At the 2013 Annual Meeting of the House of Delegates (HOD), the HOD adopted Policy D-165.938, “Redefining AMA’s Position on ACA and Healthcare Reform,” which called on our American Medical Association (AMA) to “develop a policy statement clearly outlining this organization’s policies” on a number of specific issues related to the Affordable Care Act (ACA) and health care reform. The adopted policy went on to call for our AMA to report back at each meeting of the HOD. BOT Report 6-I-13, “Redefining AMA’s Position on ACA and Healthcare Reform,” accomplished the original intent of the policy. This report serves as an update on the issues and related developments occurring since the most recent meeting of the HOD.

EFFORTS TO REPEAL THE ACA

Beginning prior to the introduction on March 7, 2017 of the component parts of what would become the American Health Care Act through the Senate’s failure to adopt the so-called “skinny bill” in the early morning hours of July 28, 2017, the AMA consistently engaged with policymakers in support of AMA policies related to the Affordable Care Act. While acknowledging that improvements were needed in the ACA, the AMA opposed repeal on the basis of several policy points adopted by the House of Delegates. Specifically:

• Ensure that individuals currently covered do not become uninsured and take steps toward coverage and access for all Americans;
• Maintain key insurance market reforms, such as pre-existing conditions, guaranteed issue and parental coverage for young adults;
• Stabilize and strengthen the individual insurance market;
• Ensure that low/moderate income patients are able to secure affordable and meaningful coverage;
• Ensure that Medicaid, The Children’s Health Insurance Program (CHIP) and other safety net programs are adequately funded;
• Reduce regulatory burdens that detract from patient care and increase costs;
• Provide greater cost transparency throughout the health care system;
• Incorporate common sense medical liability reforms; and
• Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

A number of factors played into the inability of Congress to advance repeal of the ACA, including the decision to act under the limitations imposed by the budget reconciliation process and efforts to go beyond ACA reform to include significantly restructuring the financing of the Medicaid program without hearings or stakeholder input. Ideological differences among Republican members of Congress and discomfort with projections of significant increases in the number of Americans without health insurance as a result of Congressional action further compromised the pathway to repeal.
Following the failure to repeal ACA as a whole or in part, Congress was expected to turn to efforts to stabilize the current system in the short term through continuing Cost-Sharing Reduction (CSR) payments to health plans and reinsurance. However, despite bipartisan efforts to reach agreement, no plan to strengthen the ACA marketplaces had been brought to the floor for a vote. On October 12, 2017, President Trump announced that we would end CSR payments, which had continued to be made during pending litigation on their legality. On the same day, the President signed an Executive Order directing relevant agencies to explore options for more people to buy health insurance that is exempt from many of the ACA’s requirements.

As a result of the Executive Order, the Administration has released two proposed rules. The first, released January 4, 2018, would allow more flexibility to groups and small businesses to join together in an association health plan (AHP). While the AMA supports efforts to maximize health plan choices for individuals and small businesses, the policy of the House of Delegates also calls on the AMA to work with federal legislators to ensure that AHP programs safeguard state and federal patient protection laws. In comments to the Department of Labor (DOL) on the proposal, the AMA urged DOL to withdraw the proposed rule and work with state insurance commissioners and health care stakeholders to seek a solution that would expand affordable insurance coverage options through AHPs without undermining state authority to regulate AHPs to protect patients and physicians against such things as fraud and insurer solvency. AMA expressed concern that “DOL’s proposal does not maintain key consumer protections and does not meet the AMA’s key principles on health system reform ... and would result in substandard health insurance coverage.”

The AMA also warned that without proper oversight to account for insolvency and fraud, AHPs have the potential to increase already high insurance premiums and overall health care costs, while threatening patients’ health and financial security and the financial stability of physician practices and made recommendations to address those concerns.

On February 20, 2018, the Administration released a second proposed rule in keeping with the Executive Order, this time to make it easier for individuals to buy health plans that do not comply with ACA coverage requirements. The proposal would extend the time that consumers may be covered by short-term, limited duration health plans that are not required to comply with coverage requirements from three months to 364 days. These plans may not provide coverage for pre-existing conditions and benefits such as maternity care and mental health care are often excluded. Critics have charged that the proposal would fracture the individual market, though administration officials have disagreed with that assessment. At this writing, the AMA is reviewing the proposal.

Throughout the autumn of 2017, Congress also turned its attention to tax reform. While many in Congress had considered the possibility of using tax reform to repeal portions of the ACA, such as the requirement to obtain coverage, to take advantage of the protections from filibuster afforded it by the Reconciliation process, others expressed serious reservations. Many thought that including efforts to undermine ACA would erode support for the tax legislation. On November 8, 2017, the Congressional Budget Office (CBO) released an estimate that repeal of the individual mandate would result in 13 million fewer individuals having health coverage and premiums increasing an average of 10 percent. However, CBO also predicted that repeal would produce $338 billion in budgetary savings over 10 years, savings which could be used to offset some of the deficits produced by the growing tax cut proposal. On November 16, 2017, the Tax Cuts and Jobs Act bill passed the House by a vote of 227-205. The Senate followed on December 2, 2017 on a vote of 51-49. On December 19, the reconciled version of the Tax Cuts and Jobs Act passed both chambers and was signed into law by President Trump December 22, 2017. The new law eliminates the penalty for failure to obtain coverage repealing the individual mandate beginning in 2019.
REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-
PERFORMANCE

Our AMA continues to work with Congress and the Administration on the implementation of and improvements to the Quality Payment Program (QPP) established by the Medicare Access and CHIP Reauthorization Act (MACRA). Considerable progress was made in this regard through multiple provisions of the Bipartisan Budget Act of 2018.

On February 9, 2018, the President signed the Bipartisan Budget Act of 2018. The budget bill accomplished a number of critical Congressional priorities, including enacting continuing appropriations through March 22 and setting spending caps for fiscal years 2018 and 2019, suspending the debt ceiling for approximately one year, providing badly needed disaster relief (including increased Medicaid spending for Puerto Rico and the U.S. Virgin Islands as called for by the AMA House of Delegates), extending CHIP reauthorization for an additional four years (through 2027) and addressing the so-called Medicare extenders, including repealing Medicare outpatient therapy caps.

As a result of the work of our AMA and numerous state and national specialty medical associations, a number of improvements to the QPP program were included in the final bill. These included additional flexibility on the establishment of performance thresholds and the application of cost measures, both of which will allow the Centers for Medicare & Medicaid Services to continue to work with the physician community on implementation issues rather than having to proceed immediately to more stringent requirements. Provisions of MACRA that applied the Merit-based Incentive Payment System (MIPS) payment adjustments to Part B drugs were also repealed and the authority of the Physician-focused Payment Model Technical Advisory Committee (PTAC) to provide technical assistance to physicians developing alternative payment models was clarified and broadened. Additionally, the requirement that the Advancing Care Information requirements for physicians under MIPS become more stringent each year was repealed.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which had been put into place by the ACA. Prior to its repeal, no appointments had ever been made to IPAB and the requirement for recommendations for Medicare cuts by the board was never triggered.

SUPPORT FOR MEDICAL SAVINGS ACCOUNTS, FLEXIBLE SPENDING ACCOUNTS, AND THE MEDICARE PATIENT EMPOWERMENT ACT

While the AMA continues to support efforts to expand access to health savings accounts and expand the use of flexible spending accounts, including support of the “Restoring Access to Medication Act,” no new developments have occurred since the last meeting of the HOD.

The Medicare Patient Empowerment Act has not been reintroduced in the 115th Congress. The AMA will continue to seek opportunities, however, to increase private contacting opportunities under the Medicare program without penalty to the patient or physician.

STEPS TO LOWER HEALTH CARE COSTS

Policymakers continue to explore legislative and regulatory options to reduce the cost of care, particularly as it relates to the costs of pharmaceuticals. While dozens of bills have been introduced and multiple Congressional hearings have been held, no action on these proposals has been
scheduled to date. Our AMA continues to engage physicians and the public
through www.TruthinRX.org, including collecting patient stories.

On February 28, 2018, a bipartisan group of U.S. Senators, including Sen. Bill Cassidy, MD, (R-
LA) wrote to the AMA and other health care stakeholders regarding their efforts “to increase health
care price and information transparency to empower patients, improve the quality of health care,
and lower health care costs.” The letter requests stakeholder views on currently available
information, what is not available, different methods to achieve price transparency, and other
“common-sense” policies to empower patients and lower health care costs. Our AMA will respond
to the inquiry and looks forward to engaging with these Senators and others on ways to lower
health care costs.

One way to lower costs that is not in dispute is to lower the tremendous amount of time, effort, and
resources that go into complying with overly burdensome, duplicative, and unnecessary
administrative and regulatory requirements that do not benefit patient care. Physicians and other
providers are spending more and more time on paperwork and less time directly on patient care,
driving up costs for everyone. Since last summer, the House Committee on Ways and Means has
been collecting information from health care providers as part of its Medicare Red Tape Relief
Project. In announcing the efforts, Ways and Means Chairman Kevin Brady (R-TX) stated “we will
be doing outreach to health care providers, doctors, nurses, hospitals, clinicians on what red tape
and regulation out of Washington is interfering with the doctor-patient relationship, driving up the
cost of health care, or simply getting in the way of the highest quality health care possible. And so
Chairman Tiberi is going to be the one leading that effort. It will include soliciting ideas on what
the Administration and executive branch can do, as well, and ultimately leading – we hope – to
some action legislatively, as well.” While Subcommittee Chairman Tiberi has left Congress, we are
pleased that the new Subcommittee Chairman, Peter Roskam (R-IL), has taken up this mantle, and
we will continue to work with him and the committee to identify regulatory changes that can
reduce the burden of providing care to Medicare beneficiaries as well as lower health care costs for
all.

REPEAL NON-PHYSICIAN PROVIDER NON-DISCRIMINATION PROVISIONS OF THE
ACA

Guidance released by the Department of Health and Human Services in 2014 included a positive
interpretation of health plan requirements under section 2706(a) of the ACA, specifically clarifying
that the section does not require “that a group health plan or health insurance issuer contract with
any provider willing to abide by the terms and conditions for participation.” Nevertheless, the
AMA will continue to seek legislative opportunities to repeal this provision.

CONCLUSION

While much of the federal activity since the 2017 Interim Meeting of the House of Delegates has
centered on tax cuts and budgetary issues, health care is never far from the center of the debate. As
we have over the last several months, our AMA will continue to seek opportunities to advance the
policies that are the subject of this report as well as others adopted by the HOD.