REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2 - A-04
(June 2004)

Subject: Comparing Health Insurance Premium Subsidies and Tax Credits (Resolution 108, A-03)

Presented by: Ardis D. Hoven, MD, Chair

Referred to: Reference Committee A
(Joan E. Cummings, MD, Chair)

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1 At the 2003 Annual Meeting, the House of Delegates referred Resolution 108, which was
2 introduced by the Medical Student Section and calls for the AMA to "expand health system reform
3 efforts to integrate other federal health insurance premium subsidies in addition to refundable tax
4 credits for attaining universal health care." The Board of Trustees referred Resolution 108 (A-03)
5 to the Council on Medical Service for study.
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7 BACKGROUND
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9 Testimony regarding Resolution 108 (A-03), as described in the relevant Reference Committee
10 report, supported referral because of potential misunderstanding of the term "other federal health
11 insurance premium subsidies." One of the whereas clauses in the preamble of Resolution 108
12 (A-03) states that "In proposals for universal health access, the largest medical societies advocate
13 health insurance premium subsidies beyond refundable tax credits, including direct federal
14 subsidies (vouchers)." It was noted by the Reference Committee that "other subsidies" also could
15 be interpreted as federal health program eligibility expansions, which would conflict with Policy
16 H-165.920[17] (AMA Policy Database), which supports tax credits over public sector expansions
17 as a means of providing coverage to the uninsured.
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19 This report describes the many forms in which health insurance is and can be subsidized, reviews
20 relevant AMA policy, delineates health insurance tax credits as advocated by AMA policy, and
21 concludes that health insurance premium subsidies is a broad term that can be useful to further the
22 AMA goal of fostering individually owned health insurance.
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24 HEALTH INSURANCE SUBSIDIES
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26 The concern raised in Resolution 108 (A-03) is largely one of the often imprecise nomenclature for
27 describing health insurance subsidies. Subsidies for health insurance take many forms, some of
28 which incorporate or overlap with other forms. Those with employment-based coverage, who are
29 self-employed and purchase coverage individually, or who are eligible for public sector programs,
30 are all entitled to public subsidies for health insurance. In general, people who are uninsured, or
31 who purchase coverage individually and are not self-employed, do not receive government health
32 insurance premium subsidies.
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Premium Subsidies

Premium subsidies are the most general form of subsidy. Generally, premium subsidies are not used to purchase health care items or to cover patient cost-sharing obligations. Rather, premium subsidies are oriented toward the payment of health insurance premiums. Premium subsidies can be structured as risk-based vouchers or tax credits. Conversely, premium subsidies can be funded by such mechanisms as vouchers or tax credits.

For example, premium subsidies are used to subsidize the premiums of employment-based coverage in the form of a defined contribution or as used in the Federal Employee Health Benefits Program (FEHBP). They also have been proposed to subsidize beneficiary costs for participating in Medicaid buy-in programs and to subsidize premiums for individually-based or COBRA group coverage premiums, as exemplified with the Health Coverage Tax Credit program created by the Trade Act of 2002, and described in Council on Medical Service Report 11 (A-03).

Tax Deduction

Tax deductions decrease the taxable income on which individuals pay income taxes and do not affect other payroll taxes. Tax deductions provide unequal benefit per dollar spent because the benefit varies by tax rate. An example of how tax deductions can be used to subsidize heath insurance involves self-employed individuals, who can deduct the full cost of their health insurance.

Tax Exclusion

Tax exclusion decreases taxable income on which individuals pay both income and payroll taxes. Currently, the purchase of health insurance through employment is an example of the tax exclusion subsidy because the employer’s share of the costs is excluded from taxable income for employees. This tax exclusion is only available to those who have employment-based coverage, and is viewed by many as being socially inequitable because it provides a higher subsidy for those who pay higher tax rates. Two-thirds of the estimated $100 billion subsidy goes to the one-third of Americans with the highest incomes. It is a transparent subsidy as most who receive it are unaware they have it, and they do not need to do anything to activate it.

Tax Credits

Tax credits can be allotted to individuals and allow for individual ownership of health insurance, the philosophical cornerstone of the AMA proposal for health system reform. AMA support for tax credits grew out of the fundamental goal to improve the choice and power of individual patients by lessening employer and government control over individual choices and de-linking health insurance from the realm of employment. As envisioned by the AMA, tax credits should be refundable and advanceable. Refundable tax credits can benefit those who owe no taxes. They could be structured simply as a check from the government in the amount of the tax credit due to the individual. Advanceable tax credits would be distributed independently of the typical tax reconciliation process, which happens at year’s end. Making tax credits advanceable enables low-income individuals to afford monthly premium costs.

Tax credits put the means for purchasing health insurance at the disposal of individuals, regardless of whether they have employment-based coverage or any tax liability. The poorest individuals with no option for employment coverage and who do not qualify for Medicaid would receive some of the largest tax credits. Tax credits can be designed as premium subsidies, vouchers, or other subsidy forms.

Vouchers

Vouchers may be a simpler mechanism to deliver subsidies to low-income individuals than tax credits, as addressed in Policy H-165.867. Vouchers can have the same impact as tax credits that are refundable and advanceable, and they can be used either for defined contribution or defined benefit models. They are for use only for the purpose for which they are intended and can take on many forms, such as debit cards or coupons. The Food Stamp Program is one example of how voucher programs are used to provide public funding to eligible individuals.

Risk-Based Subsidies

While the subsidies discussed above are based on income or premium costs, subsidies also can be tied to the health risks of individuals. With the adoption of principles outlined in Policy H-165.856 and detailed in Council on Medical Service Report 7 (A-03), the AMA supports risk-based subsidies for "uninsurable" individuals, who require special, targeted policies in order to both subsidize their coverage and ensure that health insurance is affordable for the general population. In particular, Policy H-165.856[3] states that risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.

Public "In-Kind" Program Subsidies

Health insurance also is subsidized through public sector entitlement programs, such as Medicare and Medicaid, for certain populations. Medicare and Medicaid beneficiaries receive covered health care services as a direct "in-kind" subsidy. The services they receive are publicly financed so long as they continue to meet the eligibility requirements.

AMA POLICY

The current AMA proposal for health system reform is based on extensive policy adopted by the House of Delegates. There are various policies that delineate the proposal for individually owned health insurance using a system of tax credits and defined contributions. Chief among these policies is Policy H-165.920.

Policy H-165.920[3a] supports providing employers with the same tax treatment whether the employer provides health insurance coverage for employees or provides a defined financial contribution that employees can use to purchase individually selected and individually owned coverage; [5] supports individually selected and individually owned health insurance as the preferred method for people to obtain health insurance coverage; [6] supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; [12] supports a replacement of the present exclusion from

employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families; and [17] believes that tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured.

Policy explicitly supports the use of vouchers as one mechanism to distribute tax credits to those with low incomes. Policy H-165.887[2] supports efforts to move patients in public programs into the private sector, through the implementation of vouchers or other mechanisms, thereby enabling individual patients to participate in the prioritization of their health care services. Additionally, Policy H-165.867 advocates 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.

Policy H-165.865[1] outlines AMA principles for structuring health insurance tax credits. According to that policy, tax credits should be contingent on the purchase of health insurance, refundable, of a size that is inversely related to income, large enough to ensure that health insurance is affordable for most people, and capped in any given year, among other things. In addition, Policy H-165.865[2] states 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.

Policy H-165.856 supports a number of principles for health insurance market regulation in order to generate more stability, affordability, and uniformity of individually owned health insurance.

Policy H-165.855 supports converting the medical care portion of the Medicaid program to a program of federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the FEHBP. Cost-sharing obligations should be based on income, with no cost-sharing obligation for those who would otherwise qualify for mandatory Medicaid eligibility and with moderate cost-sharing for low-income individuals who would not otherwise qualify for Medicaid.

TAX CREDITS ADVOCATED BY THE AMA

Just as there is variation in methods of subsidization, there is variation among tax credit proposals and designs. Some tax credits, such as the Health Coverage Tax Credit (HCTC) described earlier, are based on a set percent of premium costs. Others provide a flat amount for individuals and a higher amount for families, with the tax credit phasing out at some predetermined income level. The tax credits proposed by the AMA resemble such proposals only to the extent that they use the same mechanism for delivering the tax credit subsidy. The HCTC provides an active example of how tax credits can function as premium subsidies. The HCTC was designed to pay for up to 65% of qualified health plan premiums. Therefore, the HCTC is very mindful of subsidizing premium costs.

Tax credits as advocated by the AMA (i.e., refundable and advanceable) would be direct federal subsidies to individuals. This could take the form of direct vouchers for those with low incomes as previously described. Policy H-165.867 established the principle that tax credits should be

advanceable, and states that appropriate entities could 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.

As such, tax credits as advocated by the AMA are simply one way to subsidize the health insurance costs of those most in need of financial assistance. In particular, the AMA believes that subsidies should be directed at individuals regardless of employment, or the availability of employment-based coverage, in order to provide true portability and patient freedom of choice. In addition, the AMA believes the subsidy should be inversely related to income, refundable, and advanceable in order to respond first and foremost to the needs of those with the lowest incomes.

DISCUSSION

The distinction between health insurance premium subsidies and health insurance tax credits can be viewed in both theoretical and practical terms. Premium subsidies can encompass any financial support toward the cost of health insurance premiums. Accordingly, health insurance tax credits are one type of premium support.

The current regressive exclusion of employer expenses toward employment-sponsored health insurance from the taxable income of employees is also a premium subsidy. Tax credits as advocated by the AMA are simple. The theoretical underpinning of AMA support for tax credits is individual choice by patients. The tax credits advocated by the AMA, therefore, are not for employers, but for individuals, regardless of employment status. The practical advantage of individual ownership is that health insurance belongs to the individuals, thus creating true portability, expanding individual choice, and fostering real patient cost-consciousness.

In practical terms, “premium subsidy” is generally used to advocate financial support for the employees’ costs for employment-sponsored insurance, and particularly to improve the take-up rate of uninsured employees who forego coverage because they cannot afford their share of the premiums. Tax credits for health insurance premiums also meet this practical definition of premium subsidy because tax credits, whether provided to employers or individuals, subsidize the cost of the premium.

The concern raised in Resolution 108 (A-03) is largely a problem with nomenclature. The Council believes that the use of the term “tax credits” continues to be the most accurate and precise nomenclature for the purposes of strongly advocating that health insurance coverage should be chosen by the individuals being covered. Tax credits are flexible and can be administered through a number of payment mechanisms. Tax credits are also the term and method being used in current legislative proposals. Moreover, AMA policy supports the use of vouchers to foster private and individually owned health insurance. Nonetheless, the Council is sensitive to the myriad of ways in which the AMA can accomplish its policy goals and, therefore, supports the use of various subsidy forms toward the goal of enabling individuals to purchase individually owned health insurance.

As articulated in Council on Medical Report 7 (A-03), there is sufficient evidence that with appropriate regulations and public policies, the individual and nonemployer group markets can flourish with safeguards for high-risk individuals and widespread choice of affordable coverage for

the general population. In addition, Council on Medical Service Report 1 (I-03) emphasized that the model of coverage for low-income tax credit recipients should be the same coverage available to members of Congress (i.e., FEHBP).

RECOMMENDATION

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108 (A-03) and the remainder of the report be filed:

1. That the American Medical Association (AMA) support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits (Policy H-165.865) and when designed to enable individuals to purchase individually owned health insurance. (New HOD Policy)

2. That the AMA Communications Department develop a simple, understandable, glossary of terms in Council on Medical Service Report 2 (A-04), including, but not limited to refundable and advanceable tax credits. (Directive to Take Action)

Fiscal Note: None