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2025-0647-S

FOIA Number:
2025-0647-S

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REPORT OF THE BOARD OF TRUSTEES

Report:
(A-90)

Subject: Minimum Benefits in Required Employer Health Insurance

Presented by: John J. Ring, MD, Chairman

Referred to: Reference Committee

Board of Trustees Report Q (I-89), on Covering the Uninsured, was adopted by the House of Delegates. That report reviewed various elements of AMA policy to address the issue of the uninsured. In regard to the policy of a phased-in requirement of employer health coverage, the report presented one approach to accomplish this policy. The report described one package of basic health insurance benefits for all employer coverage, but did so without a great deal of specificity. In adopting the report, the House requested that the Board and the Councils on Medical Service and Legislation continue efforts to identify basic health care benefits.

This report presents a more basic package of benefits for the required employer insurance program which is more fully discussed in Report Q (I-89). The Board and the two Councils believe that enactment of any program requiring employer coverage should not create insurmountable financial obligations on small employers. In combination with tax incentives, employers should have available insurance coverage at moderate cost. In assuming that Congress will impose limited costs on small employers, difficult decisions had to be made in developing the proposed package of benefits for required employer insurance.

The Board and Councils believe that most employer-provided health insurance will continue in the future to exceed substantially the level being recommended herein as a requirement. This report does not present a package of benefits that is recommended for most employer coverage nor the set of needed benefits in other programs such as Medicaid and Medicare. Thus, the intent here is to limit the applicability of this recommended package of benefits to the specific purpose of coverage for this new program. It represents only the minimum package that should be required in any employer setting. The desire is to extend affordable coverage where none now exists. We have interpreted the request of the House of Delegates to specify a package of benefits more limited and less costly than that described in Report Q (I-89). Employers who now provide

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Past House Action:

coverage beyond this level should not reduce their present benefit packages.

In formulating a basic benefit package, the AMA has worked closely with The Wyatt Company, a leading actuarial firm with substantial expertise in pricing employee health benefits. In view of the fact that new financial obligations would be imposed on small employers, the goal in designing this package was to create a benefit level that would not only meet reasonable financial constraints but would at the same time meet certain health benefit criteria, as follows:

- Overall, it should do the most good for those that do not have coverage.

- It should provide care for injury and active illness both acute and chronic.

- Catastrophic benefits should be included.

- Preventive services are important, including pre- and post-natal care and immunizations, and consideration should be given to other cost effective preventive and screening care depending on the level of funding.

- Benefits for certain additional services, while of more limited applicability to the needs of the intended general age group covered in the employment setting, can be provided for very nominal cost and should, therefore, be included to provide additional benefits for those in need of them.

The following package has been estimated to cost employers an average of $1,700 annually per employee (based on 70% family policies and 30% individual policies and employer paying 80% of premiums). If indeed Congress imposes a premium cost either greater or less than this figure, the package can and should be adjusted in order to reach an equitable distribution of costs on the employer and employee and, at the same time, provide access to appropriate care to benefit as many workers and dependents as possible. The Board and Councils point out that for any given amount of premium there can be marked variations in the scope and kind of benefits provided, together with varying levels of deductibles and coinsurance. The package proposed herein for new employer coverage requirements would be significantly less expensive than national average employer costs of $2,300 to $2,600 per employee for employers who now provide health coverage.

The Board and Councils are well aware that, in selection of health benefits for the required insurance, certain elements of the profession may feel favored or disadvantaged. The point should be made, however, that the goal is to provide health benefits coverage where none now exists--and that some limitations are essential to make the coverage affordable. Thus, this report presents varying degrees of coverage for different types of benefits, limitations on some types of benefits and different levels of deductibles and coinsurance depending on the type of benefit.

Benefits

Covered: Medically necessary physician services (MD and DO) as determined by physicians; office visits limited to 20 per person per year; Outpatient Services; Inpatient semi-private room and board and Ancillary (inpatient days limited to 45 days per person per year); Skilled Nursing Facility (180 days per person per year); Home Health Care (240 visits per person per year); Ambulance; [skilled nursing, home health care and ambulance services can be covered at very minimal premium and hold potential for cost savings]; Dental (office or hospital limited to only repair necessitated by injury to sound teeth or jaw); overall benefit limit per person - one million dollars lifetime, and ICU at 3 times semi-private room rate.

Not Covered: Routine physicals, including routine screening tests and exams; detoxification; sterilization, reverse of sterilization, artificial insemination and family planning; cosmetic surgery; obesity treatment and weight loss programs; custodial or domicilary care; eye glasses, hearing aids, orthopedic shoes, orthodontic appliances; personal comfort items; hospice; outpatient prescription and nonprescription drugs; outpatient speech, occupational and physical therapy.

Physician Services. Inpatient and outpatient physician services including diagnostic and therapeutic services provided in an inpatient or outpatient setting including the physician's office. Such services include: diagnostic and medical or surgical treatment of illness or injury; diagnostic imaging and laboratory services; pre- and post-natal care of mother and infant, including delivery; immunizations and well-child care in accordance with guidelines of the American Academy of Pediatrics.

Outpatient Services. Outpatient facility services include emergency, outpatient facility and diagnostic services such as x-rays, lab tests, etc.; use of operating room and supplies; use of emergency room and supplies for emergencies; dialysis care.

Inpatient Hospital Services. Inpatient hospital care includes facility charges for services including semi-private room, board and nursing services; drugs, oxygen, blood, biologicals, supplies, appliances and equipment used in the facility; operating, delivery, and recovery room charges; all medically necessary special types of care including but not limited to intensive, coronary, special care, dialysis, rehabilitation unit charges; diagnostic services; care for pregnancy and complications; and medically necessary ancillary services.

Home Health Services. Medically necessary home health services prescribed by a physician including the services of physicians, home health aides, medical social workers and nurses under the supervision of physicians; and ancillary services, medical supplies and appliances; oxygen, blood, and biologicals; and rental of durable medical equipment.

Deductible:

Basic deductible	$350 per individual $750 per family

No deductible on pre-natal and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8 in accordance with guidelines of American Academy of Pediatrics

Coinsurance:

In General--20%, except as otherwise provided

Graduated coinsurance	First $1,000 of services, after deductible, at 30% coinsurance , after that at 20%, except as otherwise provided
Inpatient room and board	30%
Outpatient facility services	30%
Emergency room coinsurance after the deductible	$25 per visit

No coinsurance on pre-natal and post-natal care of mother and infant, nor for well-child care and immunizations up to age 8 in accordance with guidelines of American Academy of Pediatrics

Out-of-pocket limits: $1,500 per individual
$3,000 per family

Deductible and coinsurance amounts, but not premium payments, go toward meeting out-of-pocket expenses.

Premium: Employee share no more than 20%

More extended inpatient benefits:

As an additional optional benefit, employers should be required to offer, solely at the employee's expense, coverage for unlimited hospital days.

Conclusion

The Board and Councils have made difficult decisions in developing the proposed package of minimum benefits for required employer insurance. While refinements may be needed in the future, the Board and Councils believe that the foregoing package provides a minimal level of medical coverage for those who now have none, proposed as another example of basic benefits which could be considered in initiating a new program. Again, it must be stressed that priorities for benefits and allocation of deductibles and coinsurance could vary depending upon the level of total premium costs imposed by Congress upon the employer and employee. The profession must be involved in the final process of determining benefits. The Board and Councils recommend adoption of this report.

Ed- As requested, will follow up on meeting date on Friday.

LEE J. STILLWELL
VICE PRESIDENT
PUBLIC AFFAIRS

AMERICAN MEDICAL ASSOCIATION
1101 VERMONT AVENUE, N.W.
WASHINGTON, D.C. 20005

AREA CODE 202
789-7441