



U.S. Senate Committee on Health, Education, Labor and Pensions
Affordable Health Choices Act
July 10, 2009

Comments of the American Medical Association

The American Medical Association (AMA) appreciates the opportunity to offer our comments on the Committee on Health, Education, Labor and Pensions' draft health system reform proposal, the Affordable Health Choices Act. We commend the Committee Members for their leadership in developing a framework to transform our nation's health care system. The AMA is committed to working with the Committee, Congress, the Administration, and other stakeholders to advance proposals that expand coverage, improve quality, reform government programs, reduce costs, increase focus on wellness and prevention, and provide payment and delivery reforms.

Health Insurance Market Reform

We strongly agree that health insurance market reforms are required to ensure greater accessibility to affordable health insurance coverage and to make the health insurance market work better for both patients and physicians. Reforms should create a more competitive insurance market in which plans compete on price and quality, and patients gain more control over their choice of health insurance coverage and their own care. The AMA supports greater national uniformity in market regulation and we support the insurance market reform provisions in Title I of the Committee's draft bill relating to guaranteed issue, guaranteed renewability, modified community rating, pre-existing condition limitations, and nondiscrimination based on health status or gender.

We also support the provisions in Title I (Part I, Sec. 2704) that require insurers to provide a clear accounting for their non-claims costs. AMA policy supports transparency to prospective enrollees and to regulatory bodies regarding reporting of medical loss ratios by insurers. Health plans should be required to report data relating to administrative costs, expenses, and rate setting to appropriate regulatory bodies so that the calculation of medical expense ratios is consistent on the state level. We recommend including in section 2704(d) that the Secretary propose a standard definition of administrative costs.

Health Insurance Exchanges—Gateways

The AMA supports the provisions in section 131 of the bill that allow individuals who currently have coverage and small employers who currently provide insurance to their employees, and who are satisfied with their coverage, to retain or renew that coverage. For those individuals who do not have access to or do not select employer-based insurance, we support establishing

state-based Gateways (exchanges), as proposed in the draft bill (section 142), to increase choice, facilitate plan comparisons, and streamline enrollment that will assist individuals in choosing coverage that best suits their needs. We are pleased that the Committee is proposing to require qualified health benefits plans to provide understandable and comparable information about their policies, benefits, and administrative costs to empower patients, employers, and other purchasers and consumers to make more informed decisions about plan choice. We also support the provisions to allow individuals to decide whether to purchase coverage either within or outside of the Gateways; however, **we recommend that affordability credits be provided to all eligible individuals, regardless of where they obtain their insurance.**

We support the delineated responsibilities of the HHS Secretary in terms of general oversight and enforcement of the operation of the Gateways and criteria for certification of qualified health plans operating in the Gateways (section 142). However, **we recommend maintaining the important regulatory role of state insurance commissioners with regard to patient protections, such as grievance procedures, external review, oversight of agent practices and training, and market conduct, as well as provider protections, especially state prompt pay laws, protections against health plan insolvency, and fair marketing practices.** While a previous version of the draft bill included language in subsection (n) of section 142 stating that “Nothing in this title shall be construed to preempt any State law regarding market conduct or related consumer protections,” the language in the Amendment dated July 1, 2009, deleted the specific reference to market conduct and related consumer protections. The text now states that nothing in the title preempts any state law that does not prevent the application of the title’s provisions. We are concerned that this language is too vague and broad, and accordingly, **we recommend that the bill language be amended to make it clear that all of the state law protections mentioned previously in this paragraph, especially those impacting patient protections, market conduct, and physician prompt pay, are not preempted and will continue to be regulated by state insurance commissioners.**

Community Health Insurance Option

As we have stated on other occasions, the AMA does not believe that creating a government-run health insurance option for non-disabled individuals under age 65 is the best way to expand health insurance coverage and lower costs across the health care system. Indeed, a reformed private insurance market, with health insurance exchanges that provide a variety of plans from which to choose, would achieve our common objective of providing access for all consumers to a broad range of coverage options.

We remain open, however, to considering alternative insurance options that would provide competition from a non-profit entity and that operates under a similar framework as the private insurance market. Any alternative should: be self-supporting and not directly administered by the government; be subject to the same solvency requirements as private plans; not receive special advantages from government subsidies; establish payment rates through meaningful negotiations and contracts; not require provider participation; and allow enrollees access to the sort of out-of-network benefits that are available in private plans. In short, we are open to exploring health system reform alternatives that are consistent with the principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. One alternative we

recommend the Committee consider is allowing individuals to have access to coverage through exchanges such as state employee purchasing pools or the Federal Employee Health Benefits Program.

We are pleased that the Committee has addressed many of our concerns with a public plan option and we consider this a positive development. The Committee's proposal for a community health insurance option would not link to Medicare rates, would not mandate physician participation, would be subject to a federal solvency standard, would operate under a similar framework as private plans, and could be administered by non-governmental, non-profit entities. However, **we recommend that the language require, not merely authorize, the Secretary to contract out the operation and administration of the public plan option to a non-governmental third-party entity.** In addition, we believe the language regarding the "contracting administrator" is ambiguous. **We recommend that the Committee clarify whether the intent is to allow the Secretary to contract with one entity that would administer the public plan option nationwide, or with multiple entities that would administer the public plans on a local basis.**

We also recommend the language be amended to clarify and ensure that enrollees have access to out-of-network services and providers, similar to what is available through private health plans where enrollees have the option to receive and pay for out-of-network services. Further, we recommend maintaining the important regulatory role of state insurance commissioners with regard to patient protections (e.g., grievance and appeals procedures, external review, oversight of agent practices and training, market conduct, etc.), as well as provider protections, including but not limited to state prompt pay laws and fair contracting practices.

Standardized Benefits

The AMA supports an alternative approach to the language proposed in Section 142 that requires the establishment of standard benefit options that plans must offer and that individuals must obtain in order to be eligible for premium subsidies. In lieu of a mandate for a particular benefit package or setting minimum benefit standards in statute, the AMA supports using existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) to assess whether a given plan would provide meaningful coverage. The AMA strongly supports patient choice of a wide variety of health plans and believes the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options, including health savings accounts (HSAs) with high-deductible health plans. We recommend that the Committee clarify whether an HSA-qualified high deductible health plan would be considered "qualifying coverage" in section 163 of the draft bill.

Affordability Credits

We support the provisions in the bill (section 151) that would provide advanceable, sliding-scale subsidies to low-income individuals who need financial assistance to purchase private health insurance. The premium assistance framework proposed in the draft bill is consistent with AMA principles that tax credits or subsidies should be inversely related to income, refundable, and advanceable, and large enough to ensure that health insurance is affordable for most people.

Individual Responsibility

The provisions in section 161 requiring individuals to have insurance coverage or pay a tax penalty are generally consistent with AMA policy. We support requiring individuals and families who can afford coverage to obtain it. Those earning more than 500 percent of the federal poverty level should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. Those who cannot afford it and do not qualify for public programs should receive tax credits or subsidies for the purchase of health insurance. Upon implementation of subsidies or tax credits for those who need financial assistance obtaining coverage, the AMA believes everyone should have the responsibility to obtain health insurance.