

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - A-04
(June 2004)

Subject: Federal Health Insurance Reserve System
(Resolution 110, A-03)

Presented by: Ardis D. Hoven, MD, Chair

Referred to: Reference Committee A
(Joan E. Cummings, MD, Chair)

1 At the 2003 Annual Meeting, the House of Delegates referred Resolution 110, which was
2 introduced by Robert D. Burnett, MD, a Delegate of California. Resolution 110 (A-03) asked that
3 our American Medical Association (AMA) endorse a system embodying an extensive list of
4 Congressional actions pertaining to the development of a stable health care financing system for
5 the nation. The Board of Trustees referred Resolution 110 (A-03) to the Council on Medical
6 Service for study. The full text of Resolution 110 (A-03) appears below in the policy section of
7 this report, in the form of a “crosswalk” with relevant existing policies.
8

9 BACKGROUND

10
11 Dr. Burnett is a former member and chair of the Council on Medical Service. The Council
12 commends Dr. Burnett for his innovative and thoughtful proposal, which was published in the
13 journal *Pediatrics*.
14

15 Briefly, Resolution 110 (A-03) calls for: (1) individually owned health insurance, with individuals
16 mandated to purchase coverage and with subsidy of individual coverage to be in the form of tax-
17 deductible defined contributions and tax credits inversely related to income; (2) the bifurcation of
18 Medicaid; (3) financing the Medicare system as a forced savings or investment program; (4)
19 allowing balance billing; and (5) creation of a Federal Health Insurance Reserve System (FHIRS)
20 to be independent and isolated from politics and special interests in order to advance the health care
21 of the United States.
22

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

1 As noted in a communication to the Council from Dr. Burnett, many components of the proposal
2 outlined in Resolution 110 (A-03) are already embodied in AMA policy. The outstanding issues
3 raised in Resolution 110 (A-03) that are not addressed in policy or conflict with policy include
4 mandating “universal compulsory catastrophic health insurance” and the creation of a “federal
5 health insurance reserve system.” The Council is currently studying the merits of an individual
6 mandate within the context individually owned health insurance.
7

8 As a result, the Council has focused this report in response to Resolution 110 (A-03) on the merits
9 of creating a federal health insurance reserve system. The report provides a “crosswalk” of
10 Resolution 110 (A-03) with relevant AMA policy, describes the history and function of the Federal
11 Reserve Board, and discusses the merits of establishing a federal health insurance reserve system.
12 An Appendix of all the cited policy is included.
13

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

15

16 Below is the actual language of Resolution 110 (A-03). Following each point is the citation for
17 related AMA policy and directives, which appear in parentheses. The policies and directives that
18 are cited can be found in the Appendix. As previously noted, the proposal is highly consistent with
19 AMA policy. Resolution 110 (A-03) asked:
20

21 “That our American Medical Association (AMA) endorse a system embodying the following
22 Congressional actions:
23

- 24 1. To eliminate employer purchase or partial purchase of health insurance for employees and
25 encourage a voluntary defined contribution by the employer that is tax deductible; (Policy
26 H-165.920 supports moving toward a system of individually selected and owned health
27 insurance, while Policy H-165.983[1] endorses the concept that employers provide a defined
28 contribution for the purchase of health insurance.)
29
- 30 2. To mandate Universal Compulsory Catastrophic Health Insurance and additional basic
31 coverage for all children, both governmentally subsidized for the poor; (Policy H-165.920[15],
32 supports the use of tax incentives, and other non-compulsory measures, rather than a mandate
33 requiring individuals to purchase health insurance coverage. The issue of an individual
34 mandate is currently under reconsideration by the Council. Policy H-165.882 places particular
35 emphasis on advocating policies and proposals designed to expand health insurance coverage
36 to presently uninsured children in accordance with AMA policy to use tax credits for
37 individually owned health insurance.)
38
- 39 3. To provide tax credits inversely related to income for the purchase of health insurance by the
40 individual (defined contributions that are not used to purchase qualified health insurance plans
41 would be taxable as ordinary income); (Policy H-165.865 supports a series of principles for
42 structuring health insurance tax credits, including that they be in amounts that are inversely
43 related to income.)
44

- 1 4. To bifurcate Medicaid and make the medical portion a national program with national benefits
2 and national funding and leave long term care to the states; (Policy H-165.855 recommends
3 federalizing the cost of treating acute care Medicaid patients. Long-term care financing is an
4 ongoing item of study by the Council on Medical Service.)
5
- 6 5. To change the financing of the Medicare system from its present cross-generational financing
7 scheme to a forced savings or investment program; (Policy H-165.987[1] supports a shift in the
8 funding of Medicare from the current tax financed pay-as-you-go system to a system of
9 mandatory individually-owned private savings.)
10
- 11 6. To require that hospital and pharmaceutical outlets that receive payments from any insurance
12 policy involving tax credits to the patient or payments from other government subsidized
13 programs invoke an all payor system for the same service allowing each hospital or pharmacy
14 to have its own rate structure; (This point would fall under the rubric of the FHIRS. See point
15 9[h] of Resolution 110 [A-03] below.)
16
- 17 7. To allow balance billing in tax favored programs, provided patients are informed and the
18 amount of balance bill is posted on the Internet; (Policy H-385.991 supports the right of
19 physicians to balance bill.)
20
- 21 8. To set the amount of decrease in income that the government can afford from providing tax
22 credits; the amount of funding allocated to pay for the basic medical care package along with
23 the catastrophic coverage for those on Medicaid or below a stipulated poverty level and the
24 increased expense incurred by the Federal Government in transitioning Medicare to a forced
25 savings program (versus keeping the old program while those under 40 are in the new forced
26 savings program) and to transmit to the Federal Health Insurance Reserve System the amount
27 that the government is willing to subsidize and forgo from tax credits; (Policies H-165.855 and
28 H-165.987 support the Medicaid and Medicare transitions, respectively. As stated in the
29 language of the resolution, this point would be a function of the FHIRS and is addressed
30 below.)
31
- 32 9. To create a Federal Health Insurance Reserve System (FHIRS) to be independent with the
33 board appointed by the President from districts approved by Congress and isolated from
34 politics and special interests in order to advance the health care of the United States, with the
35 following duties:
36
 - 37 (a) Promote freedom of choice, equality and justice for patients and physicians. (Policies
38 H-165.920[7] and H-380.994, among many others.)
 - 39 (b) Specify benefits to be included in the mandated catastrophic policies and the basic health
40 insurance policies for those on Medicaid or below a certain percentage of the poverty level,
41 as well as those required for children. The subsidized benefits are to keep within the fiscal
42 constraint set by Congress. (Although the AMA standard and minimum benefit packages
43 are still contained in the AMA Policy Database, more recent Policy H-185.964 limits
44 support for benefit mandates. Policy H-165.855 advocates that low-income individuals be
45 provided with tax credits that enable them to purchase coverage modeled after the Federal
46 Employees Health Benefit Program.)
 - 47 (c) Specify benefits qualifying for maximum tax dollars as determined by Congress. (Policy
48 H-165.865[2] addresses qualifying expenses for tax credits.)

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

41
42 FEDERAL RESERVE SYSTEM

43
44 In assessing the merits of a federal reserve system, the Council reviewed the history and function of
45 the Federal Reserve Board. Created by the Federal Reserve Act of 1913, the Federal Reserve
46 Board was intended to provide a safer, more flexible, and more stable monetary and financial
47 system. Prior to the Federal Reserve Board's creation, the nation suffered periodic "financial
48 panics" that led to bank failures, bankruptcies and economic downturns. Following a severe

1 financial crisis in 1907, Congress established the National Monetary Commission, which
2 envisioned an institution with the stabilizing function that eventually became the Federal Reserve
3 Board.

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

12
13 The Council does not believe, however, that there is a parallel between the banking and financial
14 markets a century ago and the health insurance markets of today. Indisputably, the relentlessly
15 high number of uninsured Americans constitutes something of a financial crisis that will be costly
16 for society to address, just as the financial crises early in the 20th century caused monetary turmoil.
17 Yet, the current health care delivery system is functioning, whereas the Federal Reserve Board was
18 established to address the complete failure of the banking system in the early 20th century. The
19 major problem for the United States is that health care is not appropriately and efficiently financed.
20 For example, a majority of Americans currently receive health insurance through their employers
21 with the aid of a regressive tax subsidy.

22
23 Applying the FHIRS to all Americans, including those who are content with their existing
24 coverage, could engender deep patient dissatisfaction with the health care system. Many
25 Americans will recall the comprehensive health reform plan proposed by President Clinton in the
26 early 1990s, which included an oversight board that generated a strong negative response. The size
27 and power of the proposed FHIRS also could potentially undermine its laudable goal of being
28 apolitical.

29 30 DISCUSSION

31
32 While it is clear that many of the goals of the proposed FHIRS are consistent with current AMA
33 policy, the Council is concerned that the complex and increased bureaucracy of a federal health
34 insurance reserve board would hinder rather than facilitate the implementation of those goals for
35 health system reform. On balance, the Council believes that it would be better to accomplish the
36 goals of such a board without actually creating the board.

37
38 The Council believes that the FHIRS proposal would change much more than is necessary to
39 accomplish many of the goals outlined in Resolution 110 (A-03). In particular, the FHIRS
40 proposal would (1) be expensive to establish; (2) specify a "one size fits all" benefits package; (3)
41 require increased bureaucracy; (4) establish a board that would potentially need to work in secret in
42 order to remain apolitical; (5) duplicate work, such as clinical trials, being done by other agencies;
43 and (6) involve such a high level of micromanagement that medical innovation could be
44 diminished.

45
46 The AMA has developed a proposal to greatly expand health insurance coverage in a manner that
47 is highly consistent with the majority of the concepts described in Resolution 110 (A-03). Both are
48 comprehensive proposals to expand health insurance coverage and increase patient choice. The

1 Council also believes that a more uniform, national approach to health insurance market regulation
2 as previously detailed in Council on Medical Service Report 7, A-03 (Policy H-165.856), would
3 lead to expanded health insurance coverage and choice. Such a regulatory approach would
4 improve health insurance market function whether in the context of the existing, predominantly
5 employment-based health care system, or an individually based system as proposed by the AMA.
6

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

10
11 RECOMMENDATION

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13 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
14 110 (A-03) and the remainder of the report be filed:

15
16 That the American Medical Association continue to make the expansion of individual health
17 insurance coverage and choice, using a system of tax credits and improved market regulation, a
18 priority throughout the 2004 political campaigns and beyond. (Directive to Take Action)

Fiscal Note: Continue to advocate for the AMA's health insurance reform proposal at an estimated
total staff cost of \$2,998.

APPENDIX

AMA Policies and Directives Relevant to Resolution 110 (A-03)

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

Our AMA: (1) compliments the Pharmaceutical Research and Manufacturers of America (PhRMA) on its programs for indigent patients and encourages the PhRMA to develop a universal application process and eligibility criteria to facilitate enrollment of patients and physicians in all the programs providing pharmaceuticals to indigent patients that are provided by pharmaceutical manufacturers; (2) encourages the PhRMA to provide information to physicians and hospital medical staffs about the members of PhRMA that provide pharmaceuticals to indigent patients; (3) (a) urges drug companies, through the PhRMA, to accelerate the development of user-friendly and culturally sensitive uniform centralized policies and procedures for certifying indigent patients for free or discounted medications. The process should not require physician participation beyond providing the prescription and individual patients, once certified, should be able to obtain medications from the pharmacy of choice; and (b) encourages pharmaceutical manufacturers to expand their already generous free drug programs for the indigent; (4) encourages physicians to facilitate the expansion of free drug programs for the indigent by declining to receive noneducational promotional materials from drug manufacturers and by urging that the funds otherwise spent on such materials be redirected to support expanded free drug programs for the indigent; and (5) will continue to meet with the PhRMA to develop more uniform, universally accepted, rapid mechanisms for physicians to request and obtain useful quantities of medications from American pharmaceutical companies for use by indigent patients. (Sub. Res. 105, I-92; Sub. Res. 507, A-96; Appended: Sub. Res. 513, I-97; Reaffirmation I-98; Reaffirmation I-00; Reaffirmation A-01; Amended: Res. 513, A-02)

H-165.855 Medical Care for Patients with Low Incomes

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

assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care; (6) that state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available as either a mandatory or optional services under Medicaid, but are not medical benefits per se; and (7) that as individuals in the acute care population transition into chronic care needs, they should be eligible for sufficient additional subsidization to allow them to maintain their current coverage.

H-165.856 Health Insurance Market Regulation

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

H-165.865 Principles for Structuring a Health Insurance Tax Credit

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

expenses are defined by Title 26 Section 213(d) of the United States Code. (CMS Rep. 4, A-00; Reaffirmation I-00; Reaffirmation A-02)

H-165.882 Improving Access for the Uninsured and Underinsured

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

while safeguarding state and federal patient protection laws. Any support for such small employer and voluntary purchasing cooperatives shall be strictly contingent upon safeguarding state and federal patient protections. For purposes of such legislation, small employers should be defined in terms of the number of lives insured, not the total number employed; (15) through appropriate channels, encourages unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups to serve as voluntary choice cooperatives for both children and the general uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope. (CMS Rep. 7, A-97; Reaffirmed and Amended by CMS Rep. 9, A-98; Reaffirmation A-99; Reaffirmed: CMS Rep. 5, I-99; Reaffirmed: Res. 238 and Reaffirmation A-00; Modified: BOT Rep. 17, I-00; Reaffirmation A-02)

H-165.920 Individual Health Insurance

Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, the AMA will: (a) Support legislation that would provide the employer with the same tax treatment for payment of health expense coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health expense coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health expense coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; and (e) To ensure that the health insurance plan purchased by the individual employee is sufficient to provide a basic level of health care and does not increase the probability that the employee will become uninsured, the AMA would work toward the establishment of the following guidelines: (i) minimum benefit requirements, including catastrophic protection, (ii) fiscal solvency of the plan, (iii) provision of basic consumer information, (iv) protection of the consumer from fraud, (v) guaranteed issue, (vi) guaranteed renewability, and (vii) rate reform; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health expense coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to

select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) strongly supports legislation promoting the establishment and use of medical savings accounts (MSA)s and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance; (8) continues to place a high priority on enactment of federal legislation to expand opportunities for employees and others to individually own health insurance through vehicles such as medical savings accounts; (9) supports legislation requiring a “maintenance of effort” period, such as one or two years, during which employers would be required to add to the employee’s salary the cash value of any health expense coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health expense coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present exclusion from employees’ taxable income of employer-provided health expense coverage with tax credits for individuals and families; (13) encourages continued experimentation with and monitor the success of approaches to minimizing or compensating for adverse selection among the individually purchased and owned health expense plans available, including risk adjustment across plans, reinsurance pools, and limiting enrollment and disenrollment opportunities through such mechanisms as multi-year policy contracts; (14) upon legislative enactment of Policy H-165.920(3a) and Policy H-165.920(6) ,the AMA should rescind Policy H-165.995(2)(a), which calls for tax code changes to allow persons paying the entire premium for their health insurance to deduct the full cost of their premium separately from their gross income; (15) supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage; (16) seeks federal legislation to rescind Internal Revenue Service tax regulations requiring annual forfeiture of unspent funds in employer provided flexible spending accounts; and (17) believes that tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured. (BOT Rep. I-93-41; CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation; Reaffirmed: CMS Rep. 1 and 3; Appended: CMS Rep. 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03)

H-165.983 Covering the Uninsured

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

H-165.987 Long-Term Funding of Medicare

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

H-185.964 Status Report on the Uninsured

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

H-240.999 Relationship of Hospital Costs and Hospital Charges

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

H-285.998 Managed Care

...(5) Utilization Review The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payors should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All

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

H-380.994 Physicians' Freedom to Establish Their Fees

Our AMA (1) affirms that it is a basic right and privilege of each physician to set fees for service that are reasonable and appropriate, while always remaining sensitive to the varying resources of

patients and retaining the freedom to choose instances where courtesy or charity could be extended in a dignified and ethical manner; (2) supports the concept that health insurance should be treated like any other insurance (i.e., a contract between a patient and a third party for indemnification for expense or loss incurred by virtue of obtaining medical or other health care services); and (3) believes that the contract for care and payment is between the physician and patient. (BOT Rep. JJ, I-83; Reaffirmed: CLRPD Rep. I-93-1; Reaffirmed: Sub. Res. 704 and Reaffirmation A-01)

H-385.976 Physician Collective Bargaining

Our AMA's present view on the issue of physician collective negotiation is as follows: (1) There is more that physicians can do within existing antitrust laws to enhance their collective bargaining ability, and medical associations can play an active role in that bargaining. Education and instruction of physicians is a critical need. The AMA supports taking a leadership role in this process through an expanded program of assistance to independent and employed physicians. (2) Our AMA supports continued intervention in the courts and meetings with the Justice Department and FTC to enhance their understanding of the unique nature of medical practice and to seek interpretations of the antitrust laws which reflect that unique nature. (3) Our AMA supports continued advocacy for changes in the application of federal labor laws to expand the number of physicians who can bargain collectively. (4) Our AMA vigorously opposes any legislation that would further restrict the freedom of physicians to independently contract with Medicare patients. (5) Our AMA supports obtaining for the profession the ability to fully negotiate with the government about important issues involving reimbursement and patient care. (BOT Rep. P, I-88; Modified: Sunset Report, I-98; Reaffirmation A-00; Reaffirmation I-00; Reaffirmation A-01)

H-385.989 Payment for Physicians Services

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

H-385.990 Payment for Physicians Services

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

H-385.991 Balance Billing

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

H-400.960 Harnessing Market Forces in Medical Pricing.

Our AMA: (1) continues its non-endorsement of the Medicare RBRVS-based physician payment system until such time as it is adequately corrected and refined and will continue to pursue all efforts to correct the problems with this system identified in Policies 400.965 and 400.972, especially as they affect primary care services; (2) calls for CMS to conduct a study and collect cost data necessary for development of a methodologically sound resource-based approach to practice expenses for the Medicare RBRVS, with all deliberate speed. In addition, the AMA advocates that CMS be given the authority to immediately correct identified anomalies in the current RBRVS practice expense relative value units. All applications of these methods should refrain from reductions in payments for services without complementary increases in services that this method identifies as “undervalued”; (3) advocates the following additional principles for physician payment under Health Access America and any other relevant health system reform proposal: (a) An RBRVS that is annually updated and rigorously validated could be a basis for non-Medicare physician fee and payment schedules. This policy pertains to the RBRVS relative values only. It does not apply to Medicare’s conversion factor, balance billing limits, GPCIs, and inappropriate payment policies. In addition, the AMA will continue to seek the reversal of the 2.8% across-the-board “budget neutrality” reduction in the 1993 Medicare RBRVS relative value units (RVUs), with all RVUs restored to the levels that would have been in effect without this reduction. The AMA will vigorously oppose any such future reductions in the Medicare RBRVS relative values. (b) There should be two or more affordable fee-for-service plans offered on an annual basis by each employer or “health alliance.” Each health alliance should be required to make a good faith effort, to ensure that there are at least two such plans. In all but the most extreme circumstances, which do not include the level of the plan premium, each alliance must have at least one fee-for-service plan. (c) There should be advance disclosure of physician and all other provider fees and charges and plan payments. With RBRVS payment, physicians and payors would set or contract for conversion factors. (d) Physician fees should not be regulated by governments or health alliances. (Reaffirmed: Sub. Res. 132, A-94) (e) There should be no annual

regulated budgets for fee-for-service plans. If such budgets are required, fees outside of plan allowances should not be subject to the budgets; patients should be free to make such unsubsidized payments; (4) will provide assistance and guidance to state medical associations, national medical specialty societies, physician practices, and public and private third party payors to help ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods; and (5) supports the position that the RBRVS should not be implemented by private payors as a cost containment device; savings from payment reductions should be used for the purpose of increasing payments for undervalued services. (BOT Rep. UU, A-93; Reaffirmed: BOT Rep. I-93-37; Reaffirmed: Res. 101, I-93; BOT Rep. 25-A-94; Reaffirmed: CMS Rep. 11-A-94; Reaffirmed by Sub. Res. 802, A-96; Reaffirmed: CMS Rep. 12, A-99; Reaffirmed: CMS Rep. 2, I-00)