

REPORT 9 OF THE COUNCIL ON MEDICAL SERVICE (A-98)
(June 1998)
Empowering Our Patients: Individually Selected,
Purchased and Owned Health Expense Coverage
(Reference Committee A)

EXECUTIVE SUMMARY

AMA Policy H-165.920 supports individually selected and individually owned health insurance as the preferred method for people to obtain health expense coverage. To help implement that policy, the Council on Medical Service presents 17 recommendations as to how such a system of individually selected, purchased and owned health expense coverage should be structured so as to provide optimum access to coverage.

This report identifies the current AMA policies and recommended new or modified policies that should be advocated to encourage movement toward individually selected, purchased and owned health expense coverage, and provides the rationale for each. The recommendations address needed changes in the tax treatment of health expense coverage, in individual insurance market reforms, in methods of employer contributions toward employee coverage, in incentives to obtain coverage, and in mechanisms for group purchasing and risk pooling. They represent a basic policy agenda for change that will provide the AMA with the flexibility to respond to evolving initiatives in Congress on this subject and to participate effectively in debate on more limited aspects of reform.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9 - A-98
(June 1998)

Subject: Empowering Our Patients: Individually Selected, Purchased and
Owned Health Expense Coverage

Presented by: Arthur R. Traugott, MD, Chair

Referred to: Reference Committee A
(Mark Ivey, Jr., MD, Chair)

INTRODUCTION

At the 1996 Interim Meeting, the House of Delegates amended Policy H-165.920, (AMA Policy Compendium), to support individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage. To help implement this policy, the Council on Medical Service undertook to develop further recommendations as to how such an individually selected and owned system should be structured.

To provide the maximum opportunity for comment on this subject by the Federation, questions regarding options for implementing individually purchased and owned health expense coverage were sent by the Council to the state medical associations and national medical specialty societies in October 1997, and the same questions were provided to the House of Delegates for discussion in an interim report by the Council at the 1997 Interim Meeting. The Council is most appreciative of the comments and responses to these questions provided by different organizations within the Federation. The Council also consulted with widely published economists and policy analysts who have studied this issue.

After careful consideration, taking into account past AMA policy, comments from the Federation, and the proposals of other policy analysts and economists, the Council has formulated the conclusions and recommendations provided in this report.

GOALS AND PREMISES

The Council's recommendations are designed to facilitate transition to a system offering the following advantages:

- Increased access to adequate private-sector coverage for all persons, including the self-employed and persons who are disadvantaged economically or by health risk.
- Expanded freedom by individuals to choose the source, type and extent of their health expense coverage.
- Increased portability of coverage and job mobility for those in the labor market.

- 1 • Reduction in the amount of uncompensated or undercompensated care.
- 2
- 3 • Elimination of inequities in the tax subsidization of insurance spending.
- 4
- 5 • Reduction of incentives to over-insure.
- 6
- 7 • The opportunity for employers to establish total compensation levels independent of the costs
- 8 of health care.
- 9
- 10 • The opportunity for unions to assume an expanded role for their members in providing group
- 11 purchasing mechanisms, education about coverage choices, and negotiation services.
- 12
- 13 • Potential savings to employers in the costs of benefits administration.
- 14
- 15 • A reduced drain on the federal treasury than that which would result from full implementation
- 16 of present federal legislation and present AMA proposals.
- 17
- 18 • Enhanced use of private sector mechanisms rather than centralized public programs in
- 19 financing health care.
- 20

21 The Council's conclusions and recommendations are based on these underlying premises:

- 22
- 23 1. The AMA's participation and leadership in efforts to implement an individually selected,
- 24 purchased and owned insurance system will be best guided by agreement on the basic policy
- 25 agenda for change that should be advocated by the Association. An exhaustively detailed "all
- 26 or nothing" AMA proposal for moving to such an individually owned system is
- 27 contraindicated because:
- 28
 - 29 • it deprives the AMA of the flexibility to respond to evolving initiatives in Congress on this
 - 30 subject and to participate effectively in debate on more limited aspects of reform; and
 - 31
 - 32 • it may be difficult to understand or be perceived by a significant segment of the
 - 33 membership and/or the public as a return to the massively complicated health system
 - 34 reform proposal debated and rejected by Congress and the public in 1993.
 - 35
- 36 2. For the same reasons, attempting to identify and advocate a detailed sequence for transition to
- 37 such a system is counterproductive in today's dynamic political environment. What is
- 38 important, rather, is that none of the changes, whenever implemented, act in conflict with one
- 39 another.
- 40

41 Accordingly, this report essentially identifies the current AMA policies and recommended new or

42 modified policies that should be advocated to encourage movement toward individually selected,

43 purchased and owned health expense coverage, and provides the rationale for each. The full text

44 of each current AMA policy cited in the report is appended for reference. With respect to some

45 changes, the report also identifies both an acceptable interim objective and what the Council

46 believes should be the ultimate goal—again to allow the AMA, through its Council on Legislation

47 and Washington staff, needed flexibility in pursuing this agenda.

1
2 Finally, an appended glossary defines selected terms as they are used in this report. Included in
3 the glossary is the term “health expense coverage.” That term is used consistently wherever
4 appropriate throughout this report as a more encompassing replacement for such overlapping or
5 more restricted terms as “health insurance,” “health plan” and “health expense protection”
6 currently used in many AMA policy statements. Future Council reports on this subject will
7 continue to use these terms as defined in the glossary, and the Council will recommend
8 modification of existing policies to correspond with this usage as the opportunity arises.
9

10 One basic economic principle underlies many of the Council’s conclusions—particularly those
11 regarding needed tax changes—and should be emphasized at the outset. In any freely competitive
12 labor market, fringe benefits, including health expense coverage, are not a “gift” from the
13 employer or union, but are part of the total compensation paid an employee. An individual in a job
14 without such benefits will receive a commensurately higher cash salary. Therefore, all money
15 spent for health insurance in the employment setting is truly the employee’s, and any tax subsidy
16 for such spending should accrue to that employee. Broader public understanding of this fact will
17 be crucial to acceptance of the changes proposed in this report.
18

19 CONCLUSIONS

- 20
21 1. To enhance the individual’s ability to select his/her health expense coverage, the Council on
22 Medical Service believes that the AMA should reaffirm and continue to advocate Policy
23 H-165.918(3), supporting availability of a choice of health care financing mechanisms;
24 Policy H-165.895(3), also supporting a wide choice of plans and calling for a defined
25 employer contribution toward the employee’s health expense coverage regardless of the plan
26 chosen, where an employer contributes to health plan costs; and Policies H-165.985(1) and H-
27 285.998(1), calling for free market competition among all modes of health care delivery and
28 financing, with the growth of any one system determined by popular preference and not
29 preferential regulation or subsidy.
30

31 Discussion and rationale: Implementation of these policies would help to minimize employer
32 incentives to offer only one, low-cost method of coverage to employees, and to assure a variety
33 of both group and individual health expense plans from which to make a selection continue to
34 be available.
35

- 36 2. The AMA should support and advocate a system where individually-purchased and owned
37 health expense coverage is the preferred option, but employer-provided coverage is still
38 available to the extent the market demands it.
39

40 Discussion and rationale: This position accommodates individual and employer preferences,
41 does not mandate an immediate change in coverage mechanisms, and is consistent with AMA
42 policies that support pluralism in delivery and financing mechanisms (including Policy H-
43 165.920(1). It allows for a natural evolution to a system where all health expense coverage
44 will become individually owned to the extent that individual choices over time dictate it.

- 45 3. The AMA should expand Policy H-165.920(3)(a) to specify that the same tax treatment for
46 employer direct contributions toward individually purchased health expense coverage as for
47 employer-provided coverage should include exemption of both employer and employee

1 contributions from FICA (Social Security and Medicare) and federal and state unemployment
2 taxes.

3
4 Discussion and rationale: Employers direct contributions to employees for purchase of
5 individual health expense coverage are currently treated the same as cash wages subject to
6 both the above taxes, as would be the employee's contribution to cost of the individually-
7 purchased coverage, creating a disincentive on both employers and employees to utilize this
8 approach. An exemption from these taxes should not appreciably decrease tax revenues, since
9 the direct contribution mechanism is seldom used currently. Such an exemption and the
10 administrative savings associated with direct contributions would encourage more employers
11 to utilize this mechanism. Employers would continue to have a business expense tax
12 deduction, whether for premium payments or a direct contribution.

- 13
14 4. The AMA should adopt new policy supporting a "maintenance of effort" period such as one or
15 two years for employers during which they would be required to add to the employee's salary
16 the cash value of any health expense coverage they presently provide if they discontinue that
17 coverage or if the employee opts out of the employer-provided plan.

18
19 Discussion and rationale: The cost to an employed individual may be more--at least
20 temporarily--if his/her employer discontinues previously provided health expense coverage
21 without an increase in cash wages, or if the employee opts out of an employer-provided plan
22 and the employer declines to provide a comparable direct contribution toward employee
23 purchase of individual coverage. Over the longer term, the market, union negotiation activity,
24 and employers' needs for a capable work force will act to eliminate such practices, but a
25 "maintenance of effort" safeguard may be needed during the transition to wider use of non-
26 employment-based health expense coverage.

- 27
28 5. The AMA should strongly encourage through all appropriate channels the development of
29 educational programs to assist consumers in making informed choices as to sources of
30 individual health expense coverage.

31
32 Discussion and rationale: The key to a successful transition to wider use of individually
33 selected and purchased health expense coverage will be consumers who are knowledgeable as
34 to the benefits and limitations of the different types of products that will be offered, and able
35 to easily compare the extent and type of health expense protection provided by each through
36 the availability of the type of standardized disclosure formats already supported by Policy
37 H-180.961. Among the logical sponsors of educational programs on this subject would be
38 employers, unions, and consumer organizations.

- 39
40 6. The AMA should encourage employers, unions and other employee groups to consider the
41 merits of risk-adjusting the amount of the employer direct contribution toward individually
42 purchased coverage. Under such an approach, useful risk adjustment measures such as age,
43 sex and family status would be used to provide higher-risk employees with a larger
44 contribution and lower-risk employees with a lesser one.

45
46 Discussion and rationale: Rating restrictions on non-employment based coverage and use of
47 alternative risk pooling mechanisms (addressed later in this report) will help assure access to

1 affordable individual coverage by higher risk individuals opting out of the employer-provided
2 plan. However, a increase in the direct contribution for the higher risk “drop-out” would
3 further facilitate access to adequate coverage, while a decrease in the direct contribution
4 amount for lower risk workers who opt out would avoid excess employer subsidization of their
5 true insurance costs and insufficient premium dollars for those remaining in the employer-
6 provided plan. Risk adjusting the direct contribution could be done fairly easily by the
7 employer, the employer’s insurance carrier or third-party administrator based on prior claims
8 experience for different age groups.
9

- 10 7. The AMA should refine Policy H-165.920(6) to call for the individual to receive the same tax
11 treatment for individually purchased coverage, for contributions toward employer-provided
12 coverage, and for completely employer provided coverage (emphasis added).
13
- 14 8. Contingent on legislative enactment of the changes called for in Recommendation 3 and 7, the
15 AMA should also rescind Policy H-165.995(2)(a), that calls for tax code changes to allow
16 persons paying the entire premium for their health insurance to deduct the full cost of their
17 premium separately from their gross income.
18
- 19 9. In place of Policy H-165.995(2)(a), the AMA should adopt new policy, expressing a
20 preference for replacement of the present exemption from employees’ taxable income of
21 employer-provided health expense coverage and of individual out-of-pocket health care
22 expenses exceeding 7.5% with a tax credit for individuals equal to a percentage of the total
23 amount spent for health coverage by the individual and/or his/her employer (up to a specified
24 actuarial value or “cap” in coverage, so as to discourage over-insurance).
25

26 Discussion and rationale: Present AMA policy supports the deduction (exemption) from
27 employee taxable income of employer provided coverage, and a separate 100% deduction from
28 taxable income (not subject to the 7.5% spending threshold) for individuals who pay the entire
29 premium themselves for health expense coverage providing adequate benefits. This policy has
30 the following shortcomings:
31

- 32 • The 100% tax deduction or exemption for self-paid coverage would not be available to
33 employees who pay part of the cost of employer-provided coverage (except for any
34 payment in excess of 7.5% of gross income). All employer spending for employee health
35 expense coverage is essentially with the employee’s money, and it is inconsistent to
36 provide a tax subsidy for the employer’s contribution but not for the employee’s.
37 Legislative enactment of the changes called for in Recommendation 7 would provide an
38 equivalent subsidy for employee contributions toward coverage. This can be particularly
39 important given the current trend by employers to shift more of premium costs to workers,
40 and can relieve pressure on unions to “hold the line” against such premium cost shifting.
- 41 • Even if the 100% individual tax exemption were extended to all expenditures for health
42 coverage by individuals and employers, the net result would be a further decrease in tax
43 revenue and drain on the federal treasury, in contrast to changing to a tax credit which
44 could be made budget-neutral.
45
- 46 • The present individual tax exemption of employer-provided coverage is socially
47 inequitable, since only the employed are eligible for it, and it provides a higher subsidy

1 toward coverage to those who need it less. Employees in the highest tax bracket (39.6% in
2 1998) save 39.6% of the employer's contribution to coverage off their tax bill, while those
3 in the 15% tax bracket save only 15% of this contribution. A tax credit, up to a specified
4 cap in coverage so as to discourage over-insurance, would be a more equitable approach to
5 subsidizing health expense coverage.
6

7 Use of such tax credits only to defray costs of health expense coverage is assured by the fact
8 that, in most instances, payment for the coverage—whether by employee, employer, or self-
9 employed person—must occur before the tax credit is claimed; the credit is reimbursement for
10 an expenditure already made. If coverage is not purchased, the credit is forfeited. Persons
11 whose incomes are too low to have an income tax liability could still purchase coverage and
12 file to receive a refundable credit that would be directly paid to them. For low-income persons
13 who could not afford the monthly out-of-pocket premium costs even if they were entitled to a
14 tax credit at the end of the year, an existing organization such as the local welfare agency or
15 other appropriate entity could verify income status, issue a voucher immediately for the cost of
16 coverage, and receive the tax credit due the individual at the end of the year, thus providing
17 “up front” funds to purchase the coverage.
18

19 Thus, changing the tax subsidy for coverage from an exemption to a credit would require
20 neither new federal or state bureaucracies nor a major change in the process of filing
21 individual income tax returns. In addition, changing from an individual tax exemption to a tax
22 credit does not eliminate or reduce the employer's business expense deduction for any
23 contributions toward employees' health coverage or increases in their total compensation. The
24 change from an individual tax exemption to a tax credit is “budget neutral” for the employer,
25 and enactment of the changes called for in Recommendation 3 would further eliminate the
26 present FICA and payroll tax penalty on employer direct contributions. To achieve federal
27 budget neutrality, the tax credit percentage could be set at a level that would utilize the
28 increased tax revenue available from replacing the tax exemption of employer-provided
29 coverage and of individual out-of-pocket expenses exceeding the 7.5% threshold, but also
30 compensate for any revenue lost from extending the new tax subsidy (credit) to all individuals
31 who obtain health expense coverage, whether through employer contributions, their own
32 purchase, or a combination thereof, rather than just to individuals who pay the entire cost
33 directly.
34

- 35 10. The AMA should amend Policy H-165.983, calling for all employers to provide private health
36 insurance coverage to all full-time employees, to support the desirability of employers
37 providing a direct contribution to all employees for purchase of individually selected and
38 owned health expense coverage.
39

1 Discussion and rationale: With achievement of the tax changes outlined above, the cost to any
2 individual for obtaining health expense coverage will be the same regardless of whether or
3 how much an employer contributes to that cost, since the total compensation paid to any
4 employee includes the cost of fringe benefits. Therefore, an employer mandate is no longer
5 needed to increase access to coverage. However, employers should be encouraged to utilize
6 the direct contribution mechanism as a way of helping to ensure that employees do purchase
7 coverage.
8

- 9 11. The AMA should adopt policy that expresses a preference for relating the individual tax credit
10 for health coverage expenditures to the individual's income, rather than being a uniform
11 percentage of such expenditures by all individuals and/or their employers.
12

13 Discussion and rationale: Relating the tax credit to income, suggested by a number of
14 economists and health policy institutes, would significantly increase access by lower income
15 persons to adequate health expense coverage and reduce the extent of uncompensated care,
16 while retaining budget neutrality. Under this approach, for example, middle-income persons
17 could receive a tax credit equal to 30% of their expenditure for health expense coverage; this
18 percentage would rise as income decreased and sink as income increased. This would "level
19 the playing field" by making the tax subsidy for health coverage exactly proportional to the
20 individual's need for such a subsidy. An AMA policy identifying this as a preferred approach
21 acknowledges the initial resistance it may encounter from those presently receiving a more
22 generous tax subsidy for health expense coverage, and that a uniform tax credit percentage
23 applicable to all would be an acceptable interim objective. It also allows time for the real,
24 offsetting benefits to upper and middle income individuals of the change from a tax exemption
25 to an income-related tax credit to become more apparent, including:
26

- 27 • The reduction in cost shifting caused by care of the uninsured, and the resulting decrease
28 in cost of health expense coverage purchased by the well-to-do -- a decrease that could
29 substantially offset their increased tax obligation.
30
- 31 • Elimination of the tax penalty for individuals who wish to reduce the extent (and cost) of
32 their coverage down to the cap actuarial value. Under current law, the individual's taxes
33 rise as the cost of health expense coverage decreases, thus eliminating a significant part of
34 any premium savings. With a tax credit rather than exemption, the individual would
35 pocket all of the premium savings, since his/her taxes would be unaffected by the
36 costliness of any plan equal to or exceeding the cap actuarial value.
37
- 38 • Availability of an income-related tax credit providing a private sector safety net not only
39 for those of low income, but also for middle and upper income persons who experience
40 catastrophic health and/or economic events.
41
- 42 • The simple altruistic assurance that the sick poor in society will have better access to
43 needed care, since the current tax exemption provides little, if any, assistance to this
44 group.
45

- 1 12. The AMA should adopt policy that supports strong tax-based incentives, such as making tax
2 credits contingent on the purchase of a specified minimum level of coverage, as opposed to
3 compulsory approaches, to encourage individuals to obtain an adequate level of protection
4 against out-of-pocket expense for health services or benefits, through a financing mechanism
5 that incorporates the provisions of the AMA Patient Protection Act, whether a traditional
6 insurance or managed care plan or a medical savings account.

7
8 Discussion and rationale: The use of such tax incentives to encourage a minimum level of
9 protection, coupled with a greater tax credit to the low-income to assist them in obtaining this
10 protection, would further increase access to coverage and care, and would reduce both adverse
11 selection and uncompensated care. The level of out-of-pocket expense protection required,
12 and the benefits for which this protection should apply, would be societal and political
13 decisions. The strength or intensity of tax incentives used is also a matter for societal and
14 political consensus, recognizing that no approach—even a compulsory one—will achieve 100
15 % universal coverage. One example of a tax incentive approach, suggested above, would be a
16 requirement that the granting of tax credits be conditional on the purchase of coverage
17 providing the specified minimum level of protection and patient protection features, with no
18 tax credit provided for the purchase of coverage providing less than this level of protection.
19 Although this would have no effect on persons who prefer to go completely uninsured, it
20 would encourage the majority of the population who recognize the value of health coverage to
21 upgrade their coverage in order to qualify for the tax credit. A more coercive tax system-
22 centered approach would be to assess a tax penalty equal to the premium cost of the required
23 coverage on individuals who filed tax returns or presented for care without evidence of having
24 such coverage, or of personal resources sufficient to pay out-of-pocket for a catastrophic
25 illness, with the penalty funds used to enroll such individuals in a “fall-back” plan.

- 26
27 13. The AMA should modify Policy H-165.920(3)(d) to state that, to the extent that employer
28 direct contributions continue, and if such contributions are less than the cost of the agreed-
29 upon required level of coverage, such contributions should be used only for the purchase of the
30 coverage, but that in the event that the employer contribution exceeds the cost of the required
31 coverage, the excess could be used by the individual for other purposes.

32
33 Discussion and rationale: A requirement that any employer direct contribution less than the
34 cost of the required coverage be used only for insurance will help to minimize adverse
35 selection, inadequate coverage, and uncompensated care. Individuals should be free, however,
36 to use any excess of the contribution over the cost of the required coverage for other purposes,
37 so as to minimize incentives to over-insure.

- 38
39 14. The AMA should reaffirm and continue to advocate Policy H-165.882(14), supporting
40 legislation to encourage the formation of small employer and other voluntary choice
41 cooperatives, with a redefinition of “small employer” based on the number of lives insured,
42 not the number employed.

43
44 Discussion and rationale: In a system where individually purchased and owned health expense
45 coverage becomes a popular alternative, the number of individuals opting out of employer-
46 provided group coverage may jeopardize the ability of those remaining in the group to obtain
47 economically-priced coverage, because of reduction in group size and bargaining power. The

1 use of voluntary choice cooperatives may be particularly important for the employers so
2 affected.

- 3
4 15. The AMA should continue to advocate Policy H-165.882(15), encouraging the formation of
5 group purchasing cooperatives by groups other than employers, with emphasis on formation of
6 such pools by organizations which are national or regional in scope and on assuring that such
7 pools offer a choice of plans.

8
9 Discussion and rationale: An important step in increasing the affordability of
10 individually-owned coverage is the ability to pool risks and achieve the premium and
11 administrative savings available through group coverage. Utilizing local employers, churches,
12 housing organizations, chambers of commerce, or other local groups as a pooling mechanism
13 for individually-owned coverage, however, could eliminate any real “portability” of coverage,
14 since the individual changing jobs or localities would need to leave one “pool” and enroll in
15 another with different premiums, benefits, and eligibility requirements. Alternative approaches
16 to pooling risks on a national, regional or at least statewide basis, through such geographically
17 broader groups as national unions, health insurance purchasing cooperatives (HIPCs), trade
18 associations and fraternal organizations would be needed to ensure both portability and the
19 savings inherent in group coverage. Unions in particular can assume new and pivotal roles as
20 coverage purchasing agents for their members -- an even more powerful incentive toward
21 union membership -- while educating them about choices and continuing to negotiate
22 employers’ direct contribution and maintenance of effort levels.

- 23
24 16. The AMA should reaffirm and assist state medical associations to aggressively advocate
25 Policy H-165.882(13) calling for legislation requiring community rating bands in the
26 individual coverage plans made available in all states under the Health Insurance Portability
27 and Accountability Act of 1996 (HIPAA).

28
29 Discussion and rationale: Insurance departments in Kansas, Missouri, Wisconsin, and other
30 states report that some companies are discouraging purchase of the individual plans guaranteed
31 available and renewable under HIPAA by charging very high premiums for such coverage--in
32 some cases up to five times the standard rate to persons with preexisting conditions. Enactment
33 of rate restrictions on individual policies in those states currently without them will be critical
34 to assuring access to coverage for individuals who seek non-employer-based coverage but do
35 not have access to other risk-pooling or group purchasing arrangements.

- 36
37 17. The AMA should encourage continued experimentation with and should monitor the success
38 of approaches to minimizing or compensating for adverse selection among the individual plans
39 available, including risk adjustment across plans, reinsurance pools, and limiting enrollment
40 and disenrollment opportunities through such mechanisms as multi-year policy contracts.

41
42 Discussion and rationale: While they will increase access to coverage, rating restrictions such
43 as community rating bands on individual plans can encourage healthy individuals to drop out
44 of the risk pool or to gravitate to less expensive plans, thus producing adverse selection.

45 Methods to compensate for such selection may be needed.

46 AREAS FOR FURTHER STUDY

47

1 In conjunction with the Council on Legislation, the Council on Medical Service will devote further
2 study to such specifics of implementation as methods for expediting the individual insurance
3 market protections and reforms called for; the desirable duration of employer maintenance of
4 effort requirements; the impact on spending of the federal tax changes proposed; and, on final
5 enactment of federal legislation implementing these tax changes, methods to avoid any increase in
6 state income tax liability that might otherwise result from changing from a tax exemption to tax
7 credits at the federal level. The Council will monitor the extent to which implementation of these
8 recommendations increases the proportion of Americans with adequate health expense coverage
9 and improves access to care, and will consider further steps to achieve these goals as needed.

10
11 RECOMMENDATIONS

12
13 Based on its study of this subject, the Council on Medical Service recommends adoption of the
14 following, and that the remainder of this report be filed:

- 15
16 1. That the AMA reaffirm Policy H-165.918(3), supporting availability of a choice of health care
17 financing mechanisms; Policy H-165.895(3), also supporting a wide choice of plans and
18 calling for a uniform employer contribution toward the employee's health expense coverage
19 regardless of the plan chosen, where the employer contributes to health plan costs; and
20 Policies H-165.985(1) and 285.998(1), calling for free market competition among all modes of
21 health care delivery and financing, with the growth of any one system determined by popular
22 preference and not preferential regulation or subsidy.
23
24 2. That the AMA support and advocate a health care financing system where individually-
25 purchased and owned health expense coverage is the preferred option, but where employer-
26 provided coverage is still available to the extent the market demands it.
27
28 3. That the AMA amend Policy H-165.920(3)(a) by addition and deletion to read as follows:
29 "Support legislation that would provide the employer with the same tax treatment for payment
30 of health ~~insurance premiums~~ expense coverage whether the employer provides the ~~health~~
31 ~~insurance plan coverage~~ for the employee or whether the employer provides a financial
32 contribution to the employee to purchase individually selected and individually owned health
33 ~~insurance~~ expense coverage, including the exemption of both employer and employee
34 contributions toward the individually owned insurance from FICA (Social Security and
35 Medicare) and federal and state unemployment taxes."
36
37 4. That the AMA support legislation requiring a "maintenance of effort" period, such as one or
38 two years, during which employers would be required to add to the employee's salary the cash
39 value of any health expense coverage they directly provide if they discontinue that coverage or
40 if the employee opts out of the employer-provided plan.
41
42 5. That the AMA strongly encourage through all appropriate channels the development of
43 educational programs to assist consumers in making informed choices as to sources of
44 individual health expense coverage.
45 6. That the AMA encourage employers, unions, and other employee groups to consider the merits
46 of risk-adjusting the amount of the employer direct contributions toward individually
47 purchased coverage. Under such an approach, useful risk adjustment measures such as age,

- 1 sex, and family status would be used to provide higher-risk employees with a larger
2 contribution and lower-risk employees with a lesser one.
3
- 4 7. That the AMA amend Policy H-165.920(6) by addition and deletion to read as follows:
5 “Supports the individual’s right to select his/her health insurance plan and to receive the same
6 tax treatment for individually purchased insurance coverage, for contributions toward
7 employer-provided coverage, as and for completely employer-purchased provided coverage.”
8
- 9 8. That upon legislative enactment of Recommendation 3 and 7, the AMA rescind Policy H-
10 165.995(2)(a), that calls for tax code changes to allow persons paying the entire premium for
11 their health insurance to deduct the full cost of their premium separately from their gross
12 income.
13
- 14 9. That AMA policy express a preference for replacement of the present exclusion from
15 employees’ taxable income of employer-provided health expense coverage with a tax credit for
16 individuals equal to a percentage of the total amount spent for health expense coverage by the
17 individual and/or his/her employer, up to a specified actuarial value or “cap” in coverage so as
18 to discourage over-insurance.
19
- 20 10. That the AMA amend Policy H-165.983, calling for all employers to provide private health
21 insurance coverage to all full-time employees to read: “The AMA (1) endorses the concept
22 that employers provide a defined contribution for the purchase of health expense coverage
23 within the private sector for all full-time employees.” The AMA should work with the
24 employer community in transitioning from the current employer-driven health insurance
25 system to the new patient driven system to assure that employers understand the merits of the
26 new system.
27
- 28 11. That AMA policy express a preference for relating the individual tax credit for all health
29 expense coverage expenditures by individuals and/or their employers to the individual’s
30 income, rather than being a uniform percentage of such expenditures.
31
- 32 12. That the AMA support strong tax incentives, such as making tax credits contingent on
33 purchase of a specified minimum level of coverage, as opposed to compulsory approaches, to
34 encourage individuals to obtain coverage providing a specified minimum level of protection
35 against out-of-pocket expense for health services and incorporating provisions of the AMA
36 Patient Protection Act, whether through a traditional insurance or managed care plan or a
37 medical savings account.
38
- 39 13. That the AMA amend Policy H-165.920(3)(d) by addition and deletion to read as follows:
40 “Work toward establishment of safeguards, such as a health care voucher system, to ensure
41 that to the extent that employer direct contributions made to the employee for the purchase of
42 individually selected and individually owned health insurance expense coverage continue,
43 such contributions are used only for that purpose when the employer direct contributions are
44 less than the cost of the specified minimum level of coverage. Any excess of the direct
45 contribution over the cost of such coverage could be used by the individual for other
46 purposes.”
47

- 1 14. That the AMA amend Policy H-165.882(14) by addition to read as follows: “Support federal
2 legislation to encourage the formation of small employer and other voluntary choice
3 cooperatives by exempting insurance plans offered by such cooperatives from selected state
4 regulations regarding mandated benefits, premium taxes, and small group rating laws, while
5 safeguarding state and federal patient protection laws. For purposes of such legislation, small
6 employers should be defined in terms of the number of lives insured, not the total number
7 employed.”
8
- 9 15. That the AMA amend Policy H-165.882(15) by addition to read as follows: “Through
10 appropriate channels, encourages unions, trade associations, health insurance purchasing
11 cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and
12 religious groups, ethnic coalitions, and similar groups to serve as voluntary choice
13 cooperatives for both children and the general uninsured population, with emphasis on
14 formation of such pools by organizations which are national or regional in scope.”
15
- 16 16. That the AMA reaffirm Policy H-165.882(13) which encourages state medical associations to
17 seek the introduction of or support legislation requiring the use of community rating bands in
18 the individual health expense coverage plans made available under provision of the Health
19 Insurance Accountability and Portability Act of 1996 (PL 104-191) in all states presently
20 without rating restrictions on such individual coverage plans.
21
- 22 17. That the AMA encourage continued experimentation with and monitor the success of
23 approaches to minimizing or compensating for adverse selection among the individually
24 purchased and owned health expense plans available, including risk adjustment across plans,
25 reinsurance pools, and limiting enrollment and disenrollment opportunities through such
26 mechanisms as multi-year policy contracts.

Appendix I

Definition of Selected Terms as Used in this Report

Health expense coverage: Private sector protection against the cost of health services, whether provided through traditional UCR-based or benefit payment schedule insurance policies, managed care plans, medical savings accounts, or employer self-insurance.

Employer-provided coverage: The employer arranges for employee health expense coverage, either through premium payments for such coverage or through self-insurance, and allocates part of the employee's total compensation to cost of that coverage.

Employer direct contribution: As part of his/her total compensation, the employee receives funds from the employer intended or earmarked for employee purchase of his/her own health expense coverage, in lieu of employer-provided coverage.

Employer defined contribution: Where a choice of coverage plans is available, the employer's allocation of funds toward purchase is equal irrespective of the plan chosen, and irrespective of whether the allocation is in the form of a direct contribution or employer-provided coverage. If in the form of a direct contribution, however, the amount may vary across employees, based on the individual's health risk.

Tax exemption: The exclusion of that portion of an individual's income allocated to purchase of health expense coverage from income tax.

Tax deduction: Same as a tax exemption; the only difference is that a deduction is taken at the time of income tax filing, while the exemption is simply not reported as taxable income.

Tax credit: A percentage of the individual's and/or employer's spending for health expense coverage which is directly subtracted from the individual's tax bill.

Tax subsidy: A generic term denoting a tax exemption, tax deduction or tax credit.

Appendix II

AMA Policies Related to Individually Selected, Purchased and Owned Health Insurance

H-165.918 Health Care Bill of Rights

The AMA will support health system reform plans that: (1) provide universal access free from rationing, and to include reasonable basic benefits, patient education, and significant patient responsibility for their own health care choices and behavior; (2) are not biased toward managed care and include a true fee-for-service option, including balance billing; (3) allow physicians and patients choice of plans and physicians; (4) alleviate regulatory hassles and preserve high quality care; (5) provide meaningful antitrust relief, including the ability for state and county medical associations to form partnerships of physicians for the purpose of being "accountable health plans;" (6) provide true tort reform; (7) provide significant insurance market reforms; and (8) recognize the physician's responsibility and authority in medical decision making and treatment in conjunction with the patient. (Sub. Res. 117, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmation A-97)

H-165.895 Health System Reform

Setting New Directions for 1995 and Beyond: The AMA will: (1) continue to vigorously pursue with Congress and the Administration the strengthening of our health care system for the benefit of all patients and physicians by advocating policies that put patients, and the patient/physician relationships, at the forefront. (2) seek an incremental approach to health system reform, targeted by patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, medical savings accounts, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patient Protection Act. (Reaffirmed by Sub. Res. 107, I-95). (3) further increase choice and cost consciousness by advocating the development of voluntary purchasing groups, a wide variety of choice of plans and, where an employer contributes to health plan costs, a standard dollar contribution toward an employee's insurance irrespective of the plan chosen. (4) fight for adequate funding for federal health care programs, in particular, Medicare and Medicaid; that AMA further advocate for long term reform of those programs which insures their effectiveness and fiscal soundness and against reimbursement reductions which promote cost shifting, diminish access and reduce the quality of care for beneficiaries. (BOT Rep. 36 - I-94; Reaffirmation A-97)

H-165.985 Opposition to Nationalized Health Care

The AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care: (1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion. (2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services. (Reaffirmed: BOT Rep. I-93-25; Reaffirmed: CMS Rep. I-93-5). (3) Full and clear information to consumers on the

provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one. (4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third-party allowance as payment in full for a service. (5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review. (6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans. (7) The expansion of adequate health expense protection to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, tax incentives to assist small employers in buying health insurance coverage, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level. (Reaffirmed: Sub. Res. 110, A-94). (8) Replacing the present Medicare program with a system developed by the AMA of pre-funded vouchers to older persons to purchase health insurance with comprehensive benefits, including catastrophic coverage. (9) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving. (BOT Rep. U, I-88; Reaffirmed: BOT Rep. I-93-40)

H-285.998 Managed Care

1. "Introduction" The needs of patients are best served by free market competition and free choice by physicians and patients between alternative delivery and financing systems, with the growth of each system determined not by preferential regulation and subsidy, but by the number of persons who prefer that mode of delivery or financing. 2. "Definition" "Managed care" is defined as those processes or techniques used by any entity that delivers, administers, and/or assumes risk for health care services in order to control or influence the quality, accessibility, utilization, or costs and prices or outcomes of such services provided to a defined enrollee population. 3. "Techniques" Managed care techniques currently employed include any or all of the following: (a) prior, concurrent, or retrospective review of the quality, medical necessity, and/or appropriateness of services or the site of services; (b) controlled access to and/or coordination of services by a case manager; (c) efforts to identify treatment alternatives and to modify benefits for patients with high cost conditions; (d) provision of services through a network of contracting providers, selected and deselected on the basis of standards related to cost-effectiveness, quality, geographic location, specialty, and/or other criteria; (e) enrollee financial incentives and disincentives to use such providers, or specific service sites; and (f) acceptance by participating providers of financial risk for some or all of the contractually obligated services, or of discounted fees. 4. "Case Management" Health plans using the preferred provider concept should not use coverage arrangements which impair the continuity of a patient's care across different treatment settings. With the increased specialization of modern health care, it is advantageous to have one individual with overall responsibility for coordinating the medical care of the patient. The physician is best suited by professional preparation to assume this leadership role. The primary goal of high-cost

case management or benefits management programs should be to help to arrange for the services most appropriate to the patient's needs; cost containment is a legitimate but secondary objective. In developing an alternative treatment plan, the benefits manager should work closely with the patient, attending physician, and other relevant health professionals involved in the patient's care. Any health plan which makes available a benefits management program for individual patients should not make payment for services contingent upon a patient's participation in the program or upon adherence to treatment recommendations.

5. "Utilization Review" The medical protocols and review criteria used in any utilization review or utilization management program must be developed by physicians. Public and private payors should be required to disclose to physicians on request the screening and review criteria, weighting elements, and computer algorithms utilized in the review process, and how they were developed. A physician of the same specialty must be involved in any decision by a utilization management program to deny or reduce coverage for services based on questions of medical necessity. All health plans conducting utilization management or utilization review should establish an appeals process whereby physicians, other health care providers, and patients may challenge policies restricting access to specific services and decisions to deny coverage for services, and have the right to review of any coverage denial based on medical necessity by a physician independent of the health plan who is of the same specialty and has appropriate expertise and experience in the field. A physician whose services are being reviewed for medical necessity should be provided the identity of the reviewing physician on request. Any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of services should be licensed to practice medicine and actively practicing in the same jurisdiction as the practitioner who is proposing or providing the reviewed service and should be professionally and individually accountable for his or her decisions. All health benefit plans should be required to clearly and understandably communicate to enrollees and prospective enrollees in a standard disclosure format those services which they will and will not cover and the extent of coverage for the former. The information disclosed should include the proportion of plan income devoted to utilization management, marketing, and other administrative costs, and the existence of any review requirements, financial arrangements or other restrictions that may limit services, referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients. It is the responsibility of the patient and his or her health benefits plan to inform the treating physician of any coverage restrictions imposed by the plan. All health plans utilizing managed care techniques should be subject to legal action for any harm incurred by the patient resulting from application of such techniques. Such plans should also be subject to legal action for any harm to enrollees resulting from failure to disclose prior to enrollment any coverage provisions; review requirements; financial arrangements; or other restrictions that may limit services, referral, or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patient. When inordinate amounts of time or effort are involved in providing case management services required by a third-party payor which entail coordinating access to other health care services needed by the patient, or in complying with utilization review requirements, the physician may charge the payor or the patient for the reasonable cost incurred. "Inordinate" efforts are defined as those "more costly, complex and time-consuming than the completion of standard health insurance claim forms, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payor coverage." Any health plan or utilization management firm conducting a prior authorization program should act within two business days on any patient or physician request for prior authorization and respond within one business day to

other questions regarding medical necessity of services. Any health plan requiring prior authorization for covered services should provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring prior authorization are recommended by the physicians. In the absence of consistent and scientifically established evidence that preadmission review is cost-saving or beneficial to patients, the AMA strongly opposes the use of this process. (Reaffirmed by Res. 716, A-95) (Joint CMS/CLRPD Rep. I-91; Reaffirmed: CMS Rep. I-93-5; Modified by CMS Rep. 3, I-96; Modified by CMS Rep. 4, I-96; Reaffirmation A-97)

165.920 Individual Health Insurance

The AMA: (1) Affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services. (Reaffirmed by CMS Rep. 7, A-97). (2) Recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access. (CMS Rep. 7, A-97). (3) Actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, the AMA will: (a) Support legislation that would provide the employer with the same tax treatment for payment of health insurance premiums whether the employer provides the health insurance plan for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that contributions made to the employee for the purchase of individually selected and individually owned health insurance are used for that purpose; (e) To ensure that the health insurance plan purchased by the individual employee is sufficient to provide a basic level of health care and does not increase the probability that the employee will become uninsured, the AMA would work toward the establishment of the following guidelines: (i) minimum benefit requirements, including catastrophic protection, (ii) fiscal solvency of the plan, (iii) provision of basic consumer information, (iv) protection of the consumer from fraud, (v) guaranteed issue, (vi) guaranteed renewability, and (vii) rate reform. (4) Will identify any further means through which universal coverage and access can be achieved. (Reaffirmed by Amended Sub. Res. 109, I-95; Reaffirmed by Rules & Credentials Cmt., A-96). (5) Supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage. (6) Supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased insurance as for employer-purchased coverage. (7) Strongly supports legislation promoting the establishment and use of medical savings accounts (MSA)s and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. (8) Continues to place a high priority on enactment of federal legislation to expand opportunities for

employees and others to individually own health insurance through vehicles such as medical savings accounts. (BOT Rep. I-93-41; CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended by CMS Rep. 7, A-97; Reaffirmation A-97)

H-165.995 Coverage of the Uninsured Through State Risk Pooling

(1) The AMA supports 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 AMA supports amendment of the federal tax code to (a) allow persons paying 100 percent of the premium for health insurance coverage providing adequate benefits to deduct the full cost of their premiums separately from their gross income; and (b) 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. (CMS Rep. J, I-85; Reaffirmed: Res. 241, A-93; Reaffirmed by CLRPD Rep. 2, I-95; Reaffirmed by CMS Rep. 6, I-96)

H-165.983 Covering the Uninsured

The AMA (1) endorses the concept of a phased-in requirement that employers (limited initially to larger employers) provide health insurance coverage within the private sector for all full-time employees, with coverage expanding over several years and with a program of diminishing tax credits or other incentives to avoid adverse effects on employers; (2) supports continued study of all approaches to providing health services for the uninsured and cooperation with business groups to develop approaches that are best suited to the needs of small employers; and (3) supports development of a package of basic health benefits in conjunction with other health organizations. (BOT Rep. JJ, A-89)

H-165.882 Improving Access for the Uninsured and Underinsured

The AMA recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access.

Improving Access for Uninsured Children

The AMA: (1) places particular emphasis on advocating policies and proposals designed to expand the extent of health expense coverage protection for presently uninsured children in accordance with AMA policy H-165.920(2) the AMA recommends that the funding for this coverage should preferably be used to allow these children, by their parents or legal guardians, to select private insurance rather than being placed in Medicaid programs; (2) supports, and encourages state medical associations to support, a requirement by all states that all insurers in that jurisdiction make available for purchase individual and group health expense coverage solely for children up to age 18; (3) encourages state medical associations to support study by their states of the need to extend coverage under such children's policies to the age of 23; (4) seeks to have introduced or support federal legislation prohibiting employers from conditioning their provision of group coverage including children on the availability of individual coverage for this age group for direct

purchase by families; (5) advocates that, in order to be eligible for any federal or state premium subsidies or assistance, the private children's coverage offered in each state should be no less than the benefits provided under Medicaid in that state and allow states flexibility in the basic benefits package; (6) advocate that state and/or federal legislative proposals to provide premium assistance for private children's coverage provide for an appropriately graduated subsidy of premium costs for insurance benefits that meet the standards of the AMA standard benefit package; (7) supports an increase in the federal and/or state sales tax on tobacco products, with the increased revenue earmarked for an income-related premium subsidy for purchase of private children's coverage; (8) advocates consideration by Congress, and encourage consideration by states, of other sources of financing premium subsidies for children's private coverage; (9) supports and encourages state medical associations and local medical societies to support, the use of school districts as one possible risk pooling mechanism for purchase of children's health insurance coverage, with inclusion of children from birth through school age in the insured group; (10) supports and encourages state medical associations to support, study by states of the actuarial feasibility of requiring pure community rating in the geographic areas or insurance markets in which policies are made available for children; (11) encourages state medical associations, county medical societies, hospitals, emergency departments, clinics and individual physicians to assist in identifying and encouraging enrollment in Medicaid of the estimated 3 million children currently eligible for but not covered under this program.

Improving Access for All Uninsured Persons

The AMA: (12) will assist state medical associations and local medical societies to work with states and the insurance industry to design value-based private group and individual health insurance policies. Such policies should cover with low cost-sharing those services adjudged to have the greatest health benefit, should be affordable, and should be equivalent to or an improvement over the Medicaid coverage in that state, so as to provide a continuum of gradually enhanced coverage; (13) encourages state medical associations to seek the introduction of or support legislation requiring the use of community rating bands in the individual policies made available under provisions of the Health Insurance Accountability and Portability Act of 1996 (PL 104-191) in all states presently without rating restrictions on such individual policies; (14) support federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes and small group rating laws, while safeguarding state and federal patient protection laws; (15) through appropriate channels, encourages trade associations, unions, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions and similar groups to serve as group purchasing cooperatives for both children and the general uninsured population. (CMS Rep. 7, A-97)