

## REPORTS OF COUNCIL ON MEDICAL SERVICE

The following reports, 1-6, were presented by William H. Beeson, MD, Chair:

### 1. ELIGIBILITY AGE FOR MEDICARE BENEFICIARIES

#### HOUSE ACTION: FILED

At the 2003 Interim Meeting, the House of Delegates adopted Substitute Resolution 711, which calls on the AMA to “evaluate implications of any incremental changes to the Medicare eligibility age for the purpose of cost savings.” The resolution further states that “this evaluation should consider the impact that these changes may have on vulnerable populations with severe health disparities and lower than average life expectancy.” The Board of Trustees referred Substitute Resolution 711 (I-03) to the Council on Medical Service for study, with a report back to the House at the 2004 Interim Meeting.

The original language of Resolution 711 asked that the AMA evaluate the implications of raising the Medicare eligibility age only. However, testimony suggested that the scope of the resolution be expanded to include a more comprehensive view of eligibility, including a consideration of lowering the eligibility age, and evaluating changes in the context of the potential effect on health disparities.

This informational report provides an overview of the primary options being discussed regarding changes to the Medicare eligibility age, specifically: lowering it to age 62 to match the early retirement age of Social Security; raising it to match the normal retirement age for Social Security (67 by 2027); and creating buy-in options for individuals who are not yet age-eligible (e.g., beginning at age 55). The report also provides a detailed analysis of the potential effects of these changes on government spending and health insurance coverage patterns.

#### BACKGROUND

The Medicare program has provided health insurance to virtually all individuals over age 65 since the program was established in 1965. Although some younger individuals with disabilities also receive Medicare benefits, approximately 85% of enrollees are over the age of 65. The Medicare eligibility age was originally set at 65 to match the “normal” retirement age for receiving Social Security benefits. However, in 1983, Congress passed legislation to phase in an increase in the Social Security retirement age from 65 to 67, with the phase-in set to begin in 2003 and be completed by 2027. The rationale for this change was that due to overall improving health conditions and increasing life expectancies, seniors could continue in the workforce longer while still enjoying the same number of years in retirement.

As reported in Council on Medical Service Report 5-I-03, the long-term financing and benefits structure of the Medicare program is unsustainable. The ratio of workers contributing payroll taxes to the number of beneficiaries will decline steadily as “baby boomers” become eligible for Medicare, life expectancy continues to improve, and future birth rates stay at levels similar to that of the last two decades. In addition, the projections for Medicare, under current law, manifest mounting pressure on the federal budget beginning in a decade, trust fund exhaustion in little more than two decades, and unsustainable long-term growth in costs.

The Medicare eligibility age has been the focus of attention for various reasons in recent years. In light of Medicare’s financial pressures, proposals have surfaced to increase the eligibility age as a way of reducing costs and updating the program to reflect demographic trends. However, others have looked to Medicare as a means of securing health care coverage for older individuals under age 65, which, while inevitably increasing program costs, would also fill a gap in the insurance market that is likely to increase as the baby boomers age.

#### THE URBAN INSTITUTE REPORT

In December 2003, The Urban Institute published a report by Richard W. Johnson entitled, “Changing the Age of Medicare Eligibility: Implications for Older Adults, Employers and the Government.” The report provides a comprehensive overview of the current literature addressing the potential effects of changing the Medicare eligibility age or of offering buy-in options, both with and without subsidies. The Council on Medical Service found

this report to provide an excellent analysis of the potential impact of adjustments in the eligibility age by examining potential changes in insurance coverage patterns, workforce participation, and government spending. Many of the proposed options highlighted in this report are addressed in more detail in the Urban Institute report.

## HEALTH INSURANCE COVERAGE OPTIONS FOR OLDER AMERICANS

Any change in the Medicare eligibility age will have implications for health care coverage for older adults. Coverage issues currently experienced by pre-Medicare eligible adults are likely to be replicated among individuals who would lose coverage if the eligibility age were increased. Older adults are at a unique transition point where they are likely to be withdrawing from the workforce, adjusting to more limited income levels, and experiencing increasing health concerns (Government Accounting Office, June 1998). Each of these factors presents unique challenges in addressing their health insurance needs.

Although uninsurance rates are slightly lower for the pre-Medicare population than for other groups of adults, the consequences of delaying or forgoing medical care become more serious as one gets older (Johnson, 2003). The 55-64 age group is one of the fastest growing segments of the population, due to the aging of the Baby Boom generation, all of whom will reach age 55 by 2020. There is some concern that as this population ages, the limitations on insurance options for older adults will become even more acute, and that uninsurance rates among this group will increase unless alternative coverage options are identified.

### *Employer-Based Coverage*

Sixty-three percent of Americans under age 65 obtain their health insurance through the workplace (Center for Studying Health System Change, August 2004). Between the ages of 51 and 64, the percentage of individuals receiving benefits through current employers falls significantly, underscoring the fact that retirement rates in the pre-Medicare eligible years increase as individuals approach age 65. In 1998, approximately 37% of adults ages 62 - 64 received health insurance coverage through current employers, and an additional 28% received coverage through former employers (Johnson, 2003).

Coverage through former employers is available under provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or through retiree health insurance, offered voluntarily by some employers. Under COBRA, employers with 20 or more employees must provide continuation coverage to former workers for up to 18 months (29 months if the worker is disabled). Although COBRA allows former employees to access health insurance at group rates, and without individual risk assessment, it can be relatively expensive because individuals are responsible for the full cost of premiums, plus an administrative fee. In addition, once COBRA benefits are exhausted, retirees under 65 still must find alternative means of coverage, or risk being uninsured. This is particularly problematic for individuals forced to stop working due to chronic illness. Although they may ultimately be eligible for Medicare because of a disability, they often exhaust COBRA coverage before reaching the two-year waiting period between collecting Social Security Disability Insurance and becoming eligible for Medicare.

One of the most significant trends that may affect health insurance coverage rates for older adults is the shrinking number of companies offering health benefits to retirees, citing increased costs associated with retiree health obligations (Kaiser/Hewitt, 2004). In 1988, two-thirds of companies offered retiree health coverage, compared with only 38% in 2003 (Schur, *Health Affairs*, 2004). Furthermore, according to a 2003 study conducted by the Kaiser Family Foundation and Hewitt Associates, 20% of large firms surveyed indicated that it is very or somewhat likely that they will eliminate health benefits for future retirees within the next three years (Kaiser/Hewitt, 2004). Among companies that do offer retiree health insurance, a significant portion of the costs are being shifted to the retirees. Of the firms surveyed in the Kaiser/Hewitt study, 71% reported having increased retiree contributions to premiums in the past year, and 53% increased cost sharing requirements. Increasing premium and cost sharing obligations could make retiree health coverage unaffordable for some individuals. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173) provides incentives for companies to continue providing retiree health benefits, but it is unclear how companies will respond to these incentives.

### *Public Sources of Insurance*

Public sources of health insurance are limited for most older adults not yet eligible for Medicare. Americans under age 65 can access Medicare or Medicaid only if they are blind or disabled. They also can qualify for Medicaid if they meet income and asset restrictions. Many pre-Medicare eligible adults have incomes too high to qualify for

public programs, but face paying a large percentage of their income in order to obtain individual health insurance coverage, or even to take advantage of retiree health insurance or COBRA benefits.

#### *Private-Sector, Non-Group Coverage*

Adults who lack employer-related coverage generally turn to the individual market for insurance coverage. Older adults rely much more heavily on the individual insurance market than do other age groups. A primary reason for this is that older people begin to experience more health problems and, therefore, are less willing to risk being uninsured (Johnson, 2003). However, older adults also face significant obstacles to securing affordable and comprehensive private insurance.

As with other age groups, coverage in the individual market may be difficult to obtain for those with preexisting health conditions. For older people, these limitations are exacerbated; risk related premiums can be extremely high because older people tend to have more illnesses and utilize more health services. Data from the 1998 Health and Retirement Survey indicate that approximately 14% of Americans ages 55-64 have restrictions on their individual insurance policies because of preexisting conditions (Johnson, 2003).

Many older adults find themselves underinsured, having chosen policies with high deductibles and extremely limited benefits as a way of keeping premiums affordable. Still others are unable to find coverage at any price, because coverage is often denied to people with problems commonly associated with old age, such as arthritis, cardiovascular disease, or renal disease (Chollet and Kirk, 1998).

#### *Health Insurance Coverage for Vulnerable Populations*

Among the 55-64 age group, disproportionate shares of the uninsured have low incomes and health problems. In 1998, 28% of older adults with incomes below the federal poverty level were uninsured. By comparison, only 4% of those with family incomes over 400% of the poverty level were uninsured (Johnson, 2003). Low income individuals are less likely to have access to employer-sponsored benefits, and although some receive coverage through Medicare or Medicaid, the majority must obtain private, non-group insurance, or remain uninsured.

Of particular concern is the large number of older adults who are in poor health and lack health insurance. Fourteen percent of individuals reporting fair or poor health were uninsured in 1998, versus only 7% of those who said they were in excellent or very good health (Johnson, 2003). Similar to those with low incomes, individuals in poor health are less likely to have access to employer health benefits than those in good health; therefore they must rely on public programs or the individual market in order to obtain coverage. Public programs insure 29% of those in fair or poor health. Not surprisingly, the private, non-group market accounts for only 5% of the coverage of this group. Poor health exacerbates problems with securing individual coverage, including making premiums unaffordable and limiting coverage options due to health status.

Among all uninsured older adults, 22% report having both low incomes and health problems (Johnson, 2003). Since poorer health translates into higher health insurance premiums, or unavailability of coverage at any price, low income people are especially vulnerable to being uninsured because they simply cannot afford private health insurance.

#### **LOWERING THE MEDICARE ELIGIBILITY AGE**

Most proposals to lower the Medicare eligibility age expand access to individuals beginning at age 62, the age at which people are eligible to collect reduced Social Security benefits. Studies suggest that most workers now retire before age 65. In 1965, when Medicare was first established, only 41% of people began collecting Social Security benefits before they reached 65. By 1999, the percentage had increased to 75%, more than half of whom began collecting benefits at age 62 (US House of Representatives, 2000). Since health insurance coverage is closely tied to employment, the potential for change in employment conditions or status for the pre-Medicare eligible population puts this group at particular risk for becoming uninsured, especially since they may experience increasing health problems that make it difficult and expensive to obtain adequate coverage in the individual market.

Advocates of lowering the Medicare eligibility age support the change as a way of ensuring health insurance coverage for the pre-Medicare eligible population. Opponents point to the solvency problems already facing the Medicare program under the current eligibility structure.

*Projected Impact on Insurance Coverage of Older Americans*

Extending Medicare benefits to all individuals at age 62 would virtually eliminate incidence of uninsurance in those ages 62-64, and would offer security and stability for many older adults who rely primarily on the private, non-group health insurance market. Although many people in this age group still benefit from employer coverage, or choose to allocate significant resources to securing private coverage, many people who need health care services the most are unable to secure them because of income or health status. In addition, many of those individuals who currently obtain coverage through the private market are likely to be underinsured, either because of certain coverage exclusions or because they choose less expensive plans which only provide minimum levels of coverage.

*Projected Impact on the Medicare Budget*

Extending Medicare benefits to those ages 62-64 has been estimated to cost about \$5.4 billion per year (Johnson, 2003), thus adding significant costs to a program already facing solvency problems. In addition, making health insurance available through Medicare at an earlier age could encourage more people to retire earlier, which would further reduce the tax base on which Medicare and other federal programs rely. Johnson, Davidoff, and Perese (2003) estimate that lowering the Medicare eligibility age to 62 would result in a 7% increase in retirement rates.

Some have suggested that lowering the Medicare eligibility age would allow some older adults to receive medical services that would preclude later treatment of expensive acute illnesses, thus ultimately reducing per capita costs in the Medicare program. The Council did not find, however, any specific references to this level of potential cost savings. Accordingly, it seems questionable that any savings in this area would be sufficient to offset the additional costs of expanding the program.

Because of the potentially large increase in expenditures associated with lowering the Medicare eligibility age, this option has generally been proposed within the context of creating a buy-in option for pre-Medicare eligible adults. This option will be addressed later in this report.

**RAISING THE MEDICARE ELIGIBILITY AGE**

Increasing the Medicare eligibility age to 67 would reduce program costs by eliminating coverage for some individuals between ages 65 and 67. In addition, it could encourage some seniors to delay retirement and stay in the workforce in order to continue to receive health benefits provided by their employers. This would help address some of the financing issues associated with Medicare (and other government programs), as those delaying retirement would be contributing to the tax base and gaining additional years to accumulate private savings, therefore reducing reliance on public programs.

Various attempts have been made by Congress to realign the Medicare eligibility age with the Social Security retirement age. In 1997, the Senate voted to increase the Medicare eligibility age to 67 as part of the Balanced Budget Act of 1997, but the provision failed in the House of Representatives and was removed before the Act became law. Similarly, in 1999, the National Bipartisan Commission on the Future of Medicare recommended increasing the age to 67, again with the primary rationale that people are in better health and living longer than when the Medicare program was originally established.

Supporters of an increase in the Medicare eligibility age argue that it is appropriate because it reflects demographic trends related to improved health status of older people and increased life expectancies. Opponents argue that it would put more older Americans at risk for being under- or uninsured, since coverage options for this group are limited.

*Projected Impact on Insurance Coverage of Older Americans*

Amy Davidoff and Richard Johnson of The Urban Institute developed a detailed microsimulation model to estimate the effects of raising the Medicare eligibility age to 67 (Davidoff and Johnson, *Health Affairs*, 2003). According to their model, raising the eligibility age would leave approximately 9% of the 65-66 year old age group uninsured (which is the current rate of uninsurance among individuals ages 62-64). The remaining 91% of the population would access insurance in various ways.

According to Davidoff and Johnson's estimates, 52% of 65-66-year-olds who would lose Medicare coverage would secure alternative coverage through current employers or through COBRA or retiree health benefits. An increase in the Medicare eligibility age would likely encourage more workers to delay retirement in order to retain health insurance benefits through the workplace. However, a risk of increasing the Medicare eligibility age is that the change could further erode the availability of retiree health insurance, because it would extend the period during which retiree health insurance would be the sole source of health coverage for retirees, rather than being a supplement to Medicare. This could increase employer costs significantly, driving even more companies to increase retiree health insurance cost-sharing or eliminate benefits all together.

An estimated 22% of 65-66-year-olds would secure non-group coverage if the Medicare eligibility age were increased. Approximately 23% of current Medicare beneficiaries ages 65-66 purchase separate Medigap policies, suggesting the availability of and willingness of individuals to obtain at least some level of private insurance coverage (Johnson, 2003). However, the cost of primary non-group coverage would be much greater than a Medigap policy, and by itself would not likely be as comprehensive as the combined Medicare/Medigap coverage, especially if cost or preexisting health conditions were issues. Davidoff and Johnson estimate that nearly one-half of those who would obtain non-group coverage would be underinsured because they would be unable to afford comprehensive non-group coverage. In addition, as noted earlier, some individuals would be unable to obtain adequate coverage at any price because of their health status.

The remainder of the population would remain covered under public programs. Three percent would utilize Medicaid-related benefits, and approximately 14% of 65-66-year-olds would retain disability-related Medicare coverage. As noted below, this has important implications for potential cost savings for the program, since the per-capita costs of individuals retaining Medicare eligibility would exceed those of individuals who lose coverage (Waidman, *Health Affairs*, 1998).

#### *Projected Impact on Insurance Coverage for Vulnerable Populations*

According to Davidoff and Johnson's simulations, an increase in the Medicare eligibility age would disproportionately affect ethnic minorities and those with low incomes. Approximately 26% of blacks and 34% of Hispanics would become uninsured, versus only 6% of non-Hispanic whites. Similarly, about a quarter of those with incomes below 200% of the poverty level would become uninsured, versus only 3% of those with high incomes. Lack of insurance did not necessarily appear to correlate with health status, since high rates of disability coverage would offset lower rates of private insurance. However, individuals left uninsured by an increase in the Medicare eligibility age would be less likely to receive health care unless they develop serious health problems, which could further strain the health care safety-net (Johnson, 2003).

Supporters of increasing the Medicare eligibility age note that the increase per se would not disadvantage vulnerable populations any more than these populations are specifically disadvantaged by having the eligibility age set at 65. In its justification for recommending an increase in the eligibility age, the National Bipartisan Commission on the Future of Medicare explicitly addressed how the change would affect groups with differing life expectancies:

It should be noted that at the inception of the Medicare program, a single eligibility age for all people inherently meant that subgroups that tend to live longer (e.g., white women) would receive more Medicare benefits than subgroups with lower life-expectancy (e.g., African-American men). Increasing the eligibility age does not alter that relationship (National Bipartisan Commission on the Future of Medicare, Feb. 1999).

#### *Projected Impact on the Medicare Budget*

Increasing the automatic eligibility age for Medicare would result in direct savings to the Medicare program, and would likely generate additional tax revenues for the program as some workers would be encouraged to delay retirement (retirement rates would be reduced by about 5%) (Johnson, 2003). However, overall 65-66 year old beneficiaries cost the Medicare program less than two-thirds of the costs of the average beneficiary (Waidman, *Health Affairs*, 1998). As noted above, a number of 65-66 year olds would retain Medicare coverage, either because they already qualified for disability insurance, or because they would become disabled prior to age 67. This would mean that the most expensive beneficiaries would retain coverage, thus potentially off-setting much of the effects of an eligibility age increase even further.

A 2000 simulation by The Lewin Group projected that an increase in the eligibility age to 67 would result in an 11% reduction in Medicare beneficiaries, but only a 4.3% reduction in program costs, saving \$23.2 billion relative to the 1999 cost projections of the Medicare Trustees (Wittenburg, 2000). These figures are based on a phase-in of the Medicare eligibility age according to the same schedule as the increase in the Social Security normal retirement age, and account for projected changes over time in population size and health characteristics, and Medicare expenditures.

It should be noted that if an increase in the Medicare eligibility age were scheduled to correspond with the increase in the Social Security retirement age, this would not substantially affect the projections of the influence of the baby boomers on the Medicare Trust Fund. Under the Social Security phase-in schedule, the Medicare eligibility age would not fully rise to 67 until 2027, at which point most of the baby boomers will have already reached 67 and begun collecting benefits. An increase in the Medicare eligibility age would need to be accelerated if a primary goal were to alleviate pressure on the Medicare Trust Fund (Johnson, 2003).

#### INCORPORATING A BUY-IN OPTION

Expanding Medicare access through a buy-in program would reduce the costs associated with lowering the automatic Medicare eligibility age, while offering a reliable health insurance option for older adults who may have difficulty obtaining or paying for coverage. A buy-in option also could be offered in conjunction with an increase in the Medicare eligibility age, therefore mitigating the potential loss of coverage by some older adults.

Over the years, several proposals have been introduced to offer older Americans the opportunity to buy-in to Medicare before they reach the current eligibility age. In 1998, President Clinton proposed a buy-in option that would allow seniors ages 62 to 64 without employer-sponsored coverage to purchase the same package of benefits as regular Medicare beneficiaries. In addition, people as young as age 55 could purchase Medicare coverage if they had been laid off from jobs that provided health insurance and had exhausted their COBRA coverage. Although no action was ever taken on the Clinton proposal, the concept has resurfaced in bills presented to Congress in 2001, 2002, and 2003. The two most recent bills, introduced in the 108th Congress, have not progressed out of the committees of jurisdiction.

#### *Projected Impact on Insurance Coverage of Older Americans*

The impact of a buy-in on health insurance coverage depends primarily on the cost of the buy-in relative to other available coverage options. Projections of participation in buy-in programs that are designed to be “cost neutral” (like the Clinton plan) indicate that the vast majority of participating individuals would already have private coverage, but would switch to the Medicare buy-in because it would be less expensive, or because they could secure more comprehensive coverage, since cost and benefit schedules would not vary based on health status. Since many older adults find it difficult to obtain coverage that is both affordable and adequate for their health care needs, many who are able to pay moderate premiums would benefit from buying in to Medicare (Johnson, Davidoff, and Moon, 2002).

Unsubsidized buy-in plans would do little to extend health insurance options to the uninsured. Another study conducted by The Lewin Group predicted that less than 7% of individuals participating in a general buy-in plan would have been previously uninsured (Shiels and Chen, 2001). As noted above, disproportionate numbers of uninsured older adults have low income levels; therefore even moderate premiums associated with a Medicare buy-in would represent a large percentage of family income (Shiels and Chen, 2001). In order to make a significant impact on the number of uninsured older adults, a buy-in program would need to be designed with substantial income-related subsidies.

#### *Projected Impact on Medicare Budget*

While Medicare buy-in plans would cost the Federal government less than expanding the Medicare program outright, it is unlikely that even the most conservative buy-in plan would, in fact, be “cost neutral.” The Congressional Budget Office estimated that President Clinton’s original buy-in plan for adults 62 to 64 would cost about \$300 million per year (Johnson, 2003). In addition, as noted above, the primary beneficiaries of an unsubsidized buy-in program would be previously insured individuals seeking more affordable and more

comprehensive health care coverage. This could lead to an adverse selection problem, since individuals with health problems will be more inclined to seek insurance coverage, and would benefit more by enrolling in the Medicare program where they are not subject to the individual risk rating methods used in the private market (Johnson, 2003).

Implementing a buy-in program that would help reduce the number of uninsured older Americans by providing premium subsidies would be a substantial cost to the government. Clearly the cost would vary depending on the level of subsidy, but, studies indicate that subsidies would have to be very generous in order to have a significant impact on insurance levels. As an example, capping insurance rates at 5% of income would yield a 38% decrease in uninsurance rates. Yet, this level of subsidy would cost \$2.7 billion annually (Shiels and Chen, 2001).

#### RELEVANT AMA POLICY

The AMA does not have policy that directly addresses the Medicare eligibility age. However, there is extensive policy highlighting the need for fundamental changes within the Medicare program to ensure its long-term viability, including Policies H-165.890, H-165.996, and H-165.987 (AMA Policy Database). Specifically, Policy H-165.987 outlines the AMA's vision for long term Medicare reform, as follows:

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 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.

#### CONCLUSION

Proposals that examine changes to the Medicare eligibility age presume that the fundamental benefits and financing structure of the Medicare program remain unchanged. Any change to the Medicare eligibility age clearly would have some impact on costs to the federal government and on health insurance coverage rates among older Americans. The policy goals of a change in either direction would include easing the financial burden of the Medicare program and ensuring that older Americans have access to affordable and adequate health care coverage. To some extent these goals are mutually exclusive, although it may be possible to achieve both marginal cost savings and marginal increased coverage rates through a combination of increasing the Medicare eligibility age and offering a buy-in option.

The Council on Medical Service is reluctant to perpetuate the flaws in the current system by utilizing it as a means to expand insurance coverage, and does not believe that substantial cost savings can be achieved by making modifications targeting a single segment of Medicare beneficiaries. The Council does not believe that the potential reduction in Medicare spending or increase in health insurance coverage is significant enough to warrant a change in the Medicare eligibility age in the context of the current Medicare system.

As reflected in current Policy H-165.987 and several recent reports of the Council on Medical Service (Council on Medical Service Report 5-I-03, and Council on Medical Service Report 9-A-03), the Council believes that the current Medicare program and financing of health care for retirees must ultimately undergo a fundamental change in order to ensure efficient and fiscally responsible access to medical services. Given the coverage and cost trade-offs associated with a change in the Medicare eligibility age, combined with the political discourse seeking such a change would entail, the Council continues to believe that AMA advocacy would be best directed toward the eventual need to transition from the current Medicare program to a system of privately financed pre-funded savings that can be used for post-retirement medical needs.

(References pertaining to Report 1 of the Council on Medical Service are available from the Division of Socioeconomic Policy Development.)

**2. MEDICARE COST-SHARING  
(RESOLUTION 706, I-03)**

**HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF  
RESOLUTION 711 AND RESOLUTION 706 (I-03) AND  
REMAINDER OF REPORT FILED**

At the 2003 Interim Meeting, the House of Delegates referred Resolution 706 to the Board of Trustees. Introduced by the Florida Delegation, Resolution 706 (I-03) calls for the AMA to “work to establish a fair copayment for seniors in Medicare HMOs according to established traditional Medicare regulation, which is currently at 20%.” The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2004 Interim Meeting.

This report discusses the cost-sharing under Medicare’s traditional and managed care program options, examines data provided by the sponsor of Resolution 706 (I-03), emphasizes the importance of patient choice, and describes new options for Medicare beneficiaries. The report recommends that the Medicare program provide beneficiaries with the information they need to assess their cost-sharing obligations.

**BACKGROUND**

Resolution 706 (I-03) is concerned with Medicare+Choice (now called Medicare Advantage) copayments that are structured as fixed dollar amounts. According to the sponsor, fixed copayments could exceed the 20% coinsurance under the traditional Medicare program. As a result, some patients may be deterred from seeking necessary medical services.

Patient participation in Medicare managed care is voluntary. Medicare managed care cost-sharing may in some cases exceed, and in some cases be less than, cost-sharing under traditional Medicare. There are many services and procedures for which the percentage of coinsurance under traditional Medicare would be much higher than the fixed dollar amount of managed care copayment.

In response to an invitation to provide additional information, the author of Resolution 706 (I-03) submitted summary claims information in the form of Explanations of Benefits (EOBs) for some of his patients enrolled in a Medicare HMO. The physician reported that in 2003, the Medicare HMO required a \$25 copayment, as indicated in the preamble of the resolution. However, the letter accompanying the EOBs explained that the copayment had lowered to \$10 toward the end of 2003. Nonetheless, the author stated that “in some instances, that is still more than the traditional Medicare copayment would be.”

The following table contains the amount paid by Medicare, and the cost-sharing that would be required under both the 20% coinsurance of traditional Medicare and the fixed \$10 copayment under the particular Medicare managed care plan in which these patients were enrolled.

Table - Summary of Cost-Sharing Data Provided by Sponsor of Resolution 706 (I-03) for Patients Enrolled in a Medicare Managed Care Plan

<i>Amount Paid by Medicare</i>	<i>Medicare Managed Care Fixed Copayment<sup>1</sup></i>	<i>Traditional Medicare 20% Coinsurance<sup>2</sup></i>	<i>Patient Pays More Under...</i>
\$76.15	\$10.00	\$17.23	Traditional
\$82.74	\$10.00	\$18.55	Traditional
\$37.66	\$10.00	\$7.50	Managed Care
\$36.71	\$10.00	\$9.34	Managed Care
\$13.92	\$10.00	\$4.78	Managed Care
\$60.71	\$10.00	\$14.14	Traditional
\$23.35	\$10.00	\$6.67	Managed Care
\$35.71	\$10.00	\$9.14	Managed Care
\$60.71	\$10.00	\$14.14	Traditional
\$60.71	\$10.00	\$14.14	Traditional

<sup>1</sup> The patient’s Medicare managed care cost-sharing obligation, as submitted by the sponsor of Resolution 706 (I-03).

<sup>2</sup> The patient’s traditional Medicare cost-sharing obligation, as submitted by the sponsor of Resolution 706 (I-03) or constructed by adding a \$10 copayment to the Amount Paid to the physician, and then computing 20% of that total.

Of the ten paid claims, five had higher cost-sharing under traditional Medicare and five had higher cost-sharing with the HMO. Based on the small sample of EOBs provided by the sponsor of Resolution 706 (I-03), no conclusion can be drawn about which method of cost-sharing would best serve this physician's patients. What is clear, however, is that Medicare beneficiaries have a choice in this matter, and must make an affirmative decision to enroll in Medicare managed care.

#### PATIENT CHOICE

The choice between managed care and traditional Medicare involves decisions that can only be made by beneficiaries. In order to decide among competing choices, beneficiaries are provided educational materials from the Center for Medicare and Medicaid Services (CMS), as well as from advocacy groups for the elderly. Sometimes the educational materials can be difficult to understand. Moreover, information from various sources often makes it more difficult to compare competing options.

Medicare beneficiaries often receive more benefits under Medicare managed care than under traditional Medicare. The monthly traditional Medicare Part B premium for 2004 is \$66.60. Some Medicare Advantage plans charge no additional premium, while others charge higher premiums for enhanced benefits. According to the Kaiser Family Foundation, 62% of Medicare Advantage enrollees choose to pay this higher monthly premium in addition to the Medicare Part B premium. As an additional benefit to attract beneficiaries, plans are also permitted to charge a lower premium. As of early 2004, the Kaiser Family Foundation reported that six plans made the reduced premium option available to 4% of Medicare beneficiaries. Regardless of what they charge, participating plans must provide all covered Medicare Part B services.

#### NEW OPTIONS FOR MEDICARE BENEFICIARIES

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), replaced the "Medicare + Choice" managed care option with Medicare Advantage. Under Medicare Advantage, Medicare beneficiaries will have until 2006 to enroll and disenroll from any plan at any time, pending plan acceptance of new enrollees. Beginning in 2006, beneficiaries will be able to change plans only once a year, during a six month open enrollment period. The six month enrollment period will shorten to three months in later years.

The Medicare Modernization Act established a Medicare drug benefit and one-time physical for new Medicare enrollees. The Medicare prescription drug benefit will begin in 2006, but does not apply to traditional plans. All Medicare Advantage plans will be required to provide basic drug coverage to enrollees. Plans may charge more depending on the scope of drug coverage offered. Patients will need to determine from among plans with varying premiums and other cost-sharing, which ones best serve their needs and interests.

Whereas Medicare+Choice was composed predominantly of HMOs, Medicare Advantage is specifically striving to increase Preferred Provider Organization (PPO) participation. Provisions in the Medicare Modernization Act were intended to increase beneficiary options and choices regarding premium costs, cost-sharing, and benefit coverage. In order for choice to be meaningful, however, beneficiaries must continue to have the information needed to assess which program is best for them.

#### AMA POLICY

AMA policy clearly addresses the need for education of Medicare beneficiaries regarding their choices. Policy H-390.982 AMA Policy Database, (1) supports regulations that will require enrolling organizations to explain fully all the ramifications of participation by a Medicare eligible person in a health maintenance organization or a competitive medical plan; (2) urges the U.S. Department of Health and Human Services to require that specific levels of performance capabilities of the enrolling organization (e.g., adequate staffing, hospital facilities and outpatient capabilities) be documented and verified prior to awarding contracts for Medicare capitation programs; and (3) supports contacting organizations of the aged to assure that their members are aware of the pros and cons of Medicare HMO enrollment. Policy H-165.890 supports Medicare cost-sharing with appropriate incentives for patients to seek and receive preventive services. In addition, Policies H-330.922 and H-390.972 support the ability of physicians to waive Medicare cost-sharing on an individual basis for beneficiaries experiencing exceptional financial hardship.

## DISCUSSION

The Council is sympathetic to concerns that patient cost-sharing may deter some patients from seeking necessary medical care. The Council believes that physicians need to be particularly cognizant of the impact of cost-sharing on financially disadvantaged patients. Consistent with Policies H-390.972[2] and H-330.922, the Medicare program allows physicians to waive Medicare copayments and deductibles on a case-by-case basis.

At the same time, in the interest of constraining health care spending, particularly in the financially challenged Medicare program, it is prudent to continue to support patient cost-sharing. Accordingly, the Council believes there is a need to reinforce Policy H-390.982[1] by urging the Centers for Medicare and Medicaid Services to strengthen its efforts to educate Medicare beneficiaries about their coverage choices.

In particular, there is a need to improve the quality of Medicare beneficiary information. With the goal of providing patients with choice, it is important that beneficiaries receive information that allows them to compare plans in a standard format that is clearly written. Educational materials should enable beneficiaries to compare drug benefits, hospitalization charges, coverage for medical equipment, and all cost-sharing obligations.

Moreover, it is imperative that patients have the ability to choose their type of coverage and cost-sharing arrangement. The ability to choose is a valuable incentive for Medicare beneficiaries to inform themselves about their options. Beneficiaries must consider the pros and cons of each option.

The Medicare Modernization Act brings new options for Medicare beneficiaries. Starting in 2006, there will be a Medicare prescription drug benefit, and Medicare Advantage is expected to provide a broader range of options, particularly with the participation of PPOs. Medicare Advantage no longer allows beneficiaries to enroll and disenroll from chosen plans any time during the year. If beneficiaries are unhappy with their choice, they will have to wait for the next annual open enrollment. Accordingly, the information provided to beneficiaries will need to be clear on when and how often beneficiaries can change plans.

## RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 706 (I-03) and the remainder of this report be filed:

That our American Medical Association urge the Centers for Medicare and Medicaid Services to require companies that participate in the Medicare Advantage program to provide enrollees and potential enrollees timely information in a comparable, standardized, and clearly-written format that details enrollment restrictions, as well as all coverage restrictions and beneficiary cost-sharing requirements for all services.

### **3. REDUCING PRESCRIPTION DRUG PRICES (RESOLUTION 834, I-03)**

#### **HOUSE ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 834 (I-03) AND REMAINDER OF REPORT FILED**

At the 2003 Interim Meeting, the House of Delegates referred Resolution 834 to the Board of Trustees. Introduced by the New England Delegation, the resolution calls for the AMA to “support legislation to create a negotiated price reduction program with pharmaceutical companies that lowers prescription drug prices in order to make drugs affordable.” Similarly, the third and fourth resolves of Resolution 212 (A-04) asked the appropriate Council to study the idea of individual states being allowed to collectively negotiate drug prices with the pharmaceutical industry, and other mechanisms to bring down the price of prescription drugs, such as possible federal price controls. The Board of Trustees referred Resolution 834 (I-03) and the third and fourth resolves of Resolution 212 (A-04) to the Council on Medical Service for a report back to the House at the 2004 Interim Meeting.

This report broadly describes the major economic, political, and policy issues associated with concerns over prescription drug prices. The report also explores some of the practical implications of various types of solutions to these concerns, including those proposed or implemented by federal and state governments or by private entities. In addition to describing some of these current actions and proposals, the report highlights previous related work of the Council as well as recent actions by the House of Delegates.

## ECONOMICS OF PRESCRIPTION DRUG PRICES

Prescription drug expenditures in the United States have continued to grow in recent years. Although spending on prescription drugs represented only 10.5% of national health expenditures in 2002, the annual rate of growth in prescription drug spending was projected to exceed the rate of growth in all other major categories of health expenditure for the five-year period between 2000 and 2004. Over the last 10 years for which there are national data, the annual rate of growth in prescription drug spending rose from 8.4% in 1993, to a high of 19.7% in 1999, to 15.3% in 2002 (Centers for Medicare and Medicaid Services Office of the Actuary, 2004).

In a comprehensive report on pharmaceutical spending completed in 2000 (Council on Medical Service Report 3-I-00), the Council concluded that the rise in pharmaceutical spending in the US was due to a combination of factors, including increased utilization, the introduction and use of new drugs, and higher prices at the manufacturer, wholesale, and retail levels. Among the factors contributing to the growth in utilization were increased health plan coverage of pharmaceuticals; the effects of direct-to-consumer advertising; and a shift in demographics toward an older population resulting in a greater number and combination of drug regimens.

Continued patient access to new medications depends on their rate of introduction, which is usually the outcome of costly and time-consuming research and development. Because the development of most new prescription drugs requires large capital investments with uncertain prospects for market success, the willingness of pharmaceutical investors to make such investments is contingent upon the potential return on those investments. Yet the need for sufficient profitability to sustain continued research and development does not, by itself, explain why different patients face a variety of price levels when purchasing drugs.

Controlling for variation in health status, patients are affected differently by prescription drug price levels, with disparities sometimes so great as to raise legitimate concerns about access to prescription medications. These disparities occur because the effective price to a given patient of any given prescription drug depends on multiple factors such as whether or not the patient has health insurance that covers prescription drugs; which drugs are covered by a given health plan; the country in which the patient resides; whether the patient chooses a brand name or generic drug; and from what source the patient purchases the drug (e.g., retail, mail-order). Those patients who lack health insurance often pay the highest prices of all, and recent surveys suggest that their utilization patterns vary from those of the insured population as a result (Kaiser Family Foundation, 2002).

A number of factors loosely related to supply or demand drive the prices of prescription drugs. Unlike many other goods-producing industries, production, or "supply," costs do not comprise the largest share of the overall cost of goods sold by pharmaceutical manufacturers, as many medications are relatively inexpensive to produce. Rather, the bulk of resources used to create and sustain the prescription drug supply are consumed by research and development; patent protections; marketing costs; discounts, rebates and programs to assist low-income individuals with drug purchases; regulatory compliance; and executive compensation.

On the demand side, important factors that drive prescription drug prices include the real and perceived value of the drugs to the patient; the availability and price of alternative name-brand drugs and generic drugs; the prevalence of third-party financing arrangements (i.e., health insurance coverage) and their various cost-sharing incentives; the bargaining power of third-party payers and/or pharmaceutical benefit managers; the purchasing power of individuals and/or groups of individuals; and regulatory limitations.

Key to an understanding of all factors--both those of supply and those of demand--is a comprehension of their interrelationships. Specifically, changes to any one factor will generally result in changes to more than one of the other factors, potentially resulting in both intended and unintended effects on supply and demand. Any potential policy reform that does not explicitly account for these many interactions may not produce the desired outcome and, furthermore, may result in unintended consequences. Without careful consideration of all of those complex factors, the unintended consequences of reform may so adversely impact patient welfare as to more than offset any gains generated by implementation of the reform.

Except for production costs, which tend to be relatively small, each of the costs cited above is controversial. They are frequently viewed as excessive by those who would prefer that reforms target reductions in these costs so that savings realized could be used to finance price reductions for purchasers of prescription drugs. Understanding the critical policy trade-offs entailed in any reform targeting reduction of these costs, however, involves looking beyond the isolated effect it may be expected to have on price alone. One cannot evaluate any given reform without first understanding how pharmaceutical manufacturers, investors, purchasers, and consumers will respond to the various types of reforms and to each other's actions.

## PROPOSED SOLUTIONS AND THEIR COLLATERAL EFFECTS

Over the years, a variety of solutions have been proposed to address concerns related to the prices of prescription drugs. Some are based on trade regulation while others are based on direct price regulation. Still others rely on varying combinations of private market forces and government authority to influence the prices of prescription drugs. The following sections briefly describe the general characteristics and collateral effects of these solutions with respect to their impact on the size, scope, and safety of the current and future supplies of prescription drugs. Where applicable, specific programs or regulations that are in operation or which have been proposed as federal or state legislation are cited.

### *Federal Policy and Programs*

#### Medicare Program

Through enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173), a new Medicare prescription drug benefit will become available in 2006. Patients who enroll in prescription drug plans will have 75% of their first \$2,250 in drug costs covered after a \$250 deductible, and 95% of their drug costs covered after they reach \$3,600 in costs in a year. Qualifying low-income Medicare beneficiaries also will have their drug plan premium and deductible paid by Medicare and will have full coverage for all of their drug costs, except for modest copayments (e.g., \$1 to \$5 per prescription).

Beginning in May 2004 and continuing through December 31, 2005, the law also provided Medicare beneficiaries with the option of purchasing a drug discount card from one of a selected number of Medicare approved private companies at an annual enrollment cost of no more than \$30. Medicare projects that the discount cards will provide beneficiaries with savings of 10-25% on prescription drugs. In addition, qualifying low-income beneficiaries are eligible for an annual \$600 subsidy toward their drug costs, and the waiver of enrollment fee.

#### International Trade Regulations

International trade regulations essentially involve using bilateral trade agreements to limit the purchasing power of foreign nations so that they pay higher prices for patented prescription drugs, thereby contributing their fair share of the research and development costs already spent to bring new drugs to market. The problem of unfair distribution of the burden of research and development costs arises when foreign nations negotiate the prices they are willing to pay for prescription drugs using the threat of unlicensed importation or manufacture as negotiation leverage. By deeming patented prescription drugs "unavailable" at certain price points, foreign nations trigger provisions in their own laws which provide them the pretext for purchasing patented prescription drugs from sources other than the patent holders, or the pretext to manufacture the drugs themselves.

This tactic generates tremendous leverage in price negotiations. Manufacturers of patented prescription drugs often must sell at the price dictated by the nation that purchases the drugs or risk losing the entire national market for that country. These agreements are typically formed when the following two conditions are met:

- The country purchasing the drugs offers a price above the manufacturer's marginal cost (i.e., making the sale at least marginally profitable to the manufacturer, but not necessarily covering spent research and development costs).
- The country purchasing the drugs agrees not to export the drugs to other countries, enabling the pharmaceutical manufacturer to charge prices in other markets (e.g., the United States) that are great enough so that the manufacturer can recover its research and development costs and generate a return to investors.

One theory holds that the way to limit prescription drug prices in the US is to make foreign drug import policies a matter of international trade relations, negotiating agreements in which foreign nations agree to pay their fair share of the research and development costs of patented prescription drugs. While this idea has obvious appeal to drug manufacturers and may make good economic sense, it is unclear whether it would actually alleviate upward price pressure in the US market. Whether prescription drug prices in the United States would fall or grow more slowly is a question that has not yet been answered.

### *Proposed Federal Legislation*

#### Importation/Reimportation

Many of those seeking to remedy concerns over prescription drug prices in the US propose making it legal for American citizens, state agencies, and others to import drugs from Canada or other foreign nations where prices tend to be lower. In large part, this idea has gained growing interest because the press repeatedly has reported on a stream of anecdotes that verify large savings to individuals on the prices they pay for selected prescription drugs that they have purchased through Canadian pharmacies. During the 108th Congress, there were several bills introduced that seek to legalize reimportation of prescription drugs (e.g., S. 2307, S. 2328, S. 2493, and H.R. 3710).

Opponents of reimportation principally focus on three key issues. First, reimportation is viewed by many as an evasion of US patents, and as such, the mere threat of allowing circumvention of patent protections may seriously undermine the incentives of manufacturers to invest in the research and development of new patent drugs. Second, reimportation extends the production and distribution chain to new and potentially unregulated sources, threatening to make the US drug supply vulnerable to counterfeiting and adulteration, which in turn may pose a serious risk to the safety and health of patients. Third, the majority of projected savings are inaccurate, because they are based on the premise that manufacturers will continue to directly supply nations that enable the reimportation of US drugs.

Notably, an April 2004 analysis by the Congressional Budget Office (CBO) concluded that “permitting the importation of foreign-distributed prescription drugs would produce at most a modest reduction in prescription drug spending in the United States,” perhaps on the order of 1% savings per year. CBO further concluded that “permitting importation only from Canada would produce a negligible reduction in drug spending.” Among the key factors that led to this conclusion were estimated drug import volume (including limitations placed by foreign governments and drug manufacturers); price disparities among as many as 25 countries; identification of the drugs that most likely would be actually imported; and increased liability insurance costs that eventually would be passed on to consumers (Congressional Budget Office, 2004).

The issue of prescription drug importation and patient safety is addressed in a separate report of the Board of Trustees that is before the House of Delegates at this meeting.

#### Price Controls/Regulation

Just as the prices paid for supplies of prescription drugs could be regulated by federal authorities, the prices paid by certain drug purchasers in any particular market could be controlled by the government as well. For example, the “State and Local Access to Fair Prescription Drug Prices Act” (H.R. 3662), introduced during the 108th Congress, would require drug manufacturers to make their products available to all state programs, including Medicaid and state and locally administered group health or retirement plans, at a price not to exceed the manufacturer’s average price charged to six foreign nations (i.e., Canada, France, Germany, Italy, Japan, and the United Kingdom). Again, what makes it ultimately possible for price controls to work in some markets without creating supply disruptions in those same markets is the ability of manufacturers to earn at least a marginal profit in the regulated markets while capturing the balance of the necessary return on their investments in less stringently regulated and free markets.

Drug price control opponents draw an analogy to the type of cost shifting that occurs in the US market for physician services. The Medicare program controls the prices it pays physicians for the services it covers. For those services for which Medicare payment rates do not fully cover physicians’ costs, physicians cover their expenses by using revenues from other services and other payers providing higher rates of payment. The downfall of this type of strategy is that it fails when there are no longer any other payers or product lines to shift costs onto. At that point, further reductions in payment (or increases in payment that do not keep pace with practice costs) result in cutbacks

in the supply of unprofitable or less profitable services, and/or cutbacks in service to the patients whose payers provide the lowest rates. Similarly, controls on the prices of drugs ultimately could lead to reductions in the supplies of drugs available to patients.

#### Concentration of Federal Purchasing Power

Among the most controversial provisions of the Medicare Modernization Act of 2003 was a provision prohibiting the Secretary of the Department of Health and Human Services (HHS) from intervening in price negotiations between drug manufacturers and pharmacies and sponsors of prescription drug plans, or from requiring a particular formulary or price structure for covered Part D drugs. Those in favor of the provision see it as necessary to prevent the federal government from implementing “de facto” price controls. Critics claim that this authority is critical to enable the federal government to bargain effectively for fair prices on behalf of a beneficiary population that numbers close to 40 million. Numerous bills were introduced in the 108th US Congress that seek to repeal the “noninterference” provision of the Medicare Modernization Act to provide Medicare the authority to negotiate prescription drug prices directly with manufacturers (e.g., H.R. 3671, H.R. 3672/S. 1999, H.R. 3707, H.R. 3767/S. 1950, S. 1994, S. 2053).

The effects such legislation may have are unclear. Not all Medicare beneficiaries will avail themselves of the prescription drug benefit, and there are already larger purchasing consortiums and private entities that negotiate prices on behalf of consumers. Notably, in response to a congressional request to examine the effect of striking the “noninterference” provision, the CBO issued the following conclusion in January 2004:

We estimate that striking the provision would have a negligible effect on federal spending because CBO estimates that substantial savings will be obtained by the private plans and that the Secretary would not be able to negotiate prices that further reduce federal spending to a significant degree. Because they will be at substantial financial risk, private plans will have strong incentives to negotiate price discounts, both to control their own costs in providing the drug benefit and to attract enrollees with low premiums and cost-sharing requirements (Congressional Budget Office, 2004).

#### *State Legislation and Programs*

According to the National Conference of State Legislatures (NCSL), as of January 1, 2003, 26 states already had passed laws providing for state subsidies to assist certain individuals with the purchase of prescription drugs, while 16 states had established drug discount or bulk purchasing programs. During the 2003 legislative sessions, 49 states considered more than 325 bills intended to create, expand, or substantially change state pharmaceutical programs and policies. In fact, at the time that the Medicare drug discount card program was initiated in May 2004, 39 states already had enacted or operationalized pharmaceutical assistance programs. Furthermore, as of August 2004, an additional 320 pharmaceutical-related bills and resolutions had been filed in the 43 states holding legislative sessions during 2004 (National Conference of State Legislatures, 2004).

This plethora of recent state activity on prescription drug legislation continues at a level previously discussed in detail by the Council in its earlier study of state actions to control pharmaceutical costs (Council on Medical Service Report 2-A-02). In Report 2-A-02, the Council highlighted state actions intended to control pharmaceutical costs, including pharmaceutical rebate and discount programs, multi-state bulk purchasing alliances, and intra-state purchasing arrangements.

Among the variety of state approaches, interest in bulk purchasing alliances continues to grow. These alliances take many forms, but often involve different levels of government acting as a single purchaser for all the employees of all its agencies, or for all its beneficiary populations. Some examples include states or groups of states that negotiate prices for the medications obtained for state employees, retired civil service workers, and Medicaid beneficiaries.

According to NCSL, two multi-state bulk purchasing pools were operational as of July 2004. The “Rx Issuing States” project, led by West Virginia and including Maryland, Missouri, and New Mexico, issued a request for proposal and selected pharmacy benefits manager Express Scripts to negotiate discounted drug prices. The program covers 570,000 enrollees who already receive state health benefits, with estimated annual pharmaceutical spending of \$400 million. The state of West Virginia estimates that the program will produce an estimated \$25 million in savings in that state over three years (National Conference of State Legislatures, 2004).

The “National Medical Buying Pool,” a program intended to lower Medicaid prescription drug costs, includes the states of Alaska, Hawaii, Michigan, Minnesota, Montana, Nevada, New Hampshire, and Vermont. The pooled purchasing program covers approximately 1.5 million lives, with annual pharmaceutical purchases of about \$2 billion. Estimated 2004 Medicaid program savings range from \$250,000 in New Hampshire to approximately \$8 million in Michigan (National Conference of State Legislatures, 2004).

The Council continues to be impressed by the creativity and level of commitment demonstrated by state legislatures, and the subsequent state programs intended to address access to and the costs of pharmaceuticals. A comprehensive listing of 2003 and 2004 prescription drug state legislation, including a complete listing of individual multi-state and interagency pharmaceutical bulk purchasing alliances, is available on the NCSL web site at [www.ncsl.org](http://www.ncsl.org).

As previously noted in Council Report 2-A-02, the AMA’s Advocacy Resource Center (ARC) has continued its “Access to Affordable Prescription Drugs” campaign which is intended to examine the rising cost of prescription drugs and explore ways that states can address this trend, including mechanisms that states may implement to improve access to affordable pharmaceuticals. Materials related to the ARC campaign can be accessed from the ARC web site at [www.ama-assn.org/go/arc](http://www.ama-assn.org/go/arc).

#### *Pharmaceutical Assistance Programs*

Over the years, virtually every pharmaceutical manufacturer has created a program that offers prescription drugs at reduced prices or free to low income patients. According to the Pharmaceutical Research and Manufacturers of America (PhRMA), its members provided free prescription drugs to 6.2 million patients in the United States in 2003, at a cost of nearly \$3.4 billion. In general, these programs are intended to promote the welfare of low-income patients unable to afford their medications at any price; generate goodwill among the general public and policymakers in order to reduce the threat of price controls and other significant government intervention targeting price reductions; and to produce incremental profit from those patients who are able to pay for drugs but only at reduced prices.

In April 2004, PhRMA launched a web-based tool on [www.helpingpatients.org](http://www.helpingpatients.org) that is intended to provide “one-stop shopping,” in which low-income patients have easier and faster access to more than 400 different medications through 40 different pharmaceutical company assistance programs. The web site’s “Fast Access” feature allows patients or their physicians to enter data once and have the data fed into the various drug assistance programs to determine where there may be a match for that patient.

Numerous other prescription drug assistance programs and resources are available as well. One of the most well-known programs continues to be that provided by Volunteers in Health Care ([www.rxassist.org](http://www.rxassist.org)). Sponsored by the Robert Wood Johnson Foundation, the program features RxAssist which allows patients and physicians to search for information on drug assistance programs by company, brand name, generic name, and drug class. A new feature is Rx Outreach, a new program developed by Express Scripts that provides qualified low-income individuals and families with access to generic versions of brand name medications.

#### AMA POLICY

The AMA has established longstanding policy in support of pluralism and free market competition, with no preferential treatment by government that gives a competitive advantage to any form of health care delivery and financing (Policies H-165.985[1] and H-165.944[2], AMA Policy Database). The AMA also has longstanding policy opposed to price controls (Policies H-165.954[3] and H-165.987[5]).

Specific to prescription drug prices, Policy H-110.998 urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. Policy H-110.995 expresses AMA concern to PhRMA, including its CEO, and others as appropriate about the cost of prescription drugs as well as the inability of many patients to afford essential prescription drugs. Policy H-110.997[1] also supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs.

Most recently, at the 2004 Annual Meeting, the House of Delegates adopted Resolution 211, which calls for the AMA to support federal legislation which gives the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Medicare Part D drugs.

## DISCUSSION

Four years ago, the Council on Medical Service concluded that just as there are a combination of factors contributing to the rapid rise in pharmaceutical spending in the US, there will need to be a combination of solutions for addressing this increase (Council on Medical Service Report 3-I-00). The Council suggested that employers and health plans need to further analyze and disaggregate their data on pharmaceutical spending in order to better understand the underlying causes of recent spending increases, as well as develop corresponding strategies that do not adversely affect patient access to necessary pharmaceuticals nor impose undue administrative burdens. Physicians need to carefully examine their own prescribing patterns to determine the most appropriate and cost-effective medications for their patients. The American public needs to take a more active role in working with the medical community to better understand the appropriate use of pharmaceuticals in maintaining their overall health, and needs to demonstrate a continued willingness to share in the financial responsibility that accompanies the improvements in health and quality of life that such products bring.

With respect to the role of the pharmaceutical industry, Council on Medical Service Report 3-I-00 also offered the following advice:

The pharmaceutical industry has a narrowing window of opportunity to step forward with market-based solutions to addressing those factors contributing to the growth in pharmaceutical spending for which they have control, such as marketing campaigns and the pricing strategies for its product lines. Such solutions, however, will need to be proactive, creative, and viewed sincerely by policy-makers as balancing the interests of corporate shareholders with the interests of the American public. The likely alternatives to such market-based approaches, will be solutions that are more regulatory in nature, including the possible implementation of price controls.

As the information in this report has demonstrated, members of Congress and numerous state legislatures have not waited for the pharmaceutical industry to respond to the continued rise in pharmaceutical spending and to concerns over prescription drug prices. The underlying issue of referred Resolution 834 (I-03) and the third and fourth resolves of Resolution 212 (A-04)—concern over patient access to prescription drugs due to high drug prices—is consistent with the impetus behind many of these current legislative activities.

With the adoption of Resolution 211 (A-04) the AMA has been directed to support federal legislation that would repeal the “noninterference” clause of the Medicare Modernization Act of 2003, in order to allow the Secretary of the HHS the authority to negotiate contracts with manufacturers of covered Part D drugs. At the state level, NCSL and the AMA’s Advocacy Resource Center (ARC) have catalogued hundreds of state bills that have been introduced and/or passed to create pharmaceutical bulk purchasing alliances, discount drug programs, and a variety of pricing requirements and regulations.

The Council on Medical Service believes that the challenge in these types of efforts will be to ensure that the collateral effects of proposed legislation are carefully considered in advance of passage and program implementation. For example, at what point do “negotiated price reduction” programs become “price control” programs? What impact will such programs have on the safety, scope, and size of the current and future supplies of prescription drugs? Will these programs actually reduce overall prescription drug prices, or will they serve mainly to encourage parties to prescription drug transactions to simply shift costs among themselves? Will there be any unintended, adverse affects of such programs on vulnerable patient populations? As previously noted, any potential policy reform that does not explicitly account for these interactions may or may not produce the desired outcome and, furthermore, may result in unintended consequences.

Considerable concern was raised in the Reference Committee testimony regarding Resolution 834 (I-03) because its intent “runs contrary to the AMA’s support for market-based solutions.” As the House of Delegates is well aware, long-standing AMA policy supports pluralism and free market competition, and opposes price controls. As the AMA continues to move forward to provide assistance to physicians and patients with their concerns over the cost of prescription drugs, the Council believes that it will be critical that these long-standing policies are upheld. The

Council believes, therefore, that there is merit in continuing to encourage the pharmaceutical industry to exercise reasonable restraint in the pricing of prescription drugs, and to support programs whose purpose is to contain the rising costs of prescription drugs, provided that such programs adhere to AMA principles.

In addition, the Council believes that, given the substantial legislative activity already occurring at the state level, those state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, should contact NCSL which maintains a comprehensive database on all such programs and legislation. Similarly, the Council believes that members of the Federation should continue to participate in the ARC "Access to Affordable Prescription Drugs" campaign.

#### RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 834 (I-03), and the remainder of the report be filed:

1. That our American Medical Association continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs.
2. That our AMA reaffirm Policy H-110.997[1] which supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs.
3. That our AMA encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures ([www.ncsl.org](http://www.ncsl.org)) which maintains a comprehensive database on all such programs and legislation, and the AMA's Advocacy Resource Center ([www.ama-assn.org/go/arc](http://www.ama-assn.org/go/arc)) for materials from its "Access to Affordable Prescription Drugs" campaign.

(References pertaining to Report 3 of the Council on Medical Service are available from the Division of Socioeconomic Policy Development.)

#### **4. OPTIONS FOR IMPLEMENTING AND FINANCING TAX CREDITS FOR INDIVIDUALLY SELECTED AND OWNED HEALTH INSURANCE**

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

The AMA proposal for expanding health insurance coverage and choice includes three key elements: (1) a preference for individual rather than employer ownership and selection of health plan; (2) the use of income-related, refundable, advanceable tax credits toward the purchase of health insurance; and (3) appropriate market regulation based on the recognition that neither free-market mechanisms nor market regulations alone will fully meet the needs of those with expensive medical conditions (Policies H-165.920, H-165.865, and H-165.856, AMA Policy Database).

Ideally, the AMA reform proposal seeks to replace the current federal tax exclusion for employment-based health insurance with a system of income-related, refundable, advanceable tax credits to individuals and families for the purchase of health insurance of their choice. Such a change in the tax treatment of health insurance would expand

coverage by redirecting the existing inefficient and regressive subsidy toward those who most need help affording coverage; and expand choice by subsidizing coverage regardless of whether it is obtained through employment or elsewhere. However, revoking the tax exclusion would only partially finance tax credits large enough to provide near-universal coverage of the US population. Furthermore, revoking the tax exclusion would likely face considerable political opposition, particularly from middle-to-upper-income voters who stand to receive less subsidy in tax credits than from the exclusion, particularly in a relatively unstable economic climate.

Thus, it is essential that the AMA continue to seek alternative routes to achieving its vision of a pluralistic, market-based health care system with individual choice and coverage for all Americans. Alternative approaches toward an individually based system could include both incremental implementation of individual tax credits and financing mechanisms other than wholesale revocation of the tax exclusion. This report provides an overview of the AMA proposal; describes the current climate for health system reform; outlines and evaluates ways to incrementally implement tax credits; summarizes alternative sources of financing for tax credits; assesses the pros and cons of an individual mandate; and presents several policy recommendations.

## OVERVIEW OF THE AMA REFORM PROPOSAL

### *Individually Selected and Owned Health Insurance*

Under the AMA proposal for health system reform, individuals would have greater choice of health insurance because tax credits could be applied to coverage, whether obtained through an employer or elsewhere. The removal of preferential tax treatment for employment-based coverage would fuel demand for alternative sources of group coverage. Employment-based coverage would remain an option to the extent that employees demand it (and remain fully deductible as a business expense). In addition, shifting choice from employers to individuals would increase market competition among plans, making them more responsive to patient demand for access, quality, and affordability.

### *Individual Tax Credits*

The AMA proposes a system of income-related, refundable, advanceable tax credits toward the purchase of health insurance of the individual's choice. Such credits are designed to dramatically reduce the ranks of the uninsured by redirecting the current federal subsidy for health insurance toward those who most need help affording coverage. Policy H-165.865 advocates structuring tax credits according to the following principles:

- Tax credits should be contingent on the purchase of health insurance. Individuals would have to purchase health insurance to receive a tax credit. Tax credits for families would be contingent on each member of the family having health insurance.
- Tax credits should be refundable and advanceable. Low-income people who owe less income tax than the value of the credit--those most at risk for being uninsured--would still receive tax credits. Tax credits would be available in advance so coverage can be purchased without waiting for a year-end tax credit.
- The size of tax credits should be inversely related to income. By providing larger credits to those with lower incomes, the AMA proposal targets those who are more likely to be uninsured. Targeting subsidies to low-income individuals also reduces the amount of uncompensated care that currently exists in the health care system.
- The size of tax credits should be large enough to ensure that health insurance is affordable for most people. At lowest income levels, the credit would approach 100% of the premium.
- Tax credits should be applicable only for the purchase of health insurance, and not for out-of-pocket health expenditures. Allowing tax credits to be used for out-of-pocket expenses would encourage excessive use of services, necessitate detailed rules regarding which expenses qualify for credits, and dilute the incentive to purchase coverage. An exception is that tax credits can be used for all components of a Health Savings Account (HSA), including the account, which can be used for out-of-pocket expenses.

### *Appropriate Market Regulation*

The AMA proposal also includes measures to enable insurance markets to provide affordable coverage while serving the needs of individuals with above-average health needs (Policy H-165.856). The desire to protect specific target populations has been a major force behind market regulations regarding terms of issue, premium rating, and benefit mandates. Existing regulations often have unintended consequences, unfairly affect people differently depending on where they live or work, and are often burdensome, complex, and contradictory. The AMA proposes a more rational approach based on the following principles:

- There should be greater national uniformity of market regulation across health insurance markets. There should be less variation by type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan. State departures from national regulations would be permissible so long as they neither drive up the number of uninsured nor unduly hamper development of multi-state group purchasing alliances.
- The medical expenses of individuals with chronic illness or expensive conditions should be financed collectively in a manner that does not unduly restrict choice or drive up health insurance premiums for the general population. This will require a combination of market mechanisms and market regulations, and will require subsidies financed through general tax revenues rather than through strict community rating or premium surcharges.
- Strict community rating should be replaced with modified community rating, risk bands or risk corridors. Attempts to lower premiums for high-risk individuals through community rating raises premiums of low-risk individuals, reducing their enrollment, and thereby driving up average costs and premiums. By allowing some degree of premium variation to reflect individual factors, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population.
- Guaranteed issue regulations should be rescinded, and insured individuals should be protected by guaranteed renewability. Guaranteed issue in combination with strict community rating and extensive benefit mandates has had disastrous unintended effects on costs, coverage and choice, by driving up premiums and allowing healthy people to forgo coverage until sick. Instead, individuals would have powerful incentives to obtain and maintain coverage when healthy, and insurers would be prohibited from dropping or “reunderwriting” enrolled individuals who experience illness.
- The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Most barriers to the formation and operation of group purchasing alliances should be removed. Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

In addition to existing insurance options, the AMA proposal would encourage the creation or expansion of small group purchasing arrangements and other health markets that offer choices to consumers for redeeming their tax credits.

## THE CURRENT CLIMATE FOR HEALTH SYSTEM REFORM

### *Rising Health Care Costs*

Growth in US health care spending and health insurance premiums continue to outpace overall economic growth and inflation. The Centers for Medicare and Medicaid Services (CMS) report that in 2002, annual health care spending reached \$1.6 trillion, with per capita spending of \$5,440 (Levit et al., *Health Affairs*, January/February 2004). Health expenditures as a share of gross domestic product (GDP) are projected to increase from 14.9% in 2002 to 18.4% in 2013 (Heffler et al., *Health Affairs*, Web exclusive, February 2004). Health expenditure growth has been reflected in high and accelerated premium growth. Over the last half decade, private insurance premiums have risen each year at double-digit rates, reaching an average of \$3,695 for employment-based individual coverage and \$9,950 for employment-based family coverage (Kaiser Family Foundation/Health Research and Education Trust, *Survey of Employer-Sponsored Health Benefits*, 2003, and 2004).

Although research shows that additional health care expenditures are well worth it in terms of prolonged lifespan, increased quality of life, and productivity gains, employers report struggling to contain health benefit costs, and recent surveys show that many families--including those with insurance--have cost-related access problems or difficulty paying medical bills (Center for Studying Health System Change, *Issue Brief* No. 85, June 2004 and Commonwealth Fund Biennial Health Insurance Survey, 2003). Inability to pay high medical bills is a major cause of personal bankruptcy, again, even among the insured. According to a recent poll, more Americans worry about health care costs than about becoming unemployed, paying their rent or mortgage, or being a victim of a terrorist attack (Kaiser Family Foundation *Health Poll Report*, June 2004).

### *The Uninsured*

Rising rates of uninsured correspond with rising health and insurance costs. By far, the most common reason cited for being uninsured is high cost (Kaiser Family Foundation *Health Insurance Survey*, April 2003). In 2003, the latest year for which data are available, the number of uninsured rose to 45 million, or 15.6% of the non-elderly population (US Census Bureau, 2004). The biggest driver of the increase in the uninsured has been the loss of employment-based coverage, which arose from a combination of factors: job losses, rising premiums, fewer employers offering coverage (including retiree coverage), and more employees declining coverage. During a period of widespread state budget crises, enrollment in public programs only partially offset losses in private coverage. Approximately two-thirds of uninsured adults have been uninsured for more than a year (Kaiser Family Foundation Commission on Medicaid and the Uninsured, January 2004).

Rates of being uninsured correlate with demographic factors, with workers at small firms, low-income individuals, and young adults the most likely to lack coverage:

- *Age* - Approximately 20% of the uninsured are children, the remainder being roughly split between those under 35 and those who are older (US Census Bureau, Current Population Survey, September 2004). Young adults were the least likely to be insured, in part due to high unemployment among this group (Kaiser Commission on Medicaid and the Uninsured, 2003).
- *Income* - While members of low-income households were the most likely to be uninsured, the likelihood of being uninsured rose across all income categories. The uninsured are split roughly into thirds between those below 100% of the federal poverty line (FPL), those between 100-200% of FPL, and those above 200% of FPL (Kaiser Commission on Medicaid and the Uninsured, 2003). Seventeen percent of the uninsured have annual incomes over \$75,000 (US Census Bureau, Current Population Survey, September 2004).
- *Employment Status* - Approximately 80% of the uninsured come from working families (Kaiser Family Foundation, December 2003); of this subset of the uninsured, four-fifths were not offered coverage through work, and one-fifth declined such coverage (Garrett, *Employer-Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001*, Kaiser Commission on Medicaid and the Uninsured, July 2004).
- *Firm Size* - Workers at small firms experience the highest levels of being uninsured and the steepest growth in being uninsured (Kaiser Commission on Medicaid and the Uninsured, 2003 and July 2004). Multiple associated factors contribute to lower rates of coverage among workers at small firms: lower income, younger age, lower offer rates of employment-based insurance, and greater likelihood of being ineligible for employment-based insurance--in large part due to greater proportions of part-time workers.
- *Health Status* - Among uninsured working-age adults (18-64), 27% suffer from chronic conditions such as heart disease and diabetes, as compared to 39% of the insured (derived from Tu and Reed, Center for Studying Health System Change, February 2002). Those with chronic conditions are less likely to be uninsured than healthy individuals (12% vs. 15%) because of greater access to public coverage and greater likelihood of working for an employer that offers health benefits (Tu and Reed, 2002).
- *Ethnicity* - Blacks (20%), Hispanics (33%), and Asians (19%) are more likely to be uninsured than Caucasians (11%) (US Census Bureau, Current Population Survey, September 2004).
- *Sex* - Males are more likely to be uninsured than females (17% vs. 14%) due to less access to public coverage (Current Population Reports, September 2003).

### *The Federal Budget Deficit*

In 2002, the US returned to deficit spending, with expenditures exceeding revenues by close to \$500 billion in 2004 or 4.5% of gross domestic product (US Office of Management and Budget, February 2004). Although the budget is subject to change between deficit-spending and surplus for any given year, the total national debt currently approaches \$7.5 trillion, or 62% of gross domestic product (Budget of the US Government, Fiscal Year 2005, Historical Tables, Table 7.1). The five biggest components of federal spending are Social Security, defense, Medicare, Medicaid, and interest payments on the federal debt (Congressional Budget Office, *Monthly Budget Review*, October 2004). Annual interest payments on the debt alone exceed \$300 billion, constituting over a tenth of the federal budget (US Department of the Treasury Bureau of the Public Debt, 2004, Budget of the US Government, Fiscal Year 2005, Historical Tables, Table 1.1). Estimates show that covering future revenue shortfalls would require drastic tax increases, elimination of all discretionary spending, or cutting Social Security and Medicare benefits by half (Kotlikoff, *Milken Institute Review*, April 2004).

### *Public Opinion on Health System Reform*

Persistent growth in health care costs and the rate of the uninsured has led to increased public support for some sort of health system reform aimed at lowering costs and expanding coverage. Nearly 70% of Americans surveyed favor repealing or limiting recent federal tax cuts in order to guarantee health insurance security (Commonwealth Fund *Biennial Health Insurance Survey*, 2003). Polls consistently show that no one approach to health system reform garners majority public support as the most favored approach (Commonwealth Fund *Biennial Health Insurance Survey*, 2003; Harvard School of Public Health/Robert Wood Johnson, December 2003; and Kaiser Family Foundation *Health Poll Report*, March/April 2004). Proposals with the highest general support include expansion of Medicaid/SCHIP (80%), an employer mandate (76%), and individual tax credits (71%), with less support for universal Medicare coverage (55%), an individual mandate (54%), and a single national government plan (47%) (Harvard SPH/RWJF, December 2003). However, when survey respondents are forced to select a "top pick," no one proposal garners more than 22% of support among respondents. Furthermore although proposals have greater general support when respondents are not forced to pick their top choice, support is roughly halved when proposals are subjected to follow-up questions such as: What if expansion of public programs would require raising taxes? Or, what if an employer mandate would lead to layoffs? (Harvard SPH/Blue Cross Blue Shield Foundation/Cogent Research Poll, 2003).

### *Increased Recognition of the Effects of the Federal Subsidy*

During the last decade, there has been growing acknowledgement that the \$122-billion annual federal subsidy for employment-based health insurance is unfair and inefficient. This subsidy arises because the portion of employee compensation conferred in the form of health benefits is exempt from the employee's taxable income (Sheils and Haight, *Health Affairs*, Web exclusive, February 2004). In order to receive the subsidy, employees must accept whatever plan or plans their employers choose; and that those without employee health benefits, and who are not self-employed, receive no subsidy at all. Moreover, those with higher incomes--because they are in higher tax brackets--receive the largest share of the subsidy (Sheils and Hogan, *Health Affairs*, March/April 1999). At the same time, there is general recognition that continued government subsidization of health insurance is both necessary and appropriate in order to address the problem of the uninsured, given that the insured indirectly pay for a substantial portion of the health care of the uninsured through higher taxes and insurance premiums.

### *Growing Support for Tax Credits*

Against a backdrop of escalating costs, swelling ranks of the uninsured, and mounting public pressure for reform, there has been growing support for individual tax credits. Early tax credit proposals have been modified in response to criticisms that they did not do enough to assist low-income families, thereby gaining a following among former opponents (Cunningham, *Health Affairs*, 2002). Proposed credits have become more generous, refundable, available in advance, and applicable outside the individual market. Support for more widespread use of individual tax credits for the purchase of health insurance comes from a diverse array of policymakers and organizations. During the 2004 presidential primaries and general election, candidates from both major parties proposed some form of individual health insurance tax credits. Academic research demonstrating the viability of tax credit proposals has been conducted at Stanford, Columbia, the Wharton School of Business at the University of Pennsylvania, Emory, and elsewhere.

Think tanks that have put forth individual tax credit proposals include the Heritage Foundation, the American Enterprise Institute, the Galen Institute, the Cato Institute, the New America Foundation, the National Center for Policy Analysis, the Heartland Institute, the Progressive Policy Institute, Centrists.org, the Coalition for Affordable Health Insurance, the Coalition for Affordable Health Care, the Institute for Policy Innovation, and the Pacific Research Organization. A number of business and professional associations also have proposed individual tax credits, including the US Chamber of Commerce, the Blue Cross Blue Shield Association, America's Health Insurance Plans, American College of Physicians, the Massachusetts Medical Society, the Hispanic Business Roundtable, the National Association of Health Underwriters, Communicating for Agriculture and the Self-Employed, and the National Association for the Self-Employed.

In addition, national media coverage of individual tax credits, including the AMA Proposal, has appeared in the *Wall Street Journal*, *New York Times*, *Los Angeles Times*, *Detroit News*, *Journal of the American Medical Association*, and *New England Journal of Medicine*. Similarly, in recent years, there have been numerous legislative proposals introduced in Congress that include some form of individual tax credit: the Health Credits Act; HealthCARE Act; Health Care Cost Integrity and Fairness Act; Patients' Health Care Choice Act; Comprehensive Health Care Reform Act; Health Coverage Access Relief and Equity (CARE) Act; the Relief, Equity, Access, and Coverage for Health (REACH) Act; Securing Access, Value, and Equality in Health Care (SAVE) Act; the Fair Care for the Uninsured Act; and Child Health Care Affordability Act.

Bipartisan efforts to enact individual tax credits for the purchase of health insurance came to fruition with the passage of the Trade Act of 2002 (P.L. 107-210). As described in Council on Medical Service Report 11-A-03, the Trade Act provides refundable, advanceable health insurance tax credits to selected groups of workers, including those displaced by international trade. The Act provides approximately \$610 million in tax credits and grants over a five-year period, primarily to cover 65% of insurance premiums for 260,000 eligible individuals and family members. Although small in scope, the Trade Act represents a major breakthrough by establishing a precedent for individual tax credits. During the 108th Congress, the Health Care Tax Credit Enhancement for Workers and Steel Security Act (S.1018 and H.R. 1999) and the Health Care Tax Credit Expansion Act (S. 1693) were proposed to broaden the group of workers eligible for Trade Act tax credits.

#### POSSIBLE TARGETED APPROACHES

The AMA proposal to expand health insurance coverage and choice represents a coherent, workable, and equitable vision of market-based health system reform. The AMA proposal was conceived during an era of federal budget surpluses, when widespread implementation of individual tax credits financed by revoking the tax exclusion for employee health benefits appeared possible (Council on Medical Service Report 9-A-98, "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage"). Given the current reform climate--tightening budgetary constraints, the rising number of uninsured, and growing receptivity to tax credits--it is important that the AMA identify feasible, incremental steps toward implementing its proposal. Such steps should target a subset of the uninsured population and should not depend on wholesale revocation of the tax exclusion.

Any targeted approach must define verifiable eligibility criteria and confront certain tradeoffs. One of the most critical issues is "crowd out," whereby a portion of the additional public subsidy substitutes for private expenditures, rather than adding to the total dollar amount devoted to health insurance coverage. Extending tax credits to some or all of the previously insured means that a portion of the subsidy substitutes for--or "crowds out"--private insurance expenditures, thereby reducing net coverage gains. On the other hand, it may be viewed as unfair to penalize those who acted responsibly by obtaining coverage, and who are equally deserving of subsidies as otherwise-similar uninsured individuals and families.

#### *Low-Income Workers*

A number of policy analysts have suggested individual tax credits for selected workers as a practical, effective way to expand coverage incrementally (Dorn and Meyer, Economic and Social Research Institute, October 2002; Butler, Heritage Foundation *Backgrounder* No. 1769, June 2004; and Lemieux, Progressive Policy Institute *Backgrounder*, September 2003). Such proposals generally focus on low-income workers at small firms, and may or may not restrict eligibility to those without job-related coverage. Specific eligibility categories that could be used alone or in combination include:

- *Workers who have lost job-related coverage due to lay offs* - Lemieux proposes targeting such workers by expanding the Trade Act tax credit eligibility categories, as do several legislative proposals noted earlier (S.1018, H.R. 1999, and S. 1693).
- *Workers without employment-based health insurance* - One-fifth of employees offered health benefits currently decline such coverage. Defining eligibility this way could create “crowd out” because some tax credits would go to those who had already obtained coverage on their own, and more importantly, by encouraging those with health benefits to drop them in order to qualify for tax credits. Although the dropping of existing health benefits could be mitigated by imposing a waiting period for those who drop prior coverage, this would drive up verification costs.
- *Workers without access to employment-based health insurance* - While basing eligibility on access to coverage avoids “crowd out” from workers dropping existing health benefits, it could be seen as unfair to workers whose employers offer coverage, as well as to the unemployed. In addition, it could lead to “crowd out” at the firm level if employers discontinue health benefits knowing that only then will their employees qualify for tax credits. Again, a waiting period could be imposed for those who previously had job-based coverage, although this would require greater verification effort, and run the risk of penalizing workers for their employers’ decisions.
- *Workers at small firms* - Compared to larger firms, small employers pay lower average wages and are less likely to offer health benefits. Basing eligibility strictly on firm size would make targeting relatively easy but would entail “crowd out” from some currently covered workers. On the other hand, if eligibility were restricted to workers not offered coverage, some firms might drop health benefits. Similarly, if tax credits could not be used toward employment-based coverage, some firms currently offering health benefits might drop coverage. It should be noted that proposals aimed at small-firm workers often include creation of alternative pools through which to purchase group coverage, and implementation of mechanisms known to dramatically increase take-up rates, such as automatic enrollment and payroll deduction of premiums (e.g., Gruber; and Singer, Garber, and Enthoven in *Covering America*, Vol. 1, June 2001).
- *Workers at firms with a high proportion of low-income workers* - This approach simplifies targeting but creates “crowd out” to the extent that higher-paid workers at qualifying firms take advantage of the tax credit. As noted earlier, if tax credits could not be used toward employment-based coverage, some firms might drop coverage.
- *Low-income workers regardless of firm characteristics* - This approach is more direct (i.e., creates less “crowd out”) but more difficult (more costly) to implement than targeting through selected firms likely to employ larger proportions of low-income workers.
- *Selected low-income workers* - This approach would use some combination of eligibility criteria such as income, firm characteristics, and/or access to employment-based coverage in order to balance concerns about “crowd out,” fairness, and feasibility.

### *The Poor*

A straightforward way to target tax credits to low-income individuals would be to base eligibility on not being eligible for Medicaid or SCHIP, and on having income below a certain percentage of FPL such as 100% or 200%. Setting the income cut off very low results in a smaller but needier group of eligibles, and a larger subsidy per recipient. Given the relatively low rates of private coverage among those with low-incomes, the magnitude of potential “crowd out” would be minimal, and presumably tax credits would be available to both the uninsured and insured, including those covered through an employer. Pauly takes an unconventional approach in proposing to target lower-middle income families (125% to 300% FPL), rather than the very poorest, who would have public or publicly contracted coverage (*Covering America* Vol. 1, June 2001). The rationale is that, compared to the very poor, lower-middle income people would require smaller credits, so that greater coverage gains could be made with a given tax credit budget; and that this group would be relatively more able to compare and choose among competing plans. Depending on results, tax credits could later be extended to lower and higher income groups.

Some analysts have proposed targeting subsidies by tying the size of the tax credit to both the cost of coverage and the individual's income. For example, households would not pay more than 5% of income for premiums (Dorn and Meyer, Economic and Social Research Institute, October 2002; Blue Cross Blue Shield Association, January 2004; Gruber in Meyer and Wicks (eds), *Covering America: Real Remedies for the Uninsured*, Vol. 1, June 2001; and Calabrese and Rubiner, New America Foundation, January 2004). Any scheme offering larger tax credits for more expensive coverage runs the risk of encouraging overinsurance, but especially one in which the incremental cost to the household is zero beyond a certain premium level. Further, such a system would prove even more problematic if tax credits were ever extended to a broader population.

It should be noted that different, possibly overlapping, target populations and eligibility criteria are not mutually exclusive. For example, Dorn and Meyer propose defining eligibility both on the basis of income and access to employment-based coverage (Economic and Social Research Institute, October 2002). Even if income is not an explicit eligibility criteria, other forms of targeting may channel resources toward those with low-income. For example, offering tax credits to employees of small firms indirectly targets low-income workers because of the inverse association between firm size and average wages. Some policy analysts have proposed offering tax credits to all workers at firms with at least a specified proportion of low-income workers as a way of reaching low-income workers with relatively low eligibility verification costs.

### *Children*

Since insuring children is relatively inexpensive, large coverage gains could be made by targeting a given tax credit budget to children. Policy makers would have to decide whether eligibility would depend on access to coverage through Medicaid, SCHIP or a parent's employer; income, and student status for those above the ordinary age cut off. "Crowd out" can be curbed by excluding children whose parents have the option of family coverage through an employer. For example, the Child Health Care Affordability Act (H.R. 4025) proposes a partially refundable tax credit of up to \$500 per child for qualified medical expenses. Although the tax credit can be applied toward insurance premiums, there is no requirement that recipients be insured. The credit limit is raised to \$3,000 for children with "terminal disease, cancer (whether or not in remission), a disability, or any other health condition requiring hospitalization or other forms of specialized care."

### *The Sick*

There is great appeal in proposals to target tax credits to those with expensive or chronic conditions who lack access to public or employment-based coverage. However, defining and identifying the target population would be more complex than with workers, low-income individuals or children. Would eligibility be determined by diagnostic data, a dollar amount of medical expenses, participation in state high-risk pools or some other criteria? Another issue is that allowing people to qualify for tax credits only after experiencing illness creates a perverse incentive to forgo coverage when healthy. This scenario could be partially offset by imposing a waiting period to be waived only upon proof of prior coverage, although such a requirement would partially defeat the intent of delivering assistance at the time of greatest need. Because the onset of serious illness is often accompanied by loss of job-related coverage, it is important that tax credits be applicable to COBRA premiums. As noted above, the Child Health Care Affordability Act includes a provision to provide more generous coverage to those experiencing serious illness. Targeting a given amount of total dollars into tax credits for the chronically ill would reduce the uninsured by a smaller number than targeting the same dollar amount to children (Gruber, *American Economic Review*, May 2003). However, it could be argued that the goals of providing access to critically needed medical care and protecting patients against financial ruin are more important than simply reducing the number of uninsured.

### *Selected Geographic Areas*

Introducing tax credits at the state level has been proposed in the context of offering or pilot testing multiple reform approaches (Dorn and Meyer, Economic and Social Research Institute, October 2002, and Aaron and Butler, *Health Affairs*, March 2004). With federal support, states could choose from a menu of options such as individual tax credits, public program expansions, tax credits to employers, employer or individual mandates, buy-in into federal or state employee health benefit programs, creation of insurance purchasing pools or single state-wide insurance plans. Aaron and Butler argue that state pilot tests could gain widespread support and break the current political impasse on reform, so long as all stakeholders believe that their favored approach would receive a fair trial. Pilot tests also would provide valuable empirical evidence with which to compare competing reform options. Although there

would continue to be philosophical differences about the desirability of various outcomes (i.e., with regard to universality, choice, degree of compulsion, cost, etc.), there would be greater agreement on the actual implications of various policies and the magnitudes of tradeoffs between conflicting objectives. Aaron and Butler emphasize the need for adequate data collection, clear evaluation criteria, and monetary rewards to states that achieve coverage gains. In response to Resolution 118 (A-04), the Council on Medical Service is preparing a report for the 2005 Annual Meeting that examines various alternatives and demonstration projects for expanding health insurance coverage for low-income persons and reports on progress concerning development of new state options for improving the effectiveness of public health safety net programs.

## POTENTIAL FINANCING MECHANISMS

### *Limit the Tax Exclusion*

Given the current large, unlimited, and regressive subsidy arising from the tax exclusion for employment-based health coverage, many reform proposals seek to eliminate or limit the exclusion. Consistent with AMA policy, some proposals would eliminate the tax exclusion altogether (Pauly and Wicks, Meyer, and Silow-Carroll in *Covering America* Vol. 1, June 2001). Other proposals grapple with the political difficulties of revoking such a large, entrenched subsidy to middle- and upper-income voters. One proposal recommends initially capping the dollar amount that can be excluded from taxable income at twice the geographically adjusted premium of a benchmark plan (the median-cost Federal Employees Health Benefit plan). The cap on excludable premiums would be ratcheted down each year until, after ten years, it would equal the premium of the benchmark plan plus 5% (Singer, Garber, and Enthoven in *Covering America* Vol. 1, June 2001). Similarly, the New America Foundation would allow the exclusion only up to the national median premium for some specified minimum benefit package (Calabrese and Rubiner, January 2004), and Gruber proposes limiting the tax exclusion for employment-based coverage to the cost of the median-cost plan in each state-based purchasing pool (*Covering America* Vol. 1, June 2001).

Others propose leaving the exclusion alone, but reducing tax credits for those with employment-based coverage (Kendall, Lemeiux, and Levine in *Covering America* Vol. 2, November 2002). Still others favor offering households an option between the exclusion and tax credits (Miller and Steuerle in *Covering America* Vols. 2 and 3, November 2002 and December 2003), although such an approach would entail administrative challenges. Steuerle proposes a choice between a tax credit and a capped exclusion; the cap would not change over time, whereas the size of tax credits would increase with premiums. In part for administrative simplicity, Curtis and Neuschler propose offering firms the choice between credits and exclusions for their entire employee group (Economic and Social Research Institute *Occasional Paper*, August 2002). Of course, any proposal that leaves the tax exclusion intact or offers it as an option increases program costs (or, more accurately, reduces the scope of recouping tax revenues).

### *Redirect Federal Funds Currently Spent on Uninsured*

Researchers estimate that one-third of all care for the uninsured, or \$41 billion, is uncompensated (Hadley and Holahan, Kaiser Commission on Medicaid and the Uninsured, *Issue Update*, May 2004). This estimate may not fully capture uncompensated care provided by physicians, which is generally not eligible for government subsidies and, therefore, less likely to be reported. In any case, an estimated \$35 billion of uncompensated care is financed publicly, two-thirds federally (\$23.3 billion) and one-third from states (\$11.7 billion). Most federal spending on uncompensated care for the uninsured is in the form of disproportionate share hospital (DSH) payments to offset losses incurred when patients are unable to pay their hospital bills, estimated at \$8.2 billion in 2004 (Rousseau and Schneider, Kaiser Commission on Medicaid and the Uninsured, April 2004). Covering the uninsured would free up a portion of these revenues to finance tax credits.

### *Allocate Funds Through the Federal Budget Process*

Regardless of the ultimate source of funding, providing targeted individual tax credits will require congressional appropriation of a fixed-dollar budget for tax credits. President Bush has proposed budgeting \$80 billion over ten years for tax credits. In the absence of sufficient offsetting sources of funding, such as a cap on the tax exclusion or reduction in federal outlays on the uninsured, appropriating funds for tax credits translates into increased deficit spending. How the tax credit budget is ultimately, if indirectly, financed has important distributive implications. For example, collecting revenue through payroll taxes rather than income taxes places a greater burden on low- and middle-income workers because payroll taxes take effect on the first dollar earned and apply only to wages.

## CONSIDERATION OF AN INDIVIDUAL MANDATE

Some tax credit proponents argue that the effectiveness and political viability of tax credit proposals would be enhanced by including a legal mandate that all individuals obtain health insurance. The Council on Medical Service previously explored this issue in Council on Medical Service Report 5-A-00, "Benefits and Limitations of an Individual Mandate for Individually Owned Health Insurance." The report concluded that policies to promote coverage lie on a continuum with pure volunteerism at one end and strict compulsion at the other end, with an individual mandate lying at the compulsory end. The report also identified a number of "carrot" and "stick" incentives and automatic enrollment mechanisms that could be used to encourage coverage under a voluntary system, and proposed AMA policy supporting the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage (H-165.920[15]).

For the past twelve months, the Council has devoted considerable attention to revisiting the issue of an individual mandate. In deliberating whether to recommend a change in AMA policy, the Council met with outside experts Laurie Rubiner of the New America Foundation and Stuart Butler of the Heritage Foundation in June 2004.

The key potential advantages of an individual mandate are to: (a) achieve universal coverage; (b) avoid the "free-rider" problem, whereby care for the uninsured is ultimately paid for by the rest of society through higher taxes and higher premiums; and (c) avoid adverse selection, whereby low-risk individuals opt out of insurance, driving up average costs and premiums for those who are insured. Proponents of an individual mandate believe that under a voluntary system, a significant number of people will not purchase coverage, particularly those with low incomes, the young, and the healthy. The erosion of coverage under the current, voluntary system suggests that a mandatory approach may be needed to guarantee health insurance coverage for all Americans, and to ensure that risk pools include low-risk individuals. Without either mandated coverage or a national health care system, there may be too many uninsured "free riders" whose care will ultimately be paid for by the rest of society through higher taxes and higher premium prices.

On the other hand, an individual mandate could permit the government to renege on its commitment to support health insurance through adequate tax credits and other subsidies. An individual mandate also can be viewed as coercive, particularly in the context of a tax credit proposal to increase individual choice. Rather than allowing markets to meet the wide range of consumer needs, preferences, and budgets, a mandate would open the door to excessive government involvement in defining qualified coverage. Political pressure for an ever-more comprehensive and expensive "basic" benefit package would penalize those who prefer less comprehensive but more affordable coverage--particularly among the low-income--thereby largely defeating the goal of individual choice. This, in turn, would create the temptation for price setting of premiums and health care services. For example, an individual mandate coupled with strict community rating amounts to a tax on low-risk individuals, who would otherwise face more affordable premiums. Another difficulty with individual mandates is highlighted by experience from the automobile insurance industry: costly and ineffective enforcement. Significant resources would be required to identify the uninsured and compel them to purchase health insurance, particularly for certain segments of the population such as seasonal laborers. Further, an individual mandate is unlikely to be politically viable at present, and would likely reduce the political viability of a tax credit proposal.

After considerable deliberation, the Council continues to believe that existing policy supporting the use of tax incentives and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage (Policy H-165.920[15]) remains appropriate at this time. An individual mandate would be neither a panacea for achieving universal coverage, nor a substitute for adequate subsidies. The AMA reform proposal would give individuals unprecedented market power, prompting insurers to provide more affordable products and enticing many of the uninsured to seek coverage. The AMA principles for health insurance market regulation also provide strong incentives for individuals to obtain and maintain coverage, for example through replacement of guaranteed issue with guaranteed renewal (Policy H-165.856). Perhaps most importantly, public debate over an individual mandate could divert political attention away from broader reform issues, such as redistribution of the subsidy for health insurance, and reliance on market forces versus government regulation. Further, the introduction of an individual mandate could inadvertently doom the prospects of individual tax credit proposals by forestalling opportunities for incremental implementation of tax credits as discussed in this report.

However, because of the high degree of uncertainty and flux regarding the necessity, impact, and feasibility of an individual mandate, the Council will continue to monitor and reconsider the merits of recommending an individual mandate in order to achieve the ultimate goal of universal coverage.

## DISCUSSION

Since the initial adoption of the AMA proposal to expand health insurance coverage and choice in 1998, economic and political developments have altered the climate for health system reform. Escalating health care costs and swelling ranks of the uninsured have fueled public pressure for some sort of reform. The Council is pleased that during this time, there has been growing understanding of, and support for, individual tax credits as proposed by the AMA. Unfortunately, the growing federal budget deficit diminishes the short-term possibilities for widespread implementation of tax credits, with likely stiff political resistance to revocation of the tax exclusion for employment-based coverage. Given the current climate for health system reform, the Council on Medical Service believes that incremental, targeted implementation of tax credits is a realistic and worthy short- to medium-term goal.

The Council emphasizes that the vision of health system reform embodied by the AMA proposal is as vital and relevant as ever. Given current conditions, however, the most realistic way to advance the AMA reform agenda may be to offer individual tax credits on a limited basis, without reliance on full elimination of the tax exemption for employment-based health benefits. This report outlines key target groups for such consideration, as well as the tradeoffs in establishing target groups. Further discussion will be required about whether tax credits should be made available only to the uninsured, or to what extent “crowd out” is acceptable by extending tax credits to the already insured, particularly those with low incomes and/or chronic medical conditions. Another tradeoff involves providing generous tax credits to a small number of people (e.g., those with income below 100% FPL), versus offering more modest credits to a relatively large group of people (e.g., those with income below 200% FPL). A similar tradeoff is the extent to which scarce budgetary resources should be used to insure a relatively large number of children or a relatively small number of people with chronic or expensive medical conditions (Gruber, *American Economic Review*, May 2003). Regardless of how these tradeoffs are resolved, the overriding objective should be to incrementally expand health insurance coverage and choice through individual tax credits, with an eye toward more widespread use of tax credits at some point in the future.

Estimates of the costs of covering the uninsured vary widely but are in the tens of billions of dollars each year. For example, the AMA Center for Health Policy Research estimates that tax credits would require \$30 to \$60 billion per year in addition to revenues generated by revoking the tax exclusion (Wozniak and Emmons, 2000). It should be noted that the costs of covering the uninsured must take into account the expected increase in health care utilization among the newly insured, estimated at \$48 billion per year (Hadley and Holahan, Kaiser Commission on Medicaid and the Uninsured, *Issue Update*, May 2004). To date, such estimates have been based on the assumption that the uninsured would obtain coverage comparable to existing employment-based coverage. This assumption is challenged by a recent study conducted by the Kaiser Family Foundation and eHealthInsurance, Inc. (August 2004). The study found that average premiums paid for health insurance obtained on the individual market are *markedly* lower than in the group market (\$1,768 vs. \$3,695 or 52% lower for single coverage, and \$3,331 vs. \$9,950 or 66% lower for family coverage). The substantial premium differences are attributable in part to the younger ages of individual health insurance enrollees, as well as the fact that many people, when given a choice, choose less generous coverage than is typically offered by employers.

Fortunately, the implication of these findings is that the size of tax credits and corresponding total expenditure required to extend meaningful coverage to the uninsured may be lower than previously believed. The trend toward HSAs, health reimbursement arrangements (HRAs), and other forms of consumer-directed health care designed to lower premiums and contain health care costs holds promise for allowing expanded coverage at lower-than-expected cost. The Council believes that health insurance markets allowed to reflect consumer preferences will result in a shift toward less expensive coverage resembling true insurance against unforeseen loss, rather than prepayment of highly generous benefits.

Whatever the costs of covering the uninsured, the full \$122-plus-billion annual tax exemption for employment-based health insurance cannot be counted on as a source of tax credit revenue. Instead, for the short- and mid-term, the Council believes that a more realistic alternative would be to cap the tax exclusion to some benchmark amount. Oddly enough, none of the proposals reviewed in this report explored the possibility of setting the cap on the exclusion inversely related to income, thereby making the exclusion less regressive with respect to income. The Council believes that a “sliding scale” cap on the tax exclusion for employment-based health insurance warrants consideration. Another financing mechanism that could be combined with a cap on the tax exclusion is redirecting the estimated \$35 billion in public funds currently spent on the uninsured (Hadley and Holahan, May 2004). Whatever the explicit or indirect source of funding, health insurance tax credits will require Congress to appropriate a specified budget for tax credits.

Finally, many of the ideas for targeted, incremental implementation of individual tax credits discussed in this report could be tested on a limited basis. State pilot tests would allow policy makers and the public to resolve uncertainties about the magnitude of “crowd out,” tradeoffs between generous credits for the few versus more modest credits to the many, the feasibility of alternative caps on the tax exclusion, the merits of an individual mandate, and so forth. This would allow future policy to be guided by actual experience, including both the magnitudes of various effects and the public’s preferences for different outcomes. As noted earlier, the Council will be examining the use of state pilot tests of alternative reform approaches in an upcoming report for the 2005 Annual Meeting.

## RECOMMENDATIONS

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

1. That it is the policy of our American Medical Association to support implementation of individual tax credits for the purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, the chronically ill, and those living within geographic areas that are pilot testing tax credits.
2. That it is the policy of our AMA to support incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to, capping the tax exclusion for employment-based health insurance.

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

## 5. PRIVATE SECTOR OPTIONS FOR FINANCING LONG-TERM CARE

### HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

It is likely that one of the biggest health care challenges facing America in the 21st Century will be the aging of “baby boomers”—those born between 1946 and 1964. By 2030, it is estimated that the number of Americans age 65 and older will reach nearly 70 million, and a large proportion of this group may eventually need long-term care. With the aging of the baby boom generation, increasing life expectancy, and the rising costs of nursing home and home health care, there will likely be an increased demand for institutional long-term care that will overwhelm publicly financed programs such as Medicare and Medicaid, and will leave millions of Americans unprepared for both the heavy financial and non-financial burdens of providing long-term care for themselves or family members.

This report focuses on private sector options for financing long-term care, including long-term care insurance, health savings accounts, and other possible approaches such as reverse mortgages, the conversion of life insurance policies, and life care communities. In addition, recent federal proposals to encourage private sector long-term care coverage are highlighted.

### BACKGROUND

Only a small portion of “long-term care” can be considered health care services. Health insurance plans generally do not pay for long-term care services. Long-term care typically refers to the broad range of personal assistance services that allow people who have limited function, either due to a disability or chronic condition, to carry out activities of daily living (ADLs). Those seeking long-term care often have difficulty performing everyday routines such as eating, bathing, and dressing. In some cases the disability may be significant enough to require ongoing nursing care, such as ventilator use. These services are usually provided at home or in institutional settings such as nursing or residential care facilities (Congressional Research Service, 2004).

Aside from home care, nursing homes traditionally have served as the primary setting for long-term care. A 2003 study commissioned by GE Financial’s Long Term Care Insurance division evaluated the cost of nursing home care for a person suffering from Parkinson’s or Alzheimer’s disease. The survey showed that the national annual average cost of a year in a nursing home was \$57,700. The range across the country varied from \$35,900 a year in Louisiana, to \$105,500 in New York City, to \$166,700 in Alaska (National Underwriter, 2003).

According to the Centers for Medicare and Medicaid Services, during 2004, about seven million men and women over the age of 65 will need long-term care. By 2020, it has been estimated that 12 million older Americans will need long-term care. People who reach age 65 will likely have a 48.6% chance of entering a nursing home (Lewin, 1997); however, this percentage includes those who stay for a relatively short period of time to recuperate from a surgery or illness. About 10% of the people who enter a nursing home will stay there five years or more.

Many people are unaware that they will need to prepare for their own long-term needs. According to a 2001 AARP study, even though 60% of study respondents over the age of 45 claimed that they were very familiar with long-term care services, only 15% were able to gauge the actual cost of care within a 20% margin (American Demographics, 2002).

A person preparing for possible future long-term care needs has several options. Although one alternative is to “self-insure” by setting aside personal savings and assets, most seniors are not well prepared to pay for their long-term care needs. In 2000, for instance, only about 7% of seniors had income in excess of \$50,000 (about the cost of a year’s stay in a nursing home). In 1997, more than half of nursing home residents were poor enough to qualify for Medicaid coverage (Congressional Budget Office 2004).

Nevertheless, meeting the future demand for long-term care with government programs will be difficult. Medicaid is the largest source of public funding for long-term care. Currently, Medicaid faces significant challenges including struggling state budgets, a limited supply of beds, and a dwindling workforce. In 2003, two-thirds of states cut Medicaid benefits, increased co-payments, and restricted eligibility or removed people from coverage because of increasing costs and decreasing revenues (Congressional Budget Office, 2004).

Furthermore, the federal government increasingly has encouraged states to control the supply of beds with certificate of need programs. As a result, nursing homes have responded to limits to their funding by relocating healthier long-term care recipients to community based programs, while the most frail and infirm patients remain in nursing facilities. With shortages of nurses and nurses’ aides, the long-term care industry is facing a considerable scarcity in supply and an ever increasing demand for care. These factors will continue to restrict supply and fuel increases in the price of long-term care (Center for Long-Term Care Financing, 2003).

In addition, changes in family structure, such as smaller and more geographically dispersed families, can limit the pool of potential informal care providers. People without informal caregivers often are forced to leave their homes and seek institutional care, further increasing demand for institutional care.

#### CURRENT STATUS OF LONG-TERM CARE FINANCING

Long-term care services are currently financed through a patchwork system of public programs, private insurance and individual financing. According to the Centers for Medicare and Medicaid Services (CMS), of national spending on long term care in 2002, Medicaid spending accounted for 43%, out of pocket spending accounted for 24%, Medicare accounted for 17%, private insurance (including other types of health care insurance policies) accounted for 11%, and other types of public and private financing accounted for 5% (Kaiser Family Foundation, 2004). In other words, when combined, more than half (60%) of expenditures on long-term care services were covered by the Medicare and Medicaid programs.

Medicare--the federal health insurance program for people over the age of 65--provides only short-term skilled nursing home care following hospitalizations, and limits its coverage at home to those who need skilled nursing care and rehabilitative therapy. Long-term care services primarily assist people with ADLs such as dressing and bathing. Such care, often called “custodial care,” is not covered by Medicare, although some Medicare Advantage plans may offer limited skilled nursing facility (SNF) and home care coverage if the care is medically necessary.

Medicaid--the means tested entitlement program--covers long-term care services for eligible individuals in both institutional settings (e.g., nursing homes and intermediate care facilities), and homes and other community-based settings (e.g., adult day care facilities). Only nursing home care and home health care for people who would otherwise qualify for institutional care are mandatory benefits under Medicaid.

Eligibility and services covered vary from state to state. Most often, eligibility is based on income and personal resources. In general, beneficiaries are required to deplete their savings, or “spend down,” to a certain income and asset level before Medicaid will pay for services. If the individual is married, the spouse is expected to contribute toward nursing home care if monthly income is above a certain level. Council on Medical Service Report 1-I-02 previously addressed Medicaid spend-down eligibility criteria.

## PRIVATE SECTOR OPTIONS FOR FINANCING LONG-TERM CARE

### *Long-Term Care Insurance*

Long-term care insurance (LTCI) describes a wide variety of private contracts between insurance companies and policyholders. In 1989, LTCI was offered to 3% of full-time employees in private industry with 100 or more employees; by 2003, 19% of full-time workers in private industry were offered this benefit (Department of Labor, 2004). Despite the increased availability, fewer than 10% of Americans age 65 and older have purchased LTCI, and pre-retiree penetration rates are even lower (Office of Personnel Management, 2004). Nevertheless, LTCI is proving to relieve some of the pressure on public programs. In 1995, private insurance paid \$700 million or 0.8% long-term care services for seniors. It is estimated that LTCI will cover \$6 billion or 4% of long-term care services in 2004 (Congressional Budget Office, 2004).

For the individual, the primary benefit of LTCI is that it minimizes the use of personal savings to pay for long-term care needs. LTCI provides protection of retirement savings, reduces financial hardships for spouse and other family members, and promotes greater financial independence. From a societal perspective, the primary appeal of private LTCI coverage is that it may fund a substantial portion of the long-term care needs for many Americans. Furthermore, widespread LTCI coverage has the potential to shift a substantial share of the funding responsibility from the government to the individual.

In 2002, the Department of Health and Human Services (HHS) conducted a study to better understand how having a private LTCI policy affects the use of Medicare financed home health, skilled nursing, and hospital inpatient services. Not surprisingly, one of the key findings was that individuals who are receiving LTCI payments are less likely to access Medicare financed home health aide services, and among those who do use services, both the volume and the expenditure level are lower than that for non-privately insured individuals.

The range of settings for LTCI policies includes nursing homes, adult day care centers, assisted living, and formal and informal home care. For example, a “Facility Only” policy covers care that is received in a licensed setting and does not cover assisted living, or home care. Coverage under a facility only policy is typically triggered by an acute medical condition that eventually requires skilled nursing care in a SNF. In contrast, a policy with “Integrated Home Care,” covers care received in an unlicensed setting, such as in a home. Coverage under this type of policy pays for care that is provided by home health aides, nurses, social services, physical therapists, and other sources.

Several policy provisions can affect LTCI premiums, including daily dollar maximum, duration of policy, and waiting period. There may be a daily dollar maximum or a range of daily maximum coverage from which a policyholder can choose when selecting a policy. Some maximums are designed to cover most, if not all relevant expenses, while lower limits mean that the policyholder will pay the difference between the SNF or long-term care facility charges and the limits of the policy. Higher maximums result in higher premiums. Similarly, the tradeoff for purchasing a longer duration policy is a higher premium. Duration periods typically range from one year to five years, but can be selected for an unlimited number of years. In addition, the waiting or elimination period may affect the premium rate as well. The waiting period, or time before the policy is used, acts as a deductible to cover long-term care situations (i.e., the longer the waiting or elimination period, the lower the cost of the premium).

In addition to these policy options, there are other factors which affect the premium such as pre-existing conditions and prior hospitalizations. Other key policy provisions and options include, but are not limited to, guaranteed renewability, waiver of premium, premium refund provisions, and non-forfeiture of benefits.

LTCI eligibility is typically based on age, health, and affordability. Many financial planners recommend that individuals age 50 or over, with more than \$200,000 but less than \$2 million in assets, buy LTCI. The National Association of Insurance Commissioners (NAIC), in its model regulation for LTCI, suggests that consumers should be discouraged from buying a policy if the premiums account for more than 7% of income or if the purchaser does not have at least \$35,000 in financial assets. The United States Health Council suggests that individuals only consider buying a policy if assets are worth at least \$75,000 (excluding the value of the home and car), and annual retirement income is at least \$35,000.

LTCI premiums can be expensive, especially for older individuals. In 2002, the national average for a typical premium for a 50-year-old person for a policy that covers a \$150 daily benefit, four years of coverage, with a 90-day deductible, and an inflation protection feature cost, was \$1,134 annually. This same policy for a 65-year-old was about \$2,346 annually, while the cost for a person aged 79 was \$7,572 annually, or nearly 6 times the cost of a premium for a 50 year-old (Health Insurance Association of America, 2004).

The variation in premiums underscores the importance of planning ahead, especially for certain groups. To illustrate this point, consider the long-term care needs of women. Women represent nearly three quarters (72%) of nursing home residents 65 years and older, and two-thirds of home health care users (General Accounting Office, 2001).

Nevertheless, LTCI is not for everyone. For example, a person with limited assets planning to purchase LTCI before age 50 may face other important financial considerations (e.g. college tuition, retirement savings) that may take priority over the purchase of LTCI. In addition, because of the extraordinary length of time that is likely to elapse before the buyer will actually need long-term care, changes in the market could mean that a policy purchased today could fail to provide access to newly emerging service options (Kaiser Family Foundation, 2003).

#### *Health Savings Accounts*

As described in Council on Medical Service Report 6-A-04, Health Savings Accounts (HSAs) are individually funded, interest bearing accounts that permit saving for medical and retiree health expenses on a tax-free basis. To open an HSA, an individual must be under 65 and have a high-deductible health plan (an insurance policy with a deductible of at least \$1,000 for an individual and \$2,000 for a family). The investment earnings accrue interest on a tax-free basis, and are similar to Individual Retirement Accounts (IRAs) in that they can be transferred if the individual changes jobs. Ownership of an HSA can be transferred to a spouse upon the death of a beneficiary.

According to guidance issued by the Department of Treasury, qualified long-term care expenses that can be paid for using HSAs include necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services, and maintenance and personal care services that are required by a chronically ill individual, and provided pursuant to a plan of care prescribed by a "licensed health care practitioner." Upon evaluation, an individual unable to perform at least two ADLs without substantial assistance from another individual for at least 90 days, due to a loss of functional capacity, is defined as "chronically ill." In addition, if a person requires substantial supervision to be protected from threats to health and safety due to severe cognitive impairment, an HSA can be used for payment (Department of Treasury, 2004).

An account beneficiary may pay LTCI premiums with distributions from an HSA. It is important to note that the amount of distribution for qualified medical expenses may be limited to the annual adjusted amounts that are age-dependent (e.g., age 40 or under - \$250, age 41-70 between \$470 and \$2,210, and age 71 or older \$3,310). Thus, although HSA distributions to pay or reimburse tax qualified LTCI premiums meet the definition of qualified medical expenses, the exclusion from gross income is limited to the adjusted amounts.

HSAs also can be used to pay for nursing home care and nursing services, which include maintenance and personal care services. These services typically include those associated with caring for the patient's condition, such as giving medication or changing dressings, as well as bathing and grooming the patient. These services can be provided at home or in another care facility. In addition, HSAs may be used to pay for capital expenses to make reasonable modifications to a home to accommodate a disabled medical condition.

*Reverse Mortgages/Estate Recovery*

A home is the principal financial asset for many older Americans. A reverse mortgage, or home-equity conversion, is a means to pay the homeowner a fixed sum each month. The amount of money is dependent on age at the time the loan is applied for, the equity of the home, type of loan, and current interest rates. Eligibility is based on the age of the borrower (usually 60 or older) and the type of residence (i.e., single-family homes, including condominiums, but not co-operatives). A feature called "life tenure" can be added so that what is owed does not exceed the value of the home when it is sold.

The benefit of a reverse mortgage loan is that it helps an older person "age in place" while receiving the care that is needed. However, many Americans strongly value their ability to provide an inheritance for their heirs, and the option of a reverse mortgage may have a limited appeal if financing long-term care needs is a consideration.

Payments under a reverse mortgage can take several forms; some are simple lines of credit, while others are fixed-term agreements that provide a series of monthly payments. Although money from a reverse mortgage is tax-free, it counts toward income for determining Medicaid eligibility or other state assistance programs.

When a person receiving a home equity loan either sells the home, no longer permanently lives in the home, or dies, that person or his or her estate has to repay the amount received from the reverse mortgage. In addition, any interest and other fees are due. Any remaining equity belongs to the individual or their heirs.

The Home Equity Conversion Mortgage Program (HECM) is a program in which federally insured reverse mortgages are backed by the Federal Housing Administration (FHA). The FHA insures HECM loans to protect lenders against loss if amounts withdrawn exceed equity when the property is sold. Reverse mortgages that are not backed by the federal government may be more expensive, but often have the flexibility of providing larger loan amounts.

According to the National Reverse Mortgage Lenders Association, the volume of HECM reverse mortgages nationwide in the five-month period from October 2003 through February 2004 (12,848 loans) was 112% higher than the level during the five-month period ending February 2003 (6,061 loans). HECM reverse mortgage volume in February 2004 alone (4,148 loans) set a new monthly record, and was 273% higher than the level in February 2003 (1,113 loans).

*Conversion of Life Insurance Policies*

Many life insurance policies offer, at an extra cost, an "accelerated death benefit" rider. Under such riders, a portion of a beneficiary's life insurance benefit--usually no more than 80% of the face value of the policy--can be paid to the beneficiary under certain circumstances, such as when long term care is needed, rather than to the individual's beneficiary at death. Most riders stipulate this benefit for persons who have a terminal prognosis of 6 months to a year.

*Continuing Care Retirement Community*

A Continuing Care Retirement Community (CCRC), also known as a Life Care Community, is a setting which charges a substantial entrance fee (typically from \$15,000 to over \$200,000), which may or may not be refundable, as well as ongoing monthly fees (usually \$1000 or more). A CCRC provides a range of care from assisted living services to nursing home care without extra payments. It may charge additional daily fees for home health care beyond what is paid for by Medicare. Outside of the requirements for housing and nursing home care, each community is unique in what it offers.

**FEDERAL PROPOSALS**

In its 2005 budget, the Bush Administration proposed to provide \$21.4 billion over ten years to make premium payments of LTCI fully deductible. The proposed "above the line" federal tax deduction would allow taxpayers to deduct LTCI policy premiums from their taxable income, regardless of whether they itemize on their tax return. The budget also would provide for an additional personal exemption for caregivers of family members in need of long-term care.

Similar to the Bush Administration's proposal, Representative Nancy Johnson (R-CT) has introduced legislation that would provide tax deductions for purchasing LTCI and tax credits to help offset the cost of providing care to a family member at home (H.R. 2096). Supporters of these types of tax subsidies argue that promoting the purchase of LTCI earlier in life will both protect consumers against financial losses and ultimately save the federal government money by reducing Medicaid outlays. Opponents argue that the structure for tax deductions provides little or no assistance to most low- and middle-income families, while disproportionately assisting high-income individuals who already would have been inclined to buy LTCI.

#### AMA POLICY

The American Medical Association recognizes the importance of developing individual financing methods to cover long term care expenses and Policies H-280.991 and H-165.985 (AMA Policy Database) address this issue extensively. Of particular relevance, Policy H-280.991[9] encourages the creation of tax incentives to allow individuals to deduct the cost of long-term care coverage from income tax and encourages employers to offer long-term care policies as part of employee benefit packages. Policy H-165.985[9] promotes the development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately pre-funded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family care giving. More recently, Policy H-165.871 advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership, also apply to LTCI.

#### DISCUSSION

The Council on Medical Service believes that as Americans age, early awareness of the possible need for long-term care and its potential costs is critical to helping individuals adequately prepare for the future. According to AARP, among people 45 and older, the majority are unaware of the actual costs of long term care services. In 2003, the national average cost of nursing home care in a semi-private room was \$57,000 annually, and costs are expected to increase. By 2030, the cost of a semi-private room in a nursing home is expected to increase to \$190,600 per year, or more than triple the current amount (Kaiser Family Foundation, 2004).

Medicare and Medicaid currently shoulder more than half of expenditures for long-term care services. These government programs are facing considerable financial challenges as the number of older Americans is expected to reach 70 million by 2030. Assistance with ADLs over a long period of time is not covered by Medicare. Although Medicaid is the only government program that currently covers some of these services, it is facing significant financial constraints, is chronically under-funded, and requires individuals to meet strict eligibility criteria, including "spend-down" requirements.

As a result, the Council believes that the AMA should encourage Americans to become better informed about their potential need for long-term care and its associated costs. As discussed, LTCI protects retirement savings, reduces financial hardships for family and friends, and promotes financial independence. Although the number of employers offering LTCI has grown, only 19% of employers currently offer this benefit. Consistent with AMA policy H-280.991[9], therefore, the Council believes that the AMA should support legislative proposals that provide tax incentives to purchase LTCI.

The Council also believes that the insurance industry should be encouraged to continue to develop innovative programs and insurance products that anticipate long term care needs. For example, James Rice of the Governance Institute has suggested the possibility of blended annuities, which could combine classic insurance policies including annuities, LTCI, disability insurance, managed care health insurance, and life insurance. Although this type of product has not yet been offered in the market, it is an example of an innovative idea that may be more appealing to younger Americans as a means of better preparing for the possible need for long-term care.

The Council also believes that HSAs should be advocated as a supplementary solution to financing long-term care. The Council recognizes that HSAs are only a partial solution, because individuals may not be able to save the amount needed to completely finance long-term care. Nonetheless, the tax-free use of HSAs to cover the costs of LTCI premiums and long term care services is an option that should be promoted further.

## RECOMMENDATIONS

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

1. That our American Medical Association encourage the American public to become better informed about the possible future need for long-term care services, including the importance of early preparation through saving, investing, and the option to purchase long-term care insurance.
2. That our AMA reaffirm Policy H-165-871[2] which advocates that any tax treatment applied to health insurance for the purpose of encouraging individual ownership also apply to long-term care insurance.
3. That our AMA support legislative proposals that provide targeted tax incentives that encourage individuals and families to save, invest and insure for their future long-term care needs.
4. That our AMA encourage the insurance industry to continue to develop innovative programs and insurance products to cover the provision of long-term care services.
5. That our AMA encourage the American public to consider using health savings accounts as a supplemental savings mechanism to cover the future provision of long-term care services.

(References pertaining to Report 5 of the Council on Medical Service are available from the Division of Socioeconomic Policy Development.)

## 6. STATUS REPORT ON MEDICARE REVIEW ACTIVITIES

### HOUSE ACTION: RECOMMENDATIONS ADOPTED AND REMAINDER OF REPORT FILED

Since 1997, the Council on Medical Service has presented an annual report to the House of Delegates on the status of Medicare review activities. This report details the regulatory relief provisions that were included in the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (P.L. 108-173); provides an update on the status of contractor reform activities being undertaken by the Centers for Medicare and Medicaid Services (CMS); summarizes developments in resolving Medicare enrollment issues; and discusses the provisions in the 8th Quality Improvement Organization (QIO) Statement of Work.

#### MEDICARE REGULATORY RELIEF

The AMA has established extensive policy in support of regulatory relief for physicians. Accordingly, the Council was pleased that the Medicare Modernization Act included many regulatory relief provisions for which the AMA had strongly advocated over the past few years. Key provisions of the new law are listed below, along with relevant AMA policy citations:

- Limits the use of extrapolation to only those cases where there is a sustained or high payment error rate or documented education efforts have failed. (Policy H-335.975, AMA Policy Database)
- Emphasizes education of physicians about incorrect billing practices, and allows an opportunity to correct errors before repayment demands are made. (Policy H-335.976[3])
- Prohibits repayment demands until after physician appeals have been considered. (Policy H-335.976[5])
- Mandates HHS to study alternative, simplified systems of documentation for physician claims. (Policy H-330.920[1])

- Ensures that any new documentation guidelines for evaluation and management codes are thoroughly pilot-tested before they can be implemented as national policy. (Policy H-330.920[5])
- Ensures that services furnished under the prudent layperson standard and according to EMTALA requirements are covered by Medicare. (Policy H-130.970[5])
- Establishes an EMTALA Advisory Group to “review issues related to EMTALA and its implementation.” (Policy D-130.982[4])

The AMA spent several years working with members of Congress to ensure that legislation was passed that would provide meaningful regulatory relief to physicians. The inclusion of these provisions in the Medicare Modernization Act represents a major victory for the AMA on behalf of its members.

### *Regulatory Guidance*

The AMA strongly supports ensuring that physicians have access to reliable and timely information related to the proper interpretation of Medicare regulations, and has advocated forcefully for accountability by CMS and its contractors for actions taken as a result of their guidance. The Medicare Modernization Act requires carriers to provide physicians with clear, concise, and accurate answers to their billing questions within 45 business days, and eliminates penalties and interest for physicians faced with alleged overpayments who have relied on written guidance from Medicare.

In addition, the Act mandated that the Government Accounting Office (GAO) conduct a study to determine the feasibility and appropriateness of giving the Department of Health and Human Services (HHS) the authority to provide legally binding advisory opinions on appropriate interpretation and application of Medicare regulations. The GAO met with AMA representatives in August 2004, to get input for its study, and the AMA expressed its strong support for a legally binding process by which physicians could obtain guidance on Medicare procedures. The AMA urged GAO to address the following issues in its study:

- Advisory opinions should be provided by the agency responsible for enforcing the specific regulation.
- Advisory opinions should be available free to physicians (or medical societies on behalf of a group of physicians).
- Responses should be furnished in writing within 60 days.
- Physicians should be able to bill for services while waiting for guidance, and to correct errors without penalty if necessary.
- In considering ways to structure the advisory opinion process so as to minimize costs to the government, explore making advisory opinions applicable to groups (where appropriate) as well as individuals, and utilizing medical societies as a means to centralize physician inquiries.
- The advisory opinion process should not be limited to specific topics, but limits may be set on the number of opinions issued.

### **MEDICARE CONTRACTOR REFORM**

The Medicare Modernization Act also establishes a new process for selecting Medicare contractors. Over the next several years, Medicare Administrative Contractors (MACs) will replace existing Medicare carriers and fiscal intermediaries. The MACs will be selected competitively, and will be subject to annual contract renewals based on specific performance requirements. However, beginning with contracts set to begin on October 1, 2005, all MAC contracts must be completely “re-competed” every five years. CMS hopes that the introduction of competition to the Medicare contracting process will provide a mechanism for offering incentives for MACs to provide higher quality and more efficient services.

MACs will be expected to perform essentially the same functions that current fiscal intermediaries and carriers perform, including provider consultation and education, beneficiary education, claims processing, and technical assistance. However, under the new law, CMS will have the authority to assign and transfer functions among individual MACs, which has the potential to result in a fragmentation of services. For example, CMS could opt to contract with one MAC to handle beneficiary inquiries, another to handle claims processing, and a third to handle physician payment. Contractor work could be further segmented by geographic region, with certain MACs responsible for certain geographic regions.

Although it is still unclear exactly how the MACs are going to be organized, it is anticipated that the transition to MACs will result in a consolidation of work being done by the current Medicare carriers and fiscal intermediaries, and a likely reduction in the number of carrier medical directors. The AMA has strong policy supporting the availability of carrier medical directors at the local level (Policies H-335.970, D-330.974, and D-335.992), and has raised concern that proposed changes in the Medicare contracting process may compromise this availability.

To help ensure that the contractor reform process does not result in fragmented services for physicians or reduced access to medical directors, the AMA presented the following suggestions to CMS in April 2004:

- Any transition between old and new contractors should be closely monitored by CMS to assure no disruption in claims processing capabilities.
- CMS should use existing performance standards to assure that claims are paid accurately and on a timely basis.
- CMS should provide a dedicated and stable level of funding for physician education that is not transferable to other contractor functions.
- The new MACs should continue to provide a carrier advisory committee at the state level.
- The new MACs should continue to provide a carrier medical director for each state.
- Funding for the carrier medical directors should provide for travel funds to allow them to regularly participate and attend physician functions in the state.
- Any consolidation of local medical review policies should continue to provide for input from physicians at the local level.
- CMS should avoid fragmentation of the contractor functions so that physicians have a single point of contact for the Medicare program. Should CMS not provide this single point of contact, any communication from program safeguard contractors, durable medical equipment contractors, or others should clearly be identified by logo on the letterhead that it is from the MAC and the other CMS contractor. CMS should work to prevent the confusion that multiple contractors create for the physician community.

#### MEDICARE ENROLLMENT PROCESSING DELAYS

The length of time and complexity of the process associated with establishing Medicare billing privileges have been ongoing concerns for physicians. The AMA has strong policy advocating for a more streamlined enrollment process and the issuance of temporary identification numbers so physicians can bill for services while their enrollment applications are pending (Policies H-330.911 and D-330.962).

Over the past year, Medicare provider enrollment delays have been exacerbated by the introduction of a new system for enrollment/re-enrollment processing. In July 2002, CMS implemented a new national enrollment system for Medicare fiscal intermediaries called the Provider Enrollment and Chain/Ownership System (PECOS), with the goal of improving the overall infrastructure for the systems supporting the provider enrollment function. Although the system appeared to work smoothly for the fiscal intermediaries, it created overwhelming system problems and delays when its use was extended in November 2003 to physicians and other providers who interact with Medicare carriers. For much of 2004, the PECOS system was unable to handle the volume of applications carriers process, initially because of technical difficulties, and then because of a massive backlog of applications and an inadequate level of staffing to handle them. Processing times increased dramatically, and physicians were unable to bill for services while they wait for their applications to be processed.

The AMA has been in regular contact with CMS attempting to resolve or minimize the enrollment/re-enrollment problems. Specifically, the AMA advocated that funds be made available to pay for temporary staff or overtime hours to relieve the backlogs; a process be established where carriers can advance payments to physicians still awaiting their enrollment number; and physicians be paid interest on claims that have been delayed because of enrollment processing problems. In June 2004, the House of Delegates adopted Resolution 132, which directed the AMA to continue to pursue these remedies with CMS (Policy D-330.956).

In May 2004, Medicare released more than \$5 million for use by Medicare carriers to pay overtime and hire additional temporary staff to process backlogged claims. The clean-up process has been slow, but the backlogs were significantly reduced during the summer of 2004. At the time this report was written, CMS anticipated that it would be completely up to date by sometime in the fall of 2004. The AMA continues to advocate for interest payments for physicians who experienced processing delays, and CMS has not ruled this option out.

Nevertheless, the AMA is very concerned that the problems associated with the transition to the PECOS system could be magnified when all physicians are required to re-enroll in order to obtain a National Provider Identifier. In a final rule published on January 23, 2004 (45 Fed. Reg. 3434), CMS adopted the National Provider Identifier as the standard unique health identifier for physicians and other health care providers. Providers may begin applying for the number in May 2005, and all covered entities must comply by May 2007 (2008 for small health plans). Providers must complete an application process in order to be issued the Identifier. The main concern is that the National Provider System which is being created to handle the applications will experience problems similar to the PECOS system, including being overwhelmed by the sheer volume of applications associated with re-enrolling the entire physician/provider population. Policy D-330.956 also calls for the AMA to advise CMS against implementation of the National Provider Identifier until providers are assured that advance payments will be made in the case of delayed enrollment processing.

#### 8th QUALITY IMPROVEMENT ORGANIZATION STATEMENT OF WORK

CMS is currently developing the 8th Quality Improvement Organization (QIO) Statement of Work, which is scheduled to be implemented in the summer of 2005. At the time this report was written, the 8th Statement had not been released; however, CMS had issued preliminary documents in order to facilitate feedback from interested organizations. According to the summary documents, the emphasis of the 8th Statement will be on accelerating improvement in clinical quality measures. Specifically, the program will emphasize giving providers the tools and knowledge to implement changes that will help them achieve excellent outcomes.

CMS anticipates organizing the 8th Statement of Work around three main areas: creating an environment for quality; assisting providers in developing the capacity for and achieving excellence; and protecting beneficiaries and the Medicare program. The Statement of Work will emphasize the clear and consistent communication of expectations, the use of incentives for delivering higher levels of quality, and the adoption and implementation of new systems and technologies to ensure quality care delivery.

In January 2004, the AMA submitted comments to CMS based on its preliminary "Framework for the 8th Quality Improvement Organization Statement of Work." The AMA praised the continued emphasis on internal quality improvement efforts by individual physicians and the proper development of methodologically sound physician level measures designed for this purpose. In addition, the AMA emphasized the importance of increasing the use of information technology, while also recognizing the need for adequate funding to support its expanded use. The AMA plans to issue further comments when the full draft 8th Statement of Work is made available.

#### DISCUSSION

The AMA spent several years working with members of Congress to develop and pass regulatory relief legislation that would ensure that Medicare rules and their implementation were fair to physicians. The regulatory relief provisions included in the Medicare Modernization Act represent a major victory for the AMA on behalf of its members. The Council on Medical Service believes, however, that the Association will need to closely monitor the implementation of these provisions, to ensure that the intent of the law is preserved when the regulations are developed and implemented.

Although the Council is encouraged by CMS' intent to improve service delivery by introducing competition and flexibility into the Medicare contractor process, it is concerned that the transition to MACs may result in reduced access to local carrier medical directors, and subsequently a decrease in physician-carrier interaction. The Council believes that the AMA should continue to monitor this process to ensure that carrier medical directors remain available to physicians, and that services are provided in an accurate and timely manner.

The Council also remains concerned about the enrollment delays that arose as a result of implementation of the PECOS system, which took CMS nearly a year to resolve. In keeping with Policy D-330.956, the Council believes that the AMA needs to continue to advocate that CMS compensate physicians for delayed payments caused by enrollment or re-enrollment delays. The Council also believes that CMS needs to increase its efforts to ensure that physicians have the option of completing the entire enrollment or re-enrollment process (including the eventual application for the National Provider Identifier) electronically, without the need to submit a printed signature page. For physicians seeking to re-enroll, electronic application fields should be pre-populated with data already supplied to CMS during the initial enrollment process. The electronic process should be thoroughly pilot tested to ensure it can accommodate the timely processing of applications.

Although the enrollment delays precipitated by the transition to the PECOS system seem to be decreasing, it is unclear if the PECOS system will in fact result in more efficient enrollment processing in the long run. The Council believes that the successful adoption of an electronic application option would minimize enrollment delays, and could facilitate a reduction in processing time. Currently CMS requires its carriers to process 90% of enrollment applications within 60 days, and 99% within 120 days. The Council believes that these periods are too long, especially for new physicians who do not yet have billing privileges. The Council believes the AMA should advocate for a reduction in the carrier/contractor standard for enrollment and re-enrollment processing to 90% in 30 days and 99% in 60 days. An additional provision in the Medicare Modernization Act grants physicians the right to appeal in the event that their enrollment applications are denied or their billing privileges are revoked. The Council believes that this is a positive step in ensuring that the enrollment process does not disadvantage physicians.

Finally, the Council is pleased with the Administration's continued support for the ongoing quality of care focus of the Medicare QIO program. The preliminary information available on the 8th Statement of Work indicates that important issues will be highlighted, including an emphasis on enhancing the infrastructure of physician's offices and practice settings as a means to achieve high quality care delivery. The Council will continue to monitor the ongoing development and implementation of the 8th Statement of Work.

## RECOMMENDATIONS

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

1. That our American Medical Association closely monitor the Center for Medicare and Medicaid Services' (CMS) transition to the use of Medicare Administrative Contractors to ensure physician access to local-level carrier medical directors, that contractor services are provided in an accurate and timely manner, and that these issues are considered in contracting in addition to purely financial issues.
2. That our AMA continue to advocate that CMS compensate physicians who experience significant delays in the Medicare enrollment and/or re-enrollment processes.
3. That our AMA urge CMS to increase its efforts to ensure that physicians have the option of completing the entire Medicare enrollment and/or re-enrollment processes (including the eventual application for the National Provider Identifier) electronically.
4. That our AMA urge CMS to conduct pilot tests to ensure that the electronic enrollment and re-enrollment processes will accommodate the timely processing of physician applications.
5. That our AMA urge CMS to reduce the carrier/contractor standard for enrollment and/or re-enrollment processing from 90% in 60 days and 99% in 120 days, to 90% in 30 days and 99% in 60 days.