Health system reform

Following up on election campaign promises, Congress quickly considered legislation in March that would have significantly modified the health system reforms established by the Affordable Care Act (ACA). The replacement plan, known as the American Health Care Act (AHCA), was included in a budget reconciliation bill, which enjoys certain Congressional procedural advantages. Although the legislation was passed by three committees and cleared for a floor vote, it was pulled by the Speaker because it did not have sufficient votes for passage. The situation remains very fluid. Congress may attempt to pass a new bill or a series of bills, and the Administration has signaled that significant regulatory changes will be proposed.

When the 115th Congress convened on Jan. 3, 2017, the AMA sent a letter outlining the following key objectives for health system reform:

- 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.
- Continue the advancement of delivery reforms and new physician-led payment models to achieve better outcomes, higher quality and lower spending trends.

After the AMA reviewed the budget and enrollment estimates released by the Congressional Budget Office on March 12, it appeared that the AHCA fell short of many AMA objectives, particularly with respect to maintaining or increasing the number of individuals with health insurance, ensuring that low and moderate income Americans can afford meaningful coverage, and maintaining safety net programs such as Medicaid. Consequently, the AMA opposed the bill.

The AMA is partnering with Federation groups and patient advocacy organizations to develop recommendations for improving current law and for assessing any subsequent legislative and regulatory proposals as deliberations in Washington continue.

Quality Payment Program (also known as MACRA)

The Medicare Access and CHIP Reauthorization Act (MACRA) was more than a replacement for the Sustainable Growth Rate. MACRA goals included aligning and reforming a number of existing Medicare programs such as: Meaningful Use, Physician Quality Reporting System and the Value-based modifier. Working with state and specialty societies, the American Medical Association (AMA) secured significant changes in the final MACRA (now Quality Payment
Program (QPP)) regulation governing implementation for 2017. For instance, due to the AMA’s advocacy, the Centers for Medicare and Medicaid Services (CMS) instituted the Pick Your Pace program for 2017. Under Pick Your Pace only physicians who do not report any data to Medicare will receive a penalty. That said, the AMA recognizes much more needs to be done to simplify QPP.

To help physicians prepare for the QPP, the AMA has hosted webinars and regional meetings, produced podcasts with ReachMD, and created the AMA Payment Model Evaluator to help practices make decisions about the best pathway for them. Much of this material can be found on www.ama-assn.org/MACRA. Yet, despite these efforts the AMA understands that many physicians are not aware of the QPP and its requirements. Consequently, the AMA is pursuing another transitional year for the program in 2018. In each area of the QPP (quality, advancing care information, cost, and improvement activities), the AMA is actively engaged in discussions with CMS about reducing the burden on physicians and has a series of recommendations that the AMA is urging CMS to adopt. These include: reducing the number of reporting requirements, allowing physicians flexibility in performing activities and avoiding complex reporting requirements.

The AMA wants the QPP to allow physicians to focus on improving care for patients rather than having to comply with “check-the-box” exercises. The AMA is also engaging specialty societies, CMS and the Physician Technical Advisory Committee to help ensure physicians have the tools and models they need to participate in a physician-led alternative payment model.

**Health insurer mergers**

The AMA, with the help of 17 state medical association antitrust coalition partners from across the country, achieved two huge victories when federal judges blocked these massive insurance company mergers: the $37 billion Aetna-Humana merger and $54 billion Anthem-Cigna merger. Blocking the Anthem-Cigna merger alone saved an estimated $21,000 a year per physician (at minimum), in addition to protecting the integrity of the practice of medicine as well as patient access and choice.

Efforts to block the two mergers included:

- Utilizing the AMA’s updated gold standard *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*
- Preparing detailed state-specific market analysis of both the Anthem-Cigna and Aetna-Humana mergers
- Sending comprehensive, evidence-based advocacy letters to the U.S. Department of Justice (DOJ) and state regulators after the merger was announced in July 2015
- Leading a 17-state medical society coalition and engaging likeminded stakeholders, including the American Hospital Association and various patient coalitions
- Engaging the National Association of Attorneys General in an effort to convince key state AGs to join the DOJ in opposing the mergers
- Conducting extensive physician surveys to gauge impact on patient care (in conjunction with the AMA’s state medical association partners)
- Marshaling nationally-recognized economists and legal experts in support of our arguments

On March 17, 2017, the AMA urged the U.S. Court of Appeals in Washington D.C. in an amicus brief to uphold the trial court’s decision to block the Anthem-CIGNA merger. Also, at the AMA’s suggestion, the nation’s experts on antitrust and competition submitted their own amicus brief that supported our contentions in the appeals court.

The unified voice of medicine had an undeniable impact on both decisions. The AMA will continue to oppose anticompetitive health insurer mergers that threaten to undermine the medical profession and physicians’ abilities to care for patients.

**Prior authorization**

Whether through resolutions considered by the AMA House of Delegates, interaction with the Federation of Medicine, or conversations with individual physicians, the AMA increasingly has heard complaints about health plans’ prior authorization (PA) and other utilization management (UM) programs. Physicians object to the interference with patient access to timely care and clinical decision-making, as well as to the resources consumed by burdensome administrative tasks. In recognition of the growing concerns on this issue, the AMA has launched a multi-pronged advocacy effort to reform health plans’ PA programs.

Because credible, quantitative data establishing the impact of PA on patients and physicians is essential to successful advocacy on this topic, research comprises the first element in the AMA’s campaign. In December 2016, the AMA surveyed 1,000 practicing physicians (600 specialists and 400 primary care physicians) on the burdens associated with PA for medical services and prescriptions. Among the most notable survey findings was that, on average, a medical practice completes an average of 37 PAs per physician per week, which takes a physician and his/her staff an average of 16 hours, or the equivalent of two business days, to process. Given this PA workload, it is not surprising that 75 percent of surveyed physicians described PA burdens as high or extremely high. In addition to taxing practices, PA requirements can also impact patients: nearly 90 percent of surveyed physicians reported that PA sometimes, often or always delays access to care.

To tackle the PA-related concerns confirmed by the survey results, the AMA convened a workgroup of state medical associations (including North Carolina Medical Society), national medical specialty societies, national provider associations and patient representatives to create a set of best practices related to PA and other UM requirements. The workgroup identified the most common patient and provider issues surrounding UM programs and recently issued the Prior Authorization and Utilization Management Reform Principles to address these challenges.

These 21 common-sense principles were designed to improve the application of UM programs and cover five broad categories:
- Clinical validity
- Continuity of care
• Transparency and fairness
• Timely access and administrative efficiency
• Alternatives and exemptions

The principles form the foundation of a widespread, multi-faceted 2017 advocacy campaign seeking to reform PA practices and improve the quality and efficiency of health care. As part of this campaign, the AMA and other workgroup members are directly advocating with health plans, benefit managers, accreditation organizations, legislators, and standards organizations to support the principles and incorporate these concepts into UM and accreditation programs. The AMA also welcomes other interested provider and patient organizations to sign on as supporters of the principles by contacting Heather McComas (heather.mccomas@ama-assn.org), Director of AMA Administrative Simplification Initiatives. The list of supporting organizations will be posted with the principles on the AMA website.

State legislation also has proven to be an effective and successful tool for achieving meaningful PA and UM reforms. As the result of close collaboration between the AMA and state medical associations, PA bills continue to be enacted in the states. For example, AMA staff worked closely with the Medical Society of Delaware to enact one of the strongest PA laws in the country. The legislation will not only reduce delays in care by establishing timelines for payer decisions, require that an automated electronic PA system be available to prescribers, and limit retrospective denials, but it will also lead to greater transparency in PA programs by requiring payers to submit PA data to the state’s public database. Several other states, including Florida, Maryland, and Virginia, have been able to recently enact stronger regulation of PA programs, and many others, including West Virginia, have PA legislation pending.

The AMA looks forward to ongoing collaboration with all of organized medicine to reduce PA burdens for patients and physicians. To learn more about the AMA’s efforts to reform PA programs, and to access other PA-related resources, including the Prior Authorization Toolkit, visit the AMA website.

State activity

The AMA’s Advocacy Resource Center (ARC) works to help shape and inform state laws, regulations and policies in support of patients and physicians. ARC staff work directly with state medical associations to enact laws and enhance the practice of medicine – and to defeat those laws that would create barriers to high-quality care. From 2015 to the present, the AMA has worked through the ARC with SE Delegation states to either enact or defeat over 50 pieces of state legislation and regulation.

Top priority issues that exemplify this powerful collaboration include: opioids (AL, FL, GA, MD, MS, NJ, WV); biosimilars (DE, KY); pain clinic regulation (FL); naloxone access (GA, LA); physician health programs (WV); scope of practice partnership (GA, MD, NC); advance practice nursing independence (FL, KY, LA, MS, NJ, NC, SC, TN, VA); lay midwifery licensure (KY, WV); optometry and surgical authority (MD, TN); licensure of naturopaths (NJ, NC, WV); podiatry expansion (MS, SC); chiropractic (LA, VA); telemedicine (DE, VA, WV); interstate
medical licensure compact (AL, MS, WV); medical liability reform (AL, KY, MD, MS, VA); network adequacy (MD); balance billing (GA, FL), fair contracting (TN); and prior authorization (FL).