  
38 paid their first premium.<sup>16</sup> In Minnesota, 90 percent of enrollees have paid their first premium.<sup>17</sup> In  
39 the coming months, more complete data is expected concerning enrollee payment of premiums. As  
40 such, the Council will continue to monitor the rate at which exchange enrollees pay their  
41 premiums, as well as the percentage of exchange enrollees who were previously insured, due to the  
42 impact that both factors have on the number of Americans who remain uninsured this year.

43  
44 Resulting in part from implementation difficulties and pressure from the business community,  
45 additional aspects of the law have been delayed or modified through regulation and other  
46 administrative authority:

- 47  
48 • The deadline to obtain coverage and comply with the individual mandate was extended to  
49 March 31, 2014.

- 1 • The Pre-Existing Condition Insurance Plan (PCIP) was formally extended through April  
2 30, 2014. The PCIP was originally intended to operate as a temporary high-risk pool  
3 program to provide coverage through the end of 2013.  
4
- 5 • Online enrollment in the federally facilitated Small Business Health Options Program  
6 (SHOP) exchanges has been delayed until November 2014, to offer coverage effective  
7 January 1, 2015. Online enrollment in these exchanges was originally slated to begin in  
8 2013, to offer coverage effective January 1, 2014. In the interim, employers can directly  
9 enroll in a SHOP exchange plan through agents, brokers and insurance companies that  
10 offer SHOP exchange plans.  
11
- 12 • A transitional policy was adopted that provides health insurers offering plans in the  
13 individual and small group markets in 2013 that were slated to be canceled resulting from  
14 new ACA requirements with the option to renew the plans for policy years beginning on or  
15 before October 1, 2016. Therefore, some affected individuals and small businesses enrolled  
16 in these plans in 2013 have the ability to continue to be covered by these plans.  
17
- 18 • Individuals affected by the recent health insurance policy cancellations also are able to  
19 qualify for a temporary hardship exemption to allow them to purchase catastrophic plans  
20 through health insurance exchanges. Eligibility to purchase catastrophic plans was  
21 previously limited to those up to age 30 and to those who are exempt from the individual  
22 mandate.  
23
- 24 • The employer responsibility provision, which affects firms with 50 or more full-time  
25 employees, has been delayed. In 2015, firms with 100 or more full-time employees will  
26 need to offer coverage to 70 percent of their full-time employees. In 2016, these firms will  
27 have to offer coverage to 95 percent of their employees. Also in 2016, firms with between  
28 50 and 99 full-time employees will be required to offer coverage to 95 percent of their  
29 employees.  
30

## 31 EMERGING ISSUES IN ACA IMPLEMENTATION

32  
33 The Council has actively monitored the implementation of the ACA since its enactment in 2010.  
34 With the implementation of health insurance exchanges, the Medicaid expansion and other  
35 provisions of the law, issues have emerged that have the potential to impact patient access to care,  
36 physicians and their practices, and the patient-physician relationship.  
37

### 38 *Narrow Networks*

39  
40 The ACA requires that plans sold on health insurance exchanges maintain provider networks that  
41 are sufficient in number and types of providers to ensure that all services, including mental health  
42 and substance use disorder services, are accessible to enrollees without unreasonable delay. States  
43 can choose to adopt more stringent network adequacy standards than the federal requirements.  
44 Thirteen states and DC, operating their own exchanges, have outlined additional standards to  
45 supplement federal requirements on provider networks.<sup>18</sup> However, in an effort to control costs,  
46 health insurers offering plans in the exchanges appear to be relying heavily on tiered and narrow  
47 network strategies in some communities. For example, a recent study concluded that narrow  
48 hospital networks are more prevalent in exchange plans, and comprise 70 percent of all exchange  
49 plan networks.<sup>19</sup>

1 The implementation of narrow networks in plans offered through health insurance exchanges is  
2 occurring at a time when the majority of uninsured individuals seeking coverage in the exchange  
3 marketplace are not familiar with varying health plan design strategies. In 2013, approximately 60  
4 percent of uninsured nonelderly adults were not confident in their understanding of the term  
5 “provider network.”<sup>20</sup> While tiered and narrow networks may provide patients with access to plans  
6 with lower premiums and cost sharing when compared to broader network plans, patients with  
7 narrow network plans who need to seek care from out-of-network providers face the potential of  
8 significant out-of-pocket costs. Plans that do cover out-of-network services often do so with higher  
9 patient cost-sharing requirements (co-payments and deductible). Regardless of whether a plan  
10 covers out-of-network services, the annual cap on patient out-of-pocket costs (\$6,350 for an  
11 individual) does not apply to services obtained out-of-network. As a result, the Council believes  
12 that tiered and narrow network strategies have the potential to adversely impact the access to and  
13 affordability of care, as well as established patient-physician relationships.

14  
15 In addition, plans sold on health insurance exchanges are required to make their network provider  
16 directories available online. Federal regulations do not stipulate how often provider directories  
17 must be updated; there have been reports of online enrollment portals having inaccurate provider  
18 directories visible to prospective enrollees, which potentially incorrectly influenced their plan  
19 selection. Unfortunately, if health plan enrollees find themselves in plans with unduly narrow  
20 networks and cannot access the physicians or hospitals they are familiar with, they have limited  
21 recourse. Once individuals have paid their first month’s premium and have coverage that is  
22 effective, they can only move to a plan with a more inclusive provider network offered by the same  
23 issuer as the plan in which they are enrolled, and offered at the same metal level (bronze, silver,  
24 gold and platinum) and cost-sharing reduction level. Notably, such changes could only be  
25 requested during the initial open enrollment period.<sup>21</sup> The next opportunity for individuals to  
26 change plans will be the annual open enrollment period, with coverage effective the following year.

27  
28 Relevant AMA Policy and Advocacy

29  
30 Policy H-285.911 states that health insurance provider networks should be sufficient to provide  
31 meaningful access to all medically necessary and emergency care, at the preferred, in-network  
32 benefit level on a timely and geographically accessible basis. Policy H-450.941 opposes the use of  
33 tiered and narrow physician networks that deny patient access to, or attempt to steer patients  
34 towards, certain physicians primarily based on cost of care factors. Policy H-285.984 states that the  
35 AMA will advocate strongly that those health care plans or networks that use criteria to determine  
36 the number, geographic distribution, and specialties of physicians needed be required to report to  
37 the public, on a regular basis, the impact that the use of such criteria has on the quality, access,  
38 cost, and choice of health care services provided to patients enrolled in such plans or networks.  
39 Policy H-285.924 states that health plans should provide patients with their current directory of  
40 participating physicians through multiple media outlets, including the Internet.

41  
42 The AMA has been very active at the federal and state levels regarding network adequacy, tiered  
43 and narrow networks, and the provision of accurate provider directory information. Before health  
44 insurance exchanges were implemented, the AMA stressed the importance of these issues in  
45 meetings with the Administration, as well as in numerous comment letters in response to  
46 regulations. Since the exchanges have come online, AMA advocacy has continued, and has  
47 included in-person meetings and consistent communications with the Administration, as well as  
48 comments in response to the draft 2015 letter to health insurance issuers in federally facilitated  
49 exchanges from the Centers for Medicare and Medicaid Services (CMS). Responding to complaints  
50 from the AMA, other provider groups, and consumer groups, the final 2015 letter to issuers in

1 federally facilitated exchanges adopted stronger requirements for network adequacy and provider  
2 directories.

3  
4 On the state level, the Advocacy Resource Center (ARC) has created an ACA state implementation  
5 toolkit, which contains four model bills on tiered and narrow networks and access to accurate  
6 provider directories. In addition, the AMA has a model bill titled “Meaningful Access to  
7 Physicians and other Health Care Providers: Network Standards Act” to ensure network adequacy.  
8 The AMA has also been supportive of state medical association efforts advocating that states issue  
9 more stringent network adequacy standards than what is outlined in federal requirements.

10  
11 *Physician payment levels in exchange plans and Medicaid*

12  
13 In addition to instituting tiered and narrow networks, some health insurance issuers are using  
14 physician payment levels as a means to cut costs, and improve the affordability of certain plans  
15 offered through health insurance exchanges. Therefore, physicians in many states have encountered  
16 payment rates in plans participating in exchanges that are lower than the payment rates of plans  
17 offered by the same issuer outside of the exchange environment. The Council is cognizant that  
18 while some physicians were given the opportunity not to participate in these plans, others were  
19 automatically enrolled in these plans due to existing “all products” contract provisions.

20  
21 The Council notes that there is a potential of additional undercompensated care resulting from  
22 state-level Medicaid expansions depending on state payment policies, for those physicians who  
23 accept Medicaid. While the ACA contains a provision to increase Medicaid payments for  
24 evaluation and management services and immunizations provided by primary care physicians  
25 (family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare  
26 payment rates for 2013 and 2014, the provision is only temporary and does not impact the payment  
27 levels of physicians in other specialties. Council on Medical Service Report 2, also being  
28 considered at this meeting, recommends that the AMA advocate for the Medicaid primary care  
29 payment increase to continue past 2014. In addition, the report recommends the reaffirmation of  
30 AMA policy advocating that Medicaid payments to all physicians be at minimum 100 percent of  
31 Medicare payment rates.

32  
33 Relevant AMA Policy and Advocacy

34  
35 AMA policy advocates that Medicaid payments to physicians must be at minimum 100 percent of  
36 Medicare payment rates (H-290.976, H-385.921 and H-290.980). In addition, AMA policy  
37 promotes adequate Medicaid payment levels to assure broad access to care and opposes payment  
38 cuts that may reduce patient access to care and undermine the quality of care provided to patients  
39 (Policies H-290.997 and H-330.932). Policy D-290.979 states that the AMA will advocate for an  
40 increase in Medicaid payments to physicians as coverage is expanded as provided for in the ACA.

41  
42 Regarding physician payment rates of plans participating in health insurance exchanges, Policy  
43 H-165.838 states that options offered in a health insurance exchange must include payment rates  
44 established through meaningful negotiations and contracts. Overall, Policy D-385.966 advocates  
45 that reasonable payment levels should be assured for mandated benefits in health insurance policies  
46 so as to ensure that these services are readily accessible.

1 In its advocacy efforts on the state and federal levels, the AMA has highlighted physician payment  
 2 in exchange plans and Medicaid as critical issues of ACA implementation. The AMA has  
 3 prioritized this issue in comment letters, as well as meetings with the Administration. In state  
 4 advocacy, the ARC has launched a campaign to assist state medical societies in advocating for  
 5 transparency and fair contracting with insurers ([www.ama-assn.org/resources/doc/arc/hix-](http://www.ama-assn.org/resources/doc/arc/hix-transparency-summary.pdf)  
 6 [transparency-summary.pdf](http://www.ama-assn.org/resources/doc/arc/hix-transparency-summary.pdf)). Concerning Medicaid, the ARC is running a campaign focused on  
 7 issues including but not limited to physician reimbursement and access to care ([www.ama-](http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/reforming-medicaid.page)  
 8 [assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/reforming-](http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/reforming-medicaid.page)  
 9 [medicaid.page](http://www.ama-assn.org/ama/pub/advocacy/state-advocacy-arc/state-advocacy-campaigns/reforming-medicaid.page)).

10  
 11 *Affordability of exchange plan coverage*

12  
 13 The affordability of exchange plan coverage remains an area to be closely monitored, as the  
 14 premium levels of all metal tiers and their associated deductibles and cost-sharing levels are now  
 15 known. As of April 19, of the individuals who have enrolled in plans offered through health  
 16 insurance exchanges, 65 percent are enrolled in a silver plan. 20 percent of individuals are enrolled  
 17 in bronze plans, 9 percent in gold plans, 5 percent in platinum plans, and 2 percent in catastrophic  
 18 plans.<sup>5</sup> The bronze plan, which represents minimum creditable coverage, covers 60 percent of  
 19 benefit costs including out-of-pocket limits equal to the health savings account (HSA) limits  
 20 (\$6,350 for individuals and \$12,700 for families in 2014). The percentage of benefit costs covered  
 21 increases to 70 percent in the silver plan, 80 percent in the gold plan, and 90 percent in the  
 22 platinum plan.

23  
 24 Prior to the implementation of the health insurance exchanges provided for in the ACA, in 2011,  
 25 the national average monthly nongroup insurance premium for a single adult was \$258 per  
 26 month.<sup>22</sup> Considering that the typical yearly increase in per capita private health expenditures is  
 27 five percent per year, the 2014 estimate of this figure, which reflects the pre-ACA health insurance  
 28 market, would be \$299 per month. In health insurance exchanges, individuals with incomes  
 29 between 133 and 200 percent of FPL, a population that qualifies for significant premium subsidies  
 30 (outlined at [www.ama-assn.org/resources/doc/market-reforms/health-insurance-subsidies.pdf](http://www.ama-assn.org/resources/doc/market-reforms/health-insurance-subsidies.pdf)) can  
 31 obtain coverage through the second lowest cost silver plan for approximately \$80 per month. In  
 32 2014, the federal poverty level is \$11,670 for an individual and \$23,850 for a family of four. If  
 33 premium-eligible individuals choose a higher-level plan (gold, platinum), said individuals would be  
 34 responsible for paying the difference between the costs of the higher-level plan and the second-  
 35 lowest cost silver plan. Individuals with incomes between 200 percent and 300 percent FPL, who  
 36 qualify for smaller premium subsidies, can obtain silver coverage with premiums ranging from  
 37 \$160 to \$188 per month on average. Those with incomes between 300 and 400 percent FPL, still  
 38 eligible for minimal premium subsidies, are expected to pay between \$209 and \$302 per month for  
 39 the second lowest cost silver plan. All subsidy-eligible individuals can also choose to pay less for a  
 40 bronze plan, which would have higher deductibles (between \$4,500 and \$5,500 for single  
 41 coverage) and cost-sharing. For example, an individual with income between 138 and 200 percent  
 42 FPL could pay \$29 per month for a bronze plan, which represents a significant premium savings  
 43 from the \$80 per month for the silver plan.

44  
 45 Individuals who do not qualify for the ACA's premium subsidies face higher premiums in  
 46 coverage offered through health insurance exchanges. Individuals age 19 to 34 can expect to pay  
 47 on average \$219 per month for the second lowest cost silver plan and \$162 per month for the  
 48 cheapest bronze plan. On the other end of the spectrum, individuals age 55 to 64 can expect to pay,  
 49 on average, \$541 per month for the second lowest cost silver plan and \$404 per month for the  
 50 cheapest bronze plan.<sup>23</sup> Significant state variation in premium levels and the range of plans

1 available through exchanges is illustrated at  
2 <http://jama.jamanetwork.com/article.aspx?articleid=1841974>. A recent analysis showed that  
3 coverage offered through health insurance exchanges have premiums, on average, that are  
4 comparable to, or less than, similar employer-sponsored coverage.<sup>24</sup>  
5

6 The Council recognizes that it is absolutely critical for patients to be aware of and understand the  
7 deductibles and other cost-sharing responsibilities of the plans they choose to enroll in, due to their  
8 impact on patient financial stability and access to care. According to a recent survey, 39.9 percent  
9 of nonelderly adults targeted for enrollment in exchange plan coverage are confident in their  
10 understanding of basic health insurance terms (e.g., premium, deductible, copay, provider network,  
11 covered services, excluded services). Lower levels of confidence in understanding these terms were  
12 found for young adults, Spanish speakers and individuals who have completed lower levels of  
13 education.<sup>20</sup> Health insurance exchanges are offering plans with different deductibles and patient  
14 coinsurance responsibilities, with all plans including caps on out-of-pocket costs. Individuals with  
15 incomes up to 250 percent of FPL are eligible for cost-sharing subsidies to lower their out-of-  
16 pocket costs, but only if they purchase a silver-level plan. Such cost-sharing subsidies are applied  
17 automatically so that eligible individuals are enrolled in a version of the silver-level plan that has  
18 lower deductibles, copayments and coinsurance, and out-of-pocket maximums. Accordingly,  
19 individuals with incomes between 100 and 150 percent FPL would pay 6 percent of covered  
20 expenses out-of-pocket, versus 13 percent for those with incomes between 150 and 200 percent  
21 FPL, and 27 percent for those earning between 200 and 250 percent FPL. Overall, a patient's  
22 access to care can be impacted by the cost-sharing levels of the health plan in which they enroll.  
23 Patients should enroll in plans that best reflect their health and financial situations. With each  
24 annual open enrollment period, patients are expected to become more familiar with the designs of  
25 the plans offered, including differences in deductibles and cost-sharing, as well as provider  
26 networks.  
27

28 While bronze and catastrophic plans may carry the lowest premiums, they also have the highest  
29 deductibles. Bronze level plans typically have deductibles ranging from \$4,500 and \$5,500 for  
30 single coverage, and the deductible for catastrophic plans is \$6,350. These plans also have the  
31 highest cost-sharing levels after the deductible is met. Together, these high deductibles and cost-  
32 sharing responsibilities may impede access to care. Certain services are exempt from the  
33 deductible, without copayments or coinsurance, which may mitigate potential cost-sharing  
34 challenges for some patients. Patient awareness of these defined preventive services  
35 ([www.healthcare.gov/what-are-my-preventive-care-benefits/](http://www.healthcare.gov/what-are-my-preventive-care-benefits/)) is critical. Notably, in catastrophic  
36 plans, three primary care visits per year are covered at no cost to the patient, before the deductible  
37 is met.  
38

39 The ACA required the establishment of navigator programs to help individuals and businesses  
40 make informed decisions about enrolling in health insurance through the exchanges. Certified  
41 application counselors are also available to assist patients with the enrollment process. Although  
42 navigators and certified application counselors are required to complete training, the concerns have  
43 arisen with the varied levels of competence of these personnel, as well as different levels of  
44 understanding of the eligibility rules for premium and cost-sharing subsidies, Medicaid and CHIP.  
45

#### 46 Relevant AMA Policy and Advocacy 47

48 Policy H-165.839 states that health insurance exchanges should maximize health plan choice for  
49 individuals and families purchasing coverage, with participating health plans providing an array of  
50 choices, in terms of benefits covered, cost-sharing levels and other features. Policies H-165.845,

1 H-373.998, H-165.838, H-165.846, H-320.968 and H-165.985 support patient choice of health  
 2 plan, as well as the provision of full and clear information to consumers on the provisions and  
 3 benefits offered by health plans. Policy H-373.994 outlines guidelines for patient navigator  
 4 programs. Policy H-165.846 states that mechanisms must be in place to educate patients and assist  
 5 them in making informed choices, including ensuring transparency among all health plans  
 6 regarding covered services, cost-sharing obligations, out-of-pocket limits and excluded services.  
 7 The policy also states that provisions must be made to assist individuals with low-incomes or  
 8 unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing  
 9 obligations, which aligns with Policy H-165.865, which states that the size of premium credits  
 10 should be large enough to ensure that health insurance is affordable for most people.  
 11 To determine the adequacy of health insurance options, Policy H-165.846 supports using existing  
 12 federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the U.S. Tax Code  
 13 and Federal Employees Health Benefits Program (FEHBP) regulations) as a reference when  
 14 considering if a given plan would provide meaningful coverage. Notably, AMA policy strongly  
 15 supports HSAs maintaining their role in the health insurance marketplace as an option for patients  
 16 (Policy H-165.852). In addition, Policy H-165.865 states that in order to qualify for a tax credit for  
 17 the purchase of individual health insurance, per Policy H-165.920, the health insurance purchased  
 18 must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of  
 19 medical expenses as defined by Title 26 Section 9832 of the U.S. Code. Also addressing the level  
 20 of health insurance coverage patients should obtain, Policy H-165.848 advocates a requirement that  
 21 those earning greater than 500 percent of FPL obtain a minimum level of catastrophic and  
 22 preventive coverage. Only upon implementation of tax credits or other subsidies would those  
 23 earning less than 500 percent of FPL be subject to the coverage requirement. The flexibility  
 24 afforded in these policies aligns with long-standing AMA policy supporting a system of  
 25 individually owned and selected health insurance (Policy H-165.920).

26  
 27 Pursuant to policy, the AMA has submitted comments in response to federal regulations  
 28 concerning health insurance exchanges, essential health benefits, and the coverage of preventive  
 29 services. Such comments addressed the importance of maximizing health plan choice in exchanges,  
 30 allowing for a range in benefit packages, making health benefit information transparent, and setting  
 31 requirements for navigators.

32  
 33 *Balance of enrollees in state exchange risk pools*

34  
 35 The Council recognizes that the success of the coverage provisions of the ACA, particularly with  
 36 respect to coverage provided through health insurance exchanges, is directly related to the ability of  
 37 exchanges to enroll young and healthy individuals to ensure the risk pool is balanced between high-  
 38 cost and low-cost individuals. Young adults age 18-34 make up 40 percent of the population  
 39 eligible for coverage offered through health insurance exchanges (e.g., those who are currently  
 40 uninsured or buying their own insurance already, not eligible for Medicaid or affordable employer-  
 41 sponsored coverage, and who legally reside in the U.S.). As such, the goal is to enroll roughly the  
 42 same proportion of individuals age 18-34 in exchanges to ensure a balanced risk pool. As of April  
 43 19, 2014, approximately 28 percent of individuals enrolled in plans offered through health  
 44 insurance exchanges are between the ages of 18 and 34. The Council notes that young adult  
 45 enrollment in coverage offered through health insurance exchanges varies by state.<sup>5</sup>

46  
 47 Insufficient enrollment of young adults leads to the total amount of premiums collected by insurers  
 48 to be less than the total health care expenses of enrollees plus administrative overhead and profit.  
 49 Recent projections show that if young adults age 18-34 enroll at a 25 percent lower rate (33  
 50 percent) than what is considered necessary (the 40 percent target), health plan costs would be 1.1  
 51 percent higher than premium revenues. If young adults only make up 25 percent of health

1 insurance exchange enrollees, it is projected that health plan costs would be 2.4 percent higher than  
2 premium revenues. Of note, health insurers typically plan to achieve a profit margin of 3 to 4  
3 percent.<sup>25</sup>

4  
5 Resulting from insufficient young adult enrollment in health insurance exchanges, insurers may  
6 raise premiums, even with the aforementioned financial protections in place. However, it is  
7 expected that insurers would exercise caution in increasing premiums at too great of rate in the  
8 early years of exchange implementation, as doing so would limit their ability to gain market share  
9 in the exchange marketplace, hurting profits in the long term.<sup>26</sup> Also, current projections show that  
10 such premium increases would be well below what is necessary to trigger a “death spiral,” which  
11 would cause healthy people to drop their coverage, to the point that the pool of insured individuals  
12 gets smaller and less healthy, until the health plan eventually fails.<sup>25</sup> Importantly, the ACA  
13 established premium stabilization programs, including the temporary risk corridor and reinsurance  
14 programs, to provide payments during the first years of exchange implementation to health insurers  
15 that cover high-risk individuals, as well as more evenly spread the financial risk faced by insurers.  
16 The Council is cognizant that these programs provide insurers with a significant incentive to  
17 participate in the exchanges, and minimize premium increases, in the early years.

18  
19 The Council is aware that the affordability of plans offered in health insurance exchanges will  
20 impact enrollment, including for young adults. The rate at which young adults are enrolling in  
21 exchange plan coverage is raising concerns regarding the age rating provision in the ACA, which  
22 allows for limited, 3:1 premium ratio based on age. The 3:1 ratio means that premiums for a 63  
23 year-old can be three times the premium for a 21 year-old. Considering that the typical age rating  
24 before the implementation of this provision of the ACA was 5:1, which made health insurance  
25 unaffordable for many older individuals, the 3:1 ratio required in the ACA allows less variation in  
26 premiums based on age. Accordingly, risk will be shared more broadly across the population so  
27 that younger individuals will likely subsidize some of the medical expenses of older individuals.

#### 28 29 Relevant AMA Policy and Advocacy

30  
31 Policy H-165.856 supports modified community rating, risk bands, or risk corridors, and states that  
32 some degree of age rating is acceptable. Policy H-165.842 supports the health insurance coverage  
33 of high-risk patients being subsidized through direct risk-based subsidies such as high-risk pools,  
34 risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market  
35 regulation. The AMA has also submitted comments to HHS addressing standards related to  
36 reinsurance, risk corridors and risk adjustment.

#### 37 38 *The uninsured in non-expansion states*

39  
40 In June 2012, the Supreme Court ruled that Congress exceeded its authority by threatening to  
41 withhold existing Medicaid funds from states that fail to expand Medicaid to cover all non-elderly  
42 Americans with incomes up to 133 percent of FPL, thereby making the ACA’s Medicaid expansion  
43 optional for states. At the time that this report was written, 26 states and the District of Columbia  
44 are implementing the Medicaid expansion, whereas 19 states are not. Five states are still  
45 considering whether to expand.<sup>27</sup>

46  
47 In states that choose not to implement the Medicaid expansion, individuals with incomes below  
48 100 percent FPL (\$11,670 for an individual and \$23,850 for a family of four in 2014) who are  
49 ineligible for state Medicaid coverage will remain uninsured. This population is ineligible for  
50 premium and cost-sharing subsidies to purchase coverage through health insurance exchanges, and  
51 therefore will likely lack access to affordable health insurance coverage options. Eligible

1 individuals with household incomes between 100 and 400 percent FPL can receive premium credits  
2 and cost-sharing subsidies to purchase coverage through health insurance exchanges. As such, an  
3 individual earning 110 percent FPL (\$12,837) in a non-expansion state, receiving premium and  
4 cost-sharing subsidies, can be expected to pay no more than \$21.40 per month for a silver-level  
5 plan, and would only be responsible for paying for 6 percent of covered expenses out-of-pocket.  
6

7 To fill the gap in coverage under 100 percent FPL without implementing the Medicaid expansion  
8 outlined in the ACA, Wisconsin amended its Medicaid state plan and existing Section 1115 waiver  
9 to cover adults up to 100 percent FPL in Medicaid. Of note, as Wisconsin did not expand coverage  
10 to 133 percent FPL, the state is not eligible to receive the enhanced federal match provided for in  
11 the ACA. The Council notes that another alternative to ensuring that there is not a coverage gap  
12 below 100 percent FPL is to expand Medicaid, through traditional as well as using alternative  
13 mechanisms, such as premium support. Under the premium support option, states would use  
14 Medicaid funds to purchase coverage for newly eligible Medicaid beneficiaries in plans offered  
15 through health insurance exchanges. As outlined in the appendix concerning the sixth  
16 recommendation of Resolution 204-I-13, HHS approved the use of premium support with Medicaid  
17 funds to allow Arkansas and Iowa to expand their Medicaid program, with a similar waiver  
18 pending in Pennsylvania.  
19

#### 20 Relevant AMA Policy and Advocacy

21

22 Policy H-290.997 supports the creation of basic national standards of uniform eligibility in the  
23 Medicaid program, so that all persons below poverty level income are eligible. Policy D-290.979  
24 states that the AMA, at the invitation of state medical societies, will work with state and specialty  
25 medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent FPL.  
26 AMA Policy H-165.855 is conceptually consistent with the waivers approved in Arkansas and  
27 Iowa. The policy supports the use of federal funds for states to use to develop alternatives to  
28 traditional Medicaid programs, including premium assistance programs that allow nonelderly and  
29 nondisabled Medicaid beneficiaries to purchase private insurance.  
30

#### 31 DISCUSSION

32

33 The Council believes that foundational policies of the AMA in support of covering the uninsured  
34 and expanding choice continue to be sound, and therefore recommends the reaffirmation of policies  
35 addressing individually selected and owned health insurance; health insurance tax credits and other  
36 subsidies; health savings accounts; coverage of high risk patients; health insurance market  
37 regulation; and individual responsibility. However, the Council has identified critical issues that  
38 have emerged in the implementation of the ACA. At this juncture, the Council believes that  
39 existing policy is sufficient to respond to these emerging issues, and urges continued federal and  
40 state advocacy efforts to carry out AMA policy. Nevertheless, significant provisions of the ACA  
41 still need to be addressed to promote and protect the interests of physicians and patients, including  
42 those pertaining to the Independent Payment Advisory Board, the Value-Based Payment Modifier  
43 program, and the non-physician provider non-discrimination provision. In addition, the Council  
44 recognizes that the ACA did not address other critical issues, including medical liability and  
45 antitrust reform, as well as replacing the SGR. As such, the Council recommends the reaffirmation  
46 of policies in support of continued AMA advocacy to modify portions of the ACA, as well as  
47 policies addressing critical issues that the ACA did not address.

1 Resolution 204-I-13 highlighted issues associated with the ACA and its implementation. The  
2 resolution called for the AMA to consider 20 recommendations related to the ACA. As outlined in  
3 the appendix, the Council conducted a thorough analysis of each recommendation of Resolution  
4 204-I-13, and compared each recommendation to AMA policy. The Council's analysis showed that  
5 the consistency of Resolution 204-I-13 with AMA policy is mixed. Some recommendations are  
6 consistent with and already addressed by AMA policy; however, other recommendations are  
7 inconsistent with AMA policy. The Council notes there currently is not policy specifically relevant  
8 to five recommendations of the resolution. As outlined in the appendix, the Council believes that  
9 establishing policy addressing these recommendations would have unintended consequences.

10  
11 **RECOMMENDATIONS**

12  
13 The Council on Medical Service recommends that the following be adopted in lieu of Resolution  
14 204-I-13 and that the remainder of the report be filed:

- 15  
16 1. That our American Medical Association (AMA) reaffirm Policy H-165.833, which supports  
17 repeal of the Independent Payment Advisory Board and the non-physician provider non-  
18 discrimination provision, as well as the enactment of antitrust reform. (Reaffirm HOD Policy)
- 19  
20 2. That our AMA reaffirm Policy D-390.954, which supports the repeal or significant  
21 modification of the Value-Based Payment Modifier program. (Reaffirm HOD Policy)
- 22  
23 3. That our American Medical Association (AMA) reaffirm Policy H-165.920, which supports a  
24 system of individually selected and owned health insurance. (Reaffirm HOD Policy)
- 25  
26 4. That our AMA reaffirm Policy H-165.865, which supports principles for health insurance tax  
27 credits and other subsidies. (Reaffirm HOD Policy)
- 28  
29 5. That our AMA reaffirm Policy H-165.852 in support of health savings accounts. (Reaffirm  
30 HOD Policy)
- 31  
32 6. That our AMA reaffirm Policy H-165.842, which supports the principle that health insurance  
33 coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-  
34 risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely  
35 heavily on market regulation. (Reaffirm HOD Policy)
- 36  
37 7. That our AMA reaffirm Policy H-165.856, which established principles for health insurance  
38 market regulation. (Reaffirm HOD Policy)
- 39  
40 8. That our AMA reaffirm Policy H-165.848, which supports individual responsibility to obtain a  
41 minimum level of catastrophic and preventive coverage. (Reaffirm HOD Policy)
- 42  
43 9. That our AMA reaffirm Policy H-165.838, which advocates for essential elements of health  
44 system reform, including repealing and replacing the sustainable growth rate formula, and  
45 enacting meaningful medical liability reform. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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**Appendix: Crosswalk of Resolution 204-I-13 with AMA Policy**

<b>Resolution 204 Recommendation</b>	<b>AMA Policy and Council Analysis</b>
1. Replace the individual mandate with a refundable tax credit that could only be used to purchase health insurance.	INCONSISTENT with longstanding AMA policy in support of covering the uninsured and expanding choice, especially Policy H-165.848, which supports an individual mandate based on the availability of coverage tax credits.
2. Repeal the employer mandate. Businesses, as well as individuals, should be allowed to purchase health insurance with pretax dollars.	The AMA does not have policy on employer responsibility to provide health insurance, favoring individual selection and ownership of health insurance, but Policy H-165.920 supports the continuation of employment-based coverage as an option to the extent that the market demands it. Allowing individuals to continue to purchase health insurance with pretax dollars is INCONSISTENT with Policy H-165.920, which supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families.
3. Allow health insurance to be sold across state lines. Health-insurance should be portable and should follow the individual from job to job and state to state.	GENERALLY CONSISTENT with policy supporting the sale of insurance across state lines with certain important protections (Policies H-165.882, H-165.856, and H-165.839). The AMA has strong policy supporting patient and physician protections, especially state prompt pay laws, protections against health plan insolvency and fair market practices (e.g., Policies D-385.984, D-320.993, D-190.987, H-190.981, H-190.969, H-285.928 and H-285.981). Moreover, the ACA already allows the sale of insurance across state lines through interstate health care choice compacts, beginning in 2016.
4. Allow small businesses to self-insure or purchase insurance through small business health plans or association health plans. Currently, this option is available only to large businesses.	GENERALLY CONSISTENT with Policies D-165.971, H-165.862, H-165.882 and H-165.856 addressing the formation of association health plans and small employer and other voluntary choice cooperatives. However, Policy D-285.965 advocates for safeguards for self-insured plans to protect patients and physicians, and encourages states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power on SHOP exchanges.
5. Improve health-related savings accounts and consumer-driven health care plans by allowing higher deductibles and higher savings account contributions.	The AMA has extensive policy supporting HSAs and other consumer-driven health plans. The AMA supports the wide availability of HSAs (Policies D-165.963 and D-165.938) as well as improvements and their integration into health care reform as a component of freedom of choice in health insurance (H-165.833 and H-165.852).

<b>Resolution 204 Recommendation</b>	<b>AMA Policy and Council Analysis</b>
6. Allow and encourage states to develop alternatives to Medicaid by using federal funds granted by the Health and Human Services Secretary under provisions of the ACA.	CONSISTENT with AMA policy that supports the use of federal funds for states to use to develop alternatives to traditional Medicaid programs, including premium assistance that allows Medicaid beneficiaries to purchase private insurance. Policy H-290.982 supports allowing states to provide premium subsidies or a buy-in option for those with income between their state's Medicaid income eligibility level and a specified percentage of the FPL; this policy and H-165.855 also support providing some form of refundable, advanceable tax credits inversely related to income and providing vouchers for recipients to use to choose their own health plans. In addition, HHS approved the use of premium support with Medicaid funds to allow Arkansas and Iowa to expand their Medicaid programs, and other states are considering similar changes.
7. Restore funds cut from traditional Medicare.	CONSISTENT with Policy H-330.932, which opposes Medicare payment cuts and supports adequate funding for both Medicare and Medicaid. In addition, the AMA has extensive policy and advocacy efforts in support of repealing the Sustainable Growth Rate (SGR) formula.
8. Avoid reducing Medicare Advantage funding. This insurance is highly popular with seniors.	INCONSISTENT with Policy D-390.967, which supports the elimination of subsidies to the MA program.
9. Eliminate the unaccountable and unpopular Independent Payment Advisory Board.	CONSISTENT with Policies H-165.833 and D-165.938, which support repeal of the IPAB.
10. Eliminate involvement in the ACA by the Internal Revenue Service.	The IRS has key roles in determining eligibility for and managing and distributing the ACA tax credits, as well as collecting related taxes and penalties. Policy H-165.920 supports a system of individually owned health insurance, supported by refundable and advanceable tax credits, to provide coverage to the uninsured. Eliminating the involvement of the IRS in ACA implementation would be unworkable and would undermine the success of many provisions supported by AMA policy, including refundable and advanceable tax credits, and individual responsibility.
11. Maintain the guaranteed insurability, full coverage of preventative services and elimination of lifetime benefit caps under the ACA.	GENERALLY CONSISTENT with Policy H-165.856, which supports guaranteed issue in the context of an individual mandate, in addition to guaranteed renewability, as well as Policy H-165.838, which supports market reforms that eliminate denials for pre-existing conditions. CONSISTENT with Policy H-185.952, which supports the prohibition of lifetime limits on the value of benefits. CONSISTENT with several policies that support covering preventive services (e.g., H-165.840, H-185.954, H-425.992, D-330.935 and H-290.985).

<b>Resolution 204 Recommendation</b>	<b>AMA Policy and Council Analysis</b>
12. Continue the family insurance coverage of children living in a household until age 26.	CONSISTENT with Policy H-180.964, which encourages the health insurance industry, employers and health plans to make extended family coverage available to uninsured young adults to age 28.
13. Eliminate the taxes on medical devices and pharmaceuticals and health insurance companies since this added expense would only be passed on to our patients.	The AMA does not have policy specifically addressing the taxation of medical devices, pharmaceuticals and health insurance companies. If such taxes were eliminated, Congress would have to identify alternative funding sources. Policy H-290.982 suggests a range of various funding options for expanding coverage. Policy H-385.925 opposes the use of provider taxes or fees.
14. Repeal and replace the sustainable growth rate formula.	CONSISTENT with Policies D-165.938, H-165.838, H-390.852 and H-390.844. Repealing the SGR is a top AMA advocacy priority.
15. Enact meaningful medical liability reform.	CONSISTENT with policies that support medical liability reforms, and federal funding of state pilot programs on a range of alternatives (i.e., health courts, early disclosure and compensation programs, expert witness qualifications, safe harbor for the use of evidence based medicine guidelines) (e.g., Policies H-435.978, H-435.951, H-435.967, H-165.838 and D-435.974).
16. Expand the funding of medical schools and residency programs in order to increase the number of physician providers.	CONSISTENT with Policies H-310.915, H-305.929, D-305.967 and D-305.998. The AMA has launched a grassroots campaign, through the Save GME website ( <a href="http://www.savegme.org">www.savegme.org</a> ), which has generated over 25,000 lawmaker letters in support of protecting and expanding GME funding.
17. Cancel all current ACA waivers, exemptions, subsidies and discounts except for those based on patient income under provisions of the ACA. Prohibit any of these in the future unless they are based on income of the patient.	The ACA includes waivers and exemptions that are beneficial to physicians. For example, the ACA includes waivers of the fraud and abuse laws for physicians who participate in the Medicare ACO program. Canceling these waivers and exemptions would be contrary to significant, successful AMA advocacy to shape these waivers. Current subsidies to patients under the ACA, in the form of tax credits, are based on verified income, which is CONSISTENT with Policy H-165.865.
18. Prohibit any future insurance plans that are alternatives to the ACA for all federal employees, members of Congress, federal judges and the president, as well as their dependents.	INCONSISTENT with Policy H-165.920, which supports the continuation of employer-based coverage as an option to the extent that the market demands it. Members of Congress and their staffs are being required to forgo their current health insurance under the Federal Employees Health Benefits Program (FEHBP) and obtain their future insurance through the exchanges. Notably, AMA policy is very supportive of the FEHBP, using the program as a standard for adequate coverage, and supporting legislation to allow individuals to buy in the FEHBP.

<b>Resolution 204 Recommendation</b>	<b>AMA Policy and Council Analysis</b>
<p>19. Due to the complexity of improving the ACA, its implementation should be delayed at least one year.</p>	<p>The AMA does not have policy on whether the ACA should be delayed. However, many major provisions of the ACA were implemented prior to 2014, including those that improve the coverage of preventive services and continue the family insurance coverage of children living in a household until age 26. In addition, millions of Americans have already purchased coverage through the new health insurance exchanges. Therefore, a delay in implementation of the law at this point would not be feasible.</p>
<p>20. Finally, Congress should be asked to appoint a committee with a majority membership of health care providers and AMA leadership with a mandate to revise Medicare and to produce a plan that would allow its long-term viability and adequate health benefits for seniors and the disabled. The same committee would also work to identify the changes that would effectively improve the ACA and allow for its long-term vitality.</p>	<p>The AMA does not have policy on this specific recommendation, but has extensive policy supporting the long-term viability of Medicare, adequate health benefits for seniors and the disabled, as well as appropriate implementation and improvement of the ACA. Notably, if such a committee is appointed by Congress, there is the potential for the members of the committee to not support or advocate AMA policy. Also, there are already several committees in existence that work on issues raised in this recommendation. The Medicare Payment Advisory Commission (MedPAC) is an independent Congressional agency responsible for advising Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, as well as analyzing access to care, quality of care, and other issues affecting Medicare. Numerous federal advisory and technical expert panels advise the Centers for Medicare &amp; Medicaid Services (CMS) on Medicare issues – and welcome physician membership and participation – including the:</p> <ul style="list-style-type: none"> <li>• Medicare Evidence Development &amp; Coverage Advisory Committee</li> <li>• Advisory Panel on Hospital Outpatient Payment</li> <li>• Advisory Panel on Medicare Education</li> <li>• Emergency Medical Treatment and Labor Act Technical Advisory Group</li> <li>• Payment Error Rate Measurement (PERM) Technical Advisory Group</li> <li>• Medicare Economic Index Technical Advisory Panel</li> </ul>