

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports, 1–5, were presented by Paul A. Wertsch, MD, Chair.

1. AFFORDABLE CARE ACT SECTION 1332 WAIVERS (RESOLUTION 206-I-16)

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 206-I-16
REMAINDER OF REPORT FILED**
See Policy H-165.826

At the 2016 Interim Meeting, the House of Delegates referred Resolution 206, “Advocacy and Studies on Affordable Care Act Section 1332 (State Innovation Waivers),” which was sponsored by the Medical Student Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2017 Interim Meeting. Resolution 206-I-16 asked:

That our American Medical Association (AMA) advocate that the “deficit-neutrality” component of the current US Department of Health and Human Services (HHS) rule for Section 1332 waiver qualifications be considered only on long-term, aggregate cost savings of states’ innovations as opposed to having costs during any particular year, including in initial “investment” years of a program, reduce the ultimate likelihood of waiver approval; and

That our AMA study reforms that can be introduced under Section 1332 of the Affordable Care Act (ACA) in isolation and/or in combination with other federal waivers to improve healthcare benefits, access and affordability for the benefit of patients, healthcare providers and states, and encourages state societies to do the same.

This report provides background on Section 1332 waivers, outlines regulatory activity on Section 1332 waivers, highlights Section 1332 waiver applications and approvals, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Section 1332 of the ACA established a new waiver supporting state innovation in order to enable states to experiment with and implement different models to provide health insurance coverage to their residents. Under Section 1332, some of the ACA’s private insurance and coverage provisions can be waived, including those pertaining to premium tax credits and cost-sharing reductions for plans offered through the marketplaces, the individual and employer responsibility requirements and standards for health insurance marketplaces and qualified health plan standards. Other sections of the ACA cannot be waived under Section 1332, including those addressing guaranteed issue and community rating, the law’s prohibition against insurers denying coverage or charging higher premiums to people with pre-existing conditions, the ban on annual and lifetime limits, and the ability of adult dependents up to age 26 to be covered on their parents’ health plans.

Under Section 1332, the Secretaries of HHS and the Treasury are granted the authority to approve a request for a Section 1332 waiver only if the proposal meets the following four criteria:

1. The proposal will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver;
2. The proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state’s residents as would be provided absent the waiver;
3. The proposal will provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and
4. The proposal will not increase the federal deficit.

If a Section 1332 waiver is approved, a state may receive funding equal to the amount of forgone federal financial assistance that would have been provided to its residents enrolled in marketplace coverage pursuant to the ACA, a process referred to as pass-through funding. Pass-through funding is capped at the amount of forgone marketplace subsidies and does not account for any other changes in federal spending or revenues as a result of the waiver.¹ Accordingly, pass-through funding is especially essential for Section 1332 waivers under which individuals and/or small employers in the state would no longer qualify for premium tax credits, cost-sharing reductions and/or small business credits for which they would otherwise be eligible. For such waivers, the aggregate amount of such credits or reductions that would have been paid on behalf of consumers in the marketplaces had the state not received such waiver would instead be paid to the state to implement its Section 1332 waiver. Section 1332 waivers, which have been available since the beginning of this year, may be approved for periods up to five years and can be renewed.²

REGULATORY ACTIVITY ON SECTION 1332 WAIVERS

A final regulation addressing the application, review, and reporting process for Section 1332 waivers was issued in February 2012. Under the final regulation, a state submitting an application for a Section 1332 waiver must provide actuarial analyses and certifications, economic analyses, data and assumptions, targets, an implementation timeline, and other necessary information to show the proposed waiver's compliance with the ACA criteria for Section 1332 waivers as noted above. Specific to deficit reduction, the economic analyses submitted by the state are required to include a detailed 10-year budget plan that is deficit neutral to the federal government. The final regulation also allows states to submit a single application for a Section 1332 waiver along with existing waivers applicable to Medicare, Medicaid and the Children's Health Insurance Program (CHIP), which could include Section 1115 (of the Social Security Act) waivers, which currently allow states to implement experimental, pilot, or demonstration projects in the Medicaid and CHIP programs.³

In December 2015, the Centers for Medicare & Medicaid Services (CMS) and the Department of the Treasury released guidance that addressed how the agencies will evaluate state applications for Section 1332 waivers. Addressing the ACA's deficit neutrality requirement, the guidance stated that waivers must not increase the federal deficit over the period of the waiver or in total over the ten-year budget plan submitted by the state. Pertinent to referred Resolution 206-I-16, the agencies stated in the guidance that "a waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement." In addition, the guidance stated that although a state may submit a coordinated waiver application, in such a case each waiver will be evaluated independently according to applicable federal laws. Importantly, the guidance stated that there would be limitations to Section 1332 waiver applications for states that use healthcare.gov for their marketplaces, as the federal platform cannot accommodate different rules for different states. Therefore, the agencies note that states contemplating waivers that include changes to the calculation of marketplace financial assistance as well as plan management, for example, may consider establishing and administering their own platform.⁴

In March 2017, HHS Secretary Price sent a letter to governors encouraging states to submit Section 1332 waiver proposals, including proposals for high-risk pool/state-operated reinsurance programs. In the letter, Secretary Price referenced Alaska's waiver application, which was approved in July 2017, and sought federal support for a state-managed reinsurance program. The Secretary noted that if a state's plan under its waiver proposal is approved, a state may be able to receive pass-through funding to help offset a portion of the costs for the high-risk pool/state-operated reinsurance programs.⁵

In May 2017, CMS released a checklist for Section 1332 waiver applications, which also included specific items pertaining to applications that include high-risk pool/state-operated reinsurance programs. Pertaining to deficit neutrality, the checklist states as part of waiver applications, states must include an economic analysis to support the state's finding that the waiver will not increase the federal deficit over the five-year waiver period or in total over the ten-year budget period. Additionally, the checklist stipulates that the deficit analysis submitted by the state should show yearly changes in the federal deficit due to the waiver.⁶

SECTION 1332 WAIVER APPLICATIONS AND APPROVALS

As Section 1332 waivers have only been available starting this year, activity on waivers has been relatively limited. At the time that this report was prepared, nine states had submitted waiver applications – Alaska, California, Hawaii, Iowa, Massachusetts, Minnesota, Oklahoma, Oregon and Vermont. The waiver applications of three states - Hawaii, Alaska and Minnesota - have been approved. Of note, Minnesota's waiver was approved with less federal pass-

through funding than was requested by the state. The waiver applications of California and Oklahoma were withdrawn, while Vermont's was put on hold.⁷ Hawaii's Section 1332 waiver allowed the state to keep its longstanding employer coverage provisions resulting from the state's Prepaid Health Care Act, which requires employers to provide more generous coverage than is required under the ACA. As such, Hawaii's waiver sought to waive the ACA requirement that a Small Business Health Options Program (SHOP) marketplace operate in Hawaii and other provisions related to SHOP marketplaces, including the requirement that the small business tax credits could only be available through the SHOP.^{8,9}

Alaska's waiver allows the state to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP will cover claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers will relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. As a result of the ARP, it is expected that premiums will be 20 percent lower in 2018 than absent the waiver, and 1,460 additional individuals will have health insurance coverage. Because the ARP will lower premiums, the second lowest cost silver plan premium is reduced, which results in the federal government spending less on premium tax credits.¹⁰ The waiver application of Minnesota would create the Minnesota Premium Security Plan, which was estimated to yield a 20 percent reduction in average premiums in 2018.¹¹ While Minnesota's waiver was approved, the full amount the state requested in its waiver for federal pass-through funding to financially support its reinsurance program was not approved. Only federal pass-through funding reflecting savings from less spending on premium tax credits and cost-sharing reductions was approved, not the amount also requested by the state that reflects federal savings due to lower premiums for plans under the state's Basic Health Program.¹² The waiver application of Oregon, which was still under review when this report was prepared, anticipates that its waiver to establish the Oregon Reinsurance Program will reduce premiums, including those for the second-lowest cost silver plan, by 7.5 percent in 2018 (net of the premium assessment), with an increase in enrollment in the individual market by approximately 1.7 percent in the same year.¹³

Likewise, Iowa's waiver application includes a reinsurance program. However, due to concerns at the time of its waiver application that there would be no insurers participating in the state's marketplace in 2018, Iowa also proposed to make substantive changes to ACA requirements, and cited the need for "emergency regulatory relief." Iowa's Section 1332 waiver proposal calls for the creation of a single Proposed Stopgap Measure plan that would be the only plan offered by insurers in the marketplace, and provide coverage similar to that offered by a standard silver plan. In addition, the initial waiver application proposes replacing the ACA's premium tax credits with flat premium subsidies based on age and income, as well as eliminating cost-sharing reductions (CSRs).¹⁴ In response to concerns over the state's waiver application eliminating cost-sharing reductions, Iowa submitted a supplement to its waiver application in order to provide additional cost-sharing support to individuals with incomes between 133 and 150 percent of the federal poverty level (FPL), to be implemented similarly to how cost-sharing reductions are currently provided to this population.¹⁵ Of note, cost-sharing reductions are currently provided to individuals with incomes up to 250 percent of the FPL under the ACA. In addition, the state has requested that HHS waive the requirements that Section 1332 waivers include actuarial analyses, actuarial certifications, and economic analyses, including those which support the state's finding that the waiver will not increase the federal deficit over the period of the waiver or in total over the 10-year budget period.¹⁶ At the time that this report was prepared, Iowa no longer has any counties at risk of having no insurer participating in the state's marketplace in 2018.¹⁷

In response to the market volatility the uncertainty about continued funding for CSRs has caused, Massachusetts submitted a waiver request that requested waiver of CSRs and instead create a Premium Stabilization Fund that would make payments to health plans equivalent to those that would be made under federal CSR payments. Massachusetts requested expedited review of its waiver, which if approved would be effective January 1, 2018 for an initial period of at least one year, and likely blunt premium increases that would otherwise occur in the marketplace due to the uncertainty as to whether federal CSR funding will continue.¹⁸

RELEVANT AMA POLICY

Policy D-165.942 advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives 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, ensure and maximize patient choice of physician and private health plan, and include

reforms that eliminate denials for pre-existing conditions. Policy H-165.845 supports outlined principles to guide in the evaluation of state health system reform proposals, including:

- 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.
- 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.
- 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.
- The administration and governance system should be simple, transparent, accountable, efficient, and effective in order to reduce administrative costs and maximize funding for patient care.
- 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.

Policies D-165.966 and H-165.855 advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. Policy D-165.966 also supports 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.

DISCUSSION

The AMA has long advocated that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes. The Council believes that Section 1332 of the ACA provides states with a unique opportunity to build upon the progress that has been made in expanding health insurance coverage and choice under the ACA. With Section 1332 waivers, states could devise new and innovative approaches to provide quality health insurance coverage to more people, as well as make health insurance coverage more affordable. The Council believes that it is imperative that approved State Innovation Waivers follow the criteria outlined in Section 1332 of the ACA and related regulations: that Section 1332 waiver proposals will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and not increase the federal deficit.

However, additional actions should be taken, either administratively or legislatively, to make Section 1332 waivers more workable for states, and be potentially more advantageous for state residents. Under current law, Section 1332 waivers are required to not add to the federal deficit, and current guidance states that waivers must not increase the federal deficit over the period of the waiver or in total over the ten-year budget plan submitted by the state. However, the language in the federal guidance from 2015 also stated that "a waiver that increases the deficit in any given year is less likely to meet the deficit neutrality requirement." The Council believes that there could be unintended consequences for states seeking to innovate to require deficit neutrality in each individual year of a Section 1332 waiver. The Council recognizes that it would be reasonable for some waivers to project deficits in years one or two of a waiver as a result of start-up and other costs, and savings in subsequent years that offset the earlier deficits. The Council believes it is essential for Section 1332 waivers to remain deficit neutral over the period of the waiver (which may not exceed five years unless renewed), as well as in total over the ten-year budget plan submitted by the state.

The Council also believes that federal pass-through funding provided to states to implement their Section 1332 waivers should capture all federal budgetary savings achieved by the waiver. Under current law, the amount of federal pass-through funding is equal to an annual estimate of forgone marketplace subsidies and financial assistance that would have otherwise been provided pursuant to the ACA. If a Section 1332 waiver creates additional federal savings outside of the scope of marketplace subsidies, such as reducing the cost of the tax exclusion for employer-sponsored coverage, such savings should also be included in the amount of federal pass-through funding provided to the state to finance its Section 1332 waiver.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 206-I-16, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support the criteria outlined in Section 1332 of the Affordable Care Act for the approval of State Innovation Waivers:
 - a. The waiver proposal will provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver;
 - b. The waiver proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver;
 - c. The waiver proposal will provide coverage that is at least as comprehensive for the state's residents as would be provided absent the waiver; and
 - d. The waiver proposal will not increase the federal deficit.
2. That our AMA support the deficit neutrality requirement of Section 1332 waivers being enforced over the period of the waiver and in total over the ten-year budget plan submitted by a state, not in each individual year of the waiver.
3. That our AMA support legislation to allow other federal savings projected to be achieved as a result of a Section 1332 waiver, including any reductions in the cost of the tax exclusion for employer-sponsored coverage, to be included in the amount of federal pass-through funding provided to a state to subsidize state innovations.

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2. HOSPITAL SURVEYS AND HEALTH CARE DISPARITIES

Reference committee hearing: see report of Reference Committee J.

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

See Policies H-295.897, H-450.924, H-450.966, H-450.982, D-385.958 and D-450.954

At the American Medical Association's (AMA) 2016 Interim Meeting, the House of Delegates adopted Policy D-450.954, "A Study on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Survey and Healthcare Disparities," which asked the AMA to study the impact of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) on Medicare payments to hospitals serving vulnerable populations and on potential health care disparities.

The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2017 Interim Meeting. This report provides background on the purpose and use of HCAHPS surveys and the role of safety net hospitals, explains the intersection of HCAHPS scores and safety net hospitals, explores how cultural competency influences patient satisfaction and HCAHPS scores, and outlines relevant legislation. The Council recommends policy to help shield safety net hospitals from the potentially negative financial impact that hospital quality program assessments may have on hospitals that serve a disproportionate share of patients with social risk factors and policy to recognize the importance of cultural competency in patient experience and treatment plan adherence.

BACKGROUND

The HCAHPS survey is the first national, standardized, publicly reported survey of patients' perspectives of hospital care. HCAHPS has three goals.¹ First, the survey is designed to produce data about patients' perspectives of care that allow objective and meaningful comparisons of hospitals on topics that are important to patients. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting of survey results serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment.

HCAHPS survey scores over a three-year period influence a portion of each hospital's value-based purchasing (VBP) incentive payment. The VBP adjusts payments to hospitals under the Inpatient Prospective Payment System (IPPS) based on the quality of care delivered. The VBP adjusts Medicare's payment rate to hospitals based on a set of defined process, outcome, and experience of care measures. The measures are represented in four different areas: Clinical Care (Process and Outcomes), Patient Experience of Care (HCAHPS), Efficiency, and Safety. As noted, the patient experience of care measure is based off of HCAHPS.

Safety net hospitals play a critical role in providing health care to vulnerable populations, and it is important to ensure that efforts to improve quality of care do not exacerbate existing health care disparities. Generally, safety net hospitals are financially stressed because they are chronically underfunded and payments are low. Because of these financial constraints, safety net hospitals may have fewer nurses and are more likely to be older buildings, which are factors largely beyond the hospital's immediate control.²

Safety net hospitals serve many patients without the ability to pay and generally have sicker patients and a more complex patient case mix than traditional hospitals.³ Therefore, many safety net patients have conditions that require additional resources such as social work and behavioral health care; however, the hospitals often do not have the resources to devote to these services or the financial means to provide amenities that positively affect patient satisfaction.⁴

HCAHPS SCORES AND SAFETY NET HOSPITALS

According to one recent study published in the *Archives of Internal Medicine*, hospitals that serve a disproportionate share of low-income and Medicaid patients generally scored lower than other hospitals on the HCAHPS patient experience care survey and were 60 percent less likely to meet HCAHPS performance benchmarks under the Medicare VBP program.⁵ Researchers compared HCAHPS performance and improvement for safety net hospitals with other hospitals from 2007 to 2010. While scores for both groups of hospitals improved over the four year period, the performance gap between them increased. Overall, 769 hospitals that treat the largest share of low-income patients scored 5.6 percentage points lower than their 2,327 non-safety net counterparts. It is worth noting that the HCAHPS survey is only available in six languages and therefore prohibits some patients from participating.⁶

The authors of the study surmised two explanations for the disparity between the two hospital groups. One explanation was that patients in safety net hospitals have different expectations than patients in other hospitals. The other explanation was that safety net hospitals have not done as good of a job focusing on the patient issues reflected in the survey.

Safety net hospitals have pointed out that they are at a disadvantage and that their scores should be adjusted to take into consideration the diverse case mix, poverty, language barriers, and cultural issues specific to safety net hospitals. They state that the Centers for Medicare & Medicaid Services (CMS) should design incentive programs that reward safety net hospitals prior to implementing financial penalties.

HCAHPS SCORES AND CULTURAL COMPETENCY

Communication measures account for 50 percent of the HCAHPS patient experience index. As previously stated,⁷ patient characteristics such as race, ethnicity, and language preference may impact the perception of care provided.⁷ Language and communication barriers may lead to patient dissatisfaction and poor comprehension and treatment adherence.⁸ Patients and families who are non-white, speak a language other than English, and are on Medicaid report lower experience scores than those commercially insured, white, and English-speaking patients and families.⁹ Therefore, demographic and cultural differences seem to be important considerations in improving communication.

The National Quality Forum (NQF) has defined cultural competency as the “ongoing capacity of health care systems, organizations, and professionals to provide for diverse patient populations high-quality care that is safe, patient and family centered, evidence based, and equitable.”¹⁰ Cultural competency has been promoted as a strategy to enhance patient satisfaction and improve organizational performance.¹¹

Patient centered care has been an ongoing focus of the health care community to facilitate quality improvement.¹² It follows that taking into account demographics and culture is necessary for aligning hospital services and patient preferences. For example, a study of California hospitals found that hospitals with greater cultural competency have better scores for doctor and nurse communication, staff responsiveness, hospital rating, and hospital recommendation.¹³

RELEVANT LEGISLATION AND REGULATORY ACTIVITY

Recent legislation has addressed how to account for social risk factors in Medicare payment. The 21st Century Cures Act requires Medicare to account for a patient’s background when calculating reductions in payments to hospitals under the Hospital Readmissions Reduction Program.¹⁴ In addition, the Hospital Inpatient Prospective Payment Systems (IPPS) rule requested feedback on how to account for social risk factors in the Inpatient Quality Reporting program. Also, in response to the IMPACT Act, the Assistant Secretary for Planning and Evaluation (ASPE) sponsored a committee of the National Academies of Sciences, Engineering and Medicine to specify criteria that could be used in determining which socioeconomic status factors should be accounted for in Medicare quality and payment systems. The committee released its report in December 2016.¹⁵ Additionally, at the direction of the

Department of Health and Human Services, the National Academy of Medicine (NAM) released a report on how social risk factors may influence health care use, outcomes, and costs in Medicare payment and quality programs.¹⁶ Importantly, both the ASPE and NAM activities found that existing data sources used to capture social risk factors are insufficient for the purposes of developing better risk adjustment methodologies.

RELEVANT AMA ACTIVITY AND POLICY

Policy H-450.946 states that the AMA will advocate for effective quality management programs that incorporate substantial input by actively practicing physicians and physician organizations.

Policy H-450.966 states that the AMA will seek an active role in any efforts to develop national medical quality and performance standards and measures; emphasize the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts; and advocate that principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts, including that standards and measures shall have demonstrated validity and reliability, shall reflect current professional knowledge and available medical technologies, shall be linked to health outcomes and/or access to care, shall be representative of the range of health care services commonly provided by those being measured, shall account for the range of settings and practitioners involved in health care delivery, shall recognize the informational needs of patients and physicians, shall recognize variations in the local and regional health care needs of different patient populations, shall recognize the importance and implications of patient choice and preference, and shall recognize and adjust for factors that are not within the direct control of those being measured.

The AMA has numerous policies on the appropriate use of patient satisfaction surveys. Policy D-450.960 directs the AMA to urge CMS to modify the HCAHPS scoring system so that it assigns a unique value for each rating option available to patients. Policy H-450.982 states that efforts should be continued to improve the measurement of patient satisfaction and to document its relationship to favorable outcomes and other accepted criteria of high quality care. Additionally, Policy D-385.958 directs the AMA to work with CMS and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, be used only as an adjunctive and not a determinative measure of physician quality for the purpose of physician payment and to ensure that physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician. Similarly, Policy H-406.991 states that patient satisfaction surveys should be used to help improve patient care and not be used for the purpose of determining physician payment.

Consistent with the AMA's continued efforts to refine risk adjustment, Policy H-155.957 encourages further study into the possible causes of geographic variation in health care delivery and spending, with particular attention to risk adjustment methodologies and the effects of demographic factors, differences in access to care, medical liability concerns, and insurance coverage options on demand for and delivery of health care services.

Policy H-295.897 promotes cultural competency training with the goal of emphasizing cultural competence as part of professional practice and encourages training opportunities for students and residents to learn cultural competency from community health workers.

In accordance with these policies, the AMA has advocated extensively for improvements to HCAHPS. The AMA always includes a section on improvements to HCAHPS in comments related to the Medicare physician fee schedule. The AMA successfully lobbied CMS to propose removing the pain questions from HCAHPS and clarifying that HCAHPS is a hospital level survey and that it is not appropriate to tie physician compensation or measure physicians based on HCAHPS scores.

Specifically, in the AMA's recent comments on the IPPS Proposed Rule, the AMA advocated for continued refinements to HCAHPS and refinements to the risk adjustment methodology used in program measurements. Further, the AMA advocated for CMS' consideration of measuring and accounting for social risk factors in Hospital Inpatient Quality Reporting and Value-Based Purchasing Programs noting that the AMA continues to believe that in order to ensure the quality of care furnished by physicians and hospitals is assessed as fairly as possible, social risk factors must be taken into account.

DISCUSSION

Safety net hospitals play a critical role in providing needed health care to vulnerable populations. These hospitals provide a necessary function and often have more challenging patient populations and fewer resources to devote to patient care when compared to non-safety net hospitals. While patient satisfaction scores may provide an incentive for hospitals to devote more resources to the measure, safety net hospitals generally do not have the funding to do so. Although the Council believes that the goal of such patient satisfaction surveys should be to identify areas to improve patient outcomes and quality of care, the AMA must guard against efforts aimed at improving the quality of care that have the unintentional effect of stripping safety net hospitals of needed funding and thereby exacerbating health care disparities. Tying financial incentives to HCAHPS patient satisfaction scores may have the effect of financially penalizing such hospitals and unintentionally exacerbating existing inequalities in care.¹⁷

Further, numerous studies have found that patient satisfaction is not necessarily an objective measure of quality. In a nationally representative sample, higher patient satisfaction was associated with lower emergency department use but with greater use of inpatient care, higher overall health care and prescription drug expenditures, and increased mortality.¹⁸ Therefore, the limitations of patient experience surveys should be recognized. Additionally, the Council notes that, at times, a statistically minimal number of surveys may have a material effect on overall scores. To that end, the Council recommends reaffirming numerous policies emphasizing that such quality assessments should adjust for factors outside of the physician's control and recognizing variation in different patient populations, policy stating that patient satisfaction surveys should not be a determinative measure of physician quality for payment purposes, and policy advocating for the continuation of efforts to improve patient satisfaction measurement.

Socioeconomic factors such as age, income, educational level, ethnicity and others have been identified as having a role in not only health care preferences but also health care outcomes. Such factors may present obstacles to successful outcomes and can widen health care disparities. Recognizing socioeconomic factors and focusing on cultural competency in care delivery may reduce racial and ethnic health care disparities and positively contribute to quality improvement. Therefore, the Council believes it is important not only to guard against patient satisfaction surveys unintentionally depriving safety net hospitals of needed funding but also to focus on ways to improve the patient experience. Accordingly, the Council recommends continuing to advocate for improved risk models that account for social risk factors in hospital quality program assessments. The Council notes that excluding a specific mention of HCAHPS from the recommendation and instead mentioning "hospital quality program assessments" makes the policy inclusive of the numerous hospital quality programs, including HCAHPS. Further, the Council recommends reaffirming policy promoting cultural competency training and recommends new policy recognizing the importance of cultural competency to patient experience and encouraging the implementation of such practices across health care settings.

While it may be difficult to determine whether patient satisfaction scores are a result of physician performance or demands and restrictions outside of the physician's control, the Council believes valuable information can be gleaned from patient surveys. There is evidence supporting the premise that when patients better understand treatment plans, they are more likely to adhere to recommendations and return for follow up care in the future.¹⁹ The Joint Commission, which pools together best practices for HCAHPS scores, notes that positive patient perception of care may improve patient safety and staff retention. Additionally, patient experience of care quality and patient satisfaction are tied to the Triple Aim. Although experience may not necessarily be an indicator of quality, it is important for patient's perceptions of care to be positive. These perceptions reflect the physician-patient relationship and support patient retention and shared decision-making.

The Council believes improving the patient experience is a shared goal in health care. It also believes that ensuring the financial viability of safety net hospitals is vital to providing care to the most vulnerable and fighting to reduce health care disparities. Therefore, the Council recommends continuing to work with CMS and others, including America's Essential Hospitals, to address issues related to hospital quality program assessments.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-450.966 emphasizing that national medical quality and performance standards and measures should adjust for factors that are not within the direct control of those being measured and should recognize the variations in needs of different patient populations.
2. That our AMA reaffirm Policy D-385.958, which calls for the AMA to work with Centers for Medicare & Medicaid Services (CMS) and non-government payers to ensure that subjective criteria, such as patient satisfaction surveys, should not be used as a determinative measure of physician quality for the purpose of physician payment and to ensure that physician payment determination, when incorporating quality parameters, only consider measures that are under the direct control of the physician.
3. That our AMA reaffirm Policy H-450.982 stating that efforts should be continued to improve the measurement of patient satisfaction and to document its relationship to favorable outcomes and other accepted criteria of high quality.
4. That our AMA reaffirm Policy H-295.897 promoting cultural competency training with the goal of emphasizing cultural competence as part of professional practice.
5. That our AMA support that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care.
6. That our AMA recognize the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings.
7. That our AMA support that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities.
8. That our AMA continue to advocate for better risk models that account for social risk factors in hospital quality program assessments.
9. That our AMA continue to work with CMS and other stakeholders, including representatives of America's Essential Hospitals, to address issues related to hospital quality program assessments.
10. That our AMA oppose hospital quality program assessments that have the effect of financially penalizing physicians, including those practicing in safety net hospitals.
11. That our AMA rescind Policy D-450.954.

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3. NON-PHYSICIAN SCREENING TESTS (RESOLUTION 901-I-16)

Reference committee hearing: see report of Reference Committee J.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS

IN LIEU OF RESOLUTION 901-I-16

REMAINDER OF REPORT FILED

See Policies H-425.968, H-425.994, H-425.996 and H-425.997

At the American Medical Association's (AMA) 2016 Interim Meeting, the House of Delegates referred Resolution 901, "Disclosure of Screening Test Risk and Benefits Performed without a Doctor's Order," submitted by the American College of Radiology, and the Virginia, Alabama, Georgia, Kentucky, District of Columbia, Mississippi, West Virginia, and South Carolina Delegations. The Board of Trustees referred this issue to the Council on Medical Service for a report back to the House at the 2017 Interim Meeting. Resolution 901-I-16 asked:

That our AMA (1) advocate that if a screening test is being marketed as having a medical benefit and is offered and performed by a wellness program vendor without a specific order by the individual's physician or other licensed provider, they must provide the patient with the test specific evidence based guidance that supports the utility of the test; (2) advocate that if the procedure is not supported by specific evidence based guidance as a screening test for that patient and the patient still would like the screening test, the Wellness Program Vendor must offer the patient the opportunity to discuss the risks, benefits, and alternatives with a physician licensed to practice medicine in the state in which the test is being performed; (3) engage with federal regulators on whether vendors of health and wellness programs are in compliance with regulations applicable to marketing to patients in view of the impact of such programs on patients; and (4) where possible, continue to work with state medical societies, interested medical specialty societies and state agencies to provide public education regarding appropriate use of vendor wellness programs.

This report provides background on wellness program vendors, particularly focusing on employer-offered wellness programs, discussion on payment for vendor screenings, an overview of the clinical guidelines for screenings, an outline of the relevant legislation, and a series of policy recommendations regarding vendor wellness screenings.

BACKGROUND

Much of today's health care system was created to provide diagnosis and treatment versus wellness and prevention. However, not only are many diseases preventable but also there are sustained concerns about health care spending. Accordingly, recent years have brought a focus on wellness and prevention. Codified in statutes like the Affordable Care Act (ACA), wellness programs have become a cornerstone in employer and health plan behavior.

More than 5,600 vendors reportedly generate annual revenue of \$8 billion in the wellness industry, of which \$6 billion is attributable to the workplace wellness industry.¹ Many employers now provide wellness programs to employees in an effort to help employees maintain their health and reduce health care costs. The workplace wellness industry generally consists of vendors that sell companies stand-alone wellness programs or programs that are an optional part of the employee's health insurance. In addition, some screening services are provided outside of the employer-based wellness program and are often accessed at wellness centers. The Council notes that the scope of this report is limited to basic screenings by a wellness vendor and does not encompass genetic testing. Notably, CMS/CSAPH Joint Report, "Precision Medicine," also presented at the 2017 Interim Meeting, addresses payment and coverage of genetic testing.

Several companies market wellness screenings, personalized health screenings, and biometric screenings. These services are performed outside of the traditional patient-physician setting and are often marketed to employers as wellness screening programs for their employees. The services provided vary, but they usually include a number of blood tests; ultrasound imaging for conditions, such as abdominal aortic aneurysm, carotid artery disease, and bone density; ankle-brachial index for peripheral artery disease and cardiovascular disease; and sometimes electrocardiogram. Other services include body composition analysis (e.g., body fat percentage, visceral fat, muscle mass and distribution, body water balance, total body weight, body mass index).

The increasing availability of direct-to-consumer screening tests may undermine physician efforts to provide high-quality, cost-conscious screening services to patients through shared decision-making. The wellness vendor screening services at issue are not usually administered by physicians but instead by technicians or other non-physician health professionals outside of traditional health care settings. However, many of these vendor companies have physicians as part of their leadership teams serving as medical directors or members of an advisory board. Some companies are located in retail settings, and others offer services via the internet. Occasionally, the websites of these vendor companies include a disclaimer encouraging those who are interested in testing, or those who have received abnormal test results, to contact their physicians with questions. Some companies offer follow-up with a physician staff member if patients have questions about results.

PAYING FOR WELLNESS SCREENING TESTS

Employers continue to show interest in wellness and screening programs that help employees identify health issues and manage chronic diseases. Therefore, many firms pay for such screenings and tests and some offer financial incentives to encourage employees to complete the health assessments.² Many large employers offering health assessments, biometric screenings, and wellness programs offer participating employees lower premium contributions or reduced cost-sharing.³

Outside of the workplace wellness program paradigm, health insurance generally does not cover screenings that have not been recommended by physicians. Further, vendors generally make more money the more screenings they perform and therefore often recommend screenings for otherwise healthy people, a practice that has the effect of increasing overall health care costs.⁴

CLINICAL GUIDELINES FOR WELLNESS SCREENINGS

There is concern that the screening services provided by wellness vendors are not always supported by clinical guidelines. Vendor programs do not need to follow screening guidelines from the US Preventive Services Task Force (USPSTF) or other guideline-making bodies. For example, the USPSTF found insufficient evidence to recommend several wellness tests including high sensitivity C-reactive protein testing for coronary heart disease risk and ankle-brachial index to determine risk for peripheral artery disease and cardiovascular disease.⁵ Additionally, concerns exist about providing screening tests to large numbers of patients who may not need them. Wellness programs offer blanket screening tests for nearly anyone while most screening guidelines are tailored based on age,

gender, and other factors. For example, the USPSTF recommends abdominal aortic aneurysm screening only in men ages 65-75 who are or have been smokers, and when these guidelines are not followed it leads to unnecessary tests for which a given individual may have no indication. Additionally, the larger the screened population, the higher the number of false positive and false negative results. False positive results could set off a cascade of invasive, expensive, and potentially harmful follow-up tests, and false negative results could lead patients to forego necessary care.

EFFECTIVENESS OF WELLNESS PROGRAMS

The return on investment for wellness programs and screenings is mixed. Often the programs fail to pay for themselves and confer no proven health benefit.⁶ Commonly, wellness programs focus on two components: a lifestyle management program and a disease management program. The lifestyle management program focuses on individuals with health risks such as obesity and smoking while the disease management program is designed to help those who already have a chronic disease.⁷ Programs focusing on disease management provide a greater return on investment than lifestyle management.⁸ Overall, it is estimated that wellness programs reduced average health care costs by about \$30 per member per month; however, 87 percent of savings were attributable to disease management programs that focus on interventions for individuals with already-diagnosed conditions in order to reduce complications and related health care utilization.⁹ Additionally, it is expensive for employers to pay for wellness program screenings and incentives, and interventions such as subsidizing healthy food choices and reimbursing employees for gym memberships may prove more beneficial.^{10,11}

RELEVANT REGULATIONS

Many states have laws allowing patients to order their own laboratory tests. Additionally, the claims of efficacy made by the vendors are subject to Federal Trade Commission rules on truth-in-advertising, and therefore the claims must be truthful, not misleading, and must be substantiated. Many companies providing these services include language on their websites and other publications stating that test results do not constitute medical advice or diagnoses, thereby limiting their liability.

In response to public health concerns over an unregulated industry, Congress passed the Clinical Laboratory Improvement Amendments (CLIA) to establish standards for diagnostic testing including standards related to safety guidelines, standards to ensure the accuracy and reliability of test results, and standards for laboratory staff, including appropriate level of training.¹² In order to operate, wellness vendors are expected to comply with these guidelines with respect to good practices and may then apply for and receive CLIA certification. Three federal agencies are responsible for the CLIA: The Food and Drug Administration, the Centers for Medicare and Medicaid Services, and the Centers for Disease Control and Prevention.¹³ Eighteen states have rules and regulations in addition to CLIA, and some states require vendor licensure in their public health codes.¹⁴

Additionally, wellness programs must comply with a host of federal laws. These laws include the Employee Retirement Income Security Act (ERISA), the Americans with Disabilities Act (ADA), the Genetic Information Nondiscrimination Act (GINA), the ACA, and the Health Insurance Portability and Accountability Act (HIPAA).¹⁵ HIPAA applies to wellness programs offered as part of an employer's group health plan. Therefore, information collected from or created about participants in the wellness program as part of the group health plan is considered personal health information and is protected by HIPAA.¹⁶

RELEVANT AMA POLICY AND ADVOCACY

Policy H-425.996 on multiphasic health screening programs states that entities that operate or sponsor such multiphasic health screening programs should be urged to include in their promotional and explanatory materials about the availability of the program, a definitive statement that reports on the screening test results will be furnished to the individual participants only and that each participant is responsible for obtaining any needed medical evaluation or follow-up should the results of the tests deviate from the normal range. Those operating or sponsoring multiphasic health screening programs also should be urged to utilize report forms that state in bold type that the report does not constitute a medical diagnosis or evaluation and that the participant should consult a physician of his or her choice if the screening test results are not within the normal limits indicated on the report. Policy H-425.997 more generally states that preventive care should ideally be coordinated by a patient's physician.

Policy H-425.994 states that the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors and that the testing of individuals should be pursued only when adequate treatment and follow-up can be arranged for the abnormal conditions and risk factors identified.

To promote continuity of care, Policy H-160.921 states that retail health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community and that retail health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care. Further, Policy H-160.921 states that retail health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.

Policy D-35.985 recognizes non-physician providers as valuable components of the physician-led health care team. With respect to the health care team, Policy H-275.976 states that the health professional who coordinates an individual's health care has an ethical responsibility to ensure that the services rendered are provided by those whose competence and performance are suited to render those services safely and effectively.

Policy H-330.879 on providers and Medicare's Annual Wellness Visit (AWV) articulates principles reinforcing the need to protect against vendors fragmenting care and the need to preserve the physician-patient relationship. Specifically, Policy H-330.879 recognizes the need for safeguards in such circumstances and states that the AWV is a benefit most appropriately provided by a physician or a member of the physician-led health care team that establishes or continues to provide ongoing continuity of care. Further, this policy supports that, at a minimum, any clinician performing the AWV must enumerate all findings from the visit and make provisions for all appropriate follow-up care.

DISCUSSION

Though well intentioned, the wellness industry often has the effect of duplicating care that physicians are already providing, unnecessarily increasing physician workload, and obstructing the physician-patient relationship.¹⁷ The Council believes wellness programs often incentivize unnecessary testing and practices that are contrary to evidence-based medicine and medical judgment. Accordingly, the Council offers a number of principles intended to address these issues and advance the goal of reducing cost of care that does not add value and promoting quality care.

If protections are in place, evidence-based wellness programs can have a positive impact on health by encouraging healthy behaviors and proper disease management strategies. To that end and consistent with the intent of Resolution 901-I-16, the Council recommends that wellness program vendors must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines. Additionally, the Council believes vendors must inform patients of the potential benefits and risks of performing a test and of positive or negative screening test results before a test is performed. The Council believes these principles will help bring vendor practices in line with evidence-based guidelines and aid patients in informed decision-making.

Further, the Council believes it is important that wellness program vendors disclose the qualifications of any individual performing the test as well as those individuals interpreting the test results. Moreover, wellness program vendors should use local physicians as medical directors or supervisors. These recommendations advance the goals of patient education and recognition that physicians are best suited to lead health care teams pursuant to AMA policy. In addition, the Council believes it is important that any policy on vendor screenings limits a physician's liability and protects against physician administrative burden. To that end, the Council recommends that results of a screening test should only be sent to the individual and that test results showing a positive or otherwise abnormal test result should require a consultation with the patient's primary care physician or usual source of care. Additionally, the Council recommends that physicians not be held liable for delayed or missed diagnoses indicated on third party vendor tests. The Council believes that this recommendation expressly reaffirms the rule that physician liability be limited when stemming from tests that have not been shared with the physician. Finally, the Council believes that Policy H-425.996 is outdated and that its recommendations herein regarding non-physician screenings supersede the policy and therefore recommends that Policy H-425.996 be rescinded.

The following recommendations complement the body of AMA policy on non-physician tests and care including that on the Medicare Annual Wellness Visit and retail health clinics. The Council approaches this issue with the

belief that, if proper safeguards and guidelines are in place, such wellness program vendors can have an appropriate role in the health care system and help advance the goals of better, more cost effective care.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 901-I-16 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-425.994 stating that the evaluation of a healthy person by a physician can serve as a convenient reference point for preventive services and for counseling about healthful living and known risk factors.
2. That our AMA reaffirm Policy H-425.997 stating that preventive care should be coordinated by a patient's physician and encouraging development of policies and mechanisms to assure the continuity, coordination, and continuous availability of patient care, including preventive care and early-detection screening services.
3. That it be the policy of our AMA that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles:
 - a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines;
 - b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed;
 - c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test;
 - d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure;
 - e. Should send results of any screening to the individual patient and to the primary care physician or usual source of medical care, upon patient request;
 - f. Should require a consultation with the patient's primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result; and
 - g. If the test results are of a critical level or value, the patient should be contacted immediately and notified of the need for urgent or emergent medical evaluation.
4. That our AMA support that physicians not be held liable for delayed or missed diagnoses indicated on wellness program vendor non-physician ordered screenings.
5. That our AMA rescind Policy H-425.996.

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4. HEALTH INSURANCE AFFORDABILITY: ESSENTIAL HEALTH BENEFITS AND SUBSIDIZING THE COVERAGE OF HIGH-RISK PATIENTS

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policies H-165.842, H-165.846 and H-165.995

The American Medical Association (AMA) proposal to cover the uninsured and expand choice, used in AMA advocacy leading up to and following the enactment of the Affordable Care Act (ACA) and highlighted in AMA's Voice for the Uninsured campaign, is based on numerous policies developed and/or refined by the Council on Medical Service, and adopted by the House of Delegates, during the 1990s and 2000s. The proposal removed the bias toward employment-based insurance and promoted a system of individually selected and owned health insurance coverage, using tax credits, individual responsibility, and other market regulations to maximize coverage gains, make coverage affordable, and ensure patient choice of health plan and physicians.

As the House of Representatives and the Senate have been discussing and crafting legislation related to health reform, the Council spent the past year reviewing the substantial body of AMA policy pertaining to the AMA proposal for reform, as well as assessing whether to potentially revisit policy on certain health reform issues. The Council has concluded that the preponderance of AMA policy regarding coverage, choice and access remain relevant. However, in its review, the Council determined that it was necessary to revisit and modify policy on essential health benefits and the relative merits of high-risk pools versus reinsurance.

This report provides background on the issues of essential health benefits, high-risk pools and reinsurance; assesses their impact on health insurance affordability; summarizes relevant AMA policy; and presents policy recommendations.

ESSENTIAL HEALTH BENEFITS

Background

Under the ACA, all qualified health benefits plans, with the exception of grandfathered individual and employer-sponsored plans, are required to offer at least the essential health benefits (EHB) package, including those offered in health insurance marketplaces and in the individual and small group markets outside of the marketplaces. The ACA specified that the EHB package must cover the following general categories of services:

- Ambulatory patient services;
- Emergency services;
- Hospitalization;
- Maternity and newborn care;
- Mental health and substance use disorder services, including behavioral health treatment;
- Prescription drugs;
- Rehabilitative and habilitative services and devices;
- Laboratory services;
- Preventive and wellness services and chronic disease management; and
- Pediatric services, including oral and vision care.

The Secretary of the US Department of Health and Human Services (HHS) has the responsibility to determine the scope of the EHB package, which the ACA specified should be equal to the scope of benefits under a typical employer-sponsored plan. Regulations addressing EHB stated that EHB shall be defined by state-specific benchmark plans. HHS also stated that “the EHB-benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state.” HHS outlined four benchmark plan options for states:

- The largest plan by enrollment in any of the three largest small group insurance products in the state’s small group market;
- Any of the largest three state employee health benefit plans by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; and
- The largest insured commercial non-Medicaid health maintenance organization operating in the state.¹

Impact on Health Insurance Affordability

Concerns have been raised that certain categories of essential health benefits drive up premium costs. The Council notes that most of the health care claims costs associated with essential health benefits are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs. These services are arguably viewed as fundamental components of health insurance coverage. For example, Milliman estimated that removing maternity coverage from insurance coverage may lower premiums by \$8 to \$14 per month, depending on geographic, provider and other factors.² In addition, a recent analysis conducted by RAND researchers projected that, for 2017, maternity care would account for four percent of per capita insurer spending, and mental health and substance abuse treatment would account for one percent of per capita insurer spending. Spending on prescription drugs was projected to be more substantial, accounting for approximately 22 percent of per capita insurer spending.³

The ACA also prohibits annual and lifetime limits, but only for care that is considered to be under the umbrella of EHBs. In addition, the ACA requires health plans to cap out-of-pocket expenses of enrollees, but only for care that is considered EHBs. As such, several analyses have concluded that if EHB categories are removed or allowed to be waived, premiums would decrease, but individuals who use services and benefits no longer included in the EHBs could face substantial increases in out-of-pocket costs.^{4,5,6,7} If EHB categories are removed or allowed to be waived, health plans could react in multiple ways, including no longer covering affected categories; providing a level of coverage for affected categories (but caps on out-of-pocket spending, as well as annual and lifetime limits may not apply); or offer coverage “riders” for affected categories. Analyses have found that categories most likely to be removed from the EHB, if states are allowed flexibility to do so, include maternity care; mental health and substance abuse benefits; rehabilitative and habilitative services; certain pediatric services, including oral and vision care; and prescription drugs.^{8,9,10,11} The Council notes, for example, that riders for maternity services were available prior to enactment of the ACA. In addition, if prescription drugs were removed as an EHB category, plans may provide a level of coverage for them, but individuals who rely on expensive prescription drugs could face an exponential increase in out-of-pocket spending due to the loss of the ACA’s financial protections afforded to EHB categories.

In addition, analyses have found that removing EHB categories or allowing EHB waivers could cause market segmentation.^{12,13,14} If categories are removed from EHB, individuals who do not foresee a need for removed services will be attracted to more affordable, less comprehensive plans. However, individuals in need of affected services, which could range from mental health to maternity services to pediatric services, would either not have any plan options or face much higher premiums for plans that offer at least some level of coverage for removed services.

As such, health plans would be able to structure their offerings as to attract lower-risk and healthier enrollees, as sicker, higher-risk individuals would tend to gravitate toward richer, more generous coverage.

Finally, concerns have been raised that removing EHB categories or allowing waivers of EHBs could allow for mini-meds and other “sham” health insurance to have greater standing in the marketplace. As ACA’s protections against catastrophic costs are tied to EHBs, if EHBs are eliminated, individuals could increasingly enroll in health insurance coverage that does not protect them against catastrophic expenses. Notably, the health reform debates in the House of Representatives and the Senate have been impacted by the Congressional Budget Office’s definition of private health insurance coverage, which has been outlined as “consisting of a comprehensive major medical policy that, at a minimum, covers high-cost medical events and various services, including those provided by physicians and hospitals... The definition excludes policies with limited insurance benefits (known as mini-med plans); ‘dread disease’ policies that cover only specific diseases; supplemental plans that pay for medical expenses that another policy does not cover; fixed-dollar indemnity plans that pay a certain amount per day for illness or hospitalization; and single-service plans, such as dental-only or vision-only policies. In this estimate, people who have only such policies are described as uninsured because they do not have financial protection from major medical risks.”¹⁵

AMA Policy Relevant to Essential Health Benefits

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 EHB 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 US 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 cautions 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.

HIGH-RISK POOLS AND REINSURANCE

Background

The ACA established risk adjustment, reinsurance, and risk corridor programs to not only stabilize premiums during the early years of ACA implementation, but to blunt the impact of adverse risk selection. ACA’s risk adjustment program, which is permanent in nature, redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees, thereby removing insurer incentives to “cherry pick” healthier enrollees. The ACA’s temporary reinsurance program played a role in stabilizing premiums in the individual marketplace during the early years of ACA implementation. The program provided payments to plans that enrolled higher-cost individuals whose costs exceeded a certain threshold, also known as an attachment point, up to the reinsurance cap. The ACA’s temporary risk corridor program aimed to promote accurate premiums while there was uncertainty among insurers in the early years of the marketplaces about who would enroll and the cost of their care. The risk corridor program limited health plan losses and gains beyond an allowable range.¹⁶

The ACA established a temporary state-based high-risk pool program, known as the Pre-Existing Condition Insurance Plan (PCIP) program, in 2010, to be phased out when the key coverage provisions of the ACA became operational in 2014. HHS ran the PCIPs in 23 states and the District of Columbia, while 27 states administered their own programs. Individuals had to be uninsured for at least six months before enrolling, but otherwise, the program had no pre-existing condition exclusions. Unlike traditional state high-risk pools that existed before the ACA, PCIP premiums were able to vary by age but were otherwise equal to premiums paid by individuals without pre-existing conditions. In addition, there were no annual or lifetime dollar limits on covered benefits under PCIP, there were caps on out-of-pocket spending, and there was a minimum actuarial value of plans, which impacted deductibles. The ACA appropriated \$5 billion to fund net losses of PCIP programs.¹⁷

While the CBO estimated in June 2010 that an average of 200,000 individuals would be enrolled in PCIP for the 2011-2013 period,¹⁸ PCIP enrollment peaked at about 115,000 in March 2013. Also in March 2013, new PCIP enrollment had to be suspended in order to ensure that there were sufficient resources to pay the claims of individuals already enrolled. Between September 2012 and September 2013, the final 12-month period for which PCIP expense data were reported, PCIP had net losses of more than \$2 billion, with \$4 billion in total net losses reported as of September 2013.¹⁹

Impact on Health Insurance Affordability

Mechanisms to subsidize the costs of high-risk and high-cost enrollees have had various rates of success. Concerning high-risk pools, prior to implementation of the ACA, 35 states offered high-risk pools as a mechanism to cover high-risk and high-cost residents, including those with pre-existing conditions. At their peak, state high-risk pools that existed prior to passage of the ACA covered more than 200,000 people nationally, with combined net losses for the state high-risk pools totaling more than \$1.2 billion for 2011, or \$5,510 per enrollee, on average. Overall, state high-risk pools featured premiums above standard non-group market rates, with most states capping them at 150 to 200 percent of standard rates. Many also featured high deductibles, including deductibles in the \$5,000 range. Nineteen states had some degree of premium subsidy for low-income individuals. In addition, despite the fact that many individuals had to seek coverage in high-risk pools because of a pre-existing condition, most states excluded coverage for these conditions for medically eligible individuals ranging from six to 12 months. Almost all high-risk pools imposed lifetime limits on covered services, with some also imposing annual limits on covered benefits. A few states capped or closed enrollment.²⁰

The Council notes that a January 2017 report from the American Academy of Actuaries also raised concerns regarding high-risk pools, noting that “enrollment has generally been low, coverage has been limited and expensive, they require external funding, and they have typically operated at a loss... Removing high-risk individuals from the insured risk pools reduces costs in the private market only temporarily. Over time, even lower-cost individuals in the individual market can incur high health care costs, which would put upward pressure on premiums.”

The actuaries also noted that funding could be directed toward a reinsurance program that reimburses plans the costs of high-risk enrollees. For example, to fund the ACA’s transitional reinsurance program, insurers and third party administrators paid \$63 per enrollee per year in 2014, \$44 in 2015 and \$27 in 2016. These investments in reinsurance yielded premium reductions. For example, in 2014, the \$10 billion reinsurance fund, the result of the \$63 per enrollee per year contributions, was estimated to reduce premiums by 10 to 14 percent. The actuaries stated that a permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums.²¹ Reinsurance enables high-risk enrollees to remain in the same individual market risk pool and enjoy the same protections and choices as healthy plan enrollees.

States have also submitted waivers under Section 1332 of the ACA, as outlined in Council on Medical Service Report 1 being considered at this meeting, to fund state reinsurance programs. Alaska’s waiver, which has been approved, allows the state to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP will cover claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers will relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. As a result of the ARP, it is expected that premiums will be 20 percent lower in 2018 than absent the waiver, and 1,460 additional individuals will have health insurance coverage.²² The waiver application of Minnesota, which has also been approved, would create the Minnesota Premium Security Plan, which was estimated to yield a 20 percent reduction in average premiums in 2018.²³ While Minnesota’s waiver was approved, the full amount the state requested in its waiver for federal pass-through funding to financially support its reinsurance program was not approved. Only federal pass-through funding reflecting savings from less spending on premium tax credits and cost-sharing reductions was approved, not the amount also requested by the state that reflects federal savings due to lower premiums for plans under the state’s Basic Health Program.²⁴ The waiver application of Oregon, which was still under review when this report was prepared, anticipates that its waiver to establish the Oregon Reinsurance Program will reduce premiums, including those for the second-lowest cost silver plan, by 7.5 percent in 2018 (net of the premium assessment), with an increase in enrollment in the individual market by approximately 1.7 percent in the same year.²⁵

Maine also had an “invisible high-risk pool” that it implemented in 2011, which in functionality was more similar to a reinsurance program than a high-risk pool. The main difference between invisible high-risk pools and the more

traditional approach to reinsurance as included in the ACA is that the pools identify potential high-cost individuals prospectively, versus being reimbursed retrospectively for patients who actually incur high-cost claims. As a result, some plan enrollees who end up having unpredictably costly claims may not be included in invisible high-risk pools, and as such insurers would not be reimbursed for a portion of their claims. For example, under Maine's program, all health insurance applicants were required to complete a health statement with their application for insurance, and insurers used the statement to ascertain which individuals to place in the invisible high-risk pool, based on what health conditions they had. Selected individuals were enrolled in the same plan they applied for at the same premium levels, but on the back-end, their health insurers were reimbursed for 90 percent of their claims between \$7,500 and \$32,500 per year and 100 percent of claims more than \$32,500. Premium reductions were achieved as a result, which varied based on applicant age.²⁶

AMA Policy Relevant to Risk Subsidization

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.

DISCUSSION

As millions of Americans have gained coverage resulting from the ACA, the Council affirms that progress has been made on a long-time policy priority of the AMA – expanding access to affordable, quality health insurance coverage. However, in light of the health reform discussions and debates that have occurred this year, the Council believes there is an opportunity to include additional safeguards in AMA policy to ensure that patients have meaningful coverage that protects them against catastrophic expenses. While the AMA has long supported patient choice of health plan, AMA policy has also stressed that any health insurance purchased must provide meaningful coverage for hospital, surgical and medical care; protect patients against catastrophic expenses; as well as promote preventive services. AMA policy also underscores 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, and that prohibitions on annual and lifetime limits should remain in place under any reform.

Under current law, the requirement that all qualified health plans, with the exception of grandfathered individual and employer-sponsored plans, offer at least the EHBs in the EHB package, has helped ensure that individuals have had access to meaningful coverage. Importantly, the prohibition on annual and lifetime limits, as well as the cap on out-of-pocket expenses, is only required for care that is considered to be under the umbrella of essential health benefits. Consistent with previously established AMA policy, the Council believes that using the current benchmark approach to EHBs, while requiring ten categories of essential health benefits, strikes a balance between offering meaningful coverage and maintaining patient choice in health plans and their respective benefits packages. The Council believes that the benchmark approach to EHBs recognizes that there is not a “one size fits all” approach to health insurance benefits, and that some variability is needed.

The Council notes that most of the health care claims' costs associated with EHBs are attributable to such services as hospital inpatient and outpatient care, physician services, and prescription drugs. These services are arguably viewed as fundamental components of health insurance coverage. Removing any benefits from the EHB requirements, or allowing waivers of such requirements, can cause insurers to cherry pick patients based on the services their plans cover, as well as hinder patient access to necessary services. If insurers are allowed to offer plans with skimpier coverage, plan designs could potentially discriminate against people with pre-existing conditions. In

addition, individuals who use services and benefits no longer included in the EHBs could face substantial increases in out-of-pocket costs. As such, the Council is recommending that our AMA oppose the removal of categories from the EHB package. In addition, the Council believes that our AMA should also oppose waivers of EHB requirements that lead to EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses, being eliminated.

In addition, after the expiration of the ACA's reinsurance program, and with policymakers and stakeholders evaluating various options to improve the stability of health insurance premiums and the overall health insurance marketplace, the Council reevaluated AMA policy with respect to how to best subsidize the costs of high-cost and high-risk patients, who may have pre-existing conditions. Critics of high-risk pools as a viable option for covering high-risk individuals have emphasized that the funding allocated to them, in the past and in legislation that was considered this year, has not been sufficient. More importantly, however, is that traditional high-risk pools have provided individuals with pre-existing conditions with second-class insurance, with waiting periods to get pre-existing conditions covered, higher premiums, potentially high deductibles, and lifetime limits on benefits. As such, the Council is recommending that Policy H-165.995 be rescinded, resulting from the evidence that shows the consequences of high-risk pools, and their subjection of individuals with pre-existing conditions to a different level of health insurance. At this juncture, considering the success of the ACA's reinsurance program, as well as state reinsurance programs, the Council believes that, considering finite resources, that resources should be directed to reinsurance programs. Reinsurance provides an equitable, fair and cost-effective mechanism to subsidize the costs of high-risk and high-cost patients, and protects patients with pre-existing conditions. The Council concludes that data suggest that a permanent reinsurance program may be a desirable policy option, whether administered at the federal or state level.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) oppose the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
2. That our AMA oppose waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses.
3. That our AMA prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients.
4. That AMA Policy H-165.995 be rescinded.

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5. REAFFIRMATION OF AMA POLICY OPPOSING CAPS ON FEDERAL MEDICAID FUNDING

Reference committee hearing: see report of Reference Committee J.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
REMAINDER OF REPORT FILED**
See Policy H-290.963

At the 2017 Annual Meeting, the House of Delegates referred Council on Medical Service Report 9-A-17, "Capping Federal Medicaid Funding." The report advocated for a series of safeguards in the event of federal Medicaid funding being capped. Debate on the report focused on an imminent Senate bill to undo the Medicaid expansion of the Affordable Care Act (ACA) and replace it with state per capita caps or block grants.

At the same meeting, the House of Delegates adopted Policy H-290.963, "Federal Medicaid Funding," which states that our American Medical Association (AMA): (1) opposes caps on federal Medicaid funding; and (2) advocates 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.

BACKGROUND

Expanding Medicaid eligibility to most individuals with incomes up to 138 percent of the federal poverty level was a key strategy in expanding health insurance coverage under the ACA and accounted for 63 percent of coverage

gains in 2014. Medicaid expansion resulted in an estimated 11 million newly enrolled beneficiaries in 2015. The program currently covers approximately 73 million beneficiaries nationwide. The Medicaid cap safeguards proposed in Council on Medical Service Report 9-A-17 included:

- a. Individuals, including children and adolescents, who are currently eligible for Medicaid should not lose their coverage, and federal funding for the amount, duration, and scope of currently covered benefits should not be reduced;
- b. The amount of federal funding available to states must be sufficient to ensure adequate access to all statutorily required services;
- c. Cost savings mechanisms should not decrease patient access to quality care or physician payment;
- d. The methodology for calculating the federal funding amount should take into consideration the state's ability to pay for health care services, rate of unemployment, concentration of low income individuals, population growth, and overall medical costs;
- e. The federal funding amount should be based on the actual cost of health care services for each state;
- f. The federal funding amount should continue to fund the Affordable Care Act (ACA) Medicaid expansion populations in states that have expanded Medicaid and provide non-expansion states with the option to expand Medicaid with additional funding to cover their expansion populations;
- g. The federal funding amount should be indexed to accurately reflect changes in actual health care costs or state-specific trend rates, not on a preset growth index (e.g., consumer price index);
- h. Maximum cost-sharing requirements should not exceed five percent of family income; and
- i. The federal government should monitor the impact of capping federal Medicaid funding to ensure that patient access to care, physician payment and the ability of states to sustain their programs has not been compromised.

The House of Delegates had a robust discussion about the strategic AMA message that would be implied by adopting the proposed safeguards.

In 2017, Congress considered and defeated numerous proposals to repeal and replace the ACA, which included large (up to \$880 billion) reductions to Medicaid and recommendations to cap federal Medicaid spending.

- In March 2017, the American Health Care Act was introduced in the US House of Representatives to repeal and replace the ACA, in part by discontinuing funding for the ACA Medicaid expansion and capping federal Medicaid funding to states.
- In June 2017, during the Annual Meeting of the House of Delegates, the Better Care Reconciliation Act was introduced in the Senate and included a large reduction in federal Medicaid spending, a return to categorical Medicaid eligibility, and a state option to receive a federal block grant for the ACA expansion population of nondisabled adults.
- In July 2017, the Senate considered a “skinny repeal” bill that left Medicaid intact.
- In September 2017, the Senate considered the Graham Cassidy measure, which would have terminated the ACA’s Medicaid expansions, premium tax credits, cost-sharing reduction payments, and small business tax credits. It would also have imposed per capita caps on Medicaid funding and offered states the alternative of a broader Medicaid block grant.

DISCUSSION

At the time that this report was written, Congress had not taken up additional legislation to repeal and/or replace the ACA. The AMA opposed all of the noted bills and urged Congress to initiate a bipartisan effort to address shortcomings in the ACA. The Council believes the policy adopted at the 2017 Annual Meeting, which opposes caps on federal Medicaid funding, remains relevant and recommends its reaffirmation.

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Council on Medical Service Report 9-A-17 and the remainder of the report be filed:

That our American Medical Association Policy H-290.963, “Federal Medicaid Funding,” which opposes caps on federal Medicaid funding, be reaffirmed.