REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-00)
Benefits and Limitations of an Individual Mandate for Individually Owned Health Insurance
(Reference Committee A)

EXECUTIVE SUMMARY

Council on Medial Service Report 5 responds to referred Resolution 105 (I-99), which calls on the AMA to expand Policy H-165.920 by supporting mechanisms to ensure that all individuals have health expense coverage through: (1) requiring all American to own a minimum level of health expense coverage, and (2) creation of a health care safety net for the uninsured funded by the federal government through block grants to the states and the District of Columbia. Further, Resolution 105 (I-99) specifies that (a) such funds only be spent on indigent health care in ways determined by each state and the District of Columbia working in concert with their local government and (b) the amount of such grants be proportional to the number of eligible individuals in each such geographic area who have not received refundable federal tax credits for the purchase of individually selected and owned health expense coverage.

The attached report reviews available literature on individual mandates; discusses the advantages and disadvantages of imposing an individual mandate to purchase health insurance; and presents alternatives to an individual mandate that could be used to compel individuals to voluntarily purchase coverage. The report also discusses the merits of establishing a new program to serve as a health care safety net; describes existing safety net programs; and discusses ways to assure that the poor have access to tax credits through the establishment of mechanisms to advance credits to those who cannot afford the monthly out-of-pocket premium costs.

Despite some potential advantages, imposing an individual mandate to purchase health insurance entails serious philosophical and logistical drawbacks that can be avoided by using tax-based incentives and other non-compulsory measures to promote expanded coverage. Besides lacking political viability, an individual mandate is undesirable because it would permit the government to renege on its commitment to subsidize health insurance, and would entail an unreasonable administrative burden to enforce. Rather, with appropriately structured tax credits, virtually all individuals will face powerful incentives to obtain and maintain coverage.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 A-00

Subject: Benefits and Limitations of an Individual Mandate for Individually Owned Health Insurance (Resolution 105, I-99)

Presented by: Eugene Ogrod, MD, Chair

Referred to: Reference Committee A (Susan R. Wynn, MD, Chair)

At the 1999 Interim Meeting, the House of Delegates referred Resolution 105 to the Board of Trustees. Introduced by the Colorado delegation, the resolution calls for the AMA to "expand Policy H-165.920 by supporting mechanisms to ensure that all individuals have health expense coverage through: (1) requiring all Americans to own a minimum level of health expense coverage, and (2) creation of a health care safety net for the uninsured funded by the federal government through block grants to the states and the District of Columbia requiring: (a) such funds to only be spent on indigent health care in ways determined by each state and the District of Columbia working in concert with their local governments, and (b) the amount of such grants to be proportional to the number of eligible individuals in each such geographical area who have not received refundable federal tax credits for purchase of individually selected and owned health expense coverage." The Board of Trustees referred Resolution 105 (I-99) to the Council on Medical Service for a report back to the House at the 2000 Annual Meeting.

The following report provides background on the AMA's proposal for individually selected and owned health insurance; summarizes relevant AMA policy; reviews available literature on individual mandates, including mandates for automobile insurance and mandates for health insurance in other countries; discusses the advantages and disadvantages of imposing an individual mandate to purchase health insurance; and presents alternatives to an individual mandate that could be used to compel individuals to voluntarily purchase coverage. The report also discusses the merits of establishing a new program to serve as a health care safety net; describes existing safety net programs; and discusses ways to assure that the poor have access to tax credits.

BACKGROUND

The main focus of the AMA's plan for reform of the private health insurance market, as described in Policy H-165.920 (AMA Policy Database) involves expanding patient choice of health plans by making individually selected insurance a viable alternative to employer-selected insurance. Two key recommendations of this policy are: (1) eliminating the current tax exclusion of employer-based health insurance benefits and replacing it with income-related, refundable tax credits; and (2) fostering the development of "Voluntary Choice Cooperatives" as alternative risk-pooling mechanisms that would facilitate and expand patient choice.

Recently, there have been a growing number of Congressional proposals that address the use of tax credits for the purchase of health insurance. Further, there continue to be occasional calls for a national health care system. Increased attention to health system reform has reinvigorated the debate on the possible need for an individual mandate for the purchase of health insurance. At issue is whether an individual mandate is needed to achieve health insurance coverage for all Americans and to avoid the "free-rider" and adverse selection problems under a market-based system.

Regarding a health care safety net, AMA policy on individually owned insurance would provide tax credits for everyone who purchases insurance. Therefore, the only individuals who would not receive refundable federal tax credits, and would be in need of a safety net as described in Resolution 105 (I-99), would be those who choose not to purchase health expense coverage, or those who are enrolled in a public sector health care program such as Medicare, Medicaid or the Children's Health Insurance Program (CHIP).

AMA POLICY

Individually Selected and Owned Health Insurance

At the 1996 Interim Meeting, the House of Delegates adopted policy supporting individually selected and owned health insurance as the preferred method for people to obtain health insurance coverage (Policy H-165.920[5]). To assist in the development of the policy, the Council on Medical Service undertook the development of further recommendations as to how a system of individually owned insurance should be structured.

At the 1998 Annual Meeting, the House of Delegates adopted the 17 recommendations in CMS Report 9, thereby establishing the considerable policy base that underlies the AMA's current health system reform proposal. Among the key policies established by CMS Report 9 (A-98) were the following:

- Preference for replacing the present exclusion from employees' taxable income of employer-provided health expense coverage with a tax credit for individuals equal to a percentage of the total amount spent for health expense coverage by the individual and/or his/her employer, up to a specified actuarial value or "cap" in coverage so as to discourage over-insurance (Policy H-165.920[12]).

- Preference for relating the individual tax credit for all health expense coverage expenditures by individuals and/or their employers to the individual's income, rather than being a uniform percentage of such expenditures (Policy H-165.920[13]).

- Support for strong tax incentives, such as making tax credits contingent on purchase of a specified minimum level of coverage, as opposed to compulsory approaches (Policy 165.920[14]).

- Support for unions, trade associations, health insurance purchasing cooperatives, farm bureaus, fraternal organizations, chambers of commerce, churches, religious groups, ethnic coalitions, and similar groups serving as voluntary choice cooperatives for both children and the general

uninsured population, with emphasis on formation of such pools by organizations which are national or regional in scope (Policy H-165.882[15]).

Mandates

AMA policy favors tax incentives over compulsory approaches as a method of expanding health expense coverage (Policy H-165.920[14]). In addition, Policy H-180.978 supports expanding access to health insurance through market mechanisms rather than through government mandates and regulations. It should be noted that at the time the Council prepared CMS Report 9 (A-98), it did not recommend an individual mandate because the Council believed that a voluntary approach was preferable. Furthermore, the vast majority of state medical associations and national medical specialty societies that provided input to the Council prior to the development of CMS Report 9 (A-98) were opposed to the concept of an individual mandate.

Health Care Safety Nets

AMA policy supports the expansion of public sector safety net programs in a manner that is consistent with the goal of increasing choice through individually selected insurance. Specifically, Policy H-290.982(7) supports Medicaid and CHIP expansions, including providing Medicaid premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of tax credits; providing vouchers for recipients to use to choose their own health plans; and using Medicaid funds to purchase private health insurance coverage. The policy also supports additional funding for CHIP earmarked to enroll children to higher percentages of the poverty level. In addition, Policy H-165.871(1) states that in the absence of private sector reforms that would enable persons with low incomes to purchase health insurance, the AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health care coverage to otherwise uninsured groups.

INDIVIDUAL MANDATES

Most of the literature on mandated health insurance addresses employer mandates rather than individual mandates. Aaron (1994) notes that in principle, an employer mandate is easier to administer than an individual mandate because the government need only deal with employers rather than the relatively large number of employees. On the other hand, Tobin (1994) argues that an individual mandate is preferable to an employer mandate because of the difficulties that arise in considering the unemployed, the self-employed, part-time workers, people who hold multiple jobs, and families with more than one worker working for different employers. In any case, employer mandates and individual mandates can exist simultaneously, as they do in many Western European countries.

For either type of mandate, the rationales are to: (a) achieve universal coverage; (b) avoid the "free-rider" problem, whereby care for the uninsured is ultimately paid for by the rest of society through higher taxes and higher premiums; and (c) avoid adverse selection, whereby low-risk individuals opt out of insurance, driving up costs and premiums for those who are insured.

Individual Mandates for Automobile Insurance

Over half of all states have an individual mandate for some form of automobile insurance, and other states have some form of financial responsibility law, though typically with very low liability limits (Smith and Wright 1992). In practice, there are substantial numbers of uninsured drivers despite mandates to purchase automobile insurance. One reason cited for the ineffectiveness of individual mandates is that they are not accompanied by premium subsidies for low-income drivers.

In the absence of effective individual mandates, markets for automobile insurance can suffer from the "free-rider" and adverse selection market failures. The presence of safety nets leads some people to "free-ride" by driving uninsured. Two factors make it more attractive to drive uninsured: first, low-income uninsured drivers have few resources against which to collect when they are at fault; and second, if the at-fault party is unable to pay for damages, the insurance of the damaged party often pays. These safety nets are analogous to health sector safety nets such as charity care and the Emergency Medical Treatment and Active Labor Act (EMTALA). Further, compared to people with low incomes, those with higher incomes have greater motivation to be insured because they have more wealth at risk before safety nets become available.

Smith and Wright (1992) found that the presence or absence of adverse selection was responsible for the large geographic variability in automobile insurance premiums. They found that the premium differences for comparable policies were too large to be explained by differences in driver risk alone. Rather, premium differences could be explained, in large part, by differences in the proportion of low-income uninsured drivers in different areas. Where there are large numbers of low-income uninsured or underinsured drivers, premiums are higher because damaged parties with insurance are more likely to be forced to collect from their own policies. Even if all drivers were of uniform risk, the presence of uninsured drivers would create a type of adverse selection by forcing up the expected costs and premiums of those with insurance. In turn, high premiums discourage some drivers from purchasing insurance, thereby exacerbating the problem of the uninsured. This negative cycle is an example of the adverse selection market failure, which can affect health insurance markets as well.

Individual Mandates for Health Insurance in Other Countries

Approaches to universal coverage fall into two broad categories: (a) single-payor systems; and (b) mandated coverage. Single-payor systems may involve public financing of health services, as in Canada, or public financing and delivery of health services, as in Great Britain. The issue of mandated purchase of health insurance is not relevant to single-payor systems since under such systems, universal coverage is provided by the government.

Nations that have instituted individual or employer mandates to purchase health insurance generally approach but do not achieve 100% universal coverage. Most Western European countries mandate that insurance be purchased through a system of "sickness funds." Typically, employers and employees bear the costs of health insurance in agreed proportions, and the government may subsidize the funds as well as regulate them. Governments usually contribute toward coverage of groups who are difficult to insure (Center for Health Policy Research, AMA, 1989). Ballard and Goddeeris (1998) note that mandated-type proposals having the goal of universal coverage must include some system of subsidies for the poor, regardless of whether the

mandate is on the individual or the employer. Germany, France, and Japan are examples of countries that have achieved near-universal coverage through individually mandated insurance.

In Germany, health insurance is provided by non-profit, non-governmental "sickness funds" regulated by the government. Membership in a sickness fund is determined by occupation, employer or location. In general, Germans have no choice of fund and are required to purchase insurance from their assigned funds, although some occupation groups have choice between a regional fund and an occupational fund. Employers are required to contribute to premiums but there is little government subsidization of premiums. Government regulations require premiums to be community rated or on a sliding-scale basis. Only those above an income threshold are exempt from the mandate to join a fund; they are permitted but not required to purchase private insurance outside the fund system. Only about 100,000 people are uninsured in Germany (White, 1995). Although health insurance is not mandated in Switzerland, 96% of the population is insured through more than 500 sickness funds. The high rate of coverage is due largely to generous government subsidization of health insurance (AMA, 1984).

ADVANTAGES AND DISADVANTAGES OF AN INDIVIDUAL MANDATE

As previously noted, potential advantages of an individual mandate to purchase health insurance include: (a) universal coverage; (b) avoidance of the "free-rider" problem; and (c) avoidance of adverse selection. Some policy analysts believe that under a voluntary system, a significant number of people will not purchase coverage, particularly among those who are currently uninsured (e.g., those with low incomes, the young, and the healthy). They cite the erosion of coverage under the current, voluntary system as evidence that a mandatory approach is needed to guarantee health insurance coverage for all Americans, and to ensure that risk pools include low-risk individuals. According to this view, without either mandated coverage or a national health care system, there will be too many uninsured "free riders" whose care will ultimately be paid for by the rest of society through higher taxes and higher premium prices. Proponents of an individual mandate are skeptical that a voluntary system based on tax incentives will be able to expand coverage appreciably, especially if implemented in a budget-neutral manner. Further, an individual mandate coupled with tax subsidies for the poor would require less tax revenue than a single-payor system, thereby reducing the disincentives to work that go along with taxation.

Despite these potential advantages, there are serious philosophical and logistical drawbacks to imposing an individual mandate to purchase health insurance. Philosophically, an individual mandate can be viewed as coercive, particularly in the context of tax credit proposals to increase individual choice. An individual mandate could also permit the government to renege on its commitment to support health insurance through tax credits and other subsidies.

Further, a variety of logistical challenges would seriously limit the effectiveness of an individual mandate, as is the case with automobile insurance. Considerable resources which could be used to provide additional tax credits, health care or other goods and services would need to be devoted to identifying the uninsured, and then somehow compelling them to purchase health insurance. This would be especially problematic for certain sectors of the population, such as those with low incomes and seasonal laborers. Because of these philosophical and practical problems, an individual mandate would probably be politically unpalatable and could jeopardize the political viability of a tax credit proposal.

Perhaps the strongest argument against an individual mandate is that it might not be necessary to achieve a reasonable level of health insurance coverage. Income-related, refundable tax credits will give low-income individuals unprecedented market power, and the market will respond by providing more insurance products to fill their needs. Thus, tax-based incentives to purchase insurance, coupled with a greater tax credit to the low-income to assist them in obtaining health insurance could lead to virtual universal coverage. Tolerating the relatively small number of people choosing to forgo insurance under such a voluntary system is preferable to resorting to a compulsory approach.

ALTERNATIVES TO AN INDIVIDUAL MANDATE

In addition to an individual mandate, there are a variety of other policy options that can be used to expand health insurance coverage. One can think of policies to promote coverage as lying on a continuum between purely voluntary policies at one end and purely compulsory policies at the other, with mandated coverage lying at the compulsory end. Within this framework, policies to expand insurance coverage have various degrees of volunteerism or compulsion. Policies can be used alone or in combination with other policies. It should be noted that no approach, even a compulsory one, will achieve 100% universal coverage.

A variety of tax-based incentives can be used to encourage the purchase of health insurance. One tax-based approach would make the tax credit contingent on the purchase of health insurance, so that if insurance is not purchased, the credit is not provided. Although this would have no effect on persons who prefer to go uninsured, it would encourage the majority of the population who recognize the value of health insurance to obtain coverage in order to qualify for the tax credit. Tax credits could be structured so that the size of the credit is large enough at each income level to induce virtually everyone to voluntarily purchase health insurance. Should this approach prove too costly to finance, other incentives or other policies could be instituted along with the tax credits in order to encourage the purchase of health insurance. CMS Report 4 (A-00), which is before the House of Delegates at this meeting, recommends the adoption of a number of principles for structuring a health insurance tax credit.

It is possible to have a penalty without having a mandate. Under this approach, individuals who do not obtain coverage would be assessed a tax penalty. Tax penalties could be a flat amount or they could increase with income. This tax-based approach is more compulsory than positive tax incentives to purchase insurance described above but less compulsory than an outright mandate. Tax credits coupled with tax penalties could constitute a powerful “carrot and stick” approach to inducing the purchase of health insurance.

Individuals who do not choose to purchase health insurance on their own could be enrolled in “fall-back” plans or randomly assigned plans not of their choosing. Enrollment could occur automatically or only at such time as an uninsured person seeks (uncompensated) health care. Although automatic enrollment is compulsory, it *per se* is not punitive.

Financing coverage for the otherwise uninsured could be linked to revenue generated by unclaimed tax credits and/or tax penalties. Several proposals suggest that tax credits not used by the uninsured be channeled to state and local governments to finance safety net care for the indigent (Goodman, 1999 and Etheredge, 1999). Revenues from unclaimed tax credits could be used to fund a “fall-back” insurance plan, high risk pools, Medicaid expansions or the direct provision of care. Similarly, tax penalties could be equal to the premium of some minimal insurance, with the

penalty funds used to enroll such individuals in the fall-back plan. Designing the fall-back plan to be less desirable than privately purchased insurance would encourage the voluntary purchase of insurance.

Etheredge (1999) proposes that under a tax credit system, employers continue to facilitate the purchase of insurance. Regardless of whether insurance is purchased through the employer or elsewhere, there would be workplace sign-up and automatic payroll deduction for employees' premium payments. Employers would submit withheld premium payments to the plan chosen by the employee. If the employee did not specify a health plan, enrollment and premium payments would go to a plan assigned by the government. In order for employees to decline health insurance altogether, they would have to sign a statement explaining the tax credits and the benefits of basic health insurance. This approach would make the purchase of health insurance convenient and would reduce administrative costs. In the Medicare program, such automatic enrollment and deductions from Social Security checks have produced over 95% sign-up rates.

Another strategy for expanding health insurance coverage would be to impose a mandate only on individuals above a certain income level. Although this approach has the desirable goals of forcing those who can afford to purchase health insurance to do so without placing an undue financial burden on the poor, it would pose political and administrative difficulties similar to a general individual mandate. Further, people with large enough incomes to "go bare" or self-insure do not pose a "free-rider" problem.

HEALTH CARE SAFETY NET

The health care safety net recommended in Resolution 105 (I-99) has similarities to the existing Medicaid program and CHIP. Under both programs, the federal government provides grants to the states and the District of Columbia, as well as US territories to provide health care to the poor. Within federal guidelines, states are given broad authority in designing their individual programs in terms of eligibility and covered services. The amount of federal funding received by states for their Medicaid programs is inversely related to a given state's per capita income, with the richest states receiving a federal contribution of 50% of their total Medicaid expenditures, and the poorest receiving 73%. CHIP provides states even greater flexibility in program design and enhanced funding relative to Medicaid, so that federal match funding for CHIP ranges from 65% to 85% for the poorest states.

All states, the District of Columbia, and the U.S. territories have CHIP plans that provide coverage to children in families with incomes too high to be eligible for Medicaid and too low to afford private insurance. States may receive CHIP funds by expanding their existing Medicaid programs to children living in families with higher levels of income than allowed under Medicaid. Other states may establish entirely separate programs, which allows them to provide less comprehensive benefits and to require cost-sharing on the part of beneficiaries. Still other states may establish programs that combine elements of Medicaid expansion and stand-alone program techniques. For example, a state could expand Medicaid for children up to a higher percentage of the federal poverty level than offered under Medicaid alone, as well as enroll children at even higher levels of poverty, such as 250% of the federal poverty level, in another stand-alone program.

Labeling a state's plan as an expansion, separate program or combination approach can be difficult because of the wide variation in plan structures. For example, some states with stand-alone plans offer the same benefits as Medicaid, making them look like expansions. In addition, some states

with expansion programs may impose cost sharing for enrollees covered with CHIP funding because their existing Medicaid programs operate under a special waiver that allows them to do so. Therefore, there is some discrepancy in the relative number of each type of plan, but in general state CHIP programs are distributed into 21 Medicaid expansions, 16 separate programs, and 13 combination programs. The District of Columbia and the U.S. territories all have plans designed as Medicaid expansions. The preponderance of Medicaid expansions can be largely attributed to the fact that states had a limited amount of time to design their programs and expansion of an existing program presented the fewest administrative complexities. Over time, it is expected that more states will develop stand-alone or combination programs to maximize their impact in providing coverage to more children, while providing them greater budgetary control relative to Medicaid expansions.

Whereas AMA policy supports that tax credits be available to everyone, and there are existing safety net programs, the Council believes that the creation of a new safety net program for the poor is unwarranted. However, the Council does believe additional policy is needed to assure that those without means to purchase coverage receive their tax credit in advance of year's end. The AMA proposal to expand health insurance coverage, as articulated in Policy H-165.920, could be administered as a voucher system that provides recipients with a choice of health insurance. Vouchers can take many forms, and all essentially allow some level of recipient choice through government funding of specific goods and services, rather than unrestricted direct cash assistance. A popular form of government assistance, vouchers are currently used to provide a variety of services, including food and nutrition through food stamps, child care via the Child Care and Development Block Grant program, housing through Section 8 rental certificates, and education through the Pell Grant program for higher education and through several state demonstration projects for primary and secondary private education.

The issuance of tax credits as supported in Policy H-160.920[12] would most efficiently go directly to entitled individuals at the end of a given year for which such credits applied. A voucher mechanism to distribute tax credits for the purchase of health insurance would enable individuals with low incomes to secure coverage despite their lack of sufficient funds to purchase insurance without the immediate assistance of the tax credit due to them. The structure of such a voucher mechanism should be allowed sufficient flexibility to accommodate political and financing considerations. In general, however, welfare agencies and/or other entities should be authorized to verify income eligibility for such vouchers, and either the same or different appropriate agencies could issue vouchers for the amount of tax credit due the individual. Depending on the level of public commitment to expanding health insurance coverage and the budget environment in any given year, it should not be necessary for entities to wait until year's end to receive the credit due the individuals to whom they issue vouchers.

Accordingly, the Council believes AMA policy on individually owned insurance should be augmented by supporting the creation of a mechanism or mechanisms whereby tax credits could be made available as advanced payments through organizations such as local welfare agencies and/or other appropriate entities, which could verify income status and issue vouchers immediately for the amount of credit due individuals. The entities could then receive the tax credit due the individuals to whom they provided vouchers. Such mechanisms for assuring that tax credits are a feasible option for those with low incomes is necessary to ensure that individually owned insurance is viable for everyone.

DISCUSSION

The Council continues to believe that an individual mandate has serious drawbacks that can be avoided by using tax-based incentives and other policies to promote health insurance coverage. Besides lacking political viability, an individual mandate is undesirable because it would permit the government to renege on its commitment to subsidize health insurance, and would entail an unreasonable administrative burden to enforce. Rather, with appropriately structured tax credits, virtually all individuals will face powerful incentives to obtain and maintain coverage. Income-related, refundable tax credits will give low income individuals unprecedented market power, and the market will respond by providing more insurance products to fill their needs.

Regarding the safety net modification recommended in Resolution 105 (I-99), the Council notes that the AMA proposal would apply to individuals who are uninsured, but who would purchase coverage if they received tax credits for doing so and had affordable options, as well as those who currently have employer-sponsored benefits. Although there may be some indigent individuals who may not purchase coverage, public safety net programs exist for the poor, and AMA policy favors expanding eligibility for these programs in the absence of private sector reform. In addition to the existing safety net programs for the low income, EMTALA assures that acute emergency conditions will be treated regardless of ability to pay. Assuming the continuation of public sector programs such as Medicaid and CHIP, and the continuation of efforts to expand eligibility and enrollment in these programs, supporting the establishment of an additional and separate safety net for an unknown population of individuals who do not receive the tax credit would seem a premature commitment of public funds. The Council does believe, however, that there is a need for additional policy to assure that low income individuals are able to access the tax credits in advance of year's end so that they are able to purchase coverage.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 105 (I-99), and that the remainder of the report be filed:

1. That the AMA amend Policy H-165.920 by addition of the following principle:

   The AMA supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage.

2. That it is the policy of the AMA that organizations such as local welfare agencies and/or other appropriate entities be authorized to verify income status and issue vouchers immediately for the amount of tax credits due individuals; thus advancing funds to purchase the coverage for low-income persons who could not afford the monthly out-of-pocket premium costs.

References for this report are available from the AMA Division of Health Care Financing Policy.