

REPORT 9 OF THE COUNCIL ON MEDICAL SERVICE (A-11)
Covering the Uninsured and Individual Responsibility
(Resolutions 204-I-09 and 816-I-10)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2009 Interim Meeting, the House of Delegates referred Resolution 204, which asked that the AMA advocate for the replacement in federal legislation of requirements for guaranteed issue and community rating regulations with measures that support methods of direct subsidy for high risk patients. Subsequently, at the 2010 Interim Meeting, the House of Delegates referred Council on Medical Service Report 1-I-10 addressing the consistency of AMA policy on market regulation along with Resolution 816-I-10, which asked that our AMA support using tax incentives and other non-compulsory measures rather than a federally-imposed requirement that individuals purchase health insurance, and rescind AMA policy requiring individual responsibility. The Board of Trustees referred these items to the Council on Medical Service for study.

In 2006, the House of Delegates adopted the recommendations of Council on Medical Service Report 3-A-06, which considered individual responsibility an essential and complementary component of the AMA proposal for covering the uninsured and expanding choice. The policy supports a requirement that individuals and families who can afford health insurance be required to obtain it, using the tax structure to achieve compliance. The policy advocates a requirement that those earning greater than 500% of the federal poverty level (FPL) 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 FPL be subject to the requirement to obtain coverage (Policy H-165.848, AMA Database).

The Council gave thoughtful consideration to alternatives to requiring individual responsibility. Currently, there are no alternatives that have been scored by the Congressional Budget Office, and other analyses fail to show that such alternatives would be as effective in covering the uninsured and promoting a balanced risk pool of both healthy and sick individuals. Eliminating health insurance denials due to pre-existing conditions is not feasible without individual responsibility. Also, requiring individual responsibility limits “free-riders” in the health care system, who otherwise violate societal liberties because taxpayers, insured individuals, and physicians and other health care providers involuntarily pay for the care of the uninsured through higher premiums and the provision of uncompensated care. Moreover, individual responsibility supports a private market approach to covering the uninsured and expanding choice.

Requiring individuals to obtain health insurance as outlined in Policy H-165.848 remains a critical piece of the AMA proposal for covering the uninsured and expanding choice. The Council therefore recommends reaffirmation of Policy H-165.848 along with the other key policies that collectively provide the foundation for the AMA proposal for reform. Any approach to covering the uninsured based on the AMA proposal for reform, including those on the state level, that has individually selected and owned health insurance, refundable and advanceable tax credits, market reforms, and health savings accounts as its foundation cannot maximize its success in covering the uninsured without an individual responsibility requirement. Finally, the Council notes that the utility of Policy H-165.848 is not tied to the Patient Protection and Affordable Care Act (ACA, PL 111-148) or to the constitutionality of ACA individual responsibility requirement. The matter before the courts is the ACA provision, not AMA policy on individual responsibility.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 9-A-11

Subject: Covering the Uninsured and Individual Responsibility
(Resolutions 204-I-09 and 816-I-10)

Presented by: William E. Kobler, MD, Chair

Referred to: Reference Committee A
(Joseph W. Zebley, III, MD, Chair)

1 At the 2009 Interim Meeting, the House of Delegates referred Resolution 204, “Advocacy for High-
2 Risk Pools Rather than Guaranteed Issue and Community Rating Regulations.” Introduced by the
3 Kansas Delegation, Resolution 204-I-09 asked that the American Medical Association (AMA)
4 “publicly advocate for the replacement in federal legislation of requirements for guaranteed issue and
5 community rating regulations with measures that support state-based high-risk pools and other
6 methods of direct subsidy for high risk patients.”

7
8 At the 2010 Interim Meeting, in response to Resolution 204-I-09, the Council on Medical Service
9 presented Report 1, “Consistency of AMA Policy on Market Regulation.” The report noted the
10 complementary relationship of AMA policies supporting indirect methods (i.e., the combination of
11 certain market regulations such as eliminating pre-existing condition denials and individual
12 responsibility to obtain coverage) and direct methods (i.e., direct subsidies such as high-risk pools,
13 risk adjustment and reinsurance) for making coverage affordable to high risk patients. Because the
14 indirect approach relies on eliminating pre-existing condition denials within the context of individual
15 responsibility, the report also sought to amend policies that had been recently adopted by the House
16 that supported eliminating pre-existing condition denials, but did not also support requiring
17 individual responsibility. As the House has previously acknowledged, the absence of an individual
18 responsibility requirement would significantly increase the cost of health insurance if everyone could
19 wait until they got sick or injured to purchase health insurance.

20
21 CMS Report 1-I-10 was referred along with Resolution 816-I-10, “Withdraw Support for a Federal
22 Mandate for the Individual Purchase of Health Insurance,” which was introduced by the Kansas,
23 Alabama, District of Columbia, Florida and Georgia Delegations and the American Society of
24 General Surgeons. Resolution 816-I-10 asked that our AMA “support using tax incentives and other
25 non-compulsory measures, rather than a federally-imposed requirement that individuals purchase
26 health insurance,” and “rescind Policy H-165.848, Individual Responsibility to Obtain Health
27 Insurance.” The Board of Trustees assigned these items to the Council on Medical Service for a
28 report back to the House of Delegates at the 2011 Annual Meeting.

29
30 This report reviews AMA policy and advocacy efforts pertaining to covering the uninsured and
31 individual responsibility, summarizes the history of requiring individual responsibility, outlines
32 alternatives to requiring individual responsibility, and presents several policy recommendations.

1 AMA POLICY AND ADVOCACY ON COVERING THE UNINSURED

2
 3 Expanding health insurance coverage and choice have been long-standing goals of the AMA. The
 4 AMA health system reform proposal has been extensively deliberated by the House of Delegates
 5 over the past thirteen years. Based principally on recommendations developed by the Council on
 6 Medical Service, beginning in 1998, the AMA proposal for covering the uninsured and expanding
 7 choice advocates for the promotion of individually selected and owned health insurance using
 8 refundable and advanceable tax credits that are inversely related to income so that patients with the
 9 lowest incomes will receive the largest credits. These individual tax credits would allow patients to
 10 purchase coverage of their own choosing (Policies H-165.920[3] and H-165.865, AMA Policy
 11 Database). To raise awareness about the uninsured and the AMA proposal for covering the
 12 uninsured, the AMA launched the “Voice for the Uninsured” campaign in 2007, which was
 13 instrumental in strengthening the voice of the AMA in the health system reform debate. The
 14 campaign implemented House of Delegates directives to advocate the AMA health system reform
 15 proposal (Policies D-165.950, D-165.955 and D-165.984).

16
 17 AMA policy on individual responsibility was established with the adoption of the recommendations
 18 in Council on Medical Service Report 3-A-06, which considered individual responsibility an
 19 essential and complementary component of the AMA proposal for covering the uninsured and
 20 expanding choice. The resulting policy, Policy H-165.848, supports a requirement that individuals
 21 and families who can afford health insurance be required to obtain it, using the tax structure to
 22 achieve compliance. The policy advocates a requirement that those earning greater than 500% of the
 23 federal poverty level (FPL) obtain a minimum level of catastrophic and preventive coverage. Only
 24 upon implementation of tax credits or other coverage subsidies would those earning less than 500%
 25 of the FPL be subject to the requirement to obtain coverage.

26
 27 To ensure patient choice, the AMA supports the development of new health insurance markets to
 28 enhance health insurance options through legislative and regulatory changes. The viability of private
 29 market competition is core to AMA policy, which strongly opposes socialized or nationalized health
 30 care (Policy H-165.985). Council on Medical Service Report 7-A-03 established principles for
 31 health insurance market regulation (Policy H-165.856) that advocate collectively financing the
 32 medical expenses of people with predictably high costs, without unduly driving up premiums for the
 33 rest of the population, or hindering market experimentation to find attractive combinations of plan
 34 benefits, patient cost-sharing, and premiums. While originally advocating that guaranteed issue
 35 regulations should be rescinded, the principles were amended by the House of Delegates in 2009 to
 36 support health insurance coverage of pre-existing conditions with guaranteed issue within the context
 37 of requiring individual responsibility, in addition to guaranteed renewability. Therefore, AMA
 38 policy now ties the presence of an individual responsibility requirement to AMA support for health
 39 insurance coverage of pre-existing conditions with guaranteed issue.

40
 41 AMA support for the elimination of denials due to pre-existing conditions was reiterated at the 2009
 42 Interim Meeting as Congress was developing the legislation that became the Patient Protection and
 43 Affordable Care Act (ACA, PL 111-148). Substitute Resolution 203-I-09 (Policy H-165.838) asked
 44 the AMA to advocate for the enactment of health system reform that includes insurance market
 45 reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions
 46 or due to arbitrary caps. The Council notes that the intent and goal of the resulting policy (Policy
 47 H-165.838) cannot be achieved without also supporting requiring individual responsibility as
 48 outlined in Policy H-165.848. As cited in previous reports, the Council has warned that guaranteed
 49 issue and the elimination of coverage denials due to pre-existing conditions without an individual
 50 responsibility requirement invites free-riding by allowing individuals to postpone obtaining
 51 insurance until they need medical care, which leads to higher premiums for everyone.

1 Complementing AMA policy on market regulation, several policies support direct methods to protect
 2 high-risk patients. Policy H-165.995 supports the establishment in each state of a risk pooling
 3 program, in which all health care underwriting entities in the state participate, to provide adequate
 4 health insurance coverage at a premium slightly higher than the standard group rate to those who are
 5 unable to obtain such coverage because of medical considerations, and those with medically standard
 6 risks who could afford, but presently lack, access to such group coverage. It also calls for the
 7 amendment of the federal tax code to require employers to purchase group health insurance coverage
 8 from an entity participating in the state risk pool or, if self-insured, to participate in the risk pool if
 9 such a pool is available, in order to deduct the cost of their coverage as a business expense.

10
 11 Consistent with the broader AMA policy goal of covering the uninsured by providing subsidies (e.g.,
 12 tax credits) that are inversely related to income for the purchase of health insurance (Policies
 13 H-165.920 and H-165.865), Council on Medical Service Report 2-I-07 established Policy
 14 H-165.842, which supports the principle that health insurance coverage of high-risk patients be
 15 subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment, and
 16 reinsurance, rather than through indirect methods that rely heavily on market regulation; and state-
 17 based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as
 18 high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies. The importance of
 19 Policy H-165.842 in the strategy of the AMA to cover high-risk patients was expressed in referred
 20 Resolution 204-I-09.

21
 22 **THE HISTORY OF INDIVIDUAL RESPONSIBILITY**

23
 24 The concept of individual responsibility to obtain health insurance has a long history. The Council
 25 notes that the foundation of the concept of individual responsibility lies in proposals from the late
 26 1980s and 1990s that were authored by the Heritage Foundation, as well as Wharton economist Mark
 27 Pauly, then affiliated with the American Enterprise Institute and serving as an advisor to President
 28 George H.W. Bush. Ultimately, provisions of both proposals were incorporated into various bills
 29 introduced in Congress as alternatives to the Health Security Act, the health system reform plan of
 30 the Clinton administration that used an employer mandate as its central building block to universal
 31 coverage. After support for health system reform crumbled during the Clinton administration, a
 32 prominent health reform proposal with provisions requiring individual responsibility was the
 33 Massachusetts health system reform effort, which was enacted into law in 2006, and supported under
 34 the administration of former Governor Mitt Romney.

35
 36 The market regulations of the ACA were developed in the context of provisions that would require
 37 individuals to obtain minimum acceptable coverage or pay a tax penalty, which would be phased in
 38 starting in 2014. Exemptions from the requirement to purchase health insurance are available to
 39 those deemed unable to afford health insurance, those who qualify for a religious exemption,
 40 American Indians, those without coverage for less than three months, undocumented immigrants,
 41 and incarcerated individuals. The Council notes that individuals who currently obtain coverage
 42 through their employers will meet the individual responsibility requirement of the ACA without
 43 having to change their coverage. At the time of the ACA's passage, in March 2010, the
 44 Congressional Budget Office (CBO) estimated that the combined coverage provisions in the ACA
 45 (including the individual responsibility provision) would expand health insurance coverage by 32
 46 million by 2019. Subsequently, in March 2011, CBO updated its estimate and projected that the
 47 ACA will expand coverage by 32 million by 2016 and 34 million by 2021.

48
 49 Since the passage of the ACA, numerous lawsuits have been filed that challenge the constitutional
 50 authority of Congress to enact a requirement for individuals to obtain health insurance and expand
 51 the Medicaid program. Rulings addressing the individual responsibility provision of the ACA have

1 been mixed. Federal district courts in the eastern district of Michigan, the western district of
 2 Virginia and the District of Columbia upheld the ACA, including its provision requiring individuals
 3 to obtain health insurance. Rulings upholding the law have underscored that whether and how to
 4 become insured are economic decisions, and therefore relate to the authority of Congress to regulate
 5 interstate commerce as outlined in the Commerce Clause. These rulings also have stressed that no
 6 individual can successfully opt out of the health care market. In contrast, Federal District Court
 7 Judge Henry Hudson of the eastern district of Virginia ruled that the ACA's requirement that
 8 individuals obtain health insurance is unconstitutional. Judge Hudson also ruled that the
 9 unconstitutionality of the requirement did not affect the rest of the law. Importantly, he did not issue
 10 an injunction blocking the current efforts to implement the law. District Court Judge Roger Vinson
 11 of the northern district of Florida also ruled that the individual responsibility provision is
 12 unconstitutional, but unlike Judge Hudson, concluded that there is no severability clause in the law,
 13 finding that the entire law must be voided. Although Judge Vinson did not explicitly issue an
 14 injunction initially blocking the law's implementation, it was his intent that his declaratory judgment
 15 be treated as an injunction by the federal government. However, in March, 2011, Judge Vinson
 16 clarified his ruling and issued a stay in his judgment, which means the ACA can continue to be
 17 implemented as the case is appealed to the US Court of Appeals. After the US Circuit Courts of
 18 Appeals issue their rulings, it is widely expected that the constitutional challenges to the ACA will
 19 ultimately be determined by the US Supreme Court in late 2011 or 2012.

20

21 ALTERNATIVES TO REQUIRING INDIVIDUAL RESPONSIBILITY

22

23 Following the district court rulings in Virginia and Florida, analysts are reviewing previously
 24 considered alternatives to requiring individuals to obtain health insurance. Such alternatives mirror
 25 proposals that were offered during the health system reform debate. Some critics of requiring
 26 individual responsibility have discussed alternatives in recognition that some intervention is needed
 27 to maximize coverage gains while balancing out the effects of eliminating denials due to pre-existing
 28 conditions. CMS Report 7-A-03 similarly concluded that without a requirement that individuals
 29 purchase health insurance, guaranteed issue invites free-riding by allowing individuals to postpone
 30 obtaining insurance until they need medical care, which leads to higher premiums for everyone.

31

32 In March 2011, the Government Accountability Office (GAO) released a report that summarizes
 33 expert views on approaches to encourage voluntary enrollment in private health insurance coverage,
 34 as alternatives to requiring individual responsibility. The GAO interviewed leading policy experts
 35 from 21 organizations to garner feedback on and outline approaches that could be considered as
 36 alternatives to requiring individual responsibility. Organizations interviewed for the GAO report
 37 include: America's Health Insurance Plans; American Academy of Actuaries; American Enterprise
 38 Institute for Public Policy Research; American Federation of Labor and Congress of Industrial
 39 Organizations; Assurant Health; Blackstone Group; Blue Cross Blue Shield Association; CDBykerk
 40 Consulting, LLC; Columbia University; Consumers Union; Council of State Governments;
 41 Employee Benefit Research Institute; Harvard University; The Henry J. Kaiser Family Foundation;
 42 The Heritage Foundation; The Lewin Group; Mercer; Massachusetts Institute of Technology;
 43 National Business Group on Health; The Urban Institute; and the US Chamber of Commerce.

44

45 The experts that the GAO interviewed discussed the following approaches to encourage voluntary
 46 enrollment in private insurance coverage, as alternatives to requiring individual responsibility:

47

- 48 • Modify open enrollment periods and impose late enrollment penalties;
- 49 • Expand employers' roles in auto-enrolling and facilitating employees' health insurance
 50 enrollment;
- 51 • Conduct a public education and outreach campaign;

- 1 • Provide broad access to personalized assistance for health coverage enrollment;
- 2 • Impose a tax to pay for uncompensated care;
- 3 • Allow greater variation in premium rates based on enrollee age;
- 4 • Condition the receipt of certain government services upon proof of health insurance
- 5 coverage;
- 6 • Use health insurance agents and brokers differently; and
- 7 • Require or encourage credit rating agencies to use health insurance status as a factor in
- 8 determining credit ratings.

9
 10 Unlike CBO’s approach to scoring legislation or other proposals, the GAO report did not assess the
 11 impact on health care costs and expanding health insurance coverage of the proposed alternatives to
 12 requiring individual responsibility. Instead, the report provided an overview of the proposed
 13 alternatives, along with the challenges and trade-offs associated with each approach to encourage
 14 voluntary enrollment in private health insurance coverage. Importantly, the GAO stated:

15
 16 Experts expressed important cautions in interpreting their comments on these approaches. Not
 17 all the experts concurred that any particular approach merited consideration, and those who
 18 proposed an approach for consideration did not necessarily suggest its impact would be
 19 significant or comparable to that of an individual mandate. Experts noted that various
 20 approaches would have different impacts on encouraging voluntary enrollment, and that a
 21 combination of multiple approaches holds more potential to encourage voluntary enrollment than
 22 any single approach. For example, a marketing and public education campaign may be
 23 combined with other approaches, and would be important to the successful implementation of
 24 any effort to encourage enrollment in health insurance. Furthermore, they emphasized that
 25 independent research is required to fully evaluate the potential effectiveness and legal or other
 26 implications associated with any approach or combination of approaches.

27
 28 The Council notes that the package of alternatives to requiring individual responsibility outlined in
 29 the GAO report has not been scored by the CBO to date to determine if it would actually expand
 30 coverage at all. However, in February 2011, Jonathan Gruber, an economics professor at the
 31 Massachusetts Institute of Technology (MIT), released a memo that included estimates of the impact
 32 of two prominent alternatives – auto-enrollment and late enrollment penalties.

33
 34 *Auto-Enrollment*

35
 36 Under the auto-enrollment alternative, individuals would be automatically enrolled in health
 37 insurance coverage but could “opt out” and decline such coverage. Auto-enrollment, when coupled
 38 with tax credits to purchase health insurance coverage, is supported by policymakers such as
 39 Representative Paul Ryan (R-WI), chairman of the House Budget Committee, as a means to achieve
 40 universal coverage. Frequently, the success of 401(k) plans is cited in proposals supporting the
 41 potential of auto-enrollment. However, according to Gruber, under the “best-case” scenario with
 42 auto-enrollment replacing the ACA requirement that individuals purchase health insurance, the
 43 government would spend the same amount of money while covering only two-thirds as many
 44 individuals. Consistent with CBO estimates, Gruber estimated that replacing the requirement to
 45 obtain coverage with auto-enrollment would double the erosion of employment-sponsored health
 46 insurance. In addition, premiums in the nongroup market would increase by approximately 11
 47 percent because young, healthy individuals would opt out of coverage. Finally, Gruber estimated
 48 that despite the decrease in the number of newly insured, there would not be a corresponding net
 49 decrease in government costs because 80 percent of the net gains in coverage would be through the
 50 public sector under auto-enrollment.

1 *Late Enrollment Penalties*

2
3 The second alternative that Gruber evaluated is largely similar to Medicare Part D. Individuals who
4 do not obtain coverage when they first become eligible would face a penalty. Therefore, there would
5 be a financial incentive for individuals to sign up as soon as they become eligible for coverage. In
6 developing his coverage estimates for this option, Gruber acknowledged that the impact of late
7 enrollment penalties would ultimately vary based on the size of the penalty. Ultimately, Gruber
8 estimated that late-enrollment penalties would result in only one-third as many individuals being
9 covered as under the ACA requirement that individuals obtain health insurance, and premiums in
10 exchanges would increase by approximately 20 percent due to young, healthy individuals opting out
11 of coverage.

12
13 *Other Alternatives*

14
15 At the time that this report was written, the Council had not identified any proposed alternatives that
16 would be as effective in expanding health insurance coverage to the uninsured as a requirement that
17 individuals obtain health insurance. Alternatives to date also would likely cause a larger increase in
18 health insurance premiums than what is projected under the ACA. Finally, the Council notes that
19 none of the aforementioned alternatives have been scored by the CBO to date to determine their
20 impact on expanding health insurance coverage. Therefore, there is a lack of data that show that any
21 alternative would be successful in significantly decreasing net government costs without
22 jeopardizing the coverage of millions of individuals.

23
24 In summary, the Council recognizes that critics of requiring individual responsibility have proposed
25 that the requirement to obtain health insurance be removed from the ACA. However, projections to
26 date conducted by the CBO, Urban Institute, and MIT economist Jonathan Gruber all suggest that the
27 ACA would cover millions fewer individuals if the individual responsibility requirement were
28 removed. In June 2010, CBO and the Joint Committee on Taxation estimated that without requiring
29 individuals to obtain health insurance, the ACA would only cover 16 million uninsured, versus the
30 32 million uninsured that was expected with the requirement. In December 2010, the Urban Institute
31 estimated that the number of uninsured would decline by only 20 percent without the individual
32 responsibility requirement, versus 50 percent with the requirement. This projection finds that the
33 drop in the number of uninsured would be due entirely to the expansion of the Medicaid program
34 rather than an expansion of private sector coverage. Finally, Gruber estimated that removing the
35 requirement for individuals to purchase health insurance would cause the number of newly insured
36 individuals to drop by 75 percent, from 32 million to only eight million.

37
38 DISCUSSION

39
40 Through 2009, the most recent year for which the US Census Bureau has collected data, there were
41 50.7 million uninsured men, women and children in the United States—16.7 percent of the
42 population—a number and percentage, which reflective of the recession, is widely expected to rise
43 when the Census Bureau releases the 2010 uninsured data in September 2011. Between 2008 and
44 2009, the percentage of people covered by private health insurance decreased from 66.7 percent to
45 63.9 percent. During that same time, the percentage of people covered by employer-sponsored
46 health insurance fell from 58.5 percent in 2008 to 55.8 percent in 2009, reaching the lowest level
47 since 1987—the first year that the Census Bureau collected comparative data. Perhaps even more
48 relevant to the debate over the issue of individual responsibility is the fact that 30.4 percent of those
49 between ages 18 and 24, and 29.1 percent of those ages 25 to 34 were uninsured in 2009.

1 The AMA has a long and distinguished tradition of advocating for a health care system that covers
2 the uninsured and expands choice. Since the House of Delegates adopted the 17 principles contained
3 in CMS Report 9-A-98, which presented how a system of individually selected and owned health
4 insurance could be structured (Policy H-165.920), the Council has been relentless in its efforts to
5 achieve this goal. Over 50 separate reports have been presented for the House's careful deliberation
6 over the past thirteen years as a means of refining AMA policy. CMS Report 4-A-00 established a
7 series of principles for structuring health insurance tax credits (Policy H-165.865). CMS Report
8 7-A-03 established a series of principles for health insurance market regulation (Policy H.165.856).
9 CMS Report 3-A-06 established policy on individual responsibility to obtain health insurance
10 (Policy H-165.848), a policy that was reaffirmed by the House of Delegates as recently as the 2010
11 Annual Meeting. The combined policy established by the House from these four reports provides a
12 significant portion of the underlying basis for the AMA proposal for expanding health insurance
13 coverage and choice.

14
15 With respect to the expansion of health insurance coverage, the ACA embodies much of the key
16 AMA policy described above. Nevertheless, earlier this year, the AMA delineated ten additional
17 changes to the law that it supports and five other outstanding issues that need to be addressed moving
18 forward.

19
20 As previously noted, the CBO projected in March 2011 that the combined coverage provisions in the
21 ACA will expand health insurance coverage by 32 million people by 2016. The Council's review of
22 recent analyses and simulations of removing the individual responsibility provision from the ACA
23 undertaken by the CBO, the Urban Institute, and MIT economist Jonathan Gruber, result in the
24 following dire consequences:

- 25
- 26 • Expanded coverage is reduced by 50 to 75 percent (from 32 million to as few as 8 million).
 - 27
 - 28 • Government spending decreases by only 25 to 30 percent, far less than the corresponding 50 to
29 70 percent reduction in coverage.
 - 30
 - 31 • Virtually all of the remaining coverage gains are due to the Medicaid expansion.
 - 32
 - 33 • The number of individuals with employer-sponsored health insurance, which CBO projects
34 would decline by three million under the ACA, is reduced further by two- to three-fold, because
35 individuals would become uninsured rather than take up employer offers.
 - 36
 - 37 • Health insurance premiums in the nongroup market increase by 15 to 27 percent.
 - 38
 - 39 • The level of uncompensated care remains high and decreases 65 percent less than it would with
40 the individual responsibility provision.
 - 41
 - 42 • The vast majority of the remaining uninsured are essentially "free riders" who ultimately benefit
43 from taxes or higher premiums paid by others.
 - 44

45 The Council also gave thoughtful consideration to alternatives to requiring individual responsibility.
46 However, there currently are no alternatives that have been scored by the CBO, and other analyses
47 fail to prove that such alternatives would be as effective in covering the uninsured and promoting a
48 balanced risk pool of individuals between those who are sick and those who are healthy. For
49 example, Gruber's simulations on auto-enrollment conclude that only two-thirds as many of the
50 currently uninsured would be covered as with the individual responsibility requirement, and

1 government costs would be just as much because the coverage gains would come almost exclusively
 2 through auto-enrollment into public sector programs, such as Medicaid.

3
 4 Accordingly, in order to maximize the expansion of health insurance coverage to the uninsured in
 5 both the public and private sectors, and to retain the critical components underlying the AMA
 6 proposal for expanding health insurance coverage and choice as established by the House of
 7 Delegates, the Council on Medical Service recommends the reaffirmation of policies in support of
 8 individual responsibility to obtain health insurance; individually selected and owned health
 9 insurance; principles for health insurance tax credits and other subsidies; principles for health
 10 insurance market regulation; health savings accounts; and direct subsidies for the coverage of high-
 11 risk patients. The Council firmly believes that the strength of this policy foundation is contingent on
 12 all of its parts; without each complementary component, the foundation begins to crumble and, as the
 13 literature suggests, the number of uninsured Americans will continue to grow.

14
 15 The AMA proposal for reform, including its individual responsibility requirement, facilitates fairness
 16 and preserves individual liberty. Individual responsibility for health insurance enables individuals to
 17 take ownership of their potential health care needs and those of their dependents. Currently,
 18 individuals are able to receive health care services in the emergency room regardless of whether they
 19 have health insurance coverage—emergency coverage is a societal obligation and is required by
 20 federal law. Requiring everyone to obtain health insurance ensures that all individuals take steps to
 21 protect themselves and their dependents, and prevents their health care expenses from burdening the
 22 rest of society. Voluntarily choosing to be uninsured violates societal liberties because taxpayers,
 23 insured individuals, and physicians and other health care providers involuntarily pay for the care of
 24 the uninsured through higher premiums and the provision of uncompensated care.

25
 26 The Council continues its belief that the approach to individual responsibility as outlined in Policy
 27 H-165.848 is relevant and appropriate. Those who are most able to afford health insurance coverage
 28 should bear greater individual responsibility to obtain coverage. The policy also recognizes that only
 29 upon implementation of tax credits or other subsidies, is it appropriate for lower income individuals
 30 and families to be subject to an individual responsibility requirement, as the purpose of such tax
 31 credits and subsidies is to help ensure that health insurance is affordable for most people. Notably,
 32 per Policy H-165.848[2], 500% of FPL in 2011 is \$54,450 for individuals and \$111,750 for a family
 33 of four.

34
 35 Requiring individuals to obtain health insurance as outlined in Policy H-165.848 is a critical piece of
 36 the AMA proposal for covering the uninsured and expanding choice. Any approach to covering the
 37 uninsured based on the AMA proposal for reform that has individually selected and owned health
 38 insurance, refundable and advanceable tax credits and health savings accounts as its foundation
 39 cannot maximize its success in covering the uninsured without an individual responsibility
 40 requirement. As noted in the analyses and simulations undertaken by the CBO, the Urban Institute,
 41 and MIT economist Jonathan Gruber, the ACA would not be able to achieve even remotely
 42 comparable coverage gains without such a requirement. The Council believes that if the number of
 43 uninsured Americans continues to grow, more onerous options, such as a single-payer system, may
 44 become much more politically viable.

45
 46 Finally, the Council underscores the reality that Policy H-165.848 can be used in the evaluation of
 47 any health system reform proposal, whether federal or state-based. The utility of Policy H-165.848
 48 is not tied to the ACA or to the constitutionality of ACA individual responsibility requirement. The
 49 matter before the courts is the ACA provision, not AMA policy on individual responsibility.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 204-I-09 and Resolution 816-I-10 and that the remainder of the report be filed:

- 5
6 1. That our American Medical Association (AMA) reaffirm Policy H-165.920, which supports
7 a system of individually selected and owned health insurance. (Reaffirm HOD Policy)
8
9 2. That our AMA reaffirm Policy H-165.865, which supports principles for health insurance
10 tax credits and other subsidies. (Reaffirm HOD Policy)
11
12 3. That our AMA reaffirm Policy H-165.852 in support of health savings accounts. (Reaffirm
13 HOD Policy)
14
15 4. That our AMA reaffirm Policy H-165.842, which supports the principle that health insurance
16 coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-
17 risk pools, risk adjustment, and reinsurance, rather than through indirect methods that rely
18 heavily on market regulation. (Reaffirm HOD Policy)
19
20 5. That our AMA reaffirm Policy H-165.856, which established principles for health insurance
21 market regulation. (Reaffirm HOD Policy)
22
23 6. That our AMA reaffirm Policy H-165.848, which supports individual responsibility to obtain
24 a minimum level of catastrophic and preventive coverage. (Reaffirm HOD Policy)
25
26 7. That our AMA reaffirm Policy H-165.838, which states that the AMA is committed to
27 achieving the enactment of health system reforms that include health insurance coverage for
28 all Americans, and insurance market reforms that expand choice of affordable coverage, and
29 are consistent with AMA policies concerning pluralism, freedom of choice, freedom of
30 practice, and universal access for patients. (Reaffirm HOD Policy)
31
32 8. That our AMA reaffirm Policy D-165.966, which advocates that state governments be given
33 the freedom to develop and test different models for covering the uninsured. (Reaffirm HOD
34 Policy)

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

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

APPENDIX

Full Text of Policies Recommended for Reaffirmation

H-165.920 Individual Health Insurance

Our AMA:

- (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
- (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
- (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) Continue to support equal tax treatment for payment of health 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 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;
 - (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
 - (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
 - (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
- (4) will identify any further means through which universal coverage and access can be achieved;
- (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
- (6) supports the individuals right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
- (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
- (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
- (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employees salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

- (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
- (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
- (12) supports a replacement of the present federal income tax exclusion from employees taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
- (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
- (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10)

H-165.865 Principles for Structuring a Health Insurance Tax Credit

- (1) AMA support for replacement of the present exclusion from employees taxable income of employer provided health insurance coverage with tax credits will be guided by the following principles:
 - (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 Health Savings Account, and not for out-of-pocket health expenditures.
 - (j) Tax credits should be advanceable for low income persons who could not afford the monthly out-of-pocket premium costs.

- (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 defined by Title 26 Section 9832 of the United States Code.
- (3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. (CMS Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-10)

H-165.852 Health Savings Accounts

It is the policy of the AMA that :

- (1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
- (2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees taxable income of employer-provided health expense coverage with tax credits for individuals and families;
- (3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
- (4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
- (5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
- (6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and
- (7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. (CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10)

H-165.842 Health Insurance Coverage of High-Risk Patients

Our AMA: (1) supports the principle that health insurance coverage of high-risk patients be subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment , and reinsurance, rather than through indirect methods that rely heavily on market regulation; and (2) supports state-based demonstration projects to subsidize coverage of high-risk patients through mechanisms such as high-risk pools, risk adjustment, reinsurance, and other risk-based subsidies. (CMS Rep. 2, I-07)

H-165.856 Health Insurance Market Regulation

Our AMA supports the following principles for health insurance market regulation:

- (1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;
- (2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;
- (3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;
- (4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium;
- (5) Insured individuals should be protected by guaranteed renewability;
- (6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;
- (7) Guaranteed issue regulations should be rescinded;
- (8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
- (9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and preexisting conditions limitations than individuals who are newly seeking coverage; and
- (10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
 - (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed;
 - (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and
 - (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed. (CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Res. 129, A-09)

H-165.848 Individual Responsibility To Obtain Health Insurance

1. Our AMA will support a requirement that individuals and families earning greater than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.
2. Upon implementation of a system of refundable, advanceable tax credits inversely related to income or other subsidies to obtain health care coverage, our AMA will support a requirement that individuals and families earning less than 500% of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (CMS Rep. 3, A-06; Modified: CMS Rep. 8, A-08; Reaffirmation A-10)

H-165.838 Health System Reform Legislation

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
 - a. Health insurance coverage for all Americans
 - b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
 - c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
 - d. Investments and incentives for quality improvement and prevention and wellness initiatives
 - e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
 - f. Implementation of medical liability reforms to reduce the cost of defensive medicine
 - g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.
4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
 - a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
 - b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
 - c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
 - d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
 - e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
 - f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Sub. Res. 203, I-09; Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10)

D-165.966 Giving States New Options to Improve Coverage for the Poor

Our AMA will (1) advocate that state governments be given the freedom to develop and test different models for improving coverage for patients with low incomes, including combining refundable, advanceable tax credits inversely related to income to purchase health insurance coverage with converting Medicaid from a categorical eligibility program to one that allows for coverage of additional low-income persons based solely on financial need; (2) advocate for changes in federal rules and federal financing to support the ability of states to develop and test such alternatives without incurring new and costly unfunded federal mandates or capping federal funds; (3) continue to work with interested state medical associations, national medical specialty societies, and other relevant organizations to further develop such state-based options for improving health insurance coverage for low-income persons; and (4) direct the Council of Medical Service to conduct a study of various alternatives and demonstration projects for expanding health insurance coverage for low-income persons and on progress concerning development of new state options for improving the effectiveness of public health safety net programs and report back at the 2005 Annual Meeting. (Res. 118, A-04; Reaffirmed: CMS Rep. 1, A-05; Modified: CMS Rep. 8, A-08)