

Expanding health insurance:  
**The AMA proposal for reform**

The American Medical Association proposal



# Table of contents

	<b>Page</b>
Introduction.....	1
The high number of uninsured Americans .....	2
The current subsidy for health insurance .....	4
The AMA proposal: Health insurance for all Americans.....	5
Enabling individuals to own and choose health insurance.....	5
Establishing tax credits or vouchers for the purchase of health insurance .....	6
Facilitating market innovation .....	7
Health care equity for the most vulnerable Americans .....	10
Greater responsibility for those with high incomes.....	11
Two case studies .....	13
Conclusion .....	16
Glossary of terms .....	17
20 questions about the AMA proposal.....	20

# Introduction

Enabling every American to have health insurance is a top priority of the American Medical Association (AMA). In recent years, we have seen that a persistently high portion of Americans have lacked health insurance. Today there are an estimated 46.6 million uninsured Americans.

This booklet details our proposal for covering the uninsured in the United States by building on the current system. It presents a number of steps that can be taken to ensure that individuals are fully enabled to obtain the health insurance they want.

The AMA proposal to expand health care coverage and choice requires both social and individual responsibility. The pillars of the AMA proposal are:

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

We also believe that individuals with high incomes have a responsibility to obtain coverage for themselves and their families.

Under our proposal, individuals who are satisfied with the coverage they have will be able to maintain that coverage. Those who are uninsured or dissatisfied with their current coverage will be able to purchase the coverage they want. Our proposal is detailed in the remainder of this booklet.

# The high number of uninsured Americans

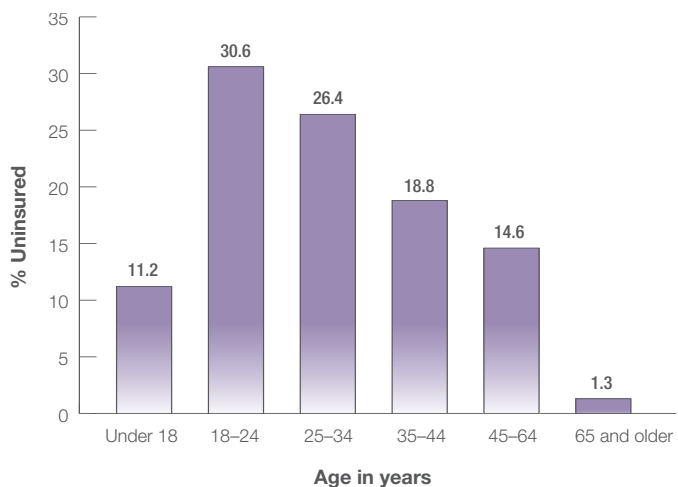
Lack of health insurance poses problems for both individuals and society. The uninsured often defer obtaining medical care and preventive services, jeopardizing their health and the healthy development of their children. Often, when they do seek medical attention, the treatment of their condition is more difficult and more costly.

Since the late 1990s, at least 40 million Americans have been without health insurance every year. In August 2006, the Census Bureau reported an all-time high number of 46.6 million Americans (15.9 percent of the population) who were uninsured in 2005. The biggest driver behind the increase in the uninsured in recent years 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. Between 2004 and 2005, the number and percent of children without health insurance increased from 7.9 million (10.8 percent) to 8.3 million (11.2 percent).

As noted in Figures 1–3, the segments of the population most likely to be uninsured are young adults, employees in smaller firms and those making relatively low wages. Among the uninsured, the vast majority (nearly 81 percent) are employed or in households headed by workers. According to a 2005 survey of employer health benefits,

**Figure 1**

Population likelihood of being uninsured by age, 2005

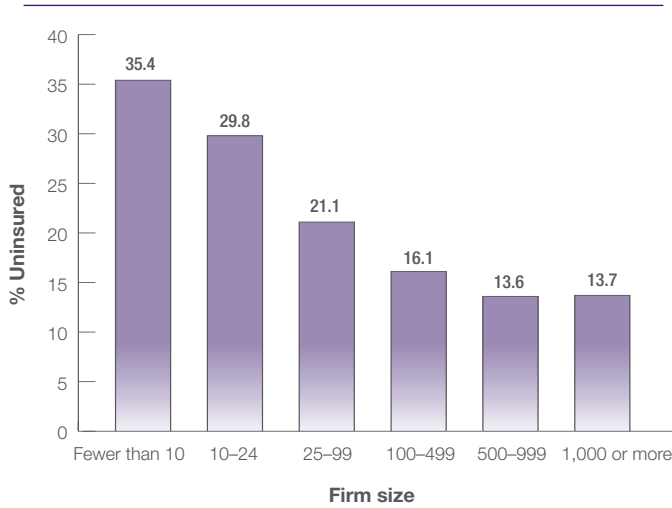


Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," August 2006, Table 8

the percentage of employers offering health coverage has declined significantly in recent years. In 2000, 69 percent of firms offered health benefits to their employees, but only 60 percent of firms offered coverage in 2005 (the Kaiser Family Foundation/Health Research and Educational Trust Employer Health Benefits 2005 Annual Survey).

**Figure 2**

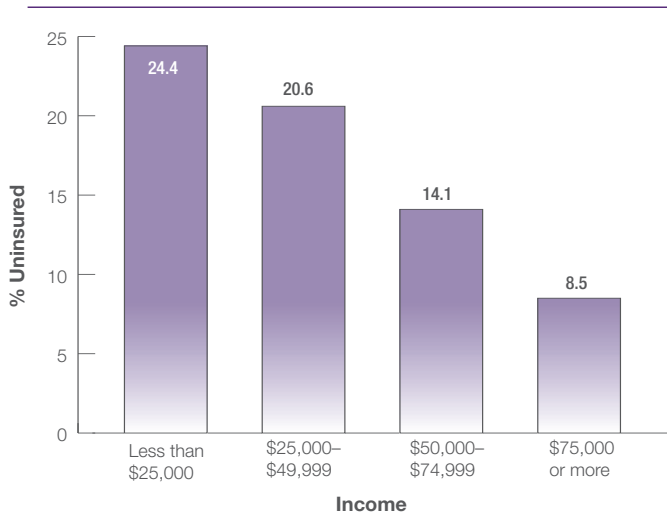
Nonelderly population likelihood of being uninsured by firm size, 2004



Source: Employee Benefit Research Institute, "EBRI Notes," November 2005, Figure 10

**Figure 3**

Population likelihood of being uninsured by household income, 2005



Source: U.S. Census Bureau, "Income, Poverty, and Health Insurance Coverage in the United States: 2005," August 2006, Table 8

## The current tax exclusion of employment-based coverage is a subsidy

Employment-based health benefits are excluded from taxable income. Someone in the 28 percent tax bracket with employment-based health insurance worth \$5,000 receives a \$1,400 tax subsidy (28 percent of \$5,000), whereas someone in the 15 percent tax bracket with the same health benefits receives only a \$750 subsidy (15 percent of \$5,000). On average, lower-income people also have less expensive coverage.

Those who receive health insurance benefits through their employers receive those benefits in lieu of higher wages. If instead, such workers received higher wages, those higher wages would be taxed as income. Indeed, employees who do not receive health benefits through their employers are taxed on all of their income and, if they want health insurance, they must purchase it without any subsidy.

During the last decade, there has been growing acknowledgment that the estimated \$100 billion annual federal subsidy for employment-based health insurance is unfair and inefficient. On one hand, 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, especially given that the insured indirectly pay for a substantial portion of the health care of the uninsured through higher taxes and insurance premiums. On the other hand, it is grossly unfair that the uninsured, most of whom either work or are in a family headed by a worker, do not have access to the health insurance subsidies enjoyed by others.

Similarly, the proportion of Americans under age 65 with employment-based health coverage fell sharply from 66.8 percent in 2000 to 62.4 percent in 2004, according to a November 2005 study by the Employee Benefit Research Institute.

In addition, according to the Kaiser Family Foundation's 2005 Annual Survey of Employer Health Benefits, 60 percent of firms offering coverage shopped for a new plan in the last year. Of those firms, 24 percent changed plans and 30 percent changed the type of plan offered to employees, meaning many patients may have had to change physicians.

The elderly are covered by Medicare, certain categories of the poor are covered by Medicaid, and most Americans are covered by employment-based health insurance. Nevertheless, the number of uninsured Americans has increased along with double-digit increases in health insurance premiums for the past four years. Uninsured workers contribute, through taxation, to the financing of Medicare and Medicaid beneficiaries, and to the subsidization of those with employment-based coverage.

## The current subsidy for health insurance

The prominence of employment-based coverage arose out of the price and wage controls that were imposed during World War II, which encouraged employers to offer health insurance and other non-wage benefits in order to provide competitive remuneration to employees, who were in high demand during the war. Subsequently, the Internal Revenue Service (IRS) ruled that employer costs for employee health insurance could be excluded from taxable compensation for the employee. That IRS ruling still stands, although it is obsolete for today's work force, which is substantially different from the work force of the 1940s and 1950s. Workers are much more mobile now, which, in a system of employment-based health insurance, means that coverage changes often. Employers did not anticipate the rise in health care costs until decades after employment-based coverage had become an entrenched worker expectation.

Currently, the government subsidizes the purchase of health insurance by excluding expenditures on health insurance from an individual's or family's taxable income—but only if insurance is obtained through an employer, and usually only on that portion of the premium paid for by the employer. The self-employed can deduct 100 percent of their insurance costs. No tax break is given to individuals who purchase their own health insurance, or to workers whose employers do not offer coverage.

The current system for subsidizing health insurance can be difficult to understand. The amount of subsidy someone gets—if any—is based on whether the coverage is job-related, how expensive the premiums are, and the person's tax bracket. Under the AMA proposal, the subsidy for health insurance would be simple and straightforward. The subsidy would be based on income, regardless of how expensive the coverage is or where it was obtained.

## The AMA proposal: Health insurance for all Americans

The AMA proposal would expand health insurance coverage by redirecting the current health insurance subsidy from higher to lower income groups, which are most likely to be uninsured. The AMA proposal allows for the continuation of employment-based insurance in the private sector, while encouraging new sources of health insurance that would be available to both the uninsured and the currently insured.

The three main elements of the AMA proposal for expanding health insurance coverage are:

- Enable the selection, choice and purchase of individually owned health insurance.
- Establish income-related, refundable and advanceable tax credits for purchasing health insurance.
- Facilitate the development of markets for the purchase of individually owned health insurance.

### Enabling individuals to own and choose their health insurance

Currently, only one in six employers offering health insurance offers a choice of plans. Under the AMA proposal, individuals, rather than employers, would choose the kind of coverage they want, whether through an employer or not. Patients could keep or change their plan regardless of where they work. This, in turn, would greatly increase competition and innovation in the health insurance market, resulting in better choices for everyone.

### Targeted and incremental approach

The AMA believes tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured.

Recognizing finite resources, the AMA supports implementing individual tax credits for the purchase of health insurance for specific target populations such as low-income workers, low-income individuals, children, and the chronically ill.

In addition, the AMA supports incremental steps toward financing tax credits, including but not limited to capping the tax exclusion of employment-based health insurance.

The AMA also supports innovative state-based demonstration projects, including, but not limited to, implementing income-related, refundable and advanceable tax credits.

## Tax credits and vouchers

Throughout this document, the AMA refers to the use of tax credits as an efficient and equitable means of subsidizing health care. Unlike many tax credits, those proposed by the AMA would be designed to apply specifically to those most likely to be uninsured. The AMA recognizes that other forms of subsidization may in fact be more practical for certain populations.

Accordingly, the AMA supports the use of vouchers, premium subsidies or direct dollar subsidies if they are designed in a manner consistent with AMA principles for structuring tax credits and if they enable individuals to purchase health insurance of their choice.

## Establishing tax credits or vouchers for the purchase of health insurance

The current subsidy for employment-based health insurance is regressive. It should be replaced with refundable and advanceable tax credits to all individuals or families who purchase health insurance. Under the current system, individuals obtain tax benefits simply by virtue of the fact that their employers' expenditures on health insurance are not included as taxable income. Under the AMA's proposed system, employer contributions to health insurance would be reported as taxable compensation and individuals would directly subtract health insurance tax credits from their tax bills.

The AMA believes that expanding health insurance coverage through the use of tax credits should be guided by the following principles:

### **The size of tax credits should be inversely related to income.**

Those with lower incomes should receive greater subsidies than those with higher incomes. Targeting subsidies toward those who would otherwise most likely be uninsured conserves budgetary resources.

### **Tax credits should be contingent on the purchase of health insurance, so that if insurance is not obtained, the credit is not provided.**

This principle provides a strong incentive for people to obtain health insurance voluntarily. Individuals and families could receive tax credits whether they obtain their health insurance through employment or elsewhere.

### **Tax credits should be refundable.**

Tax credits should be refundable so that those with low incomes would receive a check or voucher from the government, even if they owe less in taxes than the value of the tax credit. Those with higher incomes would use their tax credits to partially offset their tax liability.

### **Tax credits or vouchers should be available in advance for those with low incomes.**

Tax credits should be advanceable so that those with low incomes, and those who cannot afford the monthly out-of-pocket premium costs, would be able to purchase coverage without waiting for the year-end tax reconciliation process.

### **The size of tax credits should be large enough to ensure that health insurance is affordable for most people.**

Tax credits need to be large enough to empower virtually all individuals to obtain and maintain health insurance. At the lowest income levels the credit must approach 100 percent of the premium.

Expanding health insurance: **The AMA proposal for reform**

**The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums.**

In general, tax credits should mirror the pricing structure of health insurance premiums for individuals and families, with premiums for family policies being less than the sum of premiums for individual members.

**Tax credits should be fixed-dollar amounts for a given income and family structure.**

In order to encourage individuals to be cost-conscious and to discourage overinsurance, the size of credits should be independent of health insurance expenditures.

**The size of tax credits should be capped in any given year.**

The preceding principle calls for tax credits to be fixed-dollar amounts. If tax credits are nevertheless designed to vary with the price of insurance, the credits should be capped to prevent overinsurance.

**Tax credits for families should be contingent on each member of the family having health insurance.**

In the absence of this requirement, individuals might “game” the system by purchasing coverage only for themselves and not their healthy children, waiting to seek coverage for the children only when they experience a need for health care. This principle ensures maximum coverage.

**Tax credits should be applicable only for the purchase of health insurance, and not for out-of-pocket health expenditures.**

This principle limits the tax credits to the purchase of health insurance coverage, including health savings accounts. Allowing tax credits to be used for out-of-pocket expenses could encourage excess use of health services, would likely require detailed rules regarding which expenses qualify for credits, and could reduce incentives to purchase health insurance. Separate subsidies should be considered for those individuals whose out-of-pocket health spending is atypically high due to chronic disease or health catastrophe.

## **Facilitating market innovation**

Empowering people with tax credits and freedom of choice will dramatically transform today’s health insurance markets. The new system will make health plans more responsive to patients, rein in health care costs, and stimulate the development of new forms of insurance that better meet the wide range of needs of individuals and families. The AMA supports the development of health insurance markets that offer a wide range of affordable coverage options, as well as alternative means of pooling risk along

## **Need for regulatory reform**

In order for tax credit proposals and individual insurance to be viable, a number of regulatory reforms should be implemented. As in the existing employment-based system of health care financing, a major concern for the AMA proposal is the ability of health insurance markets 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 involving terms of issue, premium rating, benefit mandates and other aspects of health insurance.

Existing regulations often have unintended consequences and unfairly affect people differently depending on where they live or work. For example, the combination of guaranteed issue, strict community rating, and extensive benefit mandates has had disastrous unintended effects on costs, coverage and choice. Such regulations also can be burdensome, complex and contradictory.

the lines of existing prototypes, such as small group purchasing alliances and Internet-based health insurance vendors.

The AMA recognizes that for markets to function properly, it is important to establish fair ground rules. The huge number of state and federal health insurance market regulations has created as many problems as it has solved. Regulations intended to protect high-risk individuals have typically backfired by driving up premiums and leading a disproportionate number of young, healthy individuals to go without coverage. The AMA believes that a more rational regulatory environment would: assist high-risk individuals without unduly driving up health insurance premiums for the rest of the population; give individuals incentives to be continuously insured; and enable rather than impede private market innovations such as health savings accounts (HSAs), health reimbursement arrangements (HRAs), other forms of consumer-driven health care plans, defined contribution plans and new forms of coverage. In particular, the AMA supports the following principles for health insurance market regulation:

**There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location or type of health plan.**

There is clearly a need for greater rationalization and uniformity of regulations across all health insurance markets. Differential regulations add to administrative costs, impede formation of group purchasing alliances, prevent realization of economies of scale, and create adverse selection. Insurers are likely to consent to, or even welcome, certain regulations as long as they know that they are operating on an even playing field in which all insurers and plans must play by the same rules.

**State variation in market regulation is permissible as long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and as long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.**

Limited state variation in market regulation should be permitted if the impact on the cost does not make coverage unaffordable.

**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.**

Targeting risk-related subsidies through general tax revenues provides desired protections while permitting insurance markets to function properly and make high-risk individuals more attractive to insurers. High-risk pools for high-risk patients give insurers reassurance that they are unlikely to end up with extremely high costs in the “regular” market. Accordingly, high-risk pools allow

insurers to offer lower premiums, making coverage attractive to the young and healthy.

**Strict community rating should be replaced with modified community rating, risk bands or risk corridors.**

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. Evidence suggests that de facto age rating occurs under employment-based insurance because wages adjust to account for the fact that older workers incur higher health care costs.

**Insured individuals should be protected by guaranteed renewability.**

Allowing a fair degree of individual premium variation at the initial point of enrollment, along with guaranteed renewability, will encourage individuals to maintain their coverage. Guaranteed renewability would protect individuals from losing coverage or being singled out for premium hikes due to changes in health status.

**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.**

Limited “re-underwriting” of insured individuals who switch health plans would provide additional and powerful incentives for individuals to obtain and maintain coverage when healthy.

**Guaranteed issue regulations should be rescinded.**

Guaranteed issue and community rating can backfire, especially when paired together. Attempts to lower premiums for high-risk individuals can raise premiums of low-risk individuals, reducing their enrollment and, thereby, driving up average costs and premiums.

**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 multiyear insurance contracts should be identified and removed.**

Differential regulations regarding the formation of group purchasing alliances, benefit mandates and barriers to multiyear insurance contracts can add to administrative costs, prevent economies of scale and create adverse selection. Uniform regulatory reform is needed to foster a health insurance market that is viable and sustainable.

Expanding health insurance: **The AMA proposal for reform**

## The individual market

Higher per-enrollee administrative and marketing costs make premiums for comparable coverage higher on the individual market than through the group market. Higher premiums for given coverage are exacerbated by the lack of tax subsidy for individually purchased coverage that exists for employment-based insurance. On the other hand, individual market coverage is portable, especially during periods of job transition, and there is generally greater plan choice, particularly for lower-cost options.

A 2005 study conducted by eHealthInsurance Inc. found that actual premiums paid for individual market coverage are, on average, markedly lower than group market premiums: \$1,776 vs. \$4,042 per year, or 60 percent lower for single coverage, and \$3,972 vs. \$10,456, or 62 percent lower for family coverage. These substantial premium differences are attributable in large part to the fact that many people, when given a choice, opt for less generous coverage than is typically offered by employers. The study excluded health savings account plans, and reported that the major medical plans were largely preferred provider organizations (86 percent) and that more than 90 percent provided comprehensive coverage.

The individual health insurance market will expand and evolve once individuals receive tax breaks for health insurance of their choice. Individuals will have a wider range of choices from a market that is more responsive to individual, rather than employer, demand.

## A state-based approach to expanding coverage to the uninsured

Over the past decade, there have been a number of proposed approaches to increase the number of Americans with health insurance coverage. Nevertheless, the number of uninsured continues to rise. No national consensus has emerged to generate legislation that covers a broad spectrum of the uninsured population. Given the failure at the national level, the AMA supports a state-based strategy, in which states are empowered to implement health system reform within their borders.

State governments should have the freedom to develop and test different models for improving coverage for patients with low incomes. Federal rules and federal financing should be changed to enable states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds.

# Health care equity for the most vulnerable Americans

The AMA tax credit proposal, with its focus on equity and fairness and its particular concern for those with low incomes, is an ideal strategy to address systemic problems of the Medicaid program.

The Medicaid program is jointly financed by the federal government and the states. All participating states are required to ensure beneficiaries' access to medical care equal to that of the general population. Unfortunately, Medicaid patients often face difficulties accessing physicians and other health care providers. Although the Medicaid program ostensibly offers a rich benefits package, the benefits increasingly are elusive in many regions of the country.

The structure and financing of the current Medicaid program is crumbling. As Figure 4 demonstrates, states already have and plan to continue to reduce Medicaid benefits; reduce and/or restrict optional Medicaid eligibility categories; increase Medicaid beneficiary cost-sharing; and freeze and/or reduce Medicaid payments to physicians and other health care providers.

**Figure 4**

Changes in state Medicaid policies, 2002–2006

Changes in state Medicaid policies	Number of states				
	'02	'03	'04	'05	'06
Reduced or froze provider payments	22	50	50	50	50
Reduced patient benefits	9	18	19	7	16
Reduced or restricted optional eligibility categories	8	25	21	8	14
Increased patient cost-sharing obligations	4	17	20	8	13
Controlled prescription drug costs	32	46	48	43	41

Source: Kaiser Commission on Medicaid and the Uninsured: Publication; #4087-04).

As a long-term strategy, the AMA recommends that the medical care, as distinct from long-term care, portion of the Medicaid program be replaced with federally financed vouchers or tax credits to allow patients to purchase coverage individually and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP), with varying cost-sharing obligations based on income and eligibility under the current Medicaid program. Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive an amount

that is large enough to enable them to purchase coverage with no cost-sharing obligations. Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive an amount that is large enough to enable them to purchase coverage with limited cost-sharing.

Low-income individuals who do not qualify for Medicaid's current categorical eligibility standards, and cannot afford to purchase health insurance, should receive federally issued tax credits or vouchers that are large enough to enable them to cover a substantial portion of their coverage, with moderate cost-sharing.

## Greater individual responsibility for those with high incomes

Everyone pays inflated premiums because of the costs associated with treating the uninsured, and these inflated premium rates constitute an additional barrier to coverage for the uninsured.

The AMA supports requiring individuals and families earning greater than 500 percent of the federal poverty level (FPL) to obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care. The AMA believes that individuals and families at 500 percent of FPL (\$49,000 for individuals and \$100,000 for a family of four) clearly pass a threshold of responsibility. There should be tax implications for noncompliance. Society should not be penalized by the potentially costly medical treatments of those uninsured who can afford to purchase health insurance coverage. Figure 5 provides the 2006 federal poverty guidelines.

### Figure 5

Federal poverty guidelines, 2006

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

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

It is important to recognize that “individual responsibility” with tax implications for noncompliance, is distinct from an “individual mandate,” which implies that the failure to obtain coverage could result in criminal penalties.

The vast majority of the uninsured (89 percent) have incomes below 500 percent of the FPL (see Figure 6). AMA support for requiring that these individuals and families obtain coverage is contingent upon implementation of a system of refundable tax credits or other subsidies.

The AMA proposal for health system reform is fundamentally concerned with those most likely to be uninsured—those at the lowest income levels. In fact, support for the requirement that those with high incomes obtain health care coverage is borne of the concern that such individuals do not strain the health care safety net, which is intended for those with the lowest incomes.

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

### Figure 6

Uninsured by FPL, 2004

<b>% Uninsured</b>	<b>% of FPL</b>
25	Less than 100%
28	100–199%
19	200–299%
11	300–399%
6	400–499%
11	Over 500%
100	Total

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

# Two case studies

Unlike many of the tax credit proposals introduced in the U.S. Congress, there is no specific single tax credit in the AMA plan. How an individual or family would be affected by the switch from the tax exclusion to income-related, refundable tax credits depends on existing coverage, the relevant tax bracket and the amount of tax credit for given income levels.

The examples on the following pages illustrate how a family of four in different income brackets might be affected by replacing the tax exclusion with tax credits. As the examples show, any changes will depend on income levels and both current and future coverage choices. The following definitions apply to the examples:

---

Current tax subsidy =  
 $(\text{federal tax rate}) \times (\text{employer premium share}) \times (\text{premium})$

---

Effective premium, or after-tax premium =  
 $(\text{premium}) - (\text{tax subsidy})$

---

## Employers and employees win with defined contributions

The AMA encourages employers to consider providing employees with a defined contribution toward the purchase of their own choice of coverage, rather than the defined benefit of health insurance chosen by the employer. Employers gain greater predictability of costs, and workers gain enhanced control over their earnings and health benefits. Defined contributions from different household members could be combined to purchase more generous family coverage, and could be combined with tax credits.

### Family No. 1 (income \$50,000)

A family of four with annual taxable income of \$50,000, in the 15 percent tax bracket, files jointly, and has employment-based insurance. The employer's share is 75 percent of a \$10,000 health insurance premium.

#### Current tax exclusion for Family No. 1

---

Current tax subsidy .....(0.15) x (0.75) x (\$10,000) = \$1,125

---

Effective premium .....\$10,000 - \$1,125 = \$8,875

---

Effective premium as a share

of taxable income .....(\$8,875/\$50,000) = **18%**

---

Under the current exclusion, the family receives a subsidy of \$1,125 by not paying taxes on the portion of compensation given as the employer's share of the health insurance premium. Thus, the effective premium is reduced from \$10,000 to \$8,875, representing 18 percent of the family's income.

Now, let's say that the exclusion were replaced with tax credits for the purchase of health insurance, and that Family No. 1 qualified for a \$6,000 tax credit. The employer's share of the premium becomes subject to federal income tax thereby increasing taxable income to \$57,500, but now the family subtracts the tax credit from its tax bill.

#### Illustrative tax credit for Family No. 1

---

New tax subsidy (actual dollar amounts could differ) .....\$6,000

---

Additional income tax (through loss of current tax exclusion) .....\$1,125

---

Net change in tax subsidy.....\$6,000 - \$1,125 = \$4,875

---

Effective premium.....\$10,000 - \$6,000 = \$4,000

---

Effective premium as a share of

taxable income .....(\$4,000/\$57,500) = **7%**

---

With a \$6,000 tax credit for the purchase of family health insurance coverage, the change in subsidy would be a gain of \$4,875. The tax credit reduces the effective premium from \$10,000 to \$4,000. The effective premium now represents 7 percent of the family's income.

*Note about these hypothetical case studies: The effect of replacing the tax exclusion with tax credits will depend on income levels, the size of the tax credits, and coverage choices.*

## Family No. 2 (income \$150,000)

A family of four with annual taxable income of \$150,000, in the 28 percent tax bracket, files jointly and has employment-based insurance. The employer's share is 75 percent of a \$10,000 health insurance premium.

### Current tax exclusion for Family No. 2

---

Current tax subsidy..... $(0.28) \times (0.75) \times (\$10,000) = \$2,100$

---

Effective premium..... $\$10,000 - \$2,100 = \$7,900$

---

Effective premium as a share of  
taxable income..... $(\$7,900/\$150,000) = \mathbf{5\%}$

---

Because of the current exclusion, this family receives a subsidy in the form of a \$2,100 reduction in income taxes. The subsidy makes the effective premium \$7,900, or 5 percent of family income. (Note that under the current system, Family No. 2 effectively pays a lower premium than Family No. 1 for the same coverage.

If the exclusion were replaced with tax credits, and there was an income cutoff for tax credit eligibility of \$125,000, then this family would not receive a tax credit.

### Illustrative tax credit for Family No. 2

---

New tax subsidy (again, actual dollar amounts could differ) .....\$0

---

Additional income tax (through loss of current exclusion).....\$2,100

---

Net change in tax subsidy..... $0 - \$2,100 = - \$2,100$

---

Effective premium..... $\$10,000 - \$0 = \$10,000$

---

Effective premium as a share  
of taxable income..... $(\$10,000/\$157,500) = \mathbf{6\%}$

---

With a \$0 tax credit for the purchase of family health insurance coverage, the change in subsidy would be a loss of \$2,100. Thus, the effective premium is simply the full \$10,000 premium, or 6 percent spent on coverage of Family No. 2's income, still a lower proportion of income than Family No. 1.

## Financial feasibility

The AMA proposal is financially feasible precisely because of the tax changes that are recommended. In 2004 the federal government provided approximately \$100 billion per year in tax subsidies for health insurance through the tax exclusion of employment-based insurance. This is tax revenue that the government forgoes by not counting employee health benefits as taxable income. By eliminating the tax exclusion, the federal government could collect nearly \$100 billion to provide tax credits to cover the uninsured without incurring any additional costs.

Because some believe that eliminating the exclusion may be politically difficult to achieve, the AMA supports incremental steps toward financing tax credits, such as capping the amount of the tax exclusion for employment-based health insurance.

# Conclusion

Against a backdrop of escalating health care costs, swelling ranks of the uninsured and mounting public pressure for reform, there is now growing support for a system of individual tax credits or other subsidies from a diverse array of policymakers and organizations. Academic research demonstrating the viability of tax credit proposals has been conducted at a variety of universities, and think tanks of disparate political leanings have put forth individual tax credit proposals. A number of business and professional associations also have proposed individual tax credits. There also is increasing agreement that individuals have a greater responsibility to obtain coverage for themselves and their families.

When compared with alternative proposals for expanding health insurance coverage to the uninsured, the AMA proposal has several advantages, even when the comparison is with other tax credit proposals. The AMA proposal is fair because it seeks to replace a regressive subsidy, available only to those with employment-based coverage, with a universal and progressive approach that emphasizes individual choice and affordability.

The AMA proposal also is well-suited to incremental changes, although the impact of revising the tax treatment of health insurance expenditures will be profound. The AMA believes that individually owned health insurance, accomplished through fundamental changes in the current tax and individual insurance market systems, would provide the best opportunity to reverse the growth in the number of the uninsured, while also increasing the health plan choices of all Americans.

The AMA proposal retains a market-based approach to health insurance coverage, while addressing the multitude of problems caused by the current subsidy. In addition to the relentless rise in the number of uninsured individuals, the current system is marked by soaring costs and patient and physician discontent. Only when individuals, rather than employers, have the ability to select and own health insurance, will there be increased stability in the system.

Most importantly, the AMA proposal promises to expand health insurance coverage to nearly all Americans in a manner that is affordable for individuals and fiscally sound for the nation.

# Glossary of terms

**Advanceable tax credit:** Many tax credits are designed to be received at year's end as part of the tax reconciliation process. However, those with low incomes may not be able to purchase coverage without first receiving the credit. Therefore, the AMA supports advancing funds for the purchase of coverage for low-income persons who could not afford the monthly out-of-pocket premium costs. The Food Stamp Program provides a model of how subsidies can be advanceable to those with low incomes.

**Adverse selection:** The process known as adverse selection occurs when sick and healthy individuals choose separate types of coverage, which has the effect of making the option chosen by sick individuals more costly.

**Community rating:** Under a system of pure community rating, the price of insurance to all those who are eligible for coverage depends on an analysis of the health care costs in the community or region. Community rating does not take into account the individual characteristics of those eligible for coverage, such as age and sex. See also "modified community rating."

**Consumer-directed health care:** The AMA favors approaches that give patients more choice and raise their cost consciousness. Consumer-directed health care is a trend whereby employers offer a personal account for routine health expenses, which can be rolled over from year to year; and a relatively high deductible for the employee with insurance protection once the deductible is met. Cost savings for the employer include Web-based administration and information that enable employees to make decisions about benefits and cost.

**Defined benefit:** Most employment-based health insurance is a defined benefit, where the employer defines the level, model and cost of health insurance coverage offered to employees.

**Defined contribution:** The AMA encourages employers who provide a health insurance benefit to do so in the form of a defined contribution, whereby the employer defines a dollar amount of benefit, but lets employees choose the health insurance coverage that best meets their needs. Some employees will pay more for the coverage they want, while others may pay less because they will exercise their ability to shop wisely.

**Guaranteed issue:** Intended to provide true portability of coverage and end "job lock," guaranteed issue regulations require health insurers to provide coverage to any applicant. The unintended consequence is that guaranteed issue encourages people to "game the system" so that they wait until they need care to seek coverage. As a result, there are negative effects on number of insured individuals and on the cost for those who are insured.

**Guaranteed renewability:** In order to encourage individuals to obtain and keep health insurance before they need medical care, guaranteed renewability ensures that covered individuals will be able to maintain their coverage. The stability inherent with coverage renewal allows insurers to limit premium increases.

**Health reimbursement account (HRA):** HRAs are a relatively new form of health care coverage in which employers agree to reimburse qualified medical expenses incurred by employees or dependents up to a maximum dollar amount per year. Contributions by employers and reimbursements to employees are not subject to income or employment taxes. HRAs allow, but do not require, employers to roll over unused balances to increase the maximum reimbursement

amount in subsequent years. Similarly, the employer may or may not allow retirees or departing employees access to unspent balances after they have left the company. HRAs have greater flexibility in benefit design and eligibility than health savings accounts (HSAs). Some employers will prefer HSAs over HRAs because HSAs may be funded wholly or in part by employees. On the other hand, some employers will prefer HRAs since HRA accounts need not be pre-funded and payments are made only as services are used.

**Health savings account (HSA):** HSAs are an improvement over medical savings accounts. HSAs are a form of health insurance coverage that includes a high-deductible insurance plan coupled with a tax-advantaged personal savings account to be used for qualified medical expenses. HSAs give patients greater control over health care decisions and the financial consequences of those decisions.

**Modified community rating:** Less restrictive than pure community rating, modified community rating allows insurers to consider certain demographic characteristics (such as age, sex and family size) that are related to the likelihood of using health care services.

**Premium subsidies:** Generally, premium subsidies are not used to purchase health care items or to cover patient cost-sharing obligations. Rather, premium subsidies are oriented toward the payment of health insurance premiums. Premium subsidies can be structured as risk-based vouchers or tax credits. Conversely, premium subsidies can be funded by such mechanisms as vouchers or tax credits. For example, premium subsidies are used to subsidize the premiums of employment-based coverage in the form of a defined contribution or as used in the Federal Employee Health Benefits Program. They also have been proposed to subsidize beneficiary costs for participating in Medicaid buy-in programs and to subsidize premiums for individually based or COBRA group coverage premiums.

**Refundable tax credit:** Many tax credits are designed to be received in lieu of a taxpayer's tax liability. Examples of existing refundable tax credits include the federal earned income tax credit and the child care tax credit. That is, in order to receive a nonrefundable tax credit, you must owe taxes at the end of the year and the tax credit is used to reduce the amount of tax owed. A refundable tax credit would be of benefit to those who need it most in order to encourage their purchase of health insurance, those with low incomes. Those with no tax liability would receive a check or voucher in the amount of the tax credit owed to them.

**Reinsurance:** As a means to protect health plans from unusual risk, reinsurance provides plans with retrospective payments for enrollees with costs above a certain threshold.

**Risk adjustment:** Risk adjustment usually takes the form of additional, prospective payments to plans with a disproportionate number of high-risk enrollees. Risk adjustment can also take the form of direct premium subsidies to high-risk individuals, for example, tax credits adjusted to reflect risk as well as income. Direct premium subsidies are a more explicit way to subsidize high-risk individuals. In contrast to high-risk pools, they also have the virtue of allowing high-risk individuals a choice of health plans.

**Risk pooling:** The term “risk pooling” typically refers to the cross-subsidization across risk groups and, less often, the reduced administrative costs from group purchasing. In the context of current discussions about individually based health insurance, concerns about “risk pooling” revolve around potential loss of the cross-subsidization role that employment-based insurance plays or is believed to play. It is also important to note that without coverage, neither insurance nor cross-subsidization can occur. Thus, any system that reduces the number of uninsured is likely to improve both the insurance function and cross-subsidization.

**Subsidy:** A subsidy is any governmental financial assistance granted to a person or group in support of an activity regarded as in the public interest. See also “tax subsidy” and “premium subsidy.”

**Tax credit:** An amount that is subtracted from what one owes in income tax. The AMA supports tax credits (that are refundable and advanceable, among other things) as an efficient means of subsidizing health insurance. In addition, the AMA supports the use of 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.

**Tax deduction:** An amount of money included in reported income but subtracted from adjusted gross (taxable) income, for example, the amount of health insurance premiums a self-employed person deducts from taxable income. Mathematically equivalent to a tax exclusion, but administratively different (the amount of a tax exclusion is never reported as income on a W-2 form or tax return).

**Tax exclusion:** An amount of money not reported as income on a W-2 form or on an individual’s tax return, for example, the amount of an employee health benefit. Mathematically equivalent to a tax deduction, but administratively different (a tax deduction is an amount that is reported as income but then subtracted from adjusted gross (taxable) income. See also “tax subsidy,” “tax exemption” and “tax deduction.”

**Tax subsidy:** Loosely interchangeable with the terms “tax break” and “tax advantage.” An amount of money provided to households or businesses through the income tax system. Tax subsidies can take many forms. Tax exemptions, tax exclusions and tax deductions provide indirect subsidies by reducing taxable income. In contrast, tax credits are directly subtracted from taxes owed. (Public programs such as Medicare, Medicaid and SCHIP provide in-kind subsidies in the form of coverage rather than in the form of money.) See also “subsidy,” “tax credit,” “tax exemption,” “tax exclusion” and “tax deduction.”

**Tax exemption:** A general term that includes tax exclusions and tax deductions.

**Vouchers:** Health insurance subsidies take many forms. The AMA supports the use of 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. Vouchers may be a simpler mechanism to deliver subsidies to low-income individuals than tax credits. Vouchers can have the same impact as tax credits that are refundable and advanceable. They can be designed for use only for the purpose for which they are intended and can take on many forms, such as debit cards or coupons. The Food Stamp Program is one example of how voucher programs are used to provide public funding to eligible individuals.

# 20 questions about the AMA proposal

## 1. What are the basics of the AMA proposal?

**Answer:** Under the AMA proposal, a system of refundable, advanceable and income-related tax credits would replace the current federal income tax exclusion for employment-based health insurance coverage. Employers are encouraged to provide workers with a defined contribution toward the purchase of coverage of the employee's choosing, rather than the defined benefit of coverage chosen by the employer. Individuals and families with health insurance coverage would be eligible for tax credits regardless of whether their coverage was through an employer-sponsored program or purchased on the individual market.

## 2. Many aspects of the AMA proposal seem consistent with free market principles, so why does the AMA support mandated coverage?

**Answer:** The AMA's individual responsibility requirement policy is not a mandate. Individuals are free to choose not to have coverage and face the consequence of the tax structure, which can rely on tax incentives, or a combination of incentives plus penalties. The rationale for requiring individuals of high incomes (greater than 500 percent of the federal poverty level) to obtain coverage is that these individuals should not rely on the health care safety net, which is intended for those with lower incomes. AMA policy would not support a requirement that those with incomes below 500 percent of the federal poverty level obtain coverage until the government implements a system of tax credits or other subsidies for low income individuals.

## 3. Why doesn't the AMA support an employer mandate or employer responsibility?

**Answer:** In 2000 the AMA rescinded policy that previously supported an employer mandate. AMA discontent with how some employers used their control of health insurance 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.

## 4. Is the intent of the AMA proposal to destroy the employment-based system?

**Answer:** No. The AMA supports the continuation of employment-based coverage as an option to the extent that employees demand it. Given the advantages of group purchasing through the workplace, many employees will freely choose to continue with employer-based coverage. The AMA approach builds upon the strengths of the current system while allowing for a natural evolution toward greater individual choice.

**5. Won't the AMA proposal encourage employers to drop health insurance benefits?**

**Answer:** No. Employers offering health benefits currently do so voluntarily in order to attract and retain workers, and this will continue to be the case. Further, health benefits for employees will continue to be deductible business expenses, regardless of whether they are based on defined benefits or defined contributions. In addition, the AMA proposal includes a “maintenance of effort” period during which employers who stop providing health insurance would be required to add to the employee’s salary the cash value of any health expense coverage they had directly provided. Since such wage increases would add to employees’ adjusted gross income—thus subjecting employers to higher payroll taxes and employees to higher state income and FICA taxes—many employers will be discouraged from dropping health benefits.

**6. Can individuals be trusted to make competent health insurance choices?**

**Answer:** Yes. People are just as capable of choosing their own health insurance plan as they are of choosing their own car, home, mortgage and many other types of insurance. The growing interest in and success of consumer-directed health care indicates a clear void that had existed previously. Federal employees, who choose among numerous competing health plans, receive comparative information on health plans from non-governmental consumer publications geared specifically toward helping them choose among their options, as well as by word-of-mouth.

**7. Isn't insurance on the individual market terribly expensive and inadequate?**

**Answer:** Not necessarily. An August 2005 study by Kaiser Family Foundation and *eHealthInsurance.com* found that premiums for individual health insurance were much lower than the average premiums for group coverage (\$1,776 for single individual coverage vs. \$4,042 for single employment-based coverage, and \$3,972 for family individual coverage vs. \$10,456 for family employment-based coverage). Some of the savings for individual insurance may demonstrate that people are willing to make do with a more limited array of benefits when buying health insurance for themselves, whereas employment-based coverage often provides some benefits that some workers do not use. In addition, subsidizing health insurance with tax credits rather than the current employer exclusion, and shifting to individually owned coverage, will dramatically invigorate the size and extent of the market for individually purchased health insurance.

**8. Will health insurance be affordable under the new system?**

**Answer:** Affordability of health insurance depends not only on health coverage choices and premiums in the transformed market, but also on the size of tax credits. The credit must be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories. At the lowest income levels, the credit should approach 100 percent of the premium.

**9. What is unfair about the current subsidy of health insurance?**

**Answer:** The current tax exclusion is socially inequitable because it provides a higher subsidy for those with higher incomes. Nearly 85 percent of the 46.6 million uninsured Americans are in households headed by workers, who pay federal and state taxes that contribute to the financing of Medicare and Medicaid, and to the subsidization of employment-based health insurance.

**10. How are tax credits more fair?**

**Answer:** Under the AMA plan, the tax subsidy, which would take the form of a voucher or premium subsidy, would be redirected toward those who need it most. Furthermore, compared to a tax credit that does not vary with income, a sliding scale tax credit reduces the federal spending necessary to expand coverage. In addition, the AMA proposes that tax credits for the purchase of health insurance be refundable, which would allow anyone who purchases health insurance to be eligible to receive a tax credit. To the extent the credit exceeds taxes owed, the individual would receive a payment.

**11. Would people who can't afford the out-of-pocket expense of health insurance upfront have to forfeit their eligibility for the credit?**

**Answer:** No. The AMA recognizes that those most in need of a tax credit to purchase coverage live on tight budgets. Therefore, the AMA proposes that health insurance tax credits be advanceable much like the subsidy used for food stamps.

**12. Will my state income taxes or FICA taxes go up?**

**Answer:** No. Under the AMA proposal, the value of health benefits will now be subject to federal taxation, but not state income and payroll (FICA) taxation. Therefore, there will be no additional individual FICA obligation, nor will there be additional state income taxes owed under the AMA proposal.

**13. What will happen to the extent of federal tax subsidies for health insurance?**

**Answer:** Virtually all analysts agree that achieving health coverage for all Americans will require a net increase in government spending. The impact on the level of federal tax subsidies for health insurance depends on the net effect of rescinding the tax exclusion and introducing the tax credits. On the one hand, tax revenues will increase because employment-based health benefits will become subject to federal income tax. The Office of Management and Budget estimates that the level of subsidy provided in the form of forgone federal income taxes in 2004 was approximately \$100 billion. On the other hand, the federal government will spend revenue to subsidize health insurance through tax credits. In addition, increased government spending on tax credits will be partially offset by reduced spending on what is now uncompensated care for the uninsured.

**14. Won't individually owned health insurance destroy the "risk pool"?**

**Answer:** With individuals having choices beyond plans offered by employers, some analysts fear the demise of employment-based risk pools. Such fears are exaggerated because group pooling does not depend on employment-based purchasing. Group purchasing of health insurance can also occur through various alternatives. Affinity groups that currently offer insurance such as life, automobile and Medicare private supplemental ("Medigap") insurance may offer health insurance to their individual members. Following the influx of a critical mass of average-risk individuals into the individual market, insurers would no longer find it cost-effective to individually risk rate applicants. In addition, policies exist to promote cross-subsidization across risk groups, such as high risk pools, guaranteed renewal and benefits management.

**15. Will tax credits insulate employees from loss of health insurance associated with loss of job, and limit “job lock”?**

**Answer:** Yes. Because the AMA proposal relies on a system of individually owned health insurance, it prevents “job lock” and empowers individuals with greater career choice as well as increased choice of insurance. This feature is particularly important in periods of economic decline when a large number of people become unemployed. The current employer-based system, however, promotes “job lock,” which occurs when people are afraid to change jobs for fear of losing their health benefits.

**16. How is the AMA proposal different and better than a single payer system?**

**Answer:** The AMA proposal enhances patient choice, encourages patients to be conscious of health insurance costs, and maintains private sector innovation. Single payer systems have none of these advantages and are beset with problems such as undersupply of medical personnel, long waiting lines, and lack of patient choice. Individual ownership of coverage will allow patients to assert their desires in how care is delivered, empowering patients and strengthening the patient-physician relationship. In addition, patients will be more likely to change plans if they are dissatisfied with plan performance. Thus, plans will find it necessary to compete with each other on all levels, including price, benefits offered, and their willingness to deny services recommended by physicians.

**17. Could the AMA proposal be implemented incrementally?**

**Answer:** Yes! For example, tax credits may be best targeted at certain low-income wage earners who are ineligible for public programs and are not offered coverage through their employers. In addition, rather than financing tax credits by revoking the entire exclusion of employment-based coverage (a subsidy that is estimated to have cost nearly \$100 billion in 2004), the AMA supports capping the amount of the tax exclusion for employment-based health insurance.

**18. If premiums continue to rise at double-digit percentage rates, will the size of the tax credit rise as well?**

**Answer:** The AMA proposal stipulates that the size of the tax credit should be large enough to ensure that health insurance is affordable for most people. Accordingly, federal resources should increase with premium price increases. The will of the people will determine the government’s role in maintaining the health insurance subsidy.

**19. Won’t such a major subsidy change necessarily hurt the middle class and doom the proposal politically?**

**Answer:** No. While subsidies are likely to be reduced and perhaps eliminated for upper-income individuals, the AMA proposal is not purely redistributive. Whether specific middle-income families gain or lose will depend on the range of credits and the relationship between credits and income—design parameters that are as yet unlegislated. All income groups will benefit from lower medical inflation rates because greater patient choice will foster competition among insurers, and improved coverage will reduce the burden of uncompensated care. In addition, everyone will benefit from a greatly altered individual insurance market, which will address some of the problems of “job lock” and pre-Medicare retirement coverage.

**20. Does the AMA recommend a defined or standard set of health benefits?**

**Answer:** No. In fact, in recent years, the AMA has rescinded its policies related to minimum and standard benefit packages. The AMA believes that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

Visit [www.ama-assn.org/go/insurance-reform](http://www.ama-assn.org/go/insurance-reform) for more information about the AMA proposal.

*“Expanding health insurance: The AMA proposal for reform” has been produced by the  
AMA Health Policy Group, Division of Socioeconomic Policy Development.*

*Valerie Carpenter, editor*

*Robert D. Otten, director*