

# Key AMA policies related to health reform

## September 2017

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### Affordability

**Policy H-165.920** supports individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage, and states that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

**Policy H-165.865** states that tax credits should be refundable; inversely related to income; large enough to ensure that health insurance is affordable for most people; fixed-dollar amounts for a given income and family structure; and advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.

**Policy H-165.846** states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

**Policy H-165.828** supports legislation or regulation to fix the "family glitch;" supports allowing workers and their families to be eligible for subsidized exchange coverage if their employer coverage has premiums high enough to make them exempt from the individual mandate; encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.

## Association health plans

**Policy H-165.882** 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.

**Policy D-165.971** states that our AMA will work with federal legislators to ensure that any Association Health Plan program safeguard state and federal patient protection laws, including but not limited to those state regulations regarding fiscal soundness and prompt payment.

## Auto-enrollment

AMA policy does not address auto-enrollment except in the context of the Medicaid program. **Policy H-165.855** regarding allowing states to provide Medicaid coverage through private insurance, calls for auto-enrollment, with patients who are auto-enrolled being able to change plans within 90 days.

In CMS Report 9-A-11, *Covering the Uninsured and Individual Responsibility*, the Council gave thoughtful consideration to alternatives to requiring individual responsibility, including auto-enrollment. The Council found that analyses fail to prove that such alternatives would be as effective in covering the uninsured and promoting a balanced risk pool of individuals between those who are sick and those who are healthy as an individual responsibility requirement.

## Basic Health Program

**Policy H-165.832** supports the adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care. The policy also outlines the following principles for the establishment and operation of state Basic Health Programs: (A) State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in

terms of benefits covered, cost-sharing levels, and other features. (B) Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region. (C) Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts. (D) State BHPs should not require provider participation, including as a condition of licensure. (E) Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment. (F) State medical associations should be involved in the legislative and regulatory processes concerning state BHPs. (G) State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process.

## Children's Health Insurance Program (CHIP)

**Policy H-290.969** opposes any efforts to repeal the Medicaid maintenance of effort requirements in the ACA and ARRA, which mandate that states maintain eligibility levels for all children in Medicaid and CHIP until 2019.

**Policy D-290.982** states that our AMA strongly supports the State Children's Health Insurance Program reauthorization and will lobby toward this end. In addition, the policy states that our AMA will lobby Congress to: a. provide performance-based financial assistance for new coverage costs with expanded coverage of uninsured children through SCHIP through an enhanced federal match; b. allow states to use SCHIP funds to augment employer-based coverage; c. allow states to explicitly use SCHIP funding to cover eligible pregnant women; d. allow states the flexibility to cover all eligible children residing in the United States and pregnant women through the SCHIP program without a mandatory waiting period; e. provide \$60 billion in additional funding for SCHIP to ensure adequate funding of the SCHIP program and incentivize states to expand coverage to qualified children, and support incentives for physicians to participate; and f. ensure predictable funding of SCHIP in the future. Finally, the policy states that our AMA will urge Congress to provide targeted funding for SCHIP enrollment outreach.

## Continuous coverage

**Policy D-185.988** states that our AMA will seek federal legislation to ensure continued health insurance

coverage for patients with pre-existing medical conditions transitioning between insurance products.

**Policy H-165.856** supports health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

### **Cost-sharing reductions**

**Policy H-165.846** states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.

**Policy H-165.828** supports legislation or regulation to fix the “family glitch;” supports allowing workers and their families to be eligible for subsidized exchange coverage if their employer coverage has premiums high enough to make them exempt from the individual mandate; encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the “family glitch,” and individuals who forego cost-sharing subsidies despite being eligible.

### **Dependent coverage up to age 26**

**Policy H-180.964** encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family coverage to age 28.

### **Disproportionate Share Hospital (DSH) payments**

**Policy D-215.995** provides that the AMA supports federal legislation and/or regulations that would fix the flawed methodology for allocating Medicare and Medicaid Disproportionate Share Hospital (DSH) payments to help ensure the financial viability of safety-net hospitals so they can continue to provide adequate access to health care for indigent patients.

**Policy D-305.973** states that our AMA will work with the federal government to ensure adequate Disproportionate Share Hospital funding.

**Policy H-160.923** supports the transitional redistribution of Disproportionate Share Hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured.

### **Employer responsibility**

The AMA does not have policy on employer responsibility to provide health insurance, favoring individual selection and ownership of health insurance. However, **Policy H-165.920** supports the continuation of employment-based coverage as an option to the extent that the market demands it.

### **Essential health benefits/Meaningful coverage**

**Policy H-165.846** states that existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. The policy also advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.

**Policy H-165.865** states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.

**Policy H-165.848** states that under an individual mandate, individuals should be required to obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care.

**Policy D-180.986** states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against “sham” health insurers.

**Policy H-165.856** states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

**Policy H-185.964** opposes new health benefit mandates unrelated to patient protections, which jeopardize coverage to currently insured populations.

## Flexible Spending Accounts (FSAs)

**Policy H-100.957** supports the repeal of the federal restriction on the use of tax-exempt funds to buy medications without a prescription.

**Policy H-165.863** supports allowing employees to roll-over any unexpended funds in an FSA into an HSA and supports a reasonable increase in FSAs.

## Grace period

**Policy H-185.938** states that the AMA will continue to advocate that plans be required to pay providers for all claims for services rendered that would otherwise be covered under the contract during a grace period.

## Guaranteed issue and renewability

**Policy H-165.856** supports health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

**Policy H-165.838** supports insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps.

## Health insurance exchanges

**Policy H-165.839** outlines the following principles for the operation of health insurance exchanges: (A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features. (B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians. (C) Physician and patient decisions should drive the treatment of individual patients. (D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options. (E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support

available to assist physicians with the implementation process. (F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

In addition, the policy states that our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

**Policy H-165.838** states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

## Health Savings Accounts (HSAs)

**Policy H-165.852** states that legislation promoting the establishment and use of HSAs 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, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. The policy also states that contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families.

**Policy H-165.863** supports allowing employees to roll-over any unexpended funds in an FSA into an HSA and supports a reasonable increase in FSAs.

**Policy H-165.833** states that our AMA will continue to advocate to achieve needed reforms of the many defects of the ACA so as to protect the primacy of the physician-patient relationship, including expanding the use of health savings accounts as a means to provide health insurance coverage.

### High-risk pools

**Policy H-165.842** supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation; and supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies.

**Policy H-165.995** supports: (1) the establishment in each state of a risk pooling program, in which all health care underwriting entities in the state participate, to provide adequate health insurance coverage at a premium slightly higher than the standard group rate to (a) those who are unable to obtain such coverage because of medical considerations, and (b) those with medically standard risks who could afford, but presently lack, access to such group coverage; (2) the amendment of the federal tax code to require employers to purchase group health insurance coverage from an entity participating in the state risk pool or, if self-insured, to participate in the risk pool if such a pool is available, in order to deduct the cost of their coverage as a business expense; and (3) using state tax revenues as an alternative source for defraying excess pool costs.

### Independent Payment Advisory Board (IPAB)

**Policies H-165.833** and **D-165.938** support repeal of the Independent Payment Advisory Board.

### Individual mandate

**Policy H-165.848** states that individuals and families earning greater than 500 percent FPL should be required to obtain at least coverage for catastrophic health care and evidence-based preventive health care. For those earning less than 500 percent FPL, the individual responsibility requirement is supported

only upon implementation of a system of refundable tax credits or other subsidies to help obtain health insurance coverage. The policy also supports using the tax structure to achieve compliance.

### Interstate sale of insurance

**Policy H-180.946** states that, in examining proposals to sell health insurance across state lines, our AMA supports the following principles: 1. Federal or state legislation allowing the selling of health insurance across state lines, including multi-state compacts, should ensure that patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. These protections include not weakening any state's laws or regulations involving: (a) network adequacy and transparency; (b) fair contracting and claims handling; (c) prompt pay for physicians; (d) regulation of unfair health insurance market products and activities; (e) rating and underwriting rules; (f) grievance and appeals procedures; and (g) fraud. 2. Patients purchasing an out-of-state policy should retain the right to bring a claim in a state court in the state in which the patient resides.

### Lifetime limits for benefits

**Policy H-185.952** states that employers and health insurers should eliminate the lifetime maximums of health insurance benefits.

### Medicaid

**Policy H-290.963** opposes caps on federal Medicaid funding. In addition, the policy states that our AMA will advocate that Congress and the Department of Health and Human Services seek and take into consideration input from our AMA and interested state medical associations, national medical specialty societies, governors, Medicaid directors, mayors, and other stakeholders during the process of developing federal legislation, regulations, and guidelines on Medicaid funding.

**Policy H-290.965** supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the ACA Medicaid expansion exists and supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.

**Policy H-290.966** encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap.

**Policy D-290.979** states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the FPL as authorized by the ACA.

**Policy H-290.997** supports greater equity in the Medicaid program, through adoption of the following principles: (1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors); (2) the creation of basic national standards of uniform minimum adequate benefits; (3) the elimination of the existing categorical requirements; (4) the creation of adequate payment levels to assure broad access to care; and (5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions.

**Policy H-290.986** supports the position that the Medicaid program maintain its role as a safety net for the nation's most vulnerable populations.

**Policy H-330.932** opposes payment cuts in Medicaid budgets that may reduce patient access to care and undermine the quality of care provided to patients.

**Policy D-165.966** advocates for changes in federal rules and federal financing to support the ability of states to develop and test alternatives for improving coverage for patients with low incomes without incurring new and costly unfunded federal mandates or capping federal funds.

**Policy H-290.974** states that it is the policy of our AMA that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups.

**Policy H-165.855** supports states being allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee

purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. The policy also states 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 through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.

**Policy H-385.921** states that payment for physician providers for Medicaid, TRICARE, and any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare allowable.

**Policy H-290.980** states that our AMA continues to advocate for appropriate payment to physicians under the Medicaid program.

**Policy H-290.972** affirms that states offering Medicaid beneficiaries Health Savings Accounts (HSAs) should adhere to the following principles: A. Make beneficiary participation voluntary; B. Provide first-dollar coverage of preventive services regardless of whether the beneficiary has met the deductible; C. Offer positive incentives to reward healthy behavior and offset beneficiary cost-sharing, provided that such incentives do not result in punitive cuts in standard benefits or increased cost-sharing to enrollees who are unable to achieve improvements in personal behavior affecting their health; D. Set deductibles at 100% of account contributions, but no higher; E. Allow payments to non-Medicaid providers by beneficiaries to count toward deductibles and out-of-pocket spending limits; F. Allow the deductible limits for families to be the lower of either the individual or family combined deductible; G. Ensure that enrollees are protected by standard Medicaid maximum out-of-pocket spending limits; H. Provide outreach, information, and decision-support that is readily accessible through a variety of formats (e.g., written, telephone, online), and in multiple languages; I. Encourage HSA enrollees to establish a medical home, in order to assure provision of preventive care services, coordination of care and continuity of care; J. Prohibit use of HSA funds for non-medical purposes, but consider allowing HSA balances of enrollees who lose Medicaid coverage to be used to purchase private insurance, including the employee share of premium for employer-sponsored coverage; K. Monitor the impact on utilization and beneficiary

financial burden; L. Test broadening of eligibility to include currently ineligible beneficiary groups; and M. Ensure that physicians and other providers of health care services have access to up-to-date information verifying beneficiary enrollment and covered benefits, and are paid at point-of-service, or are allowed to use their standard billing procedures to obtain payment from the insurer or account custodian.

### Medical liability reform

**Policy H-435.978** supports federal legislative initiatives implementing the following medical liability reforms: (a) limitation of \$250,000 or lower on recovery of non-economic damages; (b) the mandatory offset of collateral sources of plaintiff compensation; (c) decreasing sliding scale regulation of attorney contingency fees; and (d) periodic payment for future awards of damages. The policy also states that under no circumstances would support for federal preemptive legislation be extended or maintained if it would undermine effective tort reform provisions already in place in the states or the ability of the states in the future to enact tort reform tailored to local needs. The policy states that federal preemptive legislation that endangers state-based reform will be actively opposed.

**Policy H-435.967** states that it is the policy of the AMA that effective medical liability reform, based on the California Medical Injury Compensation Reform Act (MICRA) model, is integral to health system reform. The AMA's MICRA-based federal tort reform provisions include: (a) a \$250,000 ceiling on non-economic damages, (b) the offset of collateral sources of plaintiff compensation, (c) decreasing incremental or sliding scale attorney contingency fees, (d) periodic payment of future awards of damages, and (e) a limitation on the period for suspending the application of state statutes of limitations for minors to no more than six years after birth.

### Medical Loss Ratio

**Policy D-330.923** encourages the Centers for Medicare & Medicaid Services to award Medicare Advantage Programs only to those health plans that meet all of the following criteria: (1) an 85% or higher medical loss ratio; (2) physician payment rates are no less than Medicare Fee for Service rates; and (3) use enforceable contracts that prohibit unilateral changes in physician payment rates.

**Policy H-285.967** states that our AMA will develop and support appropriate legislation to require managed

care plans to publish, on an annual basis, relevant operating and financial information.

**Policy D-155.993** states that our AMA: (1) will develop model state legislation and regulations that would require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs, using the format called for in **AMA Policy H 155.963**; (2) supports state legislation to require that all private health plans make publicly available annually, and publish separately, their medical care costs and their administrative costs; and (3) supports the development and implementation of a uniform, national accounting and reporting system to report administrative expenses and medical expense ratios as part of greater, national uniformity of market regulation.

**Policy H-155.959** states that private health plans should be required to report data related to administrative costs, expenses and rate setting to appropriate state regulatory bodies to allow for the calculation of medical expense ratios to be consistent on the state level.

### Modified community rating

**Policy H-165.856** states that strict community rating should be replaced with modified community rating, risk bands, or risk corridors. The policy stipulates that although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.

**Policy H-180.953** supports the concept of health insurance contracts with lower premiums for nonsmokers.

### Network adequacy

**Policy H-285.908** states that: 1. Our AMA supports state regulators as the primary enforcer of network adequacy requirements. 2. Our AMA supports requiring that provider terminations without cause be done prior to the enrollment period, thereby allowing enrollees to have continued access throughout the coverage year to the network they reasonably relied upon when purchasing the product. Physicians may be added to the network at any time. 3. Our AMA supports requiring health insurers to submit and make publicly available, at least quarterly, reports to state regulators that provide data on several measures of network adequacy, including the number and type of providers that have joined or left the network; the number and type of

specialists and subspecialists that have left or joined the network; the number and types of providers who have filed an in-network claim within the calendar year; total number of claims by provider type made on an out-of-network basis; data that indicate the provision of Essential Health Benefits; and consumer complaints received. 4. Our AMA supports requiring health insurers to indemnify patients for any covered medical expenses provided by out-of-network providers incurred over the co-payments and deductibles that would apply to in-network providers, in the case that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 5. Our AMA advocates for regulation and legislation to require that out-of-network expenses count toward a participant's annual deductibles and out-of-pocket maximums when a patient is enrolled in a plan with out-of-network benefits, or forced to go out-of-network due to network inadequacies. 6. Our AMA supports fair and equitable compensation to out-of-network providers in the event that a provider network is deemed inadequate by the health plan or appropriate regulatory authorities. 7. Our AMA supports health insurers paying out-of-network physicians fairly and equitably for emergency and out-of-network bills in a hospital. AMA policy is that any legislation which addresses this issue should assure that insurer payment for such care be based upon a number of factors, including the physicians' usual charge, the usual and customary charge for such service, the circumstances of the care and the expertise of the particular physician. 8. Our AMA provides assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant model state legislation, to ensure physicians and patients have access to adequate and fair appeals processes in the event that they are harmed by inadequate networks. 9. Our AMA supports the development of a mechanism by which health insurance enrollees are able to file formal complaints about network adequacy with appropriate regulatory authorities. 10. Our AMA advocates for legislation that prohibits health insurers from falsely advertising that enrollees in their plans have access to physicians of their choosing if the health insurer's network is limited. 11. Our AMA advocates that health plans should be required to document to regulators that they have met requisite standards of network adequacy including hospital-based physician specialties (i.e. radiology, pathology, emergency medicine, anesthesiologists and hospitalists) at in-network facilities, and ensure in-network adequacy is both timely and geographically accessible.

**Policy H-285.911** states that our AMA will advocate that health insurance provider networks should be sufficient to provide meaningful access to subscribers, for all medically necessary and emergency care, at the preferred, in-network benefit level on a timely and geographically accessible basis.

### **Planned Parenthood**

**Policy H-165.838** supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

**Policy H-160.901** supports policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians, and the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when appropriate care is not available within a limited network of providers.

**Policy H-373.998** states that individuals should have freedom of choice of physician and/or system of health care delivery.

### **Pre-existing condition exclusions**

**Policy H-165.856** supports health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.

**Policy H-165.838** states that our AMA is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps. The policy states that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

### **Premium tax credits**

**Policy H-165.920** 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 insurance coverage is the preferred option, but employer-provided coverage is still available to the extent



the market demands it. The policy also states that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.

**Policy H-165.865** states that AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will 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 Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.

The policy also states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.

**Policy H-165.846** states that existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.

### Prevention and Public Health Fund

**Policy H-165.838** supports investments and incentives for quality improvement and prevention and wellness initiatives as a key component of health system reform.

**Policy D-440.997** states that our AMA will work with Congress and the Administration to prevent further cuts in the funds dedicated under the ACA to preserve

state and local public health functions and activities to prevent disease.

### Risk adjustment, reinsurance and risk corridors

**Policy H-165.842** supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely heavily on market regulation; and supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies.

**Policy D-165.939** provides that any proposed assessment on "issuers of insurance" (scheduled to commence in 2014 for a 3-year period), intended to fund a "risk adjustment program" to cushion insurers against any actual uncertainties surrounding the health status of the uninsured, be taken from administrative and medical management costs.

### Small businesses self-insuring

AMA policy has consistently advocated for the elimination of the ERISA pre-emption of self-insured health plans from state insurance laws, and for additional patient protections for those covered by self-insured plans, as outlined in **Policy H-285.915**.

**Policy D-383.984** states that our AMA will actively support federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues.

**Policy H-285.945** supports changes in federal law to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care.

**Policy D-285.965** states that our AMA will: (1) advocate that stop-loss coverage of self-insured plans have minimum attachment points that are high enough to ensure the adequacy and financial security of health insurance coverage of enrollees, and be provided by stop-loss insurers that are legitimate and financially secure and solvent; and (2) encourage states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power on SHOP exchanges.

**Policy D-180.986** encourages local, state, and federal regulatory authorities to aggressively pursue action against “sham” health insurers.

### State innovation

**Policy D-165.942** supports that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.

**Policy H-165.845** supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations.

**Policy H-165.829** encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges,

and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges.

**Policy D-165.966** states that our AMA will advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; and (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons.

### Taxes on medical devices, pharmaceutical companies and health insurers

The AMA does not have policy specifically addressing the ACA's taxes on medical devices, pharmaceutical companies and health insurers.

**Policy H-385.925** states that our AMA strongly opposes the imposition of a selective revenue tax on physicians and other health care providers; strongly opposes the use of provider taxes or fees to fund health care programs or to accomplish health system reform; and believes that the cost of taxes which apply to medical services should not be borne by physicians, but through adequate broad-based taxes for the appropriate funding of Medicaid and other government health care programs.

**Policy H-290.982** advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient, nursing home, and home health services.

### Tax exclusion for employer-sponsored insurance

**Policy H-165.828** supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability.

**Policy H-165.851** supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance.

**Policy H-165.920** supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax.