REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - I-05
(November 2005)

Subject: Status Report on Expanding Health Care Coverage to All Individuals, with an Emphasis on the Uninsured

Presented by: Joseph P. Annis, MD, Chair

Referred to: Reference Committee J
(Iffath A. Hoskins, MD, Chair)

At the 2004 Interim Meeting, the House of Delegates adopted Resolution 703 as amended. The third resolve of amended Resolution 703 (I-04) calls for the AMA to study other mechanisms beyond tax credits for covering America's uninsured. The Board of Trustees referred this item to the Council on Medical Service for a report back to the House at the 2005 Interim Meeting.

In studying the third resolve of Resolution 703 (I-04), the Council broadened its response to address the complex array of issues involved in expanding coverage to the uninsured, similar to previous Council Reports 6 (A-01), 2 (A-99), and 7 (A-97). In each of those reports, the Council provided an overview of the uninsured, as well as a discussion of mechanisms to expand coverage to the uninsured.

In particular, this report provides a snapshot of the uninsured; describes current American Medical Association (AMA) advocacy efforts to expand health insurance coverage to the uninsured; summarizes a recent AMA Member Connect survey regarding the uninsured; discusses related legislative activity; and highlights AMA policy on health system reform as evolving to encompass many alternatives.

THE UNINSURED

In August 2005, the Census Bureau, which conducts the Current Population Survey, estimated that 45.8 million people were without health insurance, representing 15.7% of the population. The number and percentage of people covered through employer-sponsored insurance decreased, while the number and percentage of people covered by Medicaid and Medicare increased. In April 2005, Congress directed the House Energy and Commerce and Senate Finance committees to find $10 billion in savings over fiscal years 2006-2011, the bulk of which most likely will come from the Medicaid program. The Secretary of the Department of Health and Human Services (HHS) appointed a Medicaid advisory commission in July 2005, to offer recommendations regarding the future of the program. AMA Immediate Past President John C. Nelson, MD, was appointed as a non-voting member of the commission.

The Council is mindful that the state of being underinsured is more elusive, though likely more pervasive, than being uninsured. Council on Medical Service Report 15 (I-98) discussed, in depth, the methodology of various surveys in an attempt to ascertain how best to treat estimates of the uninsured and underinsured. The Current Population Survey is an annual survey which approximates the number of people uninsured at a specific point in time, rather than the number of people uninsured for the entire year.

As the Council has previously reported, the vast majority of the uninsured (83%) are workers or in families headed by workers. More than 59.8% of Americans receive health insurance coverage through employment. The scope and limitations of employment-based health insurance coverage is detailed in Council on Medical Service Report 5 (I-05), "Association Health Plans," which also is before the House at this meeting. As shown in Table 1, the Census data show an upward trend in the number of individuals lacking health insurance and the rate of being uninsured, with a peak in 1998, followed by a

drop-off and gradual increase since 2000. Table 1 also shows trends in the relative numbers of individuals with employer-sponsored coverage versus Medicaid coverage. Again, there are peaks and drop-offs, but the overall trend is toward less reliance upon employment-based coverage and greater reliance upon Medicaid.

Table 1: Lack of Health Insurance Coverage: 1987-2004
(Numbers in thousands)

Year	Number Lacking Coverage	% Lacking Coverage	% with Employment-based Coverage	% with Medicaid Coverage
2004	45,820	15.7	59.8	12.9
2003	44,961	15.6	60.4	12.4
2002	43,574	15.2	61.3	11.6
2001	41,207	14.6	62.6	11.2
2000	39,804	14.2	63.6	10.6
1999	40,228	14.5	63.3	10.3
1998	44,281	16.3	62.0	10.3
1997	43,448	16.1	61.4	10.8
1996	41,716	15.6	61.2	11.8
1995	40,582	15.4	61.1	12.1
1994	39,718	15.2	60.9	12.1
1993	39,713	15.3	57.1	12.2
1992	38,641	15.0	57.9	11.5
1991	35,445	14.1	59.7	10.7
1990	34,719	13.9	60.4	9.7
1989	33,385	13.6	61.6	8.6
1988	32,680	13.4	61.9	8.5
1987	31,026	12.9	62.1	8.4
Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," August, 2005, Table C-1.				

Table 2 shows that the likelihood of being uninsured is inversely related to income. According to the Census Bureau, 24.3% of those with incomes less than $25,000 were uninsured, whereas only 8.4% of those with incomes more than $75,000 were uninsured.

Table 2: Rate of Uninsured by Household Income: 2004

Household Income	Percent Lacking Health Insurance
Less than $25,000	24.3
$25,000 - $49,999	20.0
$50,000 - $74,999	13.3
$75,000 or more	8.4
Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," August, 2005, Table 7	

The income data suggest that there are likely some uninsured individuals with sufficient earnings to purchase health insurance. Council on Medical Service Report 3 (I-05), "Update on HSAs, HRAs, and Other Consumer-Directed Health Plans," describes coverage options that may be particularly relevant for this segment of the uninsured.

The likelihood of being uninsured also varies by race. As noted in Table 3, Hispanics have a high rate of uninsurance (32.7%), compared to 19.7% for blacks, 16.8% for Asians, and 11.3% for whites.

Table 3: Rate of Uninsured by Race: 2004

Race	**Percent Lacking Health Insurance**
White	11.3
Black	19.7
Asian	16.8
Hispanic	32.7
Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," August, 2005, Table 7	

The high rate of uninsurance for Hispanics is related primarily to immigration and citizenship. Among native citizens, the uninsured rate is 13.3%, whereas the rate for the foreign-born is 33.7%. Further analysis of the foreign-born statistics reveals that naturalized citizens have an uninsured rate of 17.2%, whereas noncitizens have an uninsured rate of 44.1%. The AMA has been a long-standing supporter of the U.S.-Mexico Border Health Commission, which strives to provide international leadership to optimize health and quality of life along the U.S.-Mexico border.

Table 4 displays the rate of being uninsured by various age groups. Young adults, aged 18-24, continue to have a high rate of uninsurance (31.4% in 2004), with those aged 25-34 faring only slightly better (25.9% uninsured in 2004).

Table 4: Rate of Uninsured by Age: 2004

Age	**Percent Lacking Health Insurance**
Under 18 years	11.2
18-24 years	31.4
25-34 years	25.9
35-44 years	18.7
45-64 years	14.3
65 years and older	0.8
Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2004," August, 2005, Table 7	

Among children younger than 18, 11.2% were uninsured in 2004. Adults aged 35-44 had an uninsured rate of 18.7%, and 14.3% of those aged 45-64 were uninsured in 2004. Medicare-eligible adults, those aged 65 and older, had an uninsured rate of 0.8%.

AMA ADVOCACY ON EXPANDING HEALTH INSURANCE COVERAGE

Expanding health insurance coverage to the uninsured is an AMA priority in its focused advocacy agenda. Since October 2004, the AMA has been involved in a broad-based consensus-building effort entitled "Search for Common Ground/Health Care Coverage for the Uninsured (HCCU)." The goal of the HCCU activity has been "to bridge strong differences on policy issues and reach consensus agreements that break the longstanding impasse on how to extend health insurance coverage to the uninsured." One of the guiding principles of HCCU has been to extend coverage "to as many people as possible as quickly as possible." This goal is consistent with AMA support for incremental and targeted approaches to increasing coverage (Policy H-165.851, AMA Policy Database).

In addition to the AMA, HCCU participants represent 23 other organizations, including the American Academy of Family Physicians, AARP, the American Federation of Labor-Congress of Industrial Organizations (AFL-CIO), the Service Employees International Union, the American Hospital Association, America's Health Insurance Plans, the Blue Cross and Blue Shield Association, Families USA, Johnson & Johnson, the National Association of Manufacturers, the National Conference of State Legislatures, the National Governor's Association, Pfizer, UnitedHealth Group, and the U.S. Chamber of Commerce.

AMA participants in the HCCU activity include Immediate Past President John C. Nelson, MD, and Vice Speaker Jeremy A. Lazarus, MD. In addition to serving as Chair of the Board Task Force on Medicare and Health System Reform, Dr. Lazarus is one of the Board liaisons to the Council on Medical Service.

To date, the AMA has been cautiously optimistic that the HCCU consensus-building process could lead to a meaningful and practical proposal that could be used in advocacy efforts and/or to support legislation. Key elements of the most recent draft HCCU materials include strategies for expanding coverage for people at or near the poverty level; expanding coverage for individuals and families above the poverty level, but still in need of assistance; and improving access to reasonably comprehensive and affordable coverage. At the time this report was written, the Council remained hopeful that the HCCU activity might reach meaningful consensus by the end of the year.

AMA MEMBER CONNECT SURVEY

In May 2005, an AMA Member Connect survey focused on the uninsured and was sent to AMA members during the Robert Wood Johnson Foundation's annual "Cover the Uninsured Week." The results of the survey indicated that a third of member respondents believe that the number of uninsured in the United States is a crisis, while 60% consider it a major problem. The survey also asked members to identify which segments of the population should be targeted as the highest and second highest priority for increased health insurance coverage. A third of respondents indicated that all segments of the uninsured should be targeted at the same level. Among the segments identified to receive priority for increased coverage were low-income individuals and families, followed by children and young adults.

In addition, the survey results revealed that AMA members continue to provide a significant amount of charity care, and continue to incur debt on services provided for which they had expected payment. Council on Medical Service Report 8 (A-05), "Offsetting the Costs of Providing Uncompensated Care," reported that AMA data have consistently shown that physicians provide, on average, more than $2,000 worth of uncompensated care every week.

The Member Connect survey also asked a hypothetical question regarding the most efficient use of funds if the AMA were to raise money to help address the issue of the uninsured. An AMA initiative to fund state and/or local pilot projects to expand health insurance coverage (consistent with Policy D-165.957[1]) was the highest ranking response and was supported by 33% of respondents. The second highest ranking response (21%) was providing grants to open new and/or fund existing clinics to provide free clinics. Results of the May 2005 Member Connect survey may be viewed by AMA members online at www.ama-assn.org/go/memberconnect.

LEGISLATIVE ACTIVITY

There have been approximately 50 bills introduced in the 109th Congress to address the problem of the uninsured. A wide variety of approaches are proposed, including tax credits (to individuals and to employers), public sector expansions (using individual tax credits or by providing more money to public programs), market reforms, combinations of these strategies, and support for a single national health financing system. The AMA had supported three bills at the time this report was written.

The bills supported by the AMA included H.R. 1955 and S. 637, the "Small Employers Health Benefits Program Act of 2005," which uses the Federal Employees Health Benefits Program as a model to help improve access to health insurance coverage for the low-income uninsured workers in small businesses. These bills are consistent with AMA policy supporting tax subsidies to small and low-wage employers to assist them in purchasing adequate health insurance coverage for their employees (Policy H-165.985[7]), as well as with policy supporting individual choice of health plan (Policies H-165.881, H-165.895[1c], H-165.856[9b], and H-165.920[7]).

In addition, the AMA supported S. 1049, the "Covering Kids Act of 2005," which would provide new funding for innovative outreach and enrollment efforts to pregnant women and children who are eligible for coverage under either the Medicaid or the State Children's Health Insurance Program (SCHIP). This bill is consistent with long-standing AMA policy urging states to undertake, and physicians to participate in, educational and outreach activities aimed at children who are eligible for coverage under Medicaid and SCHIP (Policy H-290.982[7]).

Although the AMA has supported various tax credit proposals in recent years, no specific legislation has yet contained the level of subsidy needed to sufficiently ensure that low-income tax credit recipients would be able to afford creditable coverage. The AMA has studied and developed policy on other mechanisms for covering the uninsured, as noted above, and has actively supported alternative approaches in the 109th Congress.

AMA POLICY

AMA policy states a preference for individually owned insurance and the use of tax credits over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920). AMA policy is explicit, however, in supporting other alternative approaches. For example, Policy D-165.966[2] advocates for changes in federal rules and federal financing to support the ability of states to develop and test different models for improving health insurance coverage for patients with low incomes without incurring new and costly unfunded federal mandates or capping federal funds.

During the past 25 years, the House of Delegates has continuously reviewed and revised AMA policy on health system reform. In the 1980s, AMA policy was dominated with concerns about managed care. During the early 1990s, the Clinton Administration's health system reform effort prompted the AMA to develop its own proposal, "Health Access America," which contained a mandate that employers provide health insurance for their employees. By the 1996 Interim Meeting, discontent with how some employers used managed care to interfere with patient choices and physician decision-making led to support for individually selected and owned health insurance as the preferred method for people to obtain health insurance coverage (Policy H-165.920[5]).

At the 1998 Annual Meeting, the House adopted the 17 recommendations in Council on Medical Service Report 9, thereby establishing comprehensive policy as to how a system of individually owned health insurance should be structured based on a premise of pluralism of health care delivery systems and financing mechanisms (Policy H-165.920). Since 1998, the Council has presented more than 30 reports related to expanding health insurance coverage and choice. Although some of these reports were initiated by the Council, most were developed in response to resolutions from the House. In response to growing debate 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. The House also adopted a series of principles for health insurance market regulation (Policy H-165.856) that were proposed in Council on Medical Service Report 7 (A-03).

The most recent AMA policy refinement has been to move toward greater support for a wider array of health system reform alternatives. In particular, Council on Medical Service Report 4 (I-04) evaluated and proposed options for implementing and financing tax credits for individually selected and owned health insurance, and recommended support for targeted and incremental implementation tax credits (Policy H-165.851). Council on Medical Service Report 1 (A-05) continued the trend toward more openness to alternative tax credit strategies by recommending that the AMA urge national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons (Policy D-165.957[1]). Council on Medical Service Report 1 (A-05) also encouraged state governments to maintain an inventory of private health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage (Policy D-165.957[2]). The full text of these and other resources, including advocacy materials, are available through the Council on Medical Service Web site at www.ama-assn.org/go/cms.

DISCUSSION

The health insurance market is evolving at an unprecedented pace. The Census Bureau reports that employment-sponsored health insurance coverage has continued to decline, dropping from 60.4% of the uninsured in 2003 to 59.8% in 2004. In addition, employment-based coverage has become less generous for America's workforce. Out-of-pocket expenses, including premiums and copayments or coinsurance, continue to increase with the overall increase in the price of health insurance. Policy-makers are seeking alternative health insurance coverage strategies. Every meeting of the House of Delegates features innovative proposals introduced by state medical associations and national medical specialty societies.

The Council has demonstrated in this report that AMA policy remains highly relevant and responsive to alternative approaches for covering the uninsured. Policy established by the House continues to guide a strong advocacy agenda, with covering the uninsured being among the AMA's highest priorities.

Policy H-165.920 provides a clear preference for covering the uninsured through the use of individually owned health insurance and tax credits rather than public sector expansions, because this type of approach offers a better mechanism for patients to have freedom of choice. The Council believes the AMA proposal for individually owned health insurance should continue to be the guiding force of our long-term efforts to expand health insurance coverage to the uninsured. It is critical that tax credit proposals be adequately funded in order to receive AMA support. The Council acknowledges, however, the difficulty of implementing such a fundamental change and, thus, the AMA has supported a number of other alternative approaches to covering the uninsured. For example, in 109th Congress, the AMA supported legislation to fund new enrollment and outreach efforts in Medicaid and SCHIP, as well as legislation to provide tax subsidies to small and low-wage employers.

Although comprehensive legislation to expand health insurance coverage to the uninsured may be unlikely until after the next Presidential election, the Council believes it is imperative for the AMA to continue to show strong support and build public pressure on this priority issue. The Council is encouraged that momentum appears to be gaining for consensus on health system reform. The results of the recent AMA Member Connect survey indicated a sense of urgency among AMA members for a proactive AMA response to the lingering problem of the uninsured. AMA involvement with HCCU, the influential and broad-based consensus-building activity, clearly has the potential to yield elements that are highly consistent with AMA policy.

RECOMMENDATIONS

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

1. That the American Medical Association continue to place a high priority on expanding health insurance coverage for all. (Directive to Take Action).

2. That the AMA continue to pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for covering all. (Directive to Take Action)

3. That the AMA continue to explore and support alternative means of ensuring health care coverage for all. (Directive to Take Action)

4. That our AMA Board of Trustees consider assisting Louisiana, and other Gulf Coast States if they should desire, in developing and evaluating a pilot project(s) utilizing AMA policy as a means of dealing with the impending public health crisis of displaced Medicaid enrollees and uninsured individuals as a result of the recent natural disasters in that region.

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

Fiscal Note: Continue to pursue bipartisan support for AMA policy on health insurance reform, and continue to explore alternative means of covering the uninsured at an estimated total staff cost of $2,500.