

HEALTH INSURANCE

Availability of Insurance Coverage Information to Patients

The American College of Physicians-American Society of Internal Medicine has as policy that health insurance providers and third party administrators must be required to maintain a 24-hour-a-day telephone line or other confidential electronic means of communication to provide information about specific coverage and benefits available to any patient presenting for medical care. [BoR 98]

Timing of Screening Examination

The American College of Physicians-American Society of Internal Medicine has as policy that patients seeking periodic covered screening examinations (e.g., mammogram) should be able to receive insurance payment for such examinations after an appropriately flexible interval has supervened (i.e., rather than having to wait precisely 365 days for an annual mammogram). [BoR 98]

Medical Savings Accounts

Medical savings accounts (MSAs) have been proposed as a supplemental mechanism for financing health care services. Medical savings accounts could be used to accumulate funds for health care expenditures just as individual retirement accounts (IRAs) accumulate funds for retirement. Changes in the Internal Revenue Service (IRS) Tax Code would be required to permit tax-deductible contributions by employees and employers to MSAs and to allow interest and earnings to accumulate without taxation. Funds could be withdrawn without penalty only for medical expenses, for the purchase of health or long-term care insurance, or for other expenditures that could be stipulated in the tax code. Each person would own and control his or her account, regardless of changes in employment, and would therefore have a financial incentive to make cost-effective use of health-care resources. Coupled with high-deductible health insurance, MSAs could empower cost-conscious patients in health care decision making, increasing competitive pressures to reduce health care costs. Administrative costs and paperwork associated with health insurance might also be reduced, and some persons who currently do not have health insurance might be able to obtain some financial protection.

However, MSAs alone will not achieve the goal of universal access. The College is concerned that MSAs may not help unemployed persons or low- and middle-income persons who cannot afford to contribute to such accounts. These accounts may result in reduced health insurance protection and greater out-of-pocket expenses for those most in need of health care services. Problems of adverse risk selection could arise if healthy persons choose to establish MSAs and obtain high-deductible health insurance; this choice would cause premiums to become less affordable for persons who desire traditional health insurance.

Consequently, the College favors legislation that would permit experimentation and examination of MSAs through research and demonstration projects that would carefully monitor the effects of MSAs and minimize their potential negative consequences. (Medical Savings Accounts, ACP 96)

Insurance Reform in a Voluntary System: Implications for the Sick, the Well, and Universal Health Care

In the absence of universal coverage, carefully designed insurance reforms can make health insurance in the individual and small-group markets more affordable for those who need it most—the sick—and more secure for all subscribers. The ACP—ASIM calls for specific strong reforms at both the state and federal levels.

ACP—ASIM reaffirms its commitment to universal health care coverage. To that end, the College recommends reforms of the private insurance market that 1) harness the benefits of economic principles, including competition based on price and quality but not risk selection and 2) spread risk, financing, and access broadly across communities. The College's insurance reform recommendations are put forth not as independent goals but as stepping stones along the path towards universal coverage.

The College supports guarantee-issue requirements on all insurers in all markets.

The College supports guaranteed renewal requirements on all insurers in all markets.

The College supports limits on preexisting condition clauses and exclusion waivers in both the individual and small-group markets and for those persons moving between these markets. Exclusion of coverage for a maximum of 1 year for conditions existing as long as 6 months before coverage would serve as a reasonable disincentive to remaining uninsured. As a protection against retrospective underwriting, an exclusion should not be enforceable for a condition unless the condition was actually treated during the applicable period before coverage.

Preexisting condition clauses and exclusion waivers should be prohibited altogether for previously insured persons.

The College supports requirements for standardized benefit plans, including one comprehensive plan. Insurers should make all of the plans they sell available in all markets, including voluntary purchasing pools.

The College recommends limiting premium variation to the following factors: geography, family composition, plan design, age, and group size, which should be phased out over time. Variation in age ratings should follow the 1995 model law developed by the National Association of Insurance Commissioners.

The College supports a federal minimum standard for both Market and rating reforms, based on the recommendations contained in this paper. States wishing to establish stronger standards could do so. (Insurance Reform in a Voluntary System: Implications for the Sick, the Well, and Universal Health Care, ACP 96)

Timely Payment on Claims

ACP—ASIM supports legislation which requires all payors in all health care payment systems to pay physicians' clean claims promptly within thirty days of receipt of claims. (HoD 96)

Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care

This position paper of the ACP—ASIM discusses how a system of well-designed voluntary purchasing pools can help protect the integrity of health care in the emerging managed care marketplace.

Recommendation 1: Choice of health plans offered through a purchasing pool must be made by individual persons.

Recommendation 2: To provided the broadest possible choice of health plans, purchasing pools should offer all qualified health plans. If that is not done, the authority of purchasing groups to

negotiate price should be limited. As an alternative, states should set a minimum threshold for the number of competing plans that must be offered, in the aggregate and by type of plan.

Recommendation 3: Purchasing pools should be as large as possible and as few as possible in a given area.

Recommendation 4: Standardize one or two benefit packages across the entire small group market—in public state-chartered purchasing pools, in private pools such as MEWAs and employer purchasing coalitions, and outside of all pools.

Recommendation 5: Standardize community rating rules and regions, as well as other market rules, across the entire small group market. Rating factors must exclude health status and claims experience.

Recommendation 6: Allow participants in public purchasing pools to use an agent's or broker's services for enrollment and employee education but require commissions to be line-itemed separately from the pool premium so that consumers know the cost of the extra administrative service and the cost of the plan.

Recommendation 7: In a system of competing public pools, require state certification and monitoring of the pools' adherence to the same market rules to deter competition among pools based on risk selection.

Recommendation 8: Eventually, make public purchasing pools available to low-income and underserved persons. Adopt federal legislation prohibiting states from pooling Medicaid population premium costs with public purchasing pools.

Recommendation 9: Make purchasing groups accountable to the purchasers they serve—employers and consumers. Minimize political appointments to the boards of state-operated purchasing pools. Create incentives for pools to minimize in-house staff and use performance-based contracting for labor-intensive tasks.

While maintaining its commitment to universal coverage, the ACP—ASIM supports the concept of voluntary purchasing pools as an incremental mechanism for 1) expanding access to small groups and individual persons, 2) reducing administrative costs, and 3) maintaining quality in a marketplace increasingly dominated by corporate managed care. The College supports federal and state initiatives that stimulate the creation of voluntary purchasing pools in every state. (Voluntary Purchasing Pools: A Market Model for Improving Access, Quality, and Cost in Health Care, ACP 95)

Employer Expenditures for Health Services

ACP—ASIM encourages all employers to provide their employees and retirees with short, clear statements of the employers' contributions for each employee's health coverage. (HoD 93)

Concurrent Care

ACP—ASIM believes that appropriate recognition of all medical subspecialties in the development of concurrent care screens should be assured. ACP—ASIM believes that the Health Care Financing Administration should instruct its carriers to distinguish (as not equivalent) internal medicine physicians from family practice and general practice physicians on its hospital concurrent care screens. (HoD 90)

Principles on Preadmission Review Programs

ACP—ASIM endorses the following AMA principles (with modifications) for preadmission review programs: All preadmission review programs should provide for immediate hospitalization, without prior authorization or subsequent denial of payment based on lack of such authorization, of any patient whose treating physician determines the admission to be of an urgent and emergency nature. Blanket preadmission review of all or the majority of hospital admissions in and of itself does not improve the quality of care and should not be mandated by government, other payers or hospitals. Policies for review should be established with input from state or local physician review committees and reflect reasonable standards of medical practice. The actual review should be performed by physicians or under the close supervision of physicians with experience in rendering the care under review. Adverse decisions concerning hospital admissions should be finalized only by physician reviewers, and only after the reviewing physician has discussed the case with the attending physician. Physicians should be able to appeal adverse decisions. There should be direct and continuing communications to physicians and patients by the review organization explaining the prior authorization and preadmission review requirements. No preadmission review program should make a payment denial based solely on the failure to obtain preadmission review, or solely on the fact that hospitalization occurred in the face of a denial for such admissions without consideration of extenuating circumstances. When appreciable amounts of physician time or effort are involved in complying with preadmission review requirements, the physician may charge the payor or the patient for the reasonable cost incurred. Preadmission review programs should train their personnel so they can collect the needed data, communicate any necessary information and make valid medical judgments with minimal disruption of physicians' offices. (HoD 88)

Preadmission Testing

ACP—ASIM approves and supports the use of acceptable preadmission testing (PAT) and professional services wherever feasible to reduce inpatient hospital costs. Preadmission tests are those radiology and laboratory services performed within a reasonable (physician-determined) period of time preceding admission by a physician or laboratory with acceptable proficiency testing programs. (HoD 87)

ACP—ASIM encourages the American Hospital Association and third-party insurance carriers to accept and promulgate the concept of preadmission testing by qualified practitioners in an out-of-hospital setting. (HoD 73; reaffirmed HoD 87)

Core Principles on Financing

1. Financing should be adequate to eliminate barriers to care. (ACP 1990; reaffirmed BoR 00)
 - a. The highest priority should go toward assuring adequate and predictable financing for “critical access” institutions and providers with a higher burden of uncompensated care, including rural and inner city hospitals, outpatient care, physicians practicing in underserved areas, community health centers, home care, rehabilitation and skilled nursing facilities, and academic medical centers. Adequate funding of such critical access institutions and providers will be particularly important until such time as affordable health insurance coverage is made available to all Americans. Durable and sustainable mechanisms to improve ease of administration should also be incorporated to enhance the economic viability of such “critical access” institutions. Adequate funding of critical access institutions should not come at the expense of diverting resources from other health care facilities and health professionals, however.

- b. Reimbursement levels for covered services must be fair and adequate to reduce barriers to care. Mechanisms to improve ease of administration should also be included to enhance participation of physicians and others in providing services to insured populations.
- c. A substantial portion of federal budget surpluses should provide funds to expand health insurance coverage to the uninsured.
- d. Financing for public programs that provide health insurance coverage should be progressive. Individuals with higher incomes should contribute more than those with lower incomes. Explicit means-testing of programs- that is, denying access to the program for those in higher income brackets- should be discouraged.
(BoR 00)

Core Principles on Patient Rights and Satisfaction

1. Health reform proposals should address sources of patient and physician dissatisfaction with the current system. (ACP 90; reaffirmed BoR 00) Though no health reform plan can be expected to resolve all sources of dissatisfaction, it should be designed so that it does not contribute to them but, to the extent possible, alleviate them. Reforms should specifically address the following sources of dissatisfaction: micro-management of clinical decision-making; diversion of health care dollars away from patient care to administrative inefficiencies; excessive pressure on physicians to reduce time spent with patients; duplicative and inconsistent coverage and payment policies by payers; lack of continuity of care; erosion of the physician-patient relationship; unnecessary or excessive administrative burdens in order to get claims paid; excessive documentation requirements; and lack of choice of insurance plans and physicians.
2. Health reform proposals should be designed to reduce administrative and medical liability costs that do not improve access and quality of care. ACP-ASIM recognizes that an appropriate level of expenditure of administrative dollars to improve the quality and cost-effectiveness of medical care is necessary. Specifically:
 - a. Public and private research bodies, such as the Agency for Health Care Research and Quality, should support research on information systems to make the administration of health care and its financing more efficient.
 - b. Reforms should be enacted to limit excessive medical liability costs, including caps on non-economic damages.
 - c. Health reform proposals should include a description of mechanisms to assure that health care dollars are directed principally for patient care, not administrative tasks; physicians and other health professionals are able to devote as much time as possible to patient care activities and the least possible time to administrative tasks; and administrative and paperwork requirements do not act as a barrier to patients obtaining appropriate care in a timely manner.
3. Patients should have a choice of physicians:
 - a. Health reform proposals should be designed to respect the importance of patients being able to select a primary care and specialty physician of their choice.
 - b. Patients should be able to stay with the physician of their choice from year-to-year, not being forced by decisions of employers or health plans to discontinue that relationship.
 - c. Patients should have sufficient and prompt access to specialty care with a real choice of specialist.
 - d. The use of hospitalists to provide care to patients in the in-patient setting should be offered as a voluntary choice to patients and their primary care admitting physicians. Use of hospitalists should not be mandated.

- e. Requiring a reasonable but higher level of patient co-payments for open-ended access to a physician of their choice is an acceptable mechanism to control costs while providing patients with greater choice of physician than would be available through closed network or staff model health plans. Other insurance models that allow greater choice of physician should also be explored.
 - f. Research should continue on ways to provide patients with meaningful quality measurements that will factor into their choice of physician.
4. Decisions on expansion of the scope of practice of non-physician health care professionals should be based on evidence that they the requisite skills and training:
- a. A defined level of responsibility, based on skills and training, should be established for each type of non-physician provider.
 - b. Appropriate use of non-physician health professionals (such as nurse practitioners and physician assistants)- based on their skills and training and acting only under the direction of a physician- can improve access to care in some circumstances. Physician-directed teams must include sufficient built-in controls to assure adequate direction of the care provided by non-physician health professionals. (BoR 00)

Core Principles on Health Disparities and Disease Prevention

1. Incentives should be provided to encourage individuals to take responsibility for their own health, seek preventive care, and pursue health promotion activities. (ACP 90; reaffirmed BoR 00)
2. Health reform should have as a goal elimination of disparities in the medical care of patients based on social, ethnic, racial, gender, sexual orientation, and demographic differences:
 - a. Health reform proposals should be designed to address barriers to care in inner city, rural and other underserved communities.
 - b. Health reform proposals should recognize that lack of health insurance is in itself a cause of disparities in the quality of care received by patients.

Core Principles on Patient Rights, System Accountability, and Professionalism

1. Health reform proposals should promote accountability at all levels of the system for quality, cost, access, and patient safety.
 - a. These could include incentives for physicians and other health care professionals to participate in the design of systems of accountability. Non-punitive and educational approaches should be favored over ones that rely on sanctions.
 - b. Decisions on medical necessity, coverage, and appropriateness of care should be based on evidence of the clinical effectiveness of medical treatments as determined by physicians and other health care professionals based on review of relevant literature.
 - c. Innovation and improvement should be fostered (ACP 90; reaffirmed BoR 00), including innovation in use of Internet technologies to improve access, quality, and health care delivery with safeguards to protect the confidentiality of medical information that is transmitted electronically.
 - d. Patients should have certain basic consumer protection rights, including the right to appeal denials of coverage to an independent external review body, the right to hold a health plan accountable in a court of law, the right to be informed about how health plan policies will affect their ability to obtain necessary and appropriate care, and the right to have confidential health information protected from unauthorized disclosure. Denials of care by insurance companies for a

- particular problem or perceived problem should be based on evidence of clinical effectiveness and predetermined benefits.
2. The medical profession must embrace its responsibility to participate in the development of reforms to improve the U.S. health care system.
 - a. The tenets of professionalism and the highest ethical standards, not self-interest, should at all times guide the medical profession's approach to reforms.
 - b. The medical profession should partner with government, business, and other stakeholders in designing reforms to reduce barriers to care, to improve accountability and quality, to reduce medical errors, to reduce fraud and abuse, and to overcome disparities in the care of patients based on social, ethnic, gender, sexual orientation, or demographic differences.

HEALTH INSURANCE: BENEFITS AND COVERAGE

Coverage of Preventive Services

ACP—ASIM supports and to the extent feasible, will initiate efforts to ensure that all insurers cover an appropriate range and frequency of preventive services supported by evidence-based medicine including: comprehensive examinations; clinical laboratory tests; and screening procedures, such as colonoscopy, sigmoidoscopy, and mammography. (HoD 97)

Insurers to Cover Hepatitis B Immunization

ACP—ASIM supports federal legislation mandating insurance coverage for medically appropriate Hepatitis B immunization. (HoD 97)

Parity of Benefits for Physician Services for Mental and Medical Illness in All Insurance Plans

ACP—ASIM opposes limitations on benefits and higher copayment/deductible payment for physician services for evaluation and management services (the 99000 CPT codes series) that are submitted with 1997 ICD-9 codes 290-320. ACP—ASIM will seek legislative and/or regulatory means to require that Medicare restore its payment to physicians for evaluation and management services submitted with diagnosis codes 1997 ICD-9 codes 290-320 to the same level for evaluation and management codes for medical diagnoses. ACP—ASIM supports the ultimate parity of reimbursement for physician services for medical and psychiatric diagnoses (1997 ICD-9 codes 290-320) by all payors. (HoD 97)

Number of Medical Opinions

Managed care and other insurance benefit programs should not arbitrarily restrict the number of medical opinions a patient may obtain to address a medical problem, but that coverage or authorization of opinion should reflect criteria of medical necessity and appropriateness judged on a case by case basis. (HoD 94)

Deductibles and Copayments

Some appropriate form of deductible and/or copayment by the patient should be a feature of any health insurance plans. (HoD 77; revised HoD 80; revised HoD 93)

Insurance Coverage of Clinical Preventive Services

ACP—ASIM promotes the inclusion of clinically effective preventive services among the benefits to be provided by all private and public health insurance programs. ACP—ASIM seeks appropriate reimbursement for physicians providing clinical preventive services according to the CPT-4 preventive medicine codes by all private and public health insurers. (HoD 92)

Emergency Circumstance Fee

ACP—ASIM believes that all third-party carriers and Health Care Financing Administration should be aware of the need to recognize and include benefits for medical services at hours which are not usual or customary and are under emergency circumstances. (HoD 73; revised HoD 87)

Core Principles on Health Insurance Coverage

1. Proposals to expand access to health insurance coverage should have an explicit goal of all Americans being covered by an adequate health insurance plan by a specified date.
2. Sequential reforms that expand coverage to targeted groups should be considered, but such proposals should:
 - a. identify the subsequent steps, targeted populations, and financing mechanisms that will result in all Americans having access to affordable coverage;
 - b. include a defined target date for achieving affordable coverage of all Americans; and
 - c. include an ongoing plan of evaluation. The evaluation plan should provide for an ongoing assessment by health policy experts, physicians, patients, and others of the effectiveness of the sequential reforms in expanding coverage to the targeted groups and in achieving the goal of making affordable coverage available to all Americans by the defined target date. The evaluation plan should include a process for proposing to Congress and the President further recommendations for reforms to achieve the goal of making coverage available to all Americans.
3. Achieving affordable coverage for all Americans will require that mechanisms be established to encourage individuals who otherwise might voluntarily choose not to obtain coverage to participate in the insurance pool. This implies that strong incentives will need to be created for participation or strong disincentives be created to discourage nonparticipation.
4. Flexibility should be provided for states to investigate different approaches to expanding coverage, controlling costs, identifying funding sources, and reducing barriers to access and quality, provided that such state-based approaches contribute to the overall goal of providing all Americans with access to affordable coverage, subject to national standards to assure portability and access to the basic benefits package. State initiatives, while encouraged, are not a substitute for federal action when state initiatives are lacking or ineffective.
5. Mechanisms should be created to make prescription drugs more affordable. Formularies that act as a barrier to patients obtaining the best drugs available to treat their medical conditions should not be permitted. Other barriers to access to affordable prescription drugs should be identified and addressed by public policy initiatives. (BoR 00)

HEALTH INSURANCE: CLAIM FORMS AND CLAIMS PROCESSING

Disclosure of Denials

ACP—ASIM will seek at the national level, to require health plans or the entities which perform preauthorization review, to track and regularly publish, in a form accessible to the public and physicians, and of worth to health services researchers, information about the numbers and rates of denials of health care services, rates of denial of payment for services and of rates of reversal of denials on appeal. (HoD 97)

Payment for Providing Information to Third Party Payers

ACP—ASIM seeks regulations that would require third-party payers to pay costs of providing information beyond standard billing information (services provided, CPT/RVS codes, diagnosis codes, date and place of service, patient and physician identifying information). This applies to

information provided on paper, by fax, or by telephone. ACP—ASIM encourages national regulations for interstate payers and payers who are currently exempt from state regulation. (HoD 93)

Electronic Billing

ACP—ASIM seeks through HCFA to insure that for electronic billing, hardware be a matter of personal choice or preference for physician users; that software packages provided by carriers be compatible with multiple operating systems and user friendly; that third parties provide updates of software to physicians operating within their system; and that a consistency of quality be maintained in software development and use for all. (HoD 92)

Medical Paperwork

ACP—ASIM encourages third-party payers whenever they wish to initiate a new policy which results in a significant increase in the work-load of the physician provider (reimbursement information, disability forms, other information from medical records) to explain the reasons for such new policy in writing to representatives of practicing physicians, such as the state medical society and appropriate specialty societies such as the respective state society of internal medicine, and solicit comments from same before the institution of the policy; and to reimburse the provider for such additional information. (HoD 91)

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