REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-03)
Health Insurance Market Regulation
(Reference Committee A)
(June 2003)

EXECUTIVE SUMMARY

Council on Medical Service Report 7 responds to Resolution 725 (I-02), which in part, calls for the AMA to study the benefits and risks of national health insurance regulation. As part of its ongoing efforts to refine and develop the AMA's long-term proposal for reform of the U.S. health insurance system, the Council had already initiated the development of guidelines for health insurance market regulation in the context of individually based insurance.

The AMA reform proposal includes three key elements designed to expand health insurance coverage and choice: (1) income-related, refundable, advanceable tax credits toward the purchase of health insurance; (2) individual rather than employer ownership and selection of health plan; and (3) promotion of alternative markets through which to purchase coverage. As in the existing system, a major concern about the proposed system is the ability of insurance markets to provide affordable coverage while serving the needs of individuals with above-average health needs. The desire to protect specific target populations has been a major force behind market regulations regarding terms of issue, premium rating, benefit mandates, and other aspects of health insurance. Existing regulations often have unintended consequences and unfairly affect people differently depending on where they live or work. Such regulations can also be burdensome, complex, and contradictory. A large body of AMA policy on health insurance market regulation has accumulated in a piecemeal fashion over many years, and itself contains a number of inconsistencies.

Council Report 7 (A-03) proposes a more uniform approach toward health insurance market regulation in support of broad policy goals. The report finds that: (a) the combination of guaranteed issue, strict community rating, and extensive benefit mandates has disastrous unintended effects on costs, coverage, and choice; (b) a more rational approach would include modified community rating, guaranteed renewability, and subsidization of high-risk individuals from general tax revenues; (c) the regulatory environment should enable rather than impede private market innovation; and (d) such a regulatory approach would improve health insurance market function whether in the context of the existing or the proposed system. The report concludes that implementation of individually based insurance should not be prevented due to inevitable unresolved questions, and that regulations can be crafted to protect target populations while expanding choice and coverage for the general population. The report proposes a series of principles for health insurance market regulation.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7 - A-03
(June 2003)

Subject: Health Insurance Market Regulation

Presented by: Cyril "Kim" Hetsko , MD, Chair

Referred to: Reference Committee A
(Kevin T. Flaherty, MD, Chair)

At the 2002 Interim Meeting, the House of Delegates adopted as amended Resolution 725, which in part, calls for the AMA to study the benefits and risks of national health insurance regulation. The Board of Trustees referred the requested study to the Council on Medical Service for a report back at the 2003 Annual Meeting. As part of its ongoing efforts to refine and develop the AMA's long-term proposal for reform of the U.S. health insurance system, the Council had already initiated the development of guidelines for health insurance market regulation.

The AMA reform proposal includes three key elements designed to expand health insurance coverage and choice: (1) income-related, refundable, advanceable tax credits toward the purchase of health insurance; (2) individual rather than employer ownership and selection of health plan; and (3) promotion of alternative markets through which to purchase coverage. As in the existing system, a major concern about the proposed system is the ability of insurance markets to provide affordable coverage while serving the needs of individuals with above-average health needs. The desire to protect specific target populations has been a major force behind market regulations regarding terms of issue, premium rating, benefit mandates, and other aspects of health insurance. Existing regulations often have unintended consequences and unfairly affect people differently depending on where they live or work. Such regulations can also be burdensome, complex, and contradictory. A large body of AMA policy on health insurance market regulation has accumulated in a piecemeal fashion over many years, and itself contains a number of inconsistencies.

The purpose of this report is to make progress toward development of a unified, rational approach toward health insurance market regulation in support of the following broad policy goals:

- To collectively finance the medical expenses of known "high spenders," such as individuals with chronic illness or conditions that are expensive to treat – explicitly recognizing that neither free-market mechanisms nor market regulations alone will fully meet the needs of such individuals.

- To provide insurers with financial incentives to accept and cover individuals who have above-average expected medical expenses.

- To subsidize medical expenses of known "high spenders" through mechanisms that do not unduly drive up health insurance premiums for the rest of the population.

- To ensure that the general population has access to a wide choice of high-quality, affordable coverage.

- To provide individuals with incentives to be continuously insured, consistent with AMA policy favoring incentives over an individual mandate. Incentives should penalize people for waiting until they are sick to purchase insurance and reward them for obtaining and maintaining coverage.

The scope of the report includes regulation of the economic aspects of health insurance markets, as well as public policies targeting subsidies by income or risk, since such policies are used to achieve the same goals as traditional market regulation. The report also addresses a number of private market developments that have desirable effects consistent with regulatory goals and are shaped by the regulatory environment. In preparing the report, the Council on Medical Service met with a panel of outside experts. The remainder of the report presents pertinent background facts and analysis, describes the AMA reform proposal, offers a cursory view of existing regulations, evaluates specific regulations, summarizes relevant AMA policy, and makes a series of policy recommendations.

BACKGROUND FACTS AND ANALYSIS

In considering a more rational, uniform, and possibly national regulatory framework, it is useful to keep in mind certain facts about the existing individual health insurance market. Figures 1-3 show how premiums vary by age, health status, and insurer risk class, and the distribution of health insurance applicants by risk class. Analysts have observed remarkable consistency in the distribution of health care expenditures for a variety of populations (Berk and Monheit, *Health Affairs*, March/April 2001):

- The least costly 50% of individuals account for only 2-5% of total expenditures.

- The most costly 10% of individuals account for about 70% of total expenditures.

- The most costly 1% of individuals account for about 30% of total expenditures.

- The most costly 2-3% of individuals in a given year do not remain in the extremely high-cost category in subsequent years. Such individuals generally have experienced truly unpredictable, random events, and tend to get better or die by the following year.

- Cost distributions across individuals become less skewed the longer the time period (e.g., for a given cohort, there is less variation in costs over the course of a lifetime than over a year).

- Even in markets with unregulated premiums, the distribution of premiums is considerably less skewed than the distribution of actual - or even expected - costs.

Council on Medical Service Report 3 (A-01), "The Effects of Individually Owned Health Insurance on Risk Pooling and Cross-Subsidization," provides conceptual and empirical analysis relevant to health insurance market regulation. The following concepts build upon those developed in Council Report 3 (A-01):

- There is a distinction between risk pooling and cross-subsidization. Risk pooling occurs when large numbers of individuals of similar risk (i.e., similar expected costs) each pay a premium equal to average expected cost (plus administrative markup). Premium revenues are used to pay costs of all covered individuals regardless of how their actual costs compare to average.

- Cross-subsidization occurs when individuals of different risk each pay a premium equal to average expected cost. In this case, low-risk individuals (i.e., those with below-average expected costs) subsidize the coverage of high-risks (i.e., those with above-average expected costs).

- In practice, existing health insurance provides both risk pooling and cross-subsidization.

- While there is consensus that insurance should provide risk pooling, the optimal degree of cross-subsidization is a value judgement about tradeoffs between the welfare of high-risk individuals and low-risk individuals.

- As shown in Figure 4, regulation of health insurance markets involves tradeoffs between high-risk individuals and low-risk individuals. At one end of the continuum, restriction of premium rating, terms of issue, and choice of plans compress differentials in premiums, lowering premiums for high-risk individuals and raising them for low-risk individuals. Premium and benefit compression result in relatively high enrollment rates for the high-risk and low enrollment for the low-risk. Moving to the other end of the continuum, the less restriction in premiums and benefit packages, the lower the premiums and greater the coverage rates for low-risk individuals, along with higher premiums and lower coverage rates for high-risk individuals.

- Attempts to regulate insurance markets in order to keep premiums low and coverage high for high-risk individuals can backfire. Since low-risk individuals face premiums that exceed their expected value of insurance, enrollment of low-risk individuals is reduced, thereby driving up average costs and premiums.

- Subsidies to high-risk individuals need not be financed through insurance markets (e.g., community rated premiums). Assistance to high-risk individuals could be financed through general tax revenues and similar mechanisms which do not "distort" the market by driving up premiums for low-risk individuals.

THE AMA REFORM PROPOSAL

The core of the AMA proposal involves refundable, advanceable tax credits inversely related to income for use toward health insurance coverage of the individual or family's choice (Policies H-165.920 and H-165.865, AMA Policy Database). Tax credits would be contingent on obtaining health insurance coverage and would apply regardless of employment status or whether insurance is obtained through an employer or elsewhere. Tax credits would replace the existing federal income tax exclusion for employment-based health insurance, thereby refocusing government subsidization of health insurance to those least able to afford coverage. The second element of the AMA proposal is individual ownership and choice of health insurance coverage, which would create direct competition among health plans for individuals, rather than employers. Such

competition will foster improved quality, restrained costs, and a wider array of insurance market offerings. Finally, the AMA proposal promotes widespread availability of affordable health insurance through alternative markets. Rather than being limited to traditional employment-based insurance and the current individual market, individuals and families would have expanded opportunities to obtain coverage, for example, through purchasing groups, the Internet, and new consumer-directed health care arrangements.

Any health care system in which coverage is provided predominantly through private insurers must define market rules governing terms of issue, enrollment, premium rating, benefit design, subsidies for targeted populations, group purchasing arrangements, and other aspects of the market. A major area of concern regarding individually based insurance as proposed by the AMA is how well markets would serve the needs of high-risk individuals. There is fear of decreased cross-subsidization from low-risk individuals to high-risk individuals due to the following factors: increased choice leading to greater risk segmentation across plans through self-selection, which would reduce cross-subsidies even under pure community rating of plan premiums; the dissolution of existing risk pools and associated cross-subsidies; and possible individual risk rating of premiums. The AMA proposal addresses this potential loss of cross-subsidization via explicit subsidies to high risk individuals, as discussed in greater detail later in this report.

THE "CRAZY QUILT" OF EXISTING REGULATIONS

A plethora of state and federal regulations apply to various health insurance markets. Which regulations apply in a given instance depends on a combination of specific characteristics: geographic location; large vs. small group; group vs. individual; self-insured vs. fully insured; government vs. private employer; employment group vs. employer purchasing alliance vs. other group; what form of insurance (e.g., managed care, indemnity or medical savings account); low-risk vs. high-risk individual; employed by a firm vs. self-employed vs. unemployed; how long unemployed; how long uninsured; previous group coverage; etc. Federal regulations alone constitute a veritable alphabet soup (e.g., ERISA, HIPAA, COBRA), not to mention the dizzying array of state and local regulations, many of which have unintended consequences such as making health insurance unaffordable for many people.

As a result, within a given geographic area, different sub-markets may operate in vastly different regulatory environments. Compared to large groups, small groups contend with unfavorable treatment under federal law, particularly the Employee Retirement Income Security Act of 1974 (ERISA), which exempts large self-insured groups from state benefit mandates and market regulations. States have the authority to extend ERISA advantages to small group purchasing arrangements, and each state has different guidelines for which features of ERISA apply to which types of entities. Furthermore, differential application of ERISA occurs against a backdrop of different small group and individual market regulations in each state. The result is a "crazy quilt" of regulations, which creates "regulatory gradients" across different markets within a given state and across state lines (Hall et. al., *Health Affairs*, January/February 2001).

For example, regulatory gradients serve as a major impediment to the formation of small group purchasing alliances. Some states permit experience rating of premiums in the small group market but prohibit experience rating by purchasing alliances formed by small employers. As a result, the purchasing alliances are subject to adverse selection and possible "death spirals" since lower-risk individuals and groups gravitate to the relatively unregulated small group market where they pay

lower premiums. In addition, various types of purchasing alliances are subject to different federal and state regulatory treatment, prompting the establishment of numerous types of alliances, each being exempt from different regulatory policies. Geographic regulatory gradients also hinder purchasing alliances by raising costs of administration and regulatory compliance in multiple states, inhibiting growth and preventing realization of economies of scale.

In 1996, the federal Health Insurance Portability and Accountability Act (HIPAA) was passed with the primary goal of expanding health insurance coverage and continuity by restricting insurers' ability to deny or discontinue coverage to specific individuals or groups on the basis of health status (Nichols and Blumberg, *Health Affairs*, May/June 1998). Supporters hoped that HIPAA would bringing greater uniformity to the patchwork of regulations governing private health insurance markets. However, HIPAA contains different provisions for large-group, small-group, and individual markets, as well as allowing some degree of state variation in its application to the individual market. HIPAA's provisions governing group markets include: (a) restricting pre-existing condition exclusions to one year; (b) applying prior group coverage toward any waiting period before which pre-existing condition exclusions are lifted; (c) guaranteeing individuals with eighteen months of continuous group coverage access to group coverage, if any, offered by a new employer; (d) requiring limited guaranteed renewability (though without the usual protection against health-related premium increases); and (e) requiring guaranteed issue of all insurance products in the small-group market (again, with no premium rating restrictions). HIPAA's individual market provisions offer certain protections for a narrowly defined group of individuals who have at least 18 months of prior group coverage and who meet additional criteria. States have considerable flexibility in determining eligibility criteria and which individual market product or products must offer guarantee access to eligible individuals. Except in the case of state high-risk pools, guaranteed access is not accompanied by any premium rating restrictions. In addition, there is limited guaranteed renewability for all individual market products, though again, without restrictions on health-related premium increases. Finally, during its passage by Congress, HIPAA grew to include a host of other regulations unrelated to portability, for example, requirements intended to protect individual privacy and reduce insurer and provider fraud.

Although it is hard to quantify HIPAA's impact – in part due to the small numbers of people to which it applies – there is general consensus that it has fallen short of its promise and led to unintended negative consequences. Critics maintain that HIPAA has done little to improve coverage, while substantially increasing the regulatory burden and costs of coverage (*The Cato Journal* special issue "Making a Federal Case Out of Health Care," Spring/Summer 2002). It is true that in the large-group market, HIPAA brought uniform standards to self-funded ERISA plans – something that could only have been achieved at the federal level (Nichols and Blumburg, *Health Affairs*, May/June 1998). However, in the small-group market, HIPAA simply replicated many state regulations. In many cases, HIPAA set lower standards than did state's regulations, possibly providing subtle impetus to, for example, lengthen pre-existing condition exclusion waiting periods (Pauly, *The Cato Journal*, Spring/Summer 2002). An employee who changes jobs but whose new employer does not offer health benefits derives no protection from the law. HIPAA's direct impact in the individual market has probably been negligible due to the limited number of eligibles and plans to which the law applies. Across all markets, the lack of premium rating restrictions has, to a large degree, rendered moot the protections intended by guaranteed issue and guaranteed renewability. In addition, by reinforcing the distinction between group and individual coverage, HIPAA has been criticized for stifling market innovations that blur this distinction, particularly

defined contribution health benefits (Miller, *The Cato Journal*, Spring/Summer 2002). In short, HIPAA turned out to be a less comprehensive and more complex law than originally envisioned.

SPECIFIC MARKET REGULATIONS

Table 1 shows the major intended and unintended consequences of a variety of specific market regulations, including impacts on different types of individuals. The typology of "Individuals or Scenarios" is designed to cover all bases without specifying every last permutation of health, risk, and income, hence, the categories are not mutually exclusive. For example, someone could be of good-to-average health, anticipate transient high costs (e.g., due to pregnancy or surgery), and/or be low-income. It should also be kept in mind that the effects of any one regulation in isolation do not necessarily apply, qualitatively or quantitatively, in the presence of other regulations.

Key "walkaways" of the table include the following:

- Guaranteed issue and community rating can backfire, especially when paired together. As noted earlier, attempts to lower premiums for high-risk individuals can raise premiums of low-risk individuals, reducing their enrollment, and thereby driving up average costs and premiums.

- "Uninsurable" individuals require special, targeted policies in order to both subsidize their coverage and ensure that insurance markets allow affordable premiums for the general population.

- It is preferable to finance risk-related subsidies through general tax revenues than through premium surcharges, because premium surcharges have the unintended consequence of driving low-risk individuals out of the market, particularly low-income, low-risk individuals.

- In addition to risk-related subsidies financed through general tax revenues, income-related tax credits, guaranteed renewability, medical savings accounts, and multi-year contracts have many advantages – including greater individual choice of coverage – and warrant further consideration by public policy makers.

- The effect of a given market regulation depends in part on the broader regulatory environment, making it important to consider packages of market regulations.

SUMMARY OF RELEVANT AMA POLICY

The Appendix to this report contains a summary of AMA policy relevant to market regulation. As the summary indicates, AMA policy strongly supports expanded health insurance coverage and choice, consistent with the broad goals of market regulation. Numerous AMA policies address various aspects of health insurance market regulation including premium rating and terms of issue, coverage and benefit mandates, income-based targeting of subsidies, high-risk pools and other measures targeted to high-risk individuals, and group purchasing arrangements. As noted earlier, this large body of policy has accumulated in a piecemeal fashion over many years, and itself contains a number of inconsistencies. Nonetheless, AMA policy generally supports modified community rating, guaranteed issue, and guaranteed renewability. AMA policy seeks to prohibit insurers from using genetic information in determining an individual's premium, and permits

premium discounts to non-smokers. AMA policy opposes preexisting condition limitations under most circumstances. AMA policy opposes benefit mandates unrelated to patient protections. Other measures supported by AMA policy include: standardized format of health plan benefit descriptions in order to facilitate plan comparisons; subsidies to high-risk individuals through high-risk pools, risk adjustment, reinsurance, and direct premium subsidies; and support for health insurance purchasing alliances (health insurance marts, voluntary choice cooperatives). In addition, the AMA has extensive policy on a number of market-based developments which support the goals of expanded coverage and choice. In particular, AMA policy supports defined contributions, medical savings accounts, and experimentation with multi-year insurance contracts.

DISCUSSION

Greater Uniformity of Market Regulations

The Council believes that there is clearly a need for greater rationalization and uniformity of regulations across all health insurance markets. Differential regulations add to administrative costs, impede formation of group purchasing alliances, prevent realization of economies of scale, and create adverse selection. Insurers are likely to consent to, or even welcome, certain regulations so long as they know that they are operating on an even playing field in which all insurers and plans must play by the same rules. Limited state variation in market regulation should be permitted so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances, or create undue "regulatory gradients" and adverse selection across sub-markets.

A more uniform national regulatory framework should build upon lessons learned from experience at the state level. During the 1990s, Kentucky, Tennessee, New Jersey, New York, and a number of other states attempted to expand coverage and contain premium costs for high-risk individuals through heavy regulation of the small group and individual markets. The combination of guaranteed issue, strict community rating, and extensive benefit mandates proved to be a potent recipe for disaster, driving low- and average-risk individuals out of the market and, ironically, driving up average costs and premiums. Observers have noted that community rating is effectively a form of taxation of the healthy through regulation that is politically more expedient to implement than changes in tax legislation.

Premium Rating and Terms of Issue

The Council believes that a more rational, fair approach to market regulation would permit markets to function better through a combination of modified community rating, guaranteed renewability, and subsidization of high-risk individuals from general tax revenues. By allowing some degree of premium variation to reflect individual factors, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population. Allowing a fair degree of individual premium variation at the initial point of enrollment, along with guaranteed renewability and limited reunderwriting of insured individuals who switch health plans, would give people powerful incentives to obtain and maintain coverage when healthy (Patel and Pauly, *Health Affairs* Web exclusive, August 2002). However, guaranteed renewability regulations should not preclude insurers from singling out individuals for rate changes or other incentives and disincentives related to changes in controllable lifestyle choices (e.g., the initiation or cessation of smoking). In order

for incentives to have maximum impact, it is important that the public be aware of both the rewards of obtaining coverage and the possible penalties of forgoing it.

Among advocates of strict community rating, there is a great deal of fear about any move toward risk rating. However, the Council believes that these fears are exaggerated for a number of reasons, particularly when alternative safeguards are enacted to protect high-risk individuals. In fact, the starting point for premium rating could just as well be individual risk rating rather than community rating, with departures from risk rating requiring justification on equity grounds – rather than departures from community rating requiring justification on efficiency grounds.

In any case, there are reasons not to be deterred from a system of individually based insurance because of possible movement toward greater risk rating. The degree of risk rating in unregulated markets is not as great as commonly believed, nor is there as much cross-subsidization from low-risk to high-risk individuals in employment-based groups as is generally assumed (Pauly and Herring, *Pooling Health Insurance Risks*, AEI Press, 1999). Evidence suggests that *de facto* age rating occurs under employment-based insurance because wages adjust to account for the fact that older workers incur higher health care costs. It should also be noted that age is positively correlated with income, raising the question of whether it is fair to expect younger workers, with lower average income, to subsidize higher-income, older workers.

Market Transformation

Furthermore, a system of individually based health insurance, financed in part through income-related tax credits, will transform health insurance markets in ways that will ultimately benefit people across risk and income classifications. For example, analysts expect a "premium rating conversion" to reduce or mitigate any loss of cross-subsidization under individually based insurance. Following the influx of a critical mass of average-risk individuals into the individual market, insurers would no longer find it cost-effective to individually risk rate applicants. Costly medical underwriting practices would be replaced by simplified, automated ones, particularly as purchasing insurance over the Internet becomes more common. The result would be *de facto* modified community rating, but as the natural byproduct of market function rather than by market regulation. The emergence of multi-year insurance contracts would also compress premium differentials that would normally occur under individual risk rating. As an individual ages, premium increases would be relatively flat compared to annual age-rating, with the individual paying somewhat more than he or she otherwise would when young and somewhat less when older. During the contract period, enrollees would have guaranteed renewability-type protection from premium increases due to illness. Multi-year contracts would also limit enrollment and disenrollment opportunities, thus preventing individuals from "gaming" the system by switching coverage on the basis of changes in health status. Another factor that could benefit high-risk individuals is the development of integrated delivery systems for people with chronic conditions. So-called "focused factories" would reduce costs, reduce variation in costs, and improve quality of care for many high-risk individuals. Thus, although people with chronic conditions might face premiums more closely reflecting their expected costs, those costs would be brought under greater control.

Targeted Risk-Related Subsidies Financed Through General Tax Revenues

As noted earlier, targeting risk-related subsidies through general tax revenues provides desired protections while permitting insurance markets to function properly and make high-risk individuals more attractive to insurers. High-risk pools give insurers reassurance that they are unlikely to end up with extremely high-risk enrollees in the "regular" market, allowing them to offer lower premiums, which in turn attracts more enrollees of low-to-average risk. Research shows that high-risk pools improve individual market function when they provide reasonably comprehensive coverage, are subsidized by general tax revenues or compulsory insurer contributions, and are not limited by enrollment caps (Nichols, Congressional Testimony, 1999).

Risk adjustment and reinsurance also protect health plans from potential adverse selection. Risk adjustment usually takes the form of additional, prospective payments to plans with a disproportionate number of high-risk enrollees. Risk adjustment can also take the form of direct premium subsidies to high-risk individuals, for example, tax credits adjusted to reflect risk as well as income. Direct premium subsidies are a more explicit way to subsidize high-risk individuals. In contrast to high-risk pools, they also have the virtue of allowing high-risk individuals choice of health plan. Reinsurance provides plans with retrospective payments for enrollees with costs above a certain threshold. It has been proposed that the government act as reinsurer for health insurers, much the way is does in the banking and housing industries (Swartz, *Health Affairs* Web exclusive, October 2002). Some proponents of individual tax credits advocate setting tax credits equal to a percentage of premium (in addition to possibly adjusting credits for income) in order to provide a crude form of risk adjustment. Because those with poor health generally seek relatively generous insurance coverage, percentage-of-premium tax credits channel subsidies, in part, on the basis of risk. It should be noted, however, that tax credits that are a fixed-dollar amount for any given individual or family, as proposed by the AMA, have the merits of administrative simplicity and not providing incentives to over-insure.

Greater research and experimentation is needed to understand the relative merits of various approaches to targeting subsidies by risk. For example, what are the tradeoffs involved between segregating high-risk individuals into high-risk pools versus subsidizing their participation in mainstream markets through risk adjustment and reinsurance? Between risk adjusting tax credits to individuals versus risk adjusting premium payments to health plans? Between prospective risk adjustment versus retrospective reinsurance? And how effective would reinsurance be in improving overall market function – given that most of the top 2-3% of spenders experience truly random, unpredictable events and do not remain top-spenders in subsequent years? How would reinsurance reduce insurers' incentives to avoid individuals with predictably high costs?

Benefit Mandates

Benefit mandates are frequently promoted as consumer protections, to ensure inclusion of specific benefits and minimize adverse selection arising from low-risk individuals' preferences for less generous plans. Standard benefit packages are often proposed in order to facilitate comparison among plans. However, benefit mandates and packages restrict consumer choice and stifle private market innovation in benefit design. Differential application of benefit mandates artificially tie coverage specifics and premium costs to the source or form of insurance (e.g., large ERISA plans are exempt from costly state benefit mandates whereas smaller plans must comply). Furthermore,

defining the benefit package is an inherently political process entailing conflict among competing special interests and a certain degree of arbitrariness.

Group Purchasing Alliances

As with market innovation in general, the Council believes that the regulatory environment should enable rather than impede the formation and operation of health insurance purchasing alliances. Rather than regulating minimum size, number of plans offered, geographic restrictions, etc., the government should leave their formation to the private market to the extent that such alliances generate economies of scale or other advantages.

CONCLUSION

The Council believes that a more uniform, national approach to health insurance market regulation as outlined in this report would lead to expanded health insurance coverage and choice. Such a regulatory approach would improve health insurance market function whether in the context of the existing, predominantly employment-based health care system, or an individually based system as proposed by the AMA. The proposed system of refundable, advanceable tax credits inversely related to income is uncharted territory. Questions remain about changes under the new system, especially with regard to premium rating practices and cross-subsidization from low-risk to high-risk individuals. Without experience under the new system, it is impossible to know the magnitudes of these effects, short-run or long-run. Actual experience and research are also needed to determine the best specific approaches to subsidizing health care costs of high-risk individuals. Yet, few if any major innovations yielding significant societal benefits were undertaken without unanswered questions or the need to make mid-course adjustments. Moreover, the existing system has numerous troubling consequences. Accordingly, the Council strongly believes that implementation of individually based insurance should not be prevented or delayed by unresolved questions about possible effects of the proposed system. We have sufficient knowledge to be confident that with appropriate regulations and public policies, the new system can ensure safeguards for high-risk individuals and widespread choice of affordable coverage for the general population.

POLICY RECOMMENDATIONS

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

1. The American Medical Association (AMA) supports the following principles for health insurance market regulation:

   (a) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.

   (b) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.

(c) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.

(d) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.

(e) Insured individuals should be protected by guaranteed renewability.

(f) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.

(g) Guaranteed issue regulations should be rescinded.

(h) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.

(i) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:

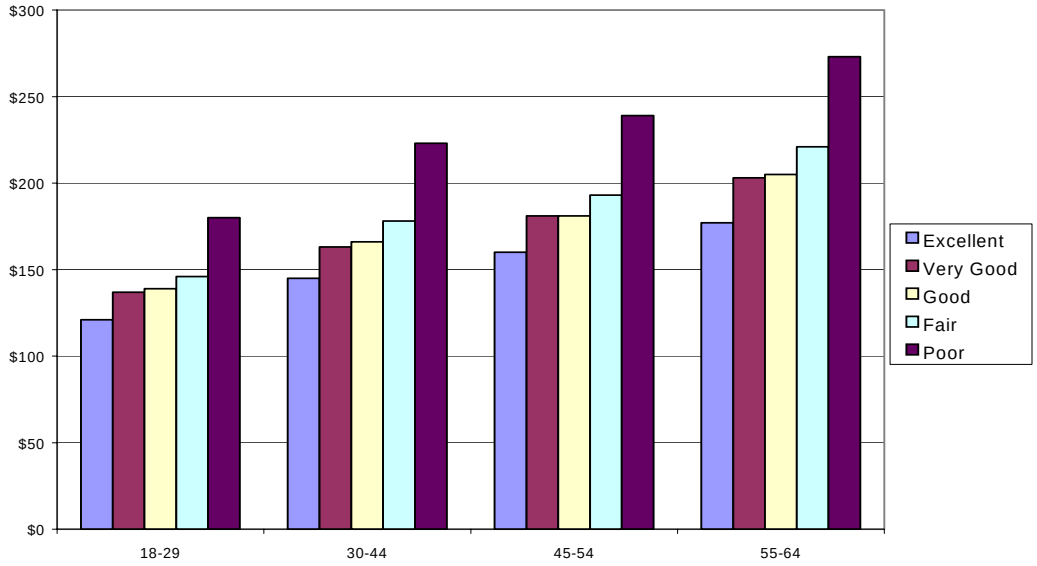
(i) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed.

(ii) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

(iii) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (New HOD Policy)

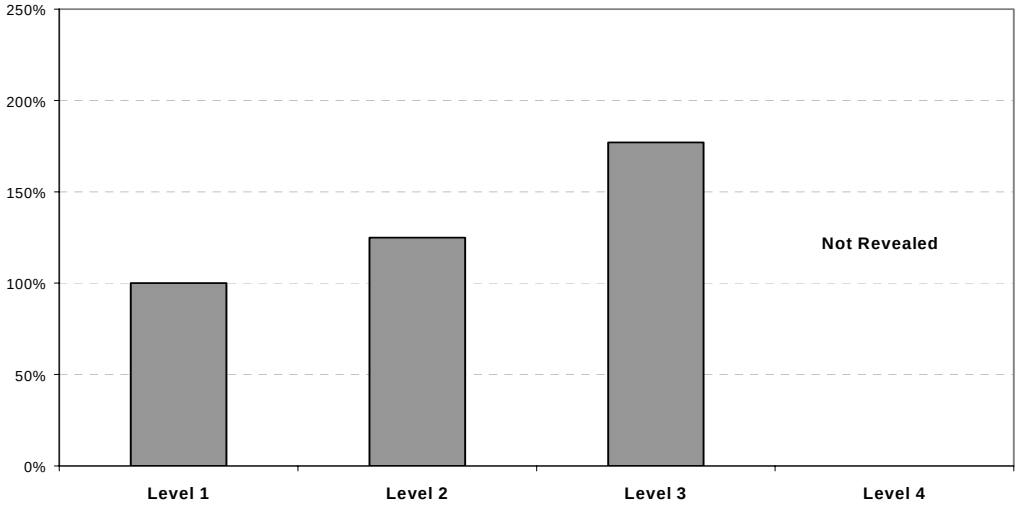
References for this report are available from the AMA Division of Socioeconomic Policy Development.

Figure 1. Monthly Premiums in Individual Market by Age, Health Status



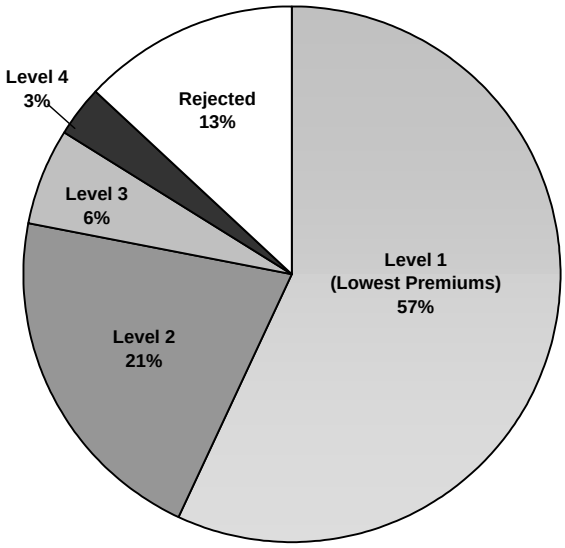
Source: Hadley and Reschovsky, "Tax Credits and the Affordibility of Individual Health Insurance," Center for Studying Health Systems Change Issue Brief No. 53, July 2002.

Figure 2. Premiums by Risk Class
As Percentage of Premiums of Lowest Risk Class (Level 1)



Source: One large insurer in the nongroup market from one state. The state requires neither guarante issue nor premium rating restrictions. Pauly and Nichols, Health Affairs Web Exclusive, October 2002.

Figure 3. Distribution of Health Insurance Applicants by Risk Class



Source: One large insurer in the nongroup market from one state. The state requires neither guaranteed issue nor premium rating restrictions. Pauly and Nichols, Health Affairs Web Exclusive, October 2002.

Figure 4. Tradeoffs Presented by Health Insurance Market Regulation

***** Caveat: Attempts to keep premiums low and coverage high for high-risk individuals can backfire by reducing enrollment of low-risk individuals, thereby driving up average costs and premiums.

Source: Adapted from Swartz, *Inquiry*, Summer 2001.

TABLE 1. Health Insurance Market Regulation: Intended and Unintended Effects by Type of Individual or Scenario

REGULATION or POLICY	TYPE OF INDIVIDUAL OR SCENARIO: ALL	Good-to-Average Health, Young	Good-to-Average Health, Older	Pre-existing Condition (e.g., Hayfever, Diabetes)	Uninsurable (e.g., Spina Bifida, AIDS)	Anticipates Transient Cost Increase (e.g., Pregnancy)	New Illness or Disability (e.g., Diabetes, AIDS)	Good Health w/Risk Factor (e.g., History of Cancer)	Low-Income, Healthy	Low-Income, Sick	GENERAL COMMENTS
TERMS OF ISSUE, ENROLLMENT REGULATIONS											
Guaranteed Issue		▶1				▶1	▶1	▶1	▶1		
Guaranteed Renewability (Prohibition of "Reunderwriting")		4A, I				4A, I	4A, I	4A, I	4A, I	1.1	
Guaranteed Continuity / Portability	4O					▶1	▶1	▶1			Unlike previously uninsured, individuals who switch plans subject only to partial risk rating and not subject to benefits exclusions or pre-existing conditions limitations.
Lump-Sum Payment From Old Plan to New Plan	4O					▶3	4C, ▶1, 2	4C, ▶1, 2			How would amount be determined?
Restricted Open Enrollment Period	4O					4A	4A, ▶23	4A, ▶23			Could be less than annual. Standardize nationally?
Individual Mandate		4D, ▶8	▶9	▶9	▶9		4I	4I	▶8, 10	▶9, 10	
PREMIUM SETTING REGULATIONS											
Community Rating (Pure)	▶7	▶6	4G, ▶2	4G, ▶2	4G, ▶2		4G, ▶2	4G, ▶2	▶6	4G, ▶2	
Modified Community Rating	*Effects are intermediate to pure community rating and pure risk rating.*										E.g., Risk Bands
Risk Rating (Pure)		4H	▶5, 4C	▶5, 4C	▶5, 4C		▶5, 4C	▶5, 4C	4H	▶5, 4C	
Age, Demographic Rating		4H	▶5, 4C								
Genetic Information OK to Use		4H	4H					▶5, 4C			
Lifestyle Information OK to Use	4N										Applies only to controllable factors such as smoking, weight loss efforts, etc.

Source: Division of Socioeconomic Policy Development, American Medical Association, March 2003.

TABLE 1. Health Insurance Market Regulation: Intended and Unintended Effects by Type of Individual or Scenario (continued)

REGULATION or POLICY	TYPE OF INDIVIDUAL OR SCENARIO: ALL	Good-to-Average Health, Young	Good-to-Average Health, Older	Pre-existing Condition (e.g., Hayfever, Diabetes)	Uninsurable (e.g., Spina Bifida, AIDS)	Anticipates Transient Cost Increase (e.g., Pregnancy)	New Illness or Disability (e.g., Diabetes, AIDS)	Good Health w/Risk Factor (e.g., History of Cancer)	Low-Income, Healthy	Low-Income, Sick	GENERAL COMMENTS
Risk Rating Waived < 21 Only	4A,D,I										At age 20, all individuals can obtain insurance without being risk rated. Covered individuals 21+ protected from rate increases due to illness.
BENEFIT DESIGN REGULATIONS											
Minimum Benefits, Benefit Mandates	▶11,18 24	▶6	▶6	4P					▶6		
Standard Benefits, Compression of Benefits	▶11,18 24, 4E, Q	▶6	▶6	4P	4P	4P	4P	4P	▶6	4P	
Prohibition of Preexisting Conditions Clauses				4P, ▶2	4P, ▶2	▶1	▶1	▶1		4P, ▶2	
SUBSIDIES BASED ON INCOME											
Income-Related Tax Credits	4N			▶12	▶12		▶12	▶12	4J	▶12	Inversely related to income, refundable, advanceable.
SUBISIDIES BASED ON RISK											
Financed Through General Tax Revenues											
Direct Premium Subsidies to High-Risk Individuals	4I	4H	4H	4C, G	4C, G		4C, G	4I	4H	4C, G	Assumes some degree of risk rating. Could be in form of risk-adjusted tax credit.
High-Risk Pools	4I	4H	4H	4C, G, ▶19,20	4F, H, ▶20		4C,G,H ▶19,20	4I	4H	4C, G, ▶19	Assumes some degree of risk rating. Pool could be condition-specific.
Risk Adjustment	4I, ▶13	4H	4H	4C, G	4C, G		4C, G	4I	4H	4C, G	Assumes some degree of community or group rating.
Reinsurance, Outlier Payments	4I, ▶13	4H	4H	4C, G	4C, G		4C, G	4I	4H	4C, G	E.g., reinsurer (partially) pays for most costly 2-3% of patients in a given year. Effectively *ex poste* risk adjustment.
Age-Adjusted Tax Credit			4C, G								Assumes some degree of age rating.

TABLE 1. Health Insurance Market Regulation: Intended and Unintended Effects by Type of Individual or Scenario (continued)

REGULATION or POLICY	TYPE OF INDIVIDUAL OR SCENARIO: ALL	Good-to-Average Health, Young	Good-to-Average Health, Older	Pre-existing Condition (e.g., Hayfever, Diabetes)	Uninsurable (e.g., Spina Bifida, AIDS)	Anticipates Transient Cost Increase (e.g., Pregnancy)	New Illness or Disability (e.g., Diabetes, AIDS)	Good Health w/Risk Factor (e.g., History of Cancer)	Low-Income, Healthy	Low-Income, Sick	GENERAL COMMENTS
Tax Credit Equal to Percentage of Premium	4F, ▶14	▶15	4G, ▶15	4G	4G		4G	4G	▶16	4G, ▶16	Assumes credits still inversely related to income, refundable, advanceable.
Financed Through Insurance Surcharges	*Same as above plus:*									1.1	
All Subsidies Based on Risk	▶11	▶6	▶6						▶6		
OTHER											
Group Purchasing Alliances with Group-Rated Premiums (e.g., Health Insurance Marts, Health Insurance Purchasing Coalitions, etc.)	4K, O ▶1, 4	▶6	▶2, 4G	▶2, 4G	▶2, 4G	▶1	▶1, 4G	▶1, 4G	▶6	▶2, 4G	The greater the plan choice, the more opportunity for risk segmentation through self-selection. ▶1 depends on rules of membership and preexisting conditions limitations.
Tax Credit Applies Only to Health Insurance Marts with Group-Rated Premiums	*Same as above but effects stronger. Also* ▶17										
Tax Credit Smaller for Those w/Access to Employment-Based Coverage	*Effects apply to those with employment-based coverage:* ▶17,18 21	▶6, 18	4G	4G	4G		4G	4G	▶6, 18	4G	Could be a temporary measure. Following introduction of individual tax credits, slows possible dissolution of employment risk pools, possible development of adverse selection and "death spirals" against employment-based coverage relative to individual market. Partially maintains cross-subsidization from low-risk to high-risk individuals presumed to occur under employment-based coverage.
Defined Contributions	4M, O										Not a true regulation but a market response, though enabled/hampered by regulation. Fixed dollar contribution toward individual's choice of plan.

TABLE 1. Health Insurance Market Regulation: Intended and Unintended Effects by Type of Individual or Scenario (continued)

REGULATION or POLICY	TYPE OF INDIVIDUAL OR SCENARIO: ALL	Good-to-Average Health, Young	Good-to-Average Health, Older	Pre-existing Condition (e.g., Hayfever, Diabetes)	Uninsurable (e.g., Spina Bifida, AIDS)	Anticipates Transient Cost Increase (e.g., Pregnancy)	New Illness or Disability (e.g., Diabetes, AIDS)	Good Health w/Risk Factor (e.g., History of Cancer)	Low-Income, Healthy	Low-Income, Sick	GENERAL COMMENTS
Medical Savings Accounts (MSAs)	4M, O	4H	4H, C	4G, C	4G, C	4C	4G, C	4G, C	4H	4G, C	Not a true regulation but a market response, though enabled/hampered by regulation.
Multi-year Contracts	4B,I,L ►22	4A, ►6	4C, G	4C		4A	4A, G	4A,C,I ►3	4A	1.1	Not a true regulation but a market response, though enabled/hampered by regulation. Similar to extending time between open enrollment periods.

4 **Intended Effects** ► **Unintended Effects (Red Flags)**

Risk Selection / Gaming

A. Encourages coverage when healthy, protecting insurers from gaming by individuals.

B. Partially overcomes asymmetry of information because individuals who know of latent risk factors face incentives to choose appropriately generous coverage.

C. Reduces incentive to "dump" or avoid bad risks and/or provides incentives to enroll bad risks.

D. Ensures supply of good risks in pools, possibly leading to reduced individual underwriting.

E. May reduce adverse selection and "death spirals" of more generous plans. Reduces ability of individuals to game, insurers to "cream skim" by offering benefits to attract good risks (e.g., health club memberships).

F. A crude form of risk adjustment since bad risks tend to purchase more coverage. Built in adjustment for geographic disparities in premium costs, inflation. Administratively simpler than other forms of risk adjustment.

1. Discourages coverage when healthy. Allows individuals to game the system; individuals can wait to obtain coverage until they become ill, or choose less generous coverage while healthy and switch to more generous coverage when ill.

2. Reinforces insurers incentives to avoid bad risks. Policy of lump-sum payments increases incentives to avoid bad risks who were previously uninsured since such individuals come with no lump-sum payment from a previous insurer.

3. Asymmetry of information between individual and insurer can lead to adverse selection if high-risk individuals buy generous coverage in anticipation of high utilization.

4. HIMs could experience adverse selection, "death spirals" if subject to stricter regulation than rest of market (i.e., "regulatory gradient").

TABLE 1. Health Insurance Market Regulation: Intended and Unintended Effects by Type of Individual or Scenario (continued)

Cost / Coverage / Cross-Subsidization

4 Intended Effects

G. Lowers premiums, increases rate of coverage for bad risks.

H. Lowers premiums, increases rate of coverage for good risks.

I. (Partially) protects covered individuals in the event of onset of illness. For subsidies based on risk, provides peace-of-mind for individuals with latent risk factors that are not used in premium rating but that may be used if the risk factors develop into reduced health status and increased costs.

J. Increases coverage for low income individuals as long as tax credits are generous enough.

K. Potential reduction in overall premiums through economies of scale.

L. Easier for insurers to predict average costs since the distribution of individual costs becomes less skewed the longer the time period for which it applies.

M. Provides incentives to make cost-conscious choices about health plans and/or health care services.

N. Encourages healthy lifestyle choices and possible long-term cost savings.

► Unintended Effects (Red Flags)

5. Raises premiums, reduces rate of coverage for bad risks (in absence of special subsidies based on risk).
6. Raises premiums, reduces rate of coverage for good risks.
7. Indirectly raises premiums by reducing participation of good risks.
8. May be hard to enforce mandate since low-risk individuals may have difficulty paying premiums without additional assistance.
9. May be hard to enforce mandate since high-risk individuals may have difficulty paying premiums under risk rating.
10. May be hard to enforce mandate since low-income and high-risk individuals may have difficulty paying premiums without additional assistance.
11. Raises premiums overall (in case of benefit design regulations, through mandated benefits).
12. Regular tax credits insufficient in absence of additional subsidies based on risk.
13. May dilute insurer cost-containment incentives – especially for high-cost cases – and/or encourage "upcoding," i.e., overtreating patients or overclassifying them as high-risk in order to trigger higher payments. (Note that measures can be taken to prevent or reduce such problems, e.g., requiring insurers with reinsurance to always pay some portion of costs for highest-cost patients.)
14. Administratively more complex than fixed tax credits. IRS would have to verify premium expenditures. Not as good as fostering price competition as fixed tax credits.
15. Encourages "overinsurance" by not capping subsidy.
16. Low-income individuals may have difficulty contributing required percentage of premium.
17. Could backfire if employees pressure employers to discontinue offering coverage.

Plan Design / Choice

4 Intended Effects

O. Allows (some) plan choice, flexibility, and better matching. In case of MSAs and HRAs, allows physician and provider choice.

P. Desired medical services (likely to be) covered.

Q. Makes price comparisons, plan choice easier.

► Unintended Effects (Red Flags)

18. Reduces plan choice, opportunity for matching. Minimum or standard benefits effectively raise premiums and reduce rate of coverage for those who prefer less generous coverage; standard benefits reduce plan benefits for those who prefer more generous coverage.
19. Segregating bad risks could compromise their quality, choice of coverage.
20. Too many moderately-high risk individuals could be put in high-risk pool.
21. Fails to fully delink health insurance and employment, expand choice. Hinders development of individual market.
22. Depending on structure of contract and other market rules, could reduce choice, opportunity for individuals to switch from low-quality plans.
23. Arbitrarily treats people differently based on timing of change in health status vis a vis open enrollment period.
24. When applied differentially, artificially ties coverage and/or choices to sub-sector of the insurance market, form of coverage, and/or form of coverage.

TABLE 1. Health Insurance Market Regulation: Intended and Unintended Effects by Type of Individual or Scenario (continued)

APPENDIX

SUMMARY OF AMA POLICY RELEVANT TO HEALTH INSURANCE MARKET REGULATION

Coverage Numerous policies express the AMA's strong support for expanding health insurance coverage (e.g., Policies H-165.920[1], H-165.992, H-165.861, H-165.870, H-165.822, H-165.904, H-165.979, H-165.979, H-165.983, H-165.992, H-180.965, H-165.877, and H-165.904, AMA Policy Database). Policies H-165.920[1] and H-165.822 recognize incremental increases in levels of coverage as a necessary interim step toward universal access. Additional policies concern expanding coverage to low-income and high-risk individuals (see below). The AMA states preference for increased coverage through private markets rather than through expansion of Medicaid and SCHIP. In association with a number of other medical societies, the AMA adopted Resolution 733 (I-02) advocating enactment of a bipartisan Congressional resolution establishing the goal of achieving health care coverage for all by the year 2009.

Choice For at least two decades, the AMA has advocated expanded freedom of patient choice of both physicians and health plans, as well as pluralism in health care delivery systems, health plan type, financing mechanisms, and third-party payment methodologies (Policies H-165.920, H-165.881, H-160.997, H-165.895, H-165.913, H-165.944[2], H-385.987, H-385.989, and H-385.990). Similarly, Policy H-160.997 calls for a multiplicity of practice options, maximum professional independence, and freedom of choice for both physicians and patients. AMA policy has historically favored free market activity over mandates imposed on patients, physicians or insurance plans (e.g., Policies H-165.920[15] and H-390.961). Policy H-180.978 expresses a preference for allowing insurance markets to operate freely rather than under government mandates and controls. Policy 165.944 specifically states that there should be no preferential treatment by government that gives a competitive advantage to any form of health insurance or health care delivery organization. Policy H-290.982[3] calls for a pluralistic approach to Medicaid health care financing and delivery including but not limited to MSAs. Finally, Policy H-165.920[17] supports providing coverage to the uninsured through refundable, advanceable tax credits inversely related to income to be used toward the individual's choice of health plan.

Premium Rating and Terms of Issue AMA policy calls for the study and use of risk rating and premium setting practices found to be most conducive to cost-effectiveness of care and fair market competition among health plans (Policy H-165.915). More specifically, the main policy establishing the AMA reform proposal calls for the establishment of guaranteed issue, guaranteed renewability, and rate reform (Policy H-165.920[3e]). Policy H-165.882[13] calls for community rating bands in individual policies made available under the Health Insurance Portability and Accountability Act (HIPAA) in all states without such rating restrictions in the individual market. Policy 165.960 calls for community rating. Policy H-185.989 opposes any attempt by insurers to cancel, reduce, refuse to renew or increase premiums under individual or group policies based on an illness occurring during the time insurance is in force and Policy 165.960 calls for guaranteed renewability. As noted earlier, Policy H-165.882[14] calls for exemption from small group rating laws for health insurance offered through health insurance marts.

Several AMA policies establish guidelines on what types of information may be used to determine premiums. Policy H-185.972 seeks to prohibit health insurers from obtaining information regarding individuals' genetic testing or requests for genetic services; and from using such information to establish differential premiums, or deny or limit coverage or renewal. Policy H-180.977 encourages insurers to give premium discounts to non-smokers. In addition, policy H-180.981 favors requiring insurance

companies to furnish applicants who have been individually risk rated or rejected with a written explanation of the reasons for rating or rejection within 21 days. It also calls for individuals to submit additional information and contest the rating or rejection within an additional 21 days.

AMA policy opposes preexisting condition limitations under certain conditions. Policy H-165.991 opposes preexisting condition limitations for new enrollees in employer group plans or state health insurance risk pools. AMA Policy H-185.980 urges private insurers to provide coverage of adopted children from the time of placement, on the same basis as biological children under all individual and group plans, with no preexisting condition limitations, and supports establishment of state legislation to that effect. Policy 165.960 calls for elimination of preexisting conditions limitations.

Coverage and Benefit Mandates, Benefit Packages Policy H-165.920915 supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage. In 2000, the AMA formally rescinded its previous support for an employer mandate (Policy H-165.980). Policy H-180.978 supports the development of a pluralistic, private market for health insurance and calls for the deregulation of state mandated benefits. Policy H-185.964 opposes new health benefit mandates unrelated to patient protections. Policy H-165.882[14] calls for the exemption of health insurance offered through health insurance marts from selected state benefit mandates.

Subsidies Targeted by Income Policy H-165.865 provides guiding principles for structuring health insurance tax credits, many of which are designed to retarget government tax subsidies to low-income individuals and families. The AMA advocates making tax credits generous enough to make coverage affordable, inversely related to income, and refundable. Policy H-165.867 advocates that organizations such as local welfare agencies help to advance tax credits to low-income individuals.

High Risk Pools AMA policy supports the development of state health insurance risk pools that do not impose preexisting condition limitations; and are restricted to the medically uninsurable, those whose economic circumstances make it difficult to purchase insurance in the private individual market, and anyone lacking access to group coverage (Policies H-165.979, H-165.988, H-165.991, H-165.995, and H-20.968). Policy H-165.995 calls for state risk pools to charge premiums slightly higher than standard group rates, and Policies H-165.985 and H-165.992[1] support the use of publicly funded, sliding-scale vouchers for low income individuals to purchase state risk pool coverage, with different levels of beneficiary premium cost-sharing based on ability to pay. All insurers and self-insured plans in the state would participate in the risk pool (Policy H-165.995).

Risk Adjustment and Reinsurance AMA policy supports the use of risk adjustment and reinsurance as a means of reducing or compensating for risk segmentation. Policies H-165.920[13], H-165.915 and H-330.933 support the use of risk adjustment across plans, with payments flowing from plans with a relatively favorable selection of enrollees to those with a relatively adverse selection. Policy H-165.920[11] encourages exploration of risk adjustment of the contributions employers and unions give employees toward individually purchased coverage, with factors such as age, sex, and family status used to provide higher-risk employees with larger contributions and lower-risk employees with smaller contributions. Policy 165.960 calls for mandatory participation by insurers in reinsurance pools.

Other Public Policies Targeted to High-Risk Populations AMA policy supports the development of specialized insurance plans and/or premium subsidies for several high-risk populations. Policy

H-185.963 urges public and private third-party payors to increase access to health insurance designed for adults with congenital and/or childhood diseases, and emphasizes that any health insurance product designed for this population include the availability of specialized treatment options, medical services, medical equipment, pharmaceuticals, and specialist physician services. Policy H-185.968 encourages the design of value-based private group and individual health insurance specifically for children with chronic and expensive illness; such policies should be affordable, have low cost-sharing, and be eligible for government premium subsidies. Policy H-20.939 calls for the government premium subsidies for private insurance for needy persons with HIV and AIDS.

Health Insurance Purchasing Alliances Policies H-165.882[14] and [15] and H-165.895 support federal legislation to encourage the formation of small employer and other health insurance marts by private organizations such as unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, ethnic coalitions, and similar groups. Insurance plans offered by such marts would be exempted from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws. More recently, Policy H-165.862 endorses the use of evolving Internet-based health insurance markets as mechanism for employers and individuals to select and purchase health insurance. Policies H-165.992, H-180.970, and H-180.998 support the formation of multiple employer welfare arrangements (MEWAs) and call for the following regulatory framework: appropriate federal and state initiatives to regulate and oversee health care plans provided through MEWAs; enactment of fiscal solvency regulations in those states without such regulations; state certification and routine monitoring of all entities financing health care services, including insurers, MEWAs, and HMOs, to guard against misrepresentation of costs of benefits; and uniform solvency standards for all such entities in a given regulatory jurisdiction.

Relevant Policy Regarding Market Developments Numerous AMA policies support expanded choice, defined contributions, medical savings accounts, and experimentation with multi-year insurance contracts. Policies H-165.920[3a,b,d], H-165.983, and H-165.895 encourage employers to provide health benefits in the form of defined contributions, whereby the employee applies a fixed-dollar amount to the purchase of health coverage of his or her choice. Policy H-165.920 states that defined contributions should be subject to equivalent tax treatment as traditional "defined benefit" health coverage. Policies H-165.890, H-330.933, and H-40.969 advocate defined contributions for Medicare beneficiaries and members of the military. Extensive, longstanding AMA policy supports promotion and expansion of MSAs (Policies H-165.869, H-165.920, H-180.957, H-165.863, H-185.982, H-165.879, H-270.969, and Council on Medical Service Report 3 (I-02) Recommendation 2). The AMA supports MSAs as a means of increasing patient choice of both coverage and physicians, as well as a means of promoting individual cost-consciousness in the utilization of health services. Policy H-165.920(7) supports legislation allowing the tax-free use of MSA accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. Policy H-165.869(3) closely parallels current legislative proposals to expand MSAs by seeking to repeal MSA demonstration status, eligibility restrictions, and numerous other legislative constraints on MSAs. Policy H-165.920[13] encourages experimentation with multi-year insurance policy contracts.