

## **REPORTS OF COUNCIL ON MEDICAL SERVICE**

The following reports, 1-6, were presented by Ardis D. Hoven, MD, Chair:

### **1. MEDICARE PAYMENT FOR SERVICES TO SKILLED NURSING FACILITY RESIDENTS IN PHYSICIANS' OFFICES**

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS AND REMAINDER OF REPORT FILED**

At the 2003 Annual Meeting, the House of Delegates adopted, as amended, Resolution 112. The resolution calls for the American Medical Association to "study the problems associated with a change in the Medicare skilled nursing facility (SNF) consolidated billing policy to allow physicians to bill the Medicare program directly for the technical component of services provided to SNF residents in a physician's office." The Board of Trustees referred the requested study to the Council on Medical Service for a report back to the House at the 2004 Annual Meeting.

This report describes how the consolidated billing protocol works in situations in which Medicare patients are treated in the offices of physicians during the terms of their SNF stays. Specifically, it addresses the issue of payment for the technical component of services rendered to those patients by physicians. It also summarizes the logic behind the law and its related regulations according to information received from staff at the Centers for Medicare and Medicaid Services (CMS). In addition, the report reviews the impact of the billing protocol on patient care and medical practice from the perspective of practicing physicians.

#### **MEDICARE SNF CONSOLIDATED BILLING PROTOCOL**

As part of the Balanced Budget Act of 1997 (P.L. 105-33), Congress mandated that payment for the majority of services provided to beneficiaries in a Medicare-covered SNF stay be included in a bundled prospective payment made through a fiscal intermediary to the SNF. These bundled services had to be billed by the SNF to the fiscal intermediary in a consolidated bill. Congress created the Medicare SNF consolidated billing protocol to address three perceived problems: payment by Medicare Part B to physicians for services already paid to SNFs under Part A; extra out-of-pocket liability for beneficiaries in meeting Part B coinsurance and deductible requirements; and suboptimal accountability on the part of SNFs for the coordination and oversight of the total package of care provided to residents.

The consolidated billing protocol requirement confers on the SNF responsibility for billing for the entire array of services provided to SNF residents during the terms of their stays, except for a limited number of services specifically excluded from the consolidated billing protocol by federal statute. Among those services specifically excluded are the professional services of physicians, which are separately billable to Medicare Part B. However, because diagnostic services do not appear on the list of those which are excluded from the consolidated billing protocol by statute, payment for the technical component of these services is included in the consolidated payment to the SNF. Therefore, in strict accordance with the law, the professional component of physician services to SNF residents is billable to Part B by the physician, but payment for the technical component of services provided by a physician can only be recovered by the physician from the SNF.

Medicare's normal payment rules apply once a patient is no longer deemed by Medicare to be in a Part A-covered SNF stay. The SNF stay is considered to be ended when any of the following has occurred:

- The beneficiary is admitted as an inpatient to a Medicare-participating hospital or critical access hospital, or as a resident to another SNF.
- The beneficiary has been discharged from the SNF and receives services from a Medicare-participating home health agency under a plan of care.
- The beneficiary receives emergency or other excluded outpatient hospital services.

- The beneficiary is formally discharged or otherwise departs from the SNF. However, if the beneficiary is readmitted or returns to that or another SNF before midnight of the same day, the beneficiary will still be considered to be in a SNF stay.

#### IMPACT ON CARE OF PATIENTS AND MEDICAL PRACTICE

The Council received input from several practicing physicians as to the impact of the consolidated billing protocol. In general, three types of concerns were raised:

- Excessive costs borne by the patient and family, including the burden of needless delays in care and unnecessary transportation costs. These may occur in some cases when physicians rely on SNFs to provide diagnostic services.
- Excessive costs to taxpayers, generated by the absence of alignment between the incentives of the consolidated billing protocol and the requirements of effective and efficient medical practice. These take the form of unnecessary office visits or higher-intensity office visits than would otherwise be necessary, in some cases in which physicians rely on SNFs to provide diagnostic services.
- Excessive costs borne by the physician, including uncompensated care and its unintended consequences, which may include inappropriate financial incentive to withhold care and inefficient curtailment of patients' access to those services. These may occur in some cases in which physicians themselves supply diagnostic services to SNF residents.

Many of the deficiencies of the consolidated billing protocol, as it currently stands, are well illustrated by the following example provided to the Council by a practicing orthopaedic surgeon:

The gist of the matter is that, as an orthopaedic surgeon, I cannot get the x-rays that I need when a SNF resident is transported to my office. If I do take the films in my office, I either must eat the costs or seek reimbursement from the SNF. The SNF is supposed to take films in the facility and send them with the patient. I have personally never been consulted beforehand by any SNF as to what x-ray views I might need. In reality, either the x-rays are not taken, or incorrect x-rays are taken, or the x-rays are taken, but not sent with the patient. This tends to result in longer and more frequent office visits, which generate higher costs to both Medicare and to the patient's family (e.g., unnecessary transportation costs; time lost from work while accompanying the patient). It can also result in the delay of proper care, as well as the clinical risks that arise from those unnecessary delays. As a consequence, I have many times taken the images the patient required without receiving payment.

Similarly, there is no effective and efficient process consistent with the consolidated billing protocol for obtaining x-rays for a broken wrist after I have reduced the fracture in my office. The "system" is preying upon my sense of medical commitment to "do the right thing" and take x-rays at my expense, rather than send the patient back to the SNF. In such cases, more than a week can elapse between the time when a fracture is reduced in my office and the time an incorrect reduction is detected using the follow-up x-ray that the SNF sends me, assuming that the SNF ever does send me the x-ray. The unnecessarily lengthy and high number of visits that stem from compliance with the consolidated billing protocol generate needless additional expense to Medicare and reduce the amount of time that I can spend giving care to other patients. As the number of doctors who treat Medicare patients decreases, those of us who are still in the trenches need to operate efficiently.

In fact, physicians may face two basic choices, either of which may have adverse implications for patients, physicians, and for Medicare. The physician may choose to provide the appropriate standard of care to the SNF patient at his or her own expense, which is inequitable to the physician, causes health care resources to be used inefficiently, and creates unintended incentives to withhold appropriate care. Alternatively, SNFs may provide the services themselves. But not all SNFs have the resources and administrative systems in place to do so as efficiently or effectively as physicians can in their own offices. In some cases, this may generate lower quality for the patient or higher costs to both the patient and to Medicare.

## PROBLEMS WITH CHANGES TO THE SNF CONSOLIDATED BILLING PROTOCOL

In reviewing these issues with staff from the CMS Division of Medicare Operations, the Council obtained important information bearing on the matter of changes to the consolidated billing protocol. The most important of these is that it is not within the authority of CMS to revise the statute, so advocacy to promote revision of the statute must be directed toward the US Congress.

In advocating revision to the statute, the issue of double payment must be addressed. The consolidated per diem payments to SNFs are adjusted according to the Resource Utilization Group assignment of the patient. These assignments are used to vary the consolidated payment amount in consideration of the expected intensity of resource utilization of each resident. So, in principle, the additional resources used by patients who require outside services are reflected in payments already made to the SNF. Payment to physicians by Part B for the technical component of services provided to these patients would, according to Medicare, constitute double payment for the service.

In addition, appropriate care would need to be taken to ensure that appropriate funding resources follow any shift in the mechanism by which physicians are to be paid for the technical component of their services to SNF residents. Specifically, any revision to the statute which would result in the exemption of payment of the technical component of physicians' services from the SNF consolidated billing protocol must also ensure that the funds allocated to the consolidated bundle of services to SNF residents be reallocated from Part A to Part B.

## RELEVANT AMA POLICY

Policies H-390.866 and H-390.970 (AMA Policy Database) are generally consistent with the intent of Resolution 112 (A-03) in that they oppose CMS implementation of a payment methodology that consolidates facility and physician components in a single prospective payment.

## DISCUSSION

Although the SNF consolidated billing protocol was created by Congress to address three perceived problems, a strong case can be made that the consolidated billing protocol is not an appropriate or effective means of addressing those problems, and that in some cases, it may create more problems than it attempts to resolve. The problem of payment to physicians under Part B for services already paid to SNFs under Part A is no longer an issue for Medicare, since Part A and Part B billing systems are now linked together and automatically reject the duplicative Part B claims. As to the argument that beneficiaries are exposed to increased liability for Part B coinsurance and deductibles, it is difficult to identify many scenarios in which large dollar values would attach to these added liabilities. For example, it is likely that many Medicare SNF residents exhaust their annual Part B deductibles, whether or not payment for the technical component of medical services provided by physicians were billed to Part B.

While the beneficiaries' coinsurance liability for those services would be greater absent the consolidated billing protocol, the increment would be very small in most cases. The patient's extra copayment liability would be calculated as 20% of the Medicare allowed amount for only the technical component of the service. For example, average incremental coinsurance payments for the technical components of ankle (CPT code 73610), wrist (CPT code 73110), and hip x-rays (CPT code 73510) would amount to only \$4.05, \$4.05, and \$4.41, respectively. The Council is sensitive to the fact that every incremental financial liability to beneficiaries, no matter how small, is of some significance. However, the Council also recognizes that these small increments are more than offset by the benefits that accrue to beneficiaries and their families when their health care services are delivered in the appropriate setting, at the time they are needed, by appropriately qualified medical staff.

The consolidated billing protocol also was intended by Congress to create a financial incentive for SNFs to meet their responsibility to oversee, coordinate, and account for the total package of care provided to its residents. The Council finds that this objective, though laudable, is not effectively or efficiently achieved, either in principle or in practice, through the implementation of the consolidated billing protocol. The theoretical limitation is obvious. Medicare SNF residents would not look to their physicians for acute or follow-up services if they could obtain the same services without having to leave the SNF. It makes just as little sense for their treating physicians to look to the SNF for partial payment of those services, when those services have nothing to do with the SNF. It appears that the presumption that SNFs are, or should be, capable of and responsible for providing or overseeing the complete

packages of their residents' care, is not always consistent with the actual clinical, financial, and administrative capabilities of some SNFs or the medical needs of some of their residents. Furthermore, although CMS believes that revision of the consolidated billing protocol statute may lead to the problem of double payment for services to SNF residents, the potential for double payment would be eliminated by the reallocation of the funds that pay for those services from Part A to Part B.

Based on its review of the experiences of several practicing physicians, the Council also believes that the consolidated billing protocol potentially results in adverse implications for the care of patients, medical practices, and conservation of precious health care resources. Specifically, the consolidated billing protocol may contribute to delayed or forgone patient care, inequitable reimbursement to physicians, and/or excessive costs to patients, their families, and taxpayers. Therefore, the Council believes that the AMA should undertake several actions to rectify the problems of nonpayment for the technical component of the services physicians provide to SNF residents. First, the AMA should communicate with CMS about the problem and propose a collaborative approach to remedial action. Second, CMS should be encouraged to improve its oversight and enforcement of SNFs' compliance with their Medicare Provider Agreements, specifically as they relate to payment to physicians for their services to SNF residents. Finally, due to the unintended consequences of the statute cited above and the lack of authority on the part of CMS to revise the statute, the Council believes the AMA should seek Congressional revision of the statute to exempt the technical component of medical services provided to SNF Part A residents in physicians' offices from the consolidated billing protocol.

#### RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association inform the Centers for Medicare and Medicaid Services (CMS) of the problems physicians and their patients experience as a result of the inclusion of the technical component of physicians' office-based services in the consolidated billing protocol for Medicare Skilled Nursing Facility residents.
2. That our AMA urge CMS to provide greater oversight of Medicare Skilled Nursing Facilities (SNFs) in meeting their obligations to pay physicians for the technical component of services those physicians provide in their offices to Medicare SNF residents.
3. That our AMA advocate to Congress that it exclude from Medicare's SNF consolidated billing protocol the technical component of medical services provided in physicians' offices to Medicare SNF residents, because of concern with the negative impact on care that could potentially occur.
4. That our AMA urge CMS to require SNFs to clearly identify those patients who fall under the Medicare SNF consolidated billing program, as opposed to non-skilled extended care facility (ECF) patients, prior to sending patients to physicians' offices for care.
5. That our AMA communicate to physicians that in order to assure payment whenever a SNF resident receives a service that is subject to SNF consolidated billing, the SNF and the physician are required to enter into an arrangement prior to providing services and the physician must look to the SNF for payment.

## **2. COMPARING HEALTH INSURANCE PREMIUM SUBSIDIES AND TAX CREDITS (RESOLUTION 108, A-03)**

### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 108 (A-03) AND REMAINDER OF REPORT FILED**

At the 2003 Annual Meeting, the House of Delegates referred Resolution 108, which was introduced by the Medical Student Section and calls for the AMA to “expand health system reform efforts to integrate other federal health insurance premium subsidies in addition to refundable tax credits for attaining universal health care.” The Board of Trustees referred Resolution 108 (A-03) to the Council on Medical Service for study.

#### **BACKGROUND**

Testimony regarding Resolution 108 (A-03), as described in the relevant Reference Committee report, supported referral because of potential misunderstanding of the term “other federal health insurance premium subsidies.” One of the whereas clauses in the preamble of Resolution 108 (A-03) states that “In proposals for universal health access, the largest medical societies advocate health insurance premium subsidies beyond refundable tax credits, including direct federal subsidies (vouchers).” It was noted by the Reference Committee that “other subsidies” also could be interpreted as federal health program eligibility expansions, which would conflict with Policy H-165.920[17] (AMA Policy Database), which supports tax credits over public sector expansions as a means of providing coverage to the uninsured.

This report describes the many forms in which health insurance is and can be subsidized, reviews relevant AMA policy, delineates health insurance tax credits as advocated by AMA policy, and concludes that health insurance premium subsidies is a broad term that can be useful to further the AMA goal of fostering individually owned health insurance.

#### **HEALTH INSURANCE SUBSIDIES**

The concern raised in Resolution 108 (A-03) is largely one of the often imprecise nomenclature for describing health insurance subsidies. Subsidies for health insurance take many forms, some of which incorporate or overlap with other forms. Those with employment-based coverage, who are self-employed and purchase coverage individually, or who are eligible for public sector programs, are all entitled to public subsidies for health insurance. In general, people who are uninsured, or who purchase coverage individually and are not self-employed, do not receive government health insurance premium subsidies.

##### *Premium Subsidies*

Premium subsidies are the most general form of subsidy. Generally, premium subsidies are not used to purchase health care items or to cover patient cost-sharing obligations. Rather, premium subsidies are oriented toward the payment of health insurance premiums. Premium subsidies can be structured as risk-based vouchers or tax credits. Conversely, premium subsidies can be funded by such mechanisms as vouchers or tax credits.

For example, premium subsidies are used to subsidize the premiums of employment-based coverage in the form of a defined contribution or as used in the Federal Employee Health Benefits Program (FEHBP). They also have been proposed to subsidize beneficiary costs for participating in Medicaid buy-in programs and to subsidize premiums for individually-based or COBRA group coverage premiums, as exemplified with the Health Coverage Tax Credit program created by the Trade Act of 2002, and described in Council on Medical Service Report 11-A-03.

##### *Tax Deduction*

Tax deductions decrease the taxable income on which individuals pay income taxes and do not affect other payroll taxes. Tax deductions provide unequal benefit per dollar spent because the benefit varies by tax rate. An example of how tax deductions can be used to subsidize health insurance involves self-employed individuals, who can deduct the full cost of their health insurance.

*Tax Exclusion*

Tax exclusion decreases taxable income on which individuals pay both income and payroll taxes. Currently, the purchase of health insurance through employment is an example of the tax exclusion subsidy because the employer's share of the costs is excluded from taxable income for employees. This tax exclusion is only available to those who have employment-based coverage, and is viewed by many as being socially inequitable because it provides a higher subsidy for those who pay higher tax rates. Two-thirds of the estimated \$100 billion subsidy goes to the one-third of Americans with the highest incomes. It is a transparent subsidy as most who receive it are unaware they have it, and they do not need to do anything to activate it.

*Tax Credits*

Tax credits can be allotted to individuals and allow for individual ownership of health insurance, the philosophical cornerstone of the AMA proposal for health system reform. AMA support for tax credits grew out of the fundamental goal to improve the choice and power of individual patients by lessening employer and government control over individual choices and de-linking health insurance from the realm of employment. As envisioned by the AMA, tax credits should be refundable and advanceable. Refundable tax credits can benefit those who owe no taxes. They could be structured simply as a check from the government in the amount of the tax credit due to the individual. Advanceable tax credits would be distributed independently of the typical tax reconciliation process, which happens at year's end. Making tax credits advanceable enables low-income individuals to afford monthly premium costs.

Tax credits put the means for purchasing health insurance at the disposal of individuals, regardless of whether they have employment-based coverage or any tax liability. The poorest individuals with no option for employment coverage and who do not qualify for Medicaid would receive some of the largest tax credits. Tax credits can be designed as premium subsidies, vouchers, or other subsidy forms.

*Vouchers*

Vouchers may be a simpler mechanism to deliver subsidies to low-income individuals than tax credits, as addressed in Policy H-165.867. Vouchers can have the same impact as tax credits that are refundable and advanceable, and they can be used either for defined contribution or defined benefit models. They are for use only for the purpose for which they are intended and can take on many forms, such as debit cards or coupons. The Food Stamp Program is one example of how voucher programs are used to provide public funding to eligible individuals.

*Risk-Based Subsidies*

While the subsidies discussed above are based on income or premium costs, subsidies also can be tied to the health risks of individuals. With the adoption of principles outlined in Policy H-165.856 and detailed in Council on Medical Service Report 7-A-03, the AMA supports risk-based subsidies for "uninsurable" individuals, who require special, targeted policies in order to both subsidize their coverage and ensure that health insurance is affordable for the general population. In particular, Policy H-165.856[3] states that risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.

*Public "In-Kind" Program Subsidies*

Health insurance also is subsidized through public sector entitlement programs, such as Medicare and Medicaid, for certain populations. Medicare and Medicaid beneficiaries receive covered health care services as a direct "in-kind" subsidy. The services they receive are publicly financed so long as they continue to meet the eligibility requirements.

**AMA POLICY**

The current AMA proposal for health system reform is based on extensive policy adopted by the House of Delegates. There are various policies that delineate the proposal for individually owned health insurance using a system of tax credits and defined contributions. Chief among these policies is Policy H-165.920.

Policy H-165.920[3a] supports providing employers with the same tax treatment whether the employer provides health insurance coverage for employees or provides a defined financial contribution that employees can use to purchase individually selected and individually owned coverage; [5] supports individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage; [6] supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; [12] supports a replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; and [17] believes that tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured.

Policy explicitly supports the use of vouchers as one mechanism to distribute tax credits to those with low incomes. Policy H-165.887[2] supports efforts to move patients in public programs into the private sector, through the implementation of vouchers or other mechanisms, thereby enabling individual patients to participate in the prioritization of their health care services. Additionally, Policy H-165.867 advocates that organizations such as local welfare agencies and/or other appropriate entities be authorized to verify income status and issue vouchers immediately for the amount of tax credits due individuals; thus advancing funds to purchase the coverage for low-income persons who could not afford the monthly out-of-pocket premium costs.

Policy H-165.865[1] outlines AMA principles for structuring health insurance tax credits. According to that policy, tax credits should be contingent on the purchase of health insurance, refundable, of a size that is inversely related to income, large enough to ensure that health insurance is affordable for most people, and capped in any given year, among other things. In addition, Policy H-165.865[2] states that, in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as such expenses are defined by Title 26 Section 213(d) of the United States Code.

Policy H-165.856 supports a number of principles for health insurance market regulation in order to generate more stability, affordability, and uniformity of individually owned health insurance.

Policy H-165.855 supports converting the medical care portion of the Medicaid program to a program of federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the FEHBP. Cost-sharing obligations should be based on income, with no cost-sharing obligation for those who would otherwise qualify for mandatory Medicaid eligibility and with moderate cost-sharing for low-income individuals who would not otherwise qualify for Medicaid.

#### TAX CREDITS ADVOCATED BY THE AMA

Just as there is variation in methods of subsidization, there is variation among tax credit proposals and designs. Some tax credits, such as the Health Coverage Tax Credit (HCTC) described earlier, are based on a set percent of premium costs. Others provide a flat amount for individuals and a higher amount for families, with the tax credit phasing out at some predetermined income level. The tax credits proposed by the AMA resemble such proposals only to the extent that they use the same mechanism for delivering the tax credit subsidy. The HCTC provides an active example of how tax credits can function as premium subsidies. The HCTC was designed to pay for up to 65% of qualified health plan premiums. Therefore, the HCTC is very mindful of subsidizing premium costs.

Tax credits as advocated by the AMA (i.e., refundable and advanceable) would be direct federal subsidies to individuals. This could take the form of direct vouchers for those with low incomes as previously described. Policy H-165.867 established the principle that tax credits should be advanceable, and states that appropriate entities could be authorized to verify income status and issue vouchers immediately for the amount of tax credits due individuals; thus advancing funds to purchase the coverage for low-income persons who could not afford the monthly out-of-pocket premium costs.

As such, tax credits as advocated by the AMA are simply one way to subsidize the health insurance costs of those most in need of financial assistance. In particular, the AMA believes that subsidies should be directed at individuals regardless of employment, or the availability of employment-based coverage, in order to provide true portability and patient freedom of choice. In addition, the AMA believes the subsidy should be inversely related to income, refundable, and advanceable in order to respond first and foremost to the needs of those with the lowest incomes.

## DISCUSSION

The distinction between health insurance premium subsidies and health insurance tax credits can be viewed in both theoretical and practical terms. Premium subsidies can encompass any financial support toward the cost of health insurance premiums. Accordingly, health insurance tax credits are one type of premium support.

The current regressive exclusion of employer expenses toward employment-sponsored health insurance from the taxable income of employees is also a premium subsidy. Tax credits as advocated by the AMA are simple. The theoretical underpinning of AMA support for tax credits is individual choice by patients. The tax credits advocated by the AMA, therefore, are not for employers, but for individuals, regardless of employment status. The practical advantage of individual ownership is that health insurance belongs to the individuals, thus creating true portability, expanding individual choice, and fostering real patient cost-consciousness.

In practical terms, “premium subsidy” is generally used to advocate financial support for the employees’ costs for employment-sponsored insurance, and particularly to improve the take-up rate of uninsured employees who forego coverage because they cannot afford their share of the premiums. Tax credits for health insurance premiums also meet this practical definition of premium subsidy because tax credits, whether provided to employers or individuals, subsidize the cost of the premium.

The concern raised in Resolution 108 (A-03) is largely a problem with nomenclature. The Council believes that the use of the term “tax credits” continues to be the most accurate and precise nomenclature for the purposes of strongly advocating that health insurance coverage should be chosen by the individuals being covered. Tax credits are flexible and can be administered through a number of payment mechanisms. Tax credits are also the term and method being used in current legislative proposals. Moreover, AMA policy supports the use of vouchers to foster private and individually owned health insurance. Nonetheless, the Council is sensitive to the myriad of ways in which the AMA can accomplish its policy goals and, therefore, supports the use of various subsidy forms toward the goal of enabling individuals to purchase individually owned health insurance.

As articulated in Council on Medical Report 7-A-03, there is sufficient evidence that with appropriate regulations and public policies, the individual and nonemployer group markets can flourish with safeguards for high-risk individuals and widespread choice of affordable coverage for the general population. In addition, Council on Medical Service Report 1-I-03 emphasized that the model of coverage for low-income tax credit recipients should be the same coverage available to members of Congress (i.e., FEHBP).

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108 (A-03) and the remainder of this report be filed:

1. That our American Medical Association support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits (Policy H-165.865) and when designed to enable individuals to purchase individually owned health insurance.
2. That the AMA Communications Department develop a simple, understandable glossary of terms in Council on Medical Service Report 2-A-04, including, but not limited to, refundable and advanceable tax credits.

### **3. FEDERAL HEALTH INSURANCE RESERVE SYSTEM (RESOLUTION 110, A-03)**

#### **HOUSE ACTION: RECOMMENDATION ADOPTED IN LIEU OF RESOLUTION 110 (A-03) AND REMAINDER OF REPORT FILED**

At the 2003 Annual Meeting, the House of Delegates referred Resolution 110, which was introduced by Robert D. Burnett, MD, a California Delegate. Resolution 110 (A-03) asked that our American Medical Association endorse a system embodying an extensive list of Congressional actions pertaining to the development of a stable health care financing system for the nation. The Board of Trustees referred Resolution 110 (A-03) to the Council on Medical Service for study. The full text of Resolution 110 (A-03) appears below in the policy section of this report, in the form of a “crosswalk” with relevant existing policies.

#### **BACKGROUND**

Dr. Burnett is a former member and chair of the Council on Medical Service. The Council commends Dr. Burnett for his innovative and thoughtful proposal, which was published in the journal *Pediatrics*.

Briefly, Resolution 110 (A-03) calls for: (1) individually owned health insurance, with individuals mandated to purchase coverage and with subsidy of individual coverage to be in the form of tax-deductible defined contributions and tax credits inversely related to income; (2) the bifurcation of Medicaid; (3) financing the Medicare system as a forced savings or investment program; (4) allowing balance billing; and (5) creation of a Federal Health Insurance Reserve System (FHIRS) to be independent and isolated from politics and special interests in order to advance the health care of the United States.

The FHIRS would: (1) promote patient and physician freedom of choice, equality and justice; (2) specify which benefits are covered and at what levels; (3) determine tax credit levels; (4) require each plan to disclose details of its benefit package; (5) conduct national clinical trials for new procedures; (6) vary the tax treatment of non-deductible copayments for services, depending on the growth of health care system spending and to keep within the budget specified by Congress; (7) require full disclosure of hospital charges, with hospitals being required to charge the same rate for all payers, but able to set their own schedule of charges; (8) require full disclosure of all physician fee schedules and credentials on the Internet; (9) develop a risk adjustment premium modifier for each insurer with the FHIRS being able to transfer premiums on the basis of risk selection in order to change or alter the incentive that often exists for insurers to enroll healthier populations; (10) set priorities for spending, particularly on costly remedies; and (11) supervise negotiations between groups of physicians and insurers in all matters of insurance coverage.

As noted in a communication to the Council from Dr. Burnett, many components of the proposal outlined in Resolution 110 (A-03) are already embodied in AMA policy. The outstanding issues raised in Resolution 110 (A-03) that are not addressed in policy or conflict with policy include mandating “universal compulsory catastrophic health insurance” and the creation of a “federal health insurance reserve system.” The Council is currently studying the merits of an individual mandate within the context individually owned health insurance.

As a result, the Council has focused this report in response to Resolution 110 (A-03) on the merits of creating a federal health insurance reserve system. The report provides a “crosswalk” of Resolution 110 (A-03) with relevant AMA policy, describes the history and function of the Federal Reserve Board, and discusses the merits of establishing a federal health insurance reserve system. An Appendix of all the cited policy is included.

#### **CROSSWALK OF RESOLUTION 110 (A-03) WITH AMA POLICY**

Below is the actual language of Resolution 110 (A-03). Following each point is the citation for related AMA policy and directives, which appear in parentheses. The policies and directives that are cited can be found in the Appendix. As previously noted, the proposal is highly consistent with AMA policy. Resolution 110 (A-03) asked:

“That our American Medical Association endorse a system embodying the following Congressional actions:

1. To eliminate employer purchase or partial purchase of health insurance for employees and encourage a voluntary defined contribution by the employer that is tax deductible. *(Policy H-165.920 supports moving toward a system of individually selected and owned health insurance, while Policy H-165.983[1] endorses the concept that employers provide a defined contribution for the purchase of health insurance.)*
2. To mandate Universal Compulsory Catastrophic Health Insurance and additional basic coverage for all children, both governmentally subsidized for the poor. *(Policy H-165.920[15] supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage. The issue of an individual mandate is currently under reconsideration by the Council. Policy H-165.882 places particular emphasis on advocating policies and proposals designed to expand health insurance coverage to presently uninsured children in accordance with AMA policy to use tax credits for individually owned health insurance.)*
3. To provide tax credits inversely related to income for the purchase of health insurance by the individual (defined contributions that are not used to purchase qualified health insurance plans would be taxable as ordinary income). *(Policy H-165.865 supports a series of principles for structuring health insurance tax credits, including that they be in amounts that are inversely related to income.)*
4. To bifurcate Medicaid and make the medical portion a national program with national benefits and national funding and leave long term care to the states. *(Policy H-165.855 recommends federalizing the cost of treating acute care Medicaid patients. Long-term care financing is an ongoing item of study by the Council on Medical Service.)*
5. To change the financing of the Medicare system from its present cross-generational financing scheme to a forced savings or investment program. *(Policy H-165.987[1] supports a shift in the funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually-owned private savings.)*
6. To require that hospital and pharmaceutical outlets that receive payments from any insurance policy involving tax credits to the patient or payments from other government subsidized programs invoke an all payer system for the same service allowing each hospital or pharmacy to have its own rate structure. *(This point would fall under the rubric of the FHIRS. See point 9[h] of Resolution 110 [A-03] below.)*
7. To allow balance billing in tax favored programs, provided patients are informed and the amount of balance bill is posted on the Internet. *(Policy H-385.991 supports the right of physicians to balance bill.)*
8. To set the amount of decrease in income that the government can afford from providing tax credits; the amount of funding allocated to pay for the basic medical care package along with the catastrophic coverage for those on Medicaid or below a stipulated poverty level and the increased expense incurred by the Federal Government in transitioning Medicare to a forced savings program (versus keeping the old program while those under 40 are in the new forced savings program) and to transmit to the Federal Health Insurance Reserve System the amount that the government is willing to subsidize and forgo from tax credits. *(Policies H-165.855 and H-165.987 support the Medicaid and Medicare transitions, respectively. As stated in the language of the resolution, this point would be a function of the FHIRS and is addressed below.)*
9. To create a Federal Health Insurance Reserve System (FHIRS) to be independent with the board appointed by the President from districts approved by Congress and isolated from politics and special interests in order to advance the health care of the United States, with the following duties:
  - (a) Promote freedom of choice, equality and justice for patients and physicians. *(Policies H-165.920[7] and H-380.994, among many others.)*
  - (b) Specify benefits to be included in the mandated catastrophic policies and the basic health insurance policies for those on Medicaid or below a certain percentage of the poverty level, as well as those required for children. The subsidized benefits are to keep within the fiscal constraint set by Congress. *(Although the AMA standard and minimum benefit packages are still contained in the AMA Policy Database, more recent Policy H-185.964 limits support for benefit mandates. Policy H-165.855 advocates that low-income individuals be provided with tax credits that enable them to purchase coverage modeled after the Federal Employees Health Benefit Program.)*

- (c) Specify benefits qualifying for maximum tax dollars as determined by Congress. (*Policy H-165.865[2] addresses qualifying expenses for tax credits.*)
- (d) Determine the percentage of maximum tax credit for which each plan qualifies. (*Under Policy H-165.920, individuals, not plans, would qualify for tax credits, and under Policy H-165.865 the amount of tax credit is determined by income of the individual, not any quality of the plans chosen by individuals.*)
- (e) Require detailed disclosure by insurers of each plan's benefit package to prospective buyers including such items as the method by which the insurer pays various providers and that the disclosure statement be approved by the FHIRS so that buyers can be clearly knowledgeable before purchase. (*Policy H-285.998[5] advocates that all health plans should be required to clearly and understandably communicate to enrollees and prospective enrollees, in a standard disclosure format, the level of coverage, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients.*)
- (f) Conduct national clinical trials for new procedures to determine their tax deductibility status. (*Appears to be within the purview of existing federal agencies, such as the Agency for Healthcare Research and Quality [AHRQ] and the Centers for Disease Control and Prevention.*)
- (g) Vary tax (on) non-deductible copayments for services, depending on the growth of health care system spending and to keep within the budget specified by Congress. (*This point should be considered within the context of the FHIRS and is not addressed in policy.*)
- (h) Require full disclosure of rates by hospitals in a system where a given hospital charges the same rate for all payers, but in which each hospital has its own schedule of charges, all posted on the Internet. (*Policy H-240.999 urges hospitals to adopt pricing policies that relate the charges to actual costs and to group these services in the general service charge or room rate consistently from one hospital to another so as to simplify comparison.*)
- (i) Require full disclosure of all physicians' fee schedules posted with credentials on the Internet. (*Policies H-385.989[2b], H-385.990, and H-400.960[c] state that there should be advance disclosure of physician and all other provider fees and charges and plan payments.*)
- (j) From a simple confidential health questionnaire filled out by all enrollees that specifies the insurance plan they selected, FHIRS is to develop a risk adjustment premium modifier for each insurer with the FHIRS ability to transfer premiums on the basis of risk selection in order to change or alter the incentive that often exists for insurers to enroll healthier populations. (*Policy H-165.856 recommends mechanisms for risk adjustment and risk rating.*)
- (k) On the basis of scientific investigation, professional and public input, set priorities for spending, particularly costly remedies. (*This is a goal of the Congressional Budget Office, the Medicare Payment Advisory Committee, AHRQ, and other agencies.*)
- (l) Supervise negotiations between groups of physicians and insurers in all matters of insurance coverage." (*Policy H-385.976 supports physician collective bargaining.*)

## FEDERAL RESERVE SYSTEM

In assessing the merits of a federal reserve system, the Council reviewed the history and function of the Federal Reserve Board. Created by the Federal Reserve Act of 1913, the Federal Reserve Board was intended to provide a safer, more flexible, and more stable monetary and financial system. Prior to the Federal Reserve Board's creation, the nation suffered periodic "financial panics" that led to bank failures, bankruptcies and economic downturns. Following a severe financial crisis in 1907, Congress established the National Monetary Commission, which envisioned an institution with the stabilizing function that eventually became the Federal Reserve Board.

The role of the Federal Reserve Board has evolved over the years so that today its duties fall into the following four areas: (1) developing the nation's monetary policy by influencing money and credit conditions in the economy to achieve full employment and stabilize prices; (2) supervising and regulating banking institutions to ensure the safety and soundness of the nation's banking and financial system and to protect the credit rights of consumers; (3) maintaining the stability of the financial system and containing systemic risk that may arise in financial markets; and (4) providing certain financial services to the US government.

The Council does not believe, however, that there is a parallel between the banking and financial markets a century ago and the health insurance markets of today. Indisputably, the relentlessly high number of uninsured Americans constitutes something of a financial crisis that will be costly for society to address, just as the financial crises early in the 20th century caused monetary turmoil. Yet, the current health care delivery system is functioning, whereas the

Federal Reserve Board was established to address the complete failure of the banking system in the early 20th century. The major problem for the United States is that health care is not appropriately and efficiently financed. For example, a majority of Americans currently receive health insurance through their employers with the aid of a regressive tax subsidy.

Applying the FHIRS to all Americans, including those who are content with their existing coverage, could engender deep patient dissatisfaction with the health care system. Many Americans will recall the comprehensive health reform plan proposed by President Clinton in the early 1990s, which included an oversight board that generated a strong negative response. The size and power of the proposed FHIRS also could potentially undermine its laudable goal of being apolitical.

## DISCUSSION

While it is clear that many of the goals of the proposed FHIRS are consistent with current AMA policy, the Council is concerned that the complex and increased bureaucracy of a federal health insurance reserve board would hinder rather than facilitate the implementation of those goals for health system reform. On balance, the Council believes that it would be better to accomplish the goals of such a board without actually creating the board.

The Council believes that the FHIRS proposal would change much more than is necessary to accomplish many of the goals outlined in Resolution 110 (A-03). In particular, the FHIRS proposal would: (1) be expensive to establish; (2) specify a "one size fits all" benefits package; (3) require increased bureaucracy; (4) establish a board that would potentially need to work in secret in order to remain apolitical; (5) duplicate work, such as clinical trials, being done by other agencies; and (6) involve such a high level of micromanagement that medical innovation could be diminished.

The AMA has developed a proposal to greatly expand health insurance coverage in a manner that is highly consistent with the majority of the concepts described in Resolution 110 (A-03). Both are comprehensive proposals to expand health insurance coverage and increase patient choice. The Council also believes that a more uniform, national approach to health insurance market regulation as previously detailed in Council on Medical Service Report 7-A-03 (Policy H-165.856), would lead to expanded health insurance coverage and choice. Such a regulatory approach would improve health insurance market function whether in the context of the existing, predominantly employment-based health care system, or an individually based system as proposed by the AMA.

The Council continues to believe that the goals of expanding health insurance coverage and choice, using a system of tax credits and market regulation, should be a high priority for the AMA, particularly during the 2004 political campaign process.

## RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 110 (A-03) and the remainder of the report be filed:

That our American Medical Association continue to make the expansion of individual health insurance coverage and choice, using a system of tax credits and improved market regulation, a priority throughout the 2004 political campaigns and beyond.

## APPENDIX - AMA POLICIES AND DIRECTIVES RELEVANT TO RESOLUTION 110 (A-03)

### *H-120.975 Certifying Indigent Patients for Pharmaceutical Manufacturers' Free Drug Programs*

Our AMA: (1) compliments the Pharmaceutical Research and Manufacturers of America (PhRMA) on its programs for indigent patients and encourages the PhRMA to develop a universal application process and eligibility criteria to facilitate enrollment of patients and physicians in all the programs providing pharmaceuticals to indigent patients that are provided by pharmaceutical manufacturers; (2) encourages the PhRMA to provide information to physicians and hospital medical staffs about the members of PhRMA that provide pharmaceuticals to indigent patients; (3) (a) urges drug companies, through the PhRMA, to accelerate the development of user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications. The process should not require physician participation beyond providing the prescription and individual patients, once

certified, should be able to obtain medications from the pharmacy of choice; and (b) encourages pharmaceutical manufacturers to expand their already generous free drug programs for the indigent; (4) encourages physicians to facilitate the expansion of free drug programs for the indigent by declining to receive noneducational promotional materials from drug manufacturers and by urging that the funds otherwise spent on such materials be redirected to support expanded free drug programs for the indigent; and (5) will continue to meet with the PhRMA to develop more uniform, universally accepted, rapid mechanisms for physicians to request and obtain useful quantities of medications from American pharmaceutical companies for use by indigent patients. (Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02)

#### *H-165.855 Medical Care for Patients with Low Incomes*

It is the policy of the American Medical Association (AMA): (1) that the medical care portion of the Medicaid program should be financed with federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP), with varying cost-sharing obligations based on income and eligibility under the current Medicaid program as described below: (a) Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive tax credits that are large enough to enable them to purchase coverage with no cost-sharing obligations; and (b) Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive tax credits that are large enough to enable them to purchase coverage with limited cost-sharing; (2) that individuals who do not qualify for Medicaid, and have resources that are insufficient to purchase health insurance, should receive federally issued tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing; (3) that, in order to assure continuity of care, there should be a seamless mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family; (4) that tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area until the next enrollment opportunity; (5) to support the development of a safety net mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care; (6) that state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available as either a mandatory or optional services under Medicaid, but are not medical benefits per se; and (7) that as individuals in the acute care population transition into chronic care needs, they should be eligible for sufficient additional subsidization to allow them to maintain their current coverage.

#### *H-165.856 Health Insurance Market Regulation*

Our AMA supports the following principles for health insurance market regulation: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection; (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges; (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium; (5) Insured individuals should be protected by guaranteed renewability; (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices; (7) Guaranteed issue regulations should be rescinded; (8) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and (9) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03)

*H-165.865 Principles for Structuring a Health Insurance Tax Credit*

(1) Our AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits, be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided; (b) Tax credits should be refundable; (c) The size of tax credits should be inversely related to income; (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people; (e) The size of tax credits should be capped in any given year; (f) Tax credits should be fixed-dollar amounts for a given income and family structure; (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums; (h) Tax credits for families should be contingent on each member of the family having health insurance; (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified MSA, and not for out-of-pocket health expenditures. (2) It is the policy of the AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as such expenses are defined by Title 26 Section 213(d) of the United States Code. (CMS Rep. 4, A-00; Reaffirmation I-00; Reaffirmation A-02)

*H-165.882 Improving Access for the Uninsured and Underinsured*

Our AMA recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access. Improving Access for Uninsured Children Our AMA: (1) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children in accordance with AMA policy 165.920(2) the AMA recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (2) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (3) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (4) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct purchase by families; (5) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (6) advocate that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits that meet the standards of the AMA standard benefit package; (7) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (8) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (9) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (10) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; (11) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated 3 million children currently eligible for but not covered under this program. Improving Access for All Uninsured Persons Our AMA: (12) will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage; (13) encourages state medical associations to seek the introduction of or support legislation requiring the use of community rating bands in the individual policies made available under provisions of the Health Insurance Accountability and Portability Act of 1996 (PL 104-191) in all states presently without rating restrictions on such individual policies; (14) supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total

number employed; (15) through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope. (CMS Rep. 7, A-97; Reaffirmed and Amended by CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Modified: BOT Rep. 17, I-00; Reaffirmation A-02)

#### *H-165.920 Individual Health Insurance*

Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, the AMA will: (a) Support legislation that would provide the employer with the same tax treatment for payment of health expense coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health expense coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health expense coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; and (e) To ensure that the health insurance plan purchased by the individual employee is sufficient to provide a basic level of health care and does not increase the probability that the employee will become uninsured, the AMA would work toward the establishment of the following guidelines: (i) minimum benefit requirements, including catastrophic protection, (ii) fiscal solvency of the plan, (iii) provision of basic consumer information, (iv) protection of the consumer from fraud, (v) guaranteed issue, (vi) guaranteed renewability, and (vii) rate reform; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health expense coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) strongly supports legislation promoting the establishment and use of medical savings accounts (MSA)s and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance; (8) continues to place a high priority on enactment of federal legislation to expand opportunities for employees and others to individually own health insurance through vehicles such as medical savings accounts; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health expense coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health expense coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; (13) encourages continued experimentation with and monitor the success of approaches to minimizing or compensating for adverse selection

among the individually purchased and owned health expense plans available, including risk adjustment across plans, reinsurance pools, and limiting enrollment and disenrollment opportunities through such mechanisms as multi-year policy contracts; (14) upon legislative enactment of Policy H-165.920(3a) and Policy H-165.920(6), the AMA should rescind Policy H-165.995(2)(a), which calls for tax code changes to allow persons paying the entire premium for their health insurance to deduct the full cost of their premium separately from their gross income; (15) supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage; (16) seeks federal legislation to rescind Internal Revenue Service tax regulations requiring annual forfeiture of unspent funds in employer provided flexible spending accounts; and (17) believes that tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured. (BOT Rep. I-93-41; CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation; Reaffirmed: CMS Rep. 1 and 3; Appended: CMS Rep. 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03)

#### *H-165.983 Covering the Uninsured*

The AMA (1) endorses the concept that employers provide a defined contribution for the purchase of health expense coverage within the private sector for all full-time employees; (2) supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers; and (3) supports development of a package of basic health benefits in conjunction with other health organizations. (BOT Rep. JJ, A-89; Amended by CMS Rep. 9, A-98; Reaffirmation I-98)

#### *H-165.987 Long-Term Funding of Medicare*

The AMA reaffirms its policy that the current Medicare program should be replaced with a self-funded, private-sector approach to financing health care for the elderly, with equitable means testing provisions. The AMA: (1) supports proposals to shift the funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually-owned private savings, with a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care. The government would provide a contribution to economically disadvantaged individuals making smaller than average contributions to their retirement accounts; (2) supports establishing incentives to encourage the use of accumulated balances in Medical Savings Accounts for the funding of post-retirement medical care; (3) recognizes that while private sector solutions can address a large portion of the long-term funding of Medicare, there will still be a need and responsibility for support from government or charitable organizations for the economically disadvantaged; (4) continues to support modernization of the traditional Medicare program by combining the cost-sharing requirements of Parts A and B into a single deductible; (5) continues to support replacing Medicare's systems of price controls with a system of price competition; (6) that the Federal Employees Health Benefit Program (FEHBP) should be used as a model for restructuring Medicare. This type of program would allow seniors to choose among competing private plans, including a modernized fee-for-service Medicare program, for the plan that best meets their needs. Private retiree health insurance also should be integrated into any FEHBP-modeled system; and (7) that, during the transition from the current Medicare program to a system of pre-funding, workers would not only establish private savings accounts for their retirement expenses, but would also continue to support current and soon-to-be retirees through some level of taxation. (Sub. Res. 84, A-88; CMS Rep. 5, A-97; Appended by CMS Rep. 10, A-98; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 19, A-99; Reaffirmation I-99; Reaffirmed: CMS Rep. 9, A-03; Modified and Appended by CMS Rep. 5, I-03)

#### *H-185.964 Status Report on the Uninsured*

Our AMA opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations. (CMS Rep. 2, A-99)

#### *H-240.999 Relationship of Hospital Costs and Hospital Charges*

Our AMA urges hospitals: (1) to adopt pricing policies which will more specifically relate the charge for a given item or service to the actual cost of that item or service, including an adequate profit margin; (2) to inform the medical staff and the public of the rationale for charges which cannot be strictly related to costs; (3) to inform medical staffs as quickly as possible of any changes in prices; and (4) to standardize their nomenclature for services, and to group these services in the general service charge or room rate consistently from one hospital to another so as to simplify comparison. (CMS Rep. H, I-79; Reaffirmed: CLRPD Rep. B, I-89; Reaffirmed: Sunset Report, A-00)

*H-285.998 Managed Care*

....(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payors should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient. When inordinate amounts of time or effort are involved in providing case management services required by a third-party payor which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payor or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payor coverage." Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process. (Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Reaffirmed: Res. 716, A-95; Modified: CMS Rep. 3, I-96; Modified: CMS Rep. 4, I-96; Reaffirmation A-97; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed: CMS Rep. 9, A-98; Reaffirmed: Sub. Res. 707, A-98; Reaffirmed: CMS Rep. 13, I-98; Reaffirmed: Res. 717, A-99; Reaffirmation A-00; Reaffirmation A-02)

*H-380.994 Physicians' Freedom to Establish Their Fees*

Our AMA (1) affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner; (2) supports the concept that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or other health care services); and (3) believes that the contract for care and payment is between the physician and patient. (BOT Rep. JJ, I-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: Sub. Res. 704 and Reaffirmation A-01)

*H-385.976 Physician Collective Bargaining*

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need.

The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care. (BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01)

*H-385.989 Payment for Physicians Services*

Our AMA: (1) supports a pluralistic approach to third-party payment methodology under fee-for-service, and does not support a preference for “usual and customary or reasonable” (UCR) or any other specific payment methodology; (2) affirms the following four principles: (a) Physicians have the right to establish their fees at a level which they believe fairly reflects the costs of providing a service and the value of their professional judgment. (b) Physicians should continue to volunteer fee information to patients, to discuss fees in advance of service where feasible, to expand the practice of accepting any third-party allowances as payment in full in cases of financial hardship, and to communicate voluntarily to their patients their willingness to make appropriate arrangements in cases of financial need. (c) Physicians should have the right to choose the basic mechanism of payment for their services, and specifically to choose whether or not to participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service. (d) All methods of physician payment should incorporate mechanisms to foster increased cost-awareness by both providers and recipients of service; and (3) supports modification of current legal restrictions, so as to allow meaningful involvement by physician groups in: (a) negotiations on behalf of those physicians who do not choose to accept third-party allowances as full payment, so that the amount of such allowances can be more equitably determined; (b) establishing additional limits on the amount or the rate of increase in charge-related payment levels when appropriate; and (c) professional fee review for the protection of the public. (CMS Rep. A, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Reaffirmed: Sub. Res. 716, A-00; Reaffirmation A-02)

*H-385.990 Payment for Physicians Services*

(1) The AMA recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as “usual and customary or reasonable” (UCR), have positive aspects which merit further study. (2) The AMA reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems. (3) The AMA reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible. (4) The AMA urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances. (CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: Sub. Res. 137, A-94)

*H-385.991 Balance Billing*

Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement. (Sub. Res. 128, I-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: Sub. Res. 704, A-01)

*H-400.960 Harnessing Market Forces in Medical Pricing.*

Our AMA: (1) continues its non-endorsement of the Medicare RBRVS-based physician payment system until such time as it is adequately corrected and refined and will continue to pursue all efforts to correct the problems with this system identified in Policies 400.965 and 400.972, especially as they affect primary care services; (2) calls for CMS to conduct a study and collect cost data necessary for development of a methodologically sound resource-based approach to practice expenses for the Medicare RBRVS, with all deliberate speed. In addition, the AMA advocates that CMS be given the authority to immediately correct identified anomalies in the current RBRVS practice expense relative value units. All applications of these methods should refrain from reductions in payments for services without complementary increases in services that this method identifies as “undervalued”; (3) advocates the

following additional principles for physician payment under Health Access America and any other relevant health system reform proposal: (a) An RBRVS that is annually updated and rigorously validated could be a basis for non-Medicare physician fee and payment schedules. This policy pertains to the RBRVS relative values only. It does not apply to Medicare's conversion factor, balance billing limits, GPCIs, and inappropriate payment policies. In addition, the AMA will continue to seek the reversal of the 2.8% across-the-board "budget neutrality" reduction in the 1993 Medicare RBRVS relative value units (RVUs), with all RVUs restored to the levels that would have been in effect without this reduction. The AMA will vigorously oppose any such future reductions in the Medicare RBRVS relative values. (b) There should be two or more affordable fee-for-service plans offered on an annual basis by each employer or "health alliance." Each health alliance should be required to make a good faith effort, to ensure that there are at least two such plans. In all but the most extreme circumstances, which do not include the level of the plan premium, each alliance must have at least one fee-for-service plan. (c) There should be advance disclosure of physician and all other provider fees and charges and plan payments. With RBRVS payment, physicians and payors would set or contract for conversion factors. (d) Physician fees should not be regulated by governments or health alliances. (Reaffirmed: Sub. Res. 132, A-94) (e) There should be no annual regulated budgets for fee-for-service plans. If such budgets are required, fees outside of plan allowances should not be subject to the budgets; patients should be free to make such unsubsidized payments; (4) will provide assistance and guidance to state medical associations, national medical specialty societies, physician practices, and public and private third party payors to help ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods; and (5) supports the position that the RBRVS should not be implemented by private payors as a cost containment device; savings from payment reductions should be used for the purpose of increasing payments for undervalued services. (BOT Rep. UU, A-93; Reaffirmed: BOT Rep. I-93-37; Reaffirmed: Res. 101, I-93; BOT Rep. 25-A-94; Reaffirmed: CMS Rep. 11-A-94; Reaffirmed by Sub. Res. 802, A-96; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 2, I-00)

#### 4. IMPACT OF THE HEALTH MAINTENANCE ORGANIZATION ACT OF 1973

##### HOUSE ACTION: FILED

At the 2003 Annual Meeting, the House of Delegates adopted Resolution 214, which calls for the AMA to provide an update on the impact of the Health Maintenance Organization Act of 1973. The Board of Trustees referred Resolution 214 (A-03) to the Council on Medical Service for study, with a report back to the House at the 2004 Annual Meeting.

This report, which is presented for the information of the House, focuses on the maturation of the managed care market over the past three decades. Specifically, it highlights the role that the AMA has played in advocating for patients and physicians on a variety of managed care issues. Over the past 10 years alone, the Council on Medical Service has presented 55 reports to the House of Delegates on issues related to managed care. These reports have contributed to the extensive AMA policy base that has facilitated improvements in the managed care practice environment for physicians and their patients. Ongoing AMA advocacy efforts are also highlighted in this report.

##### BACKGROUND

Due in large part to the creation and implementation of the Medicare and Medicaid programs, federal health care spending jumped from \$39 billion in 1965, to \$75 billion in 1971. The increase in federal spending was attributed by some policymakers to the "unregulated" use of these two new programs. Accordingly, as early as March 1970, the Department of Health, Education and Welfare proposed the possible use of federally-supported health maintenance organizations (HMOs) as an alternative for Medicare (Campion, The AMA and U.S. Health Policy Since 1940, 1984).

In February 1971, President Richard Nixon challenged Congress to develop a strategy to use the government to move health care coverage from traditional indemnity insurance to prepaid health care (Mitka, *JAMA*, December 1998). By early 1972, 110 HMO planning and development grants had been funded, and President Nixon continued to advocate for HMOs as a means of expanding patient choice. Following a number of hearings, at which some members of Congress stressed the need to test the concept of HMOs before making a "wholesale federal commitment to the idea," the HMO Act of 1973 (42 U.S.C. Sec. 300 et. seq.) was passed (Campion, The AMA and U.S. Health Policy Since 1940, 1984).

The HMO Act of 1973 stimulated private sector growth of HMOs by providing \$375 million for development and subsidization of HMO premiums, and requiring private employers with 25 employees or more to offer HMOs. For the short term, the legislation provided the start-up funding for HMOs to get into the business, and served to legitimize the concept of HMOs to employers. For the long-term, the HMO Act set the stage for the development of preferred provider organizations (PPOs), point-of-service plans, and other forms of managed care. While there is no question that the HMO Act of 1973 ushered in all forms of managed care, the effect of the actual legislation was limited by the passage of other managed care-related legislation, as well as the evolution of the private health care marketplace.

#### LEGISLATIVE HISTORY

Over the years, a number of legislative actions have altered the jurisdiction of the HMO Act. Most prominently, court interpretations of the Employment Retirement Income Security Act (ERISA) of 1974 (29 U.S.C. Sec. 18 et. seq.) have preempted the control that the HMO Act had over most managed care products. ERISA set minimum federal standards for most voluntarily established pension and health plans in the private sector to protect individuals in these plans. Currently, there exist very few federally qualified HMOs as defined by the HMO Act. The following additional legislative actions have had a direct impact on the provisions of the HMO Act:

- 1976 - The HMO Act was amended to relax requirements for “qualified” HMOs.
- 1978 - Amendments extended the HMO assistance program for 3 years.
- 1981 - Legislation eliminated almost all requirements of the HMO Act.
- 1982 - A provision in the Tax Equity and Fiscal Responsibility Act of 1982 (26 U.S.C. Sec. 6031) mandated further reductions in many federal health programs; required employers with 20 or more employees to offer active employees and their spouses aged 65-69 the same level of health care benefits offered to younger employees.
- 1988 - The HMO Act was rewritten to allow experience rating by HMOs and to allow employers to contribute less to HMO plans than to indemnity options.
- 1997 - The Balanced Budget Act of 1997 (P.L. 105-33) added new Part C to Medicare (i.e., Medicare+Choice), expanding options for enrollment in managed care plans.
- 2003 - The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) replaced the Medicare+Choice program with a new program called Medicare Advantage, which operates under Part C of Medicare.

#### MARKET PENETRATION IN THE PRIVATE SECTOR

Over the past 30 years, managed care market penetration in the private sector has grown steadily. In 2003, 63.3% of health plan enrollees were enrolled in managed care plans. Yet, HMO enrollment peaked in 1999. Of the 184.7 million people enrolled in managed care plans in 2003, only 71.8 million were enrolled in HMOs, representing a 12% decline from the 81.3 million HMO enrollees in 1999. Recent trends show a continued growth in PPO enrollment, as enrollees shift out of HMOs and traditional indemnity insurance plans.

On a geographic basis, the level of HMO penetration varies greatly from state to state. According to 2003 data from Interstudy, the following are among the states with lower than 5% HMO penetration: North Dakota (0.4%), Mississippi (0.8%), Wyoming (2.4%), Idaho (2.8%), and Alabama (3.8%). In contrast, the following states have HMO market penetrations that are over 30%: California (48.5%), Massachusetts (38.7%), Connecticut (37.8%), New York (32.4%) and Pennsylvania (31.7%).

Concentrated health insurance markets (e.g., HMO market share, PPO market share, combined HMO/PPO market share) are raising serious concerns about the market power of health insurers. For example, the AMA publication Competition in Health Insurance: A Comprehensive Study of US Markets, 2003 Update, found that:

- In 88% (23) of the 26 state-level markets studied, there is at least one insurer in each market that has a combined HMO/PPO market share in excess of 30%.
- In 42% (11) of the 26 state-level markets studied, there is at least one insurer in each market that has a combined HMO/PPO market share in excess of 50%.

The level of HMO/PPO market penetration is even more evident within metropolitan statistical areas of individual states. In terms of metropolitan areas, most health insurance markets are dominated by a few companies:

- In 90% (76) of the 84 metropolitan area markets studied nationally, there is at least one insurer in each market that has a combined HMO/PPO market share in excess of 30%.
- In 37% (31) of the 84 metropolitan area markets studied nationally, there is at least one insurer in each market that has a combined HMO/PPO market share in excess of 50%.

#### HEALTH PLAN MERGERS

Increasingly, health plan mergers are also responsible for playing a larger role in shaping the managed care industry. According to the AMA's second edition of Competition in Health Insurance: A Comprehensive Study of US Markets, there were over 384 managed care mergers and acquisitions between 1995 and 2002.

Consolidations reduced the number of Blue Cross and Blue Shield plans from 67 to 41 between 1995 and 2003. Most recently, Anthem, Incorporated announced its plans to purchase WellPoint Health Networks in a \$16.4 billion cash and stock merger to create WellPoint, the country's largest health insurer (25 million lives covered). UnitedHealth Group also announced its plans to purchase Oxford Health Plans for \$4.7 billion. As of March 2004, the top 10 largest national health plans covered at least 50% of commercially insured persons. The acceleration of health plan mergers is perceived by some policymakers as the key force in increasing the market power among insurers in major metropolitan markets.

In combination with growing market penetration, this increase in mergers has enhanced the ability of the remaining insurers to potentially exert greater control over local markets, dictate physician contract terms, and maximize premium revenue. The AMA's Private Sector Advocacy unit found that health insurance premiums have increased by more than 42% overall from 1998 to 2002, which is more than double the overall increase in medical inflation (17%) and triple the increase in overall inflation (10%) during the same time period. Consolidation of health plans is one area that the AMA is continuing to monitor.

#### CURRENT PHYSICIAN PERCEPTIONS OF MANAGED CARE

The August 2003 AMA publication *Portrait of Physicians* summarized findings on physician job satisfaction and autonomy in relation to managed care, based on a review of 22 studies that were published between 1995 and 2003. Among the key findings of these reviews were the following:

- Physicians, especially those who contract with multiple health plans, express negative views of managed care and have significant concerns about the effects of managed care on their ability to provide high-quality care to their patients.
- Due to increasing rules and regulations set by managed care organizations, physicians are finding that their professional autonomy has decreased in a variety of areas.
- Factors that affect the level of professional autonomy expressed by physicians seem to be related to the level of HMO penetration and the number of managed care plans with which the physician is involved or has contracts.
- The level of professional autonomy expressed by physicians is also related to the practice setting.

- Adequate participation in a managed care setting during training greatly increases satisfaction with managed care and the likelihood that a physician will be satisfied with the level of autonomy in a managed care setting.
- Experience with a managed care environment, specifically capitation, over the period of a year, decreased physicians' dissatisfaction with the system.
- In response to the "managed care backlash," some health insurers have loosened restrictions on prior authorization for some services, tests and procedures, as well as referrals to specialists.

#### AMA POLICY

Over the past 30 years, the AMA has established a comprehensive policy base on managed care. Perhaps of most significance is the AMA's long-standing policy that continues to advocate that the needs of patients are best served by free market competition and free choice by physicians and patients among all modes of health care delivery and financing, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing (Policies H-165.985[1] and H-285.998[1], AMA Policy Database). The AMA has long-supported the enactment of comprehensive legislation that addresses a wide range of patient protection and physician fairness issues, such as disclosure of health plan information to enrollees and prospective enrollees, utilization review and grievance procedures, due process in physician selective contracting decisions, and physician involvement in health plan medical policies (Policies H-285.941 and H-285.981). In addition, the AMA has continued to strongly advocate for changes in relevant antitrust laws to allow physicians and physician organizations to engage in collective negotiations with purchasers, managed care plans, and other insurers (Policy H-165.944[4], H-165.942[2], H-165.924, H-385.946, and H-380.987).

Among the additional managed care issues for which the AMA has established significant policy are the following: disclosure provisions (H-285.998[5], H-140.978[4,5], H-285.984[3]), and H-285.998[3]); selective contracting (H-285.991[1a], H-285.984[2], H-285.991[b], H-230.975[1], H-285.991[1c], H-285.997[2], and H-285.991[1d]); credentialing and recredentialing (H-285.948, H-285.979, H-285.953, H-285.979, and H-285.934); case management (H-285.998[4], H-385.951, H-390.878, H-285.998[4], H-200.969[4], H-285.998[4], H-165.908[1,2], and H-165.903); financial incentives (H-140.941, H-285.951[d], E-6.03, E-8.052, and H-285.951[c,h,i,g]); managed care contracts (H-285.946, H-285.952, H-285.963[2], H-285.951[b,l,j,k], H-285.940, H-285.996, H-285.932[2], H-140.942, H-285.989, H-385.989, H-385.938, H-285.955, H-285.995[1], H-285.943, H-285.947, and H-415.987); physician decision-making (H-285.954[1], H-285.931, H-165.909, H-285.983, and H-165.909[2]); utilization review (H-320.953, H-285.998[5], H-320.968[2a,2b,2d,2e,3], H-165.951[3e,4], H-320.969[4], H-285.994[3], and H-285.945); independent and external review (H-320.968[2,c], and H-320.952); disease management (H-285.944); telephone triage and counseling (H-285.944 and H-160.935); hospitalist programs (H-285.964); medical director qualifications (H-285.987, and H-285.939); and Medicare and Medicaid managed care (H-290.984, H-330.916, H-290.985, H-290.982[10], H-400.955, and H-285.957).

These policies, many of which the Council on Medical Service recommended for adoption by the House of Delegates, are included in the fourth edition of the AMA's *Principles of Managed Care*, which the Council is updating for 2004.

#### CURRENT AMA ADVOCACY EFFORTS

Reflective of its voluminous policy on managed care, the AMA has implemented a number of initiatives to address the concerns raised by physicians and patients. In 1998, the AMA created its Private Sector Advocacy unit, which is charged with addressing abusive and unfair business practices by HMOs and health insurers, and bringing greater equity to managed care practices. The main activities of the Private Sector Advocacy unit include, but are not limited to, health claims processing issues, health plan capitation, health plan contracting issues, health plan delayed or reductions in payment, health plan complaints, managed care trends and strategies, marketplace and financial analyses, and antitrust reform. Among the key products that have been developed by Private Sector Advocacy are the following:

- A model managed care contract, designed as an alternative to one-sided contracts typically offered by health insurers.
- "Claims Management Resource Kit," a practical tool to help physicians collect prompt, fair reimbursement.

- A national prompt payment brochure created to help physicians understand what they can do to expedite delinquent payments as a part of a national prompt payment campaign, and which highlights the AMA's legislative and regulatory successes in the area of prompt payment (i.e., legislative and regulatory successes).
- State specific prompt payment brochures for physicians and patients for the Maine Medical Association, the Florida Medical Association, and the Michigan State Medical Society.
- Competition in Health Insurance: A Comprehensive Study of U.S. Markets, a complete study on the competitiveness of health insurance markets in the US.
- Health Plan Complaint Form, which gives physicians and their staff an opportunity to provide the AMA with critical data on the hassles physicians experience on a day-to-day basis in the managed care environment. This information is critical in helping the AMA identify and combat unfair health insurer and payer business practices.
- The HIPAA Complaint Form, which can be used to inform the AMA about health plans and other payers that are out of compliance with the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction and code set standards.
- Three new antitrust documents, including: "Anti-Trust 101," a basic resource document created to educate physicians about the realities of the current antitrust environment; "What is a Messenger Model," which provides key points on the messenger model and its processes; and "Recent FTC Enforcement Actions Taken Against Physicians for Joint Negotiations with Health Plans," an extensive report detailing the 13 cases that have been settled with the FTC.

The above resources and other related documents can be accessed via the AMA Private Sector Advocacy web site at [www.ama-assn.org/go/PSA](http://www.ama-assn.org/go/PSA).

In addition, the Litigation Center of the AMA/State Medical Societies was created as a means to effectively advocate for the legal interests of the medical profession in the courts by bringing forth cases of broad impact, and by serving as an information and legal advocacy clearinghouse for a coalition consisting of the AMA and all 50 state medical associations, as well as the Medical Society of the District of Columbia. The Litigation Center addresses legal issues such as disputes with managed care organizations, fraud and abuse claims against physicians, relationships between hospitals and their medical staffs, medical liability and the burden of governmental regulations. The Litigation Center concentrates its legal resources on filing lawsuits or *amicus curiae* briefs in cases of general interest to physicians, and on sharing information and resources in response to emerging legal issues.

For example, an ongoing class action lawsuit filed by many state medical associations on behalf of more than 600,000 physicians, charges wholesale fraud in the payment practices of ten of the largest managed care organizations in the United States. The principal allegations are that the defendants, though edits in their payment software, have breached their physician provider contracts, violated state prompt payment laws, and conspired to violate the federal Racketeer Influenced and Corrupt Organizations Act. Recently, Aetna and CIGNA insurance companies agreed to stop certain of their bundling practices, disclose others publicly, and pay approximately \$200 million in damages to physicians. The AMA, while not a party to the consolidated complaint, provided technical support on CPT and other payment issues to the plaintiff medical associations and to counsel for the plaintiff class.

Since January 1, 2000, the AMA Litigation Center has supported 62 cases representing physician and patient interests, ranging from state-level trial courts to the US Supreme Court. One of the more notable Supreme Court cases was *Rush Prudential v. Moran*, which upheld the right of states to enforce independent review laws for HMO enrollees. The patient's physicians in *Rush Prudential v. Moran* case were longtime AMA members, and the AMA Litigation Center filed *amicus curiae* briefs supporting the patient in the appeals.

## CONCLUSION

It is clear that passage of the HMO Act of 1973 spurred the development of HMOs, as well as the subsequent growth in the managed care industry. Nonetheless, the passage of subsequent federal legislation has significantly altered the jurisdiction of the HMO Act. Today, the HMO Act has very little direct bearing on the managed care industry.

As current AMA policy and ongoing advocacy initiatives indicate, however, physicians and patients continue to seek assistance from the AMA in addressing a number of problems with managed care plans. In particular, the AMA continues to be asked to address unfair health plan contract provisions, assist in state-level prompt payment legislation, and intercede with respect to the misapplication of CPT codes and guidelines that often result in inappropriately denied payments to physicians and other non-physician health care professionals.

The AMA will continue to strongly advocate on behalf of patients and physicians, and the Council on Medical Service will remain a constant and vigilant force in undertaking further studies and generating proposed policies that are responsive to emergent issues related to managed care.

(References pertaining to Report 4 of the Council on Medical Service are available from the Division of Socioeconomic Policy Development.)

## **5. POLICY SUNSET REPORT FOR 1994 AMA SOCIOECONOMIC POLICIES**

### **HOUSE ACTION: RECOMMENDATION ADOPTED AND REMAINDER OF REPORT FILED**

Beginning in 1994, the House of Delegates established a sunset mechanism for House policies (Policy H-600.110, AMA Policy Database). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to reestablish it.

The objective of the sunset mechanism is to help ensure that the AMA Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative, and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to communicate and promote its policy positions. It also contributes to the efficiency and effectiveness of House deliberations.

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified.
- Such policies are assigned to the appropriate AMA Councils for review.
- Each AMA Council that has been asked to review policies shall develop and submit a separate report to the House that presents recommendations on how the policies assigned to it should be handled.
- For each policy under review, the reviewing Council shall recommend one of the following alternatives: (a) retain the policy; (b) rescind the policy; (c) retain part of the policy.
- For each recommendation that it makes, the reviewing Council shall provide a succinct, but cogent justification for the recommendation.
- The Speakers shall assign the policy sunset reports for consideration by the appropriate Reference Committee.

Although the policy sunset mechanism should not be used to change the meaning of AMA policies, minor editorial changes can be accomplished through the sunset review process.

The Appendix to this report contains recommended actions on 1994 AMA socioeconomic policies.

### **RECOMMENDATION**

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

That the American Medical Association policies listed in the appendix to this report be acted upon in the manner indicated in the Appendix.

## APPENDIX - RECOMMENDED ACTIONS ON 1994 AMA SOCIOECONOMIC POLICIES

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action and Rationale</i>
H-70.964	Bundling of Ventilator and Management Codes.	Retain. Still relevant.
H-85.966	Hospice Coverage and Underutilization.	Retain. Still relevant.
H-130.953	Health Care Access Education Program.	Rescind. Superseded by H-130.945[2] and H-130.970[8].
H-130.990	Emergency Medical Care.	Retain-in-part (1) and (2). Modify (3) to read as follows: The AMA endorses the <del>Commission on Emergency Medical Services'</del> <u>initial following</u> criteria to aid in determining if a full range of emergency services is being offered: <del>Among the criteria are those for</del> hours of operation, staffing and medical direction, relationship to the local emergency medical services system, ancillary service and equipment, protocols, private physician referrals, medical records, and payment for services.
H-155.988	Public Health and Safety Awareness	Retain. Still relevant.
H-160.977	Patients' Choice of Physician.	Rescind. Superseded by H-165.918, H-165.926, H-165.881, and H-165.985[2].
H-160.982	Public Education on the Importance of Continuity of Care by the Personal Physician.	Rescind. Superseded by H-165.918, H-165.926, H-180.988, and H-165.985[2].
H-160.983	Satellite and Commercial Medical Clinics.	Retain. Still relevant.
H-165.893	Medical Trust.	Retain. Still relevant.
H-165.894	Terminology for Tax-Preferred Health or Medical Accounts.	Retain-in-part. Modify to read as follows: The term " <del>medical</del> health savings accounts" ( <del>MSAs</del> <u>HSAs</u> ) will be used in all <del>future</del> AMA policy statements and communications regarding this concept.
H-165.901	Health Care Reform.	Rescind. Superseded by H-165.895.
H-165.902	Support for Core Public Health Functions in Health System Reform.	Rescind. Superseded by H-165.900 and H-240.964[1].
H-165.905	Support for Health System Reform	Rescind. Superseded by H-165.918, H-165.895, and H-165.920.
H-165.909	Safeguards for Physicians in Health Care Plans.	Retain-in-part (2). Rescind (1). Superseded by H-285.931, H-285.983, and H-285.941.
H-165.914	Inclusion in National Health System Reform of Members of Congress and All Other Governmental Employees.	Rescind. Superseded by H-165.963.
H-165.915	Risk Rating and Insurance Premiums.	Rescind. Directive accomplished--addressed by Council on Medical Service Report 3-A-01.
H-165.919	Health System Reform Action Plan.	Rescind. Superseded by H-165.918, H-165.926 and H-165.895.
H-165.972	Health Access America	Rescind. Superseded by H-165.895, H-165.882[14], H-165.985[7], H-165.874[1], and H-465.997
H-165.997	A Medical Profession Initiative for Improvement in the System Design for Health and Medical Care Plans.	Retain. Still relevant.
H-200.963	Criteria for Designation of Health Professional Shortage Areas (HPSAs).	Rescind. Directives accomplished and superseded by H-200.970 and H-465.981.
H-205.991	Development of Health Care Priorities.	Retain. Still relevant.
H-240.986	Opposition to DRG Attestation Statement.	Rescind. Directive accomplished--attestation statement removed from previous PRO scope of work.
H-240.989	Prospective Payment to Hospitals.	Rescind. Superseded by H-400.987[2].
H-240.990	Algorithmic Approach to DRGs.	Rescind. Superseded by H-240.966[3] and H-240.975.
H-280.964	Medicare Certified Beds in Nursing Facilities.	Retain. Still relevant.
H-285.972	Post-Operative Services Under Managed Care.	Retain. Still relevant.

<i>Policy Number</i>	<i>Title</i>	<i>Recommended Action and Rationale</i>
H-285.974	Residents Working with Managed Care Programs.	Retain. Still relevant.
H-285.975	Consensus Opinions.	Retain. Still relevant.
H-285.977	Physician Ownership of Managed Care Organizations.	Rescind. Directive accomplished--physicians were encouraged to consider participating in physician-directed organizations.
H-285.978	Physician Involvement in the Health Care System.	Rescind. Directive accomplished--legislation supported and AMA University Project implemented.
H-320.956	Advanced Directives and Utilization Review.	Retain. Still relevant.
H-330.944	New Durable Medical Equipment Requirements.	Retain. Still relevant.
H-330.946	Low Osmolar Contrast Agents for Radiography.	Retain. Still relevant.
H-330.947	Medicare Reimbursement for Injected Drugs.	Rescind. Directive accomplished--CMS has reformed its payment policy for injected drugs.
H-330.953	Durable Medical Equipment.	Rescind. Superseded by H-330.955.
H-335.971	Opposition to Bundling of Lab Tests for Reimbursement Purposes by Medicare Carriers.	Rescind. Directive accomplished--coding policy was completed cooperatively with CMS and AMA.
H-335.998	CMS Medicare Utilization Review Regulations.	Rescind. Superseded by H-70.928, H-330.921, H-335.976, and H-340.997.
H-340.905	Peer Review Program Status.	Rescind. Directive accomplished--CMS and QIOs no longer use the UCDS. QIOs currently in 7th Scope of Work.
H-340.906	Double Standards in PRO Review.	Rescind. Directive accomplished--CMS and QIOs no longer use the UCDS. QIOs currently in 7th Scope of Work.
H-340.913	Peer Review by Actively Practicing Physicians.	Retain-in-part. Modify to read as follows: The AMA continues to urge CMS <del>and Congress</del> to <del>change</del> <u>assure that under</u> the Medicare review process <del>so that</del> only actively practicing physicians in the same specialty and similar practice setting be allowed to perform Medicare reviews.
H-340.996	Peer Review Organization (PRO) Program.	Rescind. Superseded by H-375.975.
H-375.976	Peer Review Organization Program Status.	Rescind. Directive accomplished--QIOs currently in 7th Scope of Work.
H-380.985	Freedom of Contract Between Patients and Health Care Providers.	Rescind. Superseded by H-380.989.
H-380.992	Payment for Physicians' Services.	Rescind. Superseded by H-380.994 and H-380.989.
H-385.956	Payment for Ethics Consultations.	Retain. Still relevant.
H-385.990	Payment for Physicians Services.	Retain. Still relevant.
H-390.869	Payment for Sleep Studies.	Rescind. Directive accomplished--implemented through RBRVS expense values, refinement process, and completion of two, five-year reviews of physician work.
H-390.871	Timely Notification of Medicare Changes.	Rescind. Superseded by H-390.965.
H-390.873	Assuring Fair and Adequate Medicare Updates of Physician Services.	Rescind. Directive accomplished--AMA advocated for PPRC recommended updates.
H-390.985	CMS Consultation With Physicians.	Retain. Still relevant.
H-390.987	Medicare Assignments and Laboratory Reimbursements.	Retain. Still relevant.
H-400.958	Conversion Factor Determination by Medicare.	Rescind. Superseded by H-400.991.
H-400.989	Resource-Based Relative Value System (RBRVS).	Retain. Still relevant, but change title of policy to read as follows: "Physician Negotiations."
H-400.999	Cognitive Services Reimbursement	Retain. Still relevant.
H-450.967	Patient Care.	Rescind. Superseded by E-2.095, E-2.035, and E-2.037.
H-450.997	Quality Assurance and Peer Review for Hospital Sponsored Programs.	Retain. Still relevant.
H-450.998	Quality of Care.	Rescind. Superseded by H-450.995 and H-410.960.

## 6. HEALTH SAVINGS ACCOUNTS

### **HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 718 AND REMAINDER OF REPORT FILED**

At the 2003 Interim Meeting, the House of Delegates adopted as amended the recommendations in Council on Medical Service Report 3, "Health Reimbursement Arrangements." Recommendation 4 of the report calls for the American Medical Association to report to the House on the implementation of Health Savings Accounts (HSAs). The Board of Trustees referred the requested study to the Council on Medical Service for a report back at the 2004 Annual Meeting.

This report describes the development of HSAs out of their predecessors, Medical Savings Accounts (MSAs); outlines the legislation and regulations governing HSAs; compares HSAs to MSAs; includes a glossary of key terms (Appendix A); presents available information on HSA market activity; summarizes relevant AMA policy; highlights the successful implementation of significant AMA policy with the establishment of HSAs; and makes several policy recommendations.

#### BACKGROUND

As highlighted in Appendix B, both MSAs and HSAs are a form of health insurance coverage that includes a high-deductible insurance plan coupled with a tax-advantaged personal savings account to be used only for qualified medical expenses. Patients have incentives to utilize health care in a cost-conscious manner because they spend from their own accounts and/or out-of-pocket before meeting the deductible, and because unspent account balances accumulate and accrue interest from year-to-year. High deductibles keep premiums low, making coverage more affordable than traditional insurance and freeing up monies to fund the accounts. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little-to-no cost sharing for in-network services and limits on total out-of-pocket costs. HSAs and MSAs can result in administrative savings to the extent that services utilized before the deductible are not sent through claims processing. Account funds also can finance long-term care with untaxed dollars, and serve as retirement savings for non-medical expenses, though subject to income tax upon withdrawal.

Although MSAs had been available in some states since the 1980s, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) established a five year national demonstration of MSAs, extending the tax advantages of traditional employment-based health insurance to MSAs. Under HIPAA, MSA account contributions, interest earnings, and account expenditures were not subject to federal income taxation. HIPAA also imposed numerous rigid, complex rules regarding eligibility, benefit design, and account contributions. These constraints hampered enrollment and discouraged insurers and insurance brokers from investing in product development and marketing. Despite these obstacles, approximately 100,000 households or individuals enrolled in HIPAA-qualified MSAs, with nearly 75% of enrollees previously uninsured (Internal Revenue Service Announcement 2002-90, September 2002). MSAs appear to have saved both enrollees and employers on total premium and out-of-pocket expenditures (Bond et al., 1996).

MSA supporters sought to make MSAs permanent and eliminate restrictions hindering their growth. Legislation passed in 2001 and 2002 renewed the MSA demonstration through the end of 2003. In December 2003, the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173) established HSAs effective January 1, 2004, thereby making MSAs permanent and removing most restrictions. Almost immediately after the passage of the Medicare Act of 2003, the Treasury Department issued guidance on the implementation of HSAs, followed by further guidance from the Treasury Department in March 2004, and the Department of Labor in April 2004. The Treasury Department guidance asked the public for input on yet further guidance to be issued by June 2004, and in 2005. Since December 2003, there has been a flurry of activity surrounding HSAs by the insurance industry, employers, consumer-driven health care advocates, the financial services industry, and the media. The Treasury Department has established an e-mail address, voice mailbox, and web site to answer the public's questions about HSAs: [hsainfo@do.treas.gov](mailto:hsainfo@do.treas.gov), (202) 622-4HSA, and <http://www.treas.gov/offices/public-affairs/hsa>.

## COMPARISON OF MSAs AND HSAs

The establishment of HSAs is part of an overall trend toward consumer-directed health care, in which patients have greater control over health care decision-making, as well as experience the financial consequences of those decisions. This trend includes MSAs, HSAs, and health reimbursement arrangements (HRAs)--a relatively new form of MSA-style health coverage that has greater flexibility in benefit design and eligibility than MSAs or HSAs. As previously noted, HSAs are essentially MSAs with fewer restrictions. Although no new MSAs can be established, people with previously existing MSA accounts can continue to contribute to them so long as they are enrolled in a qualified high-deductible health plan (HDHP), or they may roll them over into HSAs by filling out a form provided by the account custodian. HSAs and MSAs are the same form of health insurance coverage, yet HSAs have a number of advantages over MSAs. HSAs are now permanent, in contrast to the temporary pilot project status of MSAs. Whereas only employees of small firms or the self-employed were eligible to establish an MSA, anyone can have an HSA, and the 750,000 enrollee limit for MSAs was removed. Under MSA rules, either the employer or the employee could make account contributions, but not both, whereas employers and/or employees may contribute to HSAs.

Under HSAs, the permitted parameters for health plan deductibles, account contributions, and account expenditures have been loosened, and HSAs may be offered in cafeteria plans offered by employers. High-deductible health plans may now have lower minimum deductibles, higher maximum deductibles, and higher out-of-pocket limits. Limits on annual HSA account contributions are up to 100% of the plan deductible, rather than 65% of the deductible for individuals or 75% for families under MSAs. Workers between age 55 and 65 may now make catch-up contributions of an additional \$500 per year, with the amount increasing by \$100 each year until 2009 when it reaches \$1,000. As with MSAs, qualified medical expenses that may be made from HSAs are defined by Section 213(d) of the Internal Revenue Code, and generally exclude health insurance premiums. In contrast to MSAs, HSA regulations permit high-deductible health plans to provide coverage for preventive services before the deductible has been met. HSA funds can be used to pay for qualified medical expenses of family members who themselves do not have HDHP coverage under less restrictive circumstances than with MSAs. Under MSAs, qualified medical expenditures were subject to federal income tax for those over age 65, whereas HSA medical expenditures are tax-free regardless of age. Finally, whereas non-medical expenditures are still subject to income tax, the penalty for non-medical expenditures for those under age 65 has been reduced from 15% to 10%.

## REGULATORY GUIDANCE

Guidance issued by the Treasury Department in December 2003, and March 2004, addressed numerous other details of HSA coverage, eligibility, contributions, expenditures, administration, reporting requirements, inheritance, and definition of preventive care.

### *HSA-Compatible Benefits and Permitted HDHP Benefit Design*

In general, an individual is ineligible for an HSA if the individual has additional coverage through a non-qualifying health plan. Exceptions include coverage for dental care, vision care, and long-term care. Coverage of drug expenses below the deductible is not permitted. However, before the Treasury Department had clarified this point, some employers and individuals offered or enrolled in health plans exempting drugs from the high deductible in the belief that such plans qualified as HSA-compatible HDHPs. In order to allow employers and enrollees time to adapt to HSA benefit requirements, the Treasury Department issued transition relief guidance allowing first-dollar or near first-dollar coverage of drugs alongside HSAs through the end of 2005.

As noted above, HDHP plans are permitted but not required to offer first-dollar coverage of preventive care services. The Treasury Department definition of preventive care for purposes of HSAs supersedes definitions set forth by state law, and includes annual physical exams, immunizations, screening tests, routine prenatal and well-child care, tobacco cessation programs, and obesity weight-loss programs, but not the treatment of existing conditions. Future guidance will clarify whether the definition of preventive includes additional benefits such as drugs under limited circumstances, employee assistance program services, or employee wellness programs.

Flexible spending account (FSA) funds are prohibited from being rolled over into HSAs. Future guidance also will clarify the exact circumstances under which FSA and HRA coverage is compatible with HSAs. In its June 2004 guidance, the Treasury Department is expected to rule that individuals' FSA and HRA funds cannot be used to pay for covered expenses below the HDHP deductible, although FSA and HRA funds can be used to pay for any post-deductible coinsurance or copayments, as well as for non-covered expenses such as dental or vision care.

For health plans with separate in-network and out-of-network annual deductibles, the in-network deductible is used to determine whether the plan qualifies as an HDHP and the annual contribution limit. As with MSAs, qualified HDHPs issued to families are effectively prohibited from incorporating "embedded" individual deductibles, common in the insurance industry. Embedded individual deductibles--lower, per-person deductibles applied to individual family members--are not permitted unless the embedded deductible is at least as high as the minimum family deductible (\$2,000 in 2004), in which case the annual contribution is limited to the amount of the embedded deductible, rather than the full family deductible.

#### *HSA Contributions and Withdrawals*

A qualified HSA account custodian can be any insurance company, bank or similar financial institution, or anyone already approved to be an individual retirement account (IRA) or MSA custodian. HSA funds can be invested in virtually the same vehicles as IRAs, including stocks, bonds, and mutual funds, but excluding life insurance policies. As with MSAs, annual contribution limits generally are prorated based on the number of months the enrollee is both enrolled in an HDHP and holding an HSA account. However, because many individuals have had difficulty locating qualified account custodians, transition relief guidance allows extra time to establish HSAs; so long as an otherwise-eligible individual is enrolled in an HDHP, qualified expenses for 2004 may be reimbursed from an HSA even if the account is established as late as April 15, 2005, and the contribution limit is determined by the number of months the individual is enrolled in an HDHP. The Treasury Department guidance puts no limit on the fraction of the maximum annual contribution that can be deposited at any time up until April 15 of the following calendar year. Once someone with an HSA turns 65, or otherwise becomes Medicare eligible, the individual can no longer make account contributions, although he or she may continue to spend account funds (with non-medical expenses subject to income tax but no additional penalty, as noted above).

#### THE OUTLOOK FOR HSAs

Since the authorization of HSAs in late 2003, employers, insurers, financial institutions, policy makers, and the media have shown intense interest in HSAs. Some observers predict that HSAs will revolutionize the US health care system, restraining health care utilization, exerting competitive pressure on prices, forcing transparency of pricing, cutting the ranks of the uninsured, boosting innovation in benefit design, spurring demand for cost-containing medical technology, reducing managed care interference in treatment decisions, and restoring the patient-physician relationship. The number of HSAs is estimated by some to grow as high as 5 million by 2006 (*Consumer Driven Market Report*, 2004). Other estimates are more conservative, forecasting relatively slow growth and minimal impact of HSAs. The real popularity and effect of HSAs remains to be seen, and will depend largely on the content of further Treasury Department guidance, the fate of legislative proposals to allow tax deductibility of HSA plan premiums, and the ability of HSAs to curb health care spending.

Although the course of the HSA market is still speculative, clearly the incentives to develop, offer, and educate the public about HSAs are far greater than under MSAs. Experience with HRAs demonstrates the ability for insurance markets to respond rapidly to enabling legislation. Less than a year after the IRS ruling establishing HRAs, 1.5 million HRAs were established (*National Journal*, 2004). HRA enrollment has been especially strong in the fully-insured small group market; satisfaction and re-enrollment rates have been high; and preliminary evidence does not suggest adverse selection, while suggesting cost-containment potential (Galen Institute, 2004).

#### *Demand for HSAs Among Individuals*

The loosening of eligibility restrictions vastly increases the potential market for HSAs. In the short run, demand for HSAs is limited by lack of availability and public awareness. As noted earlier, however, transition relief guidance allows individuals extra time to establish accounts. Eventually, demand for HSAs is likely to be particularly strong among workers whose employers do not offer health insurance benefits--the group that accounts for the majority of

the uninsured. During the first week of 2004, Assurant Health (formerly Fortis) received over 1,000 applications for HSAs, and during the first six weeks of the year, 30% of their new HSA enrollees were among the previously uninsured. HSAs also have the potential to expand coverage by funding premium payments for workers who lose their jobs (Galen Institute, 2003).

The lowering of required deductibles also makes HSAs appeal to more people, especially given that there is already a trend toward higher deductibles. More than one-third of individual policies and one-quarter of family policies sold through eHealthInsurance.com already have deductible levels consistent with HSAs (Associated Press, January 14, 2004). Many state high-risk insurance pool plans already have deductible levels within HSA parameters (*HSA Insider*, 2004). Given limits on out-of-pocket expenditures, even frequent utilizers of health care services could be attracted to HSAs as a means of wresting control over health care decisions from managed care insurers (Galen Institute, 2003). The fact that HSA health plans are now permitted to exempt a wide array of preventive services from the high-deductible will also make HSAs more attractive to many individuals and families. On the other hand, some analysts worry that families might be deterred from purchasing an HSA because, in contrast with insurance industry norms, plans generally may not apply lower embedded individual deductibles to individual family members (Ginsburg, *Modern Healthcare*, February 2004).

Individuals will be attracted to HSAs both for insurance coverage and as an investment vehicle. Since contributions and interest earnings are not taxed, HSAs have the potential to yield substantially more than ordinary investments (see Appendix C). Even if no HSA funds are rolled over to the following year, the individual reaps a tax advantage by paying for out-of-pocket medical expenses with untaxed dollars. HSA funds used for non-medical retirement expenses are tax-deferred in that they are taxed upon withdrawal, typically at a lower tax rate than applied when the individual contributed the funds. In that respect, an HSA is essentially a traditional IRA with additional tax advantages: not only are contributions untaxed, but certain withdrawals are not taxed, and certain withdrawals may be made without penalty before retirement age, those withdrawals being for qualified medical expenses. The tax advantages of HSAs, although generally greater for those in higher tax brackets, are substantial for anyone earning enough to pay income taxes. As with any investment vehicle, depending on the performance of investment choices, individuals could accumulate significant retirement savings, or see inflation erode the value of their accounts. As with IRAs, individuals own and control the investment choices. In its April 2004 guidance, the Department of Labor clarified that, although employers or plan sponsors may require enrollees to make initial deposits with specified account custodians such as a particular bank or brokerage house, individuals are then free to move HSA funds to any qualified account of their choosing.

#### *Demand for HSAs Among Employers*

Employers seeking to rein in rapidly escalating health benefit costs--or simply offer health benefits--will be attracted to HSAs. In a 2003 survey of small business owners conducted by the National Small Business Association, 73% of respondents reported that HSAs would appeal to their employees. A recent survey of large employers indicates rapid growth in the number of firms offering employees a consumer-driven health care plan (Watson Wyatt Worldwide, press release, March 2004). Some employers will prefer HSAs over HRAs because they may be funded wholly or in part by employees. On the other hand, some employers will prefer HRAs since HRA accounts need not be pre-funded and payments are made only as services are used (Galen Institute, 2003). Large firms tend to offer an HSA or HRA alongside conventional health plans, whereas small firms may view such plans as an opportunity to offer affordable health benefits for the first time.

At the time that this report was written, it was expected that the June 2004 Treasury Department guidance would resolve many issues of particular interest to large, self-insured employers new to the HSA market. For example, under what circumstances are FSAs and HRAs compatible with HSAs? Are employee assistance programs, which typically provide short-term support for problems such as drug or alcohol addiction, compatible with qualified high-deductible coverage? Until such issues have been resolved, neither employers nor insurers know the extent to which existing health benefits must be modified to conform to HSA requirements.

In the meantime, employers welcomed the Treasury Department's transition relief guidance permitting coverage of drug expenses below the deductible through the end of 2005. In its April 2004 guidance, the Department of Labor clarified that, although an HDHP for an employment group may be subject to federal Employee Retirement Income Security Act of 1974 (ERISA) regulations, HSA accounts ordinarily are not. This ruling was particularly welcomed by small and medium-sized employers that wish to avoid costly ERISA compliance requirements.

Because of the timing of the HSA regulatory guidance relative to open-enrollment periods, some employers were unable to offer HSAs in 2004, and there could be a large wave of employers offering HSAs in 2005. In April 2004, the federal Office of Personnel Management announced that, starting in 2005, HSAs will be offered to the nearly 9 million federal employees and their dependents covered through the Federal Employees Health Benefits Program. Employers offering HSAs alongside other health plan choices are likely to adjust premiums and benefits in order to mitigate any adverse selection across plans. Because employers will closely monitor HSAs, there will eventually be more complete data with which to evaluate the impact of HSAs on selection, utilization, and costs.

The potential for HSAs to reduce costs may be limited because most health care expenses are generated by the small number of people with expenses far exceeding deductible and out-of-pocket limits. On the other hand, more people exceed deductibles and out-of-pocket limits with conventional insurance than with HSAs. A critical issue will be the extent to which HSAs impact costs not only through utilization, but by containing prices of health care services, particularly through market competition among providers and insurers, stimulation of cost-saving treatment approaches, and incentives to participate in disease management programs.

#### *Supply of HSAs by the Insurance and Financial Services Industries*

In early 2004, demand for HSAs on the individual market seemed to outpace supply, with some individuals having difficulty finding knowledgeable, qualified banks or other institutions with which to establish accounts (hence, the aforementioned transition relief guidance allowing extra time to establish HSAs). Some observers believe that large investment firms will show a tepid response until HSA accounts reach thresholds such as \$25,000, leaving insurers and smaller financial institutions to establish a niche for smaller accounts (Ramthun, *HSA Insider*, March 2004). Many insurers planning to market HSA accounts along with their insurance plans will start by offering simple accounts, later offering more sophisticated investment options (Financial News Service, 2004). At least one company already plans to issue debit cards for HSA, MSA, and FSA accounts that would verify patient eligibility and track deductibles (*Business Week*, March 2004). Although some insurers are awaiting final regulatory guidance, most industry experts expect the availability of HSA plans and accounts to expand rapidly, as was the case following the liberalization of IRA eligibility restrictions in 1981. Individuals can already connect with HSA insurance and account providers through the Internet. The web site [www.HSAInsider.com](http://www.HSAInsider.com) maintains a growing list of vendors of qualified high-deductible plans and HSA accounts by state and by type of market (individual, small group, and large group).

In a recent survey of insurers serving employer groups, 42% of respondents reported having an HSA product either ready or under development, with another 25% considering entering the HSA market (Eastbridge Consulting Group, Inc., 2004). With Medicare HSAs authorized under the Medicare Advantage program (formerly Medicare+Choice), 33 companies plan to offer Medicare HSAs and another 30 are considering doing so (America's Health Insurance Plans, 2004). The first insurers offering qualifying high-deductible health plans have been companies already offering MSAs or HRAs, such as Assurant/Fortis, MSAver, Golden Rule, and Destiny, as well as large, national carriers such as Blue Cross/Blue Shield and Aetna (Eastbridge Consulting Group, Inc., 2004). The large carriers tend to offer plans with a wide range of benefit designs, some already complying with HSA requirements. Large carriers were already positioned to serve as HSA account custodians and to educate and mobilize brokers to market HSAs. Large carriers also are reportedly working with large employers to develop sophisticated benefits packages that integrate HSAs with HRAs and/or FSAs, to the extent that future Treasury Department rules permit such arrangements.

#### *Criticisms of HSAs*

The main criticism of HSAs is that they are only for the "healthy and wealthy." Based on the limited available evidence to-date from MSAs and HRAs, this concern has not been borne out. Researchers and policymakers will pay close attention as additional data accumulates on the age, health, and socioeconomic characteristics of HSA takers relative to non-takers. The General Accounting Office had been directed by HIPAA to conduct a comprehensive study by January 1999 of the effects of MSAs in the small-group market, including the effect of MSAs on adverse selection. However, low MSA enrollment prevented the GAO from conducting the study. A simulation model developed by the RAND Corporation suggested that MSAs would not disproportionately attract

younger, healthier individuals (Goldman, et al., *Health Services Research*, April 2000). At a February 2004 Galen Institute forum on consumer-directed health care, six insurers presented data showing that HRA enrollees were older and of slightly lower health status as those opting for other forms of coverage, although the analyses were unable to control for detailed individual characteristics such as prior health conditions or income. Similarly, there is evidence that, despite chronic conditions or high medical expenses, some people are attracted to HRAs because they gain greater control over health care decisions than under conventional managed care plans.

Calculations conducted by the AMA Division of Socioeconomic Policy Development show that the annual cost of an HSA compared to a PPO depends on health plan premiums, deductibles, coinsurance, and out-of-pocket limits, as well as individual medical expenses and tax bracket. Not surprisingly, individuals with little or no medical expense generally save money with an HSA because of the premium difference. Individuals with moderate to high medical expenses are more likely to find the PPO less expensive. However, two factors in addition to low premiums could make an HSA more affordable than conventional coverage even for those with higher expenses. First, although generally higher than PPO out-of-pocket limits, the HSA out-of-pocket limit serves as a powerful protection against catastrophic loss. Second, out-of-pocket expenses funded by an HSA are paid for with untaxed dollars. Because of this tax advantage, some individuals may find an HSA less expensive than the PPO regardless of their medical expenses. As noted earlier, although the tax advantages of HSAs are greater the higher an individual's tax bracket, the tax advantages are nonetheless substantial for nearly everyone.

Although policy makers and researchers should monitor HSA data for possible evidence of markedly uneven enrollment based on health status or income, these concerns appear to be overstated. The relevant question is not only whether HSAs benefit some groups more than others but, for a given individual or family, how does an HSA compare to the alternatives? People with high medical expenses will pay attention not only to their overall costs--which could be lower with an HSA than conventional coverage--but also to gaining greater choice and control over physicians and treatment decisions (Scandlen, February 2004), an advantage of HSAs. Because of their low premiums, HSAs are likely to have particular appeal to low-income individuals, putting insurance coverage within reach for the first time for some. As noted earlier, a 2002 study conducted by the IRS showed that nearly 75% of MSA enrollees had been previously uninsured.

#### RELEVANT AMA POLICY

Extensive, longstanding AMA policy supports the promotion and expansion of MSAs, and by extension, HSAs (Policies H-165.879, H-165.869, H-185.982, H-180.957, H-270.969, and H-165.920[7], AMA Policy Database). Policy H-165.869[3] closely parallels legislative proposals to expand MSAs by seeking to repeal MSA demonstration status, eligibility restrictions, and numerous other legislative constraints on MSAs. Policies H-165.920[7] and H-165.869[1] support legislation allowing the tax-free use of MSA accounts for health care expenses as an integral component of AMA proposal to expand health insurance coverage and choice. In addition to calling for a lifting of MSA eligibility restrictions and enrollment limits, Policy H-165.879 calls for MSA accounts to be available through a wide variety of sources, including banks, brokerage houses, and health insurers.

Along with efforts to liberalize MSA rules, Policy H-165.863 advocates allowing employees to rollover any unexpended funds from an FSA into an MSA. The AMA also supports HRAs (Policy H-165.854), and Policies H-165.869[2] and H-180.957 support efforts to educate patients, employers, and physicians about the advantages of MSAs and HRAs. Policy H-165.869[5] calls for the AMA to continue to promote MSAs being offered to AMA physicians through its own medical insurance programs.

#### DISCUSSION

The permanent establishment of HSAs by the Medicare Prescription Drug, Improvement, and Modernization Act and subsequent regulatory guidance represents a substantial victory for the AMA by achieving most of the AMA's legislative objectives for MSAs. Specifically, the following elements of AMA policy were achieved:

- Permanently repealing the limit on the number of MSAs (hereafter called HSAs) and removing the demonstration status of the project;
- Expanding eligibility to employees of any size employer and to any individual;

- Allowing both employees and employers to contribute to HSAs;
- Allowing annual HSA deposits up to 100% of the deductible, with no limit on the fraction that can be deposited at any time during the year;
- Reducing the permitted annual minimum deductibles and allowing higher annual maximum deductibles (Policy H-165.869[3e] called for allowing unlimited annual maximum deductibles);
- Allowing HSAs to be offered in cafeteria plans provided by employers;
- Extending a “safe harbor” to high-deductible plans in all states to allow for the coverage of preventive services regardless of whether the deductible has been met; and
- Making HSAs available from a wide variety of sources, including banks, brokerage houses, and health insurers.

One of the few AMA policy objectives for HSAs that remains unrealized is allowing insurers to offer qualified high-deductible health plans that apply lower embedded individual deductibles to individual family members, in conformance with insurance industry norms (Policy H-165.869[3j]). As noted earlier, family HDHP plans may not apply embedded individual deductibles unless they are at least as high as the minimum family deductible of \$2,000, rather than the minimum individual deductible of \$1,000 (dollar amounts apply to 2004). Because no more than one family member ordinarily has high medical expenses in a given year, a \$2,000 deductible for a family represents a higher threshold than a \$1,000 deductible for an individual (Ginsburg, *Modern Healthcare*, February 2004), particularly for smaller families. In addition, the annual account contribution is limited to the lower amount of the embedded deductible rather than the full family deductible, so a family enrolled in an HDHP with \$2,000 embedded deductibles for each family member and a \$5,000 deductible for the whole family could contribute only \$2,000 to their HSA despite being responsible for as much as \$5,000 in deductibles. It should be noted that incorporating (or prohibiting) embedded deductibles has an ambiguous effect on cost-containment incentives. On the one hand, insurance coverage for a given family member takes effect as soon as that individual’s expenses reach the lower threshold, reducing incentives for that person to restrain health care spending. On the other hand, coverage for a given family member is not triggered unless that person reaches the individual threshold him or herself (or unless the sum of family members’ below-deductible expenses reaches the level of the family deductible).

The Council on Medical Service believes that HSA high-deductible health plans offered to families should be permitted to include embedded individual deductibles as low as the minimum permitted individual deductible (\$1,000 in 2004), and that annual contribution limits should be determined by the plan’s family deductible rather than by the lower embedded deductible. While it is unknown what the net effect of embedded deductibles would have on health care spending, how much of a deterrent the restrictions on embedded deductibles present for the adoption of HSAs, or the extent to which HSA insurers and enrollees would choose to offer embedded deductibles, the Council believes that the effective prohibition on embedded deductibles puts HSAs at a competitive disadvantage in the health insurance marketplace. Giving HSA high-deductible health plans the flexibility to conform to insurance industry norms in this respect could broaden the appeal of HSAs without violating the spirit or intent behind them.

Finally, the AMA has been engaged in active dialog with representatives of the federal government regarding HSAs, expressing appreciation to Congress for authorizing HSAs and to the Treasury Department for timely issuance of regulatory guidance. The AMA has submitted formal comments on both the issued and pending rules, endorsing interpretations of HSA legislation consistent with AMA policy. The Council looks forward to disseminating additional information as the Treasury Department issues further guidance and as more data on the HSA market becomes available.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association strongly encourage employers to consider offering Health Savings Accounts as an option for their employees.
2. That it is the policy of our AMA that high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members:
  - (a) with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles; and
  - (b) with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies.
3. That our AMA continue to examine alternative means for the financing of health care consistent with AMA policy and sound principles of medical practice.

(References pertaining to Report 6 of the Council on Medical Service are available from the Division of Socioeconomic Policy Development.)

## APPENDIX A - GLOSSARY OF TERMS

*Consumer-Driven Health Care (CDHC)* - An emerging trend in health care coverage and delivery characterized by incentives for individuals to make health care decisions in a cost-conscious manner and by a high degree of individual choice regarding physicians and other health care providers, treatment decisions, and/or health insurance coverage. CDHC encompasses defined contribution (DC) health benefits, medical savings accounts (MSAs), health savings accounts (HSAs), and health reimbursement arrangements (HRAs). Also called Consumer-Directed Health Care.

*Defined Contributions (DC)* - A form of employee health benefit in which the employer or sponsor contributes a fixed-dollar amount toward the employee's health insurance, and the employee is responsible for paying any difference between the employer contribution and the premium of the chosen plan. Although the employer contribution may be higher for employees choosing family rather than individual coverage, and contributions might vary from year-to-year, at any given point in time, employees receive fixed contributions, creating incentives to choose insurance according to the costs and benefits of available plans. While plan choice can be unrestricted, employers typically restrict choice to a menu of prescreened plans. In some cases, the fixed-dollar amount is applied to a plan that the employee has customized on the basis of cost-sharing requirements and/or provider network. The definition of defined contributions has expanded to include health insurance plans in which the individuals receives or contributes a fixed-dollar amount to a personal health care account (see Health Reimbursement Arrangements).

*Embedded Deductibles* - In the context of family coverage by a health insurance plan, a deductible applied to individual family members that is lower than the family deductible. The plan reimburses the individual family member's expenses once they have reached the embedded individual deductible, even if the full family deductible has not been met yet. Expenses of other family members are not reimbursed until they have reached the embedded deductibles, or until family members collectively have reached the family deductible. Most family policies include embedded deductibles. Also called Stacked Deductibles or Nested Deductibles.

*Flexible Spending Account (FSA)* - An employee benefit offered by an employer, typically through a cafeteria plan, that allows employees to have pretax dollars withheld from their salaries to pay for qualified medical expenses as defined by Section 213(d) of the Internal Revenue Code, or dependent-care expenses. Each year, the employee must determine in advance the amount set aside, up to a limit set by the employer. Account balances cannot be carried over to the following year, and any funds remaining at the end of the year are forfeited to the employer. FSAs are governed by Section 125 of the Internal Revenue Code.

*Health Reimbursement Arrangement (HRA)* - A relatively new form of health care coverage in which the employer agrees to reimburse qualified medical expenses (as defined by Section 213[d] of the Internal Revenue Code) incurred by the employee or the employee's spouse and dependents up to a maximum dollar amount per year. Contributions by employers and reimbursements to employees are not subject to income or employment taxes. The law permits but does not require employers to roll over unused balances to increase the maximum reimbursement amount in subsequent years. Similarly, the employer may or may not allow retirees or departing employees access to unspent balances after they have left the company. HRAs have greater flexibility in benefit design than HSAs and MSAs, and are governed by Sections 105 and 106 of the Internal Revenue Code.

*Health Savings Account (HSA)* - A form of health insurance coverage that includes a high-deductible insurance plan (HDHP) coupled with a tax-advantaged personal savings account to be used only for qualified medical expenses. Unspent account balances accumulate and accrue interest from year-to-year. High deductibles keep premiums low, making coverage more affordable than traditional insurance. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little-to-no cost sharing for in-network services and limits on total out-of-pocket costs. HSAs were authorized by the Medicare Prescription Drug, Improvement, and Modernization Act (P.L. 108-173), effective January 1, 2004, effectively making MSAs permanent, removing MSA eligibility restrictions, and loosening MSA benefit design restrictions. Depending on the context, HSA can refer solely to the account, or to the package of the HDHP plus the account.

*High-Deductible Health Plan (HDHP)* - A health insurance plan with a deductible that is higher than typical deductibles seen in the insurance market. Plan reimbursement for most or all covered benefits takes effect only after the enrolled individual's or family's medical expenses have reached the deductible. Enrollment in a qualified HDHP is a condition for eligibility to establish a health savings account (HSA) or medical savings account (MSA), and HDHPs often also accompany health reimbursement arrangements (HRAs). Federal regulations establish permitted parameters for deductibles and out-of-pocket limits of HSA- and MSA-qualified HDHPs (see Appendix B).

*Individual Retirement Account (IRA) and Roth IRA* - A self-funded, tax-advantaged retirement account that allows individuals to make contributions up to a specified annual limit. IRA funds may be placed in bank accounts, or invested in stocks, bonds or mutual funds. Traditional IRA funds are tax-deferred; contributions are deductible from income tax, and withdrawals are subject to income tax, typically at a lower tax rate than applied when the individual contributed the funds. Roth IRA funds are taxed upon contribution but not upon withdrawal, and are available only to individuals below an income cutoff.

*Medical Savings Account (MSA)* - A form of health insurance coverage that includes a high-deductible insurance plan (HDHP) coupled with a tax-advantaged personal savings account to be used only for qualified medical expenses. Unspent account balances accumulate and accrue interest from year-to-year. High deductibles keep premiums low, making coverage more affordable than traditional insurance. Once the deductible has been met, coverage resembles conventional insurance, typically in the form of a preferred provider organization (PPO) with little-to-no cost sharing for in-network services and limits on total out-of-pocket costs. MSAs were authorized by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) on a demonstration basis and subject to numerous rigid, complex rules regarding eligibility, benefit design, and account contributions. Depending on the context, MSA can refer solely to the account, or to the package of the HDHP plus the account.

APPENDIX B - COMPARISON OF MEDICAL SAVINGS ACCOUNTS (MSAs) AND HEALTH SAVINGS ACCOUNTS (HSAs)

	<i>MSAs</i>	<i>HSAs</i>
<i>Program Status</i>	Temporary pilot project	Permanent
<i>Eligibility</i>	Employees of small employers (50 or less), or self-employed, not Medicare-eligible, and with qualified coverage (see below)	Anyone not eligible for Medicare and with qualified coverage (see below)
<i>Enrollment Cap</i>	750,000 people (excluding the previously uninsured)	None
<i>Ownership</i>	Individual	
<i>Carryover of Unused Funds</i>	May be carried over indefinitely	
<i>Portability</i>	Yes	
<i>Tax Treatment of Contributions</i>	Tax-free, including interest earnings.	
<i>Funding Source</i>	Either employer or employee, but not both; or self-employed	Employer and/or employee/individual
<i>Corresponding Health Plan</i>	Must have a qualified high-deductible health plan (HDHP) as defined by HIPAA (MSAs) or MMA (HSAs), and not be covered by any other plan that duplicates benefits in the HDHP.	
<i>Can Offer Thru Cafeteria Plan</i>	No	Yes
<i>Minimum Deductible</i>		
<i>Individual</i>	\$1,700	\$1,000
<i>Family</i>	\$3,450	\$2,000
<i>Maximum Deductible</i>		
<i>Individual</i>	\$2,600	\$5,000 (Replaced by annual
<i>Family</i>	\$5,150	\$10,000 out-of-pocket limits)
<i>Annual Out-of-Pocket Limit</i>		
<i>Individual</i>	\$3,450	\$5,000
<i>Family</i>	\$6,300	\$10,000
<i>Annual Contribution Limit</i>		Lesser of 100% of deductible or
<i>Individual</i>	65% of deductible	\$2,600
<i>Family</i>	75% of deductible	\$5,150
<i>Catch-up Contributions</i>	No	Yes
<i>Qualifying Medical Expenses</i>	Expenses defined by §213(d) of the Internal Revenue Code. Premiums for long-term care insurance, COBRA, insurance for those receiving unemployment comp., and Medicare Part A & B (but not Medigap). Expenses of family members even if not covered by HDHP, but only in years contributions not made to account.	Expenses of family members even if not covered by HDHP.
<i>First-dollar Coverage of Preventive Care Permitted</i>	No, except in states with mandated first-dollar coverage of preventive services	Yes
<i>Medical Expenditures</i>		
<i>under age 65</i>	Tax-free	Tax-free
<i>over age 65</i>	Taxed	Tax-free
<i>Non-Medical Expenditures</i>		
<i>under age 65</i>	Taxed +15% penalty	Taxed +10% penalty
<i>over age 65</i>	Taxed	Taxed

Note: All dollar figures refer to 2004. Sources: The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003; US Treasury Department; Council for Affordable Health Insurance; Galen Institute, and the HSA Coalition.

APPENDIX C - COMPARISON OF TAX TREATMENT OF HSAS AND IRAS

			<i>HSA</i>	<i>Traditional IRA</i>	<i>Roth IRA</i>
Contributions			Untaxed	Untaxed	Taxed
Interest			Untaxed	Taxed	Untaxed (Unless withdrawn pre-retirement)
Withdrawals	Pre-Retirement	Medical Expenses	Untaxed	Taxed + 10% Penalty	Untaxed
		Non-Medical Expenses	Taxed + 10% Penalty		
	Post-Retirement	Medical Expenses	Untaxed	Taxed	Untaxed
		Non-Medical Expenses	Taxed		

Notes: HSA retirement age is 65. IRA retirement age is 59 1/2. Traditional IRA must be fully withdrawn by age 70 1/2 or forfeited. Roth IRA has income eligibility cut-off.