American Hospital Association®

Affordable Care Act Legislative Fixes

Despite its benefits of expanded coverage and transformation of the care delivery system, the Affordable Care Act (ACA) contained flaws that need to be corrected. The American Hospital Association (AHA) recommends the following legislative changes to the ACA.

Coverage Issues

- **Fund the Cost-sharing Reduction Subsidies (CSRs) (Sec. 1401-1421).** CSRs are subsidies paid to plans to reduce deductibles and co-payments for individuals earning between 100 and 250 percent of poverty. Without an appropriation by Congress to fund the CSRs, health plans face approximately $7 billion to $10 billion annually in unreimbursed costs. Without this funding, plans likely would have to choose between exiting the marketplaces – reducing consumer coverage options – or significantly increasing premium rates to cover these costs – potentially making coverage unaffordable for many consumers. A recent analysis by the Kaiser Family Foundation estimated that premiums would increase on average 19 percent to account for uncertainty related to the CSRs, with that amount varying from 9 to 27 percent in individual states. We urge Congress to guarantee continued funding of the CSRs.
- **Fund the Children's Health Insurance Program (CHIP) (Sec. 2101, 10203).** The ACA extended federal CHIP funding authorization through fiscal year (FY) 2015, and states were required to maintain their CHIP programs until Sept. 30, 2019. Subsequently, Congress extended CHIP funding through FY 2017. CHIP and Medicaid provide health coverage for nearly 40 percent of children in America. Failure to extend CHIP funding could result in coverage losses for millions of children, and increased financial pressure for states that may lead to reductions in eligibility and benefits. We urge Congress to extend federal CHIP funding authorization for at least two years, through Sept. 30, 2019.
- **Reinstitute a Reinsurance Program (Sec. 1341).** Reinsurance is a proven way to protect plans from high-cost claims. The temporary reinsurance program that was in place for the initial three years of the health insurance marketplaces helped attract insurer participation and achieve affordable rates by spreading the costs of expensive claims. We urge Congress to reinstitute the federally administered program or a similar one.
- **Provide an Alternative Coverage Source in Instance of Marketplace Failure.** The ACA, as passed, did not include a provision for ensuring that individuals have coverage options in instances of marketplace failure, defined as when no plans are sold on a marketplace. While every market will have at least one option available in 2018, recent volatility in health plan participation and premium rates suggests that it is possible that some bare markets will emerge in the future. We urge Congress to create an alternative pathway to coverage for individuals in failed markets. This coverage should enable eligible individuals to continue to receive the advanced premium tax credits and CSRs or put the value of these subsidies toward the alternative coverage option. We strongly encourage Congress to consider opening access to the Federal Employee Health Benefit Program (FEHBP) to consumers in such markets – potentially through a "buy-in" program – as the FEHBP has health plans selling in every market.
- **Extend Eligibility for Advanced Premium Tax Credits and CSRs (Sec. 1401-1421).** The ACA does not allow most individuals below 100 percent of poverty to access either the advanced premium tax credits or CSRs because it intended for such individuals to be enrolled in Medicaid. However, subsequent to the Supreme Court's ruling in King v. Burwell, 19 states have chosen not to expand their Medicaid programs, leaving a "coverage gap" for some of the most vulnerable individuals, as they can neither enroll in Medicaid nor receive financial assistance to purchase coverage on the marketplace. The ACA should be revised to allow individuals with incomes as low as zero percent of poverty to have access to the premium tax credits and CSRs.

- **Modify the 90-Day Grace Period (Sec. 1412).** The ACA requires that health plans keep enrolled low-income individuals receiving tax credits who have not paid their premiums until three continuous months of nonpayment occurs. In implementing regulations, the Centers for Medicare & Medicaid Services (CMS) allows health plans to suspend payment of claims after 30 days of nonpayment of premiums, leaving providers at risk for bad debt during the 31st to 90th days. This provision should be changed to a 60-day grace period and clarified that health plans must provide coverage during the full 60 days.
- **Eliminate the "Family Glitch" (Sec. 1401).** Several aspects of the ACA depend on a comparison of premium cost and income, such as whether an employer's plan provides "affordable" coverage and whether an individual is eligible for subsidies. However, there is a mismatch between the bases for these calculations. For example, the employee premium affordability test is based on a comparison of the cost of individual coverage for just the employee but is compared to total household income. Further, if this affordability test is met, the spouse and children of the employee are not eligible to obtain coverage through the exchanges or to access subsidies, even though the cost of family coverage under the employer's plan may far exceed the affordability level. The AHA supports fixing the "family glitch" by aligning the bases for premium costs and income to ensure that families have access to affordable coverage and, where appropriate, to subsidies.

Medicare & Medicaid Payment Changes

- **Eliminate Productivity Adjustment to Annual Inflationary Updates (Sec. 3401, 10319, 10322).** Beginning in 2010, the ACA reduced the annual market basket update for inpatient and outpatient hospital services, inpatient psychiatric facilities, inpatient rehabilitation facilities (IRFs) and long-term care hospitals (LTCHs). The amount of the reduction beginning in 2012 is the rate of productivity growth in the economy as a whole plus 0.75 to 0.2 percentage points, depending on the year, through 2019. Then the reduction for productivity becomes permanent. Congress should sunset the productivity adjustments in light of the fact that hospitals cannot continue to achieve productivity improvements in perpetuity.
- **Protect Medicaid Disproportionate Share Hospital (DSH) Payments (Sec. 2551).** The ACA required that state Medicaid DSH allotments be reduced, based on specified amounts, beginning in FY 2014. Congress subsequently delayed the implementation of the Medicaid DSH reductions through FY 2017 given that coverage anticipated under the ACA has not been fully realized. However, beginning Oct. 1, 2017, the Medicaid DSH cuts will take effect. Medicaid DSH payments help offset hospitals' uncompensated care costs to improve access to care and the financial stability of hospitals. Given the instability of the marketplaces and that many states did not expand Medicaid coverage, we urge Congress to further delay implementation of the FY 2018 DSH allotment reductions.

Key Delivery System Reforms

- **Fix the Hospital Readmission Penalty (Sec. 3025).** The ACA penalizes inpatient prospective payment system (PPS) hospitals for higher-than-expected readmission rates. In FY 2015 and beyond, this penalty is capped at a 3 percent reduction in Medicare payments for all Medicare discharges. The program, however, overstates the cost of excess readmissions due to a flaw in the formula embedded in the legislation. This math error should be fixed so that it penalizes hospitals for the cost of their excess readmissions rather than multiplying that amount by 1/national readmission rate for the condition (e.g., in paragraph 4(a)(ii) replacing "admissions" by "expected readmissions.").

  In addition, current law dictates that CMS must include heart attack, heart failure and pneumonia measures in this program and then allows the Department of Health and Human Services (HHS) to continue to add other conditions to this program without limit. Declines in readmissions for heart attack, heart failure and pneumonia have plateaued after several years of hard work. Further, as more conditions are added, more hospitals are penalized and the total amount of penalties grows larger. As CMS adds conditions, more hospitals approach this total penalty cap of 3 percent. Congress should limit the penalties imposed by this program by limiting the number of conditions CMS can include in the program at any one time to no

more than three, and should give the HHS Secretary the flexibility to remove heart attack, heart failure and pneumonia from the program.

- **Modify the Hospital-acquired Condition (HAC) Reduction Program (Sec. 3008).** The ACA requires hospitals in the worst-performing quartile of HACs (e.g., infections, surgical complications) to receive a 1 percent payment reduction in their total Medicare payments, including all add-on payments such as indirect medical education (IME) and DSH payments. The program, however, imposes arbitrary, excessive penalties that disproportionately fall on large and teaching hospitals caring for the sickest patients, fails to recognize improved performance, and does not effectively encourage improvement in patient safety. Given that most of the HAC measures already are used in the hospital value-based purchasing (VBP) program, Congress should eliminate the HAC program and fold it into the VBP program in FY 2018, while maintaining the budget neutrality of VBP.
- **Initiate the Hospital VBP Demonstration Program for Critical Access Hospitals (CAHs) and Small Hospitals (Sec. 3001).** The ACA requires that two demonstration programs be created – one for CAHs and one for small hospitals – to test VBP models for hospitals that do not qualify for the hospital VBP program due to an insufficient number of qualifying cases. The three-year demonstration projects were to be implemented by March 23, 2012, with a report to Congress by Sept. 23, 2016. This has not occurred. Many CAHs and small hospitals want to demonstrate their quality and efficiency through VBP approaches. But they also urge against the creation of mandatory VBP program until the significant challenges to creating fair, accurate VBP programs for their settings can be studied and addressed. Congress should direct CMS to implement a voluntary – not mandated – VBP demonstration project. Specifically, we recommend CMS develop a proposal for a demonstration program in 2018 and test it with those small and rural hospitals that volunteer to participate in 2019 – 2020. CMS should be required to provide an assessment of the program no later than June 1, 2021, and the Medicare Payment Advisory Commission should be asked for recommendations regarding the feasibility and advisability of extending the program to all small and rural hospitals by Dec. 31, 2021.

Quality & Patient Safety

- **National Quality Strategy (Sec 3011-3015, 10302-10305).** The ACA established a requirement for HHS to create a National Quality Strategy and to confer with a group of stakeholders in advance of proposing measures for its quality reporting and pay-for-performance programs. The anticipated alignment that was to be created by the National Quality Strategy and the review of measures under consideration for various public programs has not occurred. Congress should rework this language to require HHS to solicit input from stakeholder representatives, identify a small number of critically important goals for quality and safety improvement, and craft a national strategy, which would be reviewed and amended annually, to achieve these national goals. Further, Congress should require CMS to ensure that the measures it includes in reporting and pay-for-performance programs align with and support the National Quality Strategy goals.

Rural Issues

- **Make the Low-volume Adjustment Permanent (Sec. 3125).** The ACA improved the low-volume payment adjustment for FYs 2011 and 2012. For these years, a low-volume hospital was defined as one that is more than 15 road miles from another comparable hospital and has up to 1,600 Medicare discharges. This broader definition has been extended on numerous occasions, with the current extension expiring on Sept. 30, 2017. Congress should make this provision permanent.
- **Increased Payment for Ambulance Services (Sec. 3105).** The ACA extends the existing add-on payment for ground ambulance services – a 3 percent add-on for rural areas and a 2 percent add-on for urban areas – through Dec. 31, 2010. This provision has been further extended on numerous occasions, with the current extension expiring on Sept. 30, 2017. Congress should make this provision permanent.

- **Increase the Healthcare Workforce in Rural Communities (Sec 5201 – 5210).** As coverage has expanded under the ACA, many communities are experiencing shortages of qualified health care personnel to meet the increased demand for services. In particular, rural communities are experiencing a substantial demand for primary care providers, both physicians and allied health workers who are able to practice independently. Further, there is a great need for those who are qualified to staff emergency departments and provide mental health services. Congress should reauthorize the various ACA loan amounts and the loan repayment programs to increase the supply of the health care work force, especially in rural areas, and help ease the financial burden of individuals pursuing a career in health care.
- **Improve Access for Mental and Behavioral Health Through Telehealth.** In the ACA, Congress required parity in the insurance for mental and behavioral health needs and provided for significant expansion of Medicaid. The implementation of these two provisions, along with the growing opioid crisis, has greatly expanded the number of patients seeking mental health/behavioral health services. This has placed a great strain on the availability of mental health services in many areas of the country. Since enactment of the ACA, many organizations have experimented with the use of telehealth services, which can make care readily available in communities where there has been a shortage of qualified specialists. Psychiatric and other professional services to support those with mental and behavioral health needs is one of those specialties where the availability of support through telehealth has been shown to be incredibly valuable. Congress should recognize the need for this and direct the HHS Secretary to relax regulations and to work with state governments to amend their regulations to make telehealth behavioral and mental health services more readily available. Further, the Secretary should be directed to ensure appropriate payments from federal programs for such services.
- **Support the Mental Health/Behavioral Health Workforce (Sec 5203 - 5205, Sec 5306).** The ACA provided additional resources, loan forgiveness and a public health loan repayment to increase the numbers of pediatricians, pediatric specialists, allied professionals and public health workforce members. Further, support was provided to expand the number of training opportunities for mental and behavioral health workers from FYs 2010 – 2013, but more is needed to address the vastly increased demand. Congress should consider renewing the expanded support training of those professionals in mental and behavioral health for FYs 2018 – 2023.