

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Mitigating the Negative Effects of High-Deductible Health Plans
(Resolution 125-A-19)
(Reference Committee G)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting, the House of Delegates referred the enclosed Resolution 125, which was sponsored by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Resolution 125-A-19 directed the American Medical Association (AMA) to advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2020 Annual Meeting.

While increasing access to health insurance has been beneficial to patients, critical challenges persist regarding health care access. Even when a service is covered by a health plan, patients may incur significant costs in the form of copayments, coinsurance, and/or large medical bills that they must pay before meeting their deductibles. Such costs have been shown to cause people, especially those with low incomes and/or chronic conditions, to forgo necessary care, and these challenges can be exacerbated in the context of high-deductible health plans (HDHPs).

This report examines clinical and financial challenges associated with HDHPs, explores several potential strategies for improvement, and makes recommendations to mitigate the negative effects of HDHPs. Specifically, in addition to reaffirming highly relevant policy, this report recommends that the AMA encourage further research and advocacy to develop and promote innovative health plan designs; that employers be encouraged to provide robust education to help patients make good use of their benefits to obtain the care they need, collaborate with their employees to understand employees' health insurance preferences and needs, tailor benefit designs to employees' preferences and needs, and pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs out across the plan year; and that state and national medical specialty societies be encouraged to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2, November 2020

Subject: Mitigating the Negative Effects of High-Deductible Health Plans
(Resolution 125-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

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2 was sponsored by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and
3 Vermont. Resolution 125-A-19 directed the AMA to advocate for legislation or regulation
4 specifying that codes for outpatient evaluation and management services, including initial and
5 established patient office visits, be exempt from deductible payments. The Board of Trustees
6 assigned this item to the Council on Medical Service (CMS) for a report back to the House of
7 Delegates at the 2020 Annual Meeting. This report examines clinical and financial challenges
8 associated with high-deductible health plans (HDHPs), explores several potential strategies for
9 improvement, and makes recommendations to mitigate the negative effects of HDHPs.

10 BACKGROUND

11 HDHPs are insurance plans associated with lower premiums, higher deductibles, and greater cost-
12 sharing requirements as compared with traditional health plans.¹ Both enrollment in HDHPs and
13 the size of deductibles has increased dramatically in recent years. In 2019, approximately 30
14 percent of enrollees in employer-sponsored health plans were covered by HDHPs, compared to 4
15 percent in 2006.² The imposition of greater consumer cost-sharing is frequently described as a
16 means of ensuring that those receiving health care services “have skin in the game,” and used as a
17 lever to minimize the growth of health insurance premiums.
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21 However, while an HDHP’s lower premium may be enticing, higher patient cost-sharing can lead
22 to significant challenges. Reductions in health care spending achieved through HDHPs have been
23 found to be due to patients simply receiving less medical care.³ Moreover, HDHPs appear to
24 reduce health care spending by decreasing the use of both appropriate care (such as recommended
25 cancer screenings) and less appropriate care (such as low-severity emergency department visits).⁴
26 Studies have found that families who have members with chronic disease and who are enrolled in
27 HDHPs are more likely to go without care due to cost and/or face substantial financial burdens,
28 such as trouble paying bills, than families enrolled in traditional plans.⁵ Another study found that
29 enrollment in an HDHP combined with a savings account led to significant increases in out-of-
30 pocket (OOP) spending, with more than half of the enrollees with lower-incomes and more than
31 one-third of the enrollees with chronic conditions facing “excessive financial burden.”⁶
32

33 The challenges of underinsurance and cost-related nonadherence (CRN) which can negatively
34 affect patient care in general can be exacerbated in the context of HDHPs. Rates of underinsurance
35 (e.g. OOP costs that are high relative to income) have risen. Even when a service is covered by a
36 health plan, patients may incur significant costs in the form of copayments, coinsurance, and/or

1 large medical bills that they must pay before meeting their deductibles. Such costs have been
 2 shown to cause people, especially those with low incomes and/or chronic conditions, to forgo
 3 necessary care.⁷ Similarly, CRN refers to a state in which patients are unable to pursue
 4 recommended medical care due to financial barriers.⁸ CRN and sub-optimal patient use of
 5 evidence-based medical services can lead to negative clinical outcomes, increased disparities, and
 6 in some cases, higher aggregate costs.⁹ CRN has been identified across the entire continuum of
 7 clinical care, including physician visits, preventive screenings, and prescription drugs,¹⁰ and the
 8 challenges of CRN may be magnified by the COVID-19 pandemic as payers experience financial
 9 pressure and strive to lower medical spending.¹¹ CRN is especially problematic for vulnerable
 10 populations, such as those with multiple chronic conditions, lower socioeconomic status, and/or
 11 belonging to diverse racial or ethnic groups.¹² For example, a recent study found that HDHPs were
 12 associated with cost-related barriers to care for cancer survivors, and these barriers were
 13 significantly greater for Black patients.¹³ Additionally, greater OOP costs for medication to treat
 14 certain chronic conditions has been found to reduce initiation and adherence, lower the likelihood
 15 of achieving desired health outcomes, and sometimes, increase utilization of acute care services.¹⁴
 16 At the same time, studies have demonstrated that reducing or eliminating cost-sharing leads to
 17 improvements in medication adherence¹⁵ and reductions in health disparities based on
 18 socioeconomic status and race.¹⁶

19
 20 In addition to increases in deductible spending, total patient OOP spending has also risen
 21 significantly in recent years. Total OOP spending, which includes pre-deductible spending,
 22 copayments, and coinsurance, increased by 54 percent between 2006 and 2016.¹⁷ Intensifying this
 23 challenge is the fact that over the past decade, growth in OOP costs has outpaced increases in
 24 workers' wages.¹⁸ The COVID-19 pandemic highlighted critical shortcomings, with many health
 25 plans not providing affordable coverage for services to treat many chronic conditions and COVID-
 26 19-related illness.¹⁹ In fact, 68 percent of adults said that OOP costs would be very or somewhat
 27 important in their decision to get care if they had COVID-19 symptoms.²⁰

28
 29 To help offset the burdens of higher deductibles and greater cost-sharing that patients face when
 30 enrolled in HDHPs, plans and employers can make available one or more of several tax-advantaged
 31 savings accounts including: Health Savings Accounts (HSAs), Health Reimbursement
 32 Arrangements (HRAs), Flexible Spending Arrangements (FSAs), and for certain small employers
 33 or self-employed individuals, Medical Savings Accounts (MSAs).²¹ Each of these savings accounts
 34 has unique benefits and drawbacks, and the "best option" is very case specific. However, many
 35 patients do not, or cannot, optimally utilize savings accounts to help them offset OOP costs
 36 associated with HDHPs.²² In light of these significant financial concerns, more needs to be done to
 37 ensure access to necessary, high-value care.

38
 39 **POTENTIAL STRATEGIES FOR IMPROVEMENT**

40
 41 Resolution 125-A-19 recommended that outpatient evaluation and management services, including
 42 initial and established patient office visits, be exempt from deductible payments in an effort to
 43 improve patient health and decrease total health care costs. The AMA supports innovative benefit
 44 designs that could allow certain physician services and prescription drugs to be provided pre-
 45 deductible. Moreover, in CMS Report 1-I-20, the Council is recommending that health plans be
 46 incentivized to offer pre-deductible coverage including physician services in their bronze plans, to
 47 maximize the value of zero-premium plans to plan enrollees. This is similar to the requirement that
 48 catastrophic plans sold on health insurance exchanges must cover at least three primary care visits
 49 per year pre-deductible.²³ Pre-deductible coverage for certain physician visits in these specific
 50 contexts, however, is a significant departure from pre-deductible coverage for all physician visits in
 51 all contexts.

1 When health plans become more generous in exempting additional items and services from a
 2 deductible, other elements of benefit design become less generous (ie, more costly to the enrollee)
 3 to counterbalance the additional cost. In theory, over a long time horizon with a consistent enrollee
 4 base, a health plan might find long-term cost savings, such as through decreases in hospital
 5 admissions or emergency department visits, to offset short-term cost increases associated with
 6 increased generosity in services exempt from deductibles. However, when short-term costs are
 7 critical, such as in health insurance exchanges and among plans sponsored by employers in
 8 industries that experience high levels of employee turnover, short-term costs heavily influence
 9 benefit design. In the health insurance exchanges, increases in plan generosity cause an increase in
 10 actuarial value (AV) of a health plan, and the plan must become less generous in other domains to
 11 maintain its AV. For example, in a study designed to test how plans could provide more generous
 12 coverage for high-value services, the more generous coverage for some services had to be offset by
 13 less generous coverage of other services in order to maintain required AV.²⁴ Similarly, in the
 14 private market, health plans might increase premiums or impose greater cost-sharing on some items
 15 or services to compensate for decreased cost-sharing for other items and services.

16
 17 While high deductibles and OOP costs pose a significant challenge to many, this challenge is not
 18 universal, so it is important to recognize that blunt instruments that simply cause health care costs
 19 to shift among deductibles, cost-sharing, and premiums will be reallocating the burden of health
 20 care costs among a general population with very disparate health care utilization. US health care
 21 spending is dramatically concentrated, with very few individuals incurring very large shares of
 22 spending, while other large portions of the population incur very little spending. In fact, in 2016,
 23 half of the population had health spending under \$971, accounted for only 2.8 percent of total
 24 health spending in the US, and incurred average OOP health care spending of only \$73.²⁵ In
 25 contrast, 10 percent of the population had health spending of at least \$12,024, accounted for 66
 26 percent of total US spending, and incurred average OOP spending of \$2,380.²⁶

27
 28 *Benefit Design Initiatives*

29
 30 Rather than applying a blunt instrument that categorically shifts health care costs, health plans
 31 could be designed with “clinical nuance,” a principle of value-based insurance design (VBID).
 32 “Clinical nuance” recognizes that medical services may differ in the amount of health produced,
 33 and that the clinical benefit derived from a specific service depends on the person receiving it, as
 34 well as when, where, and by whom the service is provided.²⁷ The same service could be high-value
 35 to one patient and low-value to another, and the ability of patients and their physicians to make this
 36 determination on a case-by-case basis is critical and well-supported by AMA policy. Achieving
 37 truly nuanced plan design is a laudable goal and one that VBID researchers have been pursuing for
 38 over a decade²⁸ with some progress. For example, the US Department of Treasury recently released
 39 Notice 2019-45, allowing HSA-HDHP plans the flexibility to cover specified medications and
 40 services used to treat chronic diseases prior to meeting the plan deductible.²⁹ While the list of
 41 specified medications and services is limited, it is a decisive step in the direction of expanding
 42 health plan flexibility to improve affordable access to high-value care.

43
 44 More recently, legislative and regulatory changes have further expanded HSA-HDHPs’ capacity
 45 for clinical nuance in the context of COVID-19. Explicitly recognizing the potential administrative
 46 and financial barriers to care present for individuals enrolled in HSA-HDHPs, the Internal Revenue
 47 Service (IRS) issued Notice 2020-15 to remove those barriers in the context of the unprecedented
 48 public health emergency.³⁰ Specifically, Notice 2020-15 makes another limited exception to the
 49 general rules governing qualification for HSA-HDHPs to allow health plans the flexibility to cover
 50 testing and treatment of COVID-19 pre-deductible and without imposition of patient cost sharing.
 51 Many of the nation’s leading insurance companies pursued this opportunity and waived patient

1 cost-sharing for COVID-19-related testing, but the scope and duration of these waivers varies
2 across insurers.³¹ IRS Notice 2020-29 further clarified that the testing and treatment of COVID-19
3 that can be provided pre-deductible includes the panel of diagnostic testing for influenza A & B,
4 norovirus and other coronaviruses, and respiratory syncytial virus (RSV).³² Additionally, the
5 Coronavirus Aid, Relief and Economic Security (CARES) Act created a temporary safe harbor
6 allowing HDHPs to cover telehealth services and other remote care without cost to participants
7 before their deductibles are met.³³ The safe harbor is currently in effect until the end of 2021.³⁴ It is
8 up to payers, though, to implement plan changes to take advantage of this legal flexibility, and it
9 remains to be seen how much relief patients will experience. As understanding of the clinical
10 impacts of COVID-19 continues to evolve and patients begin experiencing long-term impacts from
11 the infection, patients have reported receiving medical bills totaling tens of thousands of dollars for
12 treatment for COVID-19 and complications.³⁵

13
14 A second key consideration is that to effectively enhance patients' access to high-value care, health
15 plans must make high-value care across the clinical continuum affordable. Making physician visits
16 more affordable is therefore a necessary, but insufficient, step toward achieving the improved
17 access goal of Resolution 125-A-19. If only physician office visits are targeted for deductible
18 exemption, some patients and physicians may be frustrated to realize that they can identify a
19 problem but lack the resources to resolve it. For example, consider the scenario where patients can
20 visit their physician and learn that they are at risk for diabetes without incurring costs under their
21 health plan, but to pursue necessary testing, pharmaceuticals, and medical devices, they must pay
22 OOP until reaching their deductibles. In fact, a recent study found that patients enrolled in an
23 HDHP who received a prescription for a brand name antihyperglycemic medication were less
24 likely to refill that prescription than were patients enrolled in non-HDHP plans who were
25 prescribed the same medicine.³⁶ This study suggests that HDHP enrollment can impact the quality
26 and delivery of care for patients with type 2 diabetes when branded antihyperglycemic medications
27 offer optimal disease management.³⁷ Similarly, another study found that patients with diabetes
28 experienced minimal changes in outpatient visits and disease monitoring after switching to an
29 HDHP, but low-income, high-morbidity, and HSA-HDHP subgroups experienced major increases
30 in emergency department visits or expenditures for preventable acute diabetes complications.³⁸

31
32 However, VBID can be applied to reduce some of the negative impacts of HSA-HDHPs and reduce
33 health care disparities. A recent study found that when HSA-HDHPs incorporate a preventive drug
34 list (PDL) which exempts specific high-value classes of medications from deductibles, patients
35 experienced substantial decreases in annual OOP costs, increased medication utilization, and lower
36 barriers to initiating treatment.³⁹ The study authors emphasized the importance of these findings for
37 patients with lower incomes and encouraged employers to consider tailoring their benefit designs to
38 concentrate PDL coverage in lower-income employees who may benefit most from the subsidized
39 coverage. Additionally, a recent study demonstrated that an "HDHP+," a hypothetical HSA-HDHP
40 that would reduce cost-sharing for certain high-value items and services intended to treat chronic
41 conditions, would likely save the federal government money, and at a minimum, be cost neutral.⁴⁰
42 Moreover, plans that apply VBID principles to HDHPs could improve health equity by ensuring
43 that all enrollees can afford high-value services, even during the deductible phase of their
44 coverage.⁴¹ At the same time, especially with such complex benefit designs, active counseling to
45 help enrollees understand the value of their benefits may be critical to the success of these
46 programs.⁴² Collectively, these studies reinforce the principle that mitigating the deleterious effects
47 of HDHPs will require efforts from stakeholders from across the health care continuum.

1 *Payer-Driven Initiatives*

2
3 In addition to considering alternative benefit design strategies that incentivize use of high-value
4 care, payers can adopt strategies to minimize the deleterious effects of high deductibles. Given the
5 trend of increasing patient OOP spending, payers could nevertheless soften the burden of these
6 increasing OOP costs on patients and their physicians. Two key variables add to the stress of
7 increasing OOP patient spending – first, the extent to which health care expenditures may need to
8 be paid in large lump sums, and second, the extent to which patients and their physicians are unable
9 to anticipate how much a given item or service will cost a patient OOP. When deductibles reset
10 every year on January 1, many patients, including the 60 percent of Americans living with at least
11 one chronic condition, may face significant OOP costs.⁴³ Patients may delay or forgo necessary
12 care early in the year when they are facing the full OOP burden of their deductibles and have not
13 accumulated funds in health savings accounts. In fact, it has been shown that nearly all incremental
14 reductions in high-deductible health care spending occur while patients are subject to their
15 deductibles.⁴⁴ Moreover, for patients enrolled in plans with coinsurance, the cost of health care
16 items and services often cannot be known in advance, even after they have met their deductibles. In
17 contrast, plans designed with copayments allow patients and their physicians to anticipate patient
18 OOP costs.

19
20 Copayments are the most common form of patient cost-sharing associated with physician visits,⁴⁵
21 but with the increasing use of HDHPs, increasing numbers of patients and physicians are facing
22 high deductibles and unpredictable bills for coinsurance. From 2007 to 2017, among patients with
23 large employer coverage, coinsurance, deductible, and patient OOP spending increased, and
24 copayment spending decreased.⁴⁶ In 2019, approximately 15 percent of patients enrolled in an
25 HDHP paired with a savings account were subject to copayments for a physician office visit, with
26 68 percent subject to coinsurance.⁴⁷ The opposite pattern is present for patients enrolled in non-
27 HDHP plans – between 86 and 95 percent of patients in non-HDHP plans paid copayments for
28 physician office visits, with only 4 to 11 percent paying coinsurance.⁴⁸ With patients bearing
29 increasing OOP health care costs, health plans that allow patients to predict their OOP costs in
30 advance and also spread their OOP expenses over time may present a more patient-friendly and
31 physician practice-friendly benefit design.

32
33 Employers, in specific, play a unique role as designers of employee health care benefits, and
34 employers can choose to deploy a variety of strategies to encourage patients to pursue the care they
35 need. Benefit packages are increasingly important to employees, with employees seeking choice
36 and personalization, and looking to their employers to provide the tools they need to make good
37 decisions.⁴⁹ Employers can take a variety of actions to make the health insurance benefits they
38 offer valuable and accessible to their employees. For example, in 2019, JPMorgan Chase provided
39 employees with health plans that applied lower deductible and coinsurance maximum amounts to
40 lower-income employees.⁵⁰ For 2020, some JPMorgan Chase and Amazon employees have even
41 more innovative plan options via the Haven Healthcare program, the venture among JPMorgan
42 Chase, Amazon, and Berkshire Hathaway. Few details are available, but reporting indicates that the
43 JPMorgan Chase plans remove patient deductibles, and copayments for most services range from
44 \$15 to \$110.⁵¹ Employers have a variety of more incremental options for tailoring the health plans
45 they offer to their employees' needs. Some potential options for employers to consider include:

- 46
47 • Seed and/or match employee contributions to one or more types of savings accounts that
48 can be used for health care expenses to encourage savings and use of these savings
49 accounts. Employers contributing to employees' HSAs can improve employee awareness,
50 consideration, and ultimately adoption and self-funding of HSAs.⁵² Research indicates that
51 on average, employees contribute 10 percent more to their HSAs each year when their

1 employer seeds money to their HSAs, and 59 percent of employees would contribute more
 2 to their HSAs if their employer provides a matching contribution.⁵³ However, a recent
 3 study found that 55 percent of employers offering HSA-HDHPs do not make contributions
 4 toward their employees' HSAs.⁵⁴

- 5 • When possible, grant employees access to the full annual employer and/or employee
 6 contribution to a savings account at the beginning of a plan year so that patients can
 7 pursue care as they need it, rather than delaying care until savings have accumulated.
- 8 • Provide, and perhaps incentivize employees to participate in, robust health insurance and
 9 financial literacy campaigns that give them tools to choose the plan that best meets their
 10 needs and identify affordable care options throughout the plan year. When making
 11 decisions about health care savings, patients must navigate a complex set of choices, and
 12 even those with high financial literacy have trouble deciding where to save and how to
 13 spend.⁵⁵ For example, a 2018 study found that 69 percent of employees who did not enroll
 14 in an HSA say they chose not to enroll because they did not see any benefits to an HSA,
 15 did not understand what HSAs do, or simply did not take the time to understand the HSA.
 16 Moreover, only 15 percent of employees with high financial literacy choose to save their
 17 HSA money for the future.⁵⁶ Educational campaigns could include practical information
 18 regarding which items and services are available without patient cost-sharing pre-
 19 deductible and information about how funds placed in an HSA, HRA, FSA, MSA, or other
 20 savings account can be used to pay for health expenses. Via online and in-person
 21 education, employers can provide decision support and care navigation tools to help their
 22 employees at the time of health insurance enrollment and throughout the year.⁵⁷
- 23 • Consider how predictable copayments vs. variable coinsurance can influence patient
 24 tendencies to pursue necessary health care and provide patients with a variety of health
 25 plan design options whenever possible.
- 26 • Collaborate with organized medicine to ensure that their innovations in plan design are
 27 likely to achieve intended clinical goals, as well as enhanced access to affordable care.

28
 29 *Physician Practice Initiatives*

30
 31 Physician practice initiatives focused on helping patients with high deductibles can serve
 32 physicians and the patients in their care. High deductibles burden patients and their physicians
 33 when patient fears about cost of care impair joint patient-physician decision-making and care
 34 planning. High deductibles also pose billing and collection challenges for physician practices.
 35 Fortunately, there are tools available that can help physicians and their practices. The
 36 administrative simplification provisions of the Health Insurance Portability and Accountability Act
 37 (HIPAA) related to standard electronic transactions and associated operating rules empower health
 38 care providers to obtain real-time information regarding patients' health plan coverage and
 39 financial obligations. Specifically, the operating rules for the electronic eligibility standard
 40 transaction require health plans to respond in real-time (within 20 seconds)⁵⁸ to health care
 41 providers' electronic requests for information about patients' health plan benefits.⁵⁹
 42 Implementation of this legal requirement has been imperfect⁶⁰ – challenges persist – but the
 43 eligibility operating rules provide physicians with an avenue to obtain necessary data to inform
 44 their practice and their physician-patient joint decision-making. Specifically, physician practices
 45 can ascertain the patient's portion of the financial responsibility, including copayment, coinsurance
 46 and patient-specific remaining deductible. This information can help practices estimate patient
 47 costs before treatment decisions are made, and in some cases, collect patient deductibles and/or
 48 coinsurance before patients leave the office.⁶¹ To empower physicians to implement and exercise
 49 their rights under the HIPAA administrative simplification provisions and to streamline their
 50 practices' billing processes, the AMA has published several toolkits and educational resources,

1 including those entitled, “[What you need to know about electronic eligibility verification](#),”
 2 “[Managing patient payments](#),” and “[Electronic transaction toolkits for administrative](#)
 3 [simplification](#), which includes a resource on [Compliance in standard electronic transactions:](#)
 4 [Responsibilities of health plans and physicians](#).”⁶²

5
 6 RELEVANT AMA POLICY

7
 8 AMA policy strongly supports value-based care, VBID, and innovative insurance design. Policy
 9 H-185.939 broadly supports flexibility in the design and implementation of VBID programs and
 10 outlines a series of guiding principles including that VBID explicitly consider the clinical benefit of
 11 a given service or treatment when determining cost-sharing or other benefit design elements. Policy
 12 D-185.979 also supports clinical nuance in VBID to respect individual patient needs and supports
 13 legislative and regulatory flexibility to accommodate VBID, including innovations that expand
 14 access to affordable care, such as changes needed to allow HSA-HDHPs to provide pre-deductible
 15 coverage for preventive and chronic care management services. Policy D-185.979 also encourages
 16 national medical specialty societies to identify services that they consider to be high-value and
 17 collaborate with payers to experiment with benefit plan designs that align patient financial
 18 incentives with utilization of high-value services. Consistent with calls to remove legislative and
 19 regulatory barriers to innovative plan design, Policy H-165.856 states that the regulatory
 20 environment should enable rather than impede private market innovation in product development
 21 and purchasing arrangements and further states that benefit mandates should be minimized to allow
 22 markets to determine benefit packages and permit a wide choice of coverage options. Policy
 23 H-450.938 provides principles to guide physician value-based decision-making, and Policy
 24 H-155.960 supports value-based decision-making among other broad strategies for addressing
 25 rising health care costs. Moreover, this policy recognizes the role of physician leadership and
 26 collaboration among physicians, patients, insurers, employers, unions, and government in
 27 successful cost-containment and quality-improvement initiatives. The policy encourages third-party
 28 payers to use targeted benefit design, whereby patient cost-sharing is determined based on the
 29 clinical value of a health care service or treatment, with consideration given to further tailoring
 30 cost-sharing to patient income and other factors known to impact compliance. AMA policy also
 31 supports value-based pricing for pharmaceuticals (Policy H-110.986) and providing patients with
 32 information and incentives to encourage appropriate utilization of preventive services (Policy
 33 H-390.849).

34
 35 Policy H-165.846 states that provisions must be made to assist individuals with low-incomes or
 36 unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing
 37 obligations. Policy H-165.828 encourages the development of demonstration projects to allow
 38 individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze
 39 plan, to have access to an HSA partially funded by an amount determined to be equivalent to the
 40 cost-sharing subsidy. That policy also supports education regarding deductibles, cost-sharing, and
 41 HSAs. Policy H-165.852 supports, as an integral component of AMA efforts to achieve universal
 42 access and coverage and freedom of choice in health insurance, legislation promoting the
 43 establishment and use of HSAs and allowing the tax-free use of such accounts for health care
 44 expenses. That policy also supports the enhancement of activities to educate patients about the
 45 advantages and opportunities of HSAs. In addition, Policy H-165.854 supports HRAs as a
 46 mechanism for empowering patients to have greater control over their health care decision-making.

47
 48 DISCUSSION

49
 50 The Council lauds the sponsors of Resolution 125-A-19 for highlighting key challenges that
 51 HDHPs present to both patients and physicians, and it shares the goal of reducing barriers to

1 necessary health care. The Council is committed to developing AMA policy to mitigate the
 2 negative impacts of HDHPs that is consistent with the broader context of AMA policy on health
 3 reform and value-based decision-making. To accomplish this goal, the Council believes that the
 4 AMA should encourage further research and advocacy to develop and promote innovative health
 5 plan designs, including designs that can recognize that medical services may differ in the amount
 6 of health produced and that the clinical benefit derived from a specific service can vary among
 7 patients. Such policy would be consistent with AMA policy regarding “clinical nuance” in VBID
 8 (Policy D-185.979) and policy encouraging private market innovation in product development and
 9 purchasing arrangements (Policy H-165.856). Recognizing that more than half of Americans under
 10 age 65 get their health insurance through an employer,⁶³ employers have a powerful role to play in
 11 designing health plans to meet their employees’ needs and educating their employees about the
 12 benefits provided by the health plans. Accordingly, the Council recommends that employers should
 13 be encouraged to collaborate with their employees in ways that help them to better understand their
 14 employees’ health insurance preferences and needs, tailor the benefits they offer to meet the
 15 preferences and needs of employees and their dependents, and provide robust education to help
 16 patients make good use of their benefits to obtain the care they need. Moreover, to ease the
 17 financial burden of large lump sum expenditures, the Council recommends that employers pursue
 18 strategies to help enrollees spread the costs associated with high OOP costs across the plan year.
 19 Additionally, consistent with Policy H-155.960, which highlights the importance of collaboration
 20 among physicians and employers in successful cost-containment and quality-improvement
 21 initiatives, the Council encourages state medical associations and state and national medical
 22 specialty societies to actively collaborate with payers as they develop innovative plan designs to
 23 ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.
 24 In addition, to emphasize the importance of health plans designed with “clinical nuance,” the need
 25 for legislative and regulatory flexibility to accommodate innovations in health plan design that
 26 expand access to affordable care, and the critical role of collaboration among national medical
 27 specialty societies and payers in designing innovative health plans, the Council recommends
 28 reaffirming Policy D-185.979. Similarly, to highlight the importance of robust education regarding
 29 deductibles, cost-sharing, and health care savings accounts, and to amplify the AMA’s support for
 30 funding health savings accounts, the Council recommends reaffirming Policy H-165.828.
 31 Moreover, the Council notes that in CMS Report 1-I-20, it recommends incentivizing health plans
 32 to offer pre-deductible coverage, including physician services in bronze plans, to maximize the
 33 value of zero-premium plans to plan enrollees.

34

35 RECOMMENDATIONS

36

37 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
 38 125-A-19 and that the remainder of the report be filed:

39

- 40 1. That our American Medical Association (AMA) encourage ongoing research and advocacy to
 41 develop and promote innovative health plan designs, including designs that can recognize that
 42 medical services may differ in the amount of health produced and that the clinical benefit
 43 derived from a specific service can vary among patients. (New HOD Policy)
- 44
- 45 2. That our AMA encourage employers to: (a) provide robust education to help patients make
 46 good use of their benefits to obtain the care they need, (b) take steps to collaborate with their
 47 employees to understand employees’ health insurance preferences and needs, (c) tailor their
 48 benefit designs to the health insurance preferences and needs of their employees and their
 49 dependents, and (d) pursue strategies to help enrollees spread the costs associated with high
 50 out-of-pocket costs across the plan year. (New HOD Policy)

- 1 3. That our AMA encourage state medical associations and state and national medical specialty
2 societies to actively collaborate with payers as they develop innovative plan designs to ensure
3 that the health plans are likely to achieve their goals of enhanced access to affordable care.
4 (New HOD Policy)
5
- 6 4. That our AMA reaffirm Policy D-185.979, which supports health plans designed to respect
7 individual patient needs and legislative and regulatory flexibility to accommodate innovations
8 in health plan design that expand access to affordable care, and which encourages national
9 medical specialty societies to identify services that they consider to be high-value and
10 collaborate with payers to experiment with benefit plan designs that align patient financial
11 incentives with utilization of high-value services. (Reaffirm HOD Policy)
12
- 13 5. That our AMA reaffirm Policy H-165.828, which supports education regarding deductibles,
14 cost-sharing, and health savings accounts (HSAs), and encourages the development of
15 demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego
16 these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an
17 amount determined to be equivalent to the cost-sharing subsidy. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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