REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-06)
Expanding Health Insurance Coverage to the Uninsured: 2007 and Beyond
(Reference Committee J)
(November 2006)

EXECUTIVE SUMMARY

Since the House of Delegates adopted the 17 principles contained in Council on Medical Service Report 9 (A-98), "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage," the Council on Medical Service has presented nearly 50 reports related to health system reform and expanding coverage to the uninsured. This report, which was initiated by the Council, highlights key elements of the AMA health insurance reform proposal that have been developed and refined over the past eight years.

The Council's Web site, www.ama-assn.org/go/cms contains all Council reports since the 1998 Annual Meeting. The Appendix to this report lists 46 reports that are related to health system reform and expanding health insurance coverage to the uninsured.

Key elements of AMA policy are highlighted in the report to demonstrate the multifaceted nature of the AMA proposal. Despite these numerous and continually evolving policy refinements, AMA policy on health system reform has been criticized at times for being too narrow and overly complicated. The Council demonstrates that the AMA proposal was designed to allow advocacy to be targeted and incremental. As described in this report, the AMA is able to speak to and support many types of proposals for health system reform, with elements of the AMA proposal becoming increasingly viable.

Nevertheless, the Council's overview reveals several gaps in policy development that should be addressed. Specifically, the Council believes the AMA reform proposal requires additional policy refinement regarding the scope of health care benefits, the financing of care for those with known high health expenses, and in the critical estimation of the cost and coverage gains of implementing a system of tax credits.

This report concludes with recommendations to address these important policy issues to ensure the relevance of the AMA proposal for 2007 and beyond.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5 - I-06
(November 2006)

Subject: Expanding Health Insurance Coverage to the Uninsured: 2007 and Beyond

Presented by: Ronald P. Bangasser, MD, Chair

Referred to: Reference Committee J
(John H. Vassall, MD, Chair)

Since the House of Delegates adopted the 17 principles contained in Council on Medical Service Report 9 (A-98), "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage," the Council on Medical Service has presented nearly 50 reports related to health system reform and expanding coverage to the uninsured. Most of these reports contained policy refinements that have made the AMA proposal increasingly sophisticated and multifaceted, while other reports provided information for the House on the progression and advocacy of the AMA proposal.

Council on Medical Service Report 9 (A-98) stated that its recommendations were designed to facilitate transition to a system offering the following advantages:

(1) increased access to adequate private sector coverage for all persons, including the self-employed and persons who are disadvantaged economically or by health risk;

(2) expanded freedom by individuals to choose the source, type and extent of their health expense coverage;

(3) increased portability of coverage and job mobility;

(4) reduction in the amount of uncompensated care;

(5) elimination of inequities in the tax subsidization of insurance spending;

(6) reduction of incentives to over-insure;

(7) the opportunity for employers to establish total compensation levels independent of the costs of health care;

(8) the opportunity for unions to assume an expanded role for their members in providing group purchasing mechanisms, education about coverage choices, and negotiation services;

(9) potential savings to employers in the costs of benefits administration;

(10) a reduced drain on the federal treasury which would result from full implementation of present federal legislation and present AMA proposals; and

(11) enhanced use of private sector mechanisms rather than centralized public programs in financing health care.

The Council believes these goals and premises remain relevant. The Council also believes that most of these goals and premises have been addressed by AMA policy. In this report, the Council highlights the key elements of the AMA health insurance reform proposal that have been developed and refined over the past eight years.

OVERVIEW

Council Report 9 (A-98) marked a seminal shift of AMA policy away from a previous preference for employment-sponsored health insurance. In the late 1980s, AMA policy was dominated principally 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.

The AMA proposal to expand health care coverage and choice can be expressed simply with three points:

- Enable uninsured individuals and families to obtain coverage of their own choosing;

- Subsidize (via monetary assistance in the form of tax credits or vouchers) those who need financial help obtaining health insurance; and

- Foster market reforms that encourage the creation of innovative and affordable health insurance options.

At times, the AMA proposal has been criticized as being too narrowly focused on the single solution of tax credits and individually owned coverage. Recent significant policy refinements have moved toward greater support for a wider array of health system reform alternatives. Council on Medical Service Report 7 (A-03) proposed a more uniform approach toward health insurance market regulation in support of broad policy goals (Policy H-165.856, AMA Policy Database). Council on Medical Service Report 4 (I-04) evaluated and proposed options for implementing and financing tax credits, and recommended support for targeted and incremental implementation of tax credits (Policy H-165.851). Council on Medical Service Report 1 (A-05) continued the trend toward more openness to alternative 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]).

When considered together, the policies detailed in this report form a full-scale and multi-faceted proposal for expanding health insurance coverage to the uninsured. At the same time, the policies can be considered individually or in varying combinations to form an incremental and targeted approach. Either way, the flexibility of the policies positions the association for a prominent role in legislative debates in 2007 and beyond.

KEY ELEMENTS OF THE AMA REFORM PROPOSAL

The Appendix to this report lists 46 reports of the Council on Medical Service that have been presented to the House of Delegates since the adoption of the 17 recommendations in Council on Medical Service Report 9 (A-98). This section highlights key elements of AMA policy, demonstrating the multifaceted nature of the AMA proposal for health system reform.

Preference for Individually Owned Health Insurance and the Importance of Patient Choice

Patient choice of the source, type, and extent of health expense coverage is one of the most important and unwavering goals of the AMA proposal. The AMA's long-standing support of pluralism and free market competition underlies many AMA policies (Policy-165.985). Efforts that would diminish choice, such as single-payer proposals, or proposals stipulating that all individuals must have the same set of health benefits, have been persistent during the growth in the number of the uninsured. Achieving coverage for the uninsured must not compromise the ability of patients to make these important choices.

The AMA 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 which individually purchased and owned health expense coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it (Policy H-165.920[5]). Policy also states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options (Policy H-165.856). However, to ensure the health and well-being of children, the AMA policy supports that health plans or insurance policies intended for children include coverage for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services (Policy D-290.987).

Tax credits and individual ownership of health insurance create the possibility of patients having more choice of health plans than they receive through employment-based coverage. Such individually owned health insurance would be portable and would make individuals more conscientious of how they spend their health care dollars. Similarly, consumer-driven health care (CDHC) initiatives, including Health Savings Accounts (HSAs), are supported by Policies H-165.849 and H-165.852, as a means of providing individuals with more choices and more cost consciousness.

Employment Coverage and Defined Contributions

In 2000, the AMA formally rescinded policy supporting an employer mandate. The origin of AMA support for individually owned health insurance was the goal of providing patients with the power of choice. Requiring employers to provide coverage does little to achieve the goal of choice, particularly since most employers provide little or no choice of health insurance for their employees. According to a 2005 survey conducted by the Kaiser Family Foundation and the

Health Research and Educational Trust, 80% of firms offer their employees a single health plan with no choice.

Policies H-165.920[3], H-165.978[3], H-330.898 and H-40.969 support defined contribution systems for health coverage in the public and private sectors as a means of fostering beneficiary choice and cost-consciousness. The AMA advocates that employers consider converting their "defined benefit" health insurance packages to "defined contributions" for employees, in which employees are given the sum of money, typically in the form of a voucher, that would otherwise have been spent on the employer's portion of the premium. With defined contributions, employees could use that voucher toward the purchase of health insurance of their own choosing on the individual market.

To date, there has been no general trend toward defined contribution systems, despite the growth in CDHC. The forms of CDHC that are thriving are HSAs and Health Reimbursement Arrangements, which are typically arranged and provided through employment. A June 2006 study of HSAs by America's Health Insurance Plans (AHIP) found that 31% of HSAs sold on the individual market were sold to individuals who were previously uninsured, and 33% of HSAs sold in the small-group market were sold to firms that previously did not offer coverage for their employees. According to AHIP, participation in HSA plans tripled from March 2005 to January 2006, with more than 3 million individuals now enrolled.

According to a November 2005 study by the Employee Benefit Research Institute (EBRI), employment-based coverage appears to be on the decline. EBRI reported that the portion of the U.S. nonelderly population with employment-based coverage peaked at 66.8% in 2000, but declined to 62.4% in 2004. Employers will continue to provide health insurance to employees to the extent that the market demands it.

Preference for Tax Credits, Vouchers or Premium Subsidies

Policy H-165.920[13] states a preference for tax credits over public sector expansions as a means of providing coverage to the uninsured. In addition, Policy H-165.865[3] supports the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. The essential function of a tax credit is to provide a publicly funded cash contribution toward the purchase of private health insurance, with the largest subsidy going to those with the greatest need. In the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, Policy H-290.974[1] supports eligibility expansion of public sector programs, such as Medicaid and SCHIP.

Health Insurance Market Regulations

Various regulatory reforms are necessary to foster the market for individually owned health insurance. Council on Medical Service Report 7 (A-03) outlined reforms to enable the development of affordable insurance products on the individual market and addressed regulations to facilitate access for high risk individuals.

A major concern about current health insurance markets is their ability to provide affordable coverage while serving the needs of individuals with above-average health needs. The desire to

protect specific target populations has been a major force behind market regulations regarding terms of issue, premium rating, benefit mandates, and other aspects of health insurance. Existing regulations often have unintended consequences and potentially affect people differently and unfairly, depending on where they live or work. The Council's analysis found that:

(a) the combination of guaranteed issue, strict community rating, and extensive benefit mandates has disastrous unintended effects on costs, coverage, and choice;

(b) a more rational approach would include modified community rating, guaranteed renewability, and subsidization of high-risk individuals from general tax revenues;

(c) the regulatory environment should enable rather than impede private market innovation; and

(d) such a regulatory approach would improve health insurance market function whether in the context of the existing or the proposed system.

The Council proposed a more uniform approach toward health insurance market regulation, in support of protecting target populations while expanding choice and coverage for the general population. The recommendations from the report established Policy H-165.856, which supports the following principles for health insurance market regulations: (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of the type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan; (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection; (3) 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; (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium; (5) Insured individuals should be protected by guaranteed renewability; (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices; (7) Guaranteed issue regulations should be rescinded; (8) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage; and (9) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Individual Responsibility

At the 2006 Annual Meeting, the House adopted the amended recommendations of Council on Medical Service Report 3 (A-06), "Individual Responsibility to Obtain Health Insurance." These

recommendations brought renewed interest in and focus on the AMA proposal in the months following the Annual Meeting. The recommendations adopted by the House state that: (1) The AMA supports 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. (2) Upon implementation of a system of refundable tax credits or other subsidies to obtain health care coverage, the AMA supports 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 (Policy H-165.848).
Concerns have been raised that requiring individuals to obtain health care coverage creates a mandate, will potentially lead to a single payer system, and puts some individuals in an untenable position, such as those with high health expenses. The Council notes that Policy H-165.848 does not create a mandate, because high earners who choose to go uninsured could do so by paying a tax consequence. A mandate would not allow such an exception. Regarding a potentially "slippery slope" to a single payer system, the Council notes that requiring individuals to obtain coverage (with appropriate subsidies) will allow market-based reform to succeed. With respect to the inability of some individuals to obtain coverage, despite having incomes at or above 500% of the federal poverty, the Council believes additional exceptions for high health expenses may be warranted. Moreover, Policy H-165.856[3] does support risk-related subsidies such as high-risk pools, reinsurance, and risk adjustment, financed through general tax revenues rather than through strict community rating or premium surcharges, as mechanisms to assist those with high health expenses. Nevertheless, the Council believes that the details of how to subsidize high health expenses should be further developed.

In April 2006, Massachusetts passed comprehensive health system reform legislation that included provisions for individual responsibility. The Massachusetts law requires residents for whom an affordable health insurance product is available to have "creditable" health insurance coverage by July 1, 2007. The bill would require all residents to provide details about their health insurance status on their state income tax forms. Those unable to obtain an affordable plan, could obtain a waiver exempting them from the individual responsibility requirement. The law also created the Commonwealth Care Health Insurance Program, which provides subsidized insurance to individuals with incomes below 300% of the federal poverty level (FPL) who are not eligible for other publicly funded programs. In adopting 500% of the FPL as the appropriate threshold for requiring individual responsibility, the AMA determined that those with incomes below 500% of FPL could have difficulty obtaining coverage without also receiving subsidies. Similar to AMA policy, Massachusetts designed its subsidies to be on a sliding scale. In particular, those earning less than 100% FPL are eligible for total subsidization of their health insurance cost, with no premium or deductibles.

<u>Revoking or Capping the Tax Exclusion for Employment-Based Health Insurance</u>

Council Report 9 (A-98) established AMA Policy H-165.920[11], which supports replacing the exclusion from employees' taxable income of employment-based health insurance with tax credits for individuals and families. However, given subsequent budgetary constraints and the rising number of the uninsured, it became clear that revoking the tax exclusion would only partially finance tax credits large enough to provide near-universal coverage. In addition, revoking the entire tax exclusion would likely face considerable political opposition because the majority of

1 those with health insurance have employment-based coverage (62.4% of the nonelderly population
2 in 2004).
3
4 Accordingly, at the 2004 Interim Meeting, the House adopted Policy H-165.851[2], which supports
5 incremental steps toward financing individual tax credits for the purchase of health insurance,
6 including but not limited to capping the tax exclusion for employment-based health insurance.
7 There has been growing acknowledgement that the current tax exclusion of employee health
8 benefits is regressive, since employees in the higher tax brackets receive larger tax breaks than
9 those with lower incomes. The largest share of the estimated $120 billion of annually foregone
10 taxes on employment-based coverage goes to those with the highest incomes. For example,
11 someone in the lowest tax bracket – who receives $6,000 in non-taxable health care benefits – gets
12 a $600 tax break. Someone in the highest tax bracket – who receives the same $6,000 in non-
13 taxable health care benefits – gets a $2,100 tax break, which is three and a half times the amount
14 the lower income person receives. In addition, people who earn too little to owe income taxes,
15 including the working poor whose employers do not offer employment-based insurance, currently
16 receive no tax benefit.
17
18 There is growing support to at least cap the exclusion, consistent with AMA policy. Notably, in
19 November 2005, a Presidential panel charged with considering fundamental tax reform concluded
20 that revoking the exclusion for employment-based coverage could lower private health care
21 spending by between 5% and 20%. The panel's conclusion echoes the AMA's premise that
22 employment-based coverage leads to overinsurance and elevated health care spending. The panel
23 recommended a cap on the tax exclusion in which the exclusion from taxable income would be
24 limited to the first $5,000 of employee health benefits, and $11,500 for family coverage.
25 Employees and their families would be required to pay taxes on any amount that their health
26 premiums exceeded these limits.
27
28 Medical Care for Patients with Low-Incomes
29
30 The AMA supports providing Medicaid beneficiaries with vouchers adequate to enable them to
31 purchase private coverage (Policy H-165.855). A limited number of states have experimented with
32 public subsidies for private coverage for portions of their Medicaid populations. These initiatives
33 illustrate, in part, the ability of Medicaid beneficiaries to obtain private coverage.
34
35 Despite the federal requirement that all participating states ensure beneficiaries' access to medical
36 care equal to that of the general population, Medicaid patients increasingly have reason to be
37 concerned about access to physicians and other health care providers. Many states have reduced or
38 restricted eligibility, many patients feel Medicaid carries a welfare stigma, and Medicaid
39 beneficiaries often have a very limited, or no, choice of health plans and physicians. Although the
40 Medicaid program ostensibly offers a rich benefits package, the benefits increasingly are elusive in
41 many regions of the country.
42
43 With the adoption of the recommendations contained in Council on Medical Service Report 4 (A-
44 00), the AMA established support for federal tax credits that are inversely related to income,
45 refundable, and large enough to ensure that health insurance is affordable to most people (Policy
46 H-165.865). Although the AMA continued to support full enrollment of all those eligible for
47 Medicaid (Policy H-290.976 and H-165.877[13]), it seemed unfair to not allow those with the
48 lowest incomes to participate in a federal subsidy that the AMA envisions will allow greater patient

choice of health plans and physicians. Accordingly, the Council expanded the AMA proposal with the intention of eventually replacing the medical care portion of Medicaid with federal tax credits or vouchers to individuals and families, which would allow recipients to purchase coverage of their own choice.

In July 2006, the Department of Health and Human Service announced its approval of Massachusetts' Medicaid waiver to enable higher income beneficiaries to receive a Medicaid subsidy to purchase employment-based coverage. The waiver was one element of the health system reform legislation signed into law in Massachusetts in April 2006. The Centers for Medicare and Medicaid Services noted that "(t)his will allow more workers to participate in job-based insurance rather than relying on the taxpayer funded safety net pool that operates in the state with a mix of federal and state dollars."
There is a trend within the Medicaid program toward more experimentation with private sector initiatives. As described in Council on Medical Service Report 1 (I-06), three states (Arkansas, Florida, and New Jersey) have participated in the "Cash and Counseling" demonstrations for disabled and elderly Medicaid beneficiaries. In addition, the Deficit Reduction Act of 2005 established a demonstration of Medicaid Health Savings Accounts (HSAs) called Health Opportunity Accounts (HOAs) in up to ten states. Council on Medical Service Report 1 (I-06), which is before the House of Delegates at this meeting, discusses HOAs in greater detail.

Targeted and Incremental Implementation

Perhaps the most significant policy development since 1998, was the adoption of Policy H-165.851, which supports (1) 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; and (2) 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. Adopted in 2004, as part of Council on Medical Service Report 4 (I-04), this policy clarified for the first time that the AMA would support legislation that has some, but not all, of the elements of the AMA proposal.

In addition, Policy D-165.957[1] urges 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. Whereas the AMA proposal for health system reform is national in scope, advocating federal tax credits for the purchase of individually selected and owned health insurance, Policy D-165.957[1] opens the door for state demonstration projects. Local approaches may have some advantages over national approaches, such as increased cultural sensitivity and administrative feasibility. Indeed, much of progress in covering the uninsured is taking place in a number of proactive states.

OUTSTANDING POLICY DEVELOPMENT NEEDS

Although the Council believes that the AMA proposal for health system reform has continued to evolve progressively, it believes that this overview reveals several gaps in policy development that should be addressed.

Definition of Required Health Insurance Benefits

The policy supporting federal tax credits, and the more recent policy on individual responsibility, raises the question of what constitutes "adequate" coverage, which is one element of the first advantage of the proposal as articulated in Council Report 9 (A-98). AMA policy supports limiting benefit mandates and the AMA has rescinded policies outlining minimum and standard benefit packages. The Council believes a need exists to further review the scope of required health insurance benefits for such benefits to qualify for purposes of a tax credit or other federal subsidy.

Financing Chronic Illness and Catastrophic Health Expenses

AMA policy on defined contributions, consumer-driven coverage such as HSAs, and individual responsibility amplify concerns about high-risk patients, or those who have had a catastrophic event. The Council believes more work needs to be undertaken to better meet the AMA's primary goal of moving toward a system of individually owned health insurance, which is intended to increase access for all persons, including those who are disadvantaged economically or by health risk.

As the percentage of employees with employment-based coverage continues to decline, it is likely more employers will switch to defined contribution systems. While this may be a positive development for employees seeking greater choice and control over their health care, it may pose a problem for high-risk individuals as healthier persons gravitate disproportionately to less expensive, less generous plans. By reducing pooling – and cross-subsidies – across risk groups, these alternative strategies present a tradeoff between, on the one hand, expanding coverage of low-risk individuals and expanding patient choice and, on the other hand, preserving the cross-subsidies which support more comprehensive insurance.

In addition, despite previous Council work on mechanisms such as re-insurance, risk adjustment, high-risk pools, and the structure of tax credits, the Council believes that with the new requirement for individual responsibility, there is merit in further developing how best to finance care for those whose episodes or conditions have predictably high costs. Previous Council work has been focused on separate elements of health insurance and has intended to serve the general population of health insurance users. The Council is well aware that even with widespread eligibility for tax credits and defined contributions, and even after market transformation, individuals with predictably high health costs may need special assistance in order to obtain coverage.

New Tax Credit Simulations

In 2000, the AMA initiated and completed a detailed set of tax credit simulations (AMA Center for Health Policy Research, "Tax Credit Simulation Project Technical Report," June 2000, Discussion Paper 00-1). The 2000 simulations modeled five scenarios that varied according to the size of tax credits, income level, and whether the credit was capped at a given income level. Since then, the AMA has adopted numerous policy refinements. With the increasing viability of the AMA proposal, there are increasing calls for the AMA to provide estimates of the cost. The Council believes that the AMA should conduct new tax credit simulations incorporating these new policy developments. New estimates could model partial caps of the exclusion, focus on various targeted populations, and incorporate the impacts of favorable health insurance market regulations, all of which are elements not considered in the first tax credit simulation.

DISCUSSION

Despite the numerous and continually evolving policy refinements described in this report, AMA policy on health system reform has been criticized for being too narrow and overly complicated. The Council believes that many of these criticisms are unfounded because AMA policy clearly allows advocacy to be targeted and incremental. As described in this report, AMA policy is flexible and multifaceted, enabling the AMA to speak to and support many types of proposals for health system reform. Indeed, although policy states a preference for tax credits over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[13]), the AMA supports eligibility expansions of public sector programs, such as Medicaid and the Children's Health Insurance Program, in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance (Policy H-290.974[1]).

The maturity of AMA policy on health system reform has proven very helpful in discussions with broad consensus groups. Many groups, health-related or otherwise, have proposals with little or no detail. Serious efforts to expand health insurance coverage require details about eligibility, financing, and administration. The Council believes the AMA reform proposal requires additional policy refinement regarding the scope of health care benefits, the financing of care for those with high health expenses, and in the critical estimation of the cost and coverage gains of implementing a system of tax credits. The Council anticipates that new tax credit simulations may lead to the answers for some of the outstanding policy questions. The simulations also may yield empirical evidence of the tradeoffs between different policy scenarios. With the recommendations to address these outstanding policy issues, the Council believes the AMA proposal for health system reform will be strengthened and will continue to be well received.

RECOMMENDATIONS

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

1. That our American Medical Association review the appropriate scope of required health insurance benefits for such benefits to qualify for purposes of tax credit or other federal subsidy. (Directive to Take Action)

2. That our AMA review the financing of health care for and/or insurance coverage for those with chronic illness or who are experiencing catastrophic health expenses. (Directive to Take Action)

3. That our AMA conduct new tax credit simulations on varying components of its proposal to expand health insurance coverage and choice. (Directive to Take Action)

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

Fiscal Note: Conduct new tax credit simulations at an estimated total cost of $100,000.

APPENDIX

Council on Medical Service Reports Since the Adoption of CMS Report 9 (A-98) Pertaining to Policy Refinements or Policy Reviews of Health System Reform

1. Defining the Uninsured and Underinsured (CMS Report 15, I-98)
2. Status Report on Increasing Access to the Uninsured (CMS Report 2, A-99)
3. Socioeconomic Factors Impacting on the Patient-Physician Relationship (CMS Report 7, I-99)
4. Critical Expansion of Medical Savings Accounts (CMS Report 10, I-99)
5. Tax Credit Simulation Project (CMS Report 16, I-99)
6. Principles for Structuring Health Insurance Tax Credits (CMS Report 4, A-00)
7. Benefits and Limitations of an Individual Mandate for Individually Owned Health Insurance (CMS Report 5, A-00)
8. The Effects of Individually-Owned Health Insurance on Risk Pooling and Cross Subsidization (CMS Report 3, A-01)
9. Evolving Internet-Based Health Insurance Marts (CMS Report 5, A-01)
10. Status Report on Expanding Coverage to the Uninsured (CMS Report 6, A-01)
11. Uninsured Immigrants (CMS Report 8, A-01)
12. Modifications to the AMA Standard Benefits Package (CMS Report 8, I-00)
13. Impact of Eliminating the Current Threshold for Deductibility of Medical Expenses (CMS Report 5, A-02)
14. Advocating Health Insurance Tax Credits (CMS Report 10, A-02)
15. Growth in Health Care Costs and Health Insurance Premiums (CMS Report 13, A-02)
16. Medicaid Spend-down Eligibility Criteria (CMS Report 2, I-02)
17. Medical Savings Accounts and Health Care Coverage of Dependents and Children (CMS Report 3, I-02)
18. Tax Relief for Physicians Serving Uninsured and Underinsured Patients (CMS Report 5, I-02)
19. Review of U.S. Health System Financing (CMS Report 8, I-02)
20. Establishing Multi-Year Mutual MSA Trust Accounts (CMS Report 2, A-03)
21. Health Insurance Market Regulation (CMS Report 7, A-03)
22. Medical Care for Patients with Low Incomes (CMS Report 8, A-03)
23. Restructuring Medicare in the Short-Term (CMS Report 9, A-03)
24. Health Coverage Tax Credit Program Under the Trade Act of 2002 (CMS Report 11, A-03)
25. Medical Care for Patients with Low Incomes (CMS Report 1, I-03)
26. Health Reimbursement Arrangements (CMS Report 3, I-03)
27. Restructuring Medicare for the Long-Term (CMS Report 5, I-03)
28. Comparing Health Insurance Premium Subsidies and Tax Credits (CMS Report 2, A-04)
29. Federal Health Insurance Reserve System (CMS Report 3, A-04)
30. Health Savings Accounts (CMS Report 6, A-04)
31. Eligibility Age for Medicare Beneficiaries (CMS Report 1, I-04)
32. Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance (CMS Report 4, I-04)
33. State Options to Improve Coverage for the Poor (CMS Report 1, A-05)
34. Containing Catastrophic Care Costs (CMS Report 5, A-05)
35. Update on the Individual Health Insurance Market (CMS Report 6, A-05)

36. Offsetting the Costs of Providing Uncompensated Care (CMS Report 8, A-05)
37. Status Report on Providing Health Care Coverage to All Individuals, with an Emphasis on the Uninsured (CMS Report 1, I-05)
38. Update on HSAs, HRAs, and Other Consumer-Driven Health Care Plans (CMS Report 3, I-05)
39. Reinsurance and the Health Insurance Market (CMS Report 4, I-05)
40. Association Health Plans (CMS Report 5, I-05)
41. Policy Options for Addressing Medicaid Long-Term Care (CMS Report 6, I-05)
42. Health System Expenditures (CMS Report 1, A-06)
43. Individual Responsibility to Obtain Health Insurance (CMS Report 3, A-06)
44. Comparison of Selected International Health Care Systems (CMS Report 5, A-06)
45. Medicare/Medicaid Dual Eligibles (CMS Report 6, A-06)
46. Store-Based Health Clinics (CMS Report 7, A-06)

These and all Council on Medical Service reports presented to the House of Delegates since 1998 are available online at www.ama-assn.org/go/cms.