

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7 - A-07

Subject: Adequacy of Health Insurance Coverage Options

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Referred to: Reference Committee A
(Virginia E. Hall, MD, Chair)

1 The question of what constitutes adequate health insurance coverage is becoming increasingly
2 relevant in the context of federal and state health policy initiatives, and policy developments within
3 the American Medical Association (AMA). Although there is widespread agreement that
4 individuals should have access to health insurance coverage, there is virtually no consensus on
5 what criteria should be used to judge an individual plan's adequacy. To maintain consistency with
6 AMA policy, the challenge is to develop a framework for evaluating adequacy that provides
7 enough guidance to minimize the incidence of "underinsurance," and enough flexibility to permit
8 individuals to choose plans that reflect their needs and preferences.

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10 With nearly 45 million people uninsured in the United States, rising health care costs, and declining
11 levels of employer-sponsored health care, there is an increased national focus on identifying ways
12 to effectively extend health insurance coverage to the uninsured. The solution to this problem,
13 either implicitly or explicitly, requires a shared understanding about what features or benefits
14 should be included in a health insurance policy in order to ensure that it provides a meaningful
15 level of coverage, both to protect individuals, and to protect society from shouldering the burden of
16 uncompensated care.

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18 At the federal level, numerous bills have been presented to Congress that would authorize the
19 creation of Association Health Plans (AHPs) or other alternative health insurance markets that
20 would allow insurers, under certain conditions, to offer plans that could bypass at least some
21 individual state benefit mandates. These are commonly targeted toward small businesses, to
22 facilitate the expansion of the range of affordable health care options that they might offer their
23 employees. Although AMA policy supports limiting benefit mandates (Policy H-165.856, AMA
24 Policy Database), the Association has joined other groups in expressing concern that some AHP
25 proposals could potentially expose patients to inadequate insurance coverage, especially in the
26 absence of provisions guaranteeing a choice of plan offerings.

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28 There also has been an increase in efforts at the state level to expand health insurance coverage. A
29 key component of the new health insurance legislation that passed in Massachusetts in 2006 is the
30 requirement that every individual obtain health insurance. Massachusetts created the
31 Commonwealth Health Insurance Connector (the Connector) to "connect individuals and small
32 businesses with health insurance products," and through which low-income individuals can access
33 "affordable" coverage. A subcommittee of the Connector was tasked with defining the minimum
34 coverage requirements, and has been working for several months to find a balance between
35 coverage and affordability. In March 2007, the Connector Board approved a list of coverage
36 requirements, including preventive and primary care, emergency services, prescription drugs,
37 mental health and substance abuse services, and vision care. The Board also approved a sliding

1 scale of “affordability standards,” which offers guidance on how much individuals would be
2 expected to pay to obtain qualifying health insurance. The coverage requirements and affordability
3 standards are subject to a final vote in June 2007.

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5 STANDARD BENEFIT PACKAGES

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7 There is a tendency on the part of the public and many policymakers to want to define adequacy in
8 terms of a specific set of benefits that must be included in every health plan offered to or purchased
9 by individuals or families. Some believe that core health care benefits should be defined at the
10 federal level. In September 2006, the Citizen’s Health Care Working Group, which was created by
11 the Medicare Modernization and Prescription Drug Act of 2003, recommended to the president and
12 Congress that “an independent, nonpartisan group ... begin the work of defining benefits and
13 services that would be the standard for all Americans.” According to the Working Group,
14 identifying standard benefits should be accomplished:

15
16 through a transparent, evidence-based process, with consumer participation ... The group
17 making these decisions would be established as a public/private entity to insulate it from
18 both political and financial influence. It would also be an ongoing entity with stable
19 funding, to guarantee its independence and to ensure that the benefit package continues to
20 be responsive to evolving medical knowledge and practice.

21
22 Currently, the application of state benefit mandates serves as a *de facto* marker for an “adequate”
23 level of coverage in the individual health insurance market. The number and type of mandated
24 benefits vary greatly from state to state, suggesting that attempts to define and mandate appropriate
25 levels of health care coverage are subject to a political process, influenced by special interest
26 groups.

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28 Aside from the difficulty of defining a list of core health benefits, there is significant concern that
29 benefit mandates or standard benefit packages contribute to the problem of the uninsured by
30 limiting choice, increasing costs, and impeding market activity and innovation. Council on
31 Medical Service Report 7 (A-03) provided a comprehensive overview of health insurance market
32 regulations and the role they can play in impeding or facilitating health system reform. The report
33 essentially concluded that health insurance market regulations should be reformed to establish fair
34 “rules of the game” that protect vulnerable populations without unduly driving up premiums for the
35 rest of the population, or prohibiting markets from finding the most attractive combinations of plan
36 benefits, patient cost-sharing, and premiums.

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38 AMA POLICY ON BENEFIT PACKAGES

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40 In 2006, the AMA adopted the recommendations in Council on Medical Service Report 3 (A-06),
41 “Individual Responsibility to Obtain Health Insurance,” advocating that individuals with incomes
42 greater than 500% of the federal poverty level be required to “obtain, at a minimum, coverage for
43 catastrophic health care and evidence-based preventive care” (Policy H-165.848). The question of
44 health plan adequacy also has direct implications for AMA policy regarding the use of tax credits
45 to finance individually selected and owned health insurance. According to Policy H-165.865,
46 individuals would be eligible for a tax credit if the purchased insurance “provide[d] coverage for
47 hospital care, surgical care, and catastrophic coverage of medical expenses, as such expenses are
48 defined by Title 26 Section 213(d) of the United States Code.”

1 The AMA recently rescinded Policies H-165.975 and H-165.925, which defined minimum and
2 standard benefit packages. These policies had been developed in the context of previous AMA
3 support for an employer mandate, and included detailed recommendations regarding covered
4 services and procedures, benefit levels, and patient cost-sharing. The policies were superseded by
5 more recent policies emphasizing individual choice and ownership of health insurance. Current
6 AMA policy emphasizes the importance of limiting benefit mandates in favor of allowing the
7 market to determine benefit packages and permit a wide choice of coverage options (Policy H-
8 165.856). At the same time, the AMA also strongly supports ensuring that patient protections are
9 preserved under any insurance arrangements (Policy H-165.882).

10 AN ADEQUACY FRAMEWORK

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13 Attempts to strictly define an adequate benefit package will ultimately be unsuccessful in achieving
14 the goal of expanding health insurance coverage to the uninsured. As noted previously, the AMA
15 believes that promoting flexibility in health insurance markets is critical to the availability of
16 desirable and affordable health care plans. The specific features of an “adequate” health insurance
17 plan will vary based on an individual’s income (i.e., how much could someone afford to “self-
18 insure”), health status, medical history, lifestyle, etc., thus precluding the development of a strict
19 definition of an appropriate health benefits package.

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21 At the same time, the Council recognizes the need for some level of guidance that will help ensure
22 that individuals have access to meaningful coverage options. The Council believes that the best
23 way to do this is by considering the broader context in which a health plan is offered, so that
24 “adequacy” refers to the aggregate of health coverage options, rather than to any single option.
25 The Council recommends the following set of principles be used to evaluate whether “adequate”
26 provisions are being made for health insurance options:

- 27
28 1. Any insurance pool or similar structure designed to enable access to health insurance
29 coverage must include a wide variety of coverage options from which to choose.

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31 Consistent with AMA policy, the Council believes that, given the opportunity and
32 necessary information, individuals will make rational choices when evaluating their health
33 insurance needs and selecting coverage. Ensuring a range of coverage options allows
34 individuals the flexibility to determine the best mix of cost and coverage as it relates to
35 their particular circumstances. Conversely, a lack of choice could force people to sacrifice
36 quality for cost, or to pay for benefits that an individual may find unnecessary. The goal is
37 to ensure that individuals can determine for themselves what level of coverage is adequate.

38 Relevant AMA Policy

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41 • Policy H-165.881 advocates for greater choice of health plans by consumers and
42 expanded individual selection and ownership of health insurance where plans are truly
43 accountable to patients.
44 • Policy H-185.954 encourages health insurers to make available a wide variety of
45 policies that provide coverage for a range of clinical preventive services.
46 • Policy H-165.856[9b] supports limiting benefit mandates to allow markets to
47 determine benefit packages and permit a wide choice of coverage options.

- 1 • Policy H-165.848 supports a requirement that individuals and families earning greater
2 than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic
3 health care and evidence-based preventive health care.
- 4 • Policy H-165.920[3] actively supports the principle of the individual’s right to select
5 his/her health insurance plan.
- 6 • Policy D-165.996 affirms that the AMA continues to place a high priority on the
7 development and implementation of advocacy communications, coalition-building
8 initiatives, and targeted outreach activities as a means of expanding patient choice in
9 the private sector.

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- 11 2. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of
12 the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations)
13 should be used as a reference when considering whether a given plan would provide
14 meaningful coverage.

15

16 Even in the absence of an explicit list of suggested benefits, there are models that can be
17 used to help ensure the integrity of health insurance coverage. For example, the US Tax
18 Code includes a broad definition of “medical care” for the purposes of determining
19 eligibility for a tax deduction on medical expenses. This section defines medical care as
20 “the amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease, or
21 for the purpose of affecting any structure or function of the body...”

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23 In addition, the section of the Tax Code that defines qualified “group health plans” for the
24 purposes of employer tax benefits (Title 26 Section 9832) states that,

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26 “health insurance coverage” means benefits consisting of medical care (provided
27 directly, through insurance or reimbursement or otherwise) under any hospital or
28 medical service policy or certificate, hospital or medical service plan contract, or
29 health maintenance organization contract offered by a health insurer.

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31 This section also goes on to define “excepted benefits” which do not qualify as health
32 insurance coverage, which includes certain limited insurance offerings, such as disease-
33 specific plans offered separately from a more comprehensive plan.

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35 Similarly, the regulations governing FEHBP do not define specific benefits, but provide
36 broad guidelines for the types of benefits that should be covered. How these benefits are
37 provided is left to the discretion of the insurers. FEHBP’s Service Benefit Plan is often
38 mentioned as the model for a “basic but adequate” level of coverage, although some
39 believe that it may represent a richer benefit than other “basic” plans.

40

41 Relevant AMA Policy

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- 43 • Policy H-165.865[2] states that in order to qualify for a tax credit for the purchase of
44 individual health insurance, the health insurance purchased must provide coverage for
45 hospital care, surgical and medical care, and catastrophic coverage of medical expenses
46 as such expenses are defined by Title 26 Section 213(d) of the United States Code.
- 47 • Policy D-180.986[2] encourages local, state, and federal regulatory authorities to
48 aggressively pursue action against “sham” health insurers.

- 1 3. Provisions must be made to assist individuals with low-incomes or unusually high medical
2 costs in obtaining health insurance coverage and meeting cost-sharing obligations.
3

4 AMA policy clearly recognizes the need to subsidize health insurance costs for individuals
5 with low incomes and/or high medical expenses. Certainly initiatives that promote
6 individual responsibility to obtain health insurance cannot be promulgated without
7 including provisions for ensuring that insurance is affordable and accessible, including
8 costs associated with premiums, cost-sharing, and lifetime benefit maximums. Even
9 proposals that do not require that individuals obtain coverage must provide assurances that
10 affordable health care choices will be available.

11 Relevant AMA Policy

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 - 14 • Policy H-165.848 supports a requirement that individuals and families earning greater
15 than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic
16 health care and evidence-based preventive health care. Only upon implementation of a
17 system of refundable tax credits or other subsidies to obtain health care coverage, will
18 the AMA support a requirement that other individuals obtain coverage.
 - 19 • Policy H-165.851 supports implementation of individual tax credits for the purchase of
20 health insurance for specific target populations such as low-income workers, low-
21 income individuals, children, the chronically ill, and those living within geographic
22 areas that are pilot testing tax credits.
 - 23 • Policy H-165.855 supports using tax credits to allow Medicaid-eligible and other low
24 income individuals to purchase individually owned insurance.
 - 25 • Policy H-165.856[3] advocates that risk-related subsidies such as subsidies for high-
26 risk pools, reinsurance, and risk adjustment should be financed through general tax
27 revenues rather than through strict community rating or premium surcharges.
 - 28 • Policy H-165.865 defines the AMA's principles for structuring a health insurance tax
29 credit, including that the size of tax credits be inversely related to income, and that the
30 size of tax credits should be large enough to ensure that health insurance is affordable
31 for most people.
 - 32 • Policy H-165.995 supports the establishment of state risk pools to provide adequate
33 health insurance coverage at a premium slightly higher than the standard group rate to
34 those who are unable to obtain such coverage because of medical considerations.
35

- 36 4. Mechanisms must be in place to educate patients and assist them in making informed
37 choices, including ensuring transparency among all health plans regarding covered
38 services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and
39 excluded services.

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41 A patient's ability to make rational decisions depends on access to accurate and
42 comprehensive information. Efforts should be made to educate the public about the
43 process of evaluating health insurance coverage packages in general, including the
44 importance of considering factors such as family and personal health histories, behavioral
45 and lifestyle choices, and disease trends and treatment costs. Each of these factors can
46 influence what level of insurance coverage an individual needs, and what kind of benefits
47 would be most valuable. Individuals may also want to consider their financial resources,
48 and the effect that a major health episode might have on their budget if it were not covered

1 by insurance. A health insurance policy may offer generous coverage for routine medical
2 expenses, but could impose significant cost-sharing obligations, or even benefit
3 maximums, on enrollees who become sick and seek treatment for a chronic or severe
4 medical condition. It is important that patients be aware of and consider their out-of-
5 pocket responsibilities in the event of serious illness or injury.

6
7 Health insurance companies should also be required to clearly disclose all features of the
8 policies they offer, and help consumers understand circumstances in which their health
9 care expenses might not be covered. The Council notes that the market-based structure of
10 the FEHBP has resulted in a strong information network that individuals can use to
11 research plans and identify those that best meet their needs. Since insurers offering
12 coverage under the FEHBP compete for enrollees, many have responded to the increased
13 demand for consumer information by increasing the availability and accessibility of their
14 plan information.

15
16 Relevant AMA Policy

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- 18 • Policy H-165.920[9] encourages through all appropriate channels the development of
19 educational programs to assist consumers in making informed choices as to sources of
20 individual health expense coverage.
 - 21 • Policy H-165.985[3] supports providing full and clear information to consumers on the
22 provisions and benefits offered by alternative medical care and health benefit plans, so
23 that the choice of a source of medical care delivery is an informed one.
 - 24 • Policy H-320.968 supports the development of legislative initiatives to assure that
25 payers provide their insureds with information enabling them to make informed
26 decisions about choice of plan.
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28 DISCUSSION

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30 The escalating public policy debate about expanding health insurance coverage continues to lack
31 consensus on a workable definition of adequate, basic-level coverage. Attempts to define adequacy
32 in terms of a basic benefits package would likely result in contentious debates dominated by special
33 interests that would not necessarily yield the best policy guidance, since the ideal benefit mix will
34 likely vary depending on patient preferences.

35
36 The Council believes that federal tax regulations and regulations governing the FEHBP provide a
37 useful model for determining whether an individual health insurance policy provides a level of
38 coverage that elevates it above a “sham” policy. By ensuring that broad coverage categories are
39 addressed in qualifying plans, Internal Revenue Service and FEHBP regulations effectively screen
40 out plans that would provide extremely limited coverage and be useless in the event of a significant
41 medical episode or emergency.

42
43 Adequacy of health insurance coverage will vary greatly depending on the characteristics of the
44 individuals seeking insurance. In order for health insurance markets to work efficiently and
45 effectively, individuals must weigh many personal factors before determining what insurance will
46 best meet their needs. Conversely, it would be inefficient and ineffective for the government or
47 some other entity to predetermine what individuals need. Accordingly, the Council believes that a
48 more effective way of evaluating health care coverage, or proposals that intend to expand health
49 insurance options, is to apply a set of principles consistent with AMA policy that ensure that

1 individuals are choosing from among a variety of plans, and have adequate information with which
2 to make their decisions.

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4 RECOMMENDATION

5

6 The Council recommends that the following be adopted, and the remainder of this report be filed:

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8 1. That the American Medical Association (AMA) support the following principles to guide in
9 the evaluation of the adequacy of health insurance coverage options:

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11 a) Any insurance pool or similar structure designed to enable access to age-appropriate health
12 insurance coverage must include a wide variety of coverage options from which to choose.
13 (New HOD Policy)

14

15 b) Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of
16 the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations)
17 should be used as a reference when considering if a given plan would provide meaningful
18 coverage.

19

20 c) Provisions must be made to assist individuals with low-incomes or unusually high medical
21 costs in obtaining health insurance coverage and meeting cost-sharing obligations.

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23 d) Mechanisms must be in place to educate patients and assist them in making informed
24 choices, including ensuring transparency among all health plans regarding covered
25 services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and
26 excluded services. (New HOD Policy)

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

Fiscal Note: No Significant Fiscal Impact