REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-13

Subject: Monitoring the Affordable Care Act

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At the 2012 Interim Meeting, the House of Delegates adopted Resolution 210 as amended, which established Policy D-165.940. The policy was amended by Resolution 237-A-13 to read as follows:

> Our AMA will assess the progress of implementation of the Patient Protection and Affordable Care Act based on AMA policy, as well as the estimated budgetary, coverage and physician-practice impacts of the law, and report back to the House at the 2013 Interim Meeting.

The Board of Trustees assigned the implementation of Policy D-165.940 to the Council on Medical Service for a report back to the House at the 2013 Interim Meeting.

This report, which is provided for the information of the House of Delegates, provides background on how the Patient Protection and Affordable Care Act (ACA) relates to AMA policy, and outlines the expected coverage, budgetary and physician-practice impacts of the law. The appendix to this report includes a chart that assesses the implementation of ACA provisions based on AMA policy.

BACKGROUND

The enactment of the ACA achieved five of seven essential elements for health system reform that are outlined in AMA Policy H-165.838:

1. Health insurance coverage is significantly expanded.
2. Pre-existing condition limitations are removed and other health insurance market reforms are implemented.
3. The patient-physician relationship is protected.
4. Investments and incentives are provided for quality improvement, prevention and wellness.
5. Insurance claims processing is streamlined and standardized to eliminate unnecessary costs and administrative burdens.

Two of the elements of Policy H-165.838 were not achieved in the ACA – the repeal of the Medicare physician payment formula, as well as the implementation of medical liability reform. Consistent with AMA advocacy efforts seeking to modify portions of the ACA, the House of Delegates also adopted Policy D-165.938, which states that:

1. Our AMA will develop a policy statement clearly stating this organization's policies on the following aspects of the Affordable Care Act (ACA) and healthcare reform:

    A. Opposition to all Pay-for-Performance or Value-Based Purchasing that fail to comply with the AMA's Principles and Guidelines;
    B. Repeal and appropriate replacement of the Sustainable Growth Rate (SGR);

C. Repeal and replace the Independent Payment Advisory Board (IPAB); with a payment mechanism that complies with AMA principles and guidelines;
D. Support for Medical Savings Accounts, Flexible Spending Accounts, and the Medicare Patient Empowerment Act ("private contracting");
E. Support steps that will likely produce reduced health care costs, lower health insurance premiums, provide for a sustainable expansion of healthcare coverage, and protect Medicare for future generations;
F. Repeal the non-physician provider non-discrimination provisions of the ACA.

2. Our AMA will immediately direct sufficient funds toward a multi-pronged campaign to accomplish these goals.

3. There will be a report back at each meeting of the AMA HOD.

The report directed by Policy D-165.938[3] is accomplished at this meeting with Board of Trustees Report 6. In addition to the issues outlined in Policy D-165.938, the AMA continues to press for antitrust and medical liability reform. Consistent with policy, the AMA is also pursuing further changes to the ACA, including:

- Significant revision or elimination of the cost-quality index payment modifier (also known as the value-based payment modifier, addressed in Council on Medical Service Report 3-I-13), which is scheduled for implementation in 2015;
- Restoration of full physician-hospital ownership rights; and
- Elimination of prescription requirements for over-the-counter medication purchased with certain tax-preferred health spending accounts.

The appendix to this report includes a chart that outlines key provisions of the ACA, reports on the status of each provision's implementation and compares each provision to AMA policy. In addition, the Council notes that the Kaiser Family Foundation created a timeline, available online at http://kff.org/interactive/implementation-timeline/, which shows when the various provisions of the ACA will be implemented.

EXPECTED IMPACTS OF THE AFFORDABLE CARE ACT

Impacts on Coverage

In May 2013, the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) estimated that the combined coverage provisions in the ACA will expand coverage by 25 million by 2023. In 2023, 24 million individuals will receive coverage through health insurance exchanges. An estimated 13 million individuals will be added to Medicaid and the Children's Health Insurance Program (CHIP) coverage. Finally, CBO and JCT project that 7 million fewer individuals will have employer-sponsored insurance and 5 million fewer individuals will have non-group and other coverage.[1] Ultimately, 89 percent of all residents of the United States will be insured; 31 million individuals (11%) will remain uninsured in 2023.[2] The Council recognizes that the success of the coverage provisions of the ACA, particularly with respect to coverage provided through health insurance exchanges, is directly related to the ability of exchanges to enroll young and healthy individuals to ensure the risk pool is balanced between high-cost and low-cost individuals. The latest coverage projections by CBO and JCT take into consideration the Supreme Court decision on the ACA. In June 2012, the Supreme Court upheld the ACA's individual mandate as a

reasonable exercise of congressional authority to tax and spend. The Court also ruled that Congress exceeded its authority by threatening to withhold existing Medicaid funds from states that fail to expand Medicaid to cover all non-elderly Americans with incomes up to 133 percent of the federal poverty level (FPL), thereby making the ACA's Medicaid expansion optional for states. As of the drafting of this report, 25 states and the District of Columbia are planning to expand Medicaid, whereas 22 states are not. Three states are still considering whether to expand.[3] Resulting from the ruling, there will be fewer individuals enrolled in Medicaid, and more individuals enrolled in health insurance exchanges. There will also be more individuals who are uninsured.

Following the Supreme Court ruling, states that expand their Medicaid programs can enroll eligible individuals with household incomes up to 133 percent FPL in Medicaid. Eligible individuals with incomes between 133 percent and 400 percent FPL can receive premium credits and cost-sharing subsidies to assist with the purchase of coverage through health insurance exchanges. States that expand their Medicaid programs will receive 100 percent federal funding for newly eligible beneficiaries from 2014 through 2016, phasing down to 90 percent federal funding for 2020 and subsequent years.

Therefore, states that choose not to expand their Medicaid programs forego the substantial federal contribution supporting the Medicaid expansion effort. Also, in states that choose not to implement the Medicaid expansion, individuals with incomes below 100 percent FPL ($11,490 for an individual and $23,550 for a family of four in 2013) who are ineligible for state Medicaid coverage will remain uninsured. Eligible individuals with household incomes between 100 and 400 percent FPL can receive premium credits and cost-sharing subsidies to purchase coverage through health insurance exchanges, because the ACA states that individuals with household incomes between 100 percent and 400 percent FPL are eligible for premium and cost-sharing subsidies if they are ineligible for Medicaid coverage and do not have access to affordable employer-sponsored coverage. The population with incomes below 100 percent FPL is ineligible for premium and cost-sharing subsidies to purchase coverage through health insurance exchanges, and therefore will likely lack access to affordable health insurance coverage options. Therefore, while Medicaid expansion states will offer a continuum of coverage for individuals with household incomes up to 400 percent FPL through either Medicaid or exchange plan coverage, there will be a coverage gap for the individuals with the lowest incomes in states that choose not to expand their Medicaid programs. For example, using 2013 state Medicaid income eligibility levels,[4] in Alabama, Louisiana, Mississippi and Texas, parents of one child, with a household income at 40% of FPL ($7,812 in 2013), will remain ineligible for Medicaid coverage as will all non-disabled childless adults with incomes under the poverty line.

Budgetary Impacts

According to the CBO and JCT, the ACA is expected to reduce deficits by approximately $100 billion over the next decade.[5] In making their estimates of the budgetary impacts of the ACA, the CBO and JCT noted the uncertainty of their projections because of difficulties inherent in modeling various economic, behavioral and technical factors.[6] The Office of the Actuary at the Centers for Medicare & Medicaid Services (CMS) projected that the ACA will add $621 billion to cumulative health spending over the 2012-2022 period.[7] The Government Accountability Office has found that the long-term budgetary impact of the ACA depends on the sustainability of the law's provisions regarding cost containment.[8]

The most recent cost estimate of the CBO and JCT, in July 2013, only addressed the net budgetary impact of the health insurance coverage provisions of the ACA, not the total budgetary impact of

the law. The most recent estimate of the total budgetary impact of the ACA was released by the CBO and JCT in July 2012. The CBO and JCT projected that the coverage provisions of the ACA will have a net cost of $1.375 billion over the period from fiscal year (FY) 2014 to FY2023. Of that amount, Medicaid and CHIP outlays account for $710 billion; exchange subsidies and related spending account for $1.077 billion; and small employer tax credits account for $14 billion. These costs are offset by $45 billion in revenues from penalty payments associated with the individual mandate, $80 billion associated with the excise tax on high-premium insurance plans, $172 billion associated with other effects on tax revenues and outlays, and $130 billion in revenues resulting from the collection of penalty payments associated with the employer mandate.[9]

From FY2013 to FY2022, the health-related provisions of the ACA that are estimated to reduce net federal outlays total approximately $711 billion, achieved by reducing annual updates to non-physician fee-for-service (FFS) payment rates, basing Medicare Advantage rates on FFS rates and reducing Medicare and Medicaid Disproportionate Share Hospital (DSH) payments. In addition, there will be an approximate $569 billion increase in federal revenues due to provisions that increase the Hospital Insurance payroll tax and extend it to net investment income for high-income taxpayers, and impose fees or excise taxes on certain manufacturers and insurers.[5]

Impacts on Physician Practices

The ACA has the potential to impact physicians and their practices in a multitude of ways, based on factors that include practice size and specialty; physician employment status; geography; and the payer mix of patients. However, the complete impact of the law on physician practices remains uncertain, as many provisions of the law have not yet been implemented, are temporary in nature, will not have immediate effects, rely on discretionary funding, or may have more of an indirect impact. Recognizing the uncertainty and the lack of data on the impact of the ACA on physicians and their practices, the Council assessed the provisions of the law to determine possible effects the ACA will have on physicians and their practices, highlighting impacts on payment and delivery, impacts on practice efficiency, impacts on patient access, and impacts on physicians as employers.

<u>Impacts on Payment and Delivery</u>

The ACA will impact how health care is delivered, as well as how and at what level many physicians are paid. The law contains incentives to coordinate care across episodes of care, or groups of episodes of care, in addition to coordinating care around defined conditions. In addition, there are incentives for the delivery of care to focus on populations or groups of individuals, rather than being centered on the provision and management of care to individual patients.

The ACA offers new opportunities for physicians to participate in new delivery models, often as a complement to the law's provisions to expand health insurance coverage and improve access to care. Notably, the ACA authorized $10 billion over 10 years to develop and implement both delivery system and payment reforms through the Center for Medicare & Medicaid Innovation (CMMI), which is housed within CMS. Additional provisions of the ACA that relate to delivery reform include implementing Accountable Care Organizations (ACOs), developing primary care practices into medical homes, and testing models for improving care transitions from the hospital to other settings. These delivery reforms have the potential to increase integration, collaboration and coordination in the health care system, and are expected to impact how physicians organize their practices and the rate at which physicians become employed. However, the Council recognizes that physicians in solo and small group practices, and those in rural areas, may have more limited options to participate in new and innovative payment and delivery models.

Significantly, the ACA provisions impacting physician payment include the coverage provisions that yield a net decrease in the number of uninsured by 25 million by 2023, which means less uncompensated care provided by physicians. The impact of this decrease will vary from state to state, based on state decisions to expand their Medicaid programs. In addition, physicians participating in ACOs, medical homes and other delivery reform innovations have the potential to receive bonus payments. The law provides a 10 percent Medicare bonus payment over five years to primary care physicians, as well as general surgeons practicing in shortage areas. The law also contains a provision to increase Medicaid payments for evaluation and management services and immunizations provided by primary care physicians (family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare payment rates for 2013 and 2014.

There also is the potential for physician payment levels to be negatively affected under certain scenarios. For example, if the IPAB is not repealed, policy changes affecting the Medicare physician payment schedule will likely be used to meet the Medicare spending target if it is exceeded in any given year, starting in 2015. There is a potential of additional undercompensated care resulting from Medicaid expansions depending on state payment policies, for those physicians who accept Medicaid. Physicians also have concerns whether the payment rates of exchange plans will be sufficient. To assist state medical societies in advocating for transparency and fair contracting with insurers, the Advocacy Resource Center (ARC) of the AMA is seeking contract samples and other information being sent to physicians, so that it can analyze exchange contracts that physicians are being asked to sign, or exchange products in which they are being asked to participate. Physicians are encouraged to send de-identified contracts to the ARC. Details about the effort can be found at http://www.ama-assn.org/resources/doc/arc/hix-transparency-summary.

Two major provisions of the ACA are expected to increase the payments of some physicians, while cutting the payments of others. The Physician Quality Reporting System (PQRS) will initially provide bonus payments to participating physicians, but physicians who do not participate will face a 1.5 percent reduction in Medicare payments starting in 2015. In addition, the cost/quality index payment modifier, also known as the value-based payment modifier, will adjust physician payments beginning in 2015 based on performance on quality and resource use measures. As it is budget neutral in nature, the modifier will increase the payments to some physicians, and decrease the payments to others.

Impacts on Practice Efficiency

In an era in which electronic health record (EHR) systems are continuing to be adopted by physician practices, due to incentives and penalties in the American Recovery and Reinvestment Act, physicians are concerned with how provisions in the ACA will impact practice efficiency. The Council is hopeful that the establishment of the Patient-Centered Outcomes Research Institute, as well as an increased investment of comparative effectiveness research, will provide physicians with evidence-based clinical research results at the point of care to inform decision-making.

In addition, the ACA includes provisions to streamline and standardize insurance claims processing. By requiring operating rules for electronic funds transfers and health care payment and remittance advice, the ACA has the potential to reduce the paperwork and administrative costs faced by physician practices. The adoption of other provisions, such as the unique health plan identifier system, is also expected to lead to increased standardization and administrative simplification. On the other hand, the ACA also contains provisions governing patient referrals and quality reporting, as well as provisions intended to reduce the incidence of fraud and abuse, which may increase the administrative workload of physician practices.

Impacts on Patient Access

The ACA is expected to affect the demand for physician services by extending health insurance coverage to 25 million additional individuals by 2023, potentially exacerbating the physician workforce shortages, despite the provisions in the ACA aimed at strengthening the physician workforce. Realizing the impact of graduate medical education (GME) funding on the physician shortage, the AMA has launched SaveGME.org, a concerted effort to urge Congress to protect federal funding for GME. Some have argued that nurse practitioners should be granted authority to practice independently from physicians to address primary care physician shortages. Instead, to foster integration and coordination in health care delivery of primary care needs, the Council supports the increased use of physician-led teams of multidisciplinary health care professionals.

With the coverage expansion, many physician practices will have to manage an influx of newly insured patients. In some cases, the influx of newly insured may impact the length of wait times of new and existing patients to see a physician, and may lead some physicians to stop accepting new patients altogether. The newly insured may also affect the payer mix of physician practices. Existing patients may transition between employer-sponsored coverage, exchange coverage and Medicaid coverage, which affects physician payment and may impact the patient-physician relationship, as physicians may not have contracts with all involved health plans and payers.

Newly insured individuals will have the incentive to access physicians earlier instead of waiting until illnesses progress to the point where treatment is more expensive. In addition, certain benefits required by the ACA, including preventive services, further incentivize patients to seek care early, because they will face no cost-sharing for these services. However, a patient's access to care can be impacted by the cost-sharing levels of the health plan in which they enroll. Health insurance exchanges will offer plans with different deductibles and patient coinsurance responsibilities, but all plans will include caps on out-of-pocket costs. The Council notes that individuals at lower incomes are eligible for cost-sharing subsidies to lower their out-of-pocket costs.

Impacts on Physicians as Employers

The ACA will impact physicians as employers. Since 2010, small businesses with fewer than 25 employees and average annual wages of less than $50,000 have been eligible for tax credits if they subsidize at least half of the cost of health insurance for their employees. Starting in 2014, physicians who are employers will have access to Small Business Health Options Program (SHOP) exchanges, where coverage can be purchased with other small businesses, which may result in lower premiums for themselves and their employees. Starting in 2015, businesses with 50 or more employees will face penalties if they do not offer employees affordable health insurance coverage.

CONCLUSION

The Council's analysis finds that the ACA embodies much of the AMA proposal for expanding health insurance coverage and choice, and is consistent with several other aspects of AMA policy. However, significant provisions of the law need to be addressed to promote and protect the interests of physicians and patients. There also are key policy gaps that the ACA did not address, but are nonetheless critical to improving the health care system, including medical liability and antitrust reform, as well as replacing the SGR. As previously noted, Board of Trustees Report 6-I-13 highlights ongoing AMA advocacy efforts to strengthen the ACA, and take meaningful steps toward creating a stronger, better-performing health care system. Going forward, the Council will continue to monitor the implementation of the ACA.

REFERENCES

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Appendix: Crosswalk of ACA Provisions and AMA Policy

Issue	ACA Provision	AMA Policy
Access to primary care physicians, emergency physicians and OB/GYNs	Requires that plan enrollees be allowed to select a primary care provider (or pediatrician for a child) from any available participating primary care provider; no prior authorization or increased cost-sharing for emergency services, whether provided by in-network or out-of-network providers; direct access to obstetrical or gynecological care. Year effective: 2010	Consistent with Policy H-373.998, which advocates freedom of choice of physician and/or delivery system. Also consistent with Policy H-130.970 regarding prohibition of prior authorization requirements for emergency services. Consistent with Policy H-385.959 recognizing that internists, pediatricians, family physicians and OB/GYNs can provide both primary care and consultative care.
Accountable Care Organizations (ACOs)	Calls for HHS to establish ACO Medicare shared savings programs for various providers, including groups of physicians, to share in savings. Each ACO will have to be formed for at least 3 years and shall have at least 5,000 beneficiaries assigned to it. Year effective: 2012	Potentially consistent with H-160.915, which outlines ACO principles. Policy D-385.963 states that the AMA will work with CMS and other payers to participate in discussions and identify viable options for ACOs, and develop a toolkit that provides physicians best practices for starting and operating an ACO. Policy D-225.977 supports physician collaboration, teamwork, partnership, and leadership in emerging health care organizational structures, including ACOs. However, may conflict with Policy H-390.849, which advocates that such efforts must ensure appropriate physician control over distribution of shared savings or bonus funds.
Antidiscrimination provisions for health plans	Prohibits health plans from discriminating against any health care provider, acting within their state scope of practice law, that wants to participate in the plan, but plans are not required to contract with any willing provider and may have varied payment rates. Year effective: 2014	Inconsistent with Policy H-165.833, which supports repeal of the non-physician provider non-discrimination provision.
Basic Health Program (BHP)	Gives states the option to establish a BHP to cover uninsured low-income individuals and families with household incomes that exceed 133 percent of the federal poverty level (FPL)—the income threshold for Medicaid eligibility in states that choose to implement the ACA's Medicaid expansion—but do not exceed 200 percent of FPL. A state BHP also would cover lawfully present immigrants who are ineligible for Medicaid coverage and have incomes that do not exceed 133 percent FPL. Year effective: While the law outlined that BHPs could be operational beginning in 2014, HHS has announced that the start of the program is delayed until 2015.	Potentially inconsistent with Policy H-165.832, which supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans as an alternative to BHP establishment. For states that choose to establish BHPs, consistency with AMA policy depends on adherence to the principles for the establishment and operation of state BHPS as outlined in Policy H-165.832.

Issue	ACA Provision	AMA Policy
Biosimilars	Confers the FDA with immediate authority to establish an abbreviated pathway to approve biosimilars for market. Year effective: 2010	Generally consistent with AMA Policy H-125.980, which supports providing the FDA with authority to establish an abbreviated pathway for biosimilars.
CMS Innovation Center	Establishes the Center for Medicare and Medicaid Innovation (CMMI) to test care models that improve quality and slow Medicare cost growth rate, including programs that promote greater efficiencies and timely access to outpatient services through models that do not require a physician or other health professional to refer the service or be involved in establishing the plan of care. The HHS can expand the duration and scope of a model, including nationwide. Year effective: 2011	Consistency of provision with AMA policy depends on the care model proposed to be tested by CMMI. While some models may potentially be inconsistent with various policies addressing scope of practice, Policy D-390.961 supports funding of demonstration projects that allow physicians to benefit from increased efficiencies based on practice changes that best fit local needs. Policy H-160.915 states that CMMI should provide grants to physicians in order to finance up-front costs of creating an ACO.
Comparative effectiveness research	Establishes the Patient-Centered Outcomes Research Institute, to identify national priorities and provide for comparative clinical effectiveness research on health treatments and strategies. The Institute is not allowed to issue practice guidelines, coverage recommendations payment or policy recommendations. The Agency for Healthcare Research and Quality (AHRQ) is required to expand CER capacity through training grants for researchers, coordination of access to federal health care program data in order to build data capacity including support for clinical registries and health outcomes research data networks; AHRQ is required to consult with medical and clinical associations and obtain regular, structured feedback to promote uptake of CER findings in clinical practice and to determine the value of information disseminated and assistance provided by AHRQ. Medicare is authorized to use CER findings in national coverage determinations (NCD), but will be prohibited from solely relying upon CER findings for such determinations and clarifies that the "reasonable and necessary" standard used to make NCDs is not modified. Also, establishes additional limitations on the methodologies and evidence when CER is used for NCD. Year effective: 2010	Generally consistent with Policy H-460.909 addressing the creation of a comparative effectiveness research entity. Also consistent with Policy D-330.918, which states that the AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a NCD or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice.

Issue	ACA Provision	AMA Policy
CO-OPs	Creates the CO-OP program to foster the creation of non-profit, member-run health insurance companies in all 50 states and the District of Columbia to compete on a level playing field with the private market. Appropriates $6 billion to finance the program and award loans and grants to establish CO-OPs. Year effective: CO-OPs were to be established by July 1, 2013. Implementation update: The federal government has awarded roughly $2 billion in loans to help create 24 new CO-OPs in 24 states. Legislation passed at the beginning of 2013 rescinded 90% of all funds that were not committed as of January 1. The remaining $200 million is available for assisting and overseeing the 24 existing CO-OPs. There is no funding for additional CO-OPs.	Generally consistent with Policy H-165.882, which supports the development of innovative insurance options, and states that the AMA will offer advice or assistance to states to ensure that new insurance issuers, including those with physician involvement, benefit from CO-OP start-up loans.
Cost/quality index payment modifier (also known as value-based payment modifier)	Modifies Medicare physician payments based on quality/cost index and on budget neutral basis, beginning in 2015 for groups of 100 physicians or more (based on 2013 performance), and all physician payments must be subject to quality/cost payment modifications by 2017. Year effective: 2015	Inconsistent with Policy H-400.988, which states that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI)-based adjustments as needed to remedy demonstrable access problems in specific geographic areas. Policy H-165.833 calls for study of the Medicare cost/quality index.
Dependent coverage up to age 26	Requires all health plans to allow young adults to remain on their parents' insurance policy up to their 26th birthday. For coverage of young adults prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage. Year effective: 2010	Generally consistent with Policy H-180.964, which encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family coverage to age 28.
Electronic funds transfers	Requires operating rules for electronic funds transfers (EFT) and health care payment and remittance advice to be adopted no later than July 1, 2012, to take effect by January 1, 2014. Health care providers, including physicians, must also comply with EFT standard for Medicare payments by January 1, 2014. Year effective: Operating rules adopted by July 1, 2012, take effect by January 1, 2014.	Consistent with Policies H-190.978 and H-190.983, which support the greater use of electronic data interchange. Consistent with Policy H-165.838, which supports health system reforms that include streamlined and standardized insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

Issue	ACA Provision	AMA Policy
Employer responsibility	Assesses employers who have more than 50 employees but do not offer coverage and have at least one full-time employee who receives a premium subsidy a "free rider" penalty of $2,000 a month per full-time employee (FTE), excluding the first 30 employees from the assessment. The penalty is not tax-deductible. Employers who have more than 50 employees and offer coverage but have at least one FTE receiving a premium tax credit will pay the lesser of $3,000 for each employee receiving a premium credit or $2,000 for each FTE. Year effective: While the law outlined that the provision would go into effect in 2014, the Obama Administration announced it will delay the employer responsibility provision until 2015. Implementation update: The IRS has released guidance that encourages employers to offer coverage and report the relevant income and insurance data in the interim, although there will not be any penalties for non-compliance.	The AMA does not have policy on employer responsibility to provide health insurance, favoring individual selection and ownership of health insurance. However, Policy H-165.920 supports the continuation of employment-based coverage as an option to the extent that the market demands it.
Essential health benefits	Requires health plans in the small group and individual markets to include coverage of defined essential health benefits (EHB), with a specified actuarial value, and with limits on cost-sharing. Year effective: 2014 Implementation update: HHS, through rulemaking, stipulated that EHB be defined by a benchmark plan selected by each state, instead of a national standard of benefits. The selected benchmark plan would serve as a reference plan for EHB package, reflecting both the scope of services and any limits offered by a typical employer plan in that state. Also, as outlined in a Frequently Asked Questions document issued by the Departments of Labor, HHS and the Treasury, group health plans and group health insurance issuers that utilize more than one service provider to administer benefits have flexibility in implementing the annual limitation on out-of-pocket maximums for 2014.	Consistency with policy depends on the state EHB package selected. Policy supports the use of existing federal guidelines (FEHBP and Title 26 of the US Tax Code) as a standard for meaningful coverage for adults (Policies H-165.846 and H-165.845), minimal benefit mandates (Policy H-165.856), and the EPSDT program being used as the model for any EHB package for children (Policy H-165.846). Potentially inconsistent with Policy H-165.852, which supports the role of health savings accounts in the health insurance marketplace.

Issue	ACA Provision	AMA Policy
Excise tax on insurers	Imposes an excise tax on insurers and plan administrators of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. These threshold values will be indexed to the consumer price index for urban consumers (CPI-U) for years beginning in 2020. Year effective: 2018	Consistent with Policy H-290.982, which advocates consideration of a range of various funding options for expanding coverage. Also consistent with H-385.925 that opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform. Consistent with Policy H-165.845, which states that health insurance coverage should be equitable, affordable, and sustainable, and that the financing strategy should strive to emphasize personal responsibility as well as societal obligations.
Fraud and abuse	Contains a multitude of provisions to prevent or combat fraud, waste or abuse in federal health programs as well as in private health plans. Year effective: Varies. Earliest implementation dates in 2010.	Potentially inconsistent with Policies H-175.984, H-175.979 and H-175.989, which support program integrity efforts that focus on intentional fraud and abuse, including preservation of the "willfully and knowingly" evidentiary standard of identifying fraud.
Graduate medical education	Authorizes the redistribution of 65 percent of unused GME residency slots to qualifying hospitals to address physician shortages, especially in rural and other underserved areas. Effective July 1, 2011. Provides more flexibility for GME programs to count training in outpatient settings and didactic and scholarly activities towards GME payments. Effective July 1, 2010 and applies to previous cost reporting periods. Preserves GME positions from closed hospitals based on certain criteria. Directs HHS to establish a process to redistribute medical residency slots from qualifying closed hospitals. Effective 2010. Years effective: 2010 and 2011	Generally consistent with policy in support of GME funding (Policies H-305.929 and D-305.967).
Guaranteed issue and renewability	Requires every health insurance issuer that offers health insurance coverage in the individual or group market to accept every employer and individual in the state that applies for such coverage. Issuers renew or continue such coverage at the option of the plan sponsor or the individual, as long as they are in good standing. Year effective: 2014	Consistent with Policy H-165.856, which supports guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. Also consistent with Policy H-165.838 that supports insurance market reforms that eliminate denials for pre-existing conditions.
Health disparities	Requires qualified health plans to implement activities to reduce health disparities, including the use of language services, community outreach, and cultural competency trainings. Year effective: Varies. Earliest implementation dates in 2010.	Consistent with policies in support of eliminating health disparities (e.g., Policies H-295.897, H-350.974 and H-160.924).

Issue	ACA Provision	AMA Policy
Health insurance exchanges	Calls for the creation of state-based exchanges (marketplaces) for the individual market and small business health options program (SHOP) exchanges for the small-group market. The HHS is required to establish and operate an exchange in states that do not elect to establish an exchange. Only qualified health plans (QHPs) meeting specific criteria could be sold in exchanges. Large employers will be phased into the exchanges beginning in 2017. Year effective: 2014 Implementation update: 16 states and DC implementing state-based exchange; 7 planning for partnership exchange; 27 defaulting to federal exchange (as of September 16). Of the 16 states and DC implementing state-based exchange, 6 states have chosen the active purchaser model, 9 states have chosen the open marketplace model and 2 states are undecided. For plan year 2014, the federal exchanges operating in states that do not elect to establish an exchange will certify as a QHP any health plan that meets all certification standards. Federally facilitated and state SHOP exchanges will not be required to offer employee plan choice until 2015.	Consistent with Policy H-165.839 outlining principles for health insurance exchanges, and Policy H-165.856 supporting legislative and regulatory development of new markets to enhance health insurance options. Because states are given flexibility in how to structure their exchanges, consistency of state implementation with AMA policy depends on factors including the model states use for their exchanges (i.e., open marketplace vs. active purchaser); the inclusion of actively practicing physicians and patients in health insurance exchange governing structures; the inclusion of payment rates established through meaningful negotiations and contracts; and the access of enrollees to out-of-network physicians (Policies H-165.838 and H-165.839).
Health outcomes	Requires the HHS to develop guidelines for use by health insurers to report information on initiatives and programs that improve health outcomes through the use of care coordination and chronic disease management, prevent hospital readmissions and improve patient safety, and promote wellness and health. Year effective: 2012	Consistent with numerous policies related to care coordination, chronic disease management, preventing hospital readmissions, patient safety, and prevention and wellness (e.g., Policies H-160.918, H-285.944, H-335.965, and H-425.993).
Health plan appeals (internal appeals and external review)	Requires health insurers to implement an internal appeals process for appeals of coverage determinations and claims and comply with external appeals requirements. Year effective: 2010	Generally consistent with Policy H-320.952, which states that all managed-care organizations should contain an external review procedure that allows the submission of grievances involving adverse determinations. Also, generally consistent with Policy H-285.931, which states that practicing physicians and patients of a health plan should have access to a timely, expeditious internal appeals process.

Issue	ACA Provision	AMA Policy
Health plan identifier	Requires adoption of unique health plan identifier system. Year effective: 2012	Consistent with Policy H-165.838, which supports health system reforms that include streamlined and standardized insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.
HHS National Health Care Quality Strategy and Plan	Provides additional resources for development of national strategy for performance improvement, development and dissemination of quality measures and best practices, data aggregation, and public reporting of performance information. Year effective: 2011	Consistent with Policy H-165.838, which supports investments and incentives for quality improvement as part of health system reform.
High-risk pools	Creates a temporary state-based high-risk pool program, known as the Pre-Existing Condition Insurance Plan, to provide health coverage to individuals with pre-existing medical conditions. The program is to end once health insurance exchanges become operational. Year effective: 2010	Consistent with policy supporting: coverage of high-risk patients with direct risk-based subsidies such as high-risk pools, rather than indirect methods that rely on market regulation; state-based demonstrations for subsidizing high-risk patients through high-risk pools and other mechanisms; and the establishment of a high-risk pool in each state (Policies H-165.842 and H-165.995)
Hospital ownership	Bans new physician-owned hospitals in Medicare. For current hospitals, level of physician ownership and investment in the aggregate cannot increase, and there are limits on expansions of beds, operating rooms, procedure rooms, and new disclosure requirements. Year effective: Hospitals must have had a provider agreement in effect as of December 31, 2010.	Inconsistent with Policy D-215.995, which opposes a ban on physician-owned hospitals.
HSAs/FSAs for purchase of over-the-counter drugs	Excludes the costs for over-the-counter drugs not prescribed by a doctor from being reimbursed through an HRA or health FSA and from being reimbursed on a tax-free basis through an HSA or Archer Medical Savings Account. Year effective: 2011	Inconsistent with Policy H-155.960, which supports efforts to make health care delivery more efficient? Policy H-120.938 encourages the FDA to study the cost implications that switching prescription drugs to over-the-counter status will have on patient out-of -pocket costs.
ICD-10	Requires the HHS to oversee convening of stakeholders to receive input on an ICD-9-CM to ICD-10 crosswalk. Year effective: 2011	Inconsistent with Policy D-70.952, which supports stopping the implementation of ICD-10.
Imaging services: payment	Sets a 75% assumed utilization rate for expensive diagnostic imaging equipment priced at more than $1 million (MRI/CT) in determining Medicare practice expense relative values. Increases technical multiple imaging procedure payment reduction from 25% to 50%. Years effective: 2010 and 2011	Potentially inconsistent with Policy D-385.974, which opposes efforts to control utilization of imaging services, unless they can be shown to yield cost savings without compromising patient care.

Issue	ACA Provision	AMA Policy
Imaging: self-referral exception	Requires physicians (and other Medicare providers/suppliers) to inform patients in writing when they make referrals that the patient may obtain the referred services from a person other than the referring physician and the physician must provide the patient with a list of individuals who furnish the services in an area where the patient resides. Year effective: 2010	Generally consistent with Policy D-270.995, which opposes efforts to repeal the in-office ancillary exception to physician self-referral laws, including as they apply to imaging services.
Individual mandate	In combination with coverage provisions that provide subsidies to individuals with incomes up to 400 percent FPL, requires most US citizens and legal residents to have qualifying coverage or pay a tax penalty. Exemptions will be granted for financial hardship, religious objections, American Indians, those without coverage for less than three months, undocumented immigrants, incarcerated individuals, those for whom the lowest cost plan option exceeds 8 percent of income, and those with incomes below the tax filing threshold. Year effective: 2014	Generally consistent with Policy H-165.848, which states that individuals and families earning greater than 500 percent FPL should be required to obtain at least coverage for catastrophic health care and evidence-based preventive health care. For those earning less than 500 percent FPL, the individual responsibility requirement is supported only upon implementation of a system of refundable tax credits or other subsidies to help obtain health insurance coverage. The policy also supports using the tax structure to achieve compliance.
Interstate sale of insurance	Allows sale of insurance across state lines through interstate health care choice compacts. Under such compacts, qualified health plans could be offered in all participating states, but insurers will still be subject to the consumer protection laws of the purchaser's state. Insurers must be licensed in all participating states. Requires states to enact a law to enter into compacts and HHS approval. Year effective: 2016	Generally consistent with policy supporting the sale of insurance across state lines with certain protections (Policies H-165.882, H-165.856, and H-165.839). The AMA has a strong policy supporting patient and physician protections, especially state prompt pay laws, protections against health plan insolvency and fair market practices (e.g., Policies D-385.984, D-320.993, D-190.987, H-190.981, H-190.969, H-285.928 and H-285.981).
IPAB	Establishes a 15-member Independent Payment Advisory Board to extend Medicare solvency and reduce spending growth through use of a Medicare spending target system and fast track legislative approval process. Year effective: Spending rate reductions effective in 2015.	Inconsistent with H-165.833, which supports repeal of the IPAB.
Lifetime limits for benefits	Prohibits plans from placing lifetime limits on the dollar value of benefits, and prohibits annual limits beginning in 2014. Prior to January 2014, plans may only impose restricted annual limits on coverage, as defined by HHS. Years effective: Ban on lifetime limits effective in 2010. Prohibition on annual limits effective in 2014.	Consistent with Policy H-185.952, which supports the prohibition of lifetime limits on the value of benefits.

Issue	ACA Provision	AMA Policy
Loan forgiveness criteria	Amends loan forgiveness criteria by requiring medical students who receive federal loan funds to practice in primary care for 10 years or until the loan is repaid, whichever comes first.	Consistent with policies supporting loan forgiveness and loan repayment strategies (e.g., Policies H-305.928 and D-305.993).
Long-term care	Contains a multitude of provisions to improve the nation's long-term care system, including giving states new options to offer home and community-based services, to ultimately increase the proportion of non-institutionally based long-term care services.	Generally consistent with Policy H-290.982, which supports funding for home and community-based settings appropriate to the individual.
Medicaid expansion	Expands Medicaid to all individuals under age 65 with incomes up to 133 percent FPL. The Supreme Court ruled that Congress exceeded its authority by threatening to withhold existing Medicaid funds from states that fail to cover all non-elderly Americans with incomes up to 133% FPL, thereby making the ACA's Medicaid expansion optional for states. States that choose not to expand their Medicaid programs will be able to maintain existing federal funding without penalty. Year effective: 2014 Implementation update: 25 states and DC are expanding; 22 not expanding; 3 undecided (as of September 16).	Long-standing policies state a preference for private sector expansions over public sector expansions (e.g., Policies H-290.974 and H-165.920). Nonetheless, the AMA has numerous policies on improving public programs. Consistent with Policies H-290.974 and H-290.997 supporting Medicaid expansion to all individuals with incomes below poverty level. Policy D-290.979 states that the AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% FPL.
Medicaid payments to primary care physicians	Increases payments for primary care services provided by primary care physicians (family medicine, general internal medicine or pediatric medicine) to 100 percent of the Medicare payment rates for 2013 and 2014. States will receive 100 percent federal funding for the increased payment rates. Year effective: 2013 Implementation update: State implementation of this provision was delayed. Once CMS approves a state's amendment to Medicaid payment, physicians will be able to receive the increase in payments retroactively to January 1, 2013, without resubmitting any claims. CMS has approved state plan amendments of all states but California. Therefore, CMS expected Medicaid payment increases to PCPs to begin being disbursed effective July 2013 in most states.	Generally consistent with Policies H-385.921 and H-290.980, which support appropriate Medicaid payment to physicians.

Issue	ACA Provision	AMA Policy
Medical home pilot program	Establishes an independence at home demonstration program to bring primary care services to the highest cost Medicare beneficiaries with multiple chronic conditions in their home. Health teams could be eligible for shared savings if they achieve quality outcomes, patient satisfaction, and cost savings. NPs and PAs could also lead the home-based primary care team as part of an independence at home medical practice.	Generally consistent with Policies D-390.961 and H-390.849, which support efforts to explore alternative organizational structures and ways of achieving cost savings. Authorization of NPs or PAs as leaders of medical home practice is inconsistent with Policies D-35.985 and H-160.919 in support of physician led, team-based care, including care provided as part of a medical home.
Medical liability reform demonstration grants	Authorizes the HHS to award competitive grants to states for the development, implementation, and evaluation of alternative models to current tort litigation. Also, includes a provision that allows patients to opt-out of these alternatives at any time and pursue their liability claims in court. Authorizes $50 million to be appropriated for a five-fiscal year period. Year effective: 2011 Implementation update: No funding for this program has been made available. Congress has not appropriated any dollars to this program, nor has this program been included in the annual budgets submitted by the president.	Generally consistent with policies in support of meaningful medical liability reforms, and federal funding of state pilot programs on a wide range of liability reform alternatives (i.e., health courts, early disclosure and compensation programs, expert witness qualifications, safe harbor for the use of evidence based medicine guidelines) (e.g., Policies H-435.978, H-435.951, H-435.967, H-165.838 and D-435.974).
Medical loss ratio	Requires health plans (including grandfathered plans) to report to the HHS the proportion of premium dollars spent on clinical services, quality, and other costs, and provide rebates to consumers if medical loss ratio is less than 85% for plans in the large group market and 80% for plans in the individual and small group markets. The reports are to be made publicly available on the HHS website. Years effective: 2010, health plans required to provide rebates effective 2011	Consistent with policy supporting: limiting Medicare Advantage plans to an 85% or higher medical loss ratio, requiring that plans report medical loss ratios, and health plan transparency and reporting of administrative expenditures (e.g., Policies D-330.923, D-450.985, H-285.967 and H-155.963).
Medicare Advantage	Requires HHS to begin transition to fiscal neutrality between regular Medicare fee for service and MA plans. Benchmarks will vary from 95 percent of regular Medicare spending in high cost areas to 115 percent of Medicare in low cost areas. Changes are phased in over a varying number of years, depending on the level of payment reductions. Year effective: 2012	Consistent with Policy D-390.967, which supports fiscal neutrality between Medicare fee for service and Medicare Advantage.

Issue	ACA Provision	AMA Policy
Medicare bonus payments for primary care and general surgery	Provides primary care/general surgery Medicare bonus (10% over 5 years). Primary care bonus applies to primary care physicians (family medicine, internal medicine, geriatric medicine or pediatric medicine) and practitioners (NP, CNS or PA) for whom primary care services (HCPCS codes 99201-99215; 99304-99340; and 99341-99350) account for at least 60 percent of Medicare allowed charges over a designated time period. Year effective: 2011	Consistent with Policy H-390.849, which supports physician payment reforms that promote improved patient access to high-quality and cost-effective care, and don't require budget neutrality within Medicare Part B. Also consistent with Policy H-330.932, which supports needed payment increases in Medicare.
Medicare data release provision/qualified entity program	The HHS will provide Medicare claims data to qualified entities for purposes of public provider performance reports subject to certain conditions. Entities must meet certain safeguards regarding ensuring validity and reliability of the data. Physicians and other providers will have prior review of the data before publicly reported with an opportunity to appeal and correct errors. Data cannot be subject to discovery or admitted as evidence in legal proceedings without consent of provider/supplier. Year effective: 2012	Consistent with Policy H-406.990 pertaining to the release of claims and payment data from governmental programs.
Medicare doughnut hole	Reduces the coverage gap ("doughnut hole") for Medicare prescription drug benefits over time from 2010 to 2020. Year effective: Implementation of provision began in 2010.	Generally consistent with Policy D-330.933 in support of reasonable copays in the Medicare Part D program.
Medicare: geographic adjustments for Medicare physician payments	Provides new funding for 2010/2011 practice expense GPCI adjustments to help payment areas with PE GPCIs less than 1.0. Based on the results of an HHS PE GPCI study, PE GPCIs adjustments will be implemented by 2012 in a budget neutral manner. Provides additional funding to establish a practice expense GPCI floor of 1.0 for frontier states (ND, SD, MT, WY, UT) beginning January 1, 2011. Years effective: 2010-2012	Practice expense study to determine GPCI adjustments is consistent with policy advocating that GPCI revisions be based on accurate and reliable data (Policy H-400.984), although budget neutrality is not supported by the AMA (Policy H-390.849).
Modified community rating	Allows limited premium variation based only on age with a ratio of 3:1, geographic area, tobacco use, and family size. Year effective: 2014	Generally consistent with Policy H-165.856 that supports modified community rating, as well as the use of some degree of age rating. Consistent with Policy H-180.953 that supports the concept of health insurance contracts with lower premiums for nonsmokers.

Issue	ACA Provision	AMA Policy
Multi-state plans	Requires the Office of Personnel Management (OPM) to contract with health insurers to offer at least two multi-state qualified health plans (at least one non-profit) to provide individual or small group coverage through exchanges in each state. Requires OPM to negotiate contracts in a manner similar to how it negotiates contracts for FEHBP, and allows OPM to prohibit multi-state plans that do not meet standards for medical loss ratios, profit margins, and premiums. Requires multi-state plans to cover essential health benefits and meet all of the requirements of a qualified health plan. Year effective: 2014	Generally consistent with Policy H-165.882 supporting the development of innovative insurance options. However, as outlined in Policy H-165.839, multi-state plans would have to ensure consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.
National Health Care Workforce Commission	Establishes a National Health Care Workforce Commission to provide recommendations to Congress on health care workforce needs. Year effective: Appointments to the Commission were to be made by September 30, 2010. Implementation update: Although appointments were made to the Commission by the deadline, the Commission has not yet met, due to the lack of appropriated funds to support the Commission's operations. Physicians were amongst the appointments made to the Commission.	Consistent with Policies H-200.955 and D-305.958 advocating collaborative, evidence-based approach to workforce planning. Policy H-310.915 supports advocating for strong physician representation and significant participation in any proposed health-care workforce advisory committees.
National Health Service Corps	Authorizes increased funding for the National Health Service Corps (NHSC) scholarship and loan repayment program, allows part-time service and teaching time to qualify towards the NHSC service requirement, and increases the annual NHSC loan repayment amount from $35,000 to $50,000 in 2010. Years effective: 2010, appropriations effective beginning in 2011	Consistent with numerous policies that support funding for the National Health Service Corps (e.g., Policies H-200.959, D-200.980, H-200.984 and D-305.975).
National Prevention and Health Promotion Strategy	Develops a national prevention and health promotion strategy. Creates a prevention and public health investment fund, providing $7 billion in funding from 2010 through 2015, and $2 billion for each fiscal year after 2015, to expand and sustain funding for prevention and public health programs. Year effective: 2010 Implementation update: Funding of the Prevention and Public Health Fund has been reduced in order to fund other health care line items, as well as sequestration.	Consistent with Policy H-165.838, which supports investments and incentives for prevention and wellness initiatives. Policy H-165.831 supports budget allocations from the Prevention and Public Health Fund at no less than the levels adopted in the ACA, and opposes policies that aim to cut, divert, or use as an offset, dollars from the Prevention and Public Health Fund for purposes other than those stipulated in the ACA.

Issue	ACA Provision	AMA Policy
Nurse midwives	Increases Medicare payment rates for nurse-midwives from 65% to 100% of the Medicare physician fee schedule. Year effective: 2011	Inconsistent with policy advocating for physician leadership of the health care team, including practice agreements with and supervision of nurse practitioners who may be certified nurse midwives (Policy H-160.950). Policies H-360.988 and H-35.992 support the provision of payment to the employing physician for all services provided by physician assistants and nurse practitioners under the physician's supervision and direction regardless of whether such services are performed where the physician is physically present.
Physician Feedback Program / Quality and Resource Use Reports (QRURs)	Expands the Medicare physician feedback program based on episode-grouper methodology that must be developed by January 1, 2012. HHS must make methodology publicly available and seek endorsement of methodology through NQF. HHS is to provide reports to physicians comparing physicians' patterns of resource use to other physicians. Public reporting of aggregate reports for MDs and DOs. Year effective: 2012	Potentially consistent Policy H-406.991, which supports the use of physician data when used to provide accurate physician assessments and improve or maintain the quality of, and access to, medical care. Policy H-406.994 outlines principles for physician profiling.
Physician Sunshine/Gift Registry	Requires manufacturers of drugs, devices, biologicals, and medical supplies participating in federal health care program to begin reporting to HHS transfers of value to physicians and teaching hospitals. The reports will be publicly posted. Covered manufacturers and group purchasing organization are also required to report any ownership or investment interest (other than in a publicly traded security and mutual fund) held by a physician (or an immediate family member). Prior to posting individuals (and manufacturers and group purchasing organizations) will have 45 days to review and submit corrections to the information. Requires drug manufacturers and distributors to submit records to HHS on drug samples distributed, destroyed, or returned to manufacturer. These will not be subject to public disclosure. Years effective: Manufacturers are required to collect and track payment, transfer and ownership information beginning in 2013. These interactions will be published by CMS starting in 2014.	Potentially consistent with Policy E-8.061, which outlines guidelines that physicians should observe in order to avoid the acceptance of inappropriate gifts. However, Policy H-140.848 supports minimizing the burden and unauthorized expansion of the Sunshine Act by CMS.

Issue	ACA Provision	AMA Policy
PQRS, formerly known as PQRI	Provides 4 years of PQRS bonuses; 2011 (1 percent), 2012-2014 (0.5 percent). Establishes PQRS penalties for unsuccessful participation beginning in 2015 (1.5 percent) and thereafter (2 percent). Requires timely feedback for PQRS eligible professionals, and a PQRS informal appeals process must be in place for eligible professionals to seek a review of the determination that the eligible professional did not satisfactorily submit data on quality measures. Provides an additional 0.5 percent PQRS bonus for 3 years (2011-2014) if physicians and other eligible professionals report quality data to the PQRS through a maintenance of certification (MOC) process, and after 2014, HHS could require participation in an MOC as part of the physician cost/quality index. Years effective: 2011, penalties begin in 2015	Consistent with policy supporting PQRI improvements (Policies H-450.936, H-450.941), which advocate for early education and outreach to physicians by CMS, the provision of confidential feedback reports, and the development of meaningful dispute resolution processes (Policy H-450.936). However, PQRS penalties are inconsistent with H-450.947, which states that quality reporting programs should be based on rewards and not on penalties. Policy D-450.967 supports streamlining and making less arduous the reporting standard of PQRI and a delay in implementation of the mandatory nature of the program until the system has been refined to be more efficient and physician friendly.
Pre-existing condition exclusions	Bans coverage exclusions of pre-existing health conditions for children and adults. Years effective: Ban for children under age 19 effective in 2010, applicable to adults in 2014	Consistent with Policy H-165.838, which supports insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps. Also consistent with policy supporting guaranteed issue in the context of an individual mandate (Policy H-165.856).
Premium credits and cost-sharing subsidies	Provides refundable, advanceable and sliding-scale premium credits to eligible individuals and families with incomes between 100 percent and 400 percent FPL to purchase insurance through health insurance exchanges. Also provides cost-sharing subsidies to reduce the cost-sharing amounts and annual cost-sharing limits. Individuals eligible for premium and cost-sharing credits include U.S. citizens, legal immigrants, and employees who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.5 percent of income. Individuals with incomes between 100 and 133 percent FPL who reside in states that do not implement the Medicaid expansion outlined in the ACA will also be eligible for premium credits and cost-sharing subsidies. Year effective: 2014	Consistent with Policy H-165.865, which supports providing tax credits inversely related to income to help families afford insurance coverage. AMA policy does not specify subsidy amounts or applicable income levels but advocates that the size of tax credits should be inversely related to income and large enough to ensure that health insurance is affordable for most people (Policy H-165.865). Also consistent with Policy H-165.920, which supports a system of individually selected and owned health insurance coverage, supported by the provision of refundable and advanceable tax credits, to provide coverage to the uninsured.

Issue	ACA Provision	AMA Policy
Premium rate reviews	Establishes a process for reviewing increases in health plan premiums and requires plans to justify increases. Requires states to report to the HHS on trends in premium increases and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases. Provides grants to states to support efforts to review and approve premium increases. Years effective: Plan year 2010, HHS monitors premium increases for insurance offered in and outside of exchanges starting in plan year 2014	Consistent with Policy H-155.959, which supports requiring health plans to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios. Also consistent with Policy H-180.949, which opposes the practice of health insurance companies engaging in the practice of "purging" targeted subscribers by issuing intentionally inflated rate increases not supported by actuarial data. However, potentially inconsistent with Policy H-165.985 advocating free market competition among all modes of health care delivery and financing.
Preventive services	Requires first-dollar coverage (i.e., no cost-sharing) of certain preventive health services. Provides incentives for use of Medicare preventive services; eliminates co-insurance; provides annual Medicare coverage of risk assessment and wellness visit and personalized prevention plan, with incentives for healthy lifestyles; and no co-insurance. Year effective: 2011	Consistent with Policy D-440.953, which advocates that first-dollar coverage for all CDC recommended immunizations, and with Policy D-330.935, which supports the expansion of an evidence-based Welcome to Medicare Visit and provide first-dollar coverage of the preventive visit and required tests. Consistent with Policy H-425.992, which advocates that Medicare include coverage of appropriate preventive medical services.
Reinsurance for early retirees	Creates a temporary reinsurance program to provide reimbursement to participating employment-based plans for part of the cost of providing health benefits to retirees (age 55-64) and their families. Year effective: 2010	Generally consistent with Policy H-165.856, which states that reinsurance should be financed through general tax revenues rather than through strict community rating or premium surcharges.
Rescission of coverage	Prohibits insurers from rescinding coverage except in cases of fraud. Year effective: 2010	Consistent with Policies H-165.838 and H-185.989, which support prohibiting rescission.
Risk adjustment, reinsurance and risk corridors	Requires states to establish a nonprofit reinsurance entity to collect payments from insurers and make payments to insurers in the individual market that cover high-risk individuals. Requires the HHS to establish risk corridors for qualified health plans to make adjustments in payments to plans to account for higher than average costs. Requires states to assess a charge on health plans with enrollees of lower-than-average risk, and to make payments to health plans with enrollees of higher-than-average risk. Years effective: 2014-2016	Generally consistent with Policy H-165.842, which supports health insurance coverage of high-risk patients being subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation.

Issue	ACA Provision	AMA Policy
Small business tax credits	Provides tax credits to small employers with no more than 25 employees and average annual wages of less than $50,000 that purchase health insurance for employees. Year effective: 2010	Inconsistent with policy supporting a preference for individually selected and owned health insurance coverage, and tax credits for individuals to purchase health insurance coverage (Policies H-165.920 and H-165.865).
Title VII	Reauthorizes and authorizes increased funding for multiple Title VII health professions and diversity programs. Years effective: Effective dates beginning in 2010 and 2011	Consistent with Policies D-200.982, D-305.972, H-200.983, D-200.994 and H-200.956, which support adequate funding for Title VII and diversity programs.