Advocating for improvements to the Affordable Care Act

The Affordable Care Act* (ACA) is a comprehensive health system reform law that will increase health insurance coverage substantially for the uninsured and implement long overdue reforms to the health insurance market. The new law includes many major provisions that are consistent with AMA policy and hold the potential for a stronger, better performing health care system. While the new law represents a tremendous step forward on the path toward meaningful health system reform, it is not the last step, but rather the beginning.

A number of key provisions in the law have already been implemented, but many others will not become effective until a number of years in the future, allowing the AMA and state and specialty medical societies to have maximum input into the regulatory process and to seek further legislative changes. The following is a summary of some of the major provisions in the ACA that are generally consistent with AMA policy, and provisions we believe need to be refined or eliminated.

Major provisions the AMA generally supports

- Increasing health insurance coverage to 32 million more Americans
- Making health insurance more affordable for families and small businesses through the creation of state health insurance exchanges and the provision of sliding-scale premium tax credits and cost-sharing subsidies
- Health insurance market reforms to address abuses of the health insurance industry
- Preventing denials of care and coverage, including those for pre-existing conditions
- Stronger patient protections
- Administrative simplification, to eliminate billions of dollars of unnecessary costs and administrative burdens
- Medicare bonus payments for primary care physicians and general surgeons
- Increasing Medicaid payments for primary care physicians
- Increasing geographic adjustments for Medicare physician payments
- Expanding and improving coverage of preventive services in the public and private sectors
- Funding state demonstration grants to study alternative medical liability reforms
- Providing more flexibility in the Graduate Medical Education program
- Requiring individuals to have minimum health insurance coverage or pay a penalty
- Improving Medicare prescription drug benefits by reducing the coverage gap (i.e., “doughnut hole”)
- Comparative effectiveness research

Changes to the ACA already accomplished

Prior to and following enactment, the AMA successfully advocated for several favorable changes to the ACA, including:

- Repealing (on April 19, 2011) the expanded Form 1099 information reporting requirement, which would have required most businesses, including physician offices, to file a Form 1099-MISC with the IRS for certain transactions valuing $600 or more.
- Eliminating a budget neutrality adjustment for primary care and rural surgery bonuses
- Eliminating a tax on elective cosmetic surgery and medical procedures
- Eliminating a Medicare/Medicaid enrollment fee for physicians
- Eliminating a five percent Medicare payment cut for “outlier” physicians
- Postponing penalties related to quality reporting data

* H.R. 3590, the “Patient Protection and Affordable Care Act” (P.L. 111-148), as amended by H.R. 4872, the “Health Care and Education Affordability Reconciliation Act” (P.L. 111-152), collectively referred to as the Affordable Care Act (ACA).

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Additional changes the AMA supports

Medical liability reform
The AMA will continue to actively pursue medical liability reforms at the federal and state levels that are already working in states such as California and Texas. The AMA is also actively supporting the passage of H.R. 5, the "Help Efficient, Accessible, Low-cost Timely Health Care (HEALTH) Act," a federal bill with a number of liability reform provisions including a $250,000 cap on non-economic damages along with strong state rights protections so that states can maintain or enact their own effective reforms. On October 3, 2011, the AMA urged the Joint Select Committee on Deficit Reduction to include liability reforms in the deficit reduction legislation given that a package of reforms including caps on non-economic damages have been estimated by the Congressional Budget Office to reduce the federal budget deficit by $62.4 billion over 10 years. A total of 98 state and specialty medical societies joined the AMA asking the Committee members to include meaningful liability reforms in their final legislative package.

Independent Payment Advisory Board
Because of serious concerns with the current authority and framework for the Independent Payment Advisory Board (IPAB), the AMA opposes the IPAB and will continue to actively advocate for it its repeal prior to implementation of the first IPAB recommendations in 2015. The AMA supports current legislation to repeal the IPAB, including legislation introduced by Representative Roe (R-TN) and Senator Cornyn (R-TX), H.R. 452 and S. 668, respectively.

Workforce/graduate medical education
In accordance with the ACA's unfilled graduate medical education (GME) slot redistribution program, CMS redistributed 726 Medicare direct GME slots and 628 indirect medical education (IME) slots. The AMA supports GME initiatives necessary to ensure an adequate physician workforce, including preserving Medicare GME funding and lifting the cap on Medicare supported GME training positions to address physician shortages. On October 3, 2011, the AMA joined the Association of American Medical Colleges (AAMC) and 38 other physician, hospital, and educational associations urging the Joint Select Committee on Deficit Reduction to protect Medicare GME funding. The AMA also actively supported H.R. 1852, the "Children's Hospital GME Support Reauthorization Act of 2011," a federal bill that would reauthorize federal funding to support GME for freestanding children's hospitals. In addition, the AMA supports S. 1627, the "Resident Physician Shortage Reduction Act of 2011," a federal bill that would expand the number of Medicare-supported GME training positions by 15 percent (approximately 15,000 additional positions) over five years.

Cost/quality index scheduled for implementation in 2015
The ACA requires the development and application of a cost/quality index modifier, the implementation of which is premature due to the need for certain policy tools that currently do not exist. The AMA will work to modify this initiative in subsequent legislation.

Penalties for failure to report quality data
The AMA was able to postpone implementation of PQRS penalties in the ACA for two years (from 2013 to 2015), and will continue to advocate opposition to penalties.

Fraud and abuse
The ACA includes increased funding and authorities to combat fraud and abuse. The AMA is advocating for decreased administrative costs and burdens on honest physicians.

Antidiscrimination provisions for health plans
The ACA includes a provision stating that health plans may not discriminate against any health care provider—acting within its state scope-of-practice laws—that wants to participate in the plan. The AMA will seek clarification that this provision does not allow expansion of the scope of practice for nonphysician allied health practitioners.

Restrictions on hospital ownership
The ACA includes provisions that restrict physician ownership of hospitals. The AMA actively and successfully blocked previous attempts to restrict ownership going back to 2003. The AMA opposes this provision and has supported legislation to repeal it.

Health savings accounts in health exchanges
The ACA is silent on whether health savings accounts (HSA) will be deemed acceptable coverage under the individual insurance mandate. The AMA continues to advocate to the Administration that implementing regulations, including those governing health exchanges and minimum acceptable coverage, ensure that high deductible plans coupled with health savings accounts (HSAs) can be offered as acceptable options in the exchanges.

HSAs/FSAs to Pay for Over-the-Counter Drugs
The ACA includes a provision that requires individuals with tax-preferred accounts, such as health savings accounts (HSAs) or flexible spending accounts (FSAs), to obtain a prescription before using such accounts to pay for over-the-counter medications and certain supplies. The AMA is supporting pending legislation in Congress to repeal this provision.

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Administrative simplification
The ACA includes administrative simplification requirements intended to eliminate billions of dollars of unnecessary costs and administrative burdens from our health care system. Throughout 2011, the AMA has been providing critical input on electronic transaction standards and uniform operating rules in order to promote certainty, transparency, and make it possible for physicians to fully automate the administrative side of their practices so they can experience significant financial savings and free up time to focus on patient care. The AMA testified twice before the National Committee on Vital and Health Statistics (NCVHS), an advisory body to the U.S. Department of Health and Human Services (HHS), on administrative simplification solutions, including the need for standardized acknowledgment transactions and transparency on claims edits and payment rules. In addition, the AMA provided comments on operating rules for eligibility for a health plan and health care claim status electronic transactions.

Outstanding issues to be addressed

Physician payment formula/sustainable growth rate
The ACA did not include a provision to fix the flawed Medicare physician payment formula (SGR). In separate legislation, Congress extended current Medicare physician payments through the end of 2011. The AMA is aggressively working with Congress in 2011 toward permanently repealing and replacing the SGR.

Private contracting
The ACA did not include a provision to ease private contracting restrictions in Medicare. The AMA has highlighted private contracting in multiple communications and forums, and is engaged in the development of a campaign to push for the enactment of the "Medicare Patient Empowerment Act," H.R. 1700 and S. 1042, introduced in May 2011 by Representative Price (R-GA) and Senator Murkowski (R-AK), respectively. The AMA developed this proposal, working closely with the delegations that sponsored AMA private contracting policy (Resolution 204, A-10), and has conducted polling on physician perceptions of the issues surrounding the legislation, focus group testing for messaging purposes, meetings with specialties to build support, and grassroots advocacy campaigns.

Antitrust
The AMA believes that antitrust reforms should be an essential element of health system reform, and will continue to work with the Federal Trade Commission and the Department of Justice to achieve reforms that provide relief from legal and regulatory impediments to physician collaboration. In addition, the AMA is actively supporting H.R. 1409, the "Quality Health Care Coalition Act of 2011," which was introduced by Representative Conyers (D-MI). H.R. 1409 would allow physicians to jointly negotiate with health plans regarding terms that affect patient care.

New payment and delivery models
The AMA aggressively advocates for new payment and delivery models, such as accountable care organizations (ACOs), bundling, and medical homes, that enable physician-led models of care by a wide range of physician practices. The AMA is working closely with government agencies to address key issues, such as financing mechanisms, governance, use of quality measures, beneficiary attribution, risk adjustment, distribution of shared savings, and anti-kickback and antitrust barriers.

Visit **www.ama-assn.org/go/federaladvocacy** for additional AMA resources regarding ACA implementation.

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