Washington Update from the American Medical Association

Health care was on voters' minds during the 2018 elections. According to a Kaiser Family Foundation election tracking poll taken last fall, 71 percent of respondents said that health care would be "very important" in making their decision about who to vote for in Congress. The second most often mentioned issue was the economy and jobs, at 64 percent. When asked to choose the "most important" issue in making their voting decision, health care came in first at 30 percent.

Interest in health care was shared by voters irrespective of party affiliation, although their chief concerns differed. Among Democratic voters, increased access to care was the most important health care issue (31 percent), followed by health care costs (22 percent). Cost was the top-of-mind concern for Independent (27 percent) and Republican (23 percent) voters.

Members of Congress got the message. As a result, we anticipate there will be efforts to enact new health care policies in the 116th Congress, despite the highly charged partisan atmosphere in Washington and the distractions of preparations for the 2020 Presidential election campaigns. Three key health care issues that are under active discussion include: (1) Medicare expansion; (2) surprise billing; and (3) prescription drug prices.

Medicare Expansion

During the 2018 campaign season and since, there has been much conversation about the potential benefits of "Medicare for All," or perhaps a partial expansion of Medicare for those wanting to purchase individual insurance coverage. Some members of Congress and patient advocates believe the country should implement a single-payer system (Medicare for all), some advocate for expanding access to Medicare coverage for those over age 50 or 55, others believe a presumably less costly public option should be made available independently or on the health insurance exchanges. At this point, it appears that a partial Medicare expansion will gain more traction than a true single-payer proposal. However, it is important to keep in mind that the Senate and President Trump are expected to oppose all these proposals, so any real opportunity for Medicare expansion is unlikely until after the 2020 elections.

AMA policy currently does not support Medicare for All or a Medicare "buy in" option for all or a segment of the uninsured population. We support building on the foundation of our current system to reach universal coverage through a pluralistic approach involving a competitive private market, employer sponsored coverage, a publicly financed safety net, and consumer protections such as the current prohibition against pre-existing condition coverage exclusions. Following are some of the AMA's concerns about expanding Medicare to cover the uninsured.

- **Medicare benefits are not as rich as employer-sponsored or ACA plans.** Medicare does not include annual or lifetime caps on out-of-pocket costs, nor does traditional Medicare cover dental or vision care. Prescription drug coverage can be purchased separately, but the current Part D plans have the infamous benefit "donut hole." Some Medicare Advantage plans provide a broader range of benefits, but at added cost for both consumers and the government.

- **Medicare expansion will not eliminate the need for private insurance.** Beneficiaries who are happiest with their Medicare coverage have supplemental Medigap policies. Expanding Medicare means that more people will be required to carry, and pay for, at least two insurance policies to enjoy the scope of benefits typically provided by private plans.

- **Medicare payment rates are inadequate.** Medicare physician payment rates are well below those of private plans, so expansion would result in lower revenues and further reduce the operating margins needed to support practice innovation and investment in delivery reforms that promise to improve both value and population health.

- **Medicare is not on sound financial footing.** The Medicare Trust Fund is expected to be depleted in 2026, and Congress has not yet devised a plan to address this threat to the health care security of our nation's seniors.

- **Public opinion polls on the subject are misleading.** While polls have demonstrated there is public interest in the concept, potential public support decreases significantly when more detailed questions are asked that highlight the potential impacts of Medicare expansion. When asked, the public is very concerned about the prospects of higher taxes, the potential loss of employer sponsored coverage, inflexible benefit design, and undermining the fiscal stability of the traditional Medicare program.

- **The federal government is an inconsistent partner.** Medicare expansion would place a significant and growing portion of the U.S. economy and the personal health and well-being of many or all Americans in the hands of a federal government that is not a reliable partner. The 2018 partial government shutdown over a political issue that was not essential to funding the rest of the fiscal year is one recent example, during which the Indian Health Service was essentially non-operational.

In the AMA's view, abandoning the ACA, which was the product of two years of stakeholder negotiations, and other elements of the current system to secure coverage for the remaining 12.2 percent of Americans who are uninsured would threaten the stability of coverage for the vast majority of people who are generally satisfied with their coverage, while doing little to satisfy their concerns about cost. A far more rational and achievable approach is to fix what is broken in the current system, rather than expanding Medicare.

Surprise Billing

Another issue of significant bipartisan interest to lawmakers this year is unanticipated medical bills, often referred to as "surprise bills." These mostly occur when a patient seeks treatment, frequently thorough the Emergency Department, from a hospital that is part of their insurer's network. Only later does the patient learn that the physicians who provided care were not in their network. Patients are frequently unaware physicians providing care in a hospital may or may not participate in the same networks as the facility, either because they were not offered a fair contract by the plan or they were offered no contract at all. These situations often involve Emergency Medicine or on-call physicians who work to stabilize the patient, but also can involve physicians who have little direct interaction with the patient or whom the patient has limited ability to choose, such as anesthesiology, pathology, radiology and even neonatology and hospitalists. These issues can arise even during scheduled care where a patient may have carefully selected an in-network surgeon, for example, but was not able to choose other physicians who might be involved in their care. Surprise bills also occur with ambulance services, many of which are not in networks, or with hospitals when a patient is transported to an out-of-network facility in an emergency.

One contributing factor to surprise billing is the prevalence of insurance plans with narrow networks. This cost saving strategy can increase the likelihood that no in-network provider will be available to care for patients. Most plans also provide lower coverage amounts, or no coverage at all, for out-of-network care, meaning physicians are forced to collect payment directly from patients with whom they may have had little direct interaction.

The AMA and more than 100 other physician organizations have written to Congress expressing our concerns with these situations and offering suggestions on how they can be addressed. Importantly, these are primarily disputes between health plans and non-contracted providers and as such, patients should be kept out of the middle. Patient responsibility should be limited only to their expected costs had they seen an in-network provider and benefits should be assigned directly to the provider so that patients are not used as pawns in these disputes.

Patients who choose in advance to receive scheduled care from an out-of-network provider should be informed about anticipated charges and the limitations on what their plan will pay. In general, providers oppose federally set caps on payments for caring for out-of-network patients. Guidelines or limits on what payments should be for out-or-network care should be based on actual charge data from an unbiased source. Rates must not be tied to Medicare or otherwise set so low that plans have no incentive to build networks that meet the health care needs of those from whom they collect premiums. Solutions could also include an arbitration process similar to what has been adopted in several states. And critically, plans must be required to build adequate networks and adhere to the prudent layperson standard for emergency care.

At least five Congressional committees are examining possible solutions as well as a bipartisan group of senators led by Sen. Bill Cassidy, M.D. (R-LA). Think tanks and others are weighing in with possible solutions as well – including a proposal to bundle all services that a patient may receive related to emergency care and leave it to the hospital to divide the payment among providers. That is widely seen as unworkable by both physicians and hospitals.

The AMA remains deeply engaged on the issue – meeting regularly with the involved Congressional committees and representatives of the most impacted specialties. The insurance industry has rallied the support of employers with threats that any resolution favoring providers will result in increased premiums. Therefore, It is critical that providers remain united in the face of efforts to deny physicians reasonable rates for care provided to out-of-network patients.

Drug Pricing

Drug pricing and access are central topics of interest to Congress and the Trump Administration. The varied contributing causes fueling the rise in prescription drug prices and the many barriers faced by patients who need medically necessary medication complicates efforts to find effective solutions, precipitating a wide range of proposed policies, regulations, and legislation.

The AMA has a comprehensive set of policies concerning prescription medication affordability and access, and has urged policymakers at the federal and state levels to address pharmaceutical supply chain transparency, in addition to accelerated and expanded legislative and regulatory actions to increase market competition by, among other things, combating anti-competitive practices.

Since 2018, the Administration has outlined a number of approaches, primarily through reforms to the Medicare and Medicaid programs under the prescription drug benefits and physician administered drug regulations, as well as several Food and Drug Administration (FDA) initiatives and proposals to accelerate the introduction of generics and biosimilars to market.

The Administration's American Patients First: The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint) Request for Information (RFI) contained many proposals that have subsequently been advanced by the Administration. The most successful initiatives have been under the auspices of the FDA's departing Commissioner, Scott Gottlieb, who focused on decreasing the backlog on generic applications and changing policies within his authority to stop anti-competitive actions of brand manufacturers. However, there are many anti-competitive practices where the FDA, the Federal Trade Commission and the U.S. Department of Justice require expanded or clarified authorities, so Congressional action is needed.

So far in this Congress, over 40 different bills have been introduced to: address anticompetitive practices of brand manufacturers; increase transparency in pricing and costs between manufacturers, insurers, and pharmacy benefit managers; importation; and reforms to the Medicare prescription drug benefit and Medicaid rebate program. Significant bipartisan interest early in the 116th Congress has centered on reforms to stop anti-competitive practices to slow down or block generic entry into the market, including changes to FDA conferred market exclusivity and patent reform.

The AMA will press to advance policies and legislation to ensure increased transparency along the supply chain and a number of bills that will provide federal agencies with the tools to stop actions by brand manufacturers that abuse innovation incentives to maintain barriers to market competition.