

Expanding health insurance coverage and choice:  
**The AMA proposal for reform**

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# Overview: The AMA reform proposal

Problems of the U.S. health care system have become all too familiar: 47 million uninsured, skyrocketing costs, dwindling employee health benefits, avoidable illness, premature death, health disparities based on race, ethnicity and income ... Even many insured, middle-class Americans feel the threat of precarious health insurance coverage, are concerned about indirectly shouldering the medical bills of the uninsured, or are simply troubled that so many lack access to care in a country that boasts the most sophisticated medical technology. Public opinion polls and appeals from large manufacturers alike show widespread support for some sort of health care reform, but no clear consensus on specific solutions. Proposed remedies vary in scope and approach, reflecting different diagnoses of the root causes of the system's ailments.

As advocates for patients, physicians have a particular stake in finding viable, effective approaches to these issues—especially the challenge of covering the uninsured. The American Medical Association (AMA) has made covering the uninsured an ongoing, top priority, and has developed a proposal to expand health insurance coverage and choice to all patients, regardless of income or health status. Through the “Voice for the Uninsured” campaign, the AMA is focusing public attention on health system reform as we move through the 2008 election cycle. The campaign encourages everyone to vote with these issues in mind and help drive change in the American health care system.

## Synopsis

The AMA proposal to cover the uninsured and expand choice uses an approach advocated by growing numbers of scholars and policymakers from diverse quarters. The strategy is to pinpoint and address fundamental flaws in how people currently obtain and pay for health insurance in the United States, flaws that limit the availability and affordability of coverage,

especially for those with low earnings or no employee health benefits. Dramatic improvement is possible by making better use of existing government resources devoted to health care and health care coverage, including the billions of dollars in subsidies for private health insurance. These resources should be drawn upon to, in essence, give people money to pay for a health plan of their choosing, with the amount of money they receive based on their income.

The AMA proposal would expand health insurance coverage and improve fairness by shifting government spending toward those most likely to be uninsured—people with lower incomes. It would also reduce the hidden bias favoring employment-based coverage, which provides special employee income tax breaks for insurance obtained through an employer. Reducing this bias has important advantages, as well as potential drawbacks, that must be addressed. Those without the option of insurance through a job don't get this tax break, and would finally get assistance under the AMA proposal. Employees who are dissatisfied with their employers' health plan offerings could choose to buy insurance elsewhere and still be eligible for assistance. Reducing the bias, however, could accelerate the decline in employment-based insurance, causing further disruption. Especially in this context, strong safeguards are needed to ensure that people with predictably high medical costs can afford coverage. Health insurance market regulations should be reformed to establish fair rules that protect vulnerable populations without unduly driving up premiums for the rest of the population. Regulations should also allow market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing and premiums.

In short, the AMA advocates a clear role for government in financing and regulating health insurance coverage, with health plans and health care services being provided through private markets, as they are currently. The AMA proposal gives patients more control over our nation's health

care dollars, without sacrificing personal financial security or choice. It reflects important social values and traditions, such as assistance based on need, freedom of choice, market innovation and fairness. Pragmatically, the AMA proposal is fiscally sound and permits flexible implementation—for example, by improving market regulations independent of other reforms, phasing in changes in tax assistance for health insurance, or adapting reforms at the state level. Three specific actions are needed to achieve the full vision of covering the uninsured and strengthening our nation's health care system.

### Three pillars: The foundation of the AMA proposal

The AMA proposal to expand health insurance coverage is based on three pillars:

■ **Helping people buy health insurance through tax credits or vouchers.** These tax credits or vouchers should be more generous at lower income levels, and should be earmarked for health insurance coverage. It is important to note that the government *already* gives people financial assistance to buy private health insurance—well over \$125 billion each year. The form of this support—an employee income tax break on job-based insurance—is hidden from public view. This tax break gives more assistance to those in higher tax brackets, and gives no assistance to those without employee health benefits. Shifting some of this assistance to tax credits or vouchers for lower-income people would reduce the number of uninsured and improve fairness in the health care system. One way this can be achieved, for example, is by putting limits on the existing tax break so that employees do not get a bigger income tax break for simply enrolling in more expensive health plans. Under this scenario, premiums for employee health insurance below a specified limit could still be tax-free, with additional spending becoming subject to income tax. Limiting the \$125 billion tax break for job-based insurance would yield additional revenue for the government, which could be used to fund tax credits and vouchers for those who currently get little or no assistance. The limit would also encourage insurers, employers and employees to avoid excessively generous health plans, curbing the rising cost of health care and insurance premiums.

■ **Choice for individuals and families in what health plan to join.** Today, people are effectively locked into the health plans their employers offer, often just one or two, which are subject to change from year to year. A change in employment typically means a change in insurance coverage. In contrast, under the AMA plan, people could use tax credits or vouchers to help pay for premiums of any available insurance, whether offered through a job, another arrangement or the open market. As with job-based insurance today, health plans would still have to meet federal guidelines in covered benefits, but people would have greater say in what types of benefits and plan features they value. Coupled with individual choice, tax credits benefit recipients directly, and everyone indirectly, by stimulating the market for health insurance. If enough people have enough purchasing power—and enough say over how that purchasing power is used—insurers will be compelled to step up to the plate with better, more affordable coverage options that are within reach of more people.

■ **Fair rules of the game: Regulating markets and protecting high-risk patients.** For markets to function properly, it is important to establish fair ground rules. A proliferation of state and federal health insurance market regulations has made it more difficult and expensive for insurers to do business in many markets. The AMA proposes streamlined, more uniform health insurance market regulations. Regulations should permit market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing and premiums. It is also important that market regulations reward, not penalize, insurers for taking all types of patients. Market regulations intended to protect people with high health risks have typically backfired, sometimes disastrously, by driving up premiums for younger, healthier people and leading them to drop coverage.

To help high-risk people obtain coverage without paying astronomical premiums, additional government subsidies are needed. Targeted assistance for coverage of high-risk people could take the form of risk adjustment payments to individuals or insurers, reinsurance of medical expenses beyond some catastrophic limit, or funding of separate high-risk insurance pools

that allow insurers to keep premiums down in the regular market. Individuals also need to be encouraged to play fair by taking responsibility for obtaining health insurance without waiting until illness strikes or medical attention is needed. At the same time, people should have a guarantee that they will not lose coverage or be singled out for premium hikes due to changes in health status. Conversely, people who are uninsured despite being able to afford coverage should face tax implications.



## First pillar: Helping people buy health insurance through tax credits or vouchers

The AMA proposal to cover the uninsured and expand choice begins with providing individuals and families with income-based financial assistance to buy health insurance. The government already provides hefty tax assistance for purchasing health insurance, and it is clear that continued federal support will always be needed if everyone, regardless of income or health status, is to be assured of affordable, adequate, reliable health insurance. Unfortunately, the current federal subsidy for private health insurance—more than \$125 billion each year—does not reach the people most in need of financial assistance and is available only to those with health insurance through a job. Dramatic improvement in coverage of the uninsured is possible by more effectively leveraging the vast resources already devoted to subsidizing health insurance. The AMA, along with a growing number of policymakers, believes that the current subsidy—an employee income tax exclusion for employment-based insurance—should ultimately be replaced with tax credits or vouchers, awarded to individuals and families on the basis of financial need, for use toward buying health insurance of their personal choosing.

### What makes tax credits different?

Tax subsidies for health insurance can take several different forms. A tax exclusion or tax deduction reduces the amount of income tax a person owes by subtracting a given dollar amount from the amount of income that is taxed. After the exclusion or deduction is applied, the remaining income and the corresponding tax bracket are used to calculate the amount of income tax owed. (In tax jargon, tax exclusions and tax deductions are both types of tax exemptions that reduce a person's tax liability by reducing his or her taxable income. After the deduction or exclusion is applied, tax liability is calculated based on taxable income and the marginal tax rate.)

Tax credits, unlike most other tax subsidies, have the following features:

- Tax credits are subtracted directly from an individual's income tax bill, after all other calculations regarding tax brackets, deductions, etc., are made. Dollar for dollar, a tax credit reduces the recipient's tax liability.
- Tax credits can target assistance toward those most likely to be uninsured—people with lower incomes.
- Tax credits can be refundable, so that even those who owe little or nothing in income tax can still benefit from the subsidy.
- Tax credits can be “advanceable” so that they are available in advance, allowing recipients to use the credit toward insurance premium payments without waiting to file income taxes.
- Tax credits facilitate individual choice of health insurance, the second pillar of the AMA proposal.

For these reasons, the AMA believes that tax credits are a more fair, transparent and effective way of using government resources to help people buy private health insurance. For additional information on this issue, see “How the government currently helps people buy health insurance: The employee tax break on job-based insurance” and “Illustration of how tax credits or vouchers would affect households” in this series.

## A word about vouchers

Like tax credits, vouchers are simply another vehicle for helping people buy health insurance, and can also be targeted to those most likely to be uninsured, and used for the recipient's choice of health insurance. A voucher program could be designed to work like an electronic benefit transfer debit card, as is used in the Food Stamp Program. Accordingly, the AMA supports the use of vouchers or other premium subsidies as long as they are designed in a manner consistent with AMA principles for structuring tax credits, described at right, and enable individuals and families to purchase their choice of health insurance.

## Principles for structuring tax credits

For tax credits to work fairly and efficiently, they should be implemented based on the following principles:

### Size of tax credits

- The dollar amounts of tax credits should be inversely related to income.
- The amounts of tax credits should be large enough to enable recipients to afford health insurance.
- The amounts of tax credits should vary with family size to mirror the pricing structure of insurance premiums.

### Cap on tax credit amounts

- Tax credits should be fixed-dollar amounts for a given income and family structure, independent of health insurance expenditures, to encourage individuals to be cost-conscious and to discourage overinsurance.
- In the absence of fixed-dollar amounts, the size of tax credits should be capped in any given year to prevent overinsurance.

### Eligibility for tax credits

- Tax credits should be contingent on the purchase of health insurance, so that those who do not obtain health insurance forfeit their credit.
- Tax credits for families should be contingent on each family member having health insurance.

### Use of tax credits

- Tax credits should be applicable to health insurance of the individual's choice, regardless of whether coverage is obtained through an employer or elsewhere.
- Tax credits should be applicable only for the purchase of health insurance, and not for out-of-pocket health expenditures.

### Administration

- Tax credits should be refundable, so that if the credit exceeds taxes owed, the individual receives the

credit in the form of a payment. This means that individuals with incomes too low to pay income tax still would be eligible for tax credits to buy health insurance.

- Tax credits should be advanceable for those with low incomes, so that these individuals receive the credit to pay for health insurance coverage before such payment is due and do not have to wait to be reimbursed when they file their income taxes.

## Growing support for tax credits

There is growing recognition that tax credits are preferable to tax deductions, tax exclusions or other income tax breaks because they more effectively target low-income individuals. Over the past several years, many think tanks reflecting a range of political views have developed opinion papers and issue briefs outlining the advantages of tax credits over tax deductions and exclusions, and demonstrating how credits can be used to facilitate the expansion of health insurance coverage. Similarly, editorials in a number of major newspapers emphasize that issuing tax credits inversely related to income would distribute resources much more efficiently than allowing people to deduct health insurance expenditures from taxable income. As concern for the uninsured has increased over the past several years, members of Congress from both parties have introduced legislation that would provide tax credits to help individuals obtain health insurance.

Over the short term, this shift in the way tax subsidies are distributed for the purchase of health insurance is likely to result in some loss of subsidy for upper-income individuals. Over the long term, however, all income groups will benefit from lower medical inflation due to increased competition among insurers and less uncompensated care. In addition, individuals would be able to purchase the exact amount of coverage they need to keep their family secure, rather than overinsuring because of lack of plan choice and financial consequence.



## Second pillar: Individual choice of health insurance

The second pillar of the AMA proposal to cover the uninsured is individual choice of health insurance. Individual choice is facilitated by the other two pillars of the AMA proposal: *income-related tax credits or vouchers* for use toward any available health plan, whether offered through a job or elsewhere, and *regulatory reforms* to allow market experimentation to search out the most attractive combinations of plan benefits, patient cost-sharing and premiums, as well as new venues to obtain health insurance. Under the AMA proposal, individuals and families will be able to pick the coverage that meets their needs and preferences, choosing from a wide range of health plans, not just the fixed number of benefit designs selected by a human resources department or government agency. In addition, because people will own their own health insurance, they will be able to keep it regardless of any job changes.

To be clear, individual choice of health insurance should not be confused with purchasing coverage on the current individual (non-group) market for health insurance. Currently, the individual market primarily serves those who do not have access to coverage through a job or public program, while prohibiting some people from securing coverage on reasonable terms, if at all. Nor should individual choice be confused with eliminating employment-based coverage, which has distinct pros and cons. Rather, the AMA proposal allows for new opportunities to buy health insurance in addition to employment-based coverage. These new opportunities would emerge in an environment characterized by individual choice and ownership, equivalent tax breaks regardless of type or source of insurance, a surge in the number of people able to afford coverage, fair market regulations, and clear standards of individual responsibility for having health insurance.

## Limited choice, high cost of health insurance

A major argument for employment-based group insurance is lower per-person administrative expenses of marketing, enrollment, underwriting, etc. However, actual premiums paid for insurance bought on the individual market are, on average, a remarkable 60 percent to 65 percent lower than premiums for employment-based insurance (\$1,776 vs. \$4,479 for single coverage, and \$4,128 vs. \$12,106 for family coverage, according to eHealthInsurance.com<sup>1</sup> and the Kaiser HRET Employer Health Benefits Survey, 2007.<sup>2</sup> These substantial premium differences are due largely to the fact that many people, when given a choice, opt for less generous coverage than is typically offered by employers. These results also indicate that allowing individuals to determine which insurance benefits are not worth higher premiums—individual choice—is an effective means of reining in runaway health care costs and premiums, without sacrificing highly prized benefits or health care.

In 2007 only 13 percent of all employers offered employees a choice of health plans. Moreover, between 2000 and 2007, the number of employers offering health insurance declined from about 70 percent to 60 percent, while the share of the non-elderly population with employment-based insurance also eroded from about 70 percent to 60 percent. Additional challenges with employment-based insurance include lack of portability, which can lock employees into jobs to avoid losing coverage, and discontinuity when employers switch plans. In addition, those without insurance through a job receive none of the \$125 billion annual federal subsidy for job-based health insurance.

## Expanded opportunities for group coverage

Under the AMA proposal, various types of groups—such as coalitions of small employers, unions, trade associations, farm bureaus, alumni associations, churches and religious groups, and ethnic coalitions—would become able, and eager, to sponsor health plans. Conditions would also become ideal for the

formation of group purchasing associations similar to the Federal Employees Health Benefits Program (FEHBP), and state or multi-state health insurance exchanges such as the Massachusetts Connector. The FEHBP, which provides coverage to federal employees, including members of Congress, and their families offers a varied menu of health plans, benefits and premiums that have already been negotiated and pre-screened for solvency, licensing and related criteria.

Existing tax rules and regulations virtually preclude group insurance other than through employment. The existing employee tax break for buying health insurance applies exclusively to employment-based insurance. Moreover, both overregulation and arbitrary differences in regulation across 50 states and the District of Columbia create unnecessary complexity and cost that prevent realization of economies of scale. The AMA believes these barriers should be removed, and that the regulatory environment should enable, not impede, the development of new group insurance and purchasing associations. Rather than regulating minimum size, number of plans offered, geographic restrictions, etc., the government should allow the market to determine the details and success of purchasing associations based on economies of scale and other natural advantages.

Likewise, employment-based health insurance has administrative economies of scale, and surveys show that many employees value the comfort and convenience of having their employers choose their coverage. Accordingly, employers will continue to offer health insurance to the extent that the market demands it, rather than in response to preferential tax treatment and regulation. At the same time, employees who are dissatisfied with their employers' health plan offerings can decide to buy elsewhere without forfeiting a tax break on their insurance or having to change jobs to get the coverage they prefer.

## Evolution of the individual market

For the past decade, the share of the non-elderly population with individual market coverage has hovered around 6 to 7 percent. The ability to shop for

1. eHealthInsurance.com. *The Cost and Benefits of Individual Health Insurance Plans: 2007*. [www.ehealthinsurance.com/content/expertcenterNew/CostBenefitsReportSeptember2007.pdf](http://www.ehealthinsurance.com/content/expertcenterNew/CostBenefitsReportSeptember2007.pdf). Published September 2007. Accessed November 19, 2007.

2. The Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits 2007 Annual Survey*. [www.kff.org/insurance/7672.Pub0709](http://www.kff.org/insurance/7672.Pub0709). Published September 2007. Accessed November 2, 2007.

health insurance through the Internet has stimulated individual-market coverage, which would continue to evolve under the AMA proposal, offering a greater choice of affordable coverage options, and possibly becoming less distinguishable from the group market. Such market developments will ultimately benefit people across risk and income classifications. For example, the influx of a critical mass of average-risk people into the individual market would reduce the cost-effectiveness to insurers of individually risk-rating applicants. Costly medical underwriting practices would likely be replaced by simplified, automated ones, particularly as purchasing insurance over the Internet becomes more common. The result would be de facto community rating of premiums—but as the byproduct of natural market evolution rather than by market regulation.

However, the AMA also recognizes that special measures are needed to address the needs of the chronically ill and disabled, and supports targeted subsidies for coverage of high-risk individuals, as described in the third pillar of the AMA plan. Risk-based subsidies, in addition to having a direct impact, would also elicit market response, such as the development of specialized facilities or integrated delivery systems for people with specific chronic conditions, offering the full range of services required to manage and treat the condition and common co-existing conditions.

## Choosing a health plan

The FEHBP provides consumer information and assistance for comparing and choosing health plans, including annual information fairs and online decision-support tools. High demand for consumer information has also spurred enterprising publishers to issue inexpensive, authoritative, user-friendly guides to FEHBP health plans (available at newsstands and in drugstores throughout the Washington, D.C., area each year during open enrollment season). Co-workers also exchange valuable information, passed along through word-of-mouth. In the same manner, new group purchasing associations and insurance exchanges would provide consumer information and support with

plan selection, with additional formal and informal assistance forthcoming as well. As reflected by the growth of consumer-driven health care, many people are becoming more interested in being personally involved in health care decision-making, as they already are for other major personal choices, such as car and home insurance, mortgages, and education.

## Compelling insurers to step up to the plate

Individual choice and ownership of health insurance would have a profound effect on insurer behavior, market function and the types of available plan choices. Large insurers currently dominating many markets will face challenges from smaller insurers and other new sources of coverage. No longer insulated from being accountable to individual enrollees and potential enrollees, insurers will become more responsive to patients' concerns. Because enough people will have enough purchasing power—and enough say over how that purchasing power is used, insurers will be compelled to step up to the plate with better, more affordable coverage options that are within reach of more people.



# Third pillar: Fair rules of the game—regulating markets and protecting high-risk patients

The third pillar of the AMA proposal to expand health insurance coverage and choice calls for fair rules that allow health insurance markets to function properly while also protecting high-risk patients. With appropriate health insurance market regulations and federal subsidies based on income and health risk, every individual would be able to find affordable coverage in every state.

## The “crazy quilt” of regulations

Since the early 1990s, numerous state and federal health insurance market regulations have been introduced to make coverage affordable and comprehensive, particularly for people with chronic or expensive medical conditions. An excessive number of state and federal regulations apply to various health insurance markets. Even within states, different rules apply to large employer groups, small employer groups and individuals. Regulations may also differ by type of health plan and by individual factors such as health risk, age or prior coverage. Compared with large groups, small groups are treated unfavorably by federal law, particularly the Employee Retirement Income Security Act (ERISA), which exempts large, self-insured groups from state benefit mandates and market regulations.

Insurance regulations have often had unintended consequences, making coverage more expensive and driving more people into the ranks of the uninsured. Regulations intended to protect high-risk individuals typically penalize health plans for enrolling people with above-average medical costs, giving insurers incentives to avoid the sick and cherry-pick the healthy. Similarly, regulations often backfire by driving

up premiums for younger, healthier people, leading less expensive enrollees to drop coverage. In addition, the sheer number, variety and complexity of regulations has added to the cost of providing insurance.

A good example of how health insurance market regulations can backfire is the combination of strict community rating, extensive benefit mandates and guaranteed issue.

**Strict community rating** means that everyone enrolling in the same health plan pays the same premium regardless of health risk, so that the cost of covering care for expensive enrollees is spread across the community of people buying insurance.

**Benefit mandates** require health plans to cover specified health services. While any one benefit mandate might have little impact, cumulatively they can add significantly to the cost of health insurance.

**Guaranteed issue** means that insurers must accept all applicants, allowing healthy individuals to forgo coverage knowing that they can always buy insurance later should they fall ill.

These regulations make premiums inordinately expensive for people in good health or with low incomes. The greater the number of healthy people who decide to go uninsured, the higher the average cost of health care among those with insurance, and the higher premiums must be to reflect and cover average costs. In the extreme, a *death spiral* leaves fewer and sicker individuals with insurance, drives up premiums, and eventually cripples or destroys the market for health insurance.

The proliferation of market regulations has also increased insurers' costs of administration and regulatory compliance. The variation in regulatory environments makes it more difficult and expensive for insurers to operate in multiple states or markets, preventing the realization of economies of scale and inhibiting the emergence of new types of group purchasing arrangements. By both increasing the costs of offering insurance and reducing demand from relatively healthy people, market regulations have driven insurers out of some states, reducing competition among remaining insurers.

## A better approach

The AMA proposes streamlined, more uniform health insurance market regulation, building upon the lessons of state experiences. Regulations should protect high-risk individuals without unduly driving up health insurance premiums for the rest of the population. Regulations also should encourage the creation of innovative and affordable health insurance options, as well as new group purchasing arrangements. Insurers are likely to consent to, or even welcome, such market 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. The AMA has developed a set of guiding principles for health insurance market regulation. These fair rules are an integral part of the AMA proposal to cover the uninsured and expand choice but can be implemented independently, at the state or federal level.

## Guiding principles for health insurance market regulation

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 submarket (i.e., large group, small group, individual), geographic location or type of health plan.** Differential regulations add to administrative costs, prevent realization of economies of scale and impede new group purchasing arrangements. Limited state variation in market regulation should be permitted as long as it does not drive up the number of uninsured, unduly hamper the development of multi-state group purchasing alliances or create adverse selection across states.
- **The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements.** Benefit mandates should be minimized to allow market experimentation to find the most attractive combinations of plan benefits, patient cost-sharing and premiums. Removal of legislative and regulatory barriers, as well as greater uniformity in regulations, would open up opportunities to buy insurance as part of a group, buy multiyear insurance contracts and invest in other innovations that would not only reduce administrative costs but narrow premium differences between high- and low-risk individuals. More flexible regulations could also allow development of specialized coverage for people with chronic conditions, offering better coordination of care, reduction of wasteful services and quality improvements.
- **Individuals and families who can afford coverage should be required to obtain it.** Those earning greater than 500 percent of the federal poverty level (\$52,000 for an individual and \$106,000 for a family of four in 2008) should be required to obtain at least catastrophic and preventive coverage, or face adverse tax consequences. The requirement would extend to people of all incomes only after implementation of subsidies for those who need financial assistance obtaining coverage (i.e., sliding-scale, refundable tax credits or vouchers to buy insurance). A requirement to have insurance would make it less cost-effective for insurers to risk-rate individual applicants. Simplified, automated underwriting would result in de facto modified community rating, as the natural byproduct of market function rather than as a result of market regulation. See more in “Individual responsibility: Requiring those who can afford it to have health insurance” in the series.
- **Health insurance coverage of high-risk patients should be subsidized by using risk-related assistance—such as subsidies for high-risk pools, reinsurance and risk adjustment.** Explicit, targeted government subsidies are needed to help high-risk people obtain coverage without paying prohibitively high premiums, and to make high-risk people more attractive to insurers. Risk-based subsidies such as high-risk pools, reinsurance and risk adjustment can expand coverage for people of *all* risks. For example, by providing subsidized health plans for high-risk individuals, high-risk pools give insurers reassurance that they are unlikely to end up with an unfavorable selection of high-cost enrollees in the regular market, allowing them to offer lower premiums and making coverage attractive to the young and healthy.

- **Risk-related subsidies should be financed through general tax revenues rather than through strict community rating or premium surcharges.** Financing risk-based subsidies with general tax revenues rather than through premiums avoids the unintended consequences of driving up premiums and distorting health insurance markets.
- **Strict community rating should be replaced with modified community rating.** By allowing some degree of premium variation based on individual risk factors, but limiting premium differences within specified risk bands, modified community rating strikes a balance between protecting high-risk individuals and the rest of the population. Some degree of age rating is acceptable, as are lower premiums for nonsmokers, but an individual's genetic information should not be used to determine his or her premiums or eligibility for coverage.
- **Guaranteed issue regulations should be replaced by guaranteed renewability, and those wishing to switch health plans should face limited re-underwriting.** Just as homeowners cannot buy home insurance after their homes catch fire, people should not be allowed to wait to buy health

insurance until they need medical attention, as under guaranteed issue. Guaranteed renewability would protect individuals from losing coverage or being singled out for premium hikes due to changes in health status, rewarding people for obtaining and maintaining coverage. Similarly, people who wish to switch health plans should face limited underwriting and pre-existing condition limitations, compared with those who are newly seeking coverage.

## Conclusion

These three pillars provide a prescription for achieving health insurance coverage for everyone. While additional details and implementation practicalities will have to be worked out, any meaningful course of action presents challenges of similar scope and magnitude. The AMA believes that unresolved questions can no longer stand in the way of action, and that covering the uninsured is both imperative and possible.

**Visit [www.voicefortheuninsured.org](http://www.voicefortheuninsured.org) for more information on the AMA proposal and to view additional pieces in this series.**