REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (I-04)
Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance
(Reference Committee J)
(December 2004)

EXECUTIVE SUMMARY

The AMA proposal to expand health insurance coverage and choice includes three key elements: (1) a preference for individual rather than employer ownership and selection of health plan; (2) the use of income-related, refundable, advanceable tax credits toward the purchase of health insurance; and (3) appropriate market regulation based on the recognition that neither free-market mechanisms nor market regulations alone will fully meet the needs of those with expensive medical conditions (Policies H-165.920, H-165.865, and H-165.856, AMA Policy Database). As a means of further advancing the AMA reform proposal, Council on Medical Service Report 4 (I-04) describes the current climate for health system reform; outlines and evaluates ways to incrementally implement tax credits; summarizes alternative sources of financing for tax credits; assesses the pros and cons of an individual mandate; and presents several policy recommendations.

The AMA proposal seeks to redirect the government subsidy for health insurance, and expand health insurance coverage and choice, ideally, by replacing the federal tax exclusion for employment-based health insurance with a system of individual tax credits. However, given current government budgetary constraints and the rising number of uninsured, revoking the tax exclusion would only partially finance tax credits large enough to provide near-universal coverage, and would likely face considerable political opposition.

Accordingly, Council Report 4 (I-04) explores various approaches to limiting eligibility for tax credits to specific target populations, such as low-income workers, the poor, children, the sick, or those living in certain geographic areas. The report also discusses sources of financing other than wholesale revocation of the current tax exclusion, such as capping the dollar amount of the tax exclusion, redirecting public funds currently spent on uncompensated care for the uninsured, and allocating funds through the federal budget process. In addition, although the report concludes that existing policy supporting the use of tax incentives and other non-compulsory measures, rather than an individual mandate (Policy H-165.920[15]), remains appropriate at this time, it notes that the Council will continue to monitor and reconsider the merits of recommending an individual mandate in order to achieve the ultimate goal of universal coverage. Finally, the report recommends that the AMA support incremental steps toward implementation and financing of individual tax credits such as targeted approaches, capping the tax exclusion for employment-based health insurance, and redirecting public funds currently spent on uncompensated care for the uninsured.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4 - I-04
(December 2004)

Subject: Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance

Presented by: William H. Beeson, MD, Chair

Referred to: Reference Committee J (Brooks F. Bock, MD, Chair)

The AMA proposal for expanding health insurance coverage and choice includes three key elements: (1) a preference for individual rather than employer ownership and selection of health plan; (2) the use of income-related, refundable, advanceable tax credits toward the purchase of health insurance; and (3) appropriate market regulation based on the recognition that neither free-market mechanisms nor market regulations alone will fully meet the needs of those with expensive medical conditions (Policies H-165.920, H-165.865, and H-165.856, AMA Policy Database).

Ideally, the AMA reform proposal seeks to replace the current federal tax exclusion for employment-based health insurance with a system of income-related, refundable, advanceable tax credits to individuals and families for the purchase of health insurance of their choice. Such a change in the tax treatment of health insurance would expand coverage by redirecting the existing inefficient and regressive subsidy toward those who most need help affording coverage; and expand choice by subsidizing coverage regardless of whether it is obtained through employment or elsewhere. However, revoking the tax exclusion would only partially finance tax credits large enough to provide near-universal coverage of the U.S. population. Furthermore, revoking the tax exclusion would likely face considerable political opposition, particularly from middle-to-upper-income voters who stand to receive less subsidy in tax credits than from the exclusion, particularly in a relatively unstable economic climate.

Thus, it is essential that the AMA continue to seek alternative routes to achieving its vision of a pluralistic, market-based health care system with individual choice and coverage for all Americans. Alternative approaches toward an individually based system could include both incremental implementation of individual tax credits and financing mechanisms other than wholesale revocation of the tax exclusion. This report provides an overview of the AMA proposal; describes the current climate for health system reform; outlines and evaluates ways to incrementally implement tax credits; summarizes alternative sources of financing for tax credits; assesses the pros and cons of an individual mandate; and presents several policy recommendations.

OVERVIEW OF THE AMA REFORM PROPOSAL

Individually Selected and Owned Health Insurance

Under the AMA proposal for health system reform, individuals would have greater choice of health insurance because tax credits could be applied to coverage, whether obtained through an employer or elsewhere. The removal of preferential tax treatment for employment-based coverage would

fuel demand for alternative sources of group coverage. Employment-based coverage would remain an option to the extent that employees demand it (and remain fully deductible as a business expense). In addition, shifting choice from employers to individuals would increase market competition among plans, making them more responsive to patient demand for access, quality, and affordability.

Individual Tax Credits

The AMA proposes a system of income-related, refundable, advanceable tax credits toward the purchase of health insurance of the individual's choice. Such credits are designed to dramatically reduce the ranks of the uninsured by redirecting the current federal subsidy for health insurance toward those who most need help affording coverage. Policy H-165.865 advocates structuring tax credits according to the following principles:

- Tax credits should be contingent on the purchase of health insurance. Individuals would have to purchase health insurance to receive a tax credit. Tax credits for families would be contingent on each member of the family having health insurance.

- Tax credits should be refundable and advanceable. Low-income people who owe less income tax than the value of the credit – those most at risk for being uninsured – would still receive tax credits. Tax credits would be available in advance so coverage can be purchased without waiting for a year-end tax credit.

- The size of tax credits should be inversely related to income. By providing larger credits to those with lower incomes, the AMA proposal targets those who are more likely to be uninsured. Targeting subsidies to low-income individuals also reduces the amount of uncompensated care that currently exists in the health care system.

- The size of tax credits should be large enough to ensure that health insurance is affordable for most people. At lowest income levels, the credit would approach 100% of the premium.

- Tax credits should be applicable only for the purchase of health insurance, and not for out-of-pocket health expenditures. Allowing tax credits to be used for out-of-pocket expenses would encourage excessive use of services, necessitate detailed rules regarding which expenses qualify for credits, and dilute the incentive to purchase coverage. An exception is that tax credits can be used for all components of a Health Savings Account (HSA), including the account, which can be used for out-of-pocket expenses.

Appropriate Market Regulation

The AMA proposal also includes measures to enable insurance markets to provide affordable coverage while serving the needs of individuals with above-average health needs (Policy H-165.856). The desire to protect specific target populations has been a major force behind market regulations regarding terms of issue, premium rating, and benefit mandates. Existing regulations often have unintended consequences, unfairly affect people differently depending on where they live or work, and are often burdensome, complex, and contradictory. The AMA proposes a more rational approach based on the following principles:

- There should be greater national uniformity of market regulation across health insurance markets. There should be less variation by type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan. State departures from national regulations would be permissible so long as they neither drive up the number of uninsured nor unduly hamper development of multi-state group purchasing alliances.

- The medical expenses of individuals with chronic illness or expensive conditions should be financed collectively in a manner that does not unduly restrict choice or drive up health insurance premiums for the general population. This will require a combination of market mechanisms and market regulations, and will require subsidies financed through general tax revenues rather than through strict community rating or premium surcharges.

- Strict community rating should be replaced with modified community rating, risk bands or risk corridors. Attempts to lower premiums for high-risk individuals through community rating raises premiums of low-risk individuals, reducing their enrollment, and thereby driving up average costs and premiums. By allowing some degree of premium variation to reflect individual factors, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population.

- Guaranteed issue regulations should be rescinded, and insured individuals should be protected by guaranteed renewability. Guaranteed issue in combination with strict community rating and extensive benefit mandates has had disastrous unintended effects on costs, coverage and choice, by driving up premiums and allowing healthy people to forgo coverage until sick. Instead, individuals would have powerful incentives to obtain and maintain coverage when healthy, and insurers would be prohibited from dropping or "reunderwriting" enrolled individuals who experience illness.

- The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Most barriers to the formation and operation of group purchasing alliances should be removed. Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

In addition to existing insurance options, the AMA proposal would encourage the creation or expansion of small group purchasing arrangements and other health markets that offer choices to consumers for redeeming their tax credits.

THE CURRENT CLIMATE FOR HEALTH SYSTEM REFORM

Rising Health Care Costs

Growth in U.S. health care spending and health insurance premiums continue to outpace overall economic growth and inflation. The Centers for Medicare and Medicaid Services (CMS) report that in 2002, annual health care spending reached $1.6 trillion, with per capita spending of $5,440 (Levit et al., *Health Affairs*, January/February 2004). Health expenditures as a share of gross domestic product (GDP) are projected to increase from 14.9% in 2002 to 18.4% in 2013 (Heffler et al., *Health Affairs*, Web exclusive, February 2004). Health expenditure growth has been reflected

in high and accelerated premium growth. Over the last half decade, private insurance premiums have risen each year at double-digit rates, reaching an average of $3,695 for employment-based individual coverage and $9,950 for employment-based family coverage (Kaiser Family Foundation/Health Research and Education Trust, *Survey of Employer-Sponsored Health Benefits*, 2003, and 2004).

Although research shows that additional health care expenditures are well worth it in terms of prolonged lifespan, increased quality of life, and productivity gains, employers report struggling to contain health benefit costs, and recent surveys show that many families – including those with insurance – have cost-related access problems or difficulty paying medical bills (Center for Studying Health System Change, *Issue Brief* No. 85, June 2004 and Commonwealth Fund *Biennial Health Insurance Survey*, 2003). Inability to pay high medical bills is a major cause of personal bankruptcy, again, even among the insured. According to a recent poll, more Americans worry about health care costs than about becoming unemployed, paying their rent or mortgage, or being a victim of a terrorist attack (Kaiser Family Foundation *Health Poll Report*, June 2004).

The Uninsured

Rising rates of uninsured correspond with rising health and insurance costs. By far, the most common reason cited for being uninsured is high cost (Kaiser Family Foundation *Health Insurance Survey*, April 2003). In 2003, the latest year for which data are available, the number of uninsured rose to 45 million, or 15.6% of the non-elderly population (U.S. Census Bureau, 2004). The biggest driver of the increase in the uninsured has been the loss of employment-based coverage, which arose from a combination of factors: job losses, rising premiums, fewer employers offering coverage (including retiree coverage), and more employees declining coverage. During a period of widespread state budget crises, enrollment in public programs only partially offset losses in private coverage. Approximately two-thirds of uninsured adults have been uninsured for more than a year (Kaiser Family Foundation Commission on Medicaid and the Uninsured, January 2004).

Rates of being uninsured correlate with demographic factors, with workers at small firms, low-income individuals, and young adults the most likely to lack coverage:

- Age: Approximately 20% of the uninsured are children, the remainder being roughly split between those under 35 and those who are older (U.S. Census Bureau, Current Population Survey, September 2004). Young adults were the least likely to be insured, in part due to high unemployment among this group (Kaiser Commission on Medicaid and the Uninsured, 2003).

- Income: While members of low-income households were the most likely to be uninsured, the likelihood of being uninsured rose across all income categories. The uninsured are split roughly into thirds between those below 100% of the federal poverty line (FPL), those between 100-200% of FPL, and those above 200% of FPL (Kaiser Commission on Medicaid and the Uninsured, 2003). Seventeen percent of the uninsured have annual incomes over $75,000 (U.S. Census Bureau, Current Population Survey, September 2004).

- Employment Status: Approximately 80% of the uninsured come from working families (Kaiser Family Foundation, December 2003); of this subset of the uninsured, four-fifths were not offered coverage through work, and one-fifth declined such coverage (Garrett, *Employer-*

Sponsored Health Insurance Coverage: Sponsorship, Eligibility, and Participation Patterns in 2001, Kaiser Commission on Medicaid and the Uninsured, July 2004).

- Firm Size: Workers at small firms experience the highest levels of being uninsured and the steepest growth in being uninsured (Kaiser Commission on Medicaid and the Uninsured, 2003 and July 2004). Multiple associated factors contribute to lower rates of coverage among workers at small firms: lower income, younger age, lower offer rates of employment-based insurance, and greater likelihood of being ineligible for employment-based insurance – in large part due to greater proportions of part-time workers.

- Health Status: Among uninsured working-age adults (18-64), 27% suffer from chronic conditions such as heart disease and diabetes, as compared to 39% of the insured (derived from Tu and Reed, Center for Studying Health System Change, February 2002). Those with chronic conditions are *less* likely to be uninsured than healthy individuals (12% vs. 15%) because of greater access to public coverage and greater likelihood of working for an employer that offers health benefits (Tu and Reed, 2002).

- Ethnicity: Blacks (20%), Hispanics (33%), and Asians (19%) are more likely to be uninsured than Caucasians (11%) (U.S. Census Bureau, Current Population Survey, September 2004).

- Sex: Males are more likely to be uninsured than females (17% vs. 14%) due to less access to public coverage (Current Population Reports, September 2003).

The Federal Budget Deficit

In 2002, the U.S. returned to deficit spending, with expenditures exceeding revenues by close to $500 billion in 2004 or 4.5% of gross domestic product (U.S. Office of Management and Budget, February 2004). Although the budget is subject to change between deficit-spending and surplus for any given year, the total national debt currently approaches $7.5 trillion, or 62% of gross domestic product (Budget of the U.S. Government, Fiscal Year 2005, Historical Tables, Table 7.1). The five biggest components of federal spending are Social Security, defense, Medicare, Medicaid, and interest payments on the federal debt (Congressional Budget Office, *Monthly Budget Review*, October 2004). Annual interest payments on the debt alone exceed $300 billion, constituting over a tenth of the federal budget (U.S. Department of the Treasury Bureau of the Public Debt, 2004, Budget of the U.S. Government, Fiscal Year 2005, Historical Tables, Table 1.1). Estimates show that covering future revenue shortfalls would require drastic tax increases, elimination of all discretionary spending, or cutting Social Security and Medicare benefits by half (Kotlikoff, *Milken Institute Review*, April 2004).

Public Opinion on Health System Reform

Persistent growth in health care costs and the rate of the uninsured has led to increased public support for some sort of health system reform aimed at lowering costs and expanding coverage. Nearly 70% of Americans surveyed favor repealing or limiting recent federal tax cuts in order to guarantee health insurance security (Commonwealth Fund *Biennial Health Insurance Survey*, 2003). Polls consistently show that no one approach to health system reform garners majority public support as the most favored approach (Commonwealth Fund *Biennial Health Insurance Survey*, 2003; Harvard School of Public Health/Robert Wood Johnson, December 2003; and Kaiser

Family Foundation *Health Poll Report*, March/April 2004). Proposals with the highest general support include expansion of Medicaid/SCHIP (80%), an employer mandate (76%), and individual tax credits (71%), with less support for universal Medicare coverage (55%), an individual mandate (54%), and a single national government plan (47%) (Harvard SPH/RWJF, December 2003). However, when survey respondents are forced to select a "top pick," no one proposal garners more than 22% of support among respondents. Furthermore although proposals have greater general support when respondents are not forced to pick their top choice, support is roughly halved when proposals are subjected to follow-up questions such as: What if expansion of public programs would require raising taxes? Or, what if an employer mandate would lead to layoffs? (Harvard SPH/Blue Cross Blue Shield Foundation/Cogent Research Poll, 2003).

Increased Recognition of the Effects of the Federal Subsidy

During the last decade, there has been growing acknowledgement that the $122-billion annual federal subsidy for employment-based health insurance is unfair and inefficient. This subsidy arises because the portion of employee compensation conferred in the form of health benefits is exempt from the employee's taxable income (Sheils and Haught, *Health Affairs*, Web exclusive, February 2004). In order to receive the subsidy, employees must accept whatever plan or plans their employers choose; and that those without employee health benefits, and who are not self-employed, receive no subsidy at all. Moreover, those with higher incomes – because they are in higher tax brackets – receive the largest share of the subsidy (Sheils and Hogan, *Health Affairs*, March/April 1999). At the same time, there is general recognition that continued government subsidization of health insurance is both necessary and appropriate in order to address the problem of the uninsured, given that the insured indirectly pay for a substantial portion of the health care of the uninsured through higher taxes and insurance premiums.

Growing Support for Tax Credits

Against a backdrop of escalating costs, swelling ranks of the uninsured, and mounting public pressure for reform, there has been growing support for individual tax credits. Early tax credit proposals have been modified in response to criticisms that they did not do enough to assist low-income families, thereby gaining a following among former opponents (Cunningham, *Health Affairs*, 2002). Proposed credits have become more generous, refundable, available in advance, and applicable outside the individual market. Support for more widespread use of individual tax credits for the purchase of health insurance comes from a diverse array of policymakers and organizations. During the 2004 presidential primaries and general election, candidates from both major parties proposed some form of individual health insurance tax credits. Academic research demonstrating the viability of tax credit proposals has been conducted at Stanford, Columbia, the Wharton School of Business at the University of Pennsylvania, Emory, and elsewhere.

Think tanks that have put forth individual tax credit proposals include the Heritage Foundation, the American Enterprise Institute, the Galen Institute, the Cato Institute, the New America Foundation, the National Center for Policy Analysis, the Heartland Institute, the Progressive Policy Institute, Centrists.org, the Coalition for Affordable Health Insurance, the Coalition for Affordable Health Care, the Institute for Policy Innovation, and the Pacific Research Organization. A number of business and professional associations also have proposed individual tax credits, including the U.S. Chamber of Commerce, the Blue Cross Blue Shield Association, America's Health Insurance Plans, American College of Physicians, the Massachusetts Medical Society, the Hispanic Business

Roundtable, the National Association of Health Underwriters, Communicating for Agriculture and the Self-Employed, and the National Association for the Self Employed.

In addition, national media coverage of individual tax credits, including the AMA Proposal, has appeared in the *Wall Street Journal, New York Times, Los Angeles Times, Detroit News, Journal of the American Medical Association, and New England Journal of Medicine*. Similarly, in recent years, there have been numerous legislative proposals introduced in Congress that include some form of individual tax credit: the Health Credits Act; HealthCARE Act; Health Care Cost Integrity and Fairness Act; Patients' Health Care Choice Act; Comprehensive Health Care Reform Act; Health Coverage Access Relief and Equity (CARE) Act; the Relief, Equity, Access, and Coverage for Health (REACH) Act; Securing Access, Value, and Equality in Health Care (SAVE) Act; the Fair Care for the Uninsured Act; and Child Health Care Affordability Act.

Bipartisan efforts to enact individual tax credits for the purchase of health insurance came to fruition with the passage of the Trade Act of 2002 (P.L. 107-210). As described in Council on Medical Service Report 11 (A-03), the Trade Act provides refundable, advanceable health insurance tax credits to selected groups of workers, including those displaced by international trade. The Act provides approximately $610 million in tax credits and grants over a five-year period, primarily to cover 65% of insurance premiums for 260,000 eligible individuals and family members. Although small in scope, the Trade Act represents a major breakthrough by establishing a precedent for individual tax credits. During the 108th Congress, the Health Care Tax Credit Enhancement for Workers and Steel Security Act (S.1018 and H.R. 1999) and the Health Care Tax Credit Expansion Act (S. 1693) were proposed to broaden the group of workers eligible for Trade Act tax credits.

POSSIBLE TARGETED APPROACHES

The AMA proposal to expand health insurance coverage and choice represents a coherent, workable, and equitable vision of market-based health system reform. The AMA proposal was conceived during an era of federal budget surpluses, when widespread implementation of individual tax credits financed by revoking the tax exclusion for employee health benefits appeared possible (Council on Medical Service Report 9 (A-98), "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage"). Given the current reform climate – tightening budgetary constraints, the rising number of uninsured, and growing receptivity to tax credits – it is important that the AMA identify feasible, incremental steps toward implementing its proposal. Such steps should target a subset of the uninsured population and should not depend on wholesale revocation of the tax exclusion.

Any targeted approach must define verifiable eligibility criteria and confront certain tradeoffs. One of the most critical issues is "crowd out," whereby a portion of the additional public subsidy substitutes for private expenditures, rather than adding to the total dollar amount devoted to health insurance coverage. Extending tax credits to some or all of the previously insured means that a portion of the subsidy substitutes for – or "crowds out" – private insurance expenditures, thereby reducing net coverage gains. On the other hand, it may be viewed as unfair to penalize those who acted responsibly by obtaining coverage, and who are equally deserving of subsidies as otherwise-similar uninsured individuals and families.

Low-Income Workers

A number of policy analysts have suggested individual tax credits for selected workers as a practical, effective way to expand coverage incrementally (Dorn and Meyer, Economic and Social Research Institute, October 2002; Butler, Heritage Foundation *Backgrounder* No. 1769, June 2004; and Lemieux, Progressive Policy Institute *Backgrounder*, September 2003). Such proposals generally focus on low-income workers at small firms, and may or may not restrict eligibility to those without job-related coverage. Specific eligibility categories that could be used alone or in combination include:

- Workers who have lost job-related coverage due to lay offs: Lemieux proposes targeting such workers by expanding the Trade Act tax credit eligibility categories, as do several legislative proposals noted earlier (S.1018, H.R. 1999, and S. 1693).

- Workers without employment-based health insurance: One-fifth of employees offered health benefits currently decline such coverage. Defining eligibility this way could create "crowd out" because some tax credits would go to those who had already obtained coverage on their own, and more importantly, by encouraging those with health benefits to drop them in order to qualify for tax credits. Although the dropping of existing health benefits could be mitigated by imposing a waiting period for those who drop prior coverage, this would drive up verification costs.

- Workers without access to employment-based health insurance: While basing eligibility on access to coverage avoids "crowd out" from workers dropping existing health benefits, it could be seen as unfair to workers whose employers offer coverage, as well as to the unemployed. In addition, it could lead to "crowd out" at the firm level if employers discontinue health benefits knowing that only then will their employees qualify for tax credits. Again, a waiting period could be imposed for those who previously had job-based coverage, although this would require greater verification effort, and run the risk of penalizing workers for their employers' decisions.

- Workers at small firms: Compared to larger firms, small employers pay lower average wages and are less likely to offer health benefits. Basing eligibility strictly on firm size would make targeting relatively easy but would entail "crowd out" from some currently covered workers. On the other hand, if eligibility were restricted to workers not offered coverage, some firms might drop health benefits. Similarly, if tax credits could not be used toward employment-based coverage, some firms currently offering health benefits might drop coverage. It should be noted that proposals aimed at small-firm workers often include creation of alternative pools through which to purchase group coverage, and implementation of mechanisms known to dramatically increase take-up rates, such as automatic enrollment and payroll deduction of premiums (e.g., Gruber; and Singer, Garber, and Enthoven in *Covering America*, Vol. 1, June 2001).

- Workers at firms with a high proportion of low-income workers: This approach simplifies targeting but creates "crowd out" to the extent that higher-paid workers at qualifying firms take advantage of the tax credit. As noted earlier, if tax credits could not be used toward employment-based coverage, some firms might drop coverage.

- Low-income workers regardless of firm characteristics: This approach is more direct (i.e., creates less "crowd out") but more difficult (more costly) to implement than targeting through selected firms likely to employ larger proportions of low-income workers.

- Selected low-income workers: This approach would use some combination of eligibility criteria such as income, firm characteristics, and/or access to employment-based coverage in order to balance concerns about "crowd out," fairness, and feasibility.

The Poor

A straightforward way to target tax credits to low-income individuals would be to base eligibility on not being eligible for Medicaid or SCHIP, and on having income below a certain percentage of FPL such as 100% or 200%. Setting the income cut off very low results in a smaller but needier group of eligibles, and a larger subsidy per recipient. Given the relatively low rates of private coverage among those with low-incomes, the magnitude of potential "crowd out" would be minimal, and presumably tax credits would be available to both the uninsured and insured, including those covered through an employer. Pauly takes an unconventional approach in proposing to target lower-middle income families (125% to 300% FPL), rather than the very poorest, who would have public or publicly contracted coverage (*Covering America* Vol. 1, June 2001). The rationale is that, compared to the very poor, lower-middle income people would require smaller credits, so that greater coverage gains could be made with a given tax credit budget; and that this group would be relatively more able to compare and choose among competing plans. Depending on results, tax credits could later be extended to lower and higher income groups.

Some analysts have proposed targeting subsidies by tying the size of the tax credit to both the cost of coverage and the individual's income. For example, households would not pay more than 5% of income for premiums (Dorn and Meyer, Economic and Social Research Institute, October 2002; Blue Cross Blue Shield Association, January 2004; Gruber in Meyer and Wicks (eds), *Covering America: Real Remedies for the Uninsured*, Vol. 1, June 2001; and Calabrese and Rubiner, New America Foundation, January 2004). Any scheme offering larger tax credits for more expensive coverage runs the risk of encouraging overinsurance, but especially one in which the incremental cost to the household is zero beyond a certain premium level. Further, such a system would prove even more problematic if tax credits were ever extended to a broader population.

It should be noted that different, possibly overlapping, target populations and eligibility criteria are not mutually exclusive. For example, Dorn and Meyer propose defining eligibility both on the basis of income and access to employment-based coverage (Economic and Social Research Institute, October 2002). Even if income is not an explicit eligibility criteria, other forms of targeting may channel resources toward those with low-income. For example, offering tax credits to employees of small firms indirectly targets low-income workers because of the inverse association between firm size and average wages. Some policy analysts have proposed offering tax credits to all workers at firms with at least a specified proportion of low-income workers as a way of reaching low-income workers with relatively low eligibility verification costs.

Children

Since insuring children is relatively inexpensive, large coverage gains could be made by targeting a given tax credit budget to children. Policy makers would have to decide whether eligibility would

depend on access to coverage through Medicaid, SCHIP or a parent's employer; income, and student status for those above the ordinary age cut off. "Crowd out" can be curbed by excluding children whose parents have the option of family coverage through an employer. For example, the Child Health Care Affordability Act (H.R. 4025) proposes a partially refundable tax credit of up to $500 per child for qualified medical expenses. Although the tax credit can be applied toward insurance premiums, there is no requirement that recipients be insured. The credit limit is raised to $3,000 for children with "terminal disease, cancer (whether or not in remission), a disability, or any other health condition requiring hospitalization or other forms of specialized care."

The Sick

There is great appeal in proposals to target tax credits to those with expensive or chronic conditions who lack access to public or employment-based coverage. However, defining and identifying the target population would be more complex than with workers, low-income individuals or children. Would eligibility be determined by diagnostic data, a dollar amount of medical expenses, participation in state high-risk pools or some other criteria? Another issue is that allowing people to qualify for tax credits only after experiencing illness creates a perverse incentive to forgo coverage when healthy. This scenario could be partially offset by imposing a waiting period to be waived only upon proof of prior coverage, although such a requirement would partially defeat the intent of delivering assistance at the time of greatest need. Because the onset of serious illness is often accompanied by loss of job-related coverage, it is important that tax credits be applicable to COBRA premiums. As noted above, the Child Health Care Affordability Act includes a provision to provide more generous coverage to those experiencing serious illness. Targeting a given amount of total dollars into tax credits for the chronically ill would reduce the uninsured by a smaller number than targeting the same dollar amount to children (Gruber, *American Economic Review*, May 2003). However, it could be argued that the goals of providing access to critically needed medical care and protecting patients against financial ruin are more important than simply reducing the number of uninsured.

Selected Geographic Areas

Introducing tax credits at the state level has been proposed in the context of offering or pilot testing multiple reform approaches (Dorn and Meyer, Economic and Social Research Institute, October 2002, and Aaron and Butler, *Health Affairs*, March 2004). With federal support, states could choose from a menu of options such as individual tax credits, public program expansions, tax credits to employers, employer or individual mandates, buy-in into federal or state employee health benefit programs, creation of insurance purchasing pools or single state-wide insurance plans. Aaron and Butler argue that state pilot tests could gain widespread support and break the current political impasse on reform, so long as all stakeholders believe that their favored approach would receive a fair trial. Pilot tests also would provide valuable empirical evidence with which to compare competing reform options. Although there would continue to be philosophical differences about the desirability of various outcomes (i.e., with regard to universality, choice, degree of compulsion, cost, etc.), there would be greater agreement on the actual implications of various policies and the magnitudes of tradeoffs between conflicting objectives. Aaron and Butler emphasize the need for adequate data collection, clear evaluation criteria, and monetary rewards to states that achieve coverage gains. In response to Resolution 118 (A-04), the Council on Medical Service is preparing a report for the 2005 Annual Meeting that examines various alternatives and demonstration projects for expanding health insurance coverage for low-income persons and

reports on progress concerning development of new state options for improving the effectiveness of public health safety net programs.

POTENTIAL FINANCING MECHANISMS

Limit the Tax Exclusion

Given the current large, unlimited, and regressive subsidy arising from the tax exclusion for employment-based health coverage, many reform proposals seek to eliminate or limit the exclusion. Consistent with AMA policy, some proposals would eliminate the tax exclusion altogether (Pauly and Wicks, Meyer, and Silow-Caroll in *Covering America* Vol. 1, June 2001). Other proposals grapple with the political difficulties of revoking such a large, entrenched subsidy to middle- and upper-income voters. One proposal recommends initially capping the dollar amount that can be excluded from taxable income at twice the geographically adjusted premium of a benchmark plan (the median-cost Federal Employees Health Benefit plan). The cap on excludable premiums would be ratcheted down each year until, after ten years, it would equal the premium of the benchmark plan plus 5% (Singer, Garber, and Enthoven in *Covering America* Vol. 1, June 2001). Similarly, the New America Foundation would allow the exclusion only up to the national median premium for some specified minimum benefit package (Calabrese and Rubiner, January 2004), and Gruber proposes limiting the tax exclusion for employment-based coverage to the cost of the median-cost plan in each state-based purchasing pool (*Covering America* Vol. 1, June 2001).

Others propose leaving the exclusion alone, but reducing tax credits for those with employment-based coverage (Kendall, Lemeiux, and Levine in *Covering America* Vol. 2, November 2002). Still others favor offering households an option between the exclusion and tax credits (Miller and Steuerle in *Covering America* Vols. 2 and 3, November 2002 and December 2003), although such an approach would entail administrative challenges. Steuerle proposes a choice between a tax credit and a capped exclusion; the cap would not change over time, whereas the size of tax credits would increase with premiums. In part for administrative simplicity, Curtis and Neuschler propose offering *firms* the choice between credits and exclusions for their entire employee group (Economic and Social Research Institute *Occasional Paper*, August 2002). Of course, any proposal that leaves the tax exclusion intact or offers it as an option increases program costs (or, more accurately, reduces the scope of recouping tax revenues).

Redirect Federal Funds Currently Spent on Uninsured

Researchers estimate that one-third of all care for the uninsured, or $41 billion, is uncompensated (Hadley and Holahan, Kaiser Commission on Medicaid and the Uninsured, *Issue Update*, May 2004). This estimate may not fully capture uncompensated care provided by physicians, which is generally not eligible for government subsidies and, therefore, less likely to be reported. In any case, an estimated $35 billion of uncompensated care is financed publicly, two-thirds federally ($23.3 billion) and one-third from states ($11.7 billion). Most federal spending on uncompensated care for the uninsured is in the form of disproportionate share hospital (DSH) payments to offset losses incurred when patients are unable to pay their hospital bills, estimated at $8.2 billion in 2004 (Rousseau and Schneider, Kaiser Commission on Medicaid and the Uninsured, April 2004). Covering the uninsured would free up a portion of these revenues to finance tax credits.

Allocate Funds Through the Federal Budget Process

Regardless of the ultimate source of funding, providing targeted individual tax credits will require Congressional appropriation of a fixed-dollar budget for tax credits. President Bush has proposed budgeting $80 billion over ten years for tax credits. In the absence of sufficient offsetting sources of funding, such as a cap on the tax exclusion or reduction in federal outlays on the uninsured, appropriating funds for tax credits translates into increased deficit spending. How the tax credit budget is ultimately, if indirectly, financed has important distributive implications. For example, collecting revenue through payroll taxes rather than income taxes places a greater burden on low- and middle-income workers because payroll taxes take effect on the first dollar earned and apply only to wages.

CONSIDERATION OF AN INDIVIDUAL MANDATE

Some tax credit proponents argue that the effectiveness and political viability of tax credit proposals would be enhanced by including a legal mandate that all individuals obtain health insurance. The Council on Medical Service previously explored this issue in Council on Medical Service Report 5 (A-00), "Benefits and Limitations of an Individual Mandate for Individually Owned Health Insurance." The report concluded that policies to promote coverage lie on a continuum with pure volunteerism at one end and strict compulsion at the other end, with an individual mandate lying at the compulsory end. The report also identified a number of "carrot" and "stick" incentives and automatic enrollment mechanisms that could be used to encourage coverage under a voluntary system, and proposed AMA policy supporting the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage (H-165.920[15]).

For the past twelve months, the Council has devoted considerable attention to revisiting the issue of an individual mandate. In deliberating whether to recommend a change in AMA policy, the Council met with outside experts Laurie Rubiner of the New America Foundation and Stuart Butler of the Heritage Foundation in June 2004.

The key potential advantages of an individual mandate are to: (a) achieve universal coverage; (b) avoid the "free-rider" problem, whereby care for the uninsured is ultimately paid for by the rest of society through higher taxes and higher premiums; and (c) avoid adverse selection, whereby low-risk individuals opt out of insurance, driving up average costs and premiums for those who are insured. Proponents of an individual mandate believe that under a voluntary system, a significant number of people will not purchase coverage, particularly those with low incomes, the young, and the healthy. The erosion of coverage under the current, voluntary system suggests that a mandatory approach may be needed to guarantee health insurance coverage for all Americans, and to ensure that risk pools include low-risk individuals. Without either mandated coverage or a national health care system, there may be too many uninsured "free riders" whose care will ultimately be paid for by the rest of society through higher taxes and higher premium prices.

On the other hand, an individual mandate could permit the government to renege on its commitment to support health insurance through adequate tax credits and other subsidies. An individual mandate also can be viewed as coercive, particularly in the context of a tax credit proposal to increase individual choice. Rather than allowing markets to meet the wide range of consumer needs, preferences, and budgets, a mandate would open the door to excessive

government involvement in defining qualified coverage. Political pressure for an ever-more comprehensive and expensive "basic" benefit package would penalize those who prefer less comprehensive but more affordable coverage – particularly among the low-income – thereby largely defeating the goal of individual choice. This, in turn, would create the temptation for price setting of premiums and health care services. For example, an individual mandate coupled with strict community rating amounts to a tax on low-risk individuals, who would otherwise face more affordable premiums. Another difficulty with individual mandates is highlighted by experience from the automobile insurance industry: costly and ineffective enforcement. Significant 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. Further, an individual mandate is unlikely to be politically viable at present, and would likely reduce the political viability of a tax credit proposal.

After considerable deliberation, the Council continues to believe that existing policy supporting the use of tax incentives and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage (Policy H-165.920[15]) remains appropriate at this time. An individual mandate would be neither a panacea for achieving universal coverage, nor a substitute for adequate subsidies. The AMA reform proposal would give individuals unprecedented market power, prompting insurers to provide more affordable products and enticing many of the uninsured to seek coverage. The AMA principles for health insurance market regulation also provide strong incentives for individuals to obtain and maintain coverage, for example through replacement of guaranteed issue with guaranteed renewal (Policy H-165.856). Perhaps most importantly, public debate over an individual mandate could divert political attention away from broader reform issues, such as redistribution of the subsidy for health insurance, and reliance on market forces versus government regulation. Further, the introduction of an individual mandate could inadvertently doom the prospects of individual tax credit proposals by forestalling opportunities for incremental implementation of tax credits as discussed in this report.

However, because of the high degree of uncertainty and flux regarding the necessity, impact, and feasibility of an individual mandate, the Council will continue to monitor and reconsider the merits of recommending an individual mandate in order to achieve the ultimate goal of universal coverage.

DISCUSSION

Since the initial adoption of the AMA proposal to expand health insurance coverage and choice in 1998, economic and political developments have altered the climate for health system reform. Escalating health care costs and swelling ranks of the uninsured have fueled public pressure for some sort of reform. The Council is pleased that during this time, there has been growing understanding of, and support for, individual tax credits as proposed by the AMA. Unfortunately, the growing federal budget deficit diminishes the short-term possibilities for widespread implementation of tax credits, with likely stiff political resistance to revocation of the tax exclusion for employment-based coverage. Given the current climate for health system reform, the Council on Medical Service believes that incremental, targeted implementation of tax credits is a realistic and worthy short- to medium-term goal.

The Council emphasizes that the vision of health system reform embodied by the AMA proposal is as vital and relevant as ever. Given current conditions, however, the most realistic way to advance

the AMA reform agenda may be to offer individual tax credits on a limited basis, without reliance on full elimination of the tax exemption for employment-based health benefits. This report outlines key target groups for such consideration, as well as the tradeoffs in establishing target groups. Further discussion will be required about whether tax credits should be made available only to the uninsured, or to what extent "crowd out" is acceptable by extending tax credits to the already insured, particularly those with low incomes and/or chronic medical conditions. Another tradeoff involves providing generous tax credits to a small number of people (e.g., those with income below 100% FPL), versus offering more modest credits to a relatively large group of people (e.g., those with income below 200% FPL). A similar tradeoff is the extent to which scarce budgetary resources should be used to insure a relatively large number of children or a relatively small number of people with chronic or expensive medical conditions (Gruber, *American Economic Review*, May 2003). Regardless of how these tradeoffs are resolved, the overriding objective should be to incrementally expand health insurance coverage and choice through individual tax credits, with an eye toward more widespread use of tax credits at some point in the future.

Estimates of the costs of covering the uninsured vary widely but are in the tens of billions of dollars each year. For example, the AMA Center for Health Policy Research estimates that tax credits would require $30 to $60 billion per year in addition to revenues generated by revoking the tax exclusion (Wozniak and Emmons, 2000). It should be noted that the costs of covering the uninsured must take into account the expected increase in health care utilization among the newly insured, estimated at $48 billion per year (Hadley and Holahan, Kaiser Commission on Medicaid and the Uninsured, *Issue Update*, May 2004). To date, such estimates have been based on the assumption that the uninsured would obtain coverage comparable to existing employment-based coverage. This assumption is challenged by a recent study conducted by the Kaiser Family Foundation and eHealthInsurance, Inc. (August 2004). The study found that average premiums paid for health insurance obtained on the individual market are *markedly* lower than in the group market ($1,768 vs. $3,695 or *52% lower* for single coverage, and $3,331 vs. $9,950 or 66% lower for family coverage). The substantial premium differences are attributable 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.

Fortunately, the implication of these findings is that the size of tax credits and corresponding total expenditure required to extend meaningful coverage to the uninsured may be lower than previously believed. The trend toward HSAs, health reimbursement arrangements (HRAs), and other forms of consumer-directed health care designed to lower premiums and contain health care costs holds promise for allowing expanded coverage at lower-than-expected cost. The Council believes that health insurance markets allowed to reflect consumer preferences will result in a shift toward less expensive coverage resembling true insurance against unforeseen loss, rather than prepayment of highly generous benefits.

Whatever the costs of covering the uninsured, the full $122-plus-billion annual tax exemption for employment-based health insurance cannot be counted on as a source of tax credit revenue. Instead, for the short- and mid-term, the Council believes that a more realistic alternative would be to cap the tax exclusion to some benchmark amount. Oddly enough, none of the proposals reviewed in this report explored the possibility of setting the cap on the exclusion inversely related to income, thereby making the exclusion less regressive with respect to income. The Council believes that a "sliding scale" cap on the tax exclusion for employment-based health insurance warrants consideration. Another financing mechanism that could be combined with a cap on the

tax exclusion is redirecting the estimated $35 billion in public funds currently spent on the uninsured (Hadley and Holahan, May 2004). Whatever the explicit or indirect source of funding, health insurance tax credits will require Congress to appropriate a specified budget for tax credits.

Finally, many of the ideas for targeted, incremental implementation of individual tax credits discussed in this report could be tested on a limited basis. State pilot tests would allow policy makers and the public to resolve uncertainties about the magnitude of "crowd out," tradeoffs between generous credits for the few versus more modest credits to the many, the feasibility of alternative caps on the tax exclusion, the merits of an individual mandate, and so forth. This would allow future policy to be guided by actual experience, including both the magnitudes of various effects and the public's preferences for different outcomes. As noted earlier, the Council will be examining the use of state pilot tests of alternative reform approaches in an upcoming report for the 2005 Annual Meeting.

RECOMMENDATIONS

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

1. That it is the policy of the American Medical Association (AMA) to support 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 credits. (New HOD Policy)

2. That it is the policy of the AMA to support incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. (New HOD Policy)

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

Fiscal Note: Staff cost estimated to be less than $500 to implement.