REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-I-17

Subject: Redefining AMA’s Position on ACA and Healthcare Reform

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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

Efforts to repeal and replace the ACA have consumed the vast majority of health system reform efforts of the 115th Congress and, to date, have been largely unsuccessful. The AMA engaged directly with members of Congress in an effort to shape the outcome of the discussion along the lines of specified principles set forth in AMA policy and approved by the HOD. These were that any legislation should:

• 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, 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 any pathway to repeal.
The “American Health Care Act” (AHCA) was reported by the House Budget committee on March 20, 2017 and considered by the House of Representatives on March 24. As considered by the House, the bill made numerous changes to the Medicaid program, most significantly eliminating federal funding for ACA Medicaid expansion populations and converting Medicaid financing into a per-capita allotment. The AHCA effectively eliminated the individual and employer mandates established by the ACA and replaced the current premium assistance tax credit for purchasing health coverage which was based on age, income and the affordability of coverage with an advanceable, refundable credit based primarily on age and phasing out for individuals with higher incomes. Actuarial requirements for plans were eliminated and the permissible variation of premiums by age was increased from 3:1 to 5:1. To compensate for the greater instability in the individual market caused by the elimination of penalties for failure to maintain coverage and other changes, the bill established a Patient and State Stability Fund and required insurers to charge a 30 percent premium surcharge to individuals who failed to maintain coverage for more than 62 days during the previous year. The Congressional Budget Office (CBO) estimated that the bill would result in 14 million fewer Americans with health insurance coverage in 2018, increasing to 26 million by 2026. It would also reduce federal Medicaid expenditures by more than $800 billion over the next decade. Lacking the necessary support, House leadership pulled the bill from consideration prior to a vote.

On May 4, 2017, the House considered a revised version of the AHCA, incorporating amendments by both conservative and moderate members of the House Republican Conference, including: allowing the establishment of Medicaid work requirements; allowing a state to receive Medicaid funding as a block grant; increased funding for maternity coverage, newborn care, and services for those with mental health or substance use disorders; establishment of a risk sharing program for insurers; increased stability funding; state waiver of essential health benefits; and allowing insurers to vary premiums by health status for individuals who had a break in coverage. The modified legislation, considered prior to the availability of a CBO score, was passed by a vote of 217-213. On May 24, the CBO estimated that the House-passed bill would result in 14 million fewer Americans with health insurance coverage in 2018 and 23 million fewer in 2026 while reducing federal Medicaid expenditures by more than $800 billion.

Lacking Senate support for the House-passed AHCA, Senate Republican leadership undertook the drafting of revised legislation. A discussion draft, the “Better Care Reconciliation Act” (BCRA) was released on June 26, 2017. The Medicaid per-capita cap was maintained, though with a more generous growth rate in the short term and a lower allowed growth rate in later years. Funding for Medicaid expansion was also eliminated, though over a longer period of time. Premium tax credits in the Senate bill more closely reflected those in the ACA and a single actuarial benchmark of 58 percent was established for plans. As opposed the AHCA’s 30 percent premium surcharge for those with a gap in coverage, the Senate bill established a six month waiting period before coverage could begin. CBO estimated that the proposal would result in 15 million fewer Americans with health coverage in 2018 and 22 million fewer by 2026. Federal Medicaid expenditures would be reduced by more than $770 billion over the decade.

Despite these efforts, Senate leadership was unable to attract the necessary 50 votes for the proposal from the 52 Republican Senators. While moderate members, especially those from states that had successfully expanded Medicaid, remained concerned with the impact on coverage, a modified draft released on July 13 moved the Senate product decidedly to the right. The proposed amendment would allow insurers to offer plans outside of the exchanges that were exempt from ACA requirements including essential health benefits and pre-existing condition protections, as long as they also offered other compliant plans on the exchanges. To compensate for the impact on the risk pool within the exchange, additional stability funding was included. The measure also
increased funding for opioid abuse treatment and allowed Health Savings Account funds to be used for premiums. Some conservative members continued to argue that the Senate proposal largely kept the structure of the ACA intact—contrary to campaign promises to completely repeal the law. On July 19, another proposal was released called the “Obamacare Repeal Reconciliation Act” (ORRA). The ORRA largely reflected the reconciliation bill passed by the previous Congress but vetoed by President Obama. ORRA would repeal all elements of the ACA allowed under reconciliation, essentially wrecking the individual markets by repealing penalties for failure to maintain coverage while maintaining requirements that insurers offer coverage to all individuals at community rated premiums with no preexisting condition exclusions. CBO estimate that 17 million fewer Americans would have coverage under the ORRA in 2018, increasing to 32 million by 2026. Furthermore, for those purchasing coverage on the exchange, premiums would be double those projected under current law by 2026 and three-quarters of all Americans would live in areas with no plans offered in the non-group market. Federal Medicaid expenditures would be reduced by more than $840 billion over the decade.

On July 25, 2017, the Senate voted 51-50 to proceed to consideration of H.R. 1628, the American Health Care Act. Republican Senators Susan Collins of Maine and Lisa Murkowski of Alaska voted no. Vice President Mike Pence cast the tie-breaking vote. Over the next two days the Senate considered a number of secondary amendments from both sides of the aisle. On July 25, the Senate considered and rejected the “Better Care Reconciliation Act” by a vote of 43-57, with 9 Republicans joining all Democrats in opposition. The following day, the Senate also rejected the “Obamacare Repeal Reconciliation Act” by a vote of 45-55.

Still lacking the necessary 50 votes to advance ACA repeal and facing a growing backlog in the Senate agenda, Senate Majority Leader McConnell offered one last alternative, the “Health Care Freedom Act” (HCFA) or so-called skinny repeal. The HCFA reflected common provisions of previous versions—elimination of individual and employer mandate penalties, eliminate funding for the Prevention and Public Health Fund, extension of the moratorium on the device tax though 2020, a temporary increase in HSA contribution limits, increased section 1332 state waivers, increased Community Health Center Funding, and prohibition of Medicaid payments to Planned Parenthood clinics. While most of these provisions enjoyed unanimous support among Republican senators (the Planned Parenthood provision being the exception), no Senator supported the HCFA as the final Senate position on ACA repeal. Rather, leadership promoted the idea that passage of the amendment would allow the Senate to advance ACA repeal to a conference with the House where yet another new version of the bill could be written. Several Republican senators expressed the concern that the House would instead take up the Senate-passed bill and send it directly to the President. While the House leadership tried to assure the Senate that they would go to conference, messaging from different quarters on the ultimate pathway was decidedly mixed. In the end, in the early morning hours of July 28, the Senate rejected the HCFA by a vote of 49-51, with Sen. John McCain (R-AZ) joining Sens. Collins, Murkowski and all Democrats in voting no. With no viable pathway forward, Sen. McConnell pulled the bill from consideration.

Throughout House and Senate consideration of the AHCA and the Senate substitutes, the AMA consistently advocated that Congress reject proposals that would lead to fewer Americans with access to quality, affordable health care coverage and that were inconsistent with the principles and policies adopted by the House of Delegates. The AMA also consistently acknowledged that there are shortcomings in the ACA and expressed our desire to engage with Congress and other stakeholders in efforts to address those issues. In response to a May 12, 2017 request from Senate Finance Committee Chairman Orrin Hatch (R-UT), the AMA offered a number of policy suggestions to enhance plan affordability, stabilize the individual market, and protect the safety net. The partisan nature of the debate and the limitations imposed by the budget reconciliation process,
however, made advancing those proposals highly unlikely as long as repeal of the ACA remained the primary objective.

At this writing, Congress is expected to turn to efforts to stabilize the current system in the short term, likely through continuing Cost Sharing Reduction payments to health plans and reinsurance. Efforts are also likely to incorporate additional flexibilities for states in administering components of the Affordable Care Act. Members on both sides of the aisle have acknowledged that successful legislative efforts will require regular order – committee hearings, consultation with stakeholders, and compromise on all sides. The AMA will remain engaged in these efforts consistent with the principles outlined above.

REPEAL AND APPROPRIATE REPLACEMENT OF THE SGR AND PAY-FOR-PERFORMANCE

Since the enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), much of the policy making activity related to pay-for-performance programs has been subsumed by implementation activities surrounding that statute. Since the enactment of MACRA, the AMA has worked diligently with the Centers for Medicare & Medicaid Services (CMS) to ensure that the law was implemented in a manner that encourages and enables successful participation of physician practices of all sizes and structures, including appropriate exemptions. Proposed rulemaking for 2018 offers further evidence of the success achieved by the AMA and organized medicine in this regard.

The 2018 proposed rule calls for important accommodations for small practices, including expanded low volume thresholds, creation of virtual groups, bonus points for small practices and a new hardship exemption from Advancing Care Information (ACI) (formerly meaningful use). New flexibilities have also been proposed for ACI, including the use of 2014 certified electronic health records technology for 2018. Quality performance will remain weighted at 60 percent and the cost category at zero.

The proposed rule also eliminates the cross cutting measure requirement, maintains the current data completeness threshold, and allows the reporting of improvement activities through attestation while maintaining the number of activities physicians must report.

On the legislative front, the AMA is engaged in efforts to ensure that CMS has the necessary flexibility to promote successful physician participation. This includes efforts to make sure measures of resource use are developed and tested prior to their required implementation and that ACI requirements do not become overly burdensome.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The IPAB was created as part of the Affordable Care Act to reduce the per capita rate of growth in Medicare spending. Recommendations from the IPAB to reduce spending in Medicare are required should the Chief Actuary of CMS Services determine that per-capita spending exceeds a specified target. Should that occur, the IPAB would be required to make recommendations to Congress to bring spending back into line with targets. In doing so, the IPAB is generally prohibited from recommending changes to cost sharing or premiums, rationing care, or changing benefits or eligibility. These limits leave few tools for controlling spending outside of changes to provider payments. The statute also prescribes a specific time table for Congressional action on these recommendations which leaves Congress the option of replacing IPAB-recommended policies with
alternative savings, though Congress would still be required to produce total savings necessary to
match the targets.

At this time, no members have been appointed to the IPAB nor are appointments expected. The
statute contemplates this possibility by calling for the Secretary of U.S. Department of Health and
Human Services (HHS) to make the recommendation directly to Congress in lieu of
recommendations made by an appointed IPAB. However, it is not clear at this time what steps
Secretary Price would take in response to the triggering of the IPAB requirement nor is the position
of the Administration on this issue clear.

Six separate pieces of legislation have been introduced in the 115th Congress to repeal or otherwise
discontinue the functions of the IPAB. Three of these bills, by Sen. John Cornyn (R-TX), Sen. Ron
Wyden (D-OR), and Rep. Phil Roe, MD (R-TN) and Rep. Raul Ruiz, MD (D-CA) are consistent
with legislation that has been introduced in each of the previous Congresses since the enactment of
the ACA. In both the 113th and 114th Congress, bipartisan IPAB repeal legislation was considered
and passed in the House of Representatives but not considered in the Senate. In each case, the bill
was paired with provisions offsetting the cost that were not bipartisan in nature, therefore
diminishing the opportunity for successful enactment.

The second set of proposals, introduced by the same sponsors as the IPAB repeal legislation,
fulfills the requirements of an IPAB discontinuation process that was enacted as part of the IPAB
itself. Section 3403 of the ACA establishes fast track procedures for discontinuing the IPAB
process through a joint resolution that meets specific requirements. Unfortunately, the procedural
advantages offered by these resolutions expired on August 15.

On July 13, 2017, the Medicare Trustees released their annual report. Included was the
determination by the Actuary that spending targets have not been exceeded and therefore IPAB
recommendations are not triggered this year, contrary to earlier predictions. While it is certainly
positive that no cuts are currently required, the lack of a direct threat of cuts has tempered the
urgency of repealing IPAB.

The longer Congress waits to repeal the IPAB, the more expensive it will become given the fact
that the Congressional Budget Office predicts accelerating Medicare spending in future years,
increasing the likelihood of required cuts that must then be offset as part of repeal legislation. This
is unfortunate in that the true urgency lies not in the immediate threat of cuts but in the growing
cost of IPAB repeal.

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

Our AMA continues to seek opportunities to expand the use of health savings accounts and remove
ACA imposed limitations on the allowed use of Flexible Spending Account funds.

Our AMA continues to work with the Health Choices Coalition in support of the “Restoring Access
to Medications Act” which has been reintroduced by Rep. Lynn Jenkins (R-KS), Rep. Ron Kind
(D-WI), Sen. Pat Roberts (R-KS) and Sen. Heidi Heitkamp (D-ND). This legislation would repeal
ACA-imposed limitations on the use of Flexible Spending Account funds to purchase over-the-
counter medications without a prescription.

Our AMA also continues to pursue opportunities to expand the availability of Health Savings
Accounts (HSA) consistent with AMA objectives for continuing health system reform. In
suggestions provided to Sen. Hatch on improving health care affordability, for example, the AMA suggested allowing individuals who are eligible for cost sharing reductions to forgo those reductions and instead enroll in a bronze plan with a prefunded HSA and allow those funds to roll over from year to year. We also proposed providing individuals not eligible for cost sharing reductions with a moderately funded HSA.

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

STEPS TO LOWER HEALTH CARE COSTS

Beyond AMA’s extensive efforts to prevent chronic disease currently underway through the Improving Health Outcomes initiative, there are multiple opportunities in the policy arena to bring down the cost of care, among them are focusing on the rising cost of prescription drugs and the opportunity to lower the cost of providing care through regulatory reforms.

Though Congress’ attention has been focused on the Affordable Care Act, the AMA continues to work to build support for addressing the high costs of prescription drugs. Drawing on policies adopted by the House of Delegates in 2015 and 2016, and the work of an AMA task force consisting of AMA councils, state medical associations and national medical specialty associations, the AMA continues to explore opportunities to increase transparency in the pharmaceutical sector. These efforts include a website, TruthinRx.org where patients can access information and share their stories as well as sign an online petition. We believe that Congress will turn its attention to pharmaceutical pricing in the near future and the AMA is ready to fully engage at that time.

Achieving lower cost care is also dependent on reducing the cost to the physician to provide care by eliminating administrative burdens that do not contribute to better care. Our AMA continues to engage both Congress and the new Administration on a variety of proposals to reduce regulatory burden in the areas of certification and documentation, Medicare Advantage, Part D prior authorization requirements, Appropriate Use Criteria, Meaningful Use and Electronic Health Records, Program Integrity, DEA requirements, and FDA regulation of laboratory developed tests and compounding, to name a few. Some success can already be seen in the MACRA proposals noted above as well as a recent request for information on regulatory reform ideas that was part of the 2018 Medicare Physician Fee Schedule proposed rule released in July. Additionally, the House Committee on Ways and Means has initiated an effort to collect suggestions for both statutory and regulatory changes to “deliver relief from unnecessary and burdensome mandates that impede innovation, drive up costs, and ultimately stand in the way of delivering better care for Medicare beneficiaries.” The AMA is participating fully in these and other efforts to reduce regulatory burdens.

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

To date, much of the effort surrounding health system reform in the 115th Congress has been focused on efforts to repeal the Affordable Care Act. While we are pleased that those proposals have been unsuccessful to date, we will remain engaged in efforts to address the shortcomings of the ACA by vigorously pursuing the adoption of AMA policies on health care coverage and health system reform. Additionally, we will continue to seek opportunities both in the legislative and regulatory arenas to advance policies promoting the successful implementation of MACRA, the reduction of regulatory burdens on physicians, the repeal of IPAB, lowering of health care costs and other policies adopted by the House of Delegates.