

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (I-01)
Transitional Issues in Moving Toward a System of Individually Selected and Owned Health Insurance
(Reference Committee A)
(December 2001)

EXECUTIVE SUMMARY

Substitute Resolution 116 (I-00) established policy that encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance (Policy H-165.864, AMA Policy Database). The resolution also called on the AMA to study potential problems in transitioning to a system of individually selected and owned health insurance, including but not limited to the price disadvantage of the individual with a Medical Savings Account (MSA) or other high deductible insurance policy. Council on Medical Service 2 (I-01) addresses two issues in addition to the individual price disadvantage issue raised in Substitute Resolution 116 (I-00): venues for individuals to purchase health insurance prior to the widespread establishment of health insurance marts; and individuals' ability to choose health plans.

With respect to the individual's price disadvantage, the Council believes that a number of factors will mitigate the self-paying individual's price disadvantage including: increased access to discounted fees through networks and discount cards; voluntary restraint of physician fees for self-paying patients (per Policy H-390.996); increased market pressure to restrain fees as more patients choose MSAs and other arrangements involving out-of-pocket payments; and physician willingness to offer cash discounts in order to bypass submitting insurance claims. The report also summarizes factors to be considered in assessing how much flexibility physicians have in determining and varying fees individuals.

Regarding the second issue of immediate venues for individuals to purchase health insurance, the Council believes that reasonable options already exist for most individuals to purchase coverage, provided that tax credits are appropriately structured. In the view of the Council, there is cause for qualified optimism about the individual market. The Council also recognizes that special measures are needed to address the needs of individuals with chronic illness or disability, who might otherwise have difficulty obtaining coverage outside the employment-based system. Extensive AMA policy supports high-risk pools and other approaches that both protect special populations and permit insurance markets to function properly.

As for the third issue, individuals' ability to choose health plans, the Council notes that individuals rather than employers already make numerous complex decisions regarding such issues as education, life insurance, and retirement savings. The Council believes people will quickly become accustomed to choosing their health plans, just as they have become accustomed to choosing 401(k) options and long-distance telephone service, particularly since support for making informed health plan choices is becoming ever-more available.

The Council recognizes that the transition to a system of individually selected and owned health insurance will not be entirely smooth. However, the Council believes that transition problems will not be as daunting as some fear. Naturally occurring market responses, some already under way, will go a long way towards addressing the three potential transition issues discussed in this report.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2 - I-01
(December 2001)

Subject: Transitional Issues in Moving Toward a System of
Individually Selected and Owned Health Insurance

Presented by: F. Maxton "Mac" Mauney, MD, Chair

Referred to: Reference Committee A
Arthur R. Traugott, MD, Chair

1 At the 2000 Interim Meeting, the House of Delegates adopted Substitute Resolution 116, which
2 established policy that encourages physicians when setting their fees to take into consideration the
3 out-of-pocket expenses paid by patients under a system of individually selected and owned health
4 insurance (Policy H-165.864, AMA Policy Database). The resolution also called on the AMA to
5 study the potential problems in transitioning to a system of individually selected and owned health
6 insurance, including but not limited to the price disadvantage of the individual with a Medical
7 Savings Account (MSA) or other high-deductible insurance policy. The Board of Trustees referred
8 the requested study to the Council on Medical Service for a report back at the 2001 Interim
9 Meeting. The following report addresses two issues in addition to the individual price
10 disadvantage raised in Substitute Resolution 116 (I-00): venues for individuals to purchase health
11 insurance prior to the widespread establishment of health insurance marts; and individuals' ability
12 to choose health plans.

13 14 THE INDIVIDUAL'S PRICE DISADVANTAGE

15
16 Recent media reports suggest that uninsured patients typically face higher fees for medical services
17 than insured patients. Not only are uninsured patients subject to paying fees out-of-pocket, but also
18 physicians charge higher fees to the uninsured than they charge insurers for the same services. The
19 discrepancy arises from the fee discounts that managed care insurers have negotiated with
20 physicians over the last 10 to 15 years. Like the uninsured, patients with traditional indemnity
21 (fee-for-service) insurance pay for services out-of-pocket until they reach their deductibles, and
22 even after reaching their deductibles, they may initially pay out-of-pocket. The uninsured and
23 those with traditional indemnity insurance fall outside the managed care system, thus lacking the
24 leverage to negotiate fee discounts.

25
26 Historically, it was the norm for patients to pay physicians directly out-of-pocket because they
27 either had no health insurance or had indemnity coverage, and it was common for physicians to
28 charge patients on a sliding-scale basis. More recently, a variety of factors have reduced the scope
29 for physicians to reduce or waive fees for individual patients. Deeper and deeper fee discounts to
30 managed care insurers, obtained unilaterally in many instances, have created financial pressures
31 that hinder physicians from reducing fees for patients who pay out-of-pocket. The trend toward
32 larger group practices has shifted the locus of decision-making about patient fees from individual
33 physicians to group administrators, possibly making it more difficult for individual patients to
34 obtain fee discounts or waivers. In some cases, legal and contractual barriers might also interfere
35 with the use of sliding-scale fees or payments.

1 Self-Paying Patients Under a System of Individually Based Insurance

2
3 Patients who lack first-dollar coverage for whatever reason can be classified as “self-paying”
4 because they pay out-of-pocket or out of some sort of individual account. Self-paying patients
5 include those who are uninsured; those with fee-for-service insurance who have not yet reached
6 their deductibles; and those paying for care out of MSAs, flexible savings accounts or individual
7 accounts under other “consumer-directed” health plans. Accordingly, from a practical and a
8 possibly even a legal standpoint, the issue of the individual’s price disadvantage applies to all self-
9 paying patients.

10
11 There is a concern that the self-paying individual’s price disadvantage will discourage the adoption
12 of MSAs and similar insurance products, thereby impeding acceptance and development of a
13 system of individually based health insurance. Although it would be possible in principle to have
14 an individually based system without MSA-type coverage, a large part of the rationale for such a
15 system is individual freedom of choice in coverage. Further, AMA policy supports patient cost-
16 consciousness not only in purchasing coverage but also in purchasing health care, and MSA-type
17 products promote cost-consciousness at this level.

18
19 Legal and Contractual Barriers to Offering Discounts to Self-Paying Patients

20
21 Although not required by law, many physicians for purposes of administrative simplicity
22 effectively have a single fee schedule used to bill for services to all patients. It is not unusual,
23 however, for physicians to accept payments less than billed amounts, particularly for financially
24 disadvantaged patients. It is unlikely that occasional granting of discounts or waivers to low-
25 income patients would be seen as a violation of any legal or contractual requirements. From the
26 perspective of implementing the AMA proposal for individually based insurance, the main issue is
27 how much latitude a physician has to offer a discount to a non-indigent patient who is paying out-
28 of-pocket because he or she has MSA-type coverage and has not reached the deductible (assuming
29 that the physician has not entered into a preferred provider or other agreement with the patient’s
30 insurer that would specify negotiated fees to be paid by the patient). The degree of flexibility the
31 physician has appears to depend largely on the following factors:

- 32
33 • Medicare and Medicaid rates in the physician’s locality;
34 • Payment provisions of contracts the physician has entered into with private insurers;
35 • How low the discount is relative to payments collected from other payors;
36 • How routinely discounts are offered to self-pay patients;
37 • The proportion of the physician’s business made up of services to self-pay patients;
38 • Whether the patient pays in cash or is billed; and
39 • State Medicaid laws and other state laws.

40
41 In 1987, a federal law was enacted prohibiting physicians from billing Medicare or Medicaid
42 “substantially in excess” of their usual charge (US Code Title 42, Section 1320a-7[b][6][A]).
43 Since 1992—when the old Medicare charge-based payment system was replaced with a Medicare
44 fee schedule determined through a resource based relative value scale (RBRVS), and physicians
45 were to be paid the lower of their actual charge or the fee-schedule amount—federal officials have
46 issued conflicting statements about whether the 1987 law still applies. Most recently, the Office of
47 the Inspector General and the final rule on the fraud and abuse provisions contained in the Health

1 Insurance Portability and Accountability Act of 1996, have taken the position that physicians are
2 still prohibited from collecting more from Medicare than they usually accept from private payors.
3 In theory, providing discounts to individuals could result in a physician being barred from
4 participation in Medicare and Medicaid. At present, this scenario is unlikely given that the law was
5 clearly never intended to discourage fee discounts to low-income or uninsured patients, and that the
6 physician would have to charge a large portion of his or her fees substantially below Medicare and
7 Medicaid rates in the physician's locality. In the future, however, the proportion of a physician's
8 patients who had MSA-type products and who were not necessarily low-income could become
9 large enough to trigger concerns about violating the law, if such patients routinely paid less than
10 Medicare and Medicaid rates, and if the physician did not reduce charges to Medicare and
11 Medicaid accordingly.

12
13 Certain contractual agreements between physicians and private insurers may pose a more
14 immediate impediment to offering discounts to self-paying patients. Although payment for
15 physician services under most private-sector contracts is determined by fee schedules or the
16 RBRVS, a relatively small number of contracts are still based on "uniform, customary,
17 (prevailing), and reasonable" (UCR) physician payment methodologies. Under such agreements,
18 the insurer agrees to pay a discounted amount of the physician's UCR fee as determined by some
19 algorithm or guidelines specified in the contract. A problem could arise, however, if the UCR fees
20 reported to the insurer do not factor in lower amounts accepted from self-paying patients.
21 Similarly, routinely offering discounts to patients with MSA-type coverage could potentially be
22 construed as *de facto* establishment of a separate fee-schedule for such patients. Furthermore,
23 physicians who have signed "most favored nation" contracts might be in violation of their contracts
24 if the payments from self-paying patients are below the fees charged to a "most favored nation"
25 insurer. The extent to which payments from self-paying patients factored into UCR, "most favored
26 nation," and similar arrangements also could depend on whether the payments were billed or made
27 on a cash basis. Depending on the exact contract language, cash discounts to self-paying patients
28 might be treated differently from billed payments, especially given that cash discounts reduce the
29 administrative costs associated with services.

30
31 State laws, including Medicaid laws, also could impact physicians offering discounts to self-paying
32 patients. For example, in 1998 California enacted legislation authorizing physicians and other
33 health care providers to grant discounts to patients who do not have any private or public coverage
34 for the services provided. The law explicitly overrides provisions in contracts between physicians
35 and private insurers, and prohibits insurers from factoring cash payments made by such individuals
36 into UCR calculations or counting them as "most favored nation" fees. The law applies to
37 individuals who are not eligible for "insurance reimbursement" for "the health or medical care
38 provided" and makes no mention of income. Thus, depending on the specific policy provisions of
39 the MSA-type plan, the law would likely apply to the self-paying patient before he or she has
40 reached the deductible. It should be noted, however, that the California law is unusual if not
41 unique, and that physicians practicing in other states do not generally have explicit flexibility to
42 vary fees to self-paying individuals free of UCR and "most favored nation" considerations.

43
44 Relevant AMA Policy

45
46 AMA policy promotes cost-conscious health coverage choice through fixed-dollar, refundable tax
47 credits for individual purchase of health coverage (Policies H-165-920[12] and H-165.865[1f]) and
48 through employer defined contributions toward employee-selected health coverage (Policies H-

1 165.881, H-165.895, H-165.890, H-40.969, H-164.920[3], and H-165.889). AMA policy also
2 encourages patient cost-consciousness at the level of day-to-day health care consumption through
3 MSAs and other mechanisms that involve having patients pay for medical care directly out-of-
4 pocket and/or allow patients to retain control over unspent funds in individual accounts (Policies
5 H-165.869; H-165.879; H-180.957; H-165.920[7], [8], and [16]; H-165.865; H-185.982; and H-
6 165.894).

7
8 Several AMA policies bear upon the issue of fees paid directly by patients to physicians (Policies
9 H-165.864, H-380.996, H-380.994, H-185.983, H-165.884, H-385.991, H-385.990, H-380.985, and
10 H-385.986). These policies generally advocate for physicians' freedom to establish fees and to
11 balance bill. As noted previously, Policy H-165.864 encourages physicians when setting their fees
12 to take into consideration the out-of-pocket expenses paid by patients under a system of
13 individually selected and owned health insurance. Policy H-380.996 favors continued commitment
14 to programs for voluntary restraint of physician fees. Policy H-380.994 affirms the basic right of
15 each physician to set reasonable and appropriate fees, and to selectively reduce or waive fees on the
16 basis of courtesy or charity. Policy H-385.990[3] encourages physicians to volunteer fee
17 information to patients and to discuss fees in advance of services, where feasible. Additionally,
18 Policy H-385.935 opposes granting Medicare "most favored nations" status by interpreting "actual
19 charge" as meaning the negotiated rates a physician obtains from a private third-party payor or any
20 other source. Similarly, Policy H-385.938 opposes insurance contract "most favored nation"
21 clauses that require a physician or other health care provider to give the third-party payor his most
22 discounted rate for medical services.

23 Factors Mitigating the Individual's Price Disadvantage

24
25
26 Several factors are likely to mitigate the individual's price disadvantage under an individually
27 based system. Foremost, self-paying patients increasingly have access to discounted fees. MSAs
28 and other consumer-directed insurance plans may be accompanied by networks through which
29 patients can obtain services at negotiated discounts. For example, in Pennsylvania, First MSA, Inc.
30 has arranged a network of over 16,000 physicians, 150 hospitals, and 40 ambulatory centers, as
31 well as laboratories, and pharmacies. For enrollees who do not opt for access to the network, or for
32 patients going out of network, First MSA offers coaching on determining reasonable fees and on
33 negotiating with providers. Even the uninsured can have access to health care at discounted fees
34 through a new breed of companies offering "medical discount cards." Companies such as
35 HealthAllies and Care Entrée set up provider networks for the uninsured and underinsured.
36 Patients pay their own bills but they receive discounted fees because the company has negotiated
37 for them as a group or purchased preferred provider lists.

38
39 Other factors that will mitigate the individual's price disadvantage, perhaps only modestly in the
40 short run, are voluntary restraint of physician fees charged to individuals as supported by Policy H-
41 380.996, and increasing market pressure to restrain fees to individuals as more people choose
42 MSAs and other arrangements involving out-of-pocket payments. Although an individually based
43 system might indeed put patients and physicians across the proverbial negotiating table from each
44 other, explicit negotiations will not necessarily occur between individual physicians and patients or
45 at every encounter, particularly in the presence of uniform billing requirements. Rather, physicians
46 will increasingly have to take self-paying patients into account when determining fees. Eventually,
47 as price information disseminates and online and other systems for providing such information
48 develop, the time and discomfort of fee negotiations will lessen. Another factor favoring adoption

1 of MSA-type products is that many physicians will be eager to offer self-paying patients cash
2 discounts in order to bypass the costs, hassles, and delays of submitting insurance claims.

3 IMMEDIATE VENUES FOR INDIVIDUALS TO PURCHASE INSURANCE

4
5 As outlined in Council on Medical Service Report 3 (A-01), the market for health insurance is
6 expected to eventually transform along several dimensions including: new venues for purchasing
7 health insurance, particularly group coverage; containment of premium prices due to competitive
8 pressures; and expanded range of product offerings, including low-premium options such as MSAs.
9 AMA policy encourages the formation of health insurance marts (i.e., voluntary choice
10 cooperatives) as alternative venues for pooling risk beyond employment-based groups (Policies H-
11 165.882[14] and [15] and H-165.895[3]), and Council on Medical Service Report 5 (A-99)
12 reviewed existing employer health insurance purchasing alliances that could serve as prototypes for
13 health insurance marts.

14
15 A potential problem in transitioning to a system of individually based health insurance is the
16 question of where individuals, newly equipped with tax credits and defined contributions, would
17 purchase coverage prior to such market transformations. If tax credits are initially introduced for a
18 limited segment of the population (e.g., the working uninsured), the transformation of health
19 insurance markets will not be as rapid or pervasive as under more general reform (i.e., replacing the
20 tax exclusion with tax credits). Until the full-fledged development of health insurance marts, even
21 individuals of below-average expected cost could face higher premiums on the individual market
22 than under employment-based coverage, due to the loss of administrative savings from group
23 purchasing. Even after the transition to an individually based system, people with chronic or high-
24 cost conditions might have difficulty obtaining coverage without special assistance.

25
26 Recent Studies of the Individual Market

27
28 Two common misconceptions about an individually based system are that insurance would not be
29 purchased through groups and that all individuals would face strictly risk-rated premiums.
30 Although these notions are mistaken, it is possible that a relatively large number of individuals
31 would purchase coverage on the individual market during a transitional period. Several recent
32 studies consider how well the individual market functions, with particular attention to risk rating
33 and the impact of risk rating on access to coverage.

34
35 Pauly and Herring. Pauly and Herring (1999) examined risk rating of premiums using data from
36 1987, prior to the widespread adoption of state regulations on premium rating and terms of issue.
37 Their study focused specifically on the question of whether employment-based group insurance is
38 more effective than individual insurance at cross-subsidization from low-risk to high-risk
39 individuals, i.e., by charging group premiums that are higher than the expected costs of low-risk
40 individuals and less than the expected costs of high-risk individuals. Although they found
41 premiums in the individual market to be generally high, they found that the differences in cross-
42 subsidization between the individual and group markets to be much less than commonly believed.
43 They also found that, although individual-market premiums for a given level of coverage vary
44 considerably, the variation is far from proportional to risk. Specifically, people with estimated
45 expected costs twice the average pay premiums only about 20-40% higher for a given policy.
46 Further, in contrast with the Kaiser Family Foundation findings discussed below, premiums do not
47 appear to vary with the presence of high-risk chronic conditions.

1 Kaiser Family Foundation and Commonwealth Fund. A recent study by the Kaiser Family
2 Foundation (KFF) found that individuals with even relatively minor health conditions sometimes
3 face higher premiums, restricted benefits or outright rejection by insurers (Pollitz, Sorian, and
4 Thomas, 2001). In the study, hypothetical people applied for health insurance with specified cost
5 sharing features (a \$500 deductible and a \$20 co-payment per physician office visit). Each of the
6 six individuals and one family with conditions ranging from hay fever to HIV-positive status
7 applied to multiple insurers in eight different markets across the country, all in states with few
8 restrictions on premium rating or terms of issue. The study found that, compared to employment-
9 based coverage, individual insurance tends to provide limited coverage of maternity services,
10 mental health care, and prescription drug medications; and that applicants for individual coverage
11 are less likely to be offered a policy if they've been previously rejected, making comparison
12 shopping a risky prospect.

13
14 A similar study conducted by the Commonwealth Fund found that adults aged 50 to 64 face
15 individual-market premiums two to four times higher than premiums (for the same benefits) for 25-
16 year-olds, and that they face higher out-of-pocket premium payments than their peers with
17 employment-based coverage (Simantov, Schoen, and Bruegman, 2001). Premiums were found to
18 climb steeply with age: nearly half of older adults with individual-market coverage pay annual
19 premiums over \$2,000, and the median cost for a 60-year old is nearly \$6,000. The conclusion of
20 the two studies was that commonly proposed individual tax credits (e.g., \$1,000 for individuals and
21 \$2,000 for families) would be insufficient to make coverage affordable for many low-to-moderate
22 income people, particularly for those whose age, geographic location, or health status make
23 insurance relatively expensive.

24
25 Families USA. A 2001 study by Families USA concluded that a \$1,000 tax credit for individuals
26 would not be enough to purchase "standard" coverage on the individual market, and that even with
27 the tax credit, "standard" coverage would be unaffordable for most low income individuals. The
28 study used two hypothetical applicants, age 25 and 50, both healthy, non-smoking females. The
29 applicants sought coverage in 25 states, primarily through eHealthInsurance.com and
30 QuoteSmith.com, two online health insurance brokers. Two types of plans were sought: a plan
31 costing \$1,000 and a "standard" plan comparable to the most popular plan in the Federal
32 Employees Health Benefits Program, the FEHBP Blue Cross/Blue Shield PPO. The study found
33 that in many states \$1,000 plans were unavailable, particularly for the 55-year-old applicant, and
34 that available \$1,000 plans provided "substandard" or "deficient" coverage (i.e., fewer benefits
35 and/or higher cost-sharing than the FEHPB BC/BS PPO plan). "Standard" plans were found to be
36 more widely available but more expensive, averaging \$2,395 for the 25-year-old and \$4,734 for the
37 55-year-old. Compared to the healthy applicants studied, applicants with health conditions would
38 find coverage to be less available and more expensive.

39
40 eHealthInsurance. A 2001 by eHealthInsurance.com, the largest online broker of individual health
41 insurance, refutes the perception that individual-market premiums are unaffordable. Based on a
42 sample of 20,000 policies recently sold through the company, the study found individual-market
43 coverage to be comprehensive, affordable, and widely available. The 20,000 single and family
44 policies sold were for 7,000 different health plans offered by over 70 insurers (including Blue
45 Cross/Blue Shield) in 42 states covering 95% of the U.S. population. Eighty-seven percent of the
46 policies purchased had coverage at least comparable to Medicare Parts A and B plus some level of
47 Medicare supplemental coverage (Medigap), most of these (85%) with some drug coverage.
48 Average per-person annual premiums—\$1,200 to \$1,500—were far lower than in the KFF and

1 Commonwealth Fund studies. The eHealthInsurance study concluded that proposed tax credits
2 would substantially offset premium costs and significantly reduce the number of uninsured
3 Americans. Refundable tax credits of \$1,000 per individual and \$2,500 per family would fully
4 cover premiums of half of the policies studied, and would cover at least 75% of 75% of the policies
5 studied.

6
7 Pauly, Song, and Herring. Pauly, Song, and Herring (2001) used a variety of approaches to study
8 health insurance premiums in the individual market and the possible impact of a \$1,000 individual
9 tax credit on the likelihood of purchasing insurance. To study the likely beneficiaries of a targeted
10 tax credit, people without employment-based coverage, the authors used data on both those who
11 purchased individual market coverage and the uninsured. They also used data on both actual
12 premiums and premium quotes from eHealthInsurance.com. The authors point out that average
13 premium quotes overestimate premiums of policies actually bought because a rational buyer who
14 has obtained multiple premium quotes will choose coverage toward the low end of the range, not
15 the plan with the average or median price. With this in mind, they estimate annual premiums on
16 the individual market for comprehensive indemnity, PPO or HMO plans with annual deductibles
17 under \$1,000. They found premiums to range from about \$700 to \$4,000. Premiums for the
18 median individual were estimated to be in the \$1,400 to \$1,800 range. Their findings indicate that
19 a \$1,000 tax credit would fully cover the premium for approximately one-fourth of individuals and
20 would cover at least half the premium for about two-thirds of individuals (only somewhat less
21 optimistic than the eHealthInsurance findings). Based on estimated premiums, the authors
22 simulated the percentage of eligible individuals purchasing health insurance under a \$1,000 tax
23 credit. The simulated take up rates were highly sensitive to methodology and assumptions about
24 individual purchasing behavior, with the most reasonable assumptions yielding take up rates in the
25 50% to 75% range.

26 27 Analysis of Individual Market Studies

28
29 How can such divergent conclusions about the state of the individual market--and the prospects for
30 individual tax credits--be reconciled? The answer lies to some extent in different research
31 questions, methods, and empirical findings, but also to some extent in different inclinations to call
32 the glass "half empty" rather than "half full." For instance, the Commonwealth Fund study
33 reported that nearly half of all older adults pay annual premiums of more than \$2,000 on the
34 individual market, rather than reporting the more remarkable finding that over half of all older
35 adults pay less than \$2,000 per year for individual coverage. Similarly, the Families USA study
36 reported that in six of 25 states, no \$1,000 plans were available for a healthy, non-smoking 25-
37 year-old woman, rather than that \$1,000 plans were available in 76% of the states surveyed (and
38 28% of states for the 55-year-old). Likewise, there is nothing surprising about the fact that
39 premiums vary on the basis of age, gender, health history, and geographic location; that premiums
40 are higher in the individual market than in the group market; or that insurers sometimes impose
41 benefit limitations based on pre-existing conditions (a practice not uncommon even for
42 employment-based coverage). The more surprising finding, consistent across studies, is that the
43 approach to setting premiums (i.e., medical underwriting) varies widely across insurers, as do
44 premiums offered by different insurers, even for the same individual. Thus, it pays to shop around
45 for coverage in the individual market.

46
47 Although the KFF study emphasized the low percentage of all applications accepted (63%), the
48 relevant unit of analysis is the applicant. Independent analysis of the study data by the AMA's

1 Center for Health Policy Research shows that most applicants obtained coverage in most markets.
2 Four of seven applicants found coverage without pre-existing condition limitations in all eight
3 markets studied, albeit two-thirds of the time with increased premiums or cost-sharing
4 requirements. Remarkably, a seven-year breast cancer survivor got “clean offers” (with premiums
5 the same as if she had a history of perfect health) in all markets. On average, applicants found
6 coverage without pre-existing condition limitations in 73% of markets (excluding the HIV-positive
7 applicant, who was rejected by all insurers, brings this figure up to 85%).
8

9 A closer look at the data also paints a somewhat different picture about premiums relative to
10 proposed tax credits. The KFF study found that, for single individuals, a tax credit of \$1,000
11 would cover only 25% of the average premium offer (\$3,996). Because the data is skewed towards
12 high-cost individuals, a more meaningful statistic is the percentage of average premiums covered
13 for the average applicant—a more generous 37%. (For comparison, the existing tax exclusion
14 covers 20% of the typical working insured’s premium, assuming a 25% marginal tax rate and an
15 80% employer share of the premium.) Proposed tax credits would go even further than these
16 calculations imply because applicants can, and usually do, choose plans with premiums below the
17 average premium offered—as noted by Pauly, Song, and Herring. In addition, both the KFF and
18 Commonwealth Foundation studies focused on single individuals, whereas per-person premium
19 costs are generally lower for those with family coverage.
20

21 Finally, compared to the KFF, Commonwealth Fund, and Families USA studies, the
22 eHealthInsurance and Pauly, Song, and Herring studies found lower premiums, and the Pauly and
23 Herring study found less individual risk-rating. The major source of discrepancy in premiums
24 between the eHealthInsurance and Families USA studies most likely arises from different health
25 plans studied; eHealthInsurance premiums were based on a range of plans purchased by
26 individuals, whereas the Families USA premiums were based on a defined “standard” plan, i.e., the
27 FEHBP BC/BS PPO. Despite the Families USA assertion that this “standard” plan meets “the
28 public’s perception of a basic, decent health insurance plan,” it is actually quite generous, with
29 features such as 75% coverage for out-of-network office visits, zero cost-sharing for maternity
30 care, 75% coverage for prescription drugs (greater coverage if purchased by mail), \$15 copayments
31 for in-network mental health care office visits with no limit on the number of visits, and an annual
32 out-of-pocket limit of \$3,000. Another source of discrepancy in premiums is the fact that the
33 eHealthInsurance study was based on policies actually purchased, whereas the KFF and
34 Commonwealth Fund studies looked at multiple policy offers faced by an individual; policies
35 actually purchased tend to be a lower-cost subset of all policies offered. Finally, the
36 eHealthInsurance study might represent a younger, healthier population than the KFF and
37 Commonwealth study populations (i.e., those with less-than-perfect health and those aged 50 to
38 64). Unlike the other studies, the eHealthInsurance report did not provide details about the study
39 population; the degree to which premiums varied with health history and other individual
40 characteristics; or how often applicants were rejected or subject to pre-existing condition
41 limitations. Still, the study, along with the Pauly, Song, and Herring study, provides strong
42 evidence that the individual market can work well for a large portion of the population, and that
43 proposed tax credits would substantially offset premium costs and significantly reduce the number
44 of uninsured Americans.

1 Options for Individuals

2
3 In addition to the individual market, several other opportunities exist for individuals to use tax
4 credits or defined contributions to purchase coverage. The eHealthInsurance study demonstrates
5 that the Internet can reduce the premiums of individual insurance by reducing administrative and
6 marketing costs. Internet purchasing of health insurance also serves to restrain prices and enhance
7 quality by giving individuals ready access to price and quality information about competing plans.
8 Access to the Internet varies with factors such as income, education, type of employment, and
9 immigrant status, underscoring the importance of making plan information readily available to all
10 groups. However, it is not necessary for all individuals to seek elaborate plan information in order
11 for health insurance markets to respond for the benefit of all patients. Further, with the increased
12 use of the Internet by individuals to purchase health insurance, the online individual market will
13 increasingly resemble a group market. This is because as more low-to-average-risk individuals
14 switch to Internet-based purchasing, the payoff to insurers of risk rating premiums will diminish,
15 thus preserving cross-subsidies from low- to high-risk individuals. Council on Medical Service
16 Report 5 (A-01) documented the rapid rate of development of virtual health insurance marts
17 already under way. An influx of formerly uninsured individuals equipped with tax credits would
18 accelerate development of online health marts, hastening the transformation of the individual
19 market into an effective group market.

20
21 Another key issue is whether employees with defined contributions can continue to purchase
22 coverage through groups. For example, health economist Uwe Reinhardt distinguishes between the
23 “you’re on your own” and “maternal” models of defined contribution systems. The former
24 involves giving people defined contributions (or tax credits) and turning them loose on the
25 individual market, whereas the latter resembles the Federal Employees Health Benefits Program
26 (FEHBP), with a wide choice of pre-screened plans, negotiated group premiums, and extensive
27 support for plan choice and enrollment. The so-called maternal model is already taking place,
28 mostly through Internet-based insurance brokers and plans.

29
30 Some tax credit proposals, including the AMA’s, allow individuals to use tax credits toward their
31 share of premiums for employment-based coverage. Depending on the location and individual
32 characteristics, a limited number of individuals have other opportunities to purchase group
33 coverage outside of the employment-based system. A majority of states have high-risk pools with
34 subsidized premiums for those with chronic illness. In a small number of states, private purchasing
35 alliances accept individuals as well as small employment groups. Some policy analysts have even
36 proposed making such private purchasing pools the only venue through which tax credits could be
37 used to purchase coverage (Curtis, Neuschler, and Forland, 2001). In the near future, individuals
38 may be able to buy coverage through state employee purchasing pools or the
39 FEHBP. Tax credits could also be used to buy into public programs such as Medicaid or the State
40 Children’s Health Insurance Program (S-CHIP).

41
42 Finally, even with widespread eligibility for tax credits and defined contributions, and even after
43 market transformation, individuals with predictably high health costs may need special assistance
44 in order to obtain coverage. Approximately one to two percent of those who apply for private
45 coverage are turned down based on their health status (Frogue and Turner, 2001). As described in
46 Council on Medical Service Report 3 (A-01), AMA policy favors public policies that address the
47 needs of high-risk individuals without undue disruption of health insurance markets for the general
48 population. Policies H-165.920[11] and [15], H-165.995, H-165.988, H-165.882[9], and H-

1 165.992[1] support the use of state high-risk pools. Policies H-165.992[1], H-185.968, H-90.995,
2 and H-165.979 support direct premium subsidies or other support for people who are
3 disadvantaged by low income, expensive or chronic illness, or disability. Policies H-165.915 and
4 H-330.933 support the use of risk adjustment and reinsurance in order to make high-risk
5 individuals more attractive to insurers.

6
7 INDIVIDUALS' ABILITY TO CHOOSE HEALTH PLANS

8
9 There have been longstanding concerns that individuals are not equipped to make informed health
10 care plan choices. Indeed, a recent study found that many people lack a basic understanding of
11 even their own managed care plans, e.g., network, cost-sharing, and referral features (Cunningham
12 et al., 2001). On the other hand, individuals rather than employers already make numerous
13 complex decisions regarding education, life insurance, retirement savings, etc. In addition,
14 sophisticated decision-making support regarding health plan choice is available to individuals, with
15 ever-more advanced support forthcoming.

16
17 Research on Decision-Making in Health Plan Choice

18
19 In recent years, considerable effort has been put into developing information and tools to assist
20 individuals in choosing health plans. Efforts have focused on providing consumers with
21 comparative information on plan benefits, costs, and quality, as well as on providing guidance
22 through the decision-making process. The Health Plan Employer Data and Information Set
23 (HEDIS) and the Consumer Assessment of Health Plan Satisfaction (CAHPS) programs were
24 developed to provide information on relative health plan quality. HEDIS and CAHPS measures of
25 plan quality are already being used to assist some employees in plan choice and to assist Medicare
26 beneficiaries in evaluating Medicare+Choice plans. At the state level, efforts have been made to
27 present HEDIS, CAHPS, and other quality information in standardized format (e.g., the Pacific
28 business Group on Health, the New York State HMO Report Card, and the Colorado Health Plan
29 Quality Report). A recent study examined the effect on plan choice of providing supplemental
30 information on expected out-of-pocket costs, in addition to quality and other standard plan
31 information (Schoenbaum et al., 2001). All study participants were given information about plan
32 premiums, patient cost-sharing, and gatekeeping features. Half of the study participants were also
33 provided with information about how much alternative plans might actually cost them depending
34 on their patterns of health care consumption. The study found that the additional cost information
35 significantly changed consumers' choice of health plan, mainly by reducing demand for relatively
36 comprehensive and expensive plans by about 20%.

37
38 A growing body of research in the field of decision-making theory has refined understanding of
39 how consumers approach health plan choice and how to best provide decision-support for plan
40 choice to a variety of consumers. In addition to content, the presentation of plan information
41 influences whether it is used (Hibbard, 1999). For example, grouping plans into meaningful
42 subcategories such as cost strata is more helpful than providing unordered information. Ongoing
43 research is investigating how presentation format (e.g., data tables vs. graphs, measures of specific
44 quality dimensions vs. summary quality measures) affects consumers' ability to accurately take in
45 and utilize plan information. Research has also shown that patients more readily understand
46 information framed as a potential disadvantage rather than a potential advantage, e.g., a downside
47 of managed care plans is reduced access to specialists (Hibbard et al., 2000). Consumers are also
48 more able to absorb new information when it is linked to familiar information (Harris-Kojetin et

1 al., 2001). Other research indicates the usefulness of navigational aids such as worksheets and
2 graphics, and of breaking down the decision-making process into discrete steps such as narrowing
3 down plan choices, estimating future health costs, systematically comparing several plan options,
4 and finally choosing the best plan.

5
6 Relevant AMA Policy

7
8 AMA policy supports efforts to assist patients in making informed decisions about health insurance
9 choice and usage (Policies H-165.920[3iii] and [10], H-180.961, H-185.971, H-185.973, H-
10 185.984, and H-405.997). Policy H-165.920[10] encourages the development of programs to assist
11 consumers in making informed choices about sources of individual coverage. Policy H-180-961
12 advocates that all plans use standardized benefit definitions and uniform disclosure formats such as
13 those used by plans participating in the FEHBP. According to Policies H-185.971 and H-185.973,
14 plan literature should explicitly and specifically list exclusions from coverage in order that these
15 are apparent and comparable, as well as explicitly list any limitations in choice of primary care
16 physician or access to specialists.

17
18 Support for Plan Selection

19
20 Already, a variety of resources exist to assist individuals in evaluating, comparing, and choosing
21 among competing health plans. Consumer-friendly information and support is rapidly becoming
22 more available as health plans cater increasingly to individuals rather than employers. Employers
23 who switch to defined contributions—either with multiple plan choices or by contributing fixed-
24 dollar amounts to individual accounts of “consumer directed” health plans—have continued to play
25 a key role in helping employees make informed choices, in some cases redeploying human
26 resources staff to help employees navigate their choices.

27
28 For years, federal employees have obtained comparative information on health plans from health
29 fairs, word-of-mouth, and non-governmental consumer publications geared specifically toward
30 helping them navigate among numerous competing plans. For example, *Checkbook's Guide to*
31 *Health Insurance Plans for Federal Employees: 2001 Edition*, an inexpensive paperback widely
32 available at Washington D.C. newsstands and by mail, provides comparative information about
33 every FEHBP plan throughout the country. The impressive array of information about plan costs,
34 special coverage features, and patient satisfaction ratings is made manageable through easy-to-read
35 tables organized by plan type and geographic region. Information on total premium and out-of-
36 pocket costs is presented according to how many family members are covered and alternative
37 scenarios about health care use. The guide also gives advice about how to narrow down the
38 options, how to read plan brochures, and what to do under special circumstances (e.g., if your
39 spouse's employer offers health benefits or you are eligible for Medicare).

40
41 Similarly, Internet software programs can already handle multiple-choice arrangements, assimilate
42 new data, update information instantaneously, display clear price and benefit information,
43 incorporate personal preferences, and compare costs under hypothetical scenarios of health care
44 use. Starting in 1999, members of FEHBP have used an online tool called PlanSmartChoice to
45 help choose plans. PlanSmartChoice asks employees to rate the importance of plan attributes such
46 as cost, access, benefits, and patient satisfaction. Employees are then faced with tradeoffs that
47 force them to choose between plan attributes they have identified as important. On the basis of
48 these answers, the program presents a table of plan details customized to the employee. Eighty-

1 three percent of the more than 250,000 users reported that they were either extremely or very
2 satisfied with the tool. The growing number of Internet-based health insurance marts and many
3 large employers have similar decision-support programs, some for choosing physicians and
4 treatments as well as health plans. The Internet health insurance broker Sageo uses a modeling tool
5 that helps consumers consider what type of plan (HMO, PPO, POS) is right for them and rank
6 plans based on personal preferences. The sophistication of these decision-support tools lies in their
7 ability to filter and synthesize what would otherwise be an overwhelming amount of information.
8

9 DISCUSSION

10
11 The Council recognizes that the transition to a system of individually selected and owned health
12 insurance will not be entirely smooth. However, the Council believes that transition problems will
13 not be as daunting as some fear. Naturally occurring market responses, some already underway,
14 will go a long way towards addressing the three potential transition issues discussed in this report.
15 Additional measures, some advocated by existing AMA policy, also can be taken to ensure a
16 smoother transition.
17

18 With respect to the first issue, the Council believes that a number of factors will mitigate the self-
19 paying individual's price disadvantage. Mitigating factors include increased access by individuals
20 to discounted fees through networks and discount cards; voluntary restraint of physician fees
21 charged to self-paying patients (per Policy H-390.996); increased market pressure to restrain fees
22 as more patients choose MSAs and other arrangements involving out-of-pocket payments; and
23 physician willingness to offer cash discounts to bypass submitting insurance claims.
24

25 Regarding the second issue of immediate venues for individuals to purchase health insurance, the
26 Council believes that reasonable options already exist for most individuals to purchase coverage,
27 provided that tax credits are appropriately structured. As advocated by Policy H-165.865, tax
28 credits should be large enough to make insurance affordable for most people, refundable, and
29 inversely related to income. In the view of the Council, there is cause for qualified optimism about
30 the individual market. Recent research indicates that individual-market coverage is not as
31 expensive or inadequate as previously believed. The Council also recognizes that special measures
32 are needed to address the needs of individuals with chronic illness or disability, who might
33 otherwise have difficulty obtaining coverage outside the employment-based system. Extensive
34 AMA policy supports high risk pools, additional direct premium subsidies, risk adjustment, and
35 reinsurance—approaches that both protect special populations and permit insurance markets to
36 function properly.
37

38 As for the third issue, individuals' ability to choose health plans, the Council notes that individuals
39 rather than employers already make numerous complex decisions regarding education, life
40 insurance, retirement savings, etc. In fact, it is only through historical accident that employers play
41 the dominant role in choosing individuals' health insurance, and most people would strongly object
42 to the idea of employers or government making such choices for them. The Council believes that
43 the individually based system proposed by the AMA would not only expand individual choices of
44 health insurance, but give patients a stake in understanding the relative costs and value of health
45 care decisions, from choice of plan to health care consumption. People will quickly become
46 accustomed to choosing their health plans, just as they have become accustomed to choosing
47 401(k) options and long-distance telephone service, particularly since support for making informed
48 health plan choices is becoming ever-more available. Simple, yet powerful decision-making tools

1 regarding health plan choice are already available to individuals, especially via the Internet.
2 Finally, it is worth noting that it is not necessary for all individuals to seek elaborate plan
3 information, hold plans accountable for fulfilling their obligations, or push for quality and service
4 improvements in order for health insurance markets to respond for the benefit of all patients.

5
6 RECOMMENDATIONS

7
8 The Council on Medical Service recommends that the following be adopted and the remainder of
9 the report be filed:

- 10
11 1. That the AMA inform individual physicians and group practice administrators why self-
12 paying patients (e.g., those who have MSA-type coverage or are uninsured) may be at a
13 significant price disadvantage in purchasing health care services. (Directive to Take
14 Action)
15
16 2. That the AMA reaffirm Policy H-165.920(10), which supports the development of
17 educational programs to assist consumers in making informed choices as to sources of
18 individual health expense coverage. (Reaffirm HOD Policy)
19
20 3. That the AMA reaffirm Policy H-180.961, which encourages the National Association of
21 Insurance Commissioners to develop standards and a uniform disclosure format applicable
22 to health plans and policies offered in the general insurance market; and supports the
23 enactment of federal and/or state legislation requiring the use by health plans of
24 standardized uniform disclosure formats that have had appropriate input by medical
25 organizations. (Reaffirm HOD Policy)

References for this report are available from the AMA Division of Health Care Financing Policy.