REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 10 - A-02
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Subject: Advocating Health Insurance Tax Credits

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Referred to: Reference Committee A
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1 At the 1998 Annual Meeting, the House of Delegates adopted the 17 recommendations contained
2 in Council on Medical Service Report 9, which stated the AMA's preference for a system of
3 individually purchased and owned health insurance over employer-sponsored coverage. Council
4 Report 9 (A-98) also articulated a proposal to achieve such individual coverage through the
5 provision of individual tax credits and by encouraging employers to provide their employees with a
6 defined contribution for the purchase of health insurance.
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8 The House has supported numerous refinements to the AMA proposal since 1998, including the
9 adoption of the recommendations contained in Council on Medical Service Report 4 (A-00), which
10 established principles by which tax credit proposals should be assessed, and Council on Medical
11 Service Report 5 (A-00), which established policy that health insurance tax credits should be
12 advancable so that recipients would not need to wait until year's end to receive the credit and
13 purchase coverage.
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15 Public and Congressional support for expanding health insurance coverage for the uninsured has
16 been renewed as a national priority. In December 2001, during Congressional deliberation of an
17 economic stimulus package, many news organizations simplified the debate along partisan lines,
18 with Republicans characterized as favoring tax credits, and Democrats characterized as favoring
19 public sector expansions. In fact, there is bipartisan support for both approaches.
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21 It is amid this clamor of competing proposals that the Council presents the following report to
22 reiterate and strengthen AMA resolve to proactively advocate expanding coverage through a
23 system of refundable tax credits and individually owned health insurance, and to favor definitively
24 the use of tax credits over public sector expansions to expand coverage to the uninsured.
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26 <u>BACKGROUND</u>
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28 The recent recession, combined with double-digit increases in health insurance premiums, is likely
29 to yield the largest increase in the uninsured in a decade. In January 2002, the President's budget
30 proposed to provide $89 billion over 10 years to provide a refundable tax credit of $3,000 to
31 families earning $25,000 or less, and $1,000 to individuals earning $15,000 or less annually. In
32 addition, during 2001, the House of Representatives passed an economic stimulus bill that would
33 have provided involuntarily unemployed workers with refundable tax credits of up to 60% of
34 premiums paid. Similar provisions were debated but not passed in the Senate, where the economic
35 stimulus package failed to come to a vote. The increased viability of tax credit proposals has been
36 accompanied by proposals to increase funding for public sector programs.
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Despite the apparent short life of the recent recession, many individuals remain impacted by unemployment and rising health insurance premiums. The fact that job loss often leads to loss of health insurance is a strong statement in support of the AMA proposal, which would expand health insurance coverage to all Americans in a manner that would make health insurance coverage less sensitive to employment changes. Because health insurance would be individually owned, and financed with tax credits, loss of employment would not necessarily impact insurance coverage.

AMA PROPOSAL TO EXPAND COVERAGE AND PATIENT CHOICE

Patient choice was the paramount consideration in the development of the AMA proposal for expanding coverage to the uninsured. Patients would be provided with a refundable tax credit for the purchase of individually owned and selected health insurance, and the current regressive employee tax advantages of employment-sponsored insurance would be revoked. Employers could continue to offer employment-sponsored coverage to the extent that the arrangement continues to be favored by employers and employees, and employers' health benefits costs would continue to be a deductible business expense. However, employers would be encouraged to provide their employees with a defined contribution toward each employee's choice and purchase of insurance, rather than the current practice of providing a defined set of benefits for all employees.

The proposal limits the role of the government, thus avoiding a centralized one-size-fits-all approach to health insurance coverage. Public sector programs, as well as employers, are typically limited in the choices they can offer. The AMA proposal would empower patients with the ability to choose from a wide array of health plan options. Some may favor more costly comprehensive coverage with low deductibles, while others may favor the savings of high-deductible catastrophic coverage. Because it would be individually owned, patients would be able to retain their coverage, as well as their present patient/physician relationships, if they changed jobs or became unemployed. Furthermore, plans would become responsive to patient choices, rather than to the often bewildering coverage decisions of the government or the bottom-line desires of employers.

In adopting the recommendations of Council on Medical Service Report 4 (A-00), the House established Policy H-165.865(1) (AMA Policy Database), which articulates the following principles for structuring health insurance tax credits: (a) Tax credits should be contingent on the purchase of health insurance; (b) Tax credits should be refundable; (c) The size of tax credits should be inversely related to income; (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people; (e) The size of tax credits should be capped in any given year; (f) Tax credits should be fixed-dollar amounts for a given income and family structure; (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums; (h) Tax credits for families should be contingent on each member of the family having health insurance; and (i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified MSA, and not for out-of-pocket health expenditures.

In addition, Policy H-165.867 calls for tax credits to be advancable by supporting that local welfare agencies and/or other appropriate entities be authorized to verify income 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. Policy H-165.865(2) also states the policy that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as such expenses are defined by Title 26 Section 213(d) of the United States Code.

The AMA proposal for individually owned health insurance and refundable tax credits is well articulated in numerous AMA advocacy documents. Those interested in more detail on the proposal are encouraged to visit the AMA Web page for health insurance reform at www.ama-assn.org/go/insurance-reform.

PUBLIC SECTOR EXPANSIONS

The Council is concerned with proposals to expand Medicaid, the State Children's Health Insurance Program (SCHIP), and Medicare because these programs are already underfunded and leave little room for patient choice. Physician fees under Medicare were cut 5.4% in 2002. Many states are struggling with ways to finance their Medicaid and SCHIP programs. Medicaid programs in many states have payment rates that are below the cost of other insurers and some services are paid at a rate that is lower than the cost of providing the service. Such underfunding of Medicaid is a significant contributor to the Medicaid stigma because it leads to access being curtailed. Medicaid payments in many states are also subject to excessive administrative hassle and late payments.

Proponents of public sector expansions site the richness of Medicaid benefits. Such proponents fear that a tax credit approach would leave recipients with too little money to purchase a policy with a comparable benefit package. Physicians and patients are well aware, however, that Medicaid benefits are richer on paper than in practice. In May 2001, a federal district judge ruled that Michigan's Medicaid beneficiaries could not sue the state to compel it to cover Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services specified as covered under federal law. Illustrating Medicaid's sensitivity to state-by-state variation, a federal judge in Texas ruled in August 2000 that the state was not fulfilling its obligation to provide EPSDT services. The Texas Medical Association subsequently succeeded in advocating increased Medicaid payment rates.

In 2001, the Kaiser Family Foundation (KFF) published the results of a national survey of Medicaid coverage of perinatal services, and found that access to anesthesiology services continues to be a problem for pregnant Medicaid beneficiaries in many states. Despite well-publicized instances in 1998 and 1999 of Medicaid beneficiaries being denied epidural anesthesia or being asked for cash payment of anesthesia services during labor, the payment rates in many states continues to be far below the cost of providing an epidural block.

For many services, the low payment rates, combined with rising liability costs, make physicians and other providers hesitant or unable to accept new patients. According to a February 2002 study by the California HealthCare Foundation's Medi-Cal Policy Institute, nearly half of the primary care physicians and specialists in California do not treat Medicaid patients. According to the study, 45% of primary care physicians and 43% of specialists reported that they did not have any Medicaid beneficiaries in their practices in 1996 and 1998, for which there was no significant change in the percent of physician participation. Similarly, in January 2002, the Washington State Medical Association released the results of informal member polls, which indicated physician reluctance to participate in public sector programs. Regarding Medicare, 57% of physicians reported that they are limiting the number or dropping all Medicare patients from their practices. Regarding Medicaid, 30% of respondents said they had begun limiting new patients, and an additional 28% reported that they no longer participate in Medicaid.
Current constraints on state budgets are likely to exacerbate further the funding challenges of public sector programs. Accordingly, access to Medicaid services is likely to become even more difficult for beneficiaries as more physicians and other health care providers are unable to continue providing services at such low rates, and with such a high level of administrative frustration.

Nevertheless, public sector expansions continue to be an approach favored by many of those who might be philosophically receptive to an approach that provides a subsidy of a size that is inversely related to income, as does the AMA proposal.

AMA Policy on Medicaid

AMA policy on public sector programs is concerned with funding. Policy H-290.980 states that our AMA continues to advocate for appropriate payment to physicians under the Medicaid program. Policy encouraging physicians to participate in efforts to enroll children in Medicaid and SCHIP using the mechanism of "presumptive eligibility," states that the programs should be adequately funded (Policy H-290.982[2]). Under presumptive eligibility, a child may be presumed to be eligible and enrolled for coverage at the initial physician visit, and the physician will be paid for that initial visit, even if the child is subsequently found to be ineligible.

Nevertheless, despite widespread concern about the administration of public sector programs, the AMA supports the full enrollment of eligible beneficiaries in Medicaid and SCHIP. Policy H-280.982(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs. Indeed, the AMA estimates of full coverage using its tax credit proposal assume full participation in Medicaid and SCHIP of those who are eligible.

Relative Efficiency of Tax Credits versus Medicaid

There is some evidence that it may cost less to buy coverage on the individual market than it would cost to enroll a person in Medicaid. Each year, the KFF publishes comprehensive tables of information on Medicaid enrollment and expenditures by eligibility group, with the most recent data being for 1998. The KFF tables contain data compiled by the Urban Institute, whose estimates are regarded as more accurate than the original data from the Centers for Medicare and Medicaid Services (CMS). The Urban Institute contacts state Medicaid agencies to identify and correct missing or erroneous information on the files collected by CMS. In 1998 Medicaid expenditures totaled $169 billion for 40 million enrollees, as illustrated in the following table:

Medicaid Expenditures and Enrollees, by Group, 1998

	Expenditures	Enrollees	Average Spending per Enrollee by Group
Children	$25,308,460,014	20,664,617	$1,225
Adults	$16,349,616,638	8,642,895	$1,892
Blind & Disabled	$66,747,165,968	6,983,562	$9,558
Elderly	$45,948,429,579	4,089,805	$11,235
Total*	$154,353,672,199	40,380,879	$3,822

*Excludes Disproportionate Share Hospitals payments, which totaled $14,961,831,256 in 1998. Source: KFF, State Health Facts Online: Medicaid Enrollment, Distribution by Enrollment Group and Medicaid Spending, Distribution of Spending by Enrollment Group, and KFF Fact Sheet “Medicaid Enrollment and Spending Trends,” February 2001.

The table reveals that annual Medicaid spending per child in 1998 was $1,225, while spending per nondisabled and nonelderly adult was $1,892. Thus the average cost to Medicaid for two children and two nondisabled and nonelderly adults was $6,234. For one nondisabled and nonelderly adult and three children the average cost to Medicaid was $5,567. These costs are very comparable to the cost of a high-end insurance product for family coverage on the private market. A private sector family policy costing $5,500 to $6,000 would be one that assures access to health care.

Even if the costs were equal, or even if tax credits and the individually owned coverage approach were more expensive, the Council believes that tax credits would be preferable over public sector enrollment because of the choice tax credits provide individual patients. In addition, there is likely to be a substantial competitive impact on insurance prices if millions of previously uninsured individuals were newly empowered to spend their tax credits on coverage of their choosing.

TAX CREDIT POLICY REFINEMENTS

The House of Delegates has adopted a number of policy refinements pertaining to the AMA proposal. The Council recommends revisiting two of these refinements in light of more recent trends.

For example, Policy H-165.861 was adopted at the 2001 Annual Meeting when a budget surplus still was projected, and calls for a portion of any federal budget surplus to be used to provide refundable tax credits, inversely related to income, for the purchase of health insurance to uninsured Americans, and that this be communicated to the President of the United States and to the Congress. Now that the reference to a budget surplus is irrelevant, with the nation nevertheless spending from a deficit stance, the Council recommends that the policy be modified to support "that a portion of any increases in federal health care benefit spending be used to provide refundable tax credits, inversely related to income, for the purchase of health insurance to uninsured Americans." Such a policy would allow for other types of health care spending, but would focus health care coverage expansions on the provision of health insurance tax credits.

Similarly, Policy H-165.871(1) states that it is the policy of the AMA 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 the Children's Health Insurance Program, with the goal of improving access to health care coverage to otherwise uninsured groups. The Council believes this policy, which it developed in a previous report, expresses equivocation as to the AMA preference for covering the uninsured using tax credits over public sector expansions. Accordingly, the Council recommends adopting new policy that states a preference for tax credits over public sector expansions. Such a simple policy statement would leave no doubt as to the AMA's intention.

TAX CREDITS IN THE CURRENT MARKET

Legislatively, the AMA proposal is chiefly concerned with tax credits. In the private sector, however, success of the AMA proposal requires that, should a tax credit proposal pass, health plans are prepared to meet the challenges of the new tax credit dollars entering the private market. It is also important that employers be educated on the benefits of converting their health benefits from a system of defined benefits to defined contribution.

Council on Medical Service Report 2 (I-01) discussed numerous transitional issues in moving toward a system of individually selected and owned health insurance, and found that reasonable

options already exist for most individuals to purchase coverage, provided that tax credits are appropriately structured. In that report, the Council expressed qualified optimism about the individual market, recognizing that special measures are needed to address the needs of individuals with chronic illness or disability, who might otherwise have difficulty obtaining coverage outside the employment-based system. In addition, Council on Medical Service Report 5 (A-01) described the character of evolving Internet-based health insurance marts, which bring the advantages of Internet technology to health benefit administration. Success in Internet-based operations would advantageously position these ventures for the widely predicted transition of employer benefit plans from defined benefit to defined contribution, as called for in Policy H-165.983(1). Thus, the introduction of Internet-based health benefits systems has resulted in significant evolutionary advances toward AMA policy goals.

Defined contribution systems are gaining popularity because they offer employees and employers greater control over health care spending. The double-digit increases in health insurance premiums have encouraged employers to seek ways for employees to take on more responsibility for the purchase of health insurance. Existing defined contribution models typically involve the employer establishing health care spending accounts for employees, which employees use to purchase coverage, typically from an array of employer-arranged health plans, and often via the Internet.

In addition, modest market reforms could facilitate the use of tax credits. For example, the expansion of medical savings accounts, as supported in Policies H-165.920(7), H-165.879, and H-165.869, would make tax credits particularly attractive because the credits would be able to provide a direct subsidy of highly individualized coverage that contains an explicit savings component. In addition, Congress could create legislation allowing tax credit recipients to "buy in" to state employee purchasing pools or the Federal Employee Health Benefits Program (FEHBP), which would allow them to receive group rates for a range of coverage options.

Even without the market reforms advocated by AMA policy, such as the establishment of voluntary choice cooperatives or health insurance marts, there are many ways in which a refundable tax credit could be used by its recipients to purchase viable coverage in the current market. For example, Internet-based health insurance vendors increasingly offer modest policies at modest prices. As previously reported by the Council, the company eHealthInsurance.com reports that 87% of the policies it has sold are at least comparable to coverage under Medicare Parts A and B, plus some level of Medicare supplemental coverage, and most with some drug coverage. Furthermore, private purchasing alliances in some states accept individuals, as well as small employment groups for health insurance coverage. In those states where Medicaid is viable, tax credit recipients could choose to purchase health insurance coverage under Medicaid.

CONCLUSION

Public sector expansions promise a generous, but often illusory, benefits program. Given the high per-enrollee cost of Medicaid, with its inability to ensure patient access to needed care, the Council strongly reiterates its support for tax credit proposals over public sector expansions. Dollar for dollar, the Council believes tax credits would accomplish more. Not only would affordable private sector coverage be available at the prices paid by Medicaid, but recipients would be able to select their own coverage, making them more conscious of health care decisions.

Accordingly, as the debate over how to cover the uninsured intensifies, the Council believes that the AMA will need to establish more aggressive policy and take specific legislative, private sector, and communication actions. Therefore, the Council presents several proactive recommendations,

including the adoption of policy favoring tax credits over public sector expansions as a way to provide health insurance coverage to the uninsured.

RECOMMENDATIONS

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

1. That it is the policy of the AMA that tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured. (New HOD Policy)

2. That AMA Policy H-165.861 be amended to read as follows:

   AMA policy is that a portion of any ~~federal budget surplus~~ increases in federal health care benefit spending be used to provide refundable tax credits, inversely related to income, for the purchase of health insurance to uninsured Americans, and that this be communicated to the President of the United States and to the Congress. (Modify Current HOD Policy)

3. That it is the policy of the AMA to support legislation to allow individuals to "buy in" to state employee purchasing pools or the Federal Employee Health Benefits Program (FEHBP). (New HOD Policy)

4. That the AMA make expanding coverage through the use of refundable and advancable tax credits a top strategic, communications, and legislative priority for 2003 and the remainder of 2002. (Directive to Take Action)

5. That the AMA communicate and advocate its proposal for expanding health insurance coverage through the use of refundable and advancable tax credits to 2002 Congressional candidates. (Directive to Take Action)

6. That the AMA increase its outreach efforts to the employer and business community regarding the benefits of defined contribution systems for employer cost control and employee choice. (Directive to Take Action)

7. That the Board of Trustees report back to the House of Delegates regarding AMA Congressional advocacy on the AMA proposal for expanding coverage through the use of refundable and advancable tax credits and individually owned health insurance. (Directive to Take Action)