REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (I-03)
Medical Care for Patients with Low Incomes
(Reference Committee J)
(December 2003)

EXECUTIVE SUMMARY

At the 2003 Annual Meeting, the Council on Medical Service presented an outline of how better to provide medical care to patients with low incomes, including patients currently enrolled in the Medicaid program for acute care needs (Council on Medical Service Report 8, A-03). The Council requested that members of the House of Delegates, state medical associations, and national medical specialty societies provide comments and suggestions about the proposed model by August 1, 2003.

Council on Medical Service Report 1 (I-03) presents a refined version of the proposal previously developed by the Council. The Council specifically requested advice and suggestions on whether there were elements that had been left out of the proposal and needed to be considered, or whether there were elements that were included and should be deleted. The Council appreciates the input that it received in response to Council Report 8 (A-03), and in the development of this report.

The federal Medicaid statute requires that all participating states ensure beneficiaries' access to medical care equal to that of the general population. Unfortunately, Medicaid patients are concerned about access to physicians and other health care providers, enrollment difficulties, the welfare stigma, and the lack of choice among health plans and/or physicians. Although the Medicaid program ostensibly offers a rich benefits package, the benefits increasingly are elusive in many regions of the country.

As Council Report 1 (I-03) indicates, the structure and financing of the current Medicaid program is crumbling. 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. In seeking a way to better provide medical care to patients with low incomes, the Council adhered to a number of policy goals, including ensuring patient access to physicians and other health care providers; providing a choice of care systems and providers; constituting a seamless system for patients and physicians; and providing portability of coverage.

In this report, the Council recommends replacing the medical care portion of the Medicaid program with refundable and advanceable tax credits to purchase private insurance with little or no cost-sharing. This approach is consistent with Policy H-165.920[17], AMA Policy Database, which prefers tax credits over public sector expansions as a means of providing coverage to the uninsured. It also is consistent with Policy H-290.982[1] which urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1 - I-03
(December 2003)

Subject: Medical Care for Patients with Low Incomes

Presented by: Ardis D. Hoven, MD, Chair

Referred to: Reference Committee J
(Steven C. Arendt, MD, Chair)

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3 provide medical care to patients with low incomes, including patients currently enrolled in the
4 Medicaid program for acute care needs (Council on Medical Service Report 8, A-03). The Council
5 requested during the Reference Committee Hearing and recommended in Council Report 8 (A-03)
6 that members of the House of Delegates, state medical associations, and national medical specialty
7 societies provide comments and suggestions about the outlined model by August 1, 2003. The
8 Council is indebted to the following individuals and organizations for their feedback:
9
10 • The American Academy of Family Physicians (AAFP), the American Academy of Pediatrics
11 (AAP), the American College of Obstetricians and Gynecologists (ACOG), and the American
12 College of Physicians (ACP), submitted a joint letter.
13
14 • ACP President Munsey Wheby, MD, submitted an additional letter separately.
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16 • Cal Sia, MD, Chair of the AMA Section Council on Pediatrics, sent comments via email.
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18 In addition to soliciting written Federation input, the Council noted the specialty society
19 delegations that spoke to Council Report 8 (A-03) during the Reference Committee hearing at the
20 June 2003 Annual Meeting. Those specialties, AAFP, AAP and ACP, as well as ACOG, were
21 invited to meet with the Council at its September 2003 meeting to further discuss the
22 recommendations contained in this report. With Medicaid being the single largest health insurer of
23 children and maternity care in the United States, the Council greatly appreciates the contributions
24 of these diverse points of view, and believes that this report has been strengthened by addressing
25 the concerns raised.
26
27 SCOPE OF THE PROPOSAL
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29 As detailed in Council Report 8 (A-03), the outlined proposal applies to those patients in the
30 medical care portion of the Medicaid population, which constitutes 73% of current Medicaid
31 enrollees, and accounts for 27% of Medicaid expenses. In particular, the recommendations
32 contained in this report primarily encompass the Medicaid population of nonelderly and
33 nondisabled adults and children. These are the low-income patients with medical needs, as
34 opposed to disability and long-term care requirements.
35 It should be noted that the proposal outlined by the Council also applies to many low-income
36 patients who currently are not eligible for Medicaid coverage, thus providing a health insurance

subsidy to some of those low-income and uninsured individuals who currently receive no subsidy. Such an expansion is fully consistent with current Policy H-165.920 (AMA Policy Database), which supports the creation of tax credits for the purchase of individually owned health insurance, and advocates the use of tax credits rather than public sector expansions as a means of providing coverage to the uninsured. In particular, the Council advocates the use of tax credits that are inversely related to income and are large enough to entice recipients to purchase coverage, consistent with Policy H-165.865.

Significantly, the proposal outlined in this report is transitional. It serves as a tool for how the AMA can achieve its health system reform of individually owned health insurance for all individuals, including those eligible for Medicaid. Currently, the AMA health system reform proposal of tax credits for individually owned insurance presumes by default the continued coverage of needy individuals under the Medicaid program. However, the Council has continued to study the Medicaid program, which by most accounts is unsustainable in its current design. State budgets are much more sensitive to economic swings than is the federal government. In the current economic environment, every state's budget crisis is adversely affecting its Medicaid program.

The Council believes that the proposal outlined in this report strengthens the health care safety net by empowering those most in need of secure and viable coverage to purchase it with their own tax credits. As individuals who would otherwise be uninsured become insured, there is a reduction in the burden on the health care safety net. For most Medicaid recipients, the Council recognizes that tax credits will need to be equivalent to the entire cost of coverage, with little or no beneficiary cost-sharing.

Council Report 8 (A-03) stated the Council's intent to further study the complex needs of the elderly, blind, and disabled, which are separate populations from those of the Medicaid population who receive Medicaid services primarily for acute and preventive medical care. In addition, Council Report 7 (A-03) noted the need for further study of ways in which chronically disabled patients who may be uninsured, and might be appropriately covered under the medical care model of tax credits for health insurance, special high-risk pools, increased subsidization, or other mechanism. The Council anticipates that there will be some individuals who need additional subsidization.

THE MEDICAID PROGRAM

Council Report 8 (A-03) included a summary of the Medicaid Program, which is greatly abbreviated in this report. In 1965, the Medicaid program was enacted as Title 19 of the Social Security Act (SSA) as an afterthought to the enactment of Medicare. Medicaid's establishment as a joint federal and state venture, unlike Medicare's federal design, preserved state control over programs for the poor. In 1997, the State Children's Health Insurance Program (SCHIP) was created to extend coverage to children in families with incomes too high for Medicaid eligibility, but too low to purchase their own coverage.

States receive federal matching funds of at least half their Medicaid program costs through the federal medical assistance percentage (FMAP). The formula used to calculate the FMAP seeks to narrow the gap between rich and poor states (measured as per capita income) by providing higher rates to poorer states. In order to receive federal matching funds, states are required to provide a set of mandatory benefits to a mandatory group of beneficiaries. Mandatory populations include children through age 5 at or below 133% of the federal poverty level (FPL), children aged 6-19 in families with incomes at or below 100% of FPL, certain adults in families with eligible children,

pregnant women with incomes at or below 133% of FPL, disabled and elderly social security income (SSI) beneficiaries, certain working disabled, and Medicare buy-in groups.

States also receive matching funds if they provide coverage to any of the federally determined "optional" eligibility groups. States also have broad authority to experiment with alternative means of providing health care to the poor, using Health Insurance Flexibility and Accountability (HIFA) waivers or Section 1115. The HIFA waivers explicitly allow states to restrict some benefits in order to expand others. The Office of Management and Budget has estimated that total Medicaid spending for 2003 will be $280 billion for its some 40 million beneficiaries. Medicare also has some 40 million beneficiaries, with projected spending for 2003 to be $230 billion.

Medicaid Benefits

Medicaid benefits vary widely from state to state. Within states, benefits also vary depending on age and other eligibility categories. The Medicaid statute requires participating states to provide certain mandatory benefits in order to receive federal matching funds. The statute also permits states to receive matching funds for statutorily defined optional benefits. About 65% of Medicaid spending is for optional services. More than half (58.4%) of optional spending in 1998 was spent on long-term care. Optional benefits include prescription drugs; intermediate care facilities for individuals with mental retardation (ICFs/MR); personal care services authorized by a physician; case management services; prosthetics; rehabilitative services; physical therapy; clinic services; and diagnostic, screening and preventive services. States have wide discretion to determine which benefits to offer Medicaid beneficiaries, and they can institute nominal cost-sharing for certain beneficiaries for certain benefits.

Mandatory Medicaid benefits include, but are not limited to, physician services; x-ray and laboratory services; hospital services; nursing facility and home health services for individuals 21 and older; and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for individuals under 21. EPSDT covers medical, vision, hearing and dental screening, and includes immunizations, laboratory tests, and health education. The treatment component of EPSDT must include any necessary health care, diagnostic services, treatment, and other measures to "correct or ameliorate" physical and mental illnesses and conditions, whether or not such services are covered as optional benefits for adults in the state's Medicaid program. Although the federal government fully finances some screenings, treatment may be a state option and not covered in some states, as is the case with breast cancer screening.

Medicaid Cost-Sharing

States have the option to impose "nominal" cost-sharing to groups and services other than any service for children, pregnancy-related services for pregnant women, any service for terminally ill patients receiving hospice care, and care to the medically needy who had to "spend down" to qualify for Medicaid. Specifically, states are allowed to charge a deductible of up to $2 per month per family, a copayment ranging from fifty cents to $3, and a co-insurance requirement of 5% of the payment rate for the item or service. States may also charge higher cost-sharing, up to twice the "nominal" amounts, for nonemergency services provided in a hospital emergency room, if it can be shown that the beneficiary had alternative nonemergency outpatient options that were available and accessible.

THE IMPERATIVE FOR REFORM

The federal Medicaid statute requires that all participating states ensure beneficiaries' access to medical care equal to that of the general population. Unfortunately, Medicaid patients are concerned about access to physicians and other health care providers, enrollment difficulties, the welfare stigma, and the lack of choice among health plans and/or physicians. Although the Medicaid program ostensibly offers a rich benefits package, the benefits increasingly are elusive in many regions of the country.

As outlined in Council Report 8 (A-03), numerous state Medicaid programs have failed to provide the services required by law. Michigan and Texas patient groups have contended that their state Medicaid programs failed to provide EPSDT services. Some states have made enrollment more difficult with the purpose of discouraging eligible individuals from enrolling. In 1999, it was widely publicized that some Medicaid maternity patients were being denied childbirth pain management unless they could provide cash payments upon demand, a practice that was stopped by the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services).

According to data compiled by researchers Jack Hadley and John Holahan in February 2003, for the Kaiser Commission on Medicaid and the Uninsured, nearly a third (29.7%) of beneficiaries of public insurance (excluding Medicare) are enrolled for less than a year. The Council believes this high level of fluctuation between being insured and uninsured can reflect many things. At least a part of the fluidity in enrollment is likely to be attributed to rigid Medicaid eligibility rules, which vary with income and state of residence.

In September 2003, the Kaiser Commission on Medicaid and the Uninsured released its third annual survey of state budgets and Medicaid cost containment efforts. The Kaiser Commission's report is current though July 1, 2003, the beginning of the Fiscal Year (FY) 2004 for most states. Results of the Kaiser Commission survey clearly demonstrate the imperative for reform:

- All 50 states reduced or froze provider payments in FY 2003, and 45 states planned to do so in FY 2004;

- 19 states reduced benefits in FY 2003, and 20 states planned to do so in FY 2004;

- 25 states reduced or restricted optional eligibility categories in FY 2003, and 18 states planned to do so in FY 2004;

- 17 states increased cost-sharing obligations in FY 2003, and 21 states planned to do so in FY 2004; and

- 46 states controlled prescription drug costs in FY 2003, and 43 states planned to do so in FY 2004 (e.g., required prior approval, made formularies more restrictive, established new or higher prescription co-payments).

In Spring 2003, a public-private partnership under the leadership of the Office of the Surgeon General issued a report entitled "National Call to Action to Promote Oral Health." At the time of the report's publication, the public-private partnership included nearly 70 members, including the AAP and the AMA. The partnership reported that "medical insurance is a strong predictor of access to dental care." The report had the following to say about the Medicaid dental benefit for children:

> "Medicaid has not been able to fill the gap in providing dental care to poor children. Fewer than one in five Medicaid-covered children received a single dental visit in a recent year-long study period. Although new programs such as the State Children's Health Insurance Program (SCHIP) may increase the number of insured children, many will still be left without dental coverage."

Physicians cite Medicaid payment rates, which do not cover the cost of care, and excessive paperwork demands, as deterrents to seeing Medicaid patients. As previously noted, the Kaiser Commission report indicated that in FY 2003, all 50 states froze or reduced provider payments, and 45 say they plan to do so again in FY 2004. As detailed in Council Report 8 (A-03), several state medical associations have pursued legal action against their state Medicaid programs. A 2002 study of 3,773 primary care pediatricians, entitled "Factors that Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients" found that low payment, capitation, and paperwork all relate to low Medicaid participation (Berman, et al., *Pediatrics*, August 2002).

A 2002 study conducted by the University of California-San Francisco and published by the California HealthCare Foundation (CHCF) found that 45% of California's primary care physicians and 43% of its specialists say they do not have any patients covered by Medi-Cal, the state Medicaid program. CHCF found that, among physicians participating in Medi-Cal, 94% said payment rates were inadequate and 87% said the program's paperwork requirements were burdensome. An analysis by the Center for Health System Change (HSC), completed in 2002, found much higher participation rates in the 12 nationally representative communities in which HSC surveys were completed. The HSC report said that the proportion of physicians serving Medicaid patients decreased from 87.1% in 1997 to 85.4% in 2001. HSC found that the level of physician participation was sensitive to the physician payment levels, noting that payment cuts may trigger access problems.

FINANCING ISSUES

The genesis of AMA support for tax credits and individually owned health insurance is to ensure patient choice. The model outlined in this report is particularly concerned with ensuring choice for those patients with low incomes, including those whose medical care is covered by Medicaid, with its shared federal and state financing. The Council believes there are many reasons to federalize the financing of medical care for low-income patients in a way that allows them to purchase private coverage.

Tax Credits

The AMA's definition of a tax credit has been refined over the years, and has been used as a model for other tax credit proposals. Consistent with Policy H-165.865(1), which outlines AMA principles for structuring health insurance tax credit, the Council advocates tax credits for Medicaid eligibles that meet the following criteria:

(a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided.

(b) Tax credits should be refundable.

(c) The size of tax credits should be inversely related to income.

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

(e) The size of tax credits should be capped in any given year.

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

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

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

(i) Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified MSA, and not for out-of-pocket health expenditures.

In addition, Policy H-165.865(2) states that, in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as such expenses are defined by Title 26 Section 213(d) of the United States Code.

Correspondence to the Council expressed concern that tax credits would be more administratively complex for families than Medicaid and that getting the tax credits would be problematic for families. The Council notes that it is much simpler to fill out a simple 1040A tax form than it is to complete most Medicaid applications. Correspondence specifically cited the length of time it took for low-income families to take advantage of the Earned Income Tax Credit (EITC). The Council concurs that the mechanics of administering tax credits to those with low incomes can be problematic. Rather than be discouraged by the experience with the EITC, however, the Council is encouraged because the progress in that program may translate into an easier transition with health insurance tax credits. After all, many of the families eligible for the EITC would be eligible for the health insurance tax credits proposed in this report.

In addition, the Council notes that Policy H-165.867 advocates that organizations such as local welfare agencies and/or other appropriate entities be authorized to verify income status and issue vouchers immediately for the amount of tax credits due individuals; thus advancing funds to purchase the coverage for low-income persons who could not afford the monthly out-of-pocket premium costs. Other appropriate agencies would include those that can offer outreach to low-income populations. The Council concurs, however, that policy should specifically support administrative simplicity for patients in order to be successful, and has incorporated this suggestion into its recommendations. Council on Medical Service Report 5 (A-00), which established Policy H-165.867, described how such advanced credits could be accomplished (e.g. via vouchers, which can take many forms, including debit cards that can receive distributions in flexible schedules).

Health insurance tax credits increasingly have become both politically and practically viable. As reported in Council on Medical Service Report 11 (A-03), the Trade Act of 2002 created the Health Coverage Tax Credit (HCTC), for certain individuals. Although the tax credits are limited, paying for up to 65% of qualified health plan premiums, they are advancable and refundable, as supported by Policies H-165.867 and H-165.865(1,b), respectively.

State Variation

In July 2003, the General Accounting Office (GAO) issued a report finding that the Medicaid formula (i.e., the "Medicaid match") narrowed the average difference in the ability of states to fund their programs by only 20% rather than the goal of 100%, and often widens differences in the states' funding ability. The GAO found that two states using the same portion of state resources on Medicaid can spend very different amounts per beneficiary. The GAO compared California and Wisconsin, which each spends .008% of state resources on Medicaid. Whereas Wisconsin receives a relatively high matching rate (62% in 2003), California receives a relatively low rate (54% in 2003), resulting in Wisconsin being able to spend more than twice what California spends per person ($7,532 in Wisconsin versus $3,731 in California). The GAO concludes that per capita income is an insufficient measure of state resources and a poor measure of the magnitude of state poverty and the costs to serve people in poverty. The Council notes that having more resources in a state does not ensure that the state will use those resources to provide medical care for people with low incomes.

Analysts across the political spectrum agree that the current structure of Medicaid is unsustainable, particularly with the continued growth of long-term care spending as the baby-boom generation ages. The Kaiser Commission on Medicaid and the Uninsured reports state Medicaid spending cuts for the second year in a row. The economic outlook has stalled suggestions to expand the Medicaid program, as states struggle to manage their fiscal crises by trimming Medicaid budgets, particularly optional benefits and coverage for optional groups.

Federal Responsibility

Whereas the current Medicaid program is jointly financed by states and the federal government, the Council proposes that the federal government, and not the states, take the sole responsibility for financing the medical care of low income individuals. The Council is proposing private health insurance that is publicly financed. It is a fundamental change in how we think about health insurance for the poor. It is not a way for the government or vested interests to dictate the type of health insurance coverage for those with low incomes, but a way for the government to provide a funding mechanism to individuals so that those with low incomes can choose and own their own coverage.

In July 2003, a *Health Affairs Web Exclusive* reported an Urban Institute analysis questioning the shared federal/state partnership of Medicaid, which strains state budgets and leaves 40 million people uninsured (John Holahan, Alan Weil, and Joshua M. Wiener). Specifically, state financial instability, distrust between federal and state governments, the limited implementation of successful waiver programs, and state variations in coverage, were cited by the authors as indicators that the current shared partnership should be reconsidered. States experience cyclical financial instability during recessions because the pressure demand for Medicaid services grows at the same time that state revenues decline. Medicaid spending is also projected to exceed state revenue growth regardless of the economy, making state financial instability a long term problem. The Urban Institute analysts indicate that income redistribution is more equitable at higher levels of government and the properties of interstate competition can lead to a "race to the bottom" as states try to attract businesses and high-income taxpayers by cutting taxes and services for the poor.

Costs of Public and Private Coverage

In order to assess the potential cost of the Council's proposal, it is useful to compare current public and private costs of coverage. According to the Kaiser Health Research and Educational Trust

Survey of Employer-Sponsored Health Benefits, the average annual premium cost for family coverage in 2002 was $7,954. Medicaid spending data from 2002 indicate the following:

Medicaid Enrollees and Estimated Average Spending by Group, 2002

	Enrollees (in millions)	Estimated Average Spending per Enrollee by Group
Children	24	$1,483
Adults	10	$2,334
Blind & Disabled	8	$11,776
Elderly	5	$12,318

Source: Kaiser Commission on Medicaid and the Uninsured: Key Facts, The Medicaid Program at a Glance, February 2003.

These data suggest that it may be comparable or cost even less to purchase coverage privately than it would cost to enroll an individual in Medicaid. With respect to assessing the costs of acute care patients, the table reports annual Medicaid spending per child in 2002 of $1,483, while spending per nondisabled and nonelderly adult was $2,334. Thus the average cost to Medicaid for two children and two nondisabled and nonelderly adults in 2002 was $7,634. A private sector family policy costing $7,954, the average premium cost for family coverage in 2002, would be one that assures access to competitively priced and high quality health care.

COVERAGE ISSUES

The Council proposes that low-income individuals, including most of those currently eligible for Medicaid or SCHIP, should receive tax credits that are large enough to enable individuals in those groups to purchase coverage individually, and through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP), with little or no cost-sharing obligations. Correspondence to the Council questioned the premise that private coverage is superior to Medicaid and SCHIP.

Specifically, one letter stated that "state employee purchasing pools and the like are adult-oriented and offer plans for individual adults or families, but do not offer child-only policies." The policy the Council is advocating is oriented toward covering people of all ages. The Council is advocating tax credits and coverage that would encourage and enable families, and not just children, to obtain coverage, whereas the current Medicaid and SCHIP often neglect the family unit. As such, the Council's recommendations invoke state and federal employee purchasing pools as models for group coverage for low-income tax credit recipients.

Cost-Sharing

As previously noted, Medicaid currently allows states to impose some cost+sharing for some beneficiaries. The September 2003 report of the Kaiser Commission on Medicaid and the Uninsured found that, in FY 2003, 17 states increased Medicaid cost-sharing requirements, and another 21 states intend to do so in FY 2004. The Council believes that the poorest individuals, measured for at least a transitional period as those who are currently eligible for mandatory Medicaid coverage and benefits, should be free of any cost-sharing obligation. As personal financial circumstances improve, individuals would be expected to participate more in the financing of their health insurance. However, unlike the current structure of Medicaid program, which is separate from all other programs, those whose incomes improved would not be expected to switch plans or providers. Individuals for whom Medicaid coverage is optional would have limited cost-sharing obligations and would receive tax credits large enough to purchase equivalent

coverage as those whose coverage extends from having been eligible for Medicaid coverage on a mandatory basis.

The limited and moderate cost sharing could be designed to take the form of paying a portion of the premium, paying a deductible, and/or having a copayment obligation. Low-income families that currently have some members covered under Medicaid, typically the children, with the parents being uninsured, would be able to combine their tax credits to purchase family coverage. Well-child visits and child immunizations are covered benefits in the most popular plan selected under the FEHBP. In addition, according to the Kaiser Family Foundation's 2003 Annual Survey of Employer Health Benefits, 97% of insured workers in firms of all sizes had coverage that includes well-child care. Such family-oriented plans are the standard by which the Council believes the adequacy of tax credits should be judged, and the recommendations accordingly point to employee purchasing plans as the model.

Individual Coverage

Correspondence to the Council expressed concern about the long-standing AMA policy that advocates the use of tax credits to purchase individual health insurance. Specifically, it was noted that the current individual health insurance market has a limited ability to provide affordable coverage. The Council fully acknowledges that the current individual market is problematic. However, the Council believes it is possible to make the individual market affordable and accessible for individuals. Accordingly, Council Report 7 (A-03) proposed a more uniform approach to health insurance market regulation as a means of fostering individually based coverage, and the House adopted a series of principles recommended in that report (Policy H-165.856). In addition, the Council is advocating that low-income individuals also be permitted to join or form groups modeled after state and federal employee purchasing pools, in addition to purchasing coverage individually. Moreover, tax credit proponents believe that the individual and group markets will evolve with the influx of tax credit financing. The HCTC will test that theory in a limited way, since those tax credits are limited both in who is eligible to receive them and by their size.

Retroactive Enrollment

Correspondence to the Council expressed concern that the proposed system of tax credits for low-income individuals would fail to account for the Medicaid safety net feature of presumptive and retroactive enrollment, whereby unenrolled Medicaid eligibles are generally able to have services covered although they were uninsured at the time they sought treatment. The Council agrees that this Medicaid feature should be replicated to the extent possible. In particular, the Council notes that there should be very few uninsured individuals under the tax credit scenario outlined in Council Report 8 (A-03), which suggested that individuals who are eligible but do not choose a plan would be assigned a plan in their geographic area. In addition, the Council proposes in this report that a specific recommendation be adopted to provide affordable coverage for any uninsured individuals who "slip through the cracks" and require medical treatment. Although there is a potential risk of increasing adverse selection with retroactive enrollment, the Council believes that rapidly decreasing the number of people without coverage will likely lessen this concern.

BENEFIT ISSUES

With respect to health care benefits under the current Medicaid program, correspondence to the Council raised concerns with the issues of prescription drugs, prenatal care and family planning, early and periodic screening diagnosis and treatment (including the Medicaid dental benefit), and transportation.

Prescription Drugs

Prescription drugs are optional for most Medicaid populations, and all states currently provide the prescription drug option. In recent years, Medicaid programs, like private plans, have struggled with pharmaceutical costs. The Kaiser Commission on Medicaid and the Uninsured reports that nearly all states took action last year to control prescription drug costs, by expanding the list of drugs for which prior approval is required, making formularies increasingly restrictive, and establishing new or higher prescription co-payments.

According to the Kaiser/HRET Employer Health Benefits Survey for 2003, prescription drugs are a standard benefit for virtually all covered workers. Employers have responded to the increased costs by requiring additional cost sharing and providing other financial incentives for employees, rather than physicians or other providers, to encourage the consideration of lower-cost options. The survey also found a significant rise in three-tier cost-sharing arrangements, where employees face differential copayments based on whether the drug is generic, preferred, or non-preferred.

Prenatal Care and Family Planning

Correspondence to the Council noted the importance of prenatal care and underscored the potential for the cost of care to be a barrier for low-income women. The Council fully agrees with this concern, and stresses that the benefits it envisions for low-income women would include the full range of maternity benefits found in state employee purchasing pools and the FEHBP. The Council proposes that tax credits for the poorest individuals be large enough to purchase coverage comparable to state employee purchasing pools and the FEHBP with no copayment obligations. Cost of care, therefore, should not be a barrier for these individuals. Correspondence to the Council also stated that “Medicaid also provides a significant amount of well-woman care for low-income women, including maternity care, family planning, breast and cervical cancer treatment, and care for disabled women. In addition to providing a wide range of labor, delivery and postpartum care Medicaid also covers contraceptives and other pharmaceuticals. It is not clear that private insurers would be as comprehensive in their benefits.” Based on its study of these types of issues over the years, it is the view of the Council that most private commercial plans, particularly those plans upon which the Council’s proposal is modeled, routinely offer these benefits. With respect to Medicaid coverage of family planning, only 16 states provided such benefits in 2002, and such coverage is accomplished as waiver initiatives rather than as optional benefits.

Early and Periodic Screening Diagnosis and Treatment (EPSDT)

Correspondence to the Council highlighted the importance of Medicaid’s EPSDT benefit for children. The Council notes that with few lapses, family health insurance plans contain most of the provisions of EPSDT, including immunizations and well-child visits. It was noted in one letter that that commercial plans place significant limits on children’s mental health benefits and rarely cover dental services. Unfortunately, there is no sector, including the current Medicaid sector, which is free of restrictions on mental health. In fact, Medicaid programs typically carve out the mental health function for management under private commercial managed behavioral health care programs.

While it is true that dental benefits are not typically covered under private health benefits, they can be covered at a relatively low cost. The richness of Medicaid dental benefit varies by states. For adults, dental benefits are optional. For children they are mandatory, but states can vary in how they define “reasonable standards of dental practice” for purposes of setting a periodicity schedule. As previously noted in this report, as an indication of the imperative to reform Medicaid, only about one-fifth of eligible beneficiaries receive dental benefits. In addition, dental benefits can be

imbedded in new health insurance programs, or can be promoted as an inexpensive additional benefit. The American Dental Association has been very active in litigation regarding access problems under state Medicaid programs. In 1999, a class action lawsuit was filed by the Michigan chapter of AAP and the Michigan Academy of Pediatric Dentists, with various patient advocacy organizations, against the Michigan Medicaid program to find ways to ensure that all children receive the mandatory medical and dental wellness (*Westside Mothers, et al., v. Haveman*, 289 F.3d 852 (6th Cir. 2002)). In 2000, to avoid the problems with dental access in Michigan, the state replicated the model of its SCHIP program, which relies on a private carrier to administer dental benefits. The result was the Medicaid Healthy Kids Dental program, which costs Michigan $12 per enrollee per month. The private plan provided payment at levels identical to its commercial contracts and reduced the administrative burden often associated with seeing Medicaid patients. Initial results of the Healthy Kids Dental program showed that the proportion of children receiving dental treatment grew by 43% during the first 12 months. In general, the Medicaid program has failed with respect to dental coverage, except where it has provided public financing for private coverage.

Transportation

Comments received by the Council also indicated concern that the Medicaid transportation benefit is necessary for many low-income patients in rural areas. The Council notes that transportation is not a medical benefit, but a social one. Therefore, the Council recommends that states be required to cover the cost of transportation to medical appointments. It is anticipated that transportation will become less of a problem for low-income patients once they are not restricted to Medicaid providers, but instead are allowed access to physicians and hospitals affiliated with a multitude of health plans.

AMA POLICY

At the 2003 Annual Meeting, the House amended Policy H-290.982(1), as recommended in Council Report 8 (A-03), to link Medicaid reform to private sector reform, rather than to Medicare reform, as had been previously stated in the policy. The development of a Medicaid reform model that enables the low-income population to purchase their own health insurance coverage aligns AMA policy toward the medical portion of the Medicaid program with the coverage envisioned in the AMA's private sector reform proposal, articulated in Policies H-165.920, H-165.882, H-165.865, and H-165.867.

Policy H-165.920 provides a broad summary of the proposal favoring individually owned health insurance over public sector and employment-based coverage. The policy supports the use of income-related individual tax credits, financed in part by revoking the subsidy for employment-based coverage. Policy H-165.882 supports market innovations to make individual ownership of health insurance affordable, as well as the formation of small employer and other collective groups. Policies H-165.865 and H-165.867 outline principles by which tax credit proposals should be structured. As cited above, Policy H-165.865(2) states that, to qualify for a tax credit for the purchase of health insurance, the coverage must include hospital care, surgical and medical care, and catastrophic coverage of medical expenses as such expenses are defined in Title 26 Section 213(d) of the United States Code.

Taken as a whole, the policies support individually owned health insurance financed by a system of refundable and advanceable tax credits that are inversely related to income, thereby being a useful model to subsidize those with little or no tax liability. AMA policy recognizes that the current individual market can and will be transformed by the influx of dollars earmarked for individual health insurance policies. Policy H-165.856 advocates a more uniform approach to health insurance market regulation as a means of fostering individually based coverage and alternative group purchasing arrangements. By adopting the recommendations of Council Report 8 (A-03), the House supported change in Policy H-290.982(1) to urge that Medicaid reform be undertaken in conjunction with broader health system reform, rather than in conjunction with Medicare reform. Although the AMA has developed numerous policies regarding the Medicaid program, such policy lacks a coherent direction. Policy H-290.982, in particular, favors a wide array of possible mechanisms to increase patient choice and improve Medicaid budgets. Policy H-290.997 supports increased uniformity across states with regard to eligibility, benefits, and payment.

Numerous AMA policies reflect long-standing concern of the House of Delegates with poor physician payment rates under Medicaid. For example, Policy H-290.980 was adopted as an amendment to Council Report 5 (I-99), and states that the AMA continues to advocate for appropriate payment to physicians under the Medicaid program. Policy H-290.982 favors an array of possible mechanisms to increase patient choice and improve Medicaid budgets, and Policy H-290.997 supports increased uniformity across states with regard to eligibility, benefits, and payment. Several policies also ask the AMA to secure "adequate" or better payment under Medicaid, including Policies H-165.895(1), H-290.976(2), and H-290.997(4).

GOALS OF THE COUNCIL'S PROPOSAL

The Council developed the proposal contained in this report after years of study and following several meetings with nationally renowned individuals with expert knowledge of the Medicaid program. In reaching the conclusions embodied in the proposal (i.e., the transition of the acute medical care Medicaid population into a system of tax credits and individually owned health insurance), the Council adhered to the following explicit policy goals:

- To establish an equitable distribution and dispensation of monies nationwide.
- To ensure access to physicians and other health care providers.
- To provide a choice of care systems and providers.
- To eliminate the stigma of using health insurance benefits.
- To establish an intermediate step to funding health insurance, so patients do not completely lose eligibility for benefits when they lose or gain employment.
- To provide portability of coverage.
- To constitute a seamless system for patients and physicians and other providers.

PROPOSAL FOR MEDICAL CARE FOR PATIENTS WITH LOW INCOMES

On the basis of its study, the Council concludes that the most equitable and logical proposal for those patients who use Medicaid solely for medical care is to use a system of federally financed tax credits. By completely federalizing the financing of care for the 73% of Medicaid beneficiaries

(children and non-disabled, non-elderly adults), who account for 27% of Medicaid expenditures, states will be freed of a large financial obligation. However, these funds will then be available potentially to provide increased resources for long-term care and disability care.

People with low incomes do not benefit from the separate and unequal health care delivery system that has developed as a result of excessive and unfocused Medicaid administration. As a result, the Council proposes a system aligned with the AMA private sector reform proposal as follows:

(1) Finance the medical care portion of the Medicaid program with federally issued tax credits that are refundable, advanceable, inversely related to income, administratively simple for patients, and not in a shared federal/state partnership, to allow acute care 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 as described below.

Rationale: With the provided resources, Medicaid beneficiaries would be able to choose from a wide range of health insurance options. Although some states have succeeded in making changes that improve access to medical care for Medicaid beneficiaries, most have not. Poor access to mainstream medical care is a recurring problem of the Medicaid program, which promises a generous benefit package but cannot assure that there will be physicians and other health care practitioners who can afford to provide those services. The Medicaid program is also marked by a welfare stigma that will be greatly diminished when eligible individuals are able to purchase mainstream health benefits.

(a) Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive tax credits that are large enough to enable individuals in those groups to purchase coverage with no cost-sharing obligations.

Rationale: This recommendation would leave intact the premise of the Medicaid program that there are some low-income individuals whose medical care should be subsidized completely. Their incomes are so low or their care is so essential (e.g. well-child visits) that even the smallest cost-sharing obligation could prevent or delay necessary medical treatment.

Allowing individuals to use their tax credit to "buy in" to state, federal, or other purchasing pools is consistent with Policy H-165.995(3).

(b) Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive tax credits that are large enough to enable them to purchase coverage with limited cost sharing.

Rationale: This recommendation is fully consistent with AMA policy it, advocates that tax credits be inversely related to income, and states that tax credits must be large enough to entice recipients to purchase coverage. To ensure that the coverage is affordable for the optional Medicaid eligibility group, it is necessary to ensure that the cost-sharing is kept to an affordable level.

In 1998, about 44% of all Medicaid spending was for optional groups, and about 65% of all Medicaid spending was for optional services. Many states have recently terminated benefits for some optional populations, which include infants under age 1 in families with incomes at or below 185% of FPL, older children in

families with incomes above the mandatory poverty levels, pregnant women at higher levels of poverty, certain disabled and elderly individuals whose incomes exceed SSI limits, and individuals deemed "medically needy" and able to "spend down" because of their high medical expenses. As stated previously, Medicaid currently allows states to impose nominal cost-sharing, and states are increasingly imposing higher cost-sharing obligations.

(2) Individuals who do not qualify for Medicaid, and have resources that are insufficient to purchase health insurance, should receive federally issued tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing. Rationale: The intent of this recommendation duplicates AMA policy in support of tax credits that are inversely related to income. The Council hopes that the reiteration of this point will assure those who believe tax credits are solely a mechanism for wealthier individuals. Medicaid does not cover all poor people, but the Council believes it is sound policy, for instance, to provide coverage to parents of currently eligible children. Such a subsidy would not amount to an expansion of current public sector eligibility. Rather, it would be an expansion of coverage with tax credits to the uninsured, consistent with Policy H-165.920.

Eighty-five percent of the uninsured live in families headed by workers and are therefore contributing, through income taxation, to the financing of Medicaid, Medicare, and the nearly $100-billion subsidization of employment based coverage. Accordingly, these uninsured families are spending more on health insurance for others than for their own families. The Council believes it is unconscionable to continue to deprive low-income individuals of any health insurance subsidy simply because their employers do not offer coverage or because their incomes, while low, are too high for Medicaid.

(3) In order to assure continuity of care, there should be a seamless mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family.

Rationale: Under the current Medicaid program, individuals gain and lose coverage as their income changes. The portability of individually owned health insurance is assured because the size of the tax credit will only decrease as income increases, while the availability of health insurance remains unchanged by income fluctuation.

(4) Tax credit beneficiaries should be given choices of where to purchase coverage. A mechanism should be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area until the next enrollment opportunity.

Rationale: Some beneficiaries may never have had private coverage and may be uncomfortable choosing their own health insurance. Although proactively changing the coverage of a Medicaid beneficiary who has not chosen to do so may cause some confusion, doing so may be necessary to eliminate the joint federal/state Medicaid partnership that maintains contracts with health plans. The proposed change would be financed solely by the federal government, and health plan contracts would be with patients rather than a government entity.

1 (5) A safety net mechanism should be developed to allow for the presumptive assessment of
2 and retroactive coverage to the time at which an eligible person seeks medical care.
3
4 Rationale: The Medicaid program currently features presumptive enrollment and
5 retroactive coverage, whereby nonenrolled Medicaid eligibles are generally able to have
6 services covered although they were uninsured at the time they sought treatment. As
7 expressed by the concerns brought to the Council, the Council agrees that these Medicaid
8 features should be replicated to the extent possible.
9
10 Under a system of tax credits and private coverage, physicians, hospitals, and other health
11 care providers could simply and presumptively assess eligibility for tax credits for
12 uninsured individuals who seek medical treatment and had not yet availed themselves of
13 the tax credit. Consistent with the intent of the current Medicaid program, if the individual
14 seeking treatment is deemed ineligible for a tax credit, the treatment could be paid from the
15 same fund that finances the tax credits. Individuals who receive tax credits provided at the
16 point of service could be assigned a health plan, and participating plans could be required
17 to accept responsibility for the retroactive coverage.
18
19 If the proposed system worked perfectly, there would be no low-income uninsured
20 individuals. Assuming there will be low-income individuals who do not learn of or avail
21 themselves of the tax credit, the Council believes retroactive assignment is a reasonable
22 extension of the proposal to assign individuals who fail to choose a plan, and
23 acknowledges that the cost of treatment would have been covered by the assigned plan if
24 the individual had not "fallen through the cracks."
25
26 (6) Benefits that would otherwise be available as either a mandatory or optional service, but
27 which are not medical benefits per se (such as transportation services), should be covered
28 at least for a transitional period by state public health or social service programs.
29
30 Rationale: The Council received many comments regarding Medicaid benefits that enable
31 beneficiaries to seek medical treatment though some of these benefits are not strictly
32 medical. Once states are freed of the financial obligation for up to a half of the cost of
33 medical care for the acute-care population, they should be obligated to use that money to
34 enhance care in their boundaries. In particular, states should ensure that the necessary
35 social safety net exists to enable health insurance tax credit recipients to get the medical
36 care they need.
37
38 Programs such as employee purchasing pools and FEHBP offer rich benefit packages,
39 which typically include EPSDT services. However, they do not include the social services
40 now covered by Medicaid such as transportation costs and interpretation services. The
41 Council believes that these social services should continue, but under the auspices of state
42 social service agencies.
43
44 (7) As individuals in the acute care population transition into chronic care needs, they should
45 be eligible for sufficient additional subsidization to allow them to maintain their current
46 coverage.
47
48 Rationale: This recommendation addresses a concern conveyed to the Council, that
49 children with acute needs may at some point have chronic needs. The broader AMA tax
50 credit reform proposal does not yet have policy on whether individuals with chronic care
51 needs should receive an additional subsidy to purchase coverage from the same entities as
52 healthier individuals, or whether they should receive coverage in a special high-risk pool.

In the absence of such policy, and in order to maintain continuity of coverage for those with the most complex health needs, the Council supports the use of additional subsidization to enable such newly chronic patients to maintain their publicly financed private coverage. An advantage of such an approach is that it will enable policy-makers to test the efficacy of additional subsidization for chronically ill and disabled patients on a relatively small scale, rather than unveiling a proposal at this time to fully federalize the chronic care function of Medicaid as well.

CONCLUSIONS

As this report clearly indicates, the structure and financing of the current Medicaid program is crumbling. 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. Medicaid beneficiaries experience decreased access to medical care and diminished choice of physicians and other health care providers.

According to a recent study completed by researchers at the Urban Institute for the Kaiser Commission on Medicaid and the Uninsured, $35 billion was spent on caring for the uninsured in 2001, with $31 billion of that amount funded by the government (Hadley and Holahan, *Health Affairs*, February 2003). As the authors conclude, the money spent on providing services to the uninsured could be spent on premiums.

Consistent with AMA Policy 165.920(17), the Council would strongly oppose merely an expansion of eligibility to Medicaid because it would be wrong to make more people dependent upon such a tenuous program, especially when it would be unlikely that increased spending would be commensurate. The Council's development of the proposal in this report complies with Policy H-290.982 (1), which urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients. The recommendations contained in this report will fully implement the AMA's support for individual insurance using tax credits inversely related to income, so that policy broadly supports health insurance reform instead of solely "private sector reform." The subsidization as recommended by the Council would apply to the provision of medical care services for Medicaid's current mandatory and optional categories, as well as to all individuals at or below an income threshold. Support for tax credits for the purchase of individual health insurance has gained considerable viability over the past five years. For example, as described in Council on Medical Service Report 11 (A-03) the U.S. Department of the Treasury developed a program of health coverage tax credits that were approved in the Trade Act of 2002 for certain uninsured individuals. In addition, a number of presidential candidates have developed health insurance proposals that include refundable tax credits for low-income individuals.

The Council specifically requested advice and suggestions from a broad spectrum of physicians and physician organizations on whether there were elements that had been left out of the proposal and needed to be considered, or whether there were elements that were included and should be deleted. The Council appreciates the input that it has received in response to Council Report 8 (A-03), and in the development of this report. It is this type of dialogue and commitment that will lead to improved access and coverage of medical services to low-income patients.

RECOMMENDATIONS

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

1. That it is the policy of the American Medical Association (AMA) that the medical care portion of the Medicaid program should be financed with federally issued tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, to allow acute care 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 as described below:

   a. Individuals who would otherwise qualify for mandatory Medicaid eligibility groups should receive tax credits that are large enough to enable them to purchase coverage with no cost-sharing obligations.

   b. Individuals who would otherwise qualify in an optional Medicaid eligibility group should receive tax credits that are large enough to enable them to purchase coverage with limited cost-sharing. (New HOD Policy)

2. That it is the policy of the AMA that individuals who do not qualify for Medicaid, and have resources that are insufficient to purchase health insurance, should receive federally issued tax credits that are large enough to enable them to cover a substantial portion of coverage, with moderate cost-sharing. (New HOD Policy)

3. That it is the policy of the AMA that, in order to assure continuity of care, there should be a seamless mechanism to quickly reassess the eligibility group and amount of tax credit with changes in income and family. (New HOD Policy)

4. That it is the policy of the AMA that tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area until the next enrollment opportunity. (New HOD Policy)

5. That it is the policy of the AMA to support the development of a safety net mechanism to allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care. (New HOD Policy)

6. That it is the policy of the AMA that state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available as either a mandatory or optional services under Medicaid, but are not medical benefits per se. (New HOD Policy)

7. That it is the policy of the AMA that as individuals in the acute care population transition into chronic care needs, they should be eligible for sufficient additional subsidization to allow them to maintain their current coverage. (New HOD Policy)

8. That the AMA continue to work with interested national medical specialty societies, state medical associations, and other relevant organizations as it develops policy recommendations to the House of Delegates for improving the medical care provided to patients with low incomes. Issues to be addressed should include the overall costs of caring for this patients

population, options for combining tax credits with other financing mechanisms and insurance market reform, and the provision of the safety net for the most vulnerable segments of the current Medicaid population. All financing mechanisms should be sufficient to adequately fund the overall cost of caring for this patient population and to provide adequate reimbursement to physicians caring for such persons. (Directive to Take Action)

9. That the AMA encourage the development of pilot projects, including children, incorporating the above recommendations. (Directive to Take Action)

Fiscal Note: None