REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (A-08)
Standardizing AMA Policy on the Tax Treatment of Health Insurance
(Reference Committee A)

EXECUTIVE SUMMARY

In recent years, the tax treatment of health insurance has attracted growing attention, featuring prominently in numerous health system reform proposals. Tax credit proposals to expand health insurance coverage and choice, such as the AMA reform proposal, seek to redirect existing tax subsidies for coverage toward those most likely to be uninsured, those with low incomes, and to level the playing field between employer-sponsored insurance and individually purchased insurance. The AMA Voice for the Uninsured campaign has drawn increased attention to the AMA reform proposal.

A review of AMA policy by the Council on Medical Service reveals more than two dozen separate policies on the tax treatment of health insurance. Some of these policies were adopted in a piecemeal fashion and are inconsistent with other policies in substance or language. Accordingly, the Council on Medical Service believes that it is important to strengthen AMA policy by making it more consistent and standardizing the language used throughout the substantial body of relevant policy.

This report identifies policies that are inconsistent with the preponderance of related AMA policy, or otherwise outdated or inaccurate. The report concludes by making fourteen recommendations to rescind or modify policies in order to rationalize and update AMA policy. Specifically, the report recommends better aligning AMA policy with the key principles of tax parity between individually purchased and employment-based health insurance, and subsidizing coverage through tax credits that are inversely related to income. This report complements Council on Medical Service Report 5-A-08, "Tax Implications of Eliminating the Employee Income Tax Exclusion for Employment-Sponsored Health Insurance," which is also before the House at this meeting and fills in policy gaps regarding federal payroll tax and state taxes as they relate to health insurance.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8 - A-08

Subject: Standardizing AMA Policy on the Tax Treatment of Health Insurance

Presented by: Georgia A. Tuttle, MD, Chair

Referred to: Reference Committee A
(Linda B. Ford, MD, Chair)

A review of American Medical Association (AMA) policy by the Council on Medical Service reveals more than two dozen separate policies on the tax treatment of health insurance. Some of these policies were adopted in a piecemeal fashion and are inconsistent with other policies in substance or language. Attention to the AMA proposal for expanding health insurance coverage and choice has grown as a result of the Voice For The Uninsured Campaign and greater awareness of the relevance of the tax treatment of health insurance on the number of uninsured. Accordingly, the Council believes it is important to remove inconsistencies and close gaps in AMA policy.

This report recommends strengthening AMA policy on the tax treatment of health insurance by making it more consistent and clear. Specifically, the Council recommends better aligning AMA policy with the key principles of tax parity between individually purchased and employment-based health insurance, and subsidizing coverage through refundable, advanceable tax credits that are inversely related to income. This report complements Council on Medical Service Report 5-A-08, "Tax Implications of Eliminating the Employee Income Tax Exclusion for Employment-Sponsored Health Insurance," which is also before the House at this meeting, and which fills policy gaps on federal payroll tax as it relates to health insurance.

BACKGROUND

Among policy makers and researchers, there is growing recognition of the pervasive and largely detrimental effects of the existing tax treatment of health insurance. Federal tax policy on health insurance has featured prominently in numerous recent health system reform proposals. The AMA proposal for expanding health insurance coverage and choice is grounded in the analysis that health insurance coverage in the US is inextricably linked to the tax treatment of health insurance. In 1998, the House of Delegates adopted policy on restructuring the tax treatment of health insurance as part of the 17 principles contained in Council on Medical Service Report 9-A-98, "Empowering Our Patients: Individually Selected, Purchased and Owned Health Expense Coverage" (Policy H-165.920, AMA Policy Database). Subsequently, the Council has presented approximately 50 reports to the House related to health system reform, coverage of the uninsured, and the tax treatment of health insurance, thereby making the AMA proposal increasingly sophisticated, multifaceted, and flexible.

REPLACING THE TAX EXCLUSION WITH TAX CREDITS

Since 1998, AMA policy has advocated replacement of the existing employee income tax exclusion of employer-sponsored health insurance with individual tax credits for the purchase of health insurance (Policy H-165.920[11]). In 2001, the House adopted policy specifying that a

portion of any increase in federal spending on health care benefits should be used to provide tax credits to the uninsured (Policy H-165.861). In 2004, Policy H-165.851 was adopted, supporting incremental steps toward replacing the tax exclusion with tax credits, such as capping the amount of premium that may be excluded from income tax, and targeting individual tax credits to specific populations such as those with low incomes, children or the chronically ill.

The major rationale that Council on Medical Service Report 9-A-98 provided for replacing the employee income tax exclusion with individual tax credits is that the tax exclusion is socially inequitable. Only those whose employers offer health insurance are eligible for it, and it provides a bigger tax break to employees in higher tax brackets, i.e., those with higher incomes. By comparison, eligibility for individual tax credits would not depend on employment, and the size of tax credits would be inversely related to income, providing more assistance to those who most need it—those with lower incomes. A second major rationale is that removing the tax exclusion would generate tax revenue that could be used to finance tax credits. Other rationales include removing the preferential tax treatment for employment-based coverage; expanding individual choice beyond employers' coverage offerings; reducing "job lock," whereby employees refrain from switching to otherwise more desirable jobs in order to maintain coverage; and reducing discontinuities in coverage resulting from employer health plan changes and job changes.

More recently, Council on Medical Service Report 5-I-07 "Tax Treatment of Health Insurance: Comparing Credits and Tax Deductions," addressed whether the AMA should support both tax credits and tax deductions—which would extend equivalent tax treatment of employment-based insurance to individually purchased insurance, to encourage the individual ownership of health insurance. Like Council on Medical Service Report 9-A-98, Council Report 5-I-07 concluded that tax credits would be more effective than tax deductions at expanding health insurance coverage. The report cited research showing that about half of the uninsured do not owe federal income taxes, with many others falling into the 15% tax bracket.

Accordingly, making individually purchased health insurance tax deductible would have little impact on the uninsured, and would primarily benefit those who already have coverage (Gruber and Levitt, *Health Affairs*, Jan/Feb 2000). The Lewin Group estimates that only 20% of the tax benefit of a standard income tax deduction for health insurance would go to the currently uninsured, while more than half would go to those with above-median incomes of $50,000 (Sheils and Haught, The Lewin Group, January 2007). Based on the analysis presented in Council on Medical Service Report 5-I-07, the House adopted policy supporting the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage (Policy H-180.951[1]).

PRINCIPLES FOR STRUCTURING TAX CREDITS

Policy H-165.865 contains principles for structuring tax credits, including that they be inversely related to income; large enough to enable recipients to afford health insurance, the amount varying with family size to mirror the pricing structure of insurance; refundable, so that they are fully available to people who owe little or nothing in income tax; and advanceable for those with low incomes, so that they are available when payment for health insurance is due rather than after income taxes have been filed. In order to encourage individuals to be cost-conscious and to discourage over-insurance, tax credits should be capped at fixed-dollar amounts for a given income and family structure, independent of health insurance expenditures. In the absence of fixed-dollar amounts, for example, in the case of a tax credit equal to a percentage of premium, the amount of

an individual or family's tax credit should still be capped to discourage over-insurance that results from an open-ended subsidy. Eligibility for tax credits should be contingent on the purchase of health insurance. Tax credits should be applicable to health insurance of the recipient's choice, regardless of whether coverage is obtained through an employer or elsewhere. Use of tax credits should be limited to the purchase of health insurance, not for out-of-pocket expenses, and the health insurance purchased must provide coverage for hospital, surgical, and medical care, and catastrophic coverage, as defined by Title 26 Section 213(d) of the United States Code.

ADDITIONAL POLICY ON THE TAX TREATMENT OF HEALTH INSURANCE

Several additional policies establish the centrality of tax policy, and tax credits in particular, to AMA policy on health system reform and coverage of the uninsured.

AMA Advocacy of Tax Credits and Vouchers: More than half a dozen policy directives assign top most priority to tax credits in AMA advocacy efforts (Policies D-165.984, D-165.978, D-165.973, D-165.968, D-165.959, D-165.966, and D-165.955). Policy D-165.955[2] states that the AMA will continue to pursue bipartisan support for individually selected and owned health insurance through the use of adequately funded federal tax credits as a preferred long-term solution for expanding health insurance coverage. Similarly, Policy D-165.984 states that the AMA will continue to vigorously pursue Policies H-165.920, H-165.882, and H-165.865, which support income-related refundable tax credits to expand health insurance coverage and choice. The AMA advocates federal legislation authorizing and funding state-based demonstration projects of tax credits (Policies D-165.968 and D-165.966), and also advocates granting states the freedom to test different models for improving coverage of low-income patients, including combining individual tax credits with Medicaid reforms basing eligibility on financial need (Policy D-165.966).

Individual Responsibility to Obtain Health Insurance: AMA policy supports a requirement that individuals and families who can afford health insurance be required to obtain it, or face negative tax consequences (Policy H-165.848). Policy H-165.848[1] advocates a requirement that those earning greater than 500% of the federal poverty level obtain a minimum level of catastrophic and preventive coverage. Only upon implementation of tax credits or other coverage subsidies would those earning less than 500% of the federal poverty level be subject to the requirement (Policy H-165.848[2]).

Tax Subsidies for Coverage of Low-Income Patients: Numerous AMA policies advocate expanding health insurance coverage of low-income individuals through individual tax credits or vouchers (Policies H-165.920, H-165.887, H-290.982, H-165.865[3], H-165.985, D-165.970, and D-165.983). Tax credits are preferred over public sector expansions as a means of providing coverage to the uninsured (Policy H-165.920[13]. Accordingly, the AMA advocates giving Medicaid and State Children's Health Insurance Program (SCHIP) enrollees tax credits or vouchers for private health insurance of their choice, with varying out-of-pocket cost sharing obligations based on income (Policy H-165.855[1,2]). As previously noted, Policy D-165.966 advocates granting states the freedom to test different models for improving coverage of low-income patients, including combining individual tax credits with other Medicaid reforms.

Tax Subsidies for Coverage of High-Risk Patients: The AMA supports subsidizing coverage of high-risk patients through risk-based subsidies such as high-risk pools, risk adjustment, and reinsurance that are financed through general tax revenues rather than through strict community rating or premium surcharges (Policies H-165.856[3] and H-165.842). Unlike approaches that

attempt to subsidize high-risk patients through community rated premiums and other health insurance market regulations, tax-financed subsidies do not exacerbate the problem of the uninsured by driving up the cost of insurance for those likely to have average or below-average medical expenses.

Tax Neutrality and Pluralism: A general principle running through AMA policy is tax neutrality, or the removal of preferential tax treatment that biases health insurance options and choices. Longstanding AMA policy opposes preferential tax treatment, regulation or promotion of particular forms of health care and coverage, such as government subsidies favoring HMOs, advocating instead that growth of health care and coverage options should be determined through individual choice and market competition (Policies H-180.995, H-285.998, and H-165.985).

Similarly, AMA policy seeks tax equity between employment-based health insurance and insurance purchased individually or through other venues. While AMA policy prefers individually purchased and owned health insurance, it also advocates that, once the preferential tax treatment for employment-based coverage is removed, employment-based coverage should continue to be available to the extent that the market demands it (Policy H-165.920[5]). Individuals should receive the same tax treatment for individually purchased coverage, contributions toward employment-based coverage, and completely employer provided coverage (Policies H-165.920[6] and H-270.969), as well as the same tax treatment for obtaining coverage whether they are employed, self-employed or unemployed (Policies H-165.920[7] and H-270.969). Additionally, the AMA supports equal tax treatment for employee health benefits whether they take the form of defined benefits or defined contributions (Policies H-165.920[3a] and D-165.978), so long as defined contributions are at least equivalent to the dollar amount that the employer would pay for defined benefit health insurance (Policy H-165.920[3b]). An employer's contribution toward an employee's individually purchased coverage should be used only for that purpose, the exception being when the contribution exceeds the cost of a specified minimum level of coverage, in which case, any excess can be used by the employee for other purposes (Policy H-165.920[3d]).

Most AMA policy seeking equal tax treatment for employment-based and individually purchased health insurance does not specify what the tax treatment should be, only that it be equivalent. However, two policies specify that tax equity should be achieved by making the cost of individually purchased coverage tax exempt, effectively extending the existing employee income tax exclusion for employment-based insurance to individually purchased insurance (Policies D-180.987 and H-165.995[2a]). Policy H-165.995[2a] specifies further that premiums for individually purchased insurance be exempt from income tax by making premiums tax deductible.

At the same time, AMA Policy H-165.920[12] states that policy advocating a tax exemption for individually purchased insurance premiums (Policy H-165.995) should be rescinded upon legislative enactment of policies calling for tax equity between employer defined benefits and defined contributions (Policy H-165.920[3a]) and tax equity for individuals regardless of whether they purchase coverage individually or receive it through an employer (Policy H-165.920[6]).

Employer Tax Incentives: Council on Medical Service Report 9-A-98 marked a policy shift promoting individual choice and ownership of health insurance rather than strengthening employment-based coverage. Support for individual tax credits superseded previous support for a mandate requiring employers to provide employee health insurance, which was rescinded in 2000.

Nevertheless, two earlier AMA policies still support tax subsidies to small and low wage employers for the purchase of health insurance for their employees (Policies H-165.882[5] and H-165.985).

Tax Treatment of Health Savings Accounts: Longstanding AMA policy supports making health savings accounts (HSAs) available as a coverage option in the health insurance market, along with medical savings accounts (MSAs), the predecessors to HSAs, and health reimbursement arrangements (HRAs), a similar form of coverage available only through employers. HSAs, MSAs, and most HRAs consist of a high-deductible health plan coupled with a tax-advantaged savings account earmarked for out-of-pocket medical expenses. Unspent account balances of HSAs, MSAs, and under some circumstances, HRAs can be carried over into future years. High-deductible coverage is intended to reduce the premiums and provide incentives for prudent use of health care services, and the ability to save unspent account balances also provides incentives for prudent spending on care. Like standard individual retirement accounts (IRAs), contributions to accounts are tax deductible, and like Roth IRAs, withdrawals from accounts for qualified medical expenses are also untaxed. AMA principles for structuring health insurance tax credits state that tax credits can be used toward HSA coverage, including premiums for a qualified high-deductible health plan and contributions to the account (Policy H-165.865[1i]). Similarly, Policy H-270.969 extends support for tax equity to include account contributions.

Tax deductibility of HSA account contributions is similar to the employee income tax exclusion in that it provides larger tax breaks to those with higher incomes. Accordingly, AMA policy states that contributions to HSA accounts should continue to be tax deductible only until the employee income tax exclusion is replaced with individual tax credits (Policy H-165.852[2]). At that time, HSAs, like other forms of coverage, would qualify to be subsidized through tax credits (Policies H-165.865[1i] and H-270.969).

Tax Treatment of Flexible Spending Accounts: Policy H-165.863 advocates allowing employees to contribute any unspent flexible spending account (FSA) balances into an HSA, and seeks federal legislation rescinding the Internal Revenue Service (IRS) "use-it-or-lose-it" rules requiring annual forfeiture of unspent FSA balances. This policy has been partially achieved in that, through 2011, The Health Opportunity Patient Empowerment Act of 2006 authorizes employees to make one-time, untaxed rollovers from an FSA to an HSA account when switching to HSA coverage, provided that the employee maintains HSA coverage for at least one year.

Tax Treatment of Out-of-Pocket Medical Expenses: Per Section 213 of the US Tax Code, the current income tax subsidy for out-of-pocket expenses is limited to an income tax deduction on any out-of-pocket expenditures an individual or family incurs in excess of 7.5% of their adjusted gross income (AGI). Council on Medical Service Report 5-A-02 considered whether to support eliminating or lowering the 7.5% AGI threshold, thereby expanding the tax deductibility of out-of-pocket expenses. Based on the analysis of the report, the House chose not to adopt new policy seeking to eliminate or reduce the threshold, but did reaffirm policy supporting immediate tax equity for health insurance costs of self-employed and unemployed persons (Policy H-165-920[7]).

As previously noted, Policy H-165.865[1i] states that tax credits should be applicable only for the purchase of health insurance and not for out-of-pocket health expenditures. However, Policy H-180.971 calls for tax equity between out-of-pocket health expenses and health insurance premiums, and Policy D-165.983[1] more specifically calls for full deductibility of all medical expenses.

CONCLUSIONS

Within this body of policy, the Council has identified several items as inconsistent with the preponderance of related AMA policy, or otherwise outdated or inaccurate. The Council believes that the following rescissions, amendments, and standardization of language would rationalize, update, and strengthen AMA policy related to expanding health insurance coverage and choice.

1. Policy H-270.969, which calls upon the AMA to prepare model legislation based on a 1996 joint resolution in the Colorado Senate, should be rescinded.

   Discussion and rationale: Policy H-270.969 is no longer relevant and has been superseded. In addition to referencing a 1996 state legislative proposal, Policy H-270.969 calls for equal tax treatment of health insurance premiums regardless of whether they are paid by employers or individuals, and regardless of an individual's employment status, policies which have been superseded by Policy H-165.920[3a,6,7].

2. Policy H-180.971, which advocates equal tax treatment for out-of-pocket medical expenses and health insurance premiums, should be rescinded.

   Discussion and rationale: Although not explicitly stated, the clear intent of Policy H-180.971 is to extend the preferential tax treatment of employment-based insurance to out-of-pocket medical expenses by allowing them to be deductible from income tax. Tax deductibility of out-of-pocket expenses is inconsistent with the body of AMA policy supporting expansion of health insurance coverage, and specifically inconsistent with AMA policy stipulating that tax credits should be contingent on the purchase of health insurance (Policy H-165.865[1a]) and should be applicable only for the purchase of health insurance, including all components of a qualified HSA, but not for out-of-pocket health expenditures (Policy H-165.865[1i]). Additionally, tax deductibility of out-of-pocket medical expenses has many of the same shortcomings as the employee income tax exclusion, namely, providing bigger tax breaks to those in higher tax brackets and reducing tax revenues that could be used to expand coverage. Allowing out-of-pocket expenses to be tax deductible is also an ineffective way to assist high-risk patients, who would be better served by more explicit, targeted, and efficient risk-based subsidies such as high-risk pools, risk adjustment, and appropriately structured reinsurance (Policies H-165.856[3] and H-165.842). Subsidizing out-of-pocket medical expenses would also effectively lower the cost of being uninsured, possibly inducing some people to drop or forgo health insurance, and partially offsetting any tax consequences for non-compliance with an individual responsibility requirement to obtain coverage (Policy H-165.848).

3. The AMA should rescind Policy D-165.983, which calls for the AMA to advocate for medical savings accounts, full tax deductibility for all medical expenses, refundable tax credits and vouchers for medical insurance for low income individuals, and a study of the impact of eliminating the threshold for deductibility of medical expenses on federal income taxes.

   Discussion and rationale: Since its adoption in 2001, the first portion of Policy D-165.983 has become obsolete due to the enactment of the Medicare Modernization Act of 2003 (P.L. 108-173), which authorized health savings accounts, thereby making MSAs permanent and removing most MSA restrictions. The portion of Policy D-165.983 calling for refundable tax credits and vouchers for low income individuals is superseded by other AMA policy (Policies H-165.920[13], H-165.855, H-290.982[8], H-165.985[7], and D-165.970). The study

requested in the last portion of Policy D-165.983 was accomplished with Council on Medical Service Report 5, (A-02). Furthermore, eliminating the threshold for tax deductibility of medical expenses is inconsistent with AMA policy stating that tax credits should be contingent on the purchase of health insurance (Policy H-165.865[1a]) and should not be applicable to out-of-pocket health expenditures (Policy H-165.865[1i]).

4. Policy H-165.995[2a], which calls for a full income tax deduction of premium expenses for individuals who pay 100% of premiums for their coverage, should be rescinded.

5. Similarly, the AMA should rescind Policy H-165.920[12], which states that Policy H-165.995[2a] should be rescinded upon legislative enactment of Policies H-165.920[3a] and H-165.920[6] (i.e., upon legislative enactment of equal tax treatment of defined benefit and defined contribution expenditures, and individually purchased and employment-based coverage).

   Discussion and rationale: AMA policy supporting an income tax exemption (e.g., a tax deduction) for individually purchased insurance should be rescinded for the same reasons that the AMA seeks to replace the employee income tax exclusion for employment-based coverage with refundable, advanceable individual tax credits inversely related to income (Policies H-165.920[11], H-180.951[1], and H-165.851). Ample research demonstrates that tax credits would expand coverage of the uninsured far more equitably and cost-effectively than would a tax deduction. In addition, all sections of Policy H-165.995, "Coverage of the Uninsured Through State Risk Pooling," are germane to the subject of state risk pooling except section H-165.995[2a]. Finally, the recommended rescission of Policy H-165.995[2a] would render Policy H-165.920[12] obsolete.

6. Policy H-165.882[5], which encourages exploration of the feasibility of providing tax-supported subsidies to small and low wage employers to assist them in purchasing adequate health insurance coverage which they could otherwise not afford for their employees, should be rescinded.

7. Similarly, tax incentives to assist small employers in buying health insurance coverage should be deleted from the list of measures to expand coverage of the uninsured advocated in Policy H-165.985[7]. The Council also believes that the term "health expense protection" in Policy H-165.985[7] is potentially confusing and should be replaced with the more readily understood term "health insurance coverage."

   Discussion and rationale: Polices H-165.882[5] and H-165.985[7] are inconsistent with AMA policy advocating individual ownership and selection of health insurance and tax neutrality between individually purchased insurance and employment-based insurance (Policies H-165.920[5,6], D-180.987, and H-270.969). Employer tax credits would do little to address job-lock or limited individual choice of coverage, would divert scarce resources from provision of health insurance tax credits to individuals, and would be a crude way of targeting tax assistance by income given that small businesses do not exclusively employ low-wage workers and that most low-wage workers work for large companies.

8. Policy H-165.865[2] should be modified to define health insurance coverage qualifying for tax credits according to Title 26 Section 9832 of the United States Code, rather than Title 26 Section 213(d).

   Discussion and rationale: In order for the employee income tax exclusion for employment-based health insurance to apply, the IRS requires group health plans to meet certain conditions. Most notably, the health plans must conform to the definition of health insurance coverage contained in Title 26 Section 9832 of the US Code. Section 9832 defines health insurance coverage as benefits for medical care, not including disease-specific coverage (e.g., cancer insurance), hospital-only coverage or long-term care coverage. Whereas Section 9832 defines health insurance coverage, Section 213(d) defines medical expenses recognized by the IRS for a variety of purposes – including tax deductibility of medical expenses above 7.5% of adjusted gross income and qualified expenditures from HSA accounts. Portions of Section 213(d) are referenced in Section 9832, but other portions have no bearing on the definition of health insurance coverage.

9. Policy D-180.987, which supports tax equity for those who purchase health insurance individually, should be amended to advocate equitable tax treatment, rather than equitable tax-exemption, of health insurance premiums. For clarity, the Council also recommends that the policy specify that existing federal tax policy discriminates against individuals who purchase health insurance on their own rather than through an employer.

   Discussion and rationale: The proposed amendment of Policy D-180.987 upholds the principle of tax equity between those who obtain coverage through an employer and those who obtain it individually – without advocating additional income tax exemption of premiums. Policy D-180.987 should be modified for the same reasons that Policy H-165.995[2a] should be rescinded, namely, that tax exemption of premiums are far less equitable and cost-effective than tax credits at expanding coverage of the uninsured.

10. Policy H-165.920[3a] should be modified to reflect the fact that new legislation is not required for employer-provided defined contributions to receive the same tax treatment as employer-sponsored, defined benefit health insurance. For clarity, the phrase "health expense coverage" should also be replaced with "health insurance coverage."

    Discussion and rationale: In response to requests for guidance on employers' financial contributions toward employee-purchased health insurance, the IRS has ruled that such contributions may be excludable from the gross income of the employee under Title 26 Section 106 of the US Code and from payroll and unemployment taxes under Title 26 Sections 3121(a) and 3306(b) of the US Code (IRS Revenue Rulings 61-146, 1961-2 CB 25 and 2002-3, 2002-1 CB 316). In order for employer contributions to qualify as tax-excludable health benefits, the employer must substantiate that the funds were used for the purchase of health insurance, either by requiring the employee to provide proof of payment or by issuing a check payable to the employee's insurance company. Despite these IRS rulings, many employers are unaware that they have the option of providing employees with defined contribution health benefits, or that defined contributions qualify for the same tax treatment as employer-sponsored, defined benefit health insurance. Policy H-165.920[3a] reinforces this misunderstanding by calling for the AMA to support legislation that would provide the same tax treatment for defined contribution and defined benefit employee health insurance coverage.

11. Policy H-165.865[1] should be modified for clarity, including replacement of the term "health expense coverage" with "health insurance coverage."

12. All remaining references to "health expense coverage" in Policy H-165.920 should be replaced with "health insurance coverage."

    Discussion and rationale: The seven references to "health expense coverage" in Policy H-165.920 were established by Council on Medical Service Report 9-A-98, which provided the following definition: "Health expense coverage: Private sector protection against the cost of health services, whether provided through traditional [usual, customary, and reasonable]-based or benefit payment schedule insurance policies, managed care plans, medical savings accounts, or employer self-insurance." The Council believes that the term "health expense coverage" is not widely used or understood at present, means substantially the same thing as "health insurance coverage," and potentially confuses out-of-pocket medical expenditures and coverage through a health insurance plan, which are treated differently by AMA policy. In addition, AMA Principles for Structuring Tax Credits, which were adopted after Council Report 9 (A-98), make it clear that HSA coverage should qualify for the same tax treatment as other forms of health insurance coverage (Policy H-165.865[1i]). Specifically, tax credits could be used to pay premiums for an HSA-qualified high-deductible health plan or to make contributions to an associated health savings account.

13. Policy D-165.984 should be amended to replace the reference to Policy H-165.882 with Policy H-165.851. The Council also believes that the reference to "income related refundable tax credits" in Policy D-165.984 should be replaced with more specific, standardized language, "refundable, advanceable tax credits inversely related to income."

    Discussion and rationale: Policy D-165.984 advocates vigorous pursuit of AMA policies that support income-related refundable tax credits to expand coverage and patient choice, specifically Policies H-165.920, H-165.882, and H-165.865. However, Policy H-165.882 refers to tax credits only in section [5], which has been recommended for rescission because it advocates employer tax credits and would not expand patient choice. By contrast, Policy H-165.851, "Options for Implementing and Financing Tax Credits for Individually Selected and Owned Health Insurance," is one of the key AMA policies on tax credits.

14. Throughout AMA policy, references to individual health insurance tax credits should be standardized as "refundable, advanceable tax credits inversely related to income."

    Discussion and rationale: Policies H-165.920[13], H-290.982[8], H-165.848[2], H-165.861, D-165.959, D-165.966[1], and D-165.968[1] make various references to "tax credits," "income related tax credits," and "refundable tax credits." Most AMA policy refers to tax credits as being inversely related to income rather than "income related tax credits." Although, AMA Principles for Structuring Health Insurance Tax Credits contained in Policy H-165.865 advocate that tax credits be both refundable and advanceable (i.e., available in advance of purchasing health insurance), some AMA policies simply refer to "refundable tax credits." Using the standardized language of "refundable, advanceable tax credits inversely related to income" would make AMA policy more specific and clear.

RECOMMENDATIONS

Based on the analysis in this report, the Council on Medical Service recommends that the following be adopted and the remainder of this report be filed:

1. That our American Medical Association (AMA) rescind Policy H-270.969. (Rescind HOD Policy)

2. That our AMA rescind Policy H-180.971. (Rescind HOD Policy)

3. That our AMA rescind Policy D-165.983. (Rescind HOD Policy)

4. That our AMA rescind Policy H-165.995[2a]. (Rescind HOD Policy)

5. That our AMA rescind Policy H-165.920[12]. (Rescind HOD Policy)

6. That our AMA rescind Policy H-165.882[5]. (Rescind HOD Policy)

7. That our AMA amend Policy H-165.985[7] by addition and deletion to read as follows: "(7) The expansion of adequate health ~~expense protection~~ insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, ~~tax incentives to assist small employers in buying health insurance coverage,~~ and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level." (Modify Current HOD Policy)

8. That our AMA amend Policy H-165.865[2] by addition and deletion to read as follows: "(2) It is the policy of our AMA 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)~~ 9832 of the United States Code." (Modify Current HOD Policy)

9. That our AMA amend Policy D-180.987 by addition and deletion to read as follows: "Our American Medical Association seeks to eliminate federal government discrimination against individuals who purchase health insurance on their own rather than through an employer, by pursuing equitable tax ~~exemption~~ treatment for health insurance premiums." (Modify Current HOD Policy)

10. That our AMA amend Policy H-165.920[3a] by addition and deletion to read as follows: "Our AMA… (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) ~~Support legislation that would provide the employer with the same~~ Continue to support equal tax treatment for payment of health ~~expense~~ insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually

selected and individually owned health ~~expense~~ insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;" (Modify Current HOD Policy)

11. That our AMA amend Policy H-165.865[1] by addition and deletion to read as follows: "(1) ~~Our~~ That AMA support~~s~~ for replacement of the present exclusion from employees' taxable income of employer-provided health ~~expense~~ insurance coverage with tax credits~~,~~ be guided by the following principles: …" (Modify Current HOD Policy)

12. That our AMA amend Policy H-165.920 by addition and deletion to replace all references to "health expense coverage" with the term "health insurance coverage." (Modify Current HOD Policy)

13. That our AMA amend Policy D-165.984 by addition and deletion to read as follows: "Our AMA will continue to vigorously pursue its polices that support a system of ~~income-related~~ refundable, advanceable tax credits inversely related to income for the purpose of expanding coverage and patient choice (Policies H-165.920, H-165.~~882~~ 851, and H-165.865)." (Modify Current HOD Policy)

14. That our AMA amend AMA Policies H-165.920[13], H-290.982[8], H-165.848[2], H-165.861, D-165.959, D-165.966[1], and D-165.968[1] by addition and deletion to replace the words "tax credits," "income related tax credits," and "refundable tax credits" with the standardized language "refundable, advanceable tax credits inversely related to income." (Modify Current HOD Policy)

15. That our AMA study the tax treatment of health savings account contributions, earnings and withdrawals, both currently and upon enactment of legislation to replace the existing employee income tax exclusion for employer-sponsored health insurance with tax credits for individuals and families, as referenced in AMA Policy H-165.852[2]. (Directive to Take Action)

16. That our AMA study and report back at I-08 the effect of changing the tax system from the deductibility of healthcare "expenses" to the deductibility of "insurance premiums" on self-insured employers. (Directive to Take Action)

Fiscal Note: Staff cost estimated to be less than $500 to implement.

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