REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-06)
Individual Responsibility to Obtain Health Insurance
(Resolution 703, I-05)
(Reference Committee A)
(June 2006)

EXECUTIVE SUMMARY

At the 2005 Interim Meeting, the House of Delegates referred Resolution 703 to the Board of Trustees. Introduced by the California and Guam Delegations, the resolution calls for the AMA to "work with the federal government to ensure that all Americans be required to have, at a minimum, catastrophic and preventive health care coverage;" and to "work with the federal government to ensure that those with incomes between 200-400 percent of the federal poverty level, who are not eligible for Medicaid or SCHIP, be eligible for a refundable tax credit to support the purchase of health care coverage."

In this report, the Council on Medical Service expands upon the request of Resolution 703 (I-05) to revisit the issue of individual responsibility to obtain health insurance. This report reviews AMA policy and reports on health system reform and individual responsibility; highlights the advantages and disadvantages of requiring individual responsibility; presents evolving opinion about individual responsibility; discusses the costs of individually owned health insurance; establishes an income-related threshold for individual responsibility; and presents recommendations that establish new policy related to the AMA proposal for health system reform.

In 1998, when the AMA established Policy H-165.920, which stated a preference for individually owned health insurance, the rationale was to provide patients with more choice as well as to address the uninsured. In 2000, the AMA formally rescinded policy that had supported an employer mandate. At that time, employment-sponsored coverage was noted for creating "job lock" and for not offering "portability." These problems persist today at the same time that many employers increasingly cite health insurance as an unsustainable cost. The growth in the number of the uninsured in the past several years has been attributed, in large part, to a loss of employment-sponsored insurance.

As outlined in this report, the AMA proposal for health system reform has grown more sophisticated and comprehensive since the establishment of the fundamental principles in 1998. Over the years, the Council has weighed the pros and cons of supporting greater individual responsibility. Council Report 5 (A-00) established Policy H-165.920[13], which supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage." Since 2000, the Council has revisited the issue of individual responsibility on several occasions, and has been mindful of changing public opinion in favor of some degree of individual responsibility, particularly for those with high incomes.

In this report, the Council determines whether there is an income threshold above which individuals should have a responsibility to obtain health insurance. The Council distinguishes "individual responsibility" with financial penalties for noncompliance, from an "individual mandate," which implies the failure to obtain coverage could result in criminal penalties. Finally, the Council notes that although its recommendations focus primarily on those at high income levels, it is important to remember that the AMA proposal for health system reform is fundamentally concerned with those most likely to be uninsured—those at the lowest income levels.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - A-06
(June 2006)

Subject: Individual Responsibility to Obtain Health Insurance
(Resolution 703, I-05)

Presented by: Joseph P. Annis, MD, Chair

Referred to: Reference Committee A
(Richard W. Whitten, MD, Chair)

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2 Trustees. Introduced by the California and Guam Delegations, the resolution calls for the
3 American Medical Association to "work with the federal government to ensure that all Americans
4 be required to have, at a minimum, catastrophic and preventive health care coverage," and to "work
5 with the federal government to ensure that those with incomes between 200-400 percent of the
6 federal poverty level, who are not eligible for Medicaid or SCHIP, be eligible for a refundable tax
7 credit to support the purchase of health care coverage." The Board of Trustees referred Resolution
8 703 (I-05) to the Council on Medical Service for study and report back to the House at the 2006
9 Annual Meeting.
10
11 The Council announced during testimony on Resolution 703 (I-05) that it already had decided to
12 revisit the issue of individual responsibility to obtain health insurance, and welcomed referral. This
13 report reviews AMA policy on health system reform; summarizes previous Council reports
14 addressing individual responsibility; highlights the advantages and disadvantages of requiring
15 individual responsibility; presents opinion about individual responsibility; discusses the costs of
16 coverage; establishes an income-related threshold for individual responsibility; and presents policy
17 recommendations that further refine the AMA proposal for health system reform.
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19 AMA POLICY ON HEALTH SYSTEM REFORM
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21 AMA discussion of individual responsibility to obtain health insurance has occurred within the
22 context of support for individually owned health insurance. During the past two decades, the
23 House of Delegates has continuously reviewed and revised the AMA policy base on health system
24 reform. In the 1980s, AMA policy was dominated with concerns about managed care. During the
25 early 1990s, the Clinton Administration's health system reform effort prompted the AMA to
26 develop its own proposal, "Health Access America," which contained a mandate that employers
27 provide health insurance for their employees. By the 1996 Interim Meeting, discontent with how
28 some employers used managed care to interfere with patient choices and physician decision-
29 making led to support for individually selected and owned health insurance as the preferred method
30 for people to obtain health insurance coverage (Policy H-165.920[5], AMA Policy Database).
31
32 At the 1998 Annual Meeting, the House adopted the 17 recommendations in Council on Medical
33 Service Report 9, thereby establishing comprehensive policy as to how a system of individually
34 owned health insurance should be structured based on a premise of pluralism of health care
35 delivery systems and financing mechanisms (Policy H-165.920). In response to growing debate
36 about health insurance tax credits, Council on Medical Service Report 4 (A-00) established a series

of principles for structuring such credits (Policy H-165.865). Also in 2000, the House rescinded Policy H-165.980, thereby formally removing AMA support for an employer mandate from the AMA Policy Database. Policy H-165.920[5] supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually owned health insurance is the preferred option, but employer-sponsored coverage is still available to the extent the market demands it. In 2003, the House adopted a series of key principles for health insurance market regulation to facilitate the use of individual health insurance tax credits (Policy H-165.856) that were proposed in Council on Medical Service Report 7 (A-03).

AMA policy also has shifted away from specifying covered benefits. Policy H-165.865[2], which contains the AMA principles for structuring health insurance tax credits, states that 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. With respect to preventive services, Policy H-425.997[3] states that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcome or quality of life and the cost effectiveness of the service, and Policy H-425.988[1] calls for the AMA to continue to work with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services through the US Preventive Services Task Force. With respect to catastrophic services, Policy H-185.982[2] supports the study of "catastrophic only" health insurance.

Recent policy refinements have sought to broaden the advocacy potential of the AMA proposal for health system reform. For example, Policy H-165.851[1] supports implementation of individual tax credits for the purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, the chronically ill, and those living within geographic areas that are pilot testing tax credit proposals. Policy H-165.855 proposes tax credit eligibility for those with the lowest incomes. Throughout the years of policy refinements, there have been many suggestions that the AMA should support the notion of greater individual responsibility, once the AMA vision of tax credits and individually owned health insurance is achieved.

PREVIOUS COUNCIL REPORTS ADDRESSING INDIVIDUAL RESPONSIBILITY

Council on Medical Service Report 5 (A-00) established Policy H-165.920[13], which states that the AMA "supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage." On several occasions over the past six years, the Council has revisited the concept of greater individual responsibility to obtain health insurance. In fact, in 2004, the Council prepared a draft report that it did not present to the House that would have recommended support for greater individual responsibility upon implementation of key aspects of the AMA proposal for health system reform. The draft report was not presented to the House because the Council did not reach consensus regarding both the content and timing of such a shift in AMA policy.

It is important to note that the House of Delegates previously supported the establishment of an individual mandate for financing Medicare coverage coupled with an income-related subsidy, when it adopted the recommendations contained in Council on Medical Service Report 5 (I-03), "Restructuring Medicare for the Long-Term." Policy H-330.898[1] supports proposals to shift the

funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory individually-owned private savings. The policy calls for a required minimum contribution, accumulated tax-free and dedicated to funding post-retirement medical care, with the government providing a contribution to economically disadvantaged individuals who would make smaller than average contributions to their retirement accounts.

ADVANTAGES AND DISADVANTAGES OF REQUIRING INDIVIDUAL RESPONSIBILITY

Summaries of the potential advantages and disadvantages of an individual mandate appeared in two previous reports of the Council on Medical Service: Report 5 (A-00) and Report 4 (I-04). These summaries highlighted hypothetical and philosophical considerations. The key considerations have remained largely unchanged over the years. What has changed, the Council believes, is the relative weight given to elements of each position, so that the advantages of requiring individual responsibility appear increasingly compelling. Rather than emphasizing the issue of a mandate, which focuses on how government or some entity imposes on the will of the individual, the Council finds greater merit in focusing on the issue of individual responsibility. There are some individuals with high incomes whose failure to obtain health insurance coverage poses an avoidable social burden. Such individuals have a responsibility to obtain coverage. Individuals with lower incomes also have the responsibility to seek and maintain coverage, but their burden to do so is tempered by their ability to afford the potentially high cost of coverage.

Advantages

As noted in previous reports of the Council, the key reasons for requiring individuals to purchase coverage include: (a) achieving universal coverage; (b) avoiding 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) avoiding adverse selection, whereby low-risk individuals opt out of insurance, driving up average costs and premiums for those who are insured. Many policy analysts believe that under a voluntary system, a significant number of people would not purchase coverage, particularly those with low incomes, the young, and the healthy. The erosion of coverage under the current, voluntary system suggests that some level of a mandatory approach may be needed to guarantee health insurance coverage for all Americans, and to ensure that risk pools include low-risk individuals.

According to a June 2005 report by Families USA, "Paying a Premium: The Added Cost of Care for the Uninsured," the average increase in insurance premiums to pay for the health care of the uninsured in 2005 was $922 for those with family coverage and $341 for those with individual coverage. In addition, as reported in Council on Medical Service Report 8 (A-05), "Offsetting the Costs of Providing Uncompensated Care," AMA data have consistently shown that a typical physician provides, on average, more than $2,000 worth of uncompensated care every week.

Requiring greater individual responsibility to obtain health insurance would mitigate against adverse selection by generating growth in the number of average risk people in the individual market. Like tax credits, requiring more individuals to obtain coverage could lead to a "premium rating conversion" or what the Council has previously called *de facto* modified community rating (Council on Medical Service Report 7 (A-03), "Health Insurance Market Regulation"). In Council Report 7 (A-03), it was noted that following the influx of a critical mass of average-risk individuals into the individual market, it is likely that health insurers would no longer find it cost-effective to

individually risk rate applicants. Costly medical underwriting practices would be replaced by simplified, automated ones, particularly as purchasing insurance over the Internet becomes more common. The result would be *de facto* modified community rating, but as the natural byproduct of market function rather than by market regulation.

Disadvantages

Requiring individuals to take greater responsibility for obtaining coverage can be viewed as coercive, particularly in the context of tax credit proposals to increase individual choice. The Council believes it is particularly important to avoid criminal penalties for failing to obtain coverage. For this reason, the Council has chosen to address the issue of individual responsibility via taxation.

Requiring individuals to obtain and maintain coverage also could permit the government to renege on its commitment to support health insurance through the provision of tax credits and other subsidies. In order for such a requirement to be effective, resources would be required to identify the uninsured and compel them to purchase health insurance, particularly for certain segments of the population, such as seasonal laborers. A requirement that low-income individuals obtain coverage will fail in the absence of appropriate subsidies and regulatory reforms.

Requiring coverage could lead to excessive government involvement in defining qualified coverage or setting prices for premiums and health care services. For example, a requirement to obtain coverage coupled with strict community rating amounts to a tax on low-risk individuals, who would otherwise face more affordable premiums.

Finally, requiring coverage might not be necessary to achieve a reasonable level of health insurance coverage. Income-related, refundable tax credits would give low-income individuals unprecedented market power, and the market would respond by providing more affordable insurance products. 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.

OPINIONS ON GREATER INDIVIDUAL RESPONSIBILITY

With the relentless growth in the number of uninsured individuals, it appears that opinions favoring greater responsibility for individuals to obtain health insurance have gained support in recent years. Opinions supporting greater individual responsibility have acknowledged that there are some patients whose medical expenses are so high that they would have difficulty purchasing coverage even if they had high incomes.

The California Medical Association (CMA), one of the sponsors of Resolution 703 (I-05), provided the Council with its health insurance reform proposal, which supports an individual mandate. In particular, CMA supports mandated coverage, with tax credits inversely related to income, for households earning 200-400% of the federal poverty level (FPL). In 2006, for a family of four, 200% of the FPL is $40,000 and 400% of the FPL is $80,000. Households earning more than 400% of the FPL would be required to purchase coverage with no additional subsidy, or be subject to a tax penalty. A tax penalty would apply also to those households earning 200-400% of the FPL that remain uninsured. Children in households earning less than 200% of the FPL would retain

coverage under public programs (Medicaid and SCHIP). CMA proposes that adults in the lowest income bracket be allocated to a strengthened safety net. The Council recognizes the importance of maintaining a strong safety net.

Similarly, as the Council previously reported to the House, the AMA joined as a participating member of the Search for Common Ground/Health Care Coverage for the Uninsured (HCCU) consensus-building process in the fall of 2004. Consisting of 24 organizations, the HCCU consensus-building group is working to develop a strategy for expanding health insurance coverage "to as many people as possible as quickly as possible." Although the HCCU group had not completed its work at the time that this report was written, it has been the view of some group participants that individuals should bear greater responsibility for health insurance, especially for those at high income levels, and for parents with respect to coverage for their children.

The New American Foundation, a nonpartisan policy institute, supports a requirement of individual responsibility. In January 2006, the New America Foundation released an issue brief entitled "Outline of the New America Vision for a 21st Century Health Care System." The brief envisions that "just as we are required to enroll our vaccinated children in school, to buy our own auto insurance, and to pay the taxes that we the people decide we owe, obtaining private or public coverage through appropriate means will be the norm in the 21st Century health system." The New American Foundation emphasizes the need for "shared responsibility," that is, regulatory reforms must be designed to ensure that affordable options exist and the purchase of health insurance must be subsidized on a sliding scale for those who need them.

In April 2006, the Massachusetts legislature approved a bill to expand health insurance coverage that included provisions to increase individual responsibility and institute market reforms. In addition to providing sliding-scale subsidies for the purchase of health insurance by lower-income individuals, it included tax penalties for those individuals who fail to purchase coverage. The penalty for not obtaining health insurance by July 2007 would be a loss of the state personal tax exemption. At the time this report was written, Massachusetts Governor Mitt Romney was expected to sign the bill, with some possible changes.

COST OF COVERAGE

In September 2005, the Kaiser Family Foundation published "Employer Health Benefits 2005 Annual Survey," which included data on premiums for employer health plans. The Kaiser report showed that the average premium for employment-based single coverage was $4,024, and the average premium for employment-based family coverage was $10,880. These amounts include both the employer and employee shares of premiums.

In August 2004, the Kaiser Family Foundation and eHealthInsurance published a joint report entitled "Update on Individual Health Insurance," which challenged the assumption that the uninsured would not be able to obtain individually-purchased coverage comparable to existing employment-based coverage. The joint report found that average premiums paid for health insurance obtained on the individual market are *markedly* lower than in the group market ($1,768 for single coverage, and $3,331 for family coverage). The substantial premium reductions were attributed in part to the younger ages of individual health insurance enrollees, as well as the fact that many people, when given a choice, choose less generous coverage than is typically offered by employers.

In November 2005, eHealthInsurance published a report entitled "The Cost and Benefits of Individual Health Insurance Plans," which analyzed information from a sample of more than 80,000 health insurance policies sold to individuals and families through eHealthInsurance.com, and addressed concerns about the type of coverage chosen by enrollees by providing summary data on benefits and cost-sharing. The report summarized the monthly premiums and benefits for both major medical and short-term policies, and specifically excluded Health Savings Account plans from the analysis. The major medical plans were largely PPOs (86%) and more than 90% of the major medical plans provided comprehensive coverage.

The individual policy holders in the 2005 eHealthInsurance study paid an average of $148 per month or $1,776 annually for major medical coverage, whereas those with family coverage paid an average of $331 per month or $3,972 annually, with the average family size being three members. The report noted that the average cost of coverage for a child alone is $89 per month, or $1,068 annually. The eHealthInsurance report showed considerable variation of costs between states. Michigan is reported to have the lowest premiums per individual ($98 monthly or $1,176 annually) and New York the highest ($379 monthly or $4,548 annually). In large part, state variation in the cost of coverage is due to variation in state regulations.

Of the individually owned major medical policies, 60% had a deductible of $2000 or less, and 40% had a deductible of more than $2,000; 35% had a deductible of $500 or less; 25% had a deductible between $500 and $2,000. For comparable family plans, 50% had a deductible of $2000 or less. Nearly 40% of the major medical plans required no co-payments. The eHealthInsurance report analyzed its short-term policy offerings as well. These policies are useful for individuals and families experiencing gaps between periods of employment-based coverage, and are particularly popular among younger adults. Among short-term policy holders, 75% are under 35 years of age, with 40% between the ages of 25 and 34, a segment of the population with high rates of uninsurance. According to the August 2005 Census Bureau report entitled "Income, Poverty, and Health Insurance Coverage in the United States: 2004," among 25-34 year old individuals, nearly 26% were without health insurance. The average premiums for short-term policies were $78 monthly or $936 annually for individuals, and $192 monthly or $2,304 annually for families.

THRESHOLD FOR INDIVIDUAL RESPONSIBILITY

The likelihood of having health insurance coverage increases with income. It is often useful to think of income in terms of the federal poverty level (FPL), which can represent incomes of households or individuals. Each year, the U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) publishes new poverty guidelines that are used for, among other things, determining financial eligibility for certain federal programs. The Council used the poverty guidelines as it contemplated whether there is an income level at which individual responsibility should be required. For 2006, the FPL guidelines for the 48 contiguous states and the District of Columbia, which increases by $3,400 for each additional person in the family unit, were as follows:

Federal Poverty Guidelines, 2006

Family Size	Poverty Guideline
1	$9,800
2	$13,200
3	$16,600
4	$20,000
5	$23,400
6	$26,800
7	$30,200
8	$33,600

Source: http://aspe.hhs.gov/poverty/06poverty.shtml

For Alaska, the poverty guideline for one person is $12,250, with each additional person in the family unit adding $4,250. For Hawaii, the poverty guideline for one person is $11,270, and increases by $3,910 for each additional person.

ASPE also published the following data on the distribution of the uninsured by income, as measured by FPL:

Uninsured by FPL, 2004

% Uninsured	% of FPL
25	Less than 100%
28	100-199%
19	200-299%
11	300-399%
6	400-499%
11	Over 500%
100	Total

Source: http://aspe.hhs.gov/health/reports/05/uninsured-cps/ib.pdf

Data by income shows a direct inverse relationship between income and health insurance coverage, which is the rationale for AMA support for subsidizing the cost of health insurance in a manner that is inversely related to income (Policy H-165.865[1,c]).

Discussion about individual responsibility for health insurance often refers to state-based automobile insurance laws. Despite the near-universal prevalence of these state mandates, the cost of uninsured “free riders” is significant enough to impact the premiums of those who purchase automobile insurance. In part due to the elevated premiums, as well as the fact that there is no subsidy for the purchase of automobile insurance, low-income drivers are more likely to forgo automobile insurance. Comparisons of health insurance to automobile insurance may be spurious, because people can choose whether to drive, but do not always have control over their health care needs. Moreover, automobile insurance has been an “unfunded mandate” for individual drivers regardless of income, while the AMA proposal for tax credits inversely related to income provides an equitable strategy to subsidize any potential requirement to purchase health insurance.

In considering an individual requirement for health insurance, the Council believes that at some point incomes rise to a threshold where personal responsibility should be required, where it

becomes reasonable to expect that individuals and families have sufficient disposable income to purchase coverage without suffering financial hardship. The Council believes that individuals and families at 500% of FPL ($49,000 for individuals and $100,000 for a family of four) clearly meet that threshold of responsibility. Society should not be penalized by the potentially costly medical treatments of those uninsured who can afford to purchase health insurance coverage. A majority of the insured, who earn less than 500% of FPL, are paying inflated premiums because of the costs associated with treating the uninsured. The inflated premium rates constitute an additional barrier to coverage for the uninsured. Furthermore, physicians treating the uninsured often do so without any means of being paid.

Requiring those at the highest income levels to obtain coverage will not significantly reduce the number of the uninsured because the uninsurance rates at high incomes is small. The ASPE data indicate that only 11% of the uninsured have incomes at or above 500% of FPL. However, requiring individuals with the means to do so to obtain coverage establishes an important precedent. Focusing on a small segment of the population has the additional advantage of potentially facilitating the development of enforcement procedures.

The Council also conditionally supports a requirement of individual responsibility for those at incomes below 500% of FPL, once the AMA vision for health system reform is realized. Under a system of refundable and income-related tax credits or other subsidies for the purchase of health insurance, combined with appropriate market regulations, there would no longer be any legitimate rationale for “free riders.” Those at the lowest income levels would receive the greatest subsidy or be eligible for public sector programs. The Council emphasizes that it supports a requirement for individual responsibility for those with incomes below 500% of FPL only in the context of the provision of substantial subsidies for the purchase of health insurance. A requirement that individuals obtain coverage should not be seen as a substitute for adequate subsidy support for health insurance for those who need it, or as a shortcut for appropriate market regulation. An individual requirement should be contingent upon appropriately structured tax credits; additional policy measures specifically targeting patients with high medical needs; and rational market reforms that allow markets to function properly. Specifically, tax credits should be refundable, inversely related to income, large enough to ensure that health insurance is affordable for most people, applicable only for the purchase of coverage, and contingent on obtaining coverage for all family members (Policy H-165.865).

Finally, the market regulations outlined in Policy H-165.856 should be implemented to ensure that the general population has access to a wide choice of high-quality, affordable coverage; to subsidize medical expenses for those with high medical needs through mechanisms that do not unduly drive up health insurance premiums for the rest of the population; and to provide individuals with incentives to be continuously insured. Specifically, 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, and an individual’s genetic information should not be used to determine his or her premium. So that an individual requirement does not simply become a tax on low-risk individuals, strict community rating should be replaced with modified community rating, risk bands or risk corridors.

DISCUSSION

The Council has long been wary of any sort of requirement to purchase health insurance. However, in light of shifting public opinion in favor of requiring some individuals to purchase coverage, the continued rise in the number of the uninsured, and attention to the premium costs incurred by the insured to pay for the health care of the uninsured, the Council believes the AMA has the opportunity to lead further deliberations about individual responsibility. The social benefits of having everyone insured would be enormous. More money would be available to support the health care safety net, which would need to absorb fewer costs associated with treating the uninsured.

With respect to Resolution 703 (I-05), the first resolved supports a requirement that all Americans have, at a minimum, catastrophic and preventive health care coverage. While the Council conceptually shares this view, it believes that its recommendations (i.e., requiring those earning 500% of FPL or more to obtain health insurance coverage or face tax penalties, and a conditional requirement of individual responsibility for those at incomes below 500% of FPL once they have received tax credits or other subsidies) represent a fairer and more politically viable approach.

The second resolved of Resolution 703 (I-05) calls for those with incomes between 200-400% of FPL, who are not eligible for Medicaid or SCHIP, to be eligible for a refundable tax credit to support the purchase of health care coverage. While the Council continues to be a strong advocate for tax credits, it believes that limiting tax credits to those with incomes between 200-400% of FPL would effectively establish an eligibility floor, or minimum income for tax credit eligibility. Policy H-165.851[1] supports implementation of individual tax credits for the purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, the chronically ill, and those living within geographic areas that are pilot testing tax credit proposals. As such, Policy H-165.851[1] is generally consistent with the intent of the second resolve of Resolution 703 (I-05) because it supports tax credits for a targeted population. Moreover, Policy H-165.855 proposes tax credit eligibility for those with the lowest incomes. Establishing tax credits to those with incomes between 200-400% of FPL, as proposed by Resolution 703, does not preclude tax credits for lower incomes, as supported by AMA policy, nor does the proposal add to AMA policy.

The Council believes that it has proposed a level of individual responsibility to obtain health insurance that is fair and measured. In particular, the Council believes that those with the highest incomes should bear greater individual responsibility to obtain coverage. In addition, once lower-income individuals and families are able to access income-related tax credits or other subsidies, it may be appropriate to advocate for a broader-based individual requirement as well. The Council notes that there are benefit variations in how health plans define "catastrophic and preventive services," and believes that the growth of consumer-driven health insurance may give rise to even more options. For example, it may be better to avoid defining covered benefits in terms of specific diseases and conditions, and instead define covered benefits in terms of the dollar amount of accumulated medically necessary services.

With the recommendations contained in this report, the Council recommends further refinement of AMA policy with respect to covering the uninsured. Although these recommendations focus on individuals at the highest income levels, it is important to remember that the AMA proposal for

health system reform continues to be fundamentally concerned with those most likely to be uninsured—those at the lowest income levels.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 703 (I-05), and the remainder of the report be filed:

1. That our American Medical Association support a requirement that individuals and families earning greater than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (New HOD Policy)

2. That, upon implementation of a system of refundable tax credits or other subsidies to obtain health care coverage, our AMA support a requirement that individuals and families earning less than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (New HOD Policy)

3. That our AMA rescind Policy H-165.920[13], which "supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage." (Rescind HOD Policy)

References for this report are available from the AMA Division of Socioeconomic Policy Development.

Fiscal Note: No significant fiscal impact.