REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-01)
(June 2001)
Status Report on Expanding Coverage for the Uninsured
(Reference Committee A)

EXECUTIVE SUMMARY

Council on Medical Service Report 6 provides an update to Council Reports 7 (A-97) and 2 (A-99), which provided detailed information on the characteristics of the uninsured and identified relevant federal and state legislative reforms. This report includes a discussion of the following:

- Summary of the AMA proposal for expanding coverage through the use of refundable income-related tax credits and insurance market reform.
- Comparison of the AMA proposal relative to other approaches for expanding coverage.
- Legislative and regulatory initiatives designed to expand coverage.
- Information on the characteristics of the non-elderly uninsured in 1999. This report compares findings from the Council's previous reports, which contained data from 1997 and 1995.

The report expresses optimism regarding ongoing market and legislative initiatives that indicate an incremental shift toward the AMA vision for health system reform, a vision that promises to promote core values of patients and physicians, and contains recommendations to support such reform initiatives.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6 - A-01
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Subject: Status Report on Expanding Coverage for the Uninsured

Presented by: Joseph M. Heyman, MD, Chair

Referred to: Reference Committee
(John D. Holloway, MD, Chair)

At the 1997 Annual Meeting, the House of Delegates adopted the recommendations contained in Council on Medical Service (CMS) Report 7, which detailed characteristics of the uninsured; extensively reviewed AMA policy; discussed state activities to increase health care access; reviewed the anticipated impact of federal legislation that had recently been enacted, and presented 18 policy recommendations for increasing access for the uninsured. CMS Report 2 (A-99) provided an update to CMS Report 7 (A-99), and provided a comparative analysis that revealed an increase in the number of the uninsured. In particular, using 1995 and 1997 data from the Employee Benefits Research Institute (EBRI), the reports discussed the number of uninsured according to employment status, age, income, education, race and citizenship.

In September 2000, the Census Bureau reported that 42.6 million people in the United States (15.5% of the population) were uninsured during 1999, representing a decrease of 1.7 million uninsured people from 1998. Although the decline in the number of uninsured individuals provided respite from a relentless trend, the decline was small given that it occurred at the end of a period of prolonged prosperity. Most analysts agree that the decline in the uninsured was a direct result of the sustained economic boom, with significant growth in the number of people covered by employment-based coverage. The ability of employment-based coverage to determine the outlook for the uninsured underscores the volatility of this type of coverage. In particular, the Council is concerned that any downward trend in the economy will signal a return to the rise in the number of uninsured Americans. Adding to the Council's less-than-optimistic expectation for a further decline in the uninsured rate in the next year, is the fact that health insurance premium prices increased sharply in 1999 and 2000, and may increase 10% or more in 2001 and 2002. Such premium increases put additional pressure on a health care system already straining to provide coverage to the uninsured.

The following report provides an update to information contained in Council Reports 2 (A-99) and 7 (A-97). Included is a summary of the AMA proposal for expanding coverage, including ongoing market reforms that are consistent with the AMA vision; a comparison of the AMA proposal with alternative strategies to reduce the number of the uninsured; a discussion of legislative and regulatory initiatives to decrease the number of the uninsured; and information on the characteristics of the non-elderly uninsured in 1999 by employment status, industry and firm size, income, education, age, and race and citizenship.

AMA PROPOSAL FOR EXPANDING COVERAGE

In 1996, the House of Delegates adopted Policy H-165.920[5] (AMA Policy Database), which supports individually owned health insurance as the preferred method for people to obtain health

insurance coverage. To assist in the development of that policy, the Council 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 insurance reform proposal. Among the key policies established by CMS Report 9 (A-98) were the following:

- Preference for replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits in amounts that are inversely related to income (Policies H-165.920[12][13] and H-165.865[1,c]).

- Endorsement of the concept that employers provide a defined contribution for the purchase of health expense coverage within the private sector for all full-time employees (Policy H-165.983[1]).

- Creation of opportunities for alternative markets for the purchase of health insurance—"Voluntary Choice Cooperatives"—that would be exempt from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws (Policies H-165.882[14] and H-165.895[3]).

Since the 1998 Annual Meeting, the Council and the House have continued to refine this policy. Consistent with the shift in AMA policy favoring individually owned insurance, Council on Long Range Planning and Development Report 2 (I-99) rescinded Policy H-165.980, thereby formally removing previous AMA support for an employer mandate from the AMA Policy Database. Throughout 2000, the concept of using tax credits to expand health insurance coverage continued to gain bipartisan support among the 106th Congress and both presidential candidates. In order to delineate the AMA's proposal further, and to evaluate proposals put forth by others, the Council worked to develop guiding principles for structuring a health insurance tax credit.

As a result, CMS Report 4 (A-00) established a series of nine principles for structuring health insurance tax credits (Policy H-165.865), and demonstrated the viability of the AMA proposal through a series of tax credit simulations. Specifically, if combined with full enrollment of individuals eligible for coverage under Medicaid and the State Children's Health Insurance Program (known variously as CHIP and SCHIP), the AMA proposal would cover 94% of the uninsured at the relatively modest cost of an additional $30-60 billion of federal spending (in addition to the estimated $80 billion that would be gained by eliminating the current tax subsidy of employment-sponsored health benefits). One of the nine principles for structuring tax credits is that their size be inversely related to income (Policy H-165.865 [1,c]). CMS Report 5 (A-00) supported the use of tax incentives and other non-compulsory measures to encourage individuals to purchase health insurance coverage, rather than an individual mandate Policy H-165.920 [15].

The AMA proposal envisions a health system that is responsive to patients, who will be empowered through their choice of coverage and ownership of their insurance. A number of market-based developments are progressing in a manner consistent with the AMA vision for insurance reform. For example, Highmark Blue Cross and Blue Shield of Pennsylvania provided defined contribution benefits to three businesses representing 3,000 enrollees in 2000. For 2001, Highmark will market the defined contribution plans to 100 employers. Under the defined

contribution model, Highmark offers up to 16 combinations of coverage, from which employers choose at least five options. In addition, Internet technology has opened new markets for health plans, using systems that could easily evolve into defined contribution systems. A separate report before the House at this meeting addresses the evolution of Internet-based health insurance marts (CMS Report 5, A-01).

OTHER STRATEGIES TO EXPAND COVERAGE

Throughout the election year of 2000, and continuing in 2001, expanding coverage to the uninsured has been a priority issue for America and its political leaders. Accordingly, a number of organizations have advanced proposals to address the consistently high number of uninsured individuals. Generally, such alternative proposals can be characterized as advocating one of three mechanisms: single payer, public sector expansions, or enhancing the current employment-based system. The Council encourages an open discussion of the distinctions between the AMA proposal and these alternative strategies.

Single-Payer Approach

Single-payer approaches rely solely on governmental control and financing of health care. A review of the experiences of countries with single-payer systems continue to show that such systems are characterized by long waiting periods for specific services, less agile bureaucracies, slower adoption of new technologies, less choice, reduced efficiency, and diminished ability to constrain inflation. The AMA's policy preference for pluralism of payers and payment systems has been reaffirmed many times since its adoption by the House of Delegates. The AMA strongly believes that a single-payer approach would unfairly concentrate the market power of payers to the detriment of patients and physicians (Policies H-165.944[1], H-165.920 [1], and H-165.960[12]).

Public Sector Program Expansions

Most typically, public sector expansions seek to raise the upper income limits on eligibility for Medicaid and CHIP. Other expansions would extend eligibility to individuals previously not considered eligible for these programs, such as the parents of eligible children. The AMA supports public sector expansions only in the absence of private sector reforms that would enable persons with low incomes to purchase health insurance (Policies H-165.871 [1] and H-290-982 [7]). The AMA continues to strongly support streamlining the enrollment process for Medicaid and CHIP (Policy H-290.982 [4]), as well as outreach efforts to identify and encourage enrollment (Policy H-165.882 [11]). In fact, the success of the AMA proposal is dependent upon maximizing the enrollment of currently eligible beneficiaries of these programs.

Regarding the Medicare program, there continue to be occasional calls for a Medicare buy-in option for those aged 55-64. The Council has specific concerns that such proposals will exacerbate the financially troubled Medicare program, because it is doubtful whether the buy-in cost would be large enough to offset the additional program costs. A further danger of public sector expansions, such as expanding Medicaid to additional populations and instituting a lower age for Medicare eligibility, is that such expansions constitute a subtle approach to a single payer system. The Council notes that a substantial portion of the 3.4 million uninsured individuals aged 55-64 in 1999 would benefit from affordable individually owned insurance, perhaps in the form of medical savings accounts as advocated in Policy H-165.920 [7].

Employment-based Coverage Enhancements

In November 2000, the Health Insurance Association of America (HIAA) and Families USA joined to support a proposal that would provide a non-refundable tax credit to employers who provide premium assistance to employees who otherwise would not be able to afford their portion of the coverage. The HIAA/Families USA plan also contained public sector expansions that would both raise the income limit on Medicaid to 133% of the Federal Poverty Level (FPL), and allow states to cover all adults with family incomes between 133% and 200% of the FPL through Medicaid or CHIP. The tax credit distinction between the AMA proposal and that proposed by HIAA/Families USA highlights the underpinning philosophy of the AMA proposal: choice. A tax credit to employers would simply perpetuate the already subsidized, yet nevertheless failing, employment-based system, and would do nothing to improve choice for employees. Tax credits to individuals, rather than to employers, as advocated by the AMA, would provide all individuals with a refundable tax credit that would be large enough for them to cover a substantial portion of the cost of coverage, regardless of their employment status. They would be able to choose from the wide variety of plans that are being developed on the individual market.

LEGISLATIVE AND REGULATORY INITIATIVES TO EXPAND COVERAGE

In January 2001, the AMA sent a letter to the Administration supporting the use of individual tax credits as a top priority, and applauding the President's support for such credits during his candidacy. In addition, an all-Congressional mailing in February 2001 apprised the House of Representatives and the Senate of the AMA's proposal. Both the Administration and Congress were provided a booklet describing the AMA proposal. The mailings were followed by a March 2001 Congressional Hill briefing on health insurance tax credits sponsored by the AMA and the National Center for Policy Analysis. The Council is encouraged that AMA advocacy on expanding health insurance through a system of tax credits appears to be increasingly viable.

Despite intensifying public concern over the rising number of the uninsured throughout the 1990s, legislative remedies were few and piecemeal in nature. Although little has occurred legislatively in the past two years to reduce the number of the uninsured, a number of proposals were introduced in the 106th Congress that would have expanded coverage in a manner consistent with the AMA vision. For example, there were several proposals introduced that would have created tax credits for the purchase of health insurance.

The Council has previously noted the shortcomings of piecemeal federal efforts to address the number of the uninsured. In particular, the Health Insurance Portability and Accountability Act of 1996 (PL 104-191, "HIPAA") promised to make insurance more portable, thus eliminating "job lock." However, HIPAA was unable to ensure the affordability of individual insurance as it currently exists. AMA policy supports insurance market revisions that allow individually purchased insurance to be viable (Policy H-165.882 [14,15]).

The Balanced Budget Act of 1997 (PL 105-33, "BBA") authorized $24 billion in federal matching funds over five years (starting in 1998) to help states expand coverage to uninsured children though the CHIP, which generally provides coverage to children in families between the poverty level and up to 200% of poverty. Although the impact of CHIP on the total number of those lacking health insurance is obscured by the increase in coverage through employment-based coverage for children

just above the poverty level, it is estimated that some 3.3 million children were enrolled in CHIP as of December 2000.

All states now have CHIP plans that have been approved by the Health Care Financing Administration (HCFA). In general, states were quick to implement programs following the enactment of the BBA, and then struggled to enroll eligible children. In part, the early struggle to enroll children can be attributed to the CHIP program design, which limited the amount states could spend on enrollment and outreach to 10% of total program expenditures. In other words, children needed to be enrolled and receiving services in order for outreach funding to be available. Given the slow start of CHIP enrollment, efforts to enroll children by improving outreach efforts became an early program priority. In January 2001, Mathematica Policy Research issued a report that detailed the implementation and continued growth of the CHIP program, including the analysis that the 19 states that began enrolling children before July 1998 accounted for more than 75% of 1999 enrollment of 1.5 million children.

The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (PL 106-554,"BIPA") provided refinements to the BBA. For example, the BBA had required that states that do not use their annual CHIP allotments within three years must return all unused funds to the federal government for redistribution to states that had exhausted their allotments. Subsequently, BIPA contained a reallocation formula that entitles all states to a portion of any unused funds, and gives states an additional year to spend those reallocated funds. Such a reallocation acknowledges the slow use of funding during the early phase of a state's CHIP plan, and the subsequent acceleration of funding needs as a state's program matures.

BIPA also expanded the types of entities qualified to temporarily enroll children under "presumptive eligibility" in Medicaid or CHIP. Under presumptive eligibility, a state option, children whose family income appears to be below the pertinent income threshold may be temporarily enrolled until a formal determination on eligibility is made. Services provided during the period of presumptive enrollment are paid by Medicaid, regardless of whether the child is subsequently found to be ineligible for formal enrollment. Previously, presumptive eligibility could be determined only by "qualified health providers," which included pediatricians as well as county health departments, hospital clinics, federally qualified health centers, Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) programs, Head Start centers, and agencies that determine eligibility for subsidized child care.

BIPA expands presumptive eligibility to numerous entities that encounter low-income families on a regular basis. In particular, the law allows states the option of enrolling children through schools, child support enforcement agencies, homeless shelters, and offices that determine eligibility for other programs, such as housing and cash assistance. It should be noted that physicians who treat potentially Medicaid- or CHIP-eligible patients in states that exercise the option of presumptive eligibility have the authority to participate directly in the enrollment of children into CHIP or Medicaid through "presumptive eligibility." If the child subsequently is found ineligible, the physician is still paid for the service provided. The Council believes physicians should be encouraged to contact their state Medicaid agencies to learn how to enroll children in CHIP or Medicaid under the state's "presumptive eligibility" process, if applicable.

Linking enrollment in Medicaid and CHIP to enrollment in other government programs for low-income children is a strategy recommended by many organizations that study health and poverty,

such as the Urban Institute and the Kaiser Family Foundation. In November 2000, the Kaiser Family Foundation published a report that details how to practice "express lane eligibility," or using information from public benefit programs with comparable income requirements, such as the school lunch program, to expedite enrollment of low-income children into Medicaid and CHIP. The school lunch program, for example, serves about 4 million low-income uninsured children, most of whom would be eligible for CHIP or Medicaid coverage.

The community service project of the AMA Medical Student Section for 2001-2002 is the Children's Health Insurance Program Initiative, which encourages CHIP outreach and enrollment. Efforts to increase public sector enrollment of currently eligible children is consistent with AMA policy, and helps to validate the tax credit simulations of the AMA private sector proposal, which assumes full enrollment of Medicaid and CHIP eligibles. The Council believes that the Medical Student Section should be commended on this initiative.

In January 2001, HCFA published a final regulation on CHIP that generally codifies longstanding policies of the U.S. Department of Health and Human Services and current state practices, while also providing states with additional flexibility in designing their CHIP plans. For example, states are given more flexibility to experiment with employer-sponsored premium assistance programs while preventing substitution of public insurance for employer-sponsored coverage.

CHARACTERISTICS OF THE UNINSURED

The Council reviewed a December 2000 EBRI analysis of 1999 data from the Current Population Survey. In addition, 1995 data from CMS Report 7 (A-97) and 1997 data from CMS Report 2 (A-99) are provided for comparison, where applicable. Consistent with the Council's findings from 1995 and 1997, the analysis of 1999 data clearly indicates that the 42.6 million uninsured are more likely to be the near-poor, younger adults, of minority and non-citizen background, and employed in smaller firms.

Employment Status

During 1999, 20% of the nonelderly population was uninsured, while 65.8% of the nonelderly had employment-based health insurance and 14.2% of the nonelderly had some form of public health insurance. Since 1993, EBRI reports that the portion of the population insured through employment has increased relative to the portion insured through public programs.

	% Uninsured by Employment Status		
Employment Status, Family Head	1995	1997	1999
Workers	78.4	83.9	84.0
Full-year, full-time workers	52.7	59.5	61.1
Other workers	25.7	24.4	22.9
Non-Workers	21.6	16.1	16.0

Among individuals in families with a head of household employed full-time year-round in 1999, 14.0% were uninsured, an improvement over 14.6% in 1997 and consistent with 13.9% in 1995. The vast majority of the uninsured (84%) in 1999 lived in families headed by workers, with only 16.0% of the uninsured living in families in which the family head did not work. The "other workers" category includes full-year part-time workers as well as seasonal workers. That the

representation of "other workers" among the uninsured declined at the same time full-year and full-time worker representation among the uninsured increased, indicates the likely scenario that some jobs held by "other workers" shifted to full employment during the tight labor market. Overall, the comparison over the reported years indicates a substantial increase in the proportion of the uninsured whose families are connected to the work force full-year and full-time.

The nonelderly unemployed lack the opportunity for employer-sponsored coverage and most likely have low incomes. Those who are employed seasonally or part-time are likely to receive low wages and be in jobs that do not offer employer-sponsored coverage. The most poignant indication that our nation must rethink its reliance on employer-sponsored coverage is the growing proportion of the uninsured who are employed full time.

Firm Size and Industry

Size of the firm is an important indicator of insurance coverage, with workers in smaller firms and the self-employed more likely to be uninsured. The distribution of coverage by firm size has been relatively stable over the years addressed in this report, with roughly a quarter of the self-employed lacking insurance over all the years, and approximately a third of employees in firms with fewer than 10 lacking coverage.

	% of Workers Uninsured within Firm Size		
Firm Size (# employees*)	1995	1997	1999
Self-employed	25.1	24.1	24.5
Less than 10	32.7	34.7	32.8
10-24	27.6	29.7	26.2
25-99	20.3	20.9	20.7
100-499	15.3	15.8	15.4
500-999	13.0	12.7	12.9
1,000 or more	11.6	12.3	12.2

*Only employees in the private sector are considered.

Nearly a third (32.2%) of workers in the broad sector that includes agriculture, forestry, fishing, mining and construction were uninsured. Wholesale and retail trade employees also represented a large portion of the uninsured (21.6% of these workers were uninsured). Among all uninsured workers, there are more in the wholesale and retail trade sector (41.1%) than any other category, simply because nearly a third of all workers are in that industry category.

Income

Lack of insurance is largely predicted by income, so that efforts to increase coverage for the uninsured must be sensitive to the relationship between income and insurance coverage, which is precisely the reason the AMA proposal for reform calls for the size of tax credits to be larger for those with lower incomes (Policy H-165.865 [1,c]).

	% Uninsured within Poverty Level		
% of Federal Poverty Level	1995	1997	1999
0-99	33.0	34.7	35.6
100-149	32.8	35.8	31.1
150-199	27.3	28.5	25.7
200 and up	10.5	11.4	11.5

The likelihood of being uninsured decreased as income level increased, with the notable exception of 1997 for those individuals at or just above the poverty level. In 1997, the percent of individuals uninsured at or just above the federal poverty level (35.8%) was greater than the percent uninsured whose income was below the poverty level (34.7%). This anomaly is probably an artifact of a greater level of Medicaid coverage among those below the poverty level immediately following passage of the Welfare Reform Act of 1996, which suffered some administrative difficulties that disenrolled some low-income working individuals who were still eligible for Medicaid.

Age

Individuals aged 21-24 are consistently more likely to be uninsured than any other age group, with a third of this age group uninsured in 1999. The high proportion of the uninsured among young adults continues to reflect the lapse of family coverage for many prior to their entering the workforce. The second most likely uninsured age group was 18-20, which may be attributed to the fact that Medicaid eligibility for children ends at age 18 in many states. Since 1997, children aged 17 and under made gains in coverage, which can be attributed to a combination of enrollment in CHIP, as well as coverage under employment-based policies.

	% Uninsured within Age		
Age	1995	1997	1999
Less than 6	13.5	14.2	13.9
6-12	13.7	14.1	13.4
13-17	14.4	17.0	14.5
18-20	23.0	25.9	24.0
21-24	32.3	33.8	33.4
25-34	23.0	23.5	23.3
35-44	17.0	17.4	16.6
45-54	13.3	13.9	13.4
55-64	13.0	14.3	14.5

Due to near-universal Medicare coverage for the elderly, the elderly are less likely than the nonelderly population to be uninsured. Whereas 15.5% of the total population was uninsured in 1999, the lack of insurance among the nonelderly population was 17.5%. According to estimates of the U.S. Census Bureau, 1.3% of persons aged 65 and older were uninsured in 1999.

Race and Citizenship

In 1999, Hispanics were more likely than whites or blacks to be uninsured at all income levels (33.4%). Among blacks 21.2% were uninsured, while 11.0% of whites were uninsured. The 1999 rates for Hispanics and whites represented a significant reduction from 1998, when 35.3% of Hispanics and 11.9% of whites were uninsured. Coverage also improved among blacks, with the

rate of being uninsured dropping from 22.2% in 1998 to 21.2% in 1999, but the difference is not significant.

The uninsured rate for native-born Americans was 13.5%, in contrast to 33.4% for foreign-born individuals. The Welfare Reform Act restricted Medicaid benefits to previously eligible low-income legal immigrants who are not citizens. A separate report on uninsured immigrants is before the House at this meeting (CMS Report 8, A-01).

DISCUSSION

The Council is encouraged that the AMA proposal for expanding health insurance coverage through a system of income-related and refundable tax credits has become more politically viable. The new Administration, as well as key members of Congress, supports the use of tax credits to expand coverage, and the AMA has communicated its desire to work with the nation's leaders on this issue.

The Council believes that individual ownership of health insurance coverage will instill in each individual a sense of cost consciousness regarding health care choices. This will be particularly important during times of slower economic growth. For example, as the economy began to show signs of slowing early in 2001, many states began reporting revenue shortages. At the same time, state Medicaid costs were projected to rise 8% to 12% for the 2001-2002 fiscal year. For the most part, states reported that the financial constraints would be overcome without cutting Medicaid benefits. Rather, institutional providers, drug makers and pharmacies were expected to be asked to make significant concessions, and other state programs unrelated to health were being targeted for cuts. The AMA proposal, by encouraging individual responsibility for heath care choices, could help restrain future medical inflation.

A review of the characteristics of the uninsured continues to suggest the need for vigorous pursuit of AMA policy. In fairness to those who do not have employment-sponsored coverage and therefore receive no subsidy under the current system, the AMA should continue to vigorously pursue Policy H-165.920 [12][13], which establishes a preference for replacement of the present exclusion from employees' taxable income of employer-provided health expense coverage with income-related tax credits. Likewise, Policy H-165.865, which calls for tax credits that are larger for those with lower incomes, would address the poverty characteristic of the uninsured. Again, consistent with Policies H-290.982 [6], H-245.986 and H-165.882 [1], the Council supports efforts to increase access for low-income children, using a variety of coverage strategies, including enrolling all eligible children in Medicaid or CHIP, and providing a mechanism for low-income families to purchase private individually owned insurance. In addition, Policy H-165.882 supports individual insurance market reforms that would encourage coverage by persons who are not offered insurance through their employers, such as those in firms that do not offer coverage. The Council is encouraged that there is evidence that market reforms are well under way.

RECOMMENDATIONS

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

1. That the AMA continue to vigorously pursue its polices that support a system of income-related refundable tax credits for the purpose of expanding coverage and patient choice (Policies H-165.920, H-165.882, and H-165.865). (Directive to Take Action)

2. That it is the policy of the AMA to encourage physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible. (New HOD Policy)

3. That the AMA commend the Medical Student Section on its 2000-2002 community service project to encourage outreach and enrollment in the State Children's Health Insurance Program. (Directive to Take Action)