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

Following the failure of Congress to repeal the Affordable Care Act, the Administration has continued to take steps to undermine the law or provide coverage options outside of the ACA exchanges which could have the impact of weakening the individual market. Previously, the Administration had decided to discontinue payment of cost-sharing reduction benefits to support required premium support for low income individuals enrolled in the ACA exchanges. Other recent actions have included:

• On June 7, 2018, the Department of Justice filed a brief declining to defend the ACA in a case (Texas v. United States) brought by 20 state attorneys general. A week later, our AMA and four physician specialty associations filed an Amicus Brief urging the court to reject the effort to undermine the ACA. In announcing the filing, the AMA noted that “if the lawsuit were successful, federal policy could roll back to 2009, which would be remarkably disruptive to our nation’s health system and every single American.” It would void protections for those with pre-existing conditions, and provisions that allow children to remain on their parents’ plan until age 26. Insurers would no longer be held to the 85 percent medical loss ratio, meaning they could generate higher profits at the expense of coverage and payments for services, and 100 percent coverage for certain preventive services would cease. Furthermore, annual and lifetime dollar limits could be reinstated, leading to more bankruptcies due to health care costs.

• Following on an earlier Executive Order and proposed rulemaking, the Department of Labor on June 19 issued a final rule that would allow more small employers and individuals to form Association Health Plans (AHPs). The Congressional Budget Office has estimated that most individuals in AHPs will be healthier and have higher incomes than individuals in the ACA exchanges, potentially driving up premiums in the exchanges. In comments on the proposed rule, our AMA noted support for increasing health plan choices for individuals and small businesses seeking coverage in the individual and small group markets, but expressed concern that the plans outlined in the proposed rule fell short of maintaining crucial state and federal patient and provider protections and could result in substandard health coverage. Our AMA also expressed concern over the preemption of state insurance laws and the potential for insolvent and fraudulent AHPs. On July 26, attorneys general of 14 states challenged the rule...
in the U.S. District Court for the District of Columbia alleging that changing the definition of employer is inconsistent with the ACA and is a violation of the Administrative Procedures Act.

- The Centers for Medicare & Medicaid Services (CMS) announced on July 7, 2018, a delay of ACA risk adjustments for 2017. As noted in a July 16 letter opposing the decision, the risk adjustment program protects insurers from unanticipated costs in the event their enrollees are less healthy by transferring funds from plans with healthier enrollees. It is the only ACA premium stabilization program that is permanent. The letter was signed by our AMA and 27 other organizations representing physicians, hospitals, and patients. Members of both parties in Congress also expressed concern with the decision. Late on July 24, CMS announced that the program would be reinstated following changes to the methodology that had played a part in the decision to suspend the program.

- On July 10, CMS announced a significant cut to funding for consumer enrollment assistance and outreach through the navigator program. Funding for the 34 states with ACA federal market places was cut to $10 million, 80 percent less than just two years previous. Again, the patient and provider community came together to protest this action. On July 26, 190 organizations, including the AMA, wrote HHS Secretary Alex Azar and CMS administrator Seema Verma protesting the decision and urging the restoration of outreach funding.

- On August 1, the Administration gave the go ahead for short-term limited-duration plans of 364 days, with renewals allowed for up to 36 months. The plans would not be required to comply with ACA protections such as coverage for pre-existing conditions or provide for comprehensive benefits. In earlier comments urging withdrawal of the proposal, our AMA had expressed support for the goal of increasing health plan choices but warned that the proposal would undercut crucial state and federal patient protections, disrupt and destabilize the individual market and result in substandard, inadequate health insurance coverage.

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

On July 12, CMS released a proposed rule for calendar year 2019 addressing both the Medicare Physician Fee Schedule and the Quality Payment Program. In addition to the implementation of Medicare Access and CHIP Reauthorization Act (MACRA) modifications enacted as part of the Bipartisan Budget Act of 2018 (BBA18), discussed in a previous edition of this report, there are a number of additional positive elements in the 2019 Proposed Rule. These include:

- Reduced documentation burden for Evaluation & Management (E&M) office visit codes, though at this time, the degree of actual burden reduction is uncertain.
- New payments for physician services that are not part of a face-to-face visit (virtual check-ins with patients, remote consults with patients using videos/photographs, online consults with other physicians).
- Continuation of low volume threshold policy to exempt small practices from the Merit-based Incentive Payment System (MIPS).
- A reduction in problematic measures in the Promoting Interoperability provisions (formerly Meaningful Use and Advancing Care Information).

There are, however, areas of concern where the AMA will be recommending changes, including:

- E&M coding and related policies (add-on codes, multiple same day service reduction).
- AMA will urge reductions in quality measure requirements to reflect reductions in available quality measures.
- Simplifying the MIPS scoring framework to make it more clinically relevant and understandable for physicians.
• Keeping the cost category weight at 10 percent rather than increasing it to 15 percent.

The AMA is working closely with national, state and other physician groups to address widespread concerns with the proposed E&M coding changes. As part of our standard process to respond to major policy proposals our AMA is working with national specialty, state and other physician groups to develop recommendations that have broad support across the profession. A joint working group of CPT and RUC experts has been formed to develop recommendations for adjusting E&M coding policies. Given the complexity in this space, a coding change application may not be finalized until early November that may be voted on by the CPT Editorial Panel in early February. While the E&M coding issues have become a major focus, there are many important issues as part of the QPP or MACRA implementation that will have a significant impact on physician practices.

On July 24, 2018, AMA Immediate Past President David O. Barbe, MD, MHA, testified before the Health Subcommittee of the U.S. House of Representatives Committee on Energy and Commerce on the topic of “MACRA and MIPS: An Update on the Merit-based Incentive Payment System.” Dr. Barbe reminded the committee members that, despite challenges in implementing the MACRA reforms, they continue to be a significant improvement over the previous SGR update system and other legacy programs that were in place prior to MACRA. While the AMA has expressed support for recent improvements to MACRA, including those implemented as part of BBA18, we recognize the need for continued improvements to move further in the direction of choice, flexibility, simplicity and feasibility. These include further simplification and harmonization of the four separate components of MIPS. The AMA will continue to work with Congress and the Administration to refine the current system.

REPEAL AND REPLACE THE INDEPENDENT PAYMENT ADVISORY BOARD (IPAB)

The Bipartisan Budget Act of 2018 also repealed the IPAB which was to have been established under provisions of 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

On July 11, 2018, the House Committee on Ways and Means reported 10 separate pieces of legislation to promote the use of consumer directed health care plans, including health savings accounts. After review, our AMA expressed support for eight of the proposals which were consistent with policies adopted by the House of Delegates.

On July 25, the full U.S. House of Representatives considered two bills which had been modified to substantially include the subject matter of nine of the bills previously considered by the Committee on Ways and Means.

H.R. 6199, the “Restoring Access to Medication and Modernizing Health Savings Accounts Act of 2018,” passed the House by a vote of 277-142. The underlying bill accomplished a long-supported AMA policy of restoring the ability of consumers to use HSAs, MSAs and HRAs to purchase over the counter drugs and expanded that policy to include feminine hygiene products as qualified expenses. Additionally, the bill adopted by the House allows those accounts to be used for the purchase of gym memberships and equipment, within certain limits; allows high-deductible plans to cover as much as $250 of non-preventive care before the deductible is met; and allows individuals to keep eligibility for an HSA while maintaining a direct primary care service arrangement and, within limits, use HSA funds for those arrangements. The adopted bill also
excludes some items and services from being considered as other coverage if provided at an
employer-owned or retail clinic; allows transfer of funds from an FSA or HRA to an HSA under
certain circumstances; and allows individuals to maintain eligibility for an HSA if their spouse had
coverage under an FSA as long as the FSA is limited to expenses incurred by the spouse.

H.R. 6311, Increasing Access to Lower Premium Plans and Expanding Health Savings Accounts
Act of 2018, passed the House by a vote of 242-176. The bill would delay for another two years the
Health Insurance Tax imposed by the ACA. It would also allow anyone to purchase a catastrophic
plan, as opposed to the current limitation to those under age 30 or with specific hardship
conditions. The bill increases allowed HSA contributions to match the maximum in allowed out-of-
pocket costs and would allow bronze and catastrophic plans offered through ACA exchanges to be
used with an HSA. H.R. 6311 also allows beneficiaries enrolled only in Medicare Part A to
contribute to an HSA and allows FSA balances to be carried over to subsequent years, though any
contribution limits for the next year would be lowered by the amount over $500 that was carried
over.

At this writing, the potential for Senate consideration is not clear.

STEPS TO LOWER HEALTH CARE COSTS

Our AMA continues to engage with Congress and the Administration on a wide range of efforts
designed to lower health care costs. Ongoing efforts to address the cost of prescription drugs
remain among the highest profile of these efforts. On July 16, the AMA filed comments on the
Administration’s “Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs.” In the
comments, AMA noted that “patients are increasingly taking greater clinical risks when treatments
are cost prohibitive.” AMA comments, which are available on the AMA website, addressed a wide
range of cost drivers, including issues related to competition, transparency, the Part B drug benefit
program, value-based pricing, and the 340B discount program.

During June and July, the Senate Committee on Health, Education, Labor and Pensions held a
series of hearings on reducing health care costs focusing on rural health cost drivers, administrative
costs, the role of quality and value in reducing excess spending. The AMA remains engaged in
conversation with the committee as well as in other Congressional efforts to address the impact of
administrative and regulatory costs and improve transparency of health care costs.

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

Our AMA will remain engaged in efforts to improve the health care system through policies
outlined in D-165.938 and other directives of the House of Delegates.