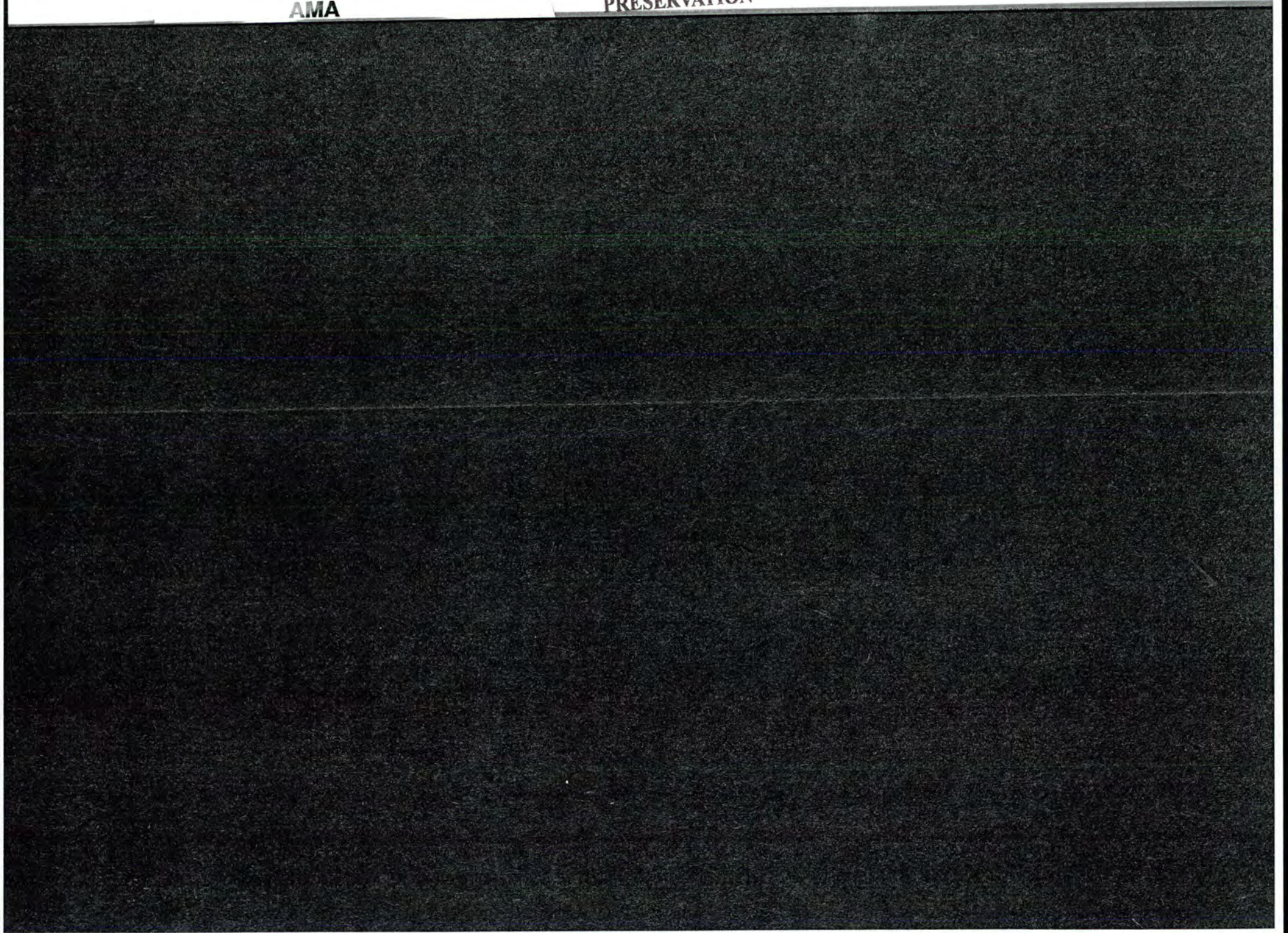

fee AMA

IN NOTING ABSENCE, A.M.A. SEES A SNUB

Doctors' Group Upset With Clinton for Not Sending Top Aide to Gathering

By ROBERT PEAR
Special to The New York Times

NEW ORLEANS, Dec. 6 — Struggling to quell a revolt within their ranks, leaders of the American Medical Association criticized the Clinton Administration today for not sending any high-ranking officials to their convention here to defend the President's plan to overhaul the nation's health care system.

The association supports Mr. Clinton's goal of guaranteeing health insurance coverage for all Americans. But with many elements of the Clinton plan coming under fire from doctors, there was no one here to speak for the White House, to rebut the critics or to defend the President's proposal to require all employers to provide insurance for their employees.

Doctors said that the absence of high-ranking Administration officials was notable because the position of the association itself was in flux, and that there was a lot of misinformation circulating about the President's plan. Moreover, officials of the association said that they told the White House last week that they expected a groundswell of opposition to parts of the Clinton plan, and that they suggested that the President or his aides hold a meeting for doctors here to allay their concerns.

Some See Signs of Drift

Hillary Rodham Clinton got an enthusiastic reception when she spoke to the medical association six months ago in Chicago. But since then, the White House seems to have lost political control of the health care issue, and Democrats in Congress say they detect ominous signs of drift in the Administration's campaign. Rival proposals to revamp the health care system are being taken more seriously. And the White House, after searching for several months, has still not named anyone to coordinate efforts by the Administration and its allies to secure passage of comprehensive health care legislation.

"We blocked out time for a discussion of health care reform this afternoon, in case there was some senior official from the Administration, but that just did not materialize," said Dr. Daniel H. Johnson Jr., speaker of the house of delegates of the medical association, the group's policy-making body.

Dr. Joycelyn Elders, the Surgeon General, has a seat in the house of delegates by virtue of her Government position. But she is not here. By contrast, Dr. C. Everett Koop used to attend regularly when he was Surgeon General in the Reagan Administration.

The highest-ranking Administration official in attendance at the association's convention here was Dr. Philip R. Lee, an Assistant Secretary of Health and Human Services, who flew in for the day on Saturday to discuss the training of doctors. But the debate today involved bigger questions about the political and economic feasibility of the Clinton plan.

Clinton Aides 'Booked Up'

The association has more than 290,000 members, accounting for nearly half of the nation's doctors, and runs an influential, well-financed lobbying operation in Washington. The house of delegates includes doctors from every state and from more than 80 medical specialty societies.

In Washington, Jeffrey L. Eller, a White House spokesman, said today that the President, Mrs. Clinton and their aides were "booked up" and did not have time to attend the association's convention. But he said the Administration intended to continue working with the association.

Leaders of the medical group say they are trying to be helpful to the Administration and need all the help they can get from the White House. The doctors are considering a significant change in policy: backing away from their position in support of a Federal law requiring employers to provide health insurance for their employees. The proposal for such an employer mandate is a central element of Mr Clinton's plan to guarantee insurance coverage for all Americans.

Dr. Raymond Scalettar, former chairman of the association, said today: "It would have been useful for Administration officials to express themselves at this meeting and to explain why they view an employer mandate as the only way to go. If Administration spokesmen had appeared, they would have been welcomed, ushered in and given the opportunity to speak."

In the absence of such spokesmen from the Administration, "many doctors are beginning to have second thoughts about the employer mandate," Dr. Scalettar said. "As they deal with patients who have small businesses, they are being asked to reconsider."

'Intolerable Burden'

Doctors from nearly a dozen states have endorsed resolutions saying that an employer mandate would, in the words of the Indiana delegation, "place an intolerable burden on small businesses."

Some doctors say this is a pocketbook issue for the doctors, because they themselves run small businesses and would have to provide comprehensive insurance coverage for all their office workers under the Clinton plan.

Mr. Eller, the White House spokesman, expressed no great concern about the possibility of a change in association's policy. "If there is a better way to reach the ultimate goal of universal coverage with comprehensive benefits but no employer mandate," he said, "we will seriously consider it."

Melanie

THE PRESIDENT'S Rx FOR HEALTH CARE:
HOW PHYSICIANS ANALYZE THE PLAN

This model op-ed is based upon the testimony of James S. Todd, MD, Executive Vice President, American Medical Association, on Oct. 5, 1993, to the U.S. Senate Committee on Labor and Human Resources. It may be submitted as written, or modified as the user deems appropriate.

"Are you for the President's plan for health system reform or against it?"

That's the question most doctors like myself are getting everyday, and like most doctors, I do not have a simple answer.

There is much in the plan that is good for patients, good for physicians and good for the country.

If you ask your own doctors, I bet they tell you they will be among the first to applaud President Clinton, along with the First Lady, for providing leadership on health system reform.

At the same time, if they are really honest about it, I bet they tell you they are uneasy about some of the strategies the President would use to achieve basic goals that we all agree on.

Fighting for reform is nothing new for medicine. In fact, the general goals in the President's plan mirror what the American Medical Association first called for nearly four years ago in its own plan, *Health Access America*.

Both the AMA and the President want to build on what already works so well. Both would make certain that the system works fairly for everyone. And both understand the need for the system to be disciplined at the same time it provides our patients with a measure of quality they can count on.

The AMA and the President agree on the need for:

* Universal coverage.

* A national package of health benefits that emphasizes preventive care.

* A requirement that all employers share in the responsibility of providing coverage that most employees already enjoy, with safeguards for small business and its workers.

* Insurance reforms that require carriers to insure risk, not avoid it.

* A competitive marketplace where health care costs at all levels have to be justified.

* A variety of health plan options, with patients having the freedom to choose, as a means to guaranteeing access and quality of care.

These are principles that physicians began discussing with the new Administration last winter, and I am pleased that many of our suggestions were accepted.

In other areas, however, I do not see the necessary level of physician participation on behalf of patients in some crucial aspects of the plan.

But I understand the door is still open, and like many of my colleagues, I am encouraged that the President has signalled a willingness to negotiate specifics.

Physicians need answers to many questions about how the plan will be implemented. Questions like:

1. Why, in the effort to cut waste, doesn't the plan limit liability costs by capping damages juries can award and limiting attorneys' fees?

2. Why do unfair antitrust restraints still prevent physicians from protecting their patients' interests in a health care market that is falling under the domination of large managed care entities?

3. Why is there so much reliance on price controls and strict spending limits when leading economic experts have testified they won't work?

4. If a new National Health Board is supposed to better regulate the health care system, why isn't it open to greater participation by physicians and organized medicine?

5. Why does government want to call the shots on medical education by dictating to students the career they must follow -- something done in no other academic field in this nation?

6. Will a new bureaucracy of quality oversight lacking adequate participation by practicing physicians improve the system or simply escalate costs?

Before physicians can decide if they support or oppose the President's plan, they will need to see detailed answers to these questions.

In the meantime, just like all Americans, doctors like

myself continue to weigh the other plans for reform that are being offered by both Republicans and Democrats. None of these are perfect, either, nor would we expect them to be at this stage of the process.

What is important is that they are on the table in the first place. Health system reform has finally been elevated to the level where real and lasting change is not just possible, but probable.

Much remains, however, to close the gap between probability and reality. As the debate heats up in the months ahead, I plan to focus on at least two important propositions.

First, patients must have the freedom to choose their own physician and hospital.

Second, physicians must be able to provide necessary, effective and efficient care without undue restrictions on their clinical judgment.

The health system that will work will be the system that passes those tests.

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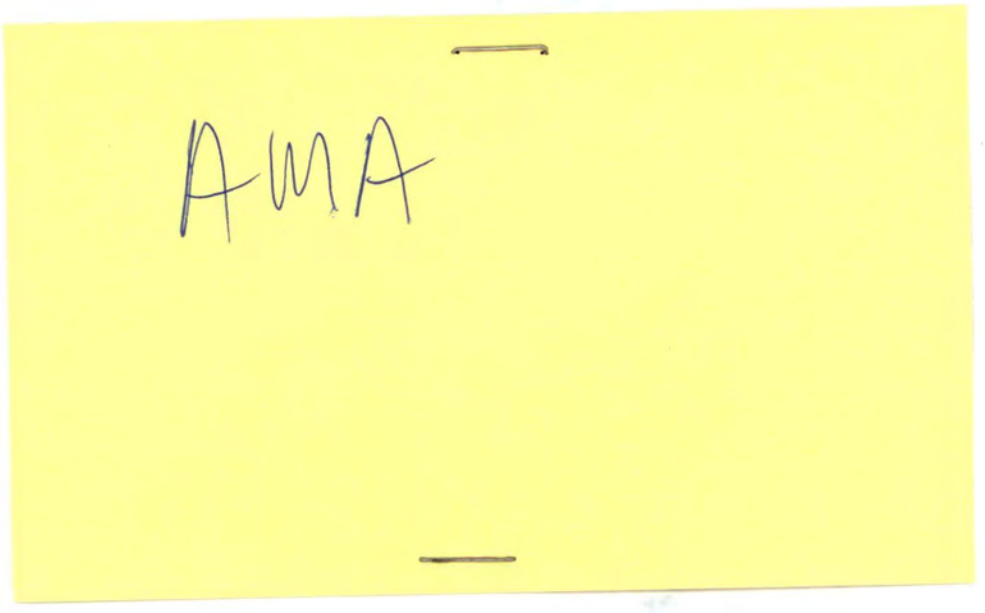
AMA

American Medical Association
Physicians dedicated to the health of America

515 North State Street
Chicago, Illinois 60610

Statement

to the

Committee on Labor and Human Resources
United States Senate

RE: PHYSICIAN'S VIEW OF THE PRESIDENT'S HEALTH PLAN

Presented by: James S. Todd, MD

October 5, 1993

Division of Federal Legislation
312 464-4775

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Committee on Labor and Human Resources

United States Senate

Physician's View of the President's Health Plan

Presented by: James S. Todd, MD

October 5, 1993

Mr. Chair and Members of the Committee:

My name is James S. Todd, MD, Executive Vice President of the American Medical Association (AMA). Accompanying me is David L. Heidorn, JD, of the AMA's Division of Federal Legislation.

On behalf of the AMA's 300,000 member physicians, I am pleased and honored to be able to share with you what I believe many individual physicians would say about the President's proposal for health system reform if they had this opportunity to be here and talk with you today.

The President's proposal is long awaited. Physicians know the limitations of the current system. They see the difficulties far too many of Americans have finding affordable, adequate health care coverage. For the past four years, the AMA has been telling whomever would listen about the need for comprehensive reform and a way to achieve meaningful change through our own proposal, **Health Access America**. Before that, we helped organize an effort of leaders

among physicians, a wide range of health care providers, academia, and both federal and state government to define the difficulties and solutions needed to address problems in the health care system -- called **Health Agenda for the American People** -- well before the problems of the health care system captured the public's attention as they have in the last several years.

We have long understood that problems with America's health care system had to be addressed, that the status quo was no longer sufficient. We applaud President Clinton for his resolve in addressing these problems, in taking the first necessary step to end the status quo. Likewise, we applaud the First Lady for her leadership in the difficult process of framing the President's proposal. It is encouraging to physicians that the President has signalled a willingness to negotiate details of the plan as long as such negotiation does not undermine the basic principles of reform. We look forward to such negotiations as the package proceeds through the Congress.

For these reasons alone, I can confidently say that the Administration, the Congress, the medical profession and others can move forward into a new era of health system reform.

Building Fairness into What Works

Our confidence that we can accomplish our joint goals is fueled by how much there is in President Clinton's proposal that reflects our own plan for health system reform. Most importantly, we share President Clinton's intended goal of building on what works well in the system now, not replacing it or tearing it down. We also recognize that a strong theme in the President's proposal is enforcing fairness on a system that, for all the world-leading wonders in medical care it makes readily available to most Americans, does not fairly ensure that all Americans have access to that same level of care.

Every American should have coverage so that the system is available to every American, and the rules of the system should work the same for everyone. President Clinton's proposal would make a great leap in ensuring that they will -- by making sure that all employers share in the responsibility of offering health care coverage that most employees in America have long enjoyed; by defining at the national level a package of health care benefits including preventive care that will be available to all Americans; by requiring health insurers to insure risk, not avoid or limit it; by reconstructing federal tax incentives so that the self-employed are treated the same as large corporations, and ending federal tax dollar underwriting of health care benefits richer than the nationally defined benefit package; and by establishing reasonable cost-sharing requirements that will encourage individuals to assume a level of responsibility for the health care choices they make. We are also encouraged that the plan recognizes the need for liability reform to be part of health system reform.

These changes alone would bring about a resolution of many of the difficulties our patients now experience in the health care system. Even more is needed, though. Unfortunately, many of the directions taken in the President's proposal beyond these basic principles create in physicians serious reservations about the effect the proposal, if enacted as it stands today, would have on the ability of physicians to provide quality health care to their patients.

One Measure: The Physician-Patient Relationship

There is only one measure by which physicians will judge this proposal -- how will it affect the ability of a physician and his or her patient together to make whatever decisions are necessary about the patient's medical needs. When a physician sits in an examining room with a patient facing a difficult, often life-threatening moment of decision, the physician needs to

know, without doubt, that a decision can be made solely in the best interests of that patient's health and well-being, nothing else. As the President's proposal stands now, far too much could come between the physician and patient at that moment of truth, making it difficult to make the best possible decisions on behalf of patients.

The combination of arbitrary global budgets, premium caps and the need to save dollars by plans could necessitate many of the same intrusive controls and second guessing of physician decisions that exist in many of today's tightly controlled insurance plans. Such interference is, has been, and continues to be inappropriate. It is inappropriate now when insurance companies arbitrarily second-guess physicians' clinical decisions in utilization review or force physicians to step out of the examining room to seek preauthorization for necessary care. It is inappropriate when the threat of liability action forces physicians to order tests that would not be necessary in a less hostile environment.

Under a new health care system, we must avoid interference that results from decisions about the availability and quality of health care made from a bureaucratic, centralized place, distant from the patient's bedside, and disconnected from the needs of a physician's individual patient. There are many positive aspects of the President's plan that could and should be carried out with little government involvement, however new levels of bureaucracy are envisioned at the federal, state, and corporate levels. Physicians wonder what role will be left for them in the new system.

Federal Interference

At the federal level, a national health board of seven individuals would have sole responsibility for establishing, administering, and disciplining the system proposed by the

President. One of its key responsibilities would be to enforce global budgets on health care spending. If such budgets were truly targets, meant as a flexible guide established with the help of physicians to assist in identifying cost difficulties and specific solutions, reflecting changing demographics and specific health care needs across the population, the AMA could support them. Instead, the "targets" here are strict spending controls based solely on changes in the Consumer Price Index and enforced through the cost of insurance premiums, with potential assessments on providers.

Nowhere in the world, in any kind of system that delivers any service or good to anyone, have such spending controls ever worked. Their implementation does nothing to control the demand for services and often times increases that demand. Such controls result in arbitrary maldistribution of services that often falls far short of meeting consumers' needs. With health care in the United States, the result will be no different. Treatment plans on how to meet individual patient needs now made between a physician and a patient in the physician's examining room could be made instead in Washington, DC. Physicians cannot accept this limitation. We do not believe our patients will either when beneficial care is not promptly available. That is not the kind of reform the American people are expecting.

Physicians have the same kinds of concerns about the control the federal government will be taking over the supply of physicians under the President's proposal. By mandating medical schools to train 50% of their physicians in primary care and allocating medical residency slots through new national and regional graduate medical education councils, the federal government will essentially nationalize medical education in this country. While there is a need for more primary care physicians throughout the nation, the incentives to practice primary care included

in the President's plan, along with changes in the health care marketplace that are already happening, may well be enough to encourage and enable medical students to pursue primary care. The AMA has advocated for these same incentives for a long time. They should finally be given an opportunity to work.

State Interference

At the state level, health alliances, as proposed in the President's plan, will only add to this bureaucratization of the health care system, providing another layer of decision-making which could undermine the physician-patient relationship. The AMA has watched with interest the development of the concept of health alliances in the managed competition proposals that have come before Congress. In a pure managed competition approach, health alliances -- or insurance purchasing cooperatives -- would act simply as unbiased conduits between health insurance plans and consumers, acting to organize the market under rules that apply equally to all. There is a need for such a role to be played to help small businesses organize their purchasing power in the insurance market. Such a system -- the Federal Employee Health Benefit Plan (FEHBP) -- provides health benefits to federal workers, members of Congress, and their dependents. With little bureaucracy, FEHBP empowers individuals to make rational insurance purchasing decisions based on their needs and desires. The American people deserve no less.

President Clinton's proposal for health alliances goes beyond this basic need, however, giving alliances what will amount to regulatory command and control authority, in concert with the national board, to enforce premium prices on insurance plans and exclude plans with higher premiums. Authority also is given to alliances to determine what kinds of health plans would be allowed to compete by limiting the number of fee-for-service plans under an alliance. This

is not competition. We recognize the need to manage competition fairly, but this limitation is not fair and is not going to promote competition, which is the only way that cost-effectiveness and quality health care can be guaranteed. An open fee-for-service plan should be available in every area of the country.

The proposal for health alliances is also problematic in that it requires all employers with up to 5000 employees to purchase coverage through them. Such a high threshold will give alliances far too much market power in a state or region, choking off pluralism and competition in a market. It is truly small employers, those with less than 500 employees, that need government help in pooling their resources to buy insurance, not employers with thousands of employees. Government involvement should be limited to where there is a need, allowing competition to work where it is able. Allowing medium sized employers to maintain their own plans will provide an appropriate counterbalance to the power of the alliance and will provide freedom for an expanded number of plans in any particular geographic area.

Corporate Interference

Finally, physicians see the erosion of their professional decision-making role and their ability to represent the best interests of their patients in the overwhelming preference the plan gives to what will no doubt become large corporate managed health care entities. The AMA does not oppose managed care. We understand the current economic pressures that are already pushing more and more physicians into managed care arrangements. That is competition, for now. A health care reform plan should not, however, codify that marketplace phenomenon. If fee-for-service is truly noncompetitive, our patients should make that decision, not the federal government. Government action should at least be neutral, or, where there is a dominance in a

market, should help balance the marketplace to encourage competition.

Instead, we see an overly narrow definition of fee-for-service under a proposal labeled fee-for-service that eliminates many of the elements of fee-for-service. Rather than giving physicians and patients the ability to choose how and where medical care is delivered, and how much the service should cost, the government will impose a price on services that all physicians choosing to practice outside large managed care entities will have to accept. It is doubtful whether many physicians will be able to make this choice outside of already underserved areas of the country where managed care corporations will not find it cost-effective to go. In a short time, managed care will have no competition in the marketplace. A physician will have little choice if she or he cannot agree to managed care decisions that limit her or his ability to meet patient's medical needs. Such a situation is unacceptable to physicians. The fee-for service option, as proposed by the President combined with the global budget would limit patient freedom of choice to only an IPA/HMO type of fee-for service plan.

True fee-for-service, without arbitrary constraints, should be given an opportunity to fully compete in a new health system. Instead of price controls, a reimbursement system based on the RBRVS could be created, giving patients an opportunity to compare prices based on physicians' choices of conversion factors they individually want to apply.

Also needed are greatly expanded protections from anti-trust constraints for physicians to ban together and organize networks to compete with the accumulation of health care market power in large corporate entities. Physician organizations like the AMA should be allowed to represent physicians. Current restraints on such activities are already no longer valid where individual physicians have little choice but to accept arrangements offered to them.

Physicians also must be given the opportunity to compete for patients in such markets, by requiring dominant managed care entities to allow physicians who meet credential requirements to provide care under a managed care arrangement. Large corporate entities should not be allowed to freeze otherwise qualified physicians out of providing needed care to their patients if those patients want to choose that physician.

Financing

Fueling physicians' concern over the President's proposal is the light brush that has been given to financing the plan. The key revenue source offered is a continued federal cutback in Medicare and Medicaid funding. Not only is this unacceptable to physicians and their patients who rely on these already underfunded programs, it is doubtful that this can be a reliable revenue source to fund the expansion of health care access hoped for in the proposal. An increased "sin" tax on tobacco has been proposed by the President, which the AMA would support. We would also support increased taxes on alcohol as well as increased cost savings that will come with administrative savings envisioned in the plan.

With some reservations, the administrative cost savings offered in the plan are laudable and necessary. But given the bureaucratization of health care at the federal, state, and corporate level provided in the plan, we see, in fact, greater administrative costs, not less. For example, the National Board will have numerous sub boards and commissions, such as in quality, benefits, graduate medical education, that will all need to develop complex rules and regulations. A system that adds levels of management, not reduces them, can only be more expensive. The absurd duplication of oversight over the physician-patient relationship physicians now experience under insurance company control will not lessen under a system dominated by large corporate health

care entities; more oversight is only added through the new state and federal superstructure of control. We simply do not see sufficient administrative cost savings in the President's proposal.

And where there are unnecessary costs in the system in the high cost of liability both in litigation costs and defensive medicine, the President's proposal takes too little action. To ensure such high costs do not continue under a new system, initiatives similar to those taken by California under its MICRA liability reform law should be enacted. A $250,000 limit on noneconomic damages must be established if true cost savings are to be achieved, and limits on attorneys' fees significantly below the 33 1/3 percent limit proposed by the plan are needed. That is no limit at all, since this is the typical share of awards taken from their clients now.

Physicians need to know from where the actual financing of the President's proposal will come.

Conclusion

The President and the First Lady should receive full credit for advancing the health reform issues and ensuring that health system reform has finally begun. Now, Congress has an unprecedented opportunity to enact legislation that will change forever the way health care is delivered in this nation. It is our intent to help ensure that change is for the positive, so that all Americans can receive the high quality, personal medical care that most Americans now receive from their physicians. That is our goal.

My comments today are general. It is my intent to provide an overview of our more basic concerns as the President's proposal applies to physicians' ability to continue to serve in their professional role of providing medical care to their patients, without constraint, a matter on which physicians have serious reservations. (A detailed response to the President's plan is attached.)

As the members of this Committee well know, many hearings can and will be held on these and many more specific issues over the next several months. I hope and trust that the AMA will have the opportunity to make more specific comments when the time is appropriate.

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American Medical Association

Physicians dedicated to the health of America

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Memo to: Washington Representatives
National Medical Specialty Societies

From: Richard A. Deem
Specialty Society Coordinator

Date: January 11, 1994

Subject: Health System Reform Planning Meeting - January 18

In order to better coordinate lobbying efforts to achieve common goals, the AMA Government Affairs staff will hold a health system reform planning meeting on Tuesday, January 18, 1994 from 2:00 p.m. to 4:00 p.m. in our Washington office (Conference Room #1, 12th Floor).

Aside from sharing the latest intelligence, our primary objective is to identify specific issues on which your specialty society may be interested in joining a coalition effort.

Attached is a suggested outline of issues which may lend themselves to effective coalition efforts. This list is a starting point for the discussion. The AMA is interested in other suggested topics or possible modification of this list. Attendees should be prepared to discuss their specialty society's priority issues.

Please RSVP to Jean Sanders at 202-789-7410.

We look forward to seeing you on January 18.

DRAFT

SUGGESTED ISSUES FOR COALITION ACTIVITIES

AMA'S AGENDA FOR THE FUTURE AND PATIENT CHOICE

Desired Outcome: (1) Expanded authority for physicians to negotiate with all health care plans including a physician organized structure within managed care plans to deal with medical practice matters. (2) Modify safe harbor zones to allow physician groups, representing up to 50% of the market in non-exclusive networks and 35% in exclusive networks, to negotiate payment levels and other practice matters with third party payers. The 50% and 35% limits would also apply to joint venture activities. (3) Eliminate regulatory barriers that impede the formation of physician sponsored networks. (4) Seek legislation and incentives to overcome the financial barriers to the formation of physician networks. (5) Seek adoption of negotiated rulemaking for key federal and state regulations.

PROFESSIONAL LIABILITY REFORM

Desired Outcome: (1) Adoption of $250,000 cap on non-economic damages. (2) Reduced limits on attorney fees (sliding scale below 33-1/3%). (3) Statute of limitations to limit time period for filing claims. (4) Prohibit the public release of all information in the NPDB.

GLOBAL BUDGETS/PREMIUM CAPS

Desired Outcome: (1) Eliminate regulatory, price control/global budget authority of National Health Board. (2) Replace premium caps/global budgets with negotiated goals approach that involve physicians in establishing reasonable spending goals that take into account demographic, disease, technology, and demand factors.

MEDICARE & MEDICAID CUTS

Desired Outcome: (1) Reduce aggregate level of Medicare spending cuts. (2) Assure that new Medicare benefits are properly financed to avoid annual cuts in provider payment levels. (3) Oppose 3% reduction in '95 CF. (4) Oppose MVPS for hospital in-patient services. (5) Seek modification of proposed MVPS and default formula. (6) Oppose financing of proposed 10% increase in practice values for primary care services. (7) Oppose/modify competitive bidding proposal for selective services. (8) Modify centers of excellence provisions.

PHYSICIAN WORKFORCE

Desired Outcome: (1) Modify and reduce scope of National Council on Graduate Medical Education. (2) Oppose federal authority to allocate numbers and types of residency slots. (3) Adopt incentive based alternative to mandatory quota approach to increase the number of primary care physicians.

SCOPE OF PRACTICE

Desired Outcome: Modify/eliminate federal standards for scope of practice. (2) Assure proper collaboration and supervision of limited license practitioners.

ALLIANCES/ACCOUNTABLE HEALTH PLANS

Desired Outcome: (1) Alliance participation should be voluntary. (2) Threshold to opt out of an alliance (if it were mandatory) should be between 100-500 employees. (3) Establish defined physician role on alliance boards. (4) Require alliances to accept all qualified plans and to eliminate 120% rule. (5) Require disclosure of physician selection and UR criteria as well as provider due process procedures for denials and exclusions.

FEE FOR SERVICE PLANS

Desired Outcome: (1) Eliminate ban on balance billing. (2) Ensure reasonable co-pays for fee-for-service plan and point of service option. (3) Eliminate prospective budgeting for fee-for-service option.

QUALITY

Desired Outcome: (1) Obtain formal recognition for private sector efforts as an alternative to new federal system of quality management. (2) Reduce overlap and duplication in proposed quality management program. (3) Require formal physician representation if National Quality Management Council is established.

ADMINISTRATIVE SIMPLIFICATION

Desired Outcome: (1) Maximum possible reduction in CLIA burden. (2) Ensure confidentiality of medical records.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 1-93-52

Subject: Health System Reform Update

Presented by: Lonnie R. Bristow, MD, Chair

Referred to: Reference Committee A
(J. William Cox, MD, Chair)

This informational report presents an update on the American Medical Association's (AMA) recent efforts to advance the AMA's health system reform policy and goals. Section I of this report provides a review of President Clinton's health system reform proposal, the "Health Security Act of 1993" (HR 3600; S 1757), and identifies elements of the proposal that are consistent with AMA policy and *Health Access America*. Those elements of the proposal that are inconsistent with policy and to which the AMA will aggressively pursue modifications during debate and reconciliation of health system reform legislation in the Congress are also identified. Because this report was written just prior to introduction of the actual legislative bill, language quoted herein is from the proposal as presented to the Congress in late October 1993. Section II of this report discusses the current legislative reform environment and provides an overview of several major congressional reform proposals and highlights some major areas of consistency and inconsistency between these congressional alternatives and AMA policy *Health Access America*.

The Board of Trustees recognizes that it is unlikely that either the Administration's proposal or the proposals offered by members of Congress will pass in their entirety or without significant modifications. Therefore, as part of its overall strategy on reform in the months ahead — and to help ensure reform legislation that is most consistent with the AMA's goals and policies — the AMA will continue to act as a constructive agent for change, advocating meaningful and effective reform legislation that incorporates the "best" elements of proposals advanced by the Administration and the Congress.

A complete summary and analysis of the President's legislative reform proposal, the "Health Security Act of 1993," is provided in a separate memorandum to the House of Delegates at this meeting, along with a review of the major Congressional reform bills/proposals offered to date.

SECTION I: THE CLINTON HEALTH SYSTEM REFORM PLAN

The AMA's health system reform policy, as outlined in *Health Access America*, has helped drive the national reform debate for over three years and has positioned the AMA as a leading proponent of change. As the reform debate has advanced to the top of the nation's legislative agenda, the AMA has been aggressively advocating and communicating its reform position to the Administration, the Congress, and the general public on such key issues as universal coverage, cost containment through market forces, a standard benefits package, the right to negotiate, antitrust relief, professional liability reform, quality of care, and patient and physician

freedom of choice. With release of the President's reform proposal in October 1993, the Board of Trustees, with the advice of the Technical Advisory Committee on Health System Reform (TAC), completed a comprehensive review of the proposal, using *Health Access America* as a foundation for evaluation. Based on this review, provisions of the Administration's proposal that are consistent with AMA policy have been identified.

Specifically, provisions of the Administration's legislative reform proposal that are consistent with AMA policies and positions include:

- universal coverage and access to services through a phased-in requirement that employers provide health insurance to workers and their families, with appropriate financial assistance for small employers;

- insurance market reforms, including community rating, portability of coverage, and elimination of preexisting condition clauses;

- some ERISA reforms to help ensure that self-insured firms have to comply with federal standards;

- a uniform, comprehensive benefit package for all Americans that is generally consistent with AMA's own recommendations, although mental health/substance abuse benefits in the Administration's package have been scaled back to comply with actuarial estimates;

- Medicaid reform with the extension of the uniform benefits package to all low-income individuals; and

- administrative simplification to include development of a single claim form and disclosure and standardization of utilization review criteria.

Furthermore, the Board of Trustees and the TAC believe that the AMA's overall strategy to remain an active participant in all stages of the reform process facilitated a number of positive changes between the Administration's September draft plan and the current legislative reform language. This strategy is consistent with policy approved by the House of Delegates in Board of Trustees Report OO (Policy 165.945, *AMA Policy Compendium*) on obtaining the best possible outcome on health system reform for patients and physicians. This strategy was aided by concerted media pressure and the AMA's focused initiatives to position the AMA as a constructive agent for change.

To date, the AMA and Federation leaders have participated in over a dozen meetings with senior policy officials of the Administration and members of the White House Task Force Working Groups to advance the AMA's reform policies and positions. The Board recognizes full well that substantial modifications to the Administration's reform proposal are still needed. However, judicious and persistent AMA efforts to date have successfully promoted the following changes as the proposal has evolved over recent months:

- Physicians and physician organizations, including medical societies, are now authorized to collectively negotiate fee schedules for fee-for-service plans with states and health alliances.

- The practice of medicine was added as an "area of expertise" that could qualify an individual to serve on the National Health Board.

- Regional health alliances' proposed authority to limit the number of fee-for-service plans to three in a given geographic area — a restriction that did not apply to either the low-cost-sharing plan (e.g., HMO) or combination cost-sharing plan (e.g., PPO) in a given geographic area — was eliminated.

- The fee-for-service alternative became a serious option after the AMA presented convincing arguments about the importance of patient choice.

- All low-cost-sharing plans, including HMOs, are now required to offer a point-of-service option by which individuals can receive services outside the plan. However, individuals may be required to pay higher premiums and co-payments for this option.

- Although the professional liability sections of the Administration's bill are not yet adequate, if it were not for the AMA and the united Federation effort, enterprise liability may have resulted rather than the bill's current provisions.

Overall, the Board is pleased that several elements of the Administration's proposal — particularly universal coverage and access through a reasonable and fair employer requirement, a comprehensive benefits package, and some administrative simplification — are congruent with long-standing AMA policy and positions included in *Health Access America*. The AMA's positive impact on some elements of the reform proposal prior to its introduction as legislative language is also encouraging. However, many central elements of the Administration's proposal require major modifications to be in concert with organized medicine's goals on health system reform. These issues of concern are described below, along with the specific changes the AMA will pursue in Congress as the debate shifts from the White House to Capitol Hill.

ISSUES OF CONCERN AND NEEDED CHANGES

Under the Administration's legislative reform proposal, new government roles — and new bureaucratic structures — could direct the health care marketplace, as evidenced by the (1) scope and authority given the National Health Board, (2) the structure and function of the mandated "regional health alliances," and (3) the design and operations of the "accountable health plans." A review of each of these elements is presented below, along with other major elements of the Administration's proposal that will require major modifications.

National Health Board

The Administration's proposal would create a "National Health Board" (NHB), within the executive branch of the federal government, to set national standards and oversee the establishment and administration of the health system by states. The NHB would consist of seven members appointed by the President and confirmed by the Senate to staggered four-year terms. Individuals would be selected for membership on the NHB based on experience/expertise

in relevant subjects, including the practice of medicine, health care financing delivery, state health systems, consumer protection, business, law, nursing or other clinical practice, and delivery of care to vulnerable populations. During the term of employment, members would serve as employees of the federal government and could not hold other employment.

The duties of the NHB include: interpreting and updating the benefits package; developing and implementing standards for a national health information system; administering cost containment provisions, including determining caps on insurance premium increases; establishing and having responsibility for a performance-based system of quality management and improvement, and developing a risk-adjustment methodology for payment of premiums to accountable health plans.

Overall, the NHB represents a new federal bureaucracy with broad, centralized regulatory authority over the health care marketplace that could quickly lead to difficulties in heath care access and quality. The AMA has strongly voiced its objections to such an approach and will emphasize the following changes to the NHB provisions in the Congress:

- Oppose any authority of such a Board to set premium caps.

- Replace structure of the proposed NHB with a truly representative, national commission that is advisory in nature.

- Substantially reduce span of NHB authority. Areas of responsibility should be limited to such issues as recommending updates to the benefit package.

- Reserve a place on the national-level board/commission for an AMA physician representative.

Health Alliances

The Administration's proposal would create new entities — "regional health alliances" — that would act as conduits between health plans and purchasers of insurance coverage. All individuals and employers with less than 5000 employees would have to purchase insurance exclusively through a regional health alliance. The alliances would contract with state-certified health plans to provide the comprehensive benefit package and to provide consumers a choice among three different types of health plans, e.g., HMO, PPO, and fee-for-service. Employers with over 5000 workers could "opt-out" of the regional alliance and either self-insure or buy insurance or health services directly from health plans, but such employers would have to offer employees the same type of choices and benefits as those offered by the regional alliances.

Regional alliances could be either state agencies or quasi-governmental agencies. In the latter case, alliances would be governed by a board of directors with equal representation of employers and consumers; no providers could serve. Each state would determine how many alliances to have and what their geographic boundaries would be, although alliances could not compete with one another. It has been reported that in about 35 states, health dollars flowing through the alliances would exceed the dollars in the entire state budget, which creates an incentive to make the alliance a state agency.

Responsibilities of the regional alliances include: negotiating insurance premiums with health plans; collecting insurance premiums from employers and employees; calculating the appropriate payment to health plans, based on the number of subscribers to each plan; providing easily understood information to consumers/patients on plan cost, characteristics, availability of professionals, restrictions to providers/services; and having responsibility for developing an annual quality performance report to help consumers make comparisons among plans. In addition, alliances could refuse to contract with any health plan that failed to meet prior contracts or if the proposed premium exceeds 120% of the alliance's per-capita premium target.

Through the monopsony-like purchasing power granted to the alliances, these entities could substantially reduce (1) incentives for competition and innovation in the insurance market and (2) consumer choice by excluding those health plans with higher premiums from competing for subscribers. The AMA has strongly voiced its objections to such an approach and will continue to advocate constructive alternatives to the alliance concept that would accomplish the same goals of making insurance more affordable and accessible to individuals and small business — without creating the tightly structured format for the purchase of health insurance through the government-designed and created entities envisioned by the Administration in their proposal. Specific alternatives to the Administration's proposed alliance provisions that the AMA will aggressively pursue in Congress include the following:

- Create state-level risk pools that would act as conduits/information brokers for the provision of private health insurance to ensure that individuals and small employers can obtain affordable coverage, as advocated in *Health Access America*.

- Enable states to pursue reform initiatives similar to the Hawaii approach — and independent of the alliance construct — with a community-rated comprehensive benefit package and other insurance market reforms.

- Modify alliance structure and function to align more with *Health Access America*. Alliances should act as impartial conduits between health plans and purchasers, making it easier for individuals and small businesses to make insurance purchases and encouraging competitiveness among health plans — **not** regulatory, monopsony-like agencies.

  -- Reduce the threshold to "opt-out" of an alliance from 5000 employees to between 100-500 employees to ensure competition in the marketplace. For employers beneath the threshold, participation in the alliance should be voluntary. Employers above the threshold should remain out of the alliances to create true competition.

  -- Establish a clearly defined role for physicians/physician professional organizations on the alliance boards.

  -- Require alliances to accept all qualified health plans offered, instead of limiting choice to those within 120% of the alliance's per-capita premium target. Patients should have free choice of all qualified plans — and should be entitled to exercise the right to purchase or not to purchase a more costly qualified plan.

Accountable Health Plans

Under the Administration's proposal, physicians, hospitals, other providers and insurers would be organized into integrated entities called "accountable health plans," to deliver the health care covered by the comprehensive benefit package to enrollees. These health plans would have to meet federal standards and be qualified by states to offer coverage through the regional alliances.

All health plans must implement community rating, conduct open enrollment periods, and accept all eligible individuals who apply. In addition, plans may not terminate limit coverage, impose waiting periods, or exclude coverage for any pre-existing conditions. Health plans must also meet quality assurance, confidentiality, data management, and reporting requirements established by the national health board.

Consumers would have to choose from among three different types of plans (each would have to offer the same benefits package): (1) low-cost-sharing, similar to an HMO-type plan, with no deductibles, a required point-of-service option available for an additional premium, and $1500 (individuals) and $3000 (family) maximum out-of-pocket spending; (2) high cost sharing, similar to a fee-for-service type plan, with $200 (individual) and $400 (family) deductible, 20% coinsurance and $1500 (individual) and $3000 (family) maximum out-of-pocket spending; and (3) combination cost-sharing, similar to a PPO-type plan, with required point-of-service options for additional out-of-pocket payments, and maximum out-of-pocket limit of $1500 (individuals) and $3000 (family).

Physicians would be able to join more than one health plan, although the low-cost-sharing and combination-cost-sharing plans could limit the number and specialty mix of physicians accepted into the plan. Furthermore, state laws protecting against managed care plan abuses are preempted under the Administration's proposal, although disclosure of utilization review policies and criteria are required.

The AMA supports the insurance market reforms offered in the Administration's proposal. They are consistent with long-standing AMA policy. Compared to the Administration's earlier proposal, consumer choice is also now enhanced by the required offering of the point-of-service option in the low cost sharing plan. However, there are major concerns with other aspects of the heath plans' operation. Changes to the proposal that the AMA will emphasize in Congress include:

- Eliminate de facto requirement that all physicians belong to a health plan.

- Require health plans to create a committee of practicing physicians, within the plan, based on the medical staff model, that is responsible for medical coverage, quality assurance, and credentialing.

- Establish the right of physicians to apply to any health plan of their choice. Applications should be approved if the physician meets the plan's objective criteria, based primarily on professional competence and quality of care. Recognize, however, that some plans may develop and use criteria to determine the number, geographic distribution, and specialties

of physicians needed. Oppose any federal effort to preempt state "any willing provider" laws.

- Eliminate provisions that would preempt laws that states have enacted to protect against abuses in managed care plans and work toward acceptable standards for managed care programs.

- Seek legislation and incentives to overcome financial, federal, and state regulatory barriers to the formation of physician-sponsored health delivery networks and plans

Fee-for-Service

Under the Administration's proposal, payment for physician services in fee-for-service plans would be made according to a fee schedule established by each alliance after "negotiating with providers." The same fee schedule would apply to all fee-for-service plans in the alliance area, as well as to care provided under the point-of-service option for non-fee-for-service plans. States may choose to establish a state-wide fee schedule. The fee schedule could also be developed, based on prospective budgeting. Under this approach, the alliance would negotiate an annual budget with providers, with spending targets for each sector of health care expenditures. The plan would periodically review utilization and could reduce provider payments to assure compliance with the budget. Under any of the above-noted approaches, balance billing is not permitted above the alliance fee schedule.

Each regional or corporate alliance must offer at least one fee-for-service plan. All fee-for-service plans would have to accept any willing providers. Alliances, however, may limit the number of plans available to their subscribers, including fee-for-service plans, if the plan[s] fails to comply with contract requirements or the proposed premium exceeds the alliance's per-capita premium by more than 120%.

To ensure the viability of fee-for-service medicine under health system reform, the AMA will aggressively emphasize the following changes to the Administration's proposal:

- Eliminate the ban on balance billing. Establish that balance billing is an issue for negotiations between physicians/physician organizations and states and/or alliances and health plans.

- Ensure reasonable co-pays for the fee-for-service plan and point of service option to promote a level playing field among the different types of plans.

- Require each alliance to make a good faith effort to ensure that two or more fee-for-service plans are offered on an annual basis. Preclude alliances from refusing to contract with health plans for any reason not related to plan solvency or quality of care issues.

- Eliminate the prospective budgeting fee-for-service option. If this option remains, require alliances to adhere to strict standards before any physician payments can be reduced below negotiated or fee schedule levels.

- Fee-for-service and employer premium contributions. Under the Administration's proposal, the required employer contribution for the benefit package is set at 80% of the weighted average premium for an alliance. This threshold could likely raise out-of-pocket premium costs for individuals choosing the fee-for-service option. Therefore, to ensure a level playing field and to avoid any bias toward managed care, employers should pay a designated share of whichever type of plan the employee selects — rather than the weighted-average premium threshold as called for by the Administration's proposal.

- Encourage that at least one fee-for-service plan be offered which has the same deductibles and co-payments as the in-network PPO plan — recognizing that this may cause a higher premium, but that it would provide a plan emphasizing more freedom of choice for patients.

Antitrust

As noted above, payment for physician services in fee-for-service plans under the Administration's reform proposal would be made according to a fee schedule established by each alliance, after "negotiating with providers." Providers are **authorized to negotiate the fee schedule collectively** with health alliances and states; annual updates to the fee schedule are also intended to be part of the negotiations process for the fee-for-service plans. Medical societies, although not specifically named, would be allowed to negotiate with alliances on behalf of the physicians they represent. Attempts by providers to threaten or engage in a boycott or "strike" to pressure an alliance or state into accepting the fees or budget desired by the providers is prohibited.

In addition to this specific antitrust exemption for collective negotiations between physicians and alliances/states, guidelines were issued by the Department of Justice (DOJ) and the Federal Trade Commission (FTC) in September 1993. These guidelines establish "safety zones" for physicians to negotiate payments, coverage, and other matters with plans if the following criteria are met: (1) the physician group is either fully or partially integrated in a legitimate joint venture; (2) the physician group is at financial risk, through such things as capitation and fee withholds; and (3) the physician group represents no more than 20% of all the physicians in the relevant market and no more than 20% of a given specialty. In sum, these DOJ/FTC guidelines basically provide a "safe harbor" for integrated, risk-sharing physician networks to negotiate fees with managed health plans — as long as they represent less than 20% or less of the physicians in a market/specialty. The guidelines, however, offer only minimal relief, and specifically fail to address the needs of loosely integrated or competing groups of physicians.

The Board of Trustees believes that the provisions in the Administration's proposal are insufficient to let physicians compete in what will be, under the Administration's proposal, a health care system dominated by large corporate managed care entities. Therefore, to ensure meaningful antitrust relief and to promote equity of bargaining power for physicians in relation to managed care entities and health alliances, the AMA will continue to advocate the following changes to the antitrust provisions in the Congress:

- Expand negotiating authority of physicians in the fee-for-service plan to include negotiations with other plans and managed care entities.

- Modify "safe harbor" zones for physician network joint ventures as follows:

  -- The threshold for the physician group should be 35% of the market when the network is exclusive (not 20%); there should be a 50% limit of physician share of the market when the network is non-exclusive.

  -- Seek broad definition of "sharing of financial risk" to include those holding an equity interest in the physician network.

- Modify antitrust prohibitions for physicians in loosely integrated networks to ensure equity of bargaining power among the regional alliances, health plans, and the physicians

Global Budgets and Premium Caps

The Administration's reform proposal contains no specific "national global budget" language, but global budgeting is effectively established through caps on insurance premium increases. The proposal, however, does not limit the amount private citizens can spend for uncovered services out of their after-tax dollars. Importantly, however, it appears there are prohibitions/restrictions on such out-of-pocket expenditures by private citizens using after-tax dollars for covered services — similar to those that now exist in the Medicare program.

Specifically, the NHB is charged with determining several budgeting factors:

- By January 1, 1995, the NHB must determine **a national per-capita baseline premium target**. This target would be the amount of payments currently paid for services that would be included in the comprehensive benefits package (without regard to cost sharing), adjusted for increased utilization, up to a 15% alliance overhead, and inflation.

- By January 1, 1995, the NHB must also determine **a regional alliance per-capita premium target** for each regional alliance in 1996. This is the national per-capita baseline premium target, updated by the regional alliance inflation factor and adjusted for variations in health care expenditures, rates of uninsured, and the proportion of expenditures for services provided by academic centers. This amount, multiplied by the number of enrollees, serves as the basis for the alliance's budget for the first year. The alliance then negotiates premiums with the health plans, based on its overall annual budget.

- By March 1 of each year beginning in 1995, the NHB must establish a **regional alliance inflation factor** for each regional alliance for the following year. This regional alliance inflation factor is the change in the consumer price index plus the general health care inflation factor, which is established at 1.5% for 1996, 1% for 1997, .5% for 1998, and 0% for 1999. The regional alliance inflation factor is also adjusted to take into account material changes in alliance population, demographics, and socioeconomic factors and is decreased to take into account excess expenditures in the previous year.

Overall, the establishment of caps on health insurance premiums and the role of powerful, monopsonistic alliances to recoup from providers "excess" expenditures of a prior year, as described in the Administration's proposal, translates into a national budget for the services included in the comprehensive benefit package. If an alliance exceeds its per-capita target in a

year, payments to plans in subsequent years will be reduced. If a plan exceeds its target, payments to providers will be reduced, with offsets for expected increases in volume of services. This amounts to price controls, with such controls leading to insurance carrier micromanagement of clinical practice.

The AMA has and will continue to advocate against the setting of any price controls, because any decisions in health care that are based mainly on economics are not in the best interests of patients. This issue will be a key area of concern and activity in the coming months as the reform debate moves to Congress. Changes that the AMA will aggressively emphasize in Congress on this issue include:

- Eliminate regulatory, price control/global budget authority of the NHB.

- Replace arbitrary premium caps/global budgets with a negotiated goals approach that involves physicians in establishing true spending goals that take into account demographics, disease, technology, and demand.

Quality

The Administration's reform proposal would establish a new "National Quality Management Program" to be overseen by a 15-member advisory entity, the "National Quality Management Council." Representatives on the Council would include consumers, health plan representatives, states, and public health and quality experts. Duties of this advisory Council include setting up a national program to: develop and disseminate practice guidelines; develop the proposed performance reports that would be implemented at the national, health alliance, and individual health plan level; develop standards to evaluate clinical protocols used to manage health service utilization; and research priorities regarding quality, appropriateness, and effectiveness of health care. The National Council would also direct AHCPR to support research regarding a list of performance measures on outcomes, dissemination of practice guidelines, and methods of measuring quality and shared decision-making.

Regional professional foundations would also be established under the Administration's reform proposal to "foster collaboration among health plans and health care providers" and to "disseminate information about successful quality improvement programs." A National Quality Consortium — with many of the same duties as the proposed National Quality Management Council and Regional Foundations" — would also be established.

The AMA is encouraged that the Administration's proposal contains a national effort to ensure quality health care. However, duties of the different bodies established — e.g., the National Quality Council, the Regional Professional Foundations and the National Quality Consortium — appear duplicative, with "performance reports" required at the national, alliance, and health plan levels. Furthermore, no clearly defined role has been established for physicians in the advisory Council responsible for so many initiatives in quality, especially the establishment of practice parameters. The AMA has expressed its concerns regarding these elements of the proposal and will aggressively emphasize the following changes:

- Urge formal recognition and preservation of the existing private sector efforts — instead of supplanting the same with a new, federally established system of quality management. Seek

a public/private partnership to coordinate and strengthen existing private sector efforts in quality, utilization, and outcomes management.

- Reduce overlap apparent duplicative responsibilities of the newly created National Quality Council Management Council, the Professional Foundations, and the National Quality Consortium.

- Require formal physician representation in the governance of the National Quality Management Council.

Physician Workforce

Under the Administration's proposal, the Secretary of Health and Human Services (HHS) would allocate, based on recommendations developed by the new "National Council on Graduate Medical Education," the numbers and types of positions in approved physician training programs receiving federal GME funding. Specifically, the proposal mandates that the National Council shall, for each medical specialty/subspecialty, designate for each academic year the number of individuals nationwide authorized to be enrolled in training programs. The proposal also mandates that the National Council "shall ensure that, of the class of training participants entering eligible programs for academic year 1998-1999 or any subsequent academic year, the percentage of such class that completes eligible programs in primary health care is not less than 55%." This percentage was changed from the draft Administration plan of 50% and obstetrics-gynecology was added as a primary care specialty. National Council members would include physicians, medical school faculty, private practice physicians, officers/employees of health alliances, officers/employees of health plans participating in the alliance, and consumers.

The AMA has forcefully advocated against such federalization of the nation's system of medical education. While more primary care physicians are needed, the AMA opposes arbitrary quotas restricting medical student's free choice to pursue their chosen field. Governmental interference with such individual interests would be a substantial threat to quality of care. Changes that the AMA will aggressively emphasize in Congress on this issue include:

- Modify/substantially reduce the scope and power of the National Council on Graduate Medical Education. If the National Council provision cannot be eliminated, establish small, regional councils on graduate medical education to make **advisory** recommendations to the Secretary of HHS. Membership on such regional councils should consist predominately of physicians.

- Oppose governmental official or agency granted the authority to allocate numbers or types of positions in physician training programs.

- Replace the arbitrary quota approach designed to increase the supply of primary care physicians with a multi-faceted approach, including positive incentives, to stimulate interest in primary care and ensure physicians' continued freedom to pursue their chosen fields. In addition, urge that the RBRVS should not be manipulated to achieve the proposal's allocation goals between primary care and other specialties.

Scope of Practice

Under the Administration's proposal, it is ambiguous whether state scope of practice laws will remain in effect or will be subject to changes and litigation under a federal override provision. Specifically, the Secretary of HHS is authorized to establish "a program to develop and encourage the adoption of model professional practice statutes for advance practice nurses and physician assistants, and to otherwise support efforts to remove inappropriate barriers to practice by such nurses and such physician assistants." In addition, private and public coverage of and reimbursement for services of advanced practice nurses is expanded under the proposal. Plans must cover services of "health professionals" which includes non-physician services provided by professionals "legally authorized to provide such services by the State." Medicare is also amended to broaden coverage of and reimbursement for services of **all** advanced practice nurses who are working in collaboration with a physician, subject to state licensure requirements.

On this scope of practice issue, the AMA will emphasize the following changes in the Congress:

- Modify/eliminate any federal standards to supplant state authority or criteria regarding state responsibility and scope of practice laws. Federal efforts should not duplicate or supplant states' responsibility to ensure their residents health and safety through national professional practice standards.

Administrative Simplification

Under the Administration's proposal, the NHB would develop a health information system to include data on health plan enrollment and administrative and financial transactions of states, health alliances, and health plans. The NHB would also establish standards regarding the form in which records must be maintained and would create an electronic data network to collect/transmit health and claim form information of subscribers.

All individuals eligible for coverage will receive a "health security card" that will contain the name of the enrollee, name of health plan, and any policy in which the individual is enrolled. Regulations for the use of the card will be established by the NHB. The NHB must also develop standard health care benefit forms, including an enrollment and dis-enrollment form, clinical encounter record — to be transmitted to the regional information network for national trend data — and a benefit claim form. A national Privacy and Health Data Advisory Council is established, along with unique identifiers for plans, employers, practitioners, providers, and patients.

With regard to the Medicare program, the following "simplification" provisions are included: the PRO pre-certification requirements for certain surgical procedures would be repealed, with eventual phase-out of the PRO program; (2) the Secretary of HHS would be prohibited from implementing changes in billing and processing of claims within six months of previous changes; and (3) advance notice of 120 days would be given for changes in billing procedures. With regard to clinical labs, the certificate requirement for laboratories performing tests in the waived category would be eliminated.

The AMA supports encouraging advances in electronic data management and administrative simplification to allow physicians and other health care professionals more time for patient care activities, along with initiatives to improve Medicare carrier efficiency. However, there are other aspects of the administrative simplification provisions to which the AMA will emphasize changes in the months ahead, including:

- Eliminate requirement of new unique identifier created by the government. Physicians already are identified by Medicare Medicaid UPIN numbers; accepted identifiers should not be duplicated.

- Ensure patient confidentiality in electronic transmission of health care data benefits

- Reduce additional requirements/repeal the CLIA program.

Professional Liability Reform

The Administration's proposal contains the following liability provisions:

- Patients must submit claims through an alternative dispute resolution (ADR) system that each health plan must establish, using models developed by the NHB. Complaints may be pursued in court after ADR.

- Suits must include a "certificate of merit" affidavit signed by a medical specialist in a field relevant to the claimed injury.

- Attorney's fees are limited to 33 1/3% of the total amount of the judgment or settlement recovered. States, however, are granted the flexibility to impose more stringent limits on attorney fees.

- Collateral offset rule: recovery amounts must be reduced by amount received from other sources, to prevent double recovery for injuries.

- Either party may request awards to be made in periodic installments, but periodic payment is not mandatory.

- State enterprise liability demonstration projects receive federal funds.

- HHS is authorized to develop pilot studies to test the effectiveness of using practice guidelines (which is an expansion of the new Maine experiment) adopted by the new National Quality Management Program. The pilot studies are to determine the effect of applying practice guidelines in the resolution of medical liability actions. A state will be eligible to participate if it provides assurances that, under state law, it will be a complete defense to an allegation of negligence that the party followed the appropriate practice guideline. In addition, HHS must set rules for public access to information contained in the National Practitioner Data Bank (NPDB).

The Board of Trustees believes that the Administration's proposal does not meet the continuing liability crisis in health care. To ensure that the high cost of excessive litigation and awards does

not continue under a new health care system, the AMA has long-advocated initiatives similar to actions taken in California under its MICRA, including a $250,000 limit on noneconomic damages and more stringent limits on attorneys's fees. Therefore, changes to the Administration's proposal that the AMA will aggressively pursue in Congress include

- Require provision authorizing a $250,000 cap on non-economic damages.

- Reduce limits on attorney's fees — from current 33 1/3% — to a more meaningful level

- Modify/eliminate provision on state enterprise liability demonstration projects

- Require a statute of limitations on filing lawsuit claims that allows for a fair, but limited time, to bring a claim.

- Eliminate the provision on public release of information contained in the NPDB.

SECTION II: CURRENT ENVIRONMENT AND OTHER LEGISLATIVE PROPOSALS

The Clinton Administration's "Health Security Act of 1993" will likely define the health system reform debate for months ahead. To date, there have been over 35 hearings before congressional committees on health system reform, and the AMA has testified at many of these hearings. Numerous congressional committees will have jurisdiction over at least some part of the Administration's bill. In the Senate, most of the bill will be handled by the Finance Committee and the Labor and Human Resources Committee. In the House, committees with broad jurisdiction over the bill include:

- Ways and Means: Handles tax legislation and oversees the Medicare system.

- Energy and Commerce: Oversees Medicaid and the physician portion of Medicare. The committee also handles legislation related to health insurance and the Public Health Service and in the past has handled some professional liability issues.

- Education and Labor: Oversees all issues related to employee benefits, employer responsibilities, and the Employee Retirement Income Security Act (ERISA), a law that preempts most state laws regarding employee benefits.

House committees with limited jurisdiction over some parts of the bill include:

- Judiciary: Oversees health issues related to malpractice, antitrust, fraud, and possibly privacy laws.

- Post Office and Civil Service: Oversees health benefits for federal employees.

- Armed Services: Oversees the health insurance program for military retirees and family members, known as CHAMPUS.

- Natural Resources: Has jurisdiction over the Indian Health Service, which provides health care to American Indians.

To: Melanne
From: Lynn
RE: JAMA editorial

Attached is the JAMA editorial that will be released tomorrow. As you know, JAMA does not represent the official views of the American Medical Association.

In short, the highlights of the article are as follows:

- The HSA rates second highest of the bills currently being considered by the Congress. The Stark bill gets highest marks.

- The HSA is rated considerably better than the status quo. The Cooper, Nickles, Michel and the Gramm bills are all rated as worse than the status quo.

- Of all the categories, the HSA received its worst ratings (5 out of a possible 9) in the areas of cost control, administrative hassle, physician autonomy

We will be getting an advance copy of the JAMA magazine which contains additional articles on health reform.

Editorial

Editorials represent the opinions of the authors and THE JOURNAL and not those of the American Medical Association.

United States Health Care System Reform

An Era of Shared Sacrifice and Responsibility Begins

My Way

If I were starting an American health care system from scratch in 1994, this is what I would do. All persons would have a primary care physician of their own choosing, who would provide comprehensive continuing care and refer as appropriate. I would emphasize prevention and early detection of disease; proven interventions, such as immunizations, Papanicolaou tests, and mammography after age 50 years, would be free to patients and paid for by government tax revenues. Specialty and subspecialty physician care would be by referral only. All ambulatory care provided by physicians and other health care professionals or organizations would be paid by patients out of pocket, up to some annual legal maximum (perhaps $3000 per person). Patients would be expected to pay their bills. Physicians and other providers would be expected to provide a reasonable amount of free care or offer reduced charges for medications, diagnostic tests, and therapeutic procedures when a patient's economic circumstances so indicated.

Sickness insurance would be available for purchase by individuals, employers, and government, and everyone would be mandated to carry hospital and catastrophic insurance. Primary care physicians would not have admitting authority to hospitals, to decrease the temptation to overhospitalize, could not be in groups with specialty physicians, or receive kickbacks, split fees, or other inducements for referrals.

In nonemergency care situations, all mentally competent patients and all physicians would be informed of the cost of care (ambulatory or hospital) in advance of receiving or providing services, regardless of the source of payment, and then would be expected to consent to or decline such expenditures.

Physician fees and other charges for ambulatory care would be set by providers. The government would establish charges for services rendered in the hospital, taking into consideration length of stay and intensity of services so there would be no imbalance of payment for procedure-oriented care.

A "free marketplace" would decide the number of physicians and their fields of endeavor. Medical education would be a public trust with very low or no tuition or fees for training in the health professions. Fiscal resources would not enter into decisions as to who would be trained to be a physician, and no substantial debt would be incurred by the medical student. Basic and applied medical research would be encouraged, sponsored by private industry, foundations, and government.

Done "my way," competence, communication, trust, and caring would be so strong that excess malpractice problems would not be a concern.

I believe this approach would provide incentives for patients, providers, and institutions and would proceed in the right directions, those of promoting health, controlling costs, providing quality, and enduring.

A Return to Reality

Alas, the opportunity to construct a health care system from scratch is not available in the United States and is unlikely to present itself unless the current hodgepodge melts down entirely. The well-known nonsystem we have is perverted by massive third-party coverage; by excessive supply of virtually all services, institutions, and providers, albeit maldistributed; by little real incentive for most people (patients and providers) to conserve costs[1]; and by worsening access to primary care and simple basic disease prevention measures.[2]

Repairing Our 'System'

Because of all the precedents, the processes in place, the expectations of most providers and patients, and the obvious vested interests of a trillion-dollar-a-year industry, it is much more difficult to repair what we have than to build a workable, efficient system. Last year, I wrote, "[I]t is the most difficult and complicated set of challenges that the United States has faced since the Great Depression."[3] Well, it hasn't gotten any easier. In 1991, I wrote, "Although there may be consensus that our society must provide basic medical/health care for all of our people, we seem not to be close to a consensus on how to do it."[4] Today, we are closer to consensus that we must provide such care, but we are no closer to a consensus on how to accomplish it.

American health care system reform is already here, state by state, company by company, by cities and counties, and by medical schools and professional groups. It is a reality. The principal remaining question is what the federal government will or will not do and how rapidly the whole process will evolve.[5] People of good will and good knowledge throughout our country now recognize this "aura of inevitability" for serious change and have moved ahead toward major reform by their political vote, by attitudinal changes as shown by polling, by their representatives, by media presentations, and with a host of personal, professional, and business actions.

Grading the Proposed Plans for Reform

It seems useful at this point to analyze the major health system reform proposals being considered by the US Congress. While none of these proposals will survive intact and new language will be written by many subcommittees and committees as this year progresses, legislation will be based at least in part on the proposals already introduced in Congress. It behooves us to try to understand them.

The *JAMA* grading grid of 11 elements has been published three times[1,2,6] to emphasize the importance of these essential points. To evaluate how well the various major proposals currently before Congress do at meeting these needs, I consulted key individuals in various high-level congressional and senato-

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rial offices, policy analysts from academia, foundations, and associations, and performed my own analysis as well. Table 1 grades each major proposal on the *JAMA* grid. The scores reported are not science but represent an aggregation of these analyses and opinions. All contributors are considered confidential sources who participated off the record and thus will remain anonymous. Concordance of ratings among the informed and generally unbiased (ie, nonpolitical) respondents was remarkably consistent on most points of most plans.

A perfect system score on the *JAMA* grid would be 99. As we compare proposed plans, we must also compare them with the status quo. Our current health care mechanisms score 55; of new proposals, the Stark plan does best at 72; Clinton's plan is next best at 70; and Gramm scores lowest at 38. The reader may find it helpful to consider the strengths and weaknesses of various plans on a point-by-point basis. In some instances, subsequent adjustments or consolidation across the 11 points may not be possible because of profound ideologic differences, such as the Cooper plan vs the Clinton plan regarding access—one being voluntary and the other mandatory. Yet, on some points, a few changes in plans could make a big difference. For example, if the McDermott/Wellstone plan added a strong section on professional liability reform, it would move to first on the *JAMA* grid.

The 11-point *JAMA* grading grid is, necessarily, quite simplified. For instance, insurance coverage is not listed, while access is. They are not synonymous. Elsewhere in this issue, Friedman[7] analyzes why insurance coverage alone is not enough since there are many nonfinancial barriers to access.

The so-called single-payer plan scores third highest on the *JAMA* grading grid. Yet, trust in our government is at its lowest level in many years.[8] Thus, there is no way THE JOURNAL can recommend a single-payer system at this time. It's hard to imagine finding any "single payer" with the national credibility required to enact such a plan in our country in 1994.

The Politically Possible

The nature of health care system reform that will emerge remains unclear. I believe that universal coverage by health insurance "that can never be taken away" will eventually occur, but the timetable, the mechanisms of payment and method of care provision, and the national baseline of core benefits are uncertain. Consensus among the electorate and politicians has not occurred and should not be expected. Slim majorities in subcommittees, committees, the House, and the Senate are all that can be expected. Differences of opinion, even among members of the House and Senate with sound knowledge and good will, are major and understandable. They derive from personal ideologic differences, variations in their political constituencies, vulnerability to lobbying efforts by innumerable vested interest groups, their own personal and family experiences with health and disease, and their future expectations of such for their loved ones.

Politics is the art of the possible. We should continue to manage by the objectives THE JOURNAL recommended in 1993[2] and to measure our progress against these specific targets (Table 2). Progress in health system reform should be measured on a scale of how far we have moved toward meeting these objectives by the year 1996 no matter what Congress does.

Also, knowing that earlier major national political health system reform actions have been derailed by various random and spurious events (such as Watergate and Fanne Foxx),[9] we must ensure that the importance of providing universal access to basic medical care, trying to control costs, and preserving high quality transcends the diversionary potential of any other political interference (such as Whitewater).

The All-American Multiplex Health Plan (AAMHP)

I have no ethical or moral problem with a multitier health care provision system. The egalitarian ideal and the notion that there was once a single standard of medical/health care in this country to which we should return is an odd pipe dream. There never was equality in health care; there will not be now.[3] The main point of reforms is to guarantee basic medical care for all US citizens and legal aliens and to make it good enough so that it will suffice for the vast majority of our people the vast majority of the time. Over and above that, if individuals or companies want to provide a "business class" of medical and health care and wish to pay the extra money for the premiums, I think they should be allowed to do so. If individuals wish to buy "boutique class" care using their own money and with an economic informed consent, they should have every right to do so as long as what they are buying is not specifically harmful to their health and the resource is not taken from someone who needs it more.

We should retain pluralism. Every patient should have the right to choose his or her own primary care physician. Specialists' and subspecialists' care should be accessible for all patients on the core benefits plan through their primary care physician, who should serve as caregiver, adviser, advocate, manager of complex resources, and triage officer for patients under their responsibility.

How to achieve this multiplex system has been itemized in *JAMA* previously and remains sound policy today.[10] Maintaining and promoting innovation will continue to be critical in our evolving reform efforts.[11]

Rational Rationing and the Basic Benefits Package

We ration medical care every day in this country in at least 12 different ways, but mostly by access control through pricing.[4,12-14] Yet, there has been no rational basis for our random and systematic rationing. A key element in any successful health system reform will be the assurance of universal access to basic health care by universal insurance coverage. Thus, the definition of basic health care becomes the cornerstone. I believe that so far only one system has developed a sensible approach to defining basic health care in a manner that is flexible with respect to costs, is ethically and medically sound, and has staying power. That is the Oregon Health Plan.[15,16] In this plan, now being implemented for Medicaid patients in Oregon, a sliding scale of benefits based on coverage—by medical condition and treatment—and available funds has been established by participatory management of many citizens, their political representatives, and the health care community. This stratification of medical actions is based on medical need and the likelihood of real value from intervention. The ethical principle that is followed is that of the greatest good for the greatest number. I believe that the Oregon Health Plan model should become the basic benefit plan—the core—for all Americans (after abolishing Medicaid, of course). Modifications to the list should be done from time to time and the cutoff point on the list set annually (Table 3). Those companies or individuals who desire "business class" or "boutique class" care, over and above the Oregon Health Plan, may do so with their company's money or their own money. But basic class health care must be guaranteed for all Americans.

Table 1.—Rating the United States Health System Reform Proposals: The *JAMA* Grading Grid

	Perfection	"The Stark Mark"*	Health Security Act of 1993/(President Clinton) Rep Richard Gephardt (D, Mo), HR 3600; Sen George Mitchell (D, Me), S 1757	American Health Security Act of 1993/Rep Jim McDermott (D, Wash), HR 1200; Sen Paul Wellstone (D, Minn), S 491	Health Equity and Access Reform Today Act of 1993/Rep William Thomas (R, Calif), HR 3704; Sen John Chafee (R, RI), S 1770
Does it:					
Provide access for all to basic care?	9	8	8	8	6
Produce real cost control?	9	7	5	5	5
Promote continuing quality?	9	6	7	8	6
Reduce administrative hassle and cost?	9	5	5	5	4
Enhance disease prevention?	9	6	8	7	5
Encourage primary care?	9	6	7	5	6
Consider long-term care?	9	6	6	7	2
Retain necessary patient autonomy?	9	7	7	7	6
Retain necessary physician autonomy?	9	6	5	6	5
Limit professional liability?	9	7	6	0	8
Possess staying power?	9	8	6	8	4
Total	**99**	**72**	**70**	**66**	**57**

*This proposal, developed in spring 1994 by the House Ways and Means Health Subcommittee, chaired by Rep Fortney (Pete) Stark (D, Calif), would establish a new Medicare Part C program to cover Medicaid beneficiaries, the uninsured, and small firms (<100 employees). The subcommittee's legislative specifications here will now go to the entire House Ways and Means Committee for further action. It has not been formally introduced in Congress.

The Economic Informed Consent

In a nonemergency situation, all providers should inform the mentally competent adult patient or guardian of the cost of all professional services, medications, tests, procedures, hospitalization, or whatever and obtain the patient's permission prior to providing the service, no matter who is paying the bill. The purpose of this effort is to share the burden of responsibility for expending resources, to cease rendering futile care, and to curtail sharply inappropriate care or "medicine at the margins" by exercising prospective interactive responsible physician and patient autonomy.[3] The reasons cost control will work in the AAMHP are in Table 3.

How to Pay For Reforms?

Employment-based health insurance may not be the best financing strategy, but it is our traditional method, covers most of our people, and works well for many. We should build on this system with an employer mandate. Small employers and those with many minimum-wage, part-time, or contract workers could be gradually phased in with government subsidization.

The self-employed, the unemployed and their spouses and children, and those employed at levels and in circumstances (number of hours, size of company, seasonal, part-time, independent contractors with sporadic work, and freelancers) who don't qualify for the employer mandate should come under an individual statutory mandate. Each individual must then carry core benefit health insurance, the cost of which may be shared by the individual and the federal government. These payment mandates should apply to all US citizens, legal aliens, and the undocumented. (After all, when they become ill they have to be cared for too.) First-dollar coverage for services should not be allowed for basic level services but could be permitted in "business class" coverage. To retard overuse, the third-party payer and the insured should share co-payments at the time of incurring costs.

It also makes sense to try to obtain the additional money that will be needed by sin taxes because so much of our health care money is spent treating the illnesses and injuries resulting from tobacco, alcohol, firearms, and ammunition. Research has shown that taxes on tobacco already pay for the medical consequences of tobacco use while alcohol taxes do not.[17] No good data of this sort are available for firearms and ammunition. Nonetheless, on conceptual grounds, raising money for health system reform and decreasing use by increasing prices (especially the initiation of tobacco use by young people) make good sense. I favor raising federal taxes greatly on tobacco, alcohol, firearms, and ammunition.

Preventing Meltdown

Let the reader understand what I do not want to see happen to health care in this country. Even though I worked as a US Army physician for 11 years and in the Veterans Administration during my medical education and during faculty service and I greatly respect the medical care provided by military and Veterans Administration medicine, I do not believe that a total nationalization of our health care system (à la the National Health Service in the United Kingdom in 1948) is right for the United States. I do not believe that a government monopoly where all physicians, nurses, and other health care providers are conscripted as government employees, all hospitals taken over as government property, and the pharmaceutical and medical equipment companies nationalized and run by the government would provide the answer. I believe such a simplistic solution would create a monopoly of such size and complexity it would surely fail and probably would do so in a catastrophic manner. Why do I belabor this point? Because I believe nationalization of health care in this country is exactly what will happen, perhaps at a time of national panic, if we don't create a reasonable effective system in the relatively near future.[1]

Although it is helpful to understand how we got where we are today, this historical self-flagellation that often accompanies such an analysis need not be repeated here. True, if those making decisions at an earlier time had been better visionaries and wholly well-intentioned, we wouldn't be in the mess we are today. But we can't turn back the clock. We can only begin where we are and try to make the changes needed to create a rational system, not expecting perfection and anticipating huge strife from those in the health care industry (one seventh of our whole economy) who will fight hard for their own self-interests. We must all come to recognize that patients and the public must come first.

Current US System	Managed Competition Act of 1993/Rep Jim Cooper (D, Tenn), HR 3222; Sen John Breaux (D, La), S 1579	Consumer Choice Health Security Act of 1993/Rep Clifford Stearns (R, Fla), HR 3698; Sen Don Nickles (R, Okla), S 1743	Affordable Health Care Now Act of 1993/Rep Robert Michel (R, Ill), HR 3080; Sen Trent Lott (R, Miss), S 1533	Comprehensive Family Health Access and Savings Act/Not yet introduced in House; Sen Phil Gramm (R, Tex), S 1607
5	5	3	4	2
4	4	3	3	3
8	6	4	4	2
3	5	5	5	5
5	4	2	3	2
6	5	3	3	2
4	2	3	3	2
7	6	7	5	5
7	4	7	5	6
4	6	9	8	7
2	3	3	4	2
55	50	49	47	38

Table 2.—Health System Management Objectives for 1996

Decrease the uninsured population (on any one day) from 38 million to less than 10 million.
Decrease inflation rate of medical care to 1.5 times the Consumer Price Index during a 12-month period.
Achieve 50% of the *Healthy People 2000* objectives.
Increase the proportion of physicians practicing primary care from 32% to 40%.
Increase average income for primary care physicians to 90% of mean of all US physician income.
Establish futile care policies at 90% of US hospitals.
Improve childhood vaccination rates to a level in the top five nations in this hemisphere.
Decrease the cost for administering US health care from 19% to 10%.

Table 3.—Cost Control in the All-American Multiplex Health Plan

1. Shared responsibility and sacrifice by a strictly applied economic informed consent at the physician-patient interface.
2. Personal co-payments for all services.
3. Accelerated growth of managed care.[10]
4. A national annual expenditure target or goal for the basic benefit package.
5. An annual national cutoff point for covered services in the basic benefit package (à la Oregon) designated by the National Health Board. This can be overridden any year by congressional action and presidential approval.
6. Promotion of innovation by basic and applied research.
7. Emphasis on prevention and primary care.
8. Quality assurance by clinical practice guidelines and system report cards.

A Time for Shared Sacrifice

Elsewhere in this issue, Blendon and coworkers[8] provide an update on opinions of "the American public and the critical choices for health care reform."[18,19] Most people remain satisfied with their own care, first and foremost, and they will look out for themselves. While there has been leadership from many quarters to accomplish health care system reform, there has been notably little leadership in what will be the most important factor of all—shared sacrifice.[20] Fuchs[21] has stressed "no pain, no gain." He is right. In our culture of instant gratification, physicians and patients "want what they want when they want it," and they will do whatever they can to get it. That behavior, plus an abundance of science and technology, a perverse system that rewards overuse, and our huge excess supply of hospital beds and specialist physicians, has resulted in 15% of the gross domestic product being expended for medical and health care, and an angle of that spending slope becoming nearly asymptotic to the vertical. That slope must be flattened, but leaders run away as fast as they can from the drastic steps needed. In national or state health system reform, "wants" of the "haves" must be replaced by the "needs" of the general populace. Once needs for everyone are taken care of, individuals and employers may personally pay for things over and above basic benefits, either by extra insurance premiums or out-of-pocket voluntary payments. We need to create a cultural paradigm shift from the previously omnipresent "don't worry about it, the insurance will pay for it" to "we're only going to do this if you really need it and we're fairly convinced it will help." It all happens at that one-physician, one-patient interface.

Have the US electorate and its official representatives and our medical profession matured to the point of being able to support the ethical principle of the greatest good for the greatest number? Or will each person vote strictly for himself or herself, saying, "I am not my brother's keeper; don't mess with my freedom to choose what I want"? We shall soon see.

George D. Lundberg, MD

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WHAT YOU DON'T KNOW CAN HURT YOU.

That's why Congress *must* pass the Patient Protection Act.

There are things insurance companies don't want you to know about their health plans. That's why you need the facts. So you can make informed choices and get quality care in spite of their efforts to keep you in the dark.

The Patient Protection Act will require insurance companies to give you all the information you need *before* you join a health plan. They'll have to tell you what is and isn't covered in their plan. What sort of incentives they give to limit the care you get. What sort of approval process you have to go through to get the care you need. And how many people have dropped out of their plan because they were dissatisfied with the care they got.

It will also make sure your doctor has a say in your plan's medical policies and make it illegal for your plan to fire your doctor for giving you all the care you need. What's more, it will allow you to choose your *own* doctor – instead of having one chosen for you.

In short, the Patient Protection Act requires insurance companies to give you a full explanation of how their plan's limitations affect you. So you and your family can make an informed, intelligent decision about the one thing that's more important than any other. Your health.

This is the moment of truth. Call your senators and representative now. Demand that they support the Patient Protection Act. Because when you're dealing with the insurance industry, what you don't know really can hurt you.

American Medical Association

Physicians dedicated to the health of America

PATIENT PROTECTION ACT

The AMA has articulated strong policy positions on patient access to care and calling for regulation of managed care plans to assure fairness to patients and providers. As cases of insurance companies aggressively discontinuing physicians from their networks and making inappropriate coverage or other decisions have increased, the AMA has determined that development and pursuit of AMA federal legislation to assure fairness in managed care plans would provide a mechanism for delineating necessary protections for both physicians and patients. The proposed federal legislation would require the Secretary of Health and Human Services to establish federal standards for the certification of qualified managed care plans. Standards would be required to ensure patient protection, physician and provider fairness, utilization reviews safeguards, and coverage options for all patients, including the ability to enroll in a point of service plan. Patient choice of physicians and other providers would be enhanced through the availability of a point of service option for those who elect this added coverage option.

Patient Protections - Plans would be required to provide prospective enrollees/patients with information regarding plan terms and conditions of the plan to allow informed decisions about accepting a certain system of health care delivery. The standards specifically must include requirements for information to be provided on: (1) coverage provisions and exclusions; (2) prior authorization or other review requirements; (3) financial arrangements that would limit the services offered, restrict referral options, and established incentives not to deliver certain services; (4) plan limitations and the impact of any limitations upon an enrollee; (5) loss ratios; and (6) enrollee satisfaction statistics. Plans would also be required to demonstrate that they have adequate access to physicians and other providers, and that they meet financial reserve requirements.

Physician and Provider Fairness - Plans must establish credentialing criteria to allow physicians within the plan's geographic service area to apply for credentials. Credentialing would be based on standards of quality. Case mix, severity of illness, patient age, and other factors that may account for higher or lower costs would form part of any credentialing analysis. Plans may use physician-developed criteria to determine the number, geographic distribution, and specialties of physicians needed. Criteria and profiles must be made available to physicians. Plans must establish a mechanism under which physicians in the plan can provide input into the plan's medical policies. Plans would be prohibited from terminating physicians "without cause" and must provide physician applicants with all reasons for denial of an application or nonrenewal of a contract. A due process appeal containing the precise mechanisms outlined in the Health Care Quality Improvement Act of 1986 must be accorded. Procedures that ensure confidentiality of provider and individual medical records must also be followed.

Safeguards in Utilization Review - The proposed federal legislation would require the Secretary to establish federal standards for the certification of qualified utilization review programs. The standards set forth a plan model in which a medical director is responsible for all clinical decisions of the plan. Screening criteria, weighting elements, and computer algorithms used in the review must be based on sound scientific principles, developed with physicians having an essential role, and released to physicians and the public. Only a physician of the same medical specialty as the practitioner who provided a service would be permitted to recommend denial of coverage or payment. The plan would be required to provide to participating physicians the names and credentials of those who conduct medical necessity or appropriateness review. Patient or

physician requests for prior authorization of a service must be answered within two business days, with personnel available for same day responses regarding questions of medical necessity.

Patient Choice - This proposed legislation protects a patient's choice of physician and type of health plan. It requires that every sponsor of a health benefit plan that limits access to providers, must also offer a "point of service" option to allow plan enrollees access to providers outside the plan or network. The legislation would also assure that patients have a choice of a range of health plans -- including an HMO or PPO, a traditional insurance plan, and a benefit payment schedule.

103rd Congress
2nd Session

Draft

Bill No. _____

IN THE (SENATE) (HOUSE) OF THE UNITED STATES

Date_____

_____of _____ introduced the following bill;

which was read twice and referred

to the _____ Committee

A BILL

To assure fairness and choice to patients and providers under managed care health benefit plans.

Be it enacted by the Senate and the House of Representatives in the United States of America in Congress assembled.

Section 1. SHORT TITLE – This Act may be cited as the "Patient Protection Act of 1994".

TITLE I. PROTECTION OF CONSUMER CHOICE.

Sec. 1. (a) Nothing in this Act shall be construed as prohibiting the following:

(1) An individual from purchasing any health care services with that individual's own funds, whether such services are covered within the individual's standard benefit package or from another health care provider or plan.

(2) Employers from providing coverage for benefits in addition to the comprehensive benefit package.

TITLE II. CERTIFICATION OF MANAGED CARE PLANS AND UTILIZATION REVIEW PROGRAMS

Sec. 2. (a) Certification Process.--

(1) Certification.--The Secretary shall establish a process for certification of managed care plans

meeting the requirements of subsection (b)(1) and of utilization review programs meeting the requirements of subsection (b)(2).

(2) Qualified managed care plan.--For purposes of this title, the term "qualified managed care plan" means a managed care plan that the Secretary certifies, upon application by the program, as meeting the requirements of this section.

(3) Qualified utilization review program.--For purposes of this title, the term "qualified utilization review program" means a utilization review program that the Secretary certifies, upon application by the program, as meeting the requirements of this section.

(4) Utilization review program.--For purposes of this title the term "utilization review program" means a system of reviewing the medical necessity, appropriateness, or quality of health care services and supplies provided under a health insurance plan or a managed care plan using specified guidelines. Such a system may include preadmission certification, the application of practice guidelines, continued stay review, discharge planning, preauthorization of ambulatory procedures, and retrospective review.

(5) Managed care plan.--

(A) In general.--For purposes of this title the term "managed care plan" means a plan operated by a managed care entity as described in subparagraph (B), that provides for the financing and delivery of health care services to persons enrolled in such plan through--

(i) arrangements with selected providers to furnish health care services;

(ii) explicit standards for the selection of participating providers;

(iii) organizational arrangements for ongoing quality assurance, utilization review programs, and dispute resolution; and

(iv) financial incentives for persons enrolled in the plan to use the participating providers and procedures provided for by the plan.

(B) Managed care entity defined.--For purposes of this title, a managed care entity includes a licensed insurance company, hospital or medical service plan, health maintenance organization, an employer or employee organization, or a managed care contractor as described in subparagraph (C), that operates a managed care plan.

(C) Managed care contractor defined.--For purposes of this title, a managed care contractor means a person that--

(i) establishes, operates or maintains a network of participating providers;

(ii) conducts or arranges for utilization review activities; and

(iii) contracts with an insurance company, a hospital or medical service plan, an employer, an employee organization, or any other entity providing coverage for health care services to operate a managed care plan.

(6) Participating provider.--The term "participating provider" means a physician, hospital, pharmacy, laboratory, or other appropriately licensed provider of health care services or supplies, that has entered into an agreement with a managed care entity to provide such services or supplies to a patient enrolled in a managed care plan.

(7) Review and recertification --The Secretary shall establish procedures for the periodic review and recertification of qualified managed care plans and qualified utilization review programs.

(8) Termination of certification.--The Secretary shall terminate the certification of a previously qualified managed care plan or a qualified utilization review program if the Secretary determines that such plan or program no longer meets the applicable requirements for certification. Before effecting a termination, the Secretary shall provide the plan notice and opportunity for a hearing on the proposed termination.

(9) Certification through alternative requirements.--

(A) Certain organizations recognized.--An eligible organization as defined in section

1876(b), shall be deemed to meet the requirements of subsection (b) for certification as a qualified managed care plan.

(B) Recognition of accreditation.--If the Secretary finds that a State licensure program or a national accreditation body establishes a requirement or requirements for accreditation of a managed care plan or utilization review program that are at least equivalent to a requirement(s) established under subsection (b), the Secretary may, to the extent appropriate, treat a managed care plan or a utilization review program thus accredited as meeting the requirement(s) of subsection (b).

(b) Requirements for Certification.--

(1) Managed care plans.--The Secretary shall establish Federal standards for the certification of qualified managed care plans, including standards whereby--

(A) Prospective enrollees in health insurance plans must be provided information as to the terms and conditions of the plan so that they can make informed decisions about accepting a certain system of health care delivery. Where the plan is described orally to enrollees, easily understood, truthful, and objective terms must be used. All written plan descriptions must be in a readable and understandable format, consistent with standards developed for supplemental insurance coverage under Title XVIII of the Social Security Act. This format must be standardized so that customers can compare the attributes of the plans. Specific items that must be included are:

(i) coverage provisions, benefits, and any exclusions by category of service, provider or physician, and if applicable, by specific service;

(ii) any and all prior authorization or other review requirements including preauthorization review, concurrent review, post-service review, post payment review and any procedures that may lead the patient to be denied coverage for or

not be provided a particular service;

(iii) financial arrangements or contractual provisions with hospitals, review companies, physicians or any other provider of health care services that would limit the services offered, restrict referral or treatment options, or negatively affect the physician's fiduciary responsibility to his or her patients, including but not limited to financial incentives not to provide medical or other services;

(iv) explanation of how plan limitations impact enrollees, including information on enrollee financial responsibility for payment for coinsurance or other non-covered or out-of-plan services;

(v) loss ratios; and

(vi) enrollee satisfaction statistics (including percent reenrollment, reasons for leaving plan, etc,).

(B) Plans must demonstrate that they have adequate access to physicians and other providers, so that all covered health care services will be provided in a timely fashion. This requirement can not be waived and must be met in all areas where the plan has enrollees, including rural areas.

(C) Plans must meet financial reserve requirements that are established to assure proper payment for covered services provided. An indemnity fund should be established to provide for plan failures even when a plan has met the reserve requirements.

(D) All plans shall be required to establish a mechanism, with defined rights, under which physicians participating in the plan provide input into the plan's medical policy, (including coverage of new technology and procedures), utilization review criteria and procedures, quality and credentialing criteria, and medical management procedures.

(E) All plans shall be required to credential physicians within the plan, and will allow

all physicians within the plan's geographic service area to apply for such credentials. At least once per year, plans shall notify physicians of the opportunity to apply for credentials.

(i) Such a credentialing process shall begin upon application of a physician to the plan for inclusion.

(ii) Each application shall be reviewed by a credentialing committee with appropriate representation of the applicant's medical specialty.

(iii) Credentialing shall be based on objective standards of quality with input from physicians credentialed in the plan and such standards shall be available to applicants and enrollees. When economic considerations are part of the decision, objective criteria must used and must be available to applicants, participating physicians and enrollees. Any economic profiling of physicians must be adjusted to recognize case mix, severity of illness, age of patients and other features of a physician's practice that may account for higher than or lower than expected costs. Profiles must be made available to those so profiled. When graduate medical education is a consideration in credentialing, equal recognition will be given to training programs accredited by the Accrediting Council on Graduate Medical Education and by the American Osteopathic Association.

(iv) Plans shall be prohibited from discriminating against enrollees with expensive medical conditions by excluding practitioners with practices containing a substantial number of such patients.

(v) All decisions shall be made on the record and the applicant shall be provided with all reasons used if the application is denied or the contract not renewed.

(vi) Plans shall not be allowed to include clauses in physician or other provider

contracts that allow for the plan to terminate the contract "without cause".

(vii) There shall be a due process appeal from all adverse decisions. The due process appeal mechanisms shall be as set forth in the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101-11152.

(viii) The same standards and procedures used for an application for credentials shall also be used in those cases where the plan seeks to reduce or withdraw such credentials. Pripr to initiation of a proceeding leading to termination of a contract "for cause", the physician shall be provided notice, an opportunity for discussion, and an opportunity to enter into and complete a corrective action plan, except in cases where there is imminent harm to patient health or an action by a state medical board or other government agency that effectively impairs the physician's ability to practice medicine within the jurisdiction.

(F) Procedures shall be established to ensure that all applicable Federal and State laws designed to protect the confidentiality of provider and individual medical records are followed.

(2) Qualified utilization review programs.--The Secretary, shall establish Federal standards for the certification of qualified utilization review programs, including --

(A) Plans must have a medical director responsible for all clinical decisions by the plan and provide assurances that the medical review or utilization practices they use, and the medical review or utilization practices of payers or reviewers with whom they contract, comply with the following requirements:

(B) Screening criteria, weighting elements, and computer algorithms utilized in the review process and their method of development, must be released to physicians and the public;

(C) Such criteria must be based on sound scientific principles and developed in cooperation with practicing physicians and other affected health care providers;

(D) Any person who recommends denial of coverage or payment, or determines that a services should not be provided, based on medical necessity standards, must be of the same medical branch (allopathic or osteopathic medicine) and specialty (specialties as recognized by the American Board of Medical Specialties or the American Osteopathic Association) as the practitioner who provided the service;

(E) Each claimant or provider (upon assignment of a claimant) who has had a claim denied as not medically necessary must be provided an opportunity for a due process appeal to a medical consultant or peer review group not involved in the organization that performed the initial review;

(F) Any individual making a negative judgment or recommendation about the necessity or appropriateness of services or the site of service must be a physician licensed to practice medicine in the jurisdiction from which the claim arose;

(G) Upon request, physicians will be provided the names and credentials of all individuals conducting medical necessity or appropriateness review, subject to reasonable safeguards and standards;

(H) Prior authorization is not required for emergency care, and patient or physician requests for prior authorization of a non-emergency service must be answered within two business days, and qualified personnel must be available for same-day telephone responses to inquiries about medical necessity, including certification of continued length of stay;

(I) Plans must ensure that enrollees, in plans where prior authorization is a condition to coverage of a service, are required to sign medical information release consent forms upon enrollment for use where services requiring prior authorization are recommended or

proposed by their physician;

(J) When prior approval for a service or other covered item is obtained, it shall be considered approval for all purposes and the service shall be considered to be covered unless there was fraud or incorrect information provided at the time such prior approval was obtained.

(K) Procedures for ensuring that all applicable Federal and State laws designed to protect the confidentiality of provider and individual medical records are followed.

(3) Application of standards.--

(A) In general.--Standards shall first be established under this subsection by not later than 12 months after the date of the enactment of this section. In developing standards under this subsection, the Secretary shall--

(i) review standards in use by national private accreditation organizations and State licensure programs;

(ii) recognize, to the extent appropriate, differences in the organizational structure and operation of managed care plans; and

(iii) establish procedures for the timely consideration of applications for certification by managed care plans and utilization review programs.

(B) Revision of standards.--The Secretary shall periodically review the standards established under this subsection, and may revise the standards from time to time to assure that such standards continue to reflect appropriate policies and practices for the cost-effective and medically appropriate use of services within managed care plans and utilization review programs.

TITLE III. CHOICE REQUIREMENTS FOR POINT OF SERVICE PLANS

Sec. 3 (a) Choice Requirements for Point of Service Plans.

(1) Each sponsor of a health benefit plan that restricts access to providers (including such plans provided, offered, or made available by voluntary health purchasing co-operatives, employers, and self-insurers), shall offer to all eligible enrollees the opportunity to obtain coverage for out-of-network services through a "point of service" plan, as defined by subparagraph (2), at the time of enrollment and at least for a continuous one-month period annually thereafter.

(2) For purposes of this Act, an "out-of-network" or "point of service" plan provides additional coverage and/or access to care to non-network providers to an eligible enrollee of a health plan that restricts access to items and services provided by a health care provider who is not a member of the plan's provider network (as defined in subparagraph (2)), or, that may cover any other services the enrollee seeks, whether such services are provided in or outside of the enrollee's plan.

(3) A "provider network" means, with respect to a health plan that restricts access, those providers who have entered into a contract or agreement with the plan under which such providers are obligated to provide items and services in the standard benefits package to eligible individuals enrolled in the plan, or have an agreement to provide services on a fee-for-service basis.

(4) Premiums. A plan may charge an enrollee who opts to obtain point of service coverage an alternative premium that takes into account the actuarial value of such coverage.

(5) Copayments. A point of service plan may require payment of coinsurance for an out-of-network item or service, as follows:

(A) The applicable coinsurance percentage shall not be greater than 20 percent of payment for items and services; and

(B) The applicable coinsurance percentage may be applied differentially with respect to out-of-network items and services, subject to the requirements of subparagraph (i).

(6) Payment Disclosure Requirement. All sponsors of point of service plans and physicians participating in such plans shall be required to disclose their fees, applicable payment schedules, coinsurance requirements or any other financial requirements that affect patient payment levels.

(7) Poverty Exclusion. Any enrollee, including enrolled dependents, whose income does not exceed 200 percent of the established federal poverty guideline for the applicable year, shall be charged no more than amount allowed under applicable plan limits. Such amount, except for reasonable coinsurance, shall be considered payment in full.

TITLE IV. CHOICE OF HEALTH PLANS FOR ENROLLMENT

Sec. 4 (a) In General. Each sponsor of a health benefit plan, who offers, provides or makes available such benefit plan, (including voluntary health insurance purchasing co-operatives, employers, and self-insurers) must provide to each eligible enrollee a choice of health plans among available plans.

(b) Offering of Plans by Voluntary Health Insurance Purchasing Cooperatives, Employers, and other Sponsors.

(1) In general. Each voluntary health insurance purchasing cooperative, employer, or other sponsor shall include among its health plan offerings at least one of each of the following types of health benefit plans:

(A) A health maintenance organization or preferred provider organization;

(B) A traditional insurance plan (as defined in paragraph (2)); and

(C) A benefit payment schedule plan (as defined in paragraph (3)).

(2) Traditional insurance plan defined. For purposes of this act, the term "traditional insurance plan" is defined to include those plans that offer the standard benefits package that pay for medical services on a fee-for-service basis using a usual, customary or reasonable payment methodology or a resource based relative value schedule, usually linked to an annual deductible and/or coinsurance payment on each allowed amount.

(3) Benefit payment schedule plan defined.

(A) In general. For purposes of this Act, the term "benefit payment schedule plan" means a health plan that--

(i) provides coverage for all items and services included in the standard benefit package that are furnished by any lawful health care provider of the enrollee's choice (within the scope of state licensure);

(ii) makes payment for the services of a provider on a fee-for-service basis without regard to whether or not there is a contractual arrangement between the plan and the provider;

(iii) provides a benefit payment schedule that identifies covered services and the payment for each service covered by the plan. No co-payments or coinsurance shall be applied. The plan shall reimburse the enrollee the payment unless the individual authorizes direct payment to the provider. There shall be no restrictions on the amount the provider can charge and collect from the enrollee, either above or below the amount.

MAY 12 1994

American Medical Association
Physicians dedicated to the health of America

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May 9, 1994

Harold Ickes
Deputy Chief of Staff
The White House, West Wing
1600 Pennsylvania Avenue, NW
Washington, DC 20500

Dear Mr. Ickes:

At its April 1994 meeting, the Board of Trustees of the American Medical Association (AMA) approved the enclosed health system reform advocacy initiative designed to advance universal coverage and access to health services for all Americans. This initiative builds upon our January 1994 comprehensive health system reform proposal for action, Providing Health Coverage for All Americans, and is consistent with the foundation of our legislative agenda to ensure physician voice, patient choice, and universal coverage under health system reform.

Universal coverage is one key element of our prescription for cost-effective health system reform. As described in the enclosed report, our new advocacy initiative presents one approach to achieving universal coverage -- a goal we share with the President. Our initiative specifically combines:

- an employer mandate for firms with 100 or more employees;
- an individual mandate, with affordable sliding-scale subsidies for individuals in firms with less than 100 employees;
- a health IRA as an additional mechanism to complement the employer/individual mandate; and
- a phase-in mechanism established at the time reform legislation is enacted.

We believe this initiative blends some of the best approaches advanced in Congress to-date and also represents a politically and economically feasible approach to achieve universal coverage and access to health services for all Americans. However, we also recognize the need for continued flexibility in searching for the best combination of shared employer, individual, and government participation -- and broad-based taxes, if necessary -- to finance universal coverage.

Universal coverage, however, must not be linked to draconian cost-containment mechanisms, such as global budgets or price controls, with physicians and other health care providers shouldering an unfair burden. As Hawaii's system has demonstrated -- with the highest rate of health insurance coverage of any state in the union -- universal coverage helps minimize one of the major problems of our current system: cost-shifting. Universal coverage would also help eliminate several other underlying problems that contribute to rising health expenditures, including: inappropriate use of expensive services (e.g., emergency room rather than office visits); inadequate number of physicians in underserved areas; and delayed or foregone preventive care resulting in more costly acute treatment. These cost-saving changes under universal coverage -- coupled with enhanced competition in the health care marketplace and professional liability reforms -- should effectively reduce national health spending.

As we have discussed in earlier communications, the "voice and choice" elements of our campaign are designed to ensure that physicians and their patients -- not insurance companies or actuaries -- control patient care in any reformed health care system. We firmly believe that a broad physician role in all health plans and in federal health care policy is essential to protect quality of care in a new health system. Similarly, we also believe that in a reformed system, individuals -- not their employers or government -- should have the right to select from all qualified health plans in their area to maximize consumer choice, foster cost-effective competition, and stem the erosion of patient control over health care.

The universal coverage initiative also expands upon the attached editorial that recently appeared in the *Journal of the American Medical Association*. This editorial, authored by Dr. Joseph Painter, President of the American Medical Association (AMA), Dr. Lonnie Bristow, Chair, AMA Board of Trustees, and Dr. James S. Todd, AMA Executive Vice President, responds to the Health Security Act.

We commend the article to you because we believe it is a balanced and constructive addition to the current debate about health system reform. As the editorial emphasizes, physicians want to be responsible partners in the reform debate. As you continue your important work with health system reform, we urge you to consider the many positive suggestions offered in the editorial.

As we say in the close of our editorial: "The congressional deliberation on health system reform should proceed promptly and achieve a desirable compromise so that patients and their physicians together can begin to make a reformed health system work for all Americans."

The AMA hopes that in our ongoing discussions with President Clinton, other Administration officials, and congressional leaders, our legislative agenda on "voice, choice, and coverage" can be pursued to advance meaningful health system reform for all Americans.

Sincerely,

Joseph T. Painter

Joseph T. Painter, MD

Lonnie R. Bristow

Lonnie R. Bristow, MD

James S. Todd

James S. Todd, MD

Enclosures

The American Medical Association Advocacy Initiative
to Achieve
Universal Coverage for and Access to Health Care Services

This position paper describes the American Medical Association's (AMA) new health system reform advocacy initiative on universal coverage and access. The initiative, begun at the time of rapidly-evolving congressional discussions in early 1994, advances the AMA position on universal coverage for and access to health services for all Americans. This initiative presents the framework of a desirable approach. It also recognizes that as the congressional debate unfolds, flexibility will be needed in determining the relative responsibilities of individuals, employers, and government to ensure universal coverage for and access to a standard set of health care benefits for all Americans.

The AMA supports a variety of approaches--an employer mandate, an individual mandate, and health IRAs--to achieve universal coverage for and access to health care services. Our advocacy initiative is based on long-standing AMA policy reflected in *Health Access America,* as well as our updated health system reform proposal for action, *Providing Health Coverage for All Americans*. The AMA is working to achieve the goal of universal coverage and access through the implementation of these policies and through advocacy of the initiative outlined below.

Specifically, the AMA advocacy initiative presents a politically and economically feasible approach to achieve the eventual goal of universal coverage and access to health services through: (1) an employer mandate for firms with 100 or more employees; (2) an individual mandate, with affordable sliding-scale subsidies for individuals in firms with less than 100 employees; (3) a health IRA as an additional mechanism to complement the employer/ individual mandate; and (4) a phase-in mechanism established at the time reform legislation is enacted to achieve universal coverage and access by a time certain.

Background

The American Medical Association believes that:

- Universal coverage and access to health care services are not in conflict but must be pursued simultaneously under health system reform legislation.

- The terms "access" and "coverage" can best be described within the context of the current debate as follows:

  -- Access means that all Americans are able to obtain needed health care services and must include more than just access to health insurance; and

  -- Coverage means that all Americans have a mechanism to ensure payment for needed health care services.

In defining these terms, we fully recognize that there are a number of factors--other than coverage--that also affect access to care. Barriers to access include, for example, the geographic distribution of physicians, other providers, facilities, and the availability of transportation, as well as socioeconomic barriers. However, the AMA firmly believes that: (1) the ability to pay for needed health care is the most important determinant of access to care; and (2) for most Americans, that ability is secured through health coverage. Other aspects of AMA policy address access barriers other than lack of coverage. This position paper focuses on approaches to expand access through universal coverage for all Americans.

In designing and implementing the coverage and access initiative described in this paper, the AMA has considered key factors related to the characteristics of the uninsured population:

- *Employment*. The most important determinant of health insurance coverage is employment. Nearly two-thirds of the nonelderly--or 138 million Americans--have employment-based coverage.

- *Demographics*. 38.5 million Americans--or 17.4% of the nonelderly--were uninsured in 1992. In 12 states and the District of Columbia, more than 20% of the nonelderly population were uninsured. States with the highest percentage uninsured: Nevada (26.6%), Oklahoma (25.8%), Louisiana (25.7%), Texas (25.5%), and the District of Columbia (25.5%).

  -- Among the 38.5 million uninsured Americans, most were working adults (56.7%); the remainder were children (25.4%), and nonworking adults (17.8%).

- *Time without Insurance*. While 50% of uninsured spells end within four months, 30% of uninsured spells last more than a year and 15% last more than two years.

- *Work Status*. Most (84%) of the uninsured live in families headed by workers. More than half (52%) live in families headed by full-time, full-year workers.

- *Firm Size*. The uninsured are disproportionately represented in small businesses. Over half (51%) of all uninsured workers are employed in firms with less than 100 employees. The percentage uninsured is almost 31% in firms with fewer than 25 employees and 21% in firms with 25-99 employees--compared with only 10% in firms of 1,000 or more.

  -- While 51% of uninsured workers are employed by firms with less than 100 employees, only 33% of all workers are in firms of under 100 employees.

- *Income*. Over half (52.5%) of the uninsured live in families with annual family income less than $20,000; another one-fifth (18.5%) earn between $20,000 and $29,999.

- *Poverty Status*. About 40% of the uninsured--or 15.3 million--have family income above 200% of the poverty level; only 4.9 million of the these, however, have incomes above 400% of poverty. In comparison, almost 70% of the total nonelderly population have family income above 200% of poverty. Poverty Levels (1992):

One person	$ 6,810	Three persons	$11,570
Two persons	$ 9,190	Four persons	$13,950

In addition, the AMA has closely analyzed the provisions of several congressional proposals that seek to address universal coverage and access to determine whether these proposals achieve AMA reform goals and principles relevant to universal coverage and access. A brief description of this analysis, which includes congressional bills reflective of an employer mandate (Clinton approach; HR 3600), an individual mandate (Chafee approach; S 1770), and no mandate (Cooper/Grandy approach; HR 3222), is attached in Appendix A. This analysis focuses on only one aspect of the different bills (i.e., provisions to address universal coverage and access). The AMA fully recognizes that there are many other provisions in each of these bills that may or may not be consistent with AMA health system reform policy.

The AMA also has examined other legislative approaches, such as the Nickles bill, the Gramm bill, the Rowland/Bilirakis bill, the Stark proposal, and others in terms of their respective impact on universal coverage and access. We believe that the initiative described in this position paper presents a blending of the best approaches advanced in Congress and represents a politically and economically feasible approach to achieve the AMA's position on eventual attainment of universal coverage and access for all Americans.

AMA Initiative to Advance Universal Coverage/Access: A Suggested Approach

1. Premium Sharing. Support provisions on 80%/20% premium sharing between employer and employee, with premium assistance available between 100%-150% of federal poverty threshold (full premium assistance available below 100% of poverty).

   -- Support insurance market reforms (e.g., remove pre-existing condition limits, establish community rating, and make coverage portable) to improve access to affordable private health insurance and 100% tax deduction for health insurance purchased by the self-employed.

2. Employer/Individual Mandate. Apply employer mandate to firms with 100 workers or more; in firms with less than 100 workers, require individuals to purchase coverage, with subsidy assistance to individuals in such small firms. The blending of the employer/individual mandate would be phased-in over a set period of time following legislative enactment. One approach to the subsidy assistance and blending/phasing-in of the employer-individual mandate is provided below.

   Suggested Approach to Subsidy Assistance:

   -- Full premium subsidy where annual family earnings are below 150% of poverty.[1]

[1] The 150% poverty levels for 1992 are: $10,215 for one person; $13,785 for two-person family; $17,355 for three-person family; and $20,925 for four-person family.

-- Sliding-scale subsidies for those between 150%-300% of poverty. One approach to the subsidy structure is for those families between:

150%-185% of poverty -- 60% subsidy
186%-220% of poverty -- 45% subsidy
221%-256% of poverty -- 30% subsidy
257%-300% of poverty -- 15% subsidy

-- Example of impact on a family of four: At 185% of poverty ($25,807), eligible for 60% subsidy ($2,232). Responsible for premium payment of $1,488 (6.8% of after-tax income). At 300% of poverty ($41,850), eligible for 15% subsidy ($558). Responsible for premium payment of $3,162 (9.1% of after-tax income).[2]

Total subsidies under the approach described above after full phase-in are estimated, on a very preliminary basis, at about $19.5 billion.

Suggested Approach to Use of Tax System:

-- Premium assistance could be provided through the refundable tax credits approach, somewhat similar to the approach in the Nickles bill. For example, if the individual coverage mandate became effective July 1, an income tax return could be filed in the first part of the year in time to receive the refundable tax credit for purchase of the insurance by the required date.

For persons who become unemployed in a year causing a different financial situation than portrayed by the prior years' tax return, a direct subsidy tied into the unemployment compensation program should be used.

-- Implementation of the individual mandate could be tied to the income tax system, as in the Nickles bill, to: (1) identify who is eligible for a subsidy; (2) determine the size of the subsidy; and (3) establish, subject to voluntary employer/employee agreement, an individual wage deduction to meet premium costs, with separate identification of said deductions for health premium purposes to sensitize employees to costs.

Suggested Approach to the Blending and Phase-in of Employer/Individual Mandate:

-- Firms with 1000 or more workers would be subject to the employer mandate in the first year, gradually applying to all firms with 100 or more employees. Subsequently, the individual mandate (which includes the self-employed) would also be phased-in, based on firm size.

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[2] By comparison, for employees in firms over 100, at the $3,720 family premium for the AMA benefit package, an employee--regardless of income--would pay only the 20% portion of premium or $744, which at the $25,807 income level for a family of four (i.e., 185% of poverty) would be 2.3% of after-tax income and at $41,850 (i.e., 300% of poverty) would be 2.1%. At $100,000 income, the 20% premium would be 1% of after-tax income.

1st year - Employer mandate to firms with 1,000 or more employees (extends coverage to 7.2 million of the uninsured)

2nd year - Employer mandate to firm between 500-999 employees (extends coverage to additional 1.3 million of uninsured)

3rd year - Employer mandate to firms of 100-499 employees (extends coverage to an additional 4.2 million of the uninsured)

4th year - Individual mandate to firms of 25-99 employees (extends coverage to an additional 5.5 million uninsured)

5th year - Individual mandate to firms of 10-24 employees (extends coverage to an additional 4.4 million uninsured)

6th year - Individual mandate to firms with fewer than 10 employees (extends coverage to an additional 9.8 million uninsured).

The remaining 6 million uninsured individuals who are not connected to the workforce would be subject to the individual mandate beginning in the fourth year of the phase-in, with appropriate subsidy assistance as outlined earlier in this report.

3. Health IRAs. Utilize health IRAs or health savings accounts as an additional mechanism to supplement employer/individual mandates. One way in which such a mechanism could be used would be for those employers subject to the employer mandate to offer employees a choice of a standard health insurance benefit package or an equivalent amount of coverage through a health IRA/savings account with catastrophic coverage. The employer's financial contribution would be the same under either option. For the employee, the maximum out-of-pocket exposure for health services would also remain the same, although there could be additional premium responsibility if an employer's payment was not sufficient to completely cover both the cash contribution to the health savings account and the catastrophic policy premium.

Summary

The American Medical Association believes that the initiative described, which combines employer/individual mandates, health IRAs, and a phase-in mechanism, is an innovative and flexible--as well as politically and economically feasible--approach to achieve the eventual goal of universal coverage and access to health services consistent with AMA reform policy and principles. The AMA, while fully recognizing the need for continued flexibility in how to best achieve universal coverage and access, is using this one approach in its legislative and advocacy meetings on health system reform and will continue to explore all concepts that accomplish reasonable, guaranteed coverage for and access to health services for all Americans.

Appendix A
Analysis of Universal Coverage and Access Provisions
in Selected Congressional Health System Reform Proposals

Clinton/HR 3600

Employer and individual mandates, with mandatory coverage of all Americans by 1998. Employers required to pay 80% of premium costs for employees; unemployed and self-employed required to buy insurance. Fully subsidized premium coverage for those below poverty and premium assistance for those up to 150% of poverty.

Universal coverage achieved. Almost all--or about 32.5 million of the currently uninsured-- would receive coverage through their employment setting under the Clinton bill.

Example: An employed single mother with two children earning $23,600/year (after-tax income of $21,069) would now receive coverage through her employer. Her 20% share of the premium for family coverage would be $744--or about 3.5% of family after-tax income (based on the $3720 total cost of the AMA standard benefit package).

Cooper/HR 3222

No employer or individual mandate. Sliding scale subsidies provided for individuals up to 200% of poverty. Employers required to offer--but not to pay for--employee coverage.

Universal coverage not achieved. No employer or individual mandate and sliding scale premium assistance available only up to 200% of poverty. Therefore, 15.3 million uninsured Americans with incomes above 200% of poverty--or 40% of the total uninsured population-- would face paying the entire premium, if they chose to purchase health insurance. Many of these uninsured individuals would be unable to afford health coverage.

Example: Single employed mother of two children (as described in above example) would not receive any premium assistance, because her income exceeds poverty level by more than 200%. Premiums for health coverage for this family would cost $3720--or about 17.6% of family after-tax income. (Premium cost is based on AMA standard benefit package.)

Chafee/S 1770

Individual mandate, with mandatory coverage of all Americans by 2005. Individuals required to buy insurance, with federal subsidies phased-in gradually up to 240% of poverty by 2005. Employers required to offer--but not pay for--employee coverage. Without employers being required to contribute to the cost of coverage, the entire premium burden is on the individual. Based on the bill's provisions, an estimated 80% of the currently uninsured--or about 28 million Americans--would likely remain uninsured by 1997, since none in this income group would be eligible for premium assistance.

Even by 2005 (with full premium assistance phase-in), many of the 15.3 million uninsured with incomes above 200% of poverty would face paying the full premium expense--creating a financial burden for the individual/family with a disproportionate share of income going toward health coverage.

Example: A single employed mother of two children (as described in the previous example) would not be eligible for a voucher, based on her income, until the year 2003. The phase-in of voucher assistance would be further delayed if cost savings are not realized as provided for in the bill. Until such premium assistance was available, she would be responsible for full premium payment--$3720 (based on the AMA standard benefit package)--or about 17.6% of family after-tax income.

Shared Sacrifice

The AMA Leadership Response to the Health Security Act

In a February 1993 *JAMA* Editorial, leaders of the American Medical Association (AMA) wrote: "We stand at a watershed. The opportunity for physicians to do what is best for our patients in the public policy arena has never been better. Within our grasp is the chance to open the door to appropriate care for every child and adult, to see that every health dollar is invested in care that is right for every patient; to end outrageous administrative costs and wasteful paperwork; and to guarantee all patients the freedom to choose their own physician."[1] This statement sounds remarkably similar to the speech President Clinton made to Congress on September 22, 1993; the AMA has been calling for security, savings, simplicity, quality, choice, and responsibility since 1990 with the unveiling of its Health Access America[2,3] proposal. Yet in that same Editorial, AMA leaders wrote, "But as our new president himself acknowledges, the 'devil is in the details.' It is in defining those details that the physicians of America are now prepared to lend a steadying, experienced hand."[1]

On September 10, 1993, the AMA and other organizations with interest in health policy received a leaked copy of a 240-page document that outlined the bold strokes as well as the intricacies and complexities of a new health system.[4] We then anxiously awaited the "details" that were later released as the proposed Health Care Security Act.[5] We were both encouraged and dismayed by what we read in these documents. Encouraging was a vision of a health system where everyone would receive care, regardless of income, location, health, or job status. A prevention-oriented benefit package modeled on the AMA's own recommendations was included. A fee-for-service option with considerable patient choice was promised. Cost shifting would end. However, our enthusiasm was moderated by the degree of centralized regulation in a proposal that was intended to be a competitive, market-based approach, by the premium caps proposed as a "backstop" to competition, and by the apparent powers given to insurance companies or other large entities. How did this happen? How can we agree with the principles in the administration's plan and still see much that requires revision?

Administration representatives have promised to be open to suggestions and revisions and to work with Congress and others vitally concerned about health care. We are eager to continue participating in that dialogue, but we maintain that these discussions must focus on a few unanswered questions (discussed below) that are implicit in the guideposts of the Administration plan.

Security

"Health Care That's Always There" is the calling card of the administration. Both the President and Mrs Clinton have repeatedly stressed that their plan offers Americans "peace of mind" by granting everyone guaranteed access to basic health care benefits. This is an extremely appealing message in an era characterized by constant change, threats to personal safety, and fears of job loss, and it is one with which we wholeheartedly agree. The AMA has been calling for insurance reform and Medicaid reform for many years. The question is not *whether* all should have access to care, but rather, *how* society can soon afford to include everyone in the new system. The AMA questions whether the proposed $116 billion in subsidies for low-income firms and workers is really enough and whether more can safely be wrung out of Medicare, Medicaid, and sin taxes to pay for these subsidies. Why not start out with a phase-in of the most vulnerable populations and establish a track record and validate estimates of the costs and the subsidies required before including everyone by a certain date in the near future?

Savings

The administration has proposed a many-pronged attack on runaway health care costs, including limits on increases in insurance premiums, competition in the health care marketplace, a crackdown on fraud, voluntary restraint on prescription drug prices, reduction in paperwork, and elimination of any waste in Medicare and Medicaid. Few reasonable people dispute the fact that costs have to be controlled. The AMA has repeatedly offered multiple suggestions to this effect to the administration, such as encouraging more cost-effective decision making by taxing a portion of "high-end" insurance benefits; insurance reform, such as elimination of limitations on preexisting conditions; administrative simplification; professional liability reform patterned after California's MICRA statute; and practice parameter development and application, all of which are part of Health Access America. These initiatives are estimated to result in a 5-year savings of $120

From the Office of the President (Dr Painter), the Office of the Chair of the Board of Trustees (Dr Bristow), and the Office of the Executive Vice President (Dr Todd), American Medical Association, Chicago, Ill.

Reprint requests to Office of the Executive Vice President, American Medical Association, 515 N State St, Chicago, IL 60610 (Dr Todd)

billion." There is also a middle-range estimate of potential defensive medicine savings from comprehensive malpractice reform of $4.3 billion in 1994 and a total of $35.8 billion between 1994 and 1998.[8] A significant improvement in the application of market forces would occur if providers of all types would make information about the price of services available to patients prior to the provision of those services in the nonemergency setting. This, coupled with insurers' providing advance information about what they can be expected to pay for those services, would encourage more cost-conscious medical decision making.

The real dilemma is how best to control costs. The answer to that question depends on how one defines the root causes of increased health care spending. The Clintons answer the question by pointing to paperwork, waste, and fraud. While few seriously doubt that there are significant savings to be found in these areas, many thoughtful commentators believe there is more to cost increases and cite the contributions of medical technology coupled with generous insurance coverage.[9]

Economist Joseph Newhouse of Harvard University attributes a substantial proportion of the recent increases in health care spending to new medical technologies, with the rest stemming from rising population and inflation.[9] As people strive to improve the quality of their lives, physicians and hospitals order whatever seems to offer a reasonable likelihood of an improved outcome. Is this unnecessary? Is it waste? It may be that waste is in the eyes of the beholder. Under the premium caps proposed by the administration, there must be annual targets. What happens when targets are exceeded? At some point, very difficult decisions will need to be made about denying treatment to the sick. Physicians are willing to contribute to making these decisions, but only if society as a whole is willing to give guidance, based on ethical principles, about how to balance the national need for economic discipline with individuals' need for the "best" medical care and the quality of their lives.

The AMA has said repeatedly that it is against an arbitrary federal cap, imposed for budgetary reasons with no input from physicians. Fee schedules for physicians would be acceptable if there are genuine negotiations between doctors and the government and if those negotiations take into account spending across all health care sectors and the role of demographics, incidence of disease, and technological changes. We hope the administration accepts this concept.

Simplicity

The Clinton administration wisely identifies the need for greater simplicity in our health care system by offering a health security card, a single claim form, streamlined billing, and uniform benefits. Again, the AMA has long sought simplification in the system and has often requested relief from some regulations, such as CLIA, that increase paperwork. We are especially supportive of the single claim form that many insurers currently use. However, how do we achieve the delicate balance between simplicity and accountability? We now have CLIA, OSHA, PROs, and their accompanying paperwork to improve the accountability of physicians to the public, usually through government. The AMA supports the streamlining or elimination of these programs to further enhance simplicity, if it can be done without diminishing accountability.

In a proposed system with a new National Health Board, a committee to consider the pricing of "breakthrough drugs," a new National Quality Management Council, a new National Council on Graduate Medical Education, a new National Privacy and Health Data Advisory Council, and various other entities, we have a hard time believing that paperwork for providers will be reduced. It will be the responsibility of these entities to make sure that funds are being spent wisely, especially when they are under tight budget constraints, which almost ensures more forms and reports.

We want to be part of the solution. Let us work together to attempt to design a system that truly is simple and does not impose more paperwork in the name of accountability.

Choice

During the past months, as the AMA has met many times with Ira Magaziner and members of the White House task force, we were encouraged by the continued emphasis on patient choice of physician. We have extensively discussed the proposed fee-for-service plan, the ability of physicians to join more than one plan, and the point of service option so that patients can choose to receive care outside of their plan. We are happy to see these ideas in the Health Security Act. The questions yet to be answered are these: Who will make the choices about what types of treatment individuals receive? Will it be physicians working with patients in determining the most appropriate, cost-effective care? Or will it be large systems far removed from each individual patient? We believe American physicians want the opportunity to provide more choice by forming their own networks and providing significant input into networks formed by others. We want to work with the administration, Congress, insurance companies, and patients to find ways to overcome the significant fiscal, antitrust, and organizational barriers so we can give our patients not only a choice of physician, but also a choice in treatment decisions.

Quality

The AMA was very pleased to see the priority that the Clinton administration placed on quality. We were fearful that all of the discussion about improving access and reducing costs might leave quality out of the equation. We agree with the premise that the best-quality care is often the most cost-effective care. We are especially encouraged about the emphasis on preventive care and the development of properly designed information on the performance of health care plans and patient satisfaction. The AMA has been instrumental in developing over 1500 practice parameters that are based on research and physician judgment about the best way to treat certain conditions.[10] We recognize that much more research is needed, especially in outcomes research, so that costs can be controlled without sacrificing the quality of care. The question remains: Who will make the decisions that balance quality and costs for each patient? Will it be for-profit corporations? The government? Physicians?

Of all of the areas of the president's plan, this is where physicians have the most expertise, and it is also the area we worry about most. We have proposed a public-private partnership and offered our long experience in standard setting for medical education at all levels, accreditation, and peer review. We stand ready to further discuss the offer we made back in February: "Let the profession and government par-

ticipate cooperatively in developing parameters of care and technology assessment to ensure that the most appropriate health care services are provided at competitive costs."[1] On behalf of patients, physicians must have significant involvement in any new National Quality Management Program, the National Health Board, alliances, and health care plans. We also need to ascertain the effects of health system reform on medical research in the public and private sectors.

The president's plan also proposes a new entity, the National Council on Graduate Medical Education, which will allocate residency training positions to the various residency programs. The AMA would like to continue its role in maintaining the quality of residency programs and to join with government and higher education to develop a cooperative model for physician workforce planning.

Responsibility

As is vital in a democracy, President Clinton has appropriately asked all Americans to take more responsibility for their health and health care. The AMA applauds the emphasis on preventive care and the requirement for everybody to pay something, even low-wage workers, the unemployed, and small businesses. Having recently reaffirmed its support for universal coverage and access to health care services, the AMA's policy to achieve these goals supports both employer-required and individually required and owned health insurance,[11] with clear expression of the need for increased responsibility on the part of all parties.

For several years, the AMA has been very involved in campaigns against violence and tobacco because of its concern about the heavy price that society is paying for the injuries and illnesses resulting from violence and tobacco.

Our question here is: "How can physicians become more involved and more responsible for health system reform?" The administration and Congress have very little to fear and much to gain by urging and allowing physicians to do more in quality assurance, cost containment, network formation, administrative simplification, and workforce planning. Physicians, too, want to be responsible partners in the reform debate.

Conclusion

Because we want to be responsible partners in the national debate to reform America's health care system, we suggest that all of the goals in the president's plan can be achieved in a much less bureaucratic manner. Security can be achieved through insurance reform and Medicaid reform and a standard benefit package. Savings can be achieved by encouraging the intense competition currently under way, coupled with predictable spending goals negotiated with providers. Meaningful professional liability and antitrust reforms will also save money. We can have a simpler system with a single claim form and a rollback of unnecessary regulation.

Americans can enjoy freedom of choice by taking advantage of the many types of plans that are predicted to be available in most parts of the country. Quality can be improved through quicker development and application of practice parameters and outcomes research; physicians also need to be responsible for adhering to validated parameters. Responsibility can be fostered through decision making by patients, physicians, hospitals, and other providers, who must be made aware of the cost of services. Everyone would have to make sacrifices in this type of system; many might have to pay a little more. But this vision of a reformed health care system should not have so many unanswered questions or so many details yet to be worked out. Some parts of the United States (Hawaii and Rochester, NY, for example) have successfully implemented this type of system reform.

With the commencement of the second session of the 103rd Congress, America's physicians are hopeful that the plethora of congressional proposals will provide the vehicles for a workable compromise in 1994. The AMA intends to be a positive force for change, urging the adoption of portions of the many proposals currently under consideration. The debate need not continue into 1995. The congressional deliberations on health system reform should proceed promptly and achieve a desirable compromise so that patients and their physicians together can begin to make a reformed health system work for all Americans. Now is the moment of truth to achieve the president's and the AMA's goals in the simplest and most feasible way.

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