REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-I-19

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.

MACRA IMPROVEMENT

The AMA has continued work with the Centers for Medicare & Medicaid Services (CMS) to make improvements to the Merit-based Incentive Payment System (MIPS) program. While initial data on 2018 results show that 98 percent of eligible clinicians successfully participated in the program, the program's requirements have proven both costly and burdensome for physicians and will likely be increasingly so in coming years. For the past year, the AMA has worked extensively with the physician community and CMS to develop reforms that would move the program from multiple silos of reporting requirements to a more relevant and less burdensome construct centered around episodes of care, conditions, or other public health priorities.

We are pleased that the 2020 proposed rule introduces MIPS Value Pathways (MVPs) to begin in 2021. The proposed framework would incorporate a foundation that leverages promoting interoperability measures and a set of administration claims-based quality measures to focus on population health priorities, limiting the number of required specialty or condition specific measures physicians are required to report. While this proposal is an important step forward in making the MIPS program more clinically relevant and less burdensome, there are concerns such as the inclusion of population health administrative claims measures which the AMA fought to eliminate from the initial MIPS program. The AMA will work closely with state and national medical specialty societies to analyze the full impact of these and other related proposals in the 2020 proposed rule and make detailed recommendations to CMS to ensure successful implementation of proposed reforms.

While CMS can make considerable improvements to MACRA through regulations, other improvements will require statutory changes by Congress. As outlined in previous editions of this report, the AMA and state and national medical specialty societies have developed a series of recommended reforms that would build on the current efforts of CMS by providing additional flexibility for participating clinicians in MIPS, better alignment of reporting requirements, and facilitating the adoption of Alternative Payment Models (APMs). While many of these proposals could likely be implemented in a budget neutral manner, there are several which will trigger potentially significant scores.

The most significant (and costly) proposal would be to eliminate the zero percent update included in the original MACRA statute for calendar years 2020-2025. Under the law, updates through the year 2019 were to have been 0.5 percent annually, followed by zero percent for the years 2020-2025. Beginning in 2026, physicians participating in MIPS would see updates of 0.25 percent and those participating in APMs would realize updates of 0.75 percent. Updates for the years 2016-2019, however, did not materialize due to subsequent legislation that significantly reduced expected updates to offset the cost of other priorities. The history of minimal updates (and cuts) for the period following the initial SGR-produced cut in 2002 until MACRA passage in 2015 followed by lower than expected updates in the five years following MACRA adoption, has resulted in Medicare physician payment rates that have increased only 6 percent since 2001. Over the same period, the cost of running a medical practice has increased 32 percent as measured by the Medicare economic index. The AMA believes that it is critical that Medicare payment policies provide an adequate margin so that practices may make the necessary investments required to successfully implement MIPS and APMs. Discussions are underway with Congressional staff to address these shortfalls.

STEPS TO LOWER HEALTH CARE COSTS

For much of this year, Congress has been heavily focused on lowering health care for consumers by reducing the cost of prescription drugs, addressing unanticipated (or "surprise") medical bills, and other proposals to increase transparency and improve public health.

In the U.S. House of Representatives, the committees on Energy and Commerce, Ways and Means, and Judiciary have all reported legislation aimed at increasing transparency and spurring competition in the prescription drug markets, consistent with AMA priorities. In all, more than 100 proposals have been introduced that, among other goals, would increase access to data to evaluate the practices of entities within the prescription drug supply and financing chain as well as eliminate incentives and deter practices that impede market entry of generics.

Significantly, prior to the August recess, the Senate Finance Committee reported bipartisan legislation, the "Prescription Drug Pricing Reduction Act of 2019." This bill includes many AMA supported initiatives such as requiring manufacturers to pay rebates to HHS if a drug price increases faster than the rate of inflation, increased transparency of PBM and manufacturer rebate and discount arrangements, promotion of biosimilar products, and site-of-service payment neutrality for Part B drug administration. There are provisions in the bill, however, that require close scrutiny to determine their impact on physician practices, such as capping ASP add on payments for Part B drugs at $1,000 and excluding the amount of patient coupons from the calculation of ASP. While the Finance Committee proposal received bipartisan support, there are significant issues that must be addressed prior to consideration by the full Senate, including opposition by multiple members to the provision linking permissible price increases to inflation.

It is also expected that following the August recess House Democratic leadership will put forward legislation to empower the government to negotiate with manufactures for lower prescription drug prices. The bill will focus on drugs on the market without competition and give drugmakers the opportunity to recoup their investments but not maintain long standing monopolies, according to the Speaker's office.

The Administration has also put forth several proposals to address the cost of prescription drugs. Most recently, on July 31, HHS announced the "Safe Importation Action Plan" which will be the subject of an upcoming proposed regulation from the department. The plan would offer two potential pathways predicated on the invocation of Section 804 of the Federal Food, Drug and

Cosmetics Act by the Commissioner of the Food and Drug Administration. Under this provision, the Commissioner may allow for the importation from Canada of drugs if he or she certifies that doing so would not jeopardize the public health and would result in significant cost reductions. Under the proposal, there would be two possible pathways. Under the first, states, wholesalers and pharmacies could submit proposed demonstration projects for HHS review. Under a second pathway, manufacturers themselves could import of FDA approved medications. HHS noted that manufacturers have told them that they would like to offer lower cost versions of their own drugs but are prevented from doing so because they are locked into contracts with other parties in the supply chain. This option would allow them to import of their own drugs produced for the Canadian market for that purpose. Certain drugs, such as controlled substances, drugs subject to REMS, and biologics, including insulin, would not be eligible for this program.

In February 2019, the Administration proposed to eliminate safe harbor protections for rebates paid by manufacturers to PBMs, Part D plan sponsors, and Medicaid MCOs. That plan was withdrawn in July as it became clear that plan sponsors, faced with a loss of rebate revenue, would likely raise premiums for Medicare beneficiaries.

The issue of unanticipated, or "surprise," medical bills continues to be the focus of intense activity in Congress as it has since last year. All parties agree that patients who are cared for by physicians outside of their insurer's network, either due to the emergent nature of their condition or in cases of hospital-based physicians not generally selected by the patient, should not be penalized due to the fact that their plan did not have a contract with that physician. In these cases, the AMA agrees that patients should only be held liable for the same amounts they would have paid had they been seen by an in-network physician. Most of the leading legislative proposals are consistent with this goal. Significant differences exist, however, in how these proposals determine the appropriate amount that the plan should pay the physician for their services.

The "Lower Health Care Cost Act," S. 1895, was reported by the Senate Committee on Health, Education, Labor, and Pensions on June 26, 2019. While this bill contains numerous other provisions to lower health care costs, the primary source of the bill's savings is Title I, "Ending Surprise Medical Bills." Under the proposal, out-of-network (OON) physicians would be paid at the median in-network rate for physicians contracted by the plan in the same geographic region and would be banned from balance billing patients. The Congressional Budget Office has noted that since physicians who decline to accept contract terms offered by plans would be paid at the median in-network rate regardless of their contract status, average rates could fall by 15-20 percent as the average rates coverage around the median–though the absolute number of physicians who will see increases (those now below the median) and those who will see decreases (those above the median) will be roughly the same. It is noteworthy that 80 percent of the savings is derived from lower in-network rates. Going forward, CBO expresses a good deal of uncertainty on the long-term impact of these changes, with one possibility being increased provider consolidation results in upward pressure on price growth.

The AMA and impacted specialties continue to strongly advocate in the alternative that Congress adopt an independent dispute resolution (IDR) process, like the successful program in New York, to resolve physician-payer disputes while continuing to hold the patient harmless. Support for this approach has been voiced by several members of the HELP committee, including Sen. Bill Cassidy, MD (R-LA), Sen. Maggie Hassan (D-NH), and Sen. Lisa Murkowski (R-AK). During the committee consideration of the bill, Chairman Lamar Alexander (R-TN) and Ranking Member Patty Murray (D-WA) committed to consideration of an IDR process, though no resolution has been reached as of this writing.

Of the other health care cost provisions in S. 1896, many are well intentioned though potentially burdensome or impractical for physicians. One would require that all bills would have to be sent to a patient with 45 days or patients would not have to pay. Another would increase physician responsibility for the accuracy of plan's provider directories. The AMA continues to discuss these and other provisions with the committee.

On July 17, the House Committee on Energy and Commerce reported H.R. 2328, the "Reauthorizing and Extending America's Community Health Act" or the "REACH Act." Title IV of the bill is the text of the "No Surprises Act" offered by Committee Chairman Frank Pallone (D-NJ) and Ranking member Greg Walden (R-OR). The bill follows the general outline of the HELP bill, holding patients harmless from unanticipated bills and paying the OON physician at the in-network median rate. During the committee's consideration of the bill, an amendment by Rep. Raul Ruiz, MD, (D-CA) and Rep. Larry Bucshon, MD, (R-IN) was adopted to include a limited independent dispute resolution process for claims above a $1,250 threshold. While the provision is not ideal, it represents an important step forward in the efforts of organized medicine to include a fair and independent process to resolve disputes with payers.

Two additional committees of the House, Ways and Means and Education and Labor, are expected to consider proposals addressing unanticipated medical bills following the August recess. The AMA, state medical associations, and many national medical specialty societies are continuing efforts to ensure the any legislation adopted to address "surprise" bills provides for a fair resolution of payment disputes while holding patients harmless.

COVERAGE

Several House committees have reported legislation to strengthen the Affordable Care Act by increasing funding for Navigator programs, expanding the availability of ACA subsidies, providing support for the establishment of state-based marketplaces, increasing outreach and enrollment activities and other actions to preserve and strengthen current coverage options. Despite these actions, it is unlikely that similar legislation will emerge from the Senate in the current environment. Much of the current attention has been focused on single payer plans put forth in both the House and the Senate. The AMA continues to oppose this approach and remains focused on strengthening what works and expanding access to and choice of affordable, quality health insurance. Despite pressure from many members of the Democratic caucus, House leadership remains reluctant to take up single payer proposals. Polling has shown that while the concept of single payer, or "Medicare for All" proposals is popular, support falls off sharply when the implications of doing away with current coverage pathways is more closely examined. The AMA continues to support health insurance coverage for all Americans that is focused on pluralism, freedom of choice, freedom of practice and universal access for patients and will direct our advocacy efforts toward these goals.

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

Though the previous Administration determined that no action was necessary to implement the non-physician provider non-discrimination provision of the Affordable Care Act, proponents continue to encourage efforts by the Administration to propose regulations. During the July 17 mark-up of legislation in the House Committee on Energy and Commerce, an amendment was offered and later withdrawn to require the Administration to initiate rulemaking. Though legislation to repeal this provision has not been introduced during the past two Congresses, AMA will continue to seek opportunities to implement HOD policy related to this provision.

CONCLUSION

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