

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-06)
Individual Responsibility to Obtain Health Insurance
(Resolution 703, I-05)
(Reference Committee A)
(June 2006)

EXECUTIVE SUMMARY

At the 2005 Interim Meeting, the House of Delegates referred Resolution 703 to the Board of Trustees. Introduced by the California and Guam Delegations, the resolution calls for the AMA to “work with the federal government to ensure that all Americans be required to have, at a minimum, catastrophic and preventive health care coverage;” and to “work with the federal government to ensure that those with incomes between 200-400 percent of the federal poverty level, who are not eligible for Medicaid or SCHIP, be eligible for a refundable tax credit to support the purchase of health care coverage.”

In this report, the Council on Medical Service expands upon the request of Resolution 703 (I-05) to revisit the issue of individual responsibility to obtain health insurance. This report reviews AMA policy and reports on health system reform and individual responsibility; highlights the advantages and disadvantages of requiring individual responsibility; presents evolving opinion about individual responsibility; discusses the costs of individually owned health insurance; establishes an income-related threshold for individual responsibility; and presents recommendations that establish new policy related to the AMA proposal for health system reform.

In 1998, when the AMA established Policy H-165.920, which stated a preference for individually owned health insurance, the rationale was to provide patients with more choice as well as to address the uninsured. In 2000, the AMA formally rescinded policy that had supported an employer mandate. At that time, employment-sponsored coverage was noted for creating “job lock” and for not offering “portability.” These problems persist today at the same time that many employers increasingly cite health insurance as an unsustainable cost. The growth in the number of the uninsured in the past several years has been attributed, in large part, to a loss of employment-sponsored insurance.

As outlined in this report, the AMA proposal for health system reform has grown more sophisticated and comprehensive since the establishment of the fundamental principles in 1998. Over the years, the Council has weighed the pros and cons of supporting greater individual responsibility. Council Report 5 (A-00) established Policy H-165.920[13], which supports the use of tax incentives, and other non-compulsory measures, rather than a mandate requiring individuals to purchase health insurance coverage.” Since 2000, the Council has revisited the issue of individual responsibility on several occasions, and has been mindful of changing public opinion in favor of some degree of individual responsibility, particularly for those with high incomes.

In this report, the Council determines whether there is an income threshold above which individuals should have a responsibility to obtain health insurance. The Council distinguishes “individual responsibility” with financial penalties for noncompliance, from an “individual mandate,” which implies the failure to obtain coverage could result in criminal penalties. Finally, the Council notes that although its recommendations focus primarily on those at high income levels, it is important to remember that the AMA proposal for health system reform is fundamentally concerned with those most likely to be uninsured—those at the lowest income levels.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3 - A-06
(June 2006)

Subject: Individual Responsibility to Obtain Health Insurance
(Resolution 703, I-05)

Presented by: Joseph P. Annis, MD, Chair

Referred to: Reference Committee A
(Richard W. Whitten, MD, Chair)

1 At the 2005 Interim Meeting, the House of Delegates referred Resolution 703 to the Board of
2 Trustees. Introduced by the California and Guam Delegations, the resolution calls for the
3 American Medical Association to “work with the federal government to ensure that all Americans
4 be required to have, at a minimum, catastrophic and preventive health care coverage,” and to “work
5 with the federal government to ensure that those with incomes between 200-400 percent of the
6 federal poverty level, who are not eligible for Medicaid or SCHIP, be eligible for a refundable tax
7 credit to support the purchase of health care coverage.” The Board of Trustees referred Resolution
8 703 (I-05) to the Council on Medical Service for study and report back to the House at the 2006
9 Annual Meeting.

10
11 The Council announced during testimony on Resolution 703 (I-05) that it already had decided to
12 revisit the issue of individual responsibility to obtain health insurance, and welcomed referral. This
13 report reviews AMA policy on health system reform; summarizes previous Council reports
14 addressing individual responsibility; highlights the advantages and disadvantages of requiring
15 individual responsibility; presents opinion about individual responsibility; discusses the costs of
16 coverage; establishes an income-related threshold for individual responsibility; and presents policy
17 recommendations that further refine the AMA proposal for health system reform.
18

AMA POLICY ON HEALTH SYSTEM REFORM

20
21 AMA discussion of individual responsibility to obtain health insurance has occurred within the
22 context of support for individually owned health insurance. During the past two decades, the
23 House of Delegates has continuously reviewed and revised the AMA policy base on health system
24 reform. In the 1980s, AMA policy was dominated with concerns about managed care. During the
25 early 1990s, the Clinton Administration’s health system reform effort prompted the AMA to
26 develop its own proposal, “Health Access America,” which contained a mandate that employers
27 provide health insurance for their employees. By the 1996 Interim Meeting, discontent with how
28 some employers used managed care to interfere with patient choices and physician decision-
29 making led to support for individually selected and owned health insurance as the preferred method
30 for people to obtain health insurance coverage (Policy H-165.920[5], AMA Policy Database).
31

32 At the 1998 Annual Meeting, the House adopted the 17 recommendations in Council on Medical
33 Service Report 9, thereby establishing comprehensive policy as to how a system of individually
34 owned health insurance should be structured based on a premise of pluralism of health care
35 delivery systems and financing mechanisms (Policy H-165.920). In response to growing debate
36 about health insurance tax credits, Council on Medical Service Report 4 (A-00) established a series

1 of principles for structuring such credits (Policy H-165.865). Also in 2000, the House rescinded
2 Policy H-165.980, thereby formally removing AMA support for an employer mandate from the
3 AMA Policy Database. Policy H-165.920[5] supports individually selected and individually-
4 owned health insurance as the preferred method for people to obtain health insurance coverage; and
5 supports and advocates a system where individually owned health insurance is the preferred option,
6 but employer-sponsored coverage is still available to the extent the market demands it. In 2003,
7 the House adopted a series of key principles for health insurance market regulation to facilitate the
8 use of individual health insurance tax credits (Policy H-165.856) that were proposed in Council on
9 Medical Service Report 7 (A-03).

10
11 AMA policy also has shifted away from specifying covered benefits. Policy H-165.865[2], which
12 contains the AMA principles for structuring health insurance tax credits, states that the health
13 insurance purchased must provide coverage for hospital care, surgical and medical care, and
14 catastrophic coverage of medical expenses as such expenses are defined by Title 26 Section 213(d)
15 of the United States Code. With respect to preventive services, Policy H-425.997[3] states that any
16 preventive service that is being considered for inclusion in public or private sector insurance
17 products have evidence-based data to demonstrate improved outcome or quality of life and the cost
18 effectiveness of the service, and Policy H-425.988[1] calls for the AMA to continue to work with
19 the federal government, specialty societies, and others, to develop guidelines for, and effective
20 means of delivery of, clinical preventive services through the US Preventive Services Task Force.
21 With respect to catastrophic services, Policy H-185.982[2] supports the study of "catastrophic
22 only" health insurance.

23
24 Recent policy refinements have sought to broaden the advocacy potential of the AMA proposal for
25 health system reform. For example, Policy H-165.851[1] supports implementation of individual
26 tax credits for the purchase of health insurance for specific target populations such as low-income
27 workers, low-income individuals, children, the chronically ill, and those living within geographic
28 areas that are pilot testing tax credit proposals. Policy H-165.855 proposes tax credit eligibility for
29 those with the lowest incomes. Throughout the years of policy refinements, there have been many
30 suggestions that the AMA should support the notion of greater individual responsibility, once the
31 AMA vision of tax credits and individually owned health insurance is achieved.

32
33 **PREVIOUS COUNCIL REPORTS ADDRESSING INDIVIDUAL RESPONSIBILITY**

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35 Council on Medical Service Report 5 (A-00) established Policy H-165.920[13], which states that
36 the AMA "supports the use of tax incentives, and other non-compulsory measures, rather than a
37 mandate requiring individuals to purchase health insurance coverage." On several occasions over
38 the past six years, the Council has revisited the concept of greater individual responsibility to
39 obtain health insurance. In fact, in 2004, the Council prepared a draft report that it did not present
40 to the House that would have recommended support for greater individual responsibility upon
41 implementation of key aspects of the AMA proposal for health system reform. The draft report
42 was not presented to the House because the Council did not reach consensus regarding both the
43 content and timing of such a shift in AMA policy.

44
45 It is important to note that the House of Delegates previously supported the establishment of an
46 individual mandate for financing Medicare coverage coupled with an income-related subsidy, when
47 it adopted the recommendations contained in Council on Medical Service Report 5 (I-03),
48 "Restructuring Medicare for the Long-Term." Policy H-330.898[1] supports proposals to shift the

1 funding of Medicare from the current tax financed pay-as-you-go system to a system of mandatory
2 individually-owned private savings. The policy calls for a required minimum contribution,
3 accumulated tax-free and dedicated to funding post-retirement medical care, with the government
4 providing a contribution to economically disadvantaged individuals who would make smaller than
5 average contributions to their retirement accounts.

6

7 **ADVANTAGES AND DISADVANTAGES OF REQUIRING INDIVIDUAL RESPONSIBILITY**

8

9 Summaries of the potential advantages and disadvantages of an individual mandate appeared in two
10 previous reports of the Council on Medical Service: Report 5 (A-00) and Report 4 (I-04). These
11 summaries highlighted hypothetical and philosophical considerations. The key considerations have
12 remained largely unchanged over the years. What has changed, the Council believes, is the relative
13 weight given to elements of each position, so that the advantages of requiring individual
14 responsibility appear increasingly compelling. Rather than emphasizing the issue of a mandate,
15 which focuses on how government or some entity imposes on the will of the individual, the
16 Council finds greater merit in focusing on the issue of individual responsibility. There are some
17 individuals with high incomes whose failure to obtain health insurance coverage poses an
18 avoidable social burden. Such individuals have a responsibility to obtain coverage. Individuals
19 with lower incomes also have the responsibility to seek and maintain coverage, but their burden to
20 do so is tempered by their ability to afford the potentially high cost of coverage.

21

22 **Advantages**

23

24 As noted in previous reports of the Council, the key reasons for requiring individuals to purchase
25 coverage include: (a) achieving universal coverage; (b) avoiding the “free-rider” problem,
26 whereby care for the uninsured is ultimately paid for by the rest of society through higher taxes and
27 higher premiums; and (c) avoiding adverse selection, whereby low-risk individuals opt out of
28 insurance, driving up average costs and premiums for those who are insured. Many policy analysts
29 believe that under a voluntary system, a significant number of people would not purchase coverage,
30 particularly those with low incomes, the young, and the healthy. The erosion of coverage under the
31 current, voluntary system suggests that some level of a mandatory approach may be needed to
32 guarantee health insurance coverage for all Americans, and to ensure that risk pools include low-
33 risk individuals.

34

35 According to a June 2005 report by Families USA, “Paying a Premium: The Added Cost of Care
36 for the Uninsured,” the average increase in insurance premiums to pay for the health care of the
37 uninsured in 2005 was \$922 for those with family coverage and \$341 for those with individual
38 coverage. In addition, as reported in Council on Medical Service Report 8 (A-05), “Offsetting the
39 Costs of Providing Uncompensated Care,” AMA data have consistently shown that a typical
40 physician provides, on average, more than \$2,000 worth of uncompensated care every week.

41

42 Requiring greater individual responsibility to obtain health insurance would mitigate against
43 adverse selection by generating growth in the number of average risk people in the individual
44 market. Like tax credits, requiring more individuals to obtain coverage could lead to a “premium
45 rating conversion” or what the Council has previously called *de facto* modified community rating
46 (Council on Medical Service Report 7 (A-03), “Health Insurance Market Regulation”). In Council
47 Report 7 (A-03), it was noted that following the influx of a critical mass of average-risk individuals
48 into the individual market, it is likely that health insurers would no longer find it cost-effective to

1 individually risk rate applicants. Costly medical underwriting practices would be replaced by
2 simplified, automated ones, particularly as purchasing insurance over the Internet becomes more
3 common. The result would be *de facto* modified community rating, but as the natural byproduct of
4 market function rather than by market regulation.

5

6 Disadvantages

7

8 Requiring individuals to take greater responsibility for obtaining coverage can be viewed as
9 coercive, particularly in the context of tax credit proposals to increase individual choice. The
10 Council believes it is particularly important to avoid criminal penalties for failing to obtain
11 coverage. For this reason, the Council has chosen to address the issue of individual responsibility
12 via taxation.

13

14 Requiring individuals to obtain and maintain coverage also could permit the government to renege
15 on its commitment to support health insurance through the provision of tax credits and other
16 subsidies. In order for such a requirement to be effective, resources would be required to identify
17 the uninsured and compel them to purchase health insurance, particularly for certain segments of
18 the population, such as seasonal laborers. A requirement that low-income individuals obtain
19 coverage will fail in the absence of appropriate subsidies and regulatory reforms.

20

21 Requiring coverage could lead to excessive government involvement in defining qualified coverage
22 or setting prices for premiums and health care services. For example, a requirement to obtain
23 coverage coupled with strict community rating amounts to a tax on low-risk individuals, who
24 would otherwise face more affordable premiums.

25

26 Finally, requiring coverage might not be necessary to achieve a reasonable level of health insurance
27 coverage. Income-related, refundable tax credits would give low-income individuals
28 unprecedented market power, and the market would respond by providing more affordable
29 insurance products. Thus, tax-based incentives to purchase insurance, coupled with a greater tax
30 credit to the low-income to assist them in obtaining health insurance, could lead to virtual universal
31 coverage.

32

33 OPINIONS ON GREATER INDIVIDUAL RESPONSIBILITY

34

35 With the relentless growth in the number of uninsured individuals, it appears that opinions favoring
36 greater responsibility for individuals to obtain health insurance have gained support in recent years.
37 Opinions supporting greater individual responsibility have acknowledged that there are some
38 patients whose medical expenses are so high that they would have difficulty purchasing coverage
39 even if they had high incomes.

40

41 The California Medical Association (CMA), one of the sponsors of Resolution 703 (I-05), provided
42 the Council with its health insurance reform proposal, which supports an individual mandate. In
43 particular, CMA supports mandated coverage, with tax credits inversely related to income, for
44 households earning 200-400% of the federal poverty level (FPL). In 2006, for a family of four,
45 200% of the FPL is \$40,000 and 400% of the FPL is \$80,000. Households earning more than
46 400% of the FPL would be required to purchase coverage with no additional subsidy, or be subject
47 to a tax penalty. A tax penalty would apply also to those households earning 200-400% of the FPL
48 that remain uninsured. Children in households earning less than 200% of the FPL would retain

1 coverage under public programs (Medicaid and SCHIP). CMA proposes that adults in the lowest
2 income bracket be allocated to a strengthened safety net. The Council recognizes the importance
3 of maintaining a strong safety net.

4

5 Similarly, as the Council previously reported to the House, the AMA joined as a participating
6 member of the Search for Common Ground/Health Care Coverage for the Uninsured (HCCU)
7 consensus-building process in the fall of 2004. Consisting of 24 organizations, the HCCU
8 consensus-building group is working to develop a strategy for expanding health insurance coverage
9 "to as many people as possible as quickly as possible." Although the HCCU group had not
10 completed its work at the time that this report was written, it has been the view of some group
11 participants that individuals should bear greater responsibility for health insurance, especially for
12 those at high income levels, and for parents with respect to coverage for their children.

13

14 The New American Foundation, a nonpartisan policy institute, supports a requirement of individual
15 responsibility. In January 2006, the New America Foundation released an issue brief entitled
16 "Outline of the New America Vision for a 21st Century Health Care System." The brief envisions
17 that "just as we are required to enroll our vaccinated children in school, to buy our own auto
18 insurance, and to pay the taxes that we the people decide we owe, obtaining private or public
19 coverage through appropriate means will be the norm in the 21st Century health system." The New
20 American Foundation emphasizes the need for "shared responsibility," that is, regulatory reforms
21 must be designed to ensure that affordable options exist and the purchase of health insurance must
22 be subsidized on a sliding scale for those who need them.

23

24 In April 2006, the Massachusetts legislature approved a bill to expand health insurance coverage
25 that included provisions to increase individual responsibility and institute market reforms. In
26 addition to providing sliding-scale subsidies for the purchase of health insurance by lower-income
27 individuals, it included tax penalties for those individuals who fail to purchase coverage. The
28 penalty for not obtaining health insurance by July 2007 would be a loss of the state personal tax
29 exemption. At the time this report was written, Massachusetts Governor Mitt Romney was
30 expected to sign the bill, with some possible changes.

31

32 COST OF COVERAGE

33

34 In September 2005, the Kaiser Family Foundation published "Employer Health Benefits 2005
35 Annual Survey," which included data on premiums for employer health plans. The Kaiser report
36 showed that the average premium for employment-based single coverage was \$4,024, and the
37 average premium for employment-based family coverage was \$10,880. These amounts include
38 both the employer and employee shares of premiums.

39

40 In August 2004, the Kaiser Family Foundation and eHealthInsurance published a joint report
41 entitled "Update on Individual Health Insurance," which challenged the assumption that the
42 uninsured would not be able to obtain individually-purchased coverage comparable to existing
43 employment-based coverage. The joint report found that average premiums paid for health
44 insurance obtained on the individual market are *markedly* lower than in the group market (\$1,768
45 for single coverage, and \$3,331 for family coverage). The substantial premium reductions were
46 attributed in part to the younger ages of individual health insurance enrollees, as well as the fact
47 that many people, when given a choice, choose less generous coverage than is typically offered by
48 employers.

1 In November 2005, eHealthInsurance published a report entitled "The Cost and Benefits of
2 Individual Health Insurance Plans," which analyzed information from a sample of more than
3 80,000 health insurance policies sold to individuals and families through eHealthInsurance.com,
4 and addressed concerns about the type of coverage chosen by enrollees by providing summary data
5 on benefits and cost-sharing. The report summarized the monthly premiums and benefits for both
6 major medical and short-term policies, and specifically excluded Health Savings Account plans
7 from the analysis. The major medical plans were largely PPOs (86%) and more than 90% of the
8 major medical plans provided comprehensive coverage.
9

10 The individual policy holders in the 2005 eHealthInsurance study paid an average of \$148 per
11 month or \$1,776 annually for major medical coverage, whereas those with family coverage paid an
12 average of \$331 per month or \$3,972 annually, with the average family size being three members.
13 The report noted that the average cost of coverage for a child alone is \$89 per month, or \$1,068
14 annually. The eHealthInsurance report showed considerable variation of costs between states.
15 Michigan is reported to have the lowest premiums per individual (\$98 monthly or \$1,176 annually)
16 and New York the highest (\$379 monthly or \$4,548 annually). In large part, state variation in the
17 cost of coverage is due to variation in state regulations.
18

19 Of the individually owned major medical policies, 60% had a deductible of \$2000 or less, and 40%
20 had a deductible of more than \$2,000; 35% had a deductible of \$500 or less; 25% had a deductible
21 between \$500 and \$2,000. For comparable family plans, 50% had a deductible of \$2000 or less.
22 Nearly 40% of the major medical plans required no co-payments. The eHealthInsurance report
23 analyzed its short-term policy offerings as well. These policies are useful for individuals and
24 families experiencing gaps between periods of employment-based coverage, and are particularly
25 popular among younger adults. Among short-term policy holders, 75% are under 35 years of age,
26 with 40% between the ages of 25 and 34, a segment of the population with high rates of
27 uninsurance. According to the August 2005 Census Bureau report entitled "Income, Poverty, and
28 Health Insurance Coverage in the United States: 2004," among 25-34 year old individuals, nearly
29 26% were without health insurance. The average premiums for short-term policies were \$78
30 monthly or \$936 annually for individuals, and \$192 monthly or \$2,304 annually for families.
31

32 THRESHOLD FOR INDIVIDUAL RESPONSIBILITY

33

34 The likelihood of having health insurance coverage increases with income. It is often useful to
35 think of income in terms of the federal poverty level (FPL), which can represent incomes of
36 households or individuals. Each year, the U.S. Department of Health and Human Services Office
37 of the Assistant Secretary for Planning and Evaluation (ASPE) publishes new poverty guidelines
38 that are used for, among other things, determining financial eligibility for certain federal programs.
39 The Council used the poverty guidelines as it contemplated whether there is an income level at
40 which individual responsibility should be required. For 2006, the FPL guidelines for the 48
41 contiguous states and the District of Columbia, which increases by \$3,400 for each additional
42 person in the family unit, were as follows:

<u>Federal Poverty Guidelines, 2006</u>	
Family Size	Poverty Guideline
1	\$9,800
2	\$13,200
3	\$16,600
4	\$20,000
5	\$23,400
6	\$26,800
7	\$30,200
8	\$33,600

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

For Alaska, the poverty guideline for one person is \$12,250, with each additional person in the family unit adding \$4,250. For Hawaii, the poverty guideline for one person is \$11,270, and increases by \$3,910 for each additional person.

ASPE also published the following data on the distribution of the uninsured by income, as measured by FPL:

<u>Uninsured by FPL, 2004</u>	
% Uninsured	% of FPL
25	Less than 100%
28	100-199%
19	200-299%
11	300-399%
6	400-499%
11	Over 500%
100	Total

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

Data by income shows a direct inverse relationship between income and health insurance coverage, which is the rationale for AMA support for subsidizing the cost of health insurance in a manner that is inversely related to income (Policy H-165.865[1,c]).

Discussion about individual responsibility for health insurance often refers to state-based automobile insurance laws. Despite the near-universal prevalence of these state mandates, the cost of uninsured “free riders” is significant enough to impact the premiums of those who purchase automobile insurance. In part due to the elevated premiums, as well as the fact that there is no subsidy for the purchase of automobile insurance, low-income drivers are more likely to forgo automobile insurance. Comparisons of health insurance to automobile insurance may be spurious, because people can choose whether to drive, but do not always have control over their health care needs. Moreover, automobile insurance has been an “unfunded mandate” for individual drivers regardless of income, while the AMA proposal for tax credits inversely related to income provides an equitable strategy to subsidize any potential requirement to purchase health insurance.

In considering an individual requirement for health insurance, the Council believes that at some point incomes rise to a threshold where personal responsibility should be required, where it

1 becomes reasonable to expect that individuals and families have sufficient disposable income to
2 purchase coverage without suffering financial hardship. The Council believes that individuals and
3 families at 500% of FPL (\$49,000 for individuals and \$100,000 for a family of four) clearly meet
4 that threshold of responsibility. Society should not be penalized by the potentially costly medical
5 treatments of those uninsured who can afford to purchase health insurance coverage. A majority of
6 the insured, who earn less than 500% of FPL, are paying inflated premiums because of the costs
7 associated with treating the uninsured. The inflated premium rates constitute an additional barrier
8 to coverage for the uninsured. Furthermore, physicians treating the uninsured often do so without
9 any means of being paid.
10
11 Requiring those at the highest income levels to obtain coverage will not significantly reduce the
12 number of the uninsured because the uninsurance rates at high incomes is small. The ASPE data
13 indicate that only 11% of the uninsured have incomes at or above 500% of FPL. However,
14 requiring individuals with the means to do so to obtain coverage establishes an important
15 precedent. Focusing on a small segment of the population has the additional advantage of
16 potentially facilitating the development of enforcement procedures.
17
18 The Council also conditionally supports a requirement of individual responsibility for those at
19 incomes below 500% of FPL, once the AMA vision for health system reform is realized. Under a
20 system of refundable and income-related tax credits or other subsidies for the purchase of health
21 insurance, combined with appropriate market regulations, there would no longer be any legitimate
22 rationale for "free riders." Those at the lowest income levels would receive the greatest subsidy or
23 be eligible for public sector programs. The Council emphasizes that it supports a requirement for
24 individual responsibility for those with incomes below 500% of FPL only in the context of the
25 provision of substantial subsidies for the purchase of health insurance. A requirement that
26 individuals obtain coverage should not be seen as a substitute for adequate subsidy support for
27 health insurance for those who need it, or as a shortcut for appropriate market regulation. An
28 individual requirement should be contingent upon appropriately structured tax credits; additional
29 policy measures specifically targeting patients with high medical needs; and rational market
30 reforms that allow markets to function properly. Specifically, tax credits should be refundable,
31 inversely related to income, large enough to ensure that health insurance is affordable for most
32 people, applicable only for the purchase of coverage, and contingent on obtaining coverage for all
33 family members (Policy H-165.865).
34
35 Finally, the market regulations outlined in Policy H-165.856 should be implemented to ensure that
36 the general population has access to a wide choice of high-quality, affordable coverage; to
37 subsidize medical expenses for those with high medical needs through mechanisms that do not
38 unduly drive up health insurance premiums for the rest of the population; and to provide
39 individuals with incentives to be continuously insured. Specifically, risk-related subsidies such as
40 subsidies for high risk pools, reinsurance, and risk adjustment should be financed through general
41 tax revenues rather than through strict community rating or premium surcharges, and an
42 individual's genetic information should not be used to determine his or her premium. So that an
43 individual requirement does not simply become a tax on low-risk individuals, strict community
44 rating should be replaced with modified community rating, risk bands or risk corridors.

1 DISCUSSION

2

3 The Council has long been wary of any sort of requirement to purchase health insurance.

4 However, in light of shifting public opinion in favor of requiring some individuals to purchase

5 coverage, the continued rise in the number of the uninsured, and attention to the premium costs

6 incurred by the insured to pay for the health care of the uninsured, the Council believes the AMA

7 has the opportunity to lead further deliberations about individual responsibility. The social benefits

8 of having everyone insured would be enormous. More money would be available to support the

9 health care safety net, which would need to absorb fewer costs associated with treating the

10 uninsured.

11

12 With respect to Resolution 703 (I-05), the first resolved supports a requirement that all Americans

13 have, at a minimum, catastrophic and preventive health care coverage. While the Council

14 conceptually shares this view, it believes that its recommendations (i.e., requiring those earning

15 500% of FPL or more to obtain health insurance coverage or face tax penalties, and a conditional

16 requirement of individual responsibility for those at incomes below 500% of FPL once they have

17 received tax credits or other subsidies) represent a fairer and more politically viable approach.

18

19 The second resolved of Resolution 703 (I-05) calls for those with incomes between 200-400% of

20 FPL, who are not eligible for Medicaid or SCHIP, to be eligible for a refundable tax credit to

21 support the purchase of health care coverage. While the Council continues to be a strong advocate

22 for tax credits, it believes that limiting tax credits to those with incomes between 200-400% of FPL

23 would effectively establish an eligibility floor, or minimum income for tax credit eligibility. Policy

24 H-165.851[1] supports implementation of individual tax credits for the purchase of health

25 insurance for specific target populations such as low-income workers, low-income individuals,

26 children, the chronically ill, and those living within geographic areas that are pilot testing tax credit

27 proposals. As such, Policy H-165.851[1] is generally consistent with the intent of the second

28 resolve of Resolution 703 (I-05) because it supports tax credits for a targeted population.

29 Moreover, Policy H-165.855 proposes tax credit eligibility for those with the lowest incomes.

30 Establishing tax credits to those with incomes between 200-400% of FPL, as proposed by

31 Resolution 703, does not preclude tax credits for lower incomes, as supported by AMA policy, nor

32 does the proposal add to AMA policy.

33

34 The Council believes that it has proposed a level of individual responsibility to obtain health

35 insurance that is fair and measured. In particular, the Council believes that those with the highest

36 incomes should bear greater individual responsibility to obtain coverage. In addition, once lower-

37 income individuals and families are able to access income-related tax credits or other subsidies, it

38 may be appropriate to advocate for a broader-based individual requirement as well. The Council

39 notes that there are benefit variations in how health plans define "catastrophic and preventive

40 services," and believes that the growth of consumer-driven health insurance may give rise to even

41 more options. For example, it may be better to avoid defining covered benefits in terms of specific

42 diseases and conditions, and instead define covered benefits in terms of the dollar amount of

43 accumulated medically necessary services.

44

45 With the recommendations contained in this report, the Council recommends further refinement of

46 AMA policy with respect to covering the uninsured. Although these recommendations focus on

47 individuals at the highest income levels, it is important to remember that the AMA proposal for

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1 health system reform continues to be fundamentally concerned with those most likely to be
2 uninsured—those at the lowest income levels.

3

4 **RECOMMENDATIONS**

5

6 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
7 703 (I-05), and the remainder of the report be filed:

8

- 9 1. That our American Medical Association support a requirement that individuals and
10 families earning greater than 500% of the federal poverty level obtain, at a minimum,
11 coverage for catastrophic health care and evidence-based preventive health care, using the
12 tax structure to achieve compliance. (New HOD Policy)
- 13 2. That, upon implementation of a system of refundable tax credits or other subsidies to
14 obtain health care coverage, our AMA support a requirement that individuals and families
15 earning less than 500% of the federal poverty level obtain, at a minimum, coverage for
16 catastrophic health care and evidence-based preventive health care, using the tax structure
17 to achieve compliance. (New HOD Policy)
- 18 3. That our AMA rescind Policy H-165.920[13], which “supports the use of tax incentives,
19 and other non-compulsory measures, rather than a mandate requiring individuals to
20 purchase health insurance coverage.” (Rescind HOD Policy)

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

Fiscal Note: No significant fiscal impact.