REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 03-JUN-21

Subject: Universal Basic Income Pilot Studies (Resolution 236-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee G

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At the 2019 Annual Meeting, the House of Delegates referred Resolution 236, which was sponsored by the Medical Student Section and asks that the American Medical Association (AMA) support federal, state, local, and/or private Universal Basic Income pilot studies in the United States that intend to measure health outcomes and access to care for participants.

This report provides background on Universal Basic Income (UBI) proposals, outlines potential funding mechanisms for a UBI program, provides numerous examples of past and current UBI pilot programs and, where available, any resulting outcomes, details relevant AMA policy, and provides recommendations consistent with ongoing AMA advocacy efforts.

BACKGROUND

Some economists and policymakers argue that, although there was strong 3.4 percent growth in gross domestic product (GDP) in 2019 and low rates of unemployment, those numbers conceal the fact that many families are struggling financially. Wage growth remains stagnant, and nearly 1 in 10 employed adults work as contractors with limited job security and therefore employment benefits such as health insurance and long-term financial security. Moreover, the novel coronavirus (COVID-19) pandemic is severely exacerbating these health and economic issues. There have been more than 48 million jobless claims in the US since March. At the time this report was written, about 31.8 million people are receiving unemployment benefits, which equates to about 1 in 5 individuals in the workforce.[1] Simultaneously, the US continues to set record numbers of COVID-19 cases with cases trending upward in 39 states.[2] In light of the pandemic, the International Monetary Fund projects that growth in the US will fall 8 percent in 2020 and overall worldwide output will fall 4.9 percent.[3]

UBI is one method that is being suggested as having the potential to address current income inequality and to mitigate the loss of jobs caused by technological advances and COVID-19. UBI is an economic support mechanism typically intended to reach all or a large portion of the population.[4] It is particularly noteworthy and contrasted with current US welfare programs in that receipt of UBI comes with no or minimal conditions. According to the International Monetary Fund, in formulating a UBI plan, policymakers generally grapple with three primary considerations: who is eligible, the generosity of the UBI transfers, and the fiscal cost.[5] Some UBI proposals are universal while others are targeted to lower-income populations. Additionally, policymakers must weigh the incentives and disincentives of the generosity of transfers. For example, they must determine how UBI will affect decisions to enter the workforce and the number of hours worked. Finally, and perhaps most importantly, policymakers must determine the fiscal cost of implementing UBI to governments in an environment of limited financial resources.[6]

Proponents of UBI claim that it would help break the poverty cycle and dependency on welfare programs. They claim UBI will give the disadvantaged the time and money to seek higher education and needed job training.[7] Others claim that UBI would disincentivize work. However, decreased working hours has not been established in UBI trials to date.[8]

Advocates mention that UBI could replace the current complicated safety net. The US has a patchwork benefits system with programs including but not limited to:

- Supplemental Nutrition Assistance Program: Provides nutrition benefits to supplement the food budget of families in need so they can purchase healthy food.
- Temporary Assistance for Needy Families: A time-limited program that assists families with children when the parents or other responsible relatives cannot provide for the family's basic needs.
- Children's Health Insurance Program (CHIP): Provides health coverage to children in families that earn too much money to qualify for Medicaid. In some states, CHIP also covers pregnant women.
- Section 8: Housing choice voucher program assisting low-income families, the elderly, and the disabled, to afford safe and sanitary housing in the private market.
- Earned Income Tax Credit: A refundable tax credit to low- and moderate-income individuals, particularly those with children.
- Special Supplemental Nutrition Program for Women, Infants, and Children: Provides federal grants to states for supplemental food, health care referrals, and nutrition education for low-income pregnant, breastfeeding, and postpartum women, and to infants and children up to age five who are at nutritional risk.
- Supplemental Security Income: Program providing cash benefits to meet the needs of elderly, blind, and disabled individuals who otherwise have challenges paying for food and shelter.

Every year, the US spends nearly $1 trillion across dozens of state and federal programs amounting to significant administrative oversight across multiple agencies.[9] However, some critics of the programs state that the complex network of resources is a consequence of having different programs intentionally target different populations with varying needs and that the purpose of each program is distinct.[10] Critics of UBI state that it amounts to redistribution but does not necessarily advance mobility or represent an investment in human capital. Rather, they believe, society should focus its collective efforts on reforming current safety net programs to better meet their intended goals.[11]

## FUNDING

Regardless of where one stands on UBI, how to pay for it is the primary challenge. Some estimates put the annual price for a US program in the trillions. Presumably, such a high cost would have to be funded through some type of taxation.

Some UBI advocates claim that such a high cost would be offset by savings as fewer people require welfare, food stamps, and other social programs. Moreover, advocates argue, UBI could be funded through savings from averting prisons, emergency care, and homelessness,[12] based on the evidence that high health care spending in the US is a direct result of low social safety net spending.[13] In fact, the significant literature on social determinants of health (SDOH) establishes a direct link between social factors and health status, and some evidence points to a link between social spending and health outcomes.[14] However, it remains unclear exactly how much low spending on

SDOH impacts health spending and therefore how much overall spending could be reduced in a UBI program.

Former 2020 presidential candidate and current New York City mayoral candidate Andrew Yang has run on a platform of a guaranteed income. Yang's proposal, called the Freedom Dividend, suggested giving $1,000 per month to all US citizens over the age of 18 unconditionally. Yang proposed funding his UBI proposal through four sources. First, he proposed streamlining and consolidating several welfare programs. Second, he suggested implementing a Value Added Tax of ten percent to generate revenue. Third, he stated that UBI would put money into the hands of American consumers and would thereby generate economic growth. And fourth, he proposed taxing top earners and pollution through such actions as a financial transactions tax and a carbon fee.[15]

## UBI PILOT PROGRAMS AND RESULTS

### *Manitoba Basic Annual Income Experiment (Mincome)*

In 1975, the Canadian government began the Manitoba Basic Annual Income Experiment (Mincome), which lasted three years. The results of this experiment were published in 2011. Unlike most UBI pilots, Mincome allowed researchers to compare the health of those receiving UBI to the health of similar people not receiving UBI. The experiment involved 1,300 urban and rural families with incomes below $16,000 in Canadian dollars for a family of four. Families with higher incomes still received the UBI but at a reduced rate. Therefore, working was still rewarded, and the results of the pilot show that the majority of Mincome participants kept working. Importantly, families receiving the UBI had fewer hospitalizations, accidents, and injuries. Additionally, mental health hospitalizations fell dramatically in the population receiving UBI. Further, the high school completion rate for 16- to 18-year-old boys increased, and adolescent girls were less likely to give birth before the age of 25. The experiment was terminated after three years when Canada's governing party changed midway through the proposed duration of the pilot.[16] To date, Mincome remains one of the few UBI experiments measuring any health outcome related data.

### *Finland's Basic Income Experiment*

In 2017, Finland launched a UBI experiment involving a guaranteed tax-free income of about $590 per month to 2,000 randomly selected unemployed citizens. The trial experiment lasted nearly two years. As researchers explore the effects of the experiment, one general finding is that happiness and overall sense of wellbeing improved. Participants also stated that the income gave them a sense of autonomy and allowed them to return to meaningful activities. Regarding employment, the results are mixed. Employment went up slightly in the second year of the trial but not significantly. Participants stated that there were still no jobs available in the areas in which they were trained. Others noted that, due to the basic income, they were more prepared to take on lower paying jobs to enable them to reenter the workforce.[17]

### *Ontario Basic Income Pilot*

In March 2017, the government of Ontario, Canada began the Ontario Basic Income Pilot. The pilot was undertaken in three sites in Ontario with 4,000 low-income individuals participating with an additional 2,000 people participating in the comparison group. The participants were eligible to receive up to $16,989 per year for a single person, less 50 percent of any earned income or up to $24,027 per year for a couple, less 50 percent of any earned income. The pilot measured, among other markers, food security, stress and anxiety, mental health, housing stability, and health and

health care usage. Additionally, participants receiving support through social assistance needed to withdraw from those programs to participate and receive the UBI. In 2019, Ontario terminated the pilot earlier than planned two months after a change in the control of the province's government from the Liberal Party to the Progressive Conservatives Party. The new government stated that winding down the pilot will enable participants to transition back to more proven support systems without putting an undue burden on taxpayers.

*Stockton Economic Empowerment Demonstration*

In February 2019, the city of Stockton, California began giving 125 city residents a guaranteed income of $500/month for 18 months.[18] The monthly income was unconditional, and it was intended to test UBI as a solution to poverty and inequality. Though the program was scheduled to end in June 2020, it was renewed until January 2021 due to the COVID-19 pandemic. The 125 residents participated in individual onboarding appointments, which included informed consent and benefits counseling. According to the Stockton Economic Empowerment Demonstration (SEED), the purpose of the benefits counseling was to ensure that the participants were aware of any risks associated with the UBI disbursements possibly impacting their health insurance or other benefits such as food stamps or Supplemental Security Income. One of the primary outcomes that the SEED researchers planned to measure was the effect of the UBI on the participants' functioning and well-being. One of the early program results observed was that most recipients spent their money on groceries and utility bills. In the early phase of the program, food spending made up about 30 percent to 40 percent of the spending each month. However, after the pandemic started, the share of food spend increased to almost 50 percent.[19] After initial results were released, a group of mayors announced the formation of the Guaranteed Income Coalition, which is committed to investigating how to successfully build and launch UBI projects in their cities.

In March 2021, SEED released the results from the first year of the experiment. A primary finding is that the individuals who received the monthly UBI payment secured fulltime employment at more than twice the rate of those in the control group. Additionally, within a year, the proportion of recipients receiving the cash payments who had a fulltime job went from 28 percent to 40 percent. Meanwhile, the control group saw a 5 percent increase in full time employment. Another positive finding is that those receiving cash payments reported being less anxious and depressed compared to the control group. As far as how the group spent the money, of the money tracked, recipients spent more on necessities like food (37 percent), home goods and clothes (22 percent), utilities (11 percent), and car costs (10 percent). The recipients spent less than 1 percent of the UBI payment on alcohol or cigarettes. Although the study's sample size is small, the early results indicate that UBI payments give recipients stability and enhance health.[20] [21]

*OpenResearch*

Another UBI pilot being undertaken is by OpenResearch, a non-profit research lab. The study, which started in 2020, recruited about 3,000 people across two states. It randomly assigned 1,000 of those individuals to receive $1,000 per month for three years while using the other 2,000 individuals as the control group. Importantly, the pilot will measure health outcomes including health markers (e.g., body mass index, hypertension), healthy behaviors, health insurance coverage, food security, housing quality and stability, physician and mental health care utilization, crime victimization, and mental health.

RELEVANT AMA POLICY

The AMA has myriad policies on health disparities, health inequities, and diversity, and the AMA continues to provide leadership in addressing disparities (Policies H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Policy H-350.974 affirms that the AMA maintains a zero-tolerance policy toward racially or culturally based disparities in care and states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. The policy encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, Policy H-350.974 supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons. Moreover, the policy actively supports the development and implementation of training regarding implicit bias and cultural competency. Policy H-280.945 calls for better integration of health care and social services and supports. Additionally, Policy D-350.995 promotes diversity within the health care workforce, which can help expand access to care for vulnerable and underserved populations.

The AMA also has strong policy supporting Medicaid. Policy H-290.986 states that the Medicaid program is a safety net for the nation's most vulnerable populations. Moreover, the AMA is committed to expanding Medicaid coverage. In particular, Policy D-290.979 directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. Finally, Policy D-290.985 encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services.

DISCUSSION

There are risks to replacing targeted social safety net programs, which protect the most vulnerable, with a UBI program. The AMA strongly supports these existing evidence-based safety net programs. Of note, AMA Ethics Opinion 11.1.1 states that health care is a fundamental human good and the Council believes physicians have a responsibility to work to ensure access to care. The Council advises caution regarding support for any proposal that may have the effect of jeopardizing access to care.

The AMA continues to advocate for Medicaid funding and other safety net program funding. Medicaid and other safety net programs increase vital access to care for patients, reduce the number of uninsured individuals, and improve the lives of working Americans. The Council believes the AMA should continue its efforts to improve upon and expand Medicaid and other programs that improve the health of patients. Therefore, the Council recommends reaffirming the AMA's comprehensive policy on addressing health disparities, the role of Medicaid as a vital safety net program, the AMA's enduring commitment to expanding Medicaid eligibility, and sufficient funding for the program.

An evidence-based method to analyze UBI is currently unavailable. Models have been population-based and generally do not meet minimum standards for randomized control studies. They have also been subject to political influence and change. Experiments are key to understanding how and if UBI would work on a large scale. Consequently, there is a void of data on how a sustained UBI program would operate and the far-reaching effects the program would have once implemented. The Council does not believe that there are adequate data to actively support UBI pilots at this time. However, the Council recognizes that UBI may be one of myriad solutions to help address growing inequity and health care disparities. Therefore, the Council recommends that the AMA

actively monitor UBI pilots moving forward, especially pilots that intend to measure the health outcomes and access to care of its participants.

The Council understands that the concept of UBI is evolving rapidly, particularly in light of the COVID-19 pandemic. The pandemic is catalyzing support for UBI not only in the US but also worldwide. Since February 2020, governments all over the world, including the US, have started distributing direct cash payments among large portions of their populations in order to mitigate the loss of jobs and financial disruption of the pandemic. A report from the United Nations recently stated that temporary basic income payments could stem the spread of the pandemic by enabling workers, particularly those living below the poverty line, to stay at home.[22] Additionally, Spain started a UBI program offering monthly payments up to $1,145 to its poorest families in 850,000 households. The program is the largest test of UBI seen thus far. The program is seen as a way to not only soften the impact of the COVID-19 pandemic but also to become a structural instrument of stability in the country. Also, in March 2021, Congress passed, and the president signed into law the third pandemic aid package that once again includes direct payments to millions of Americans. Importantly, the law, the American Rescue Plan, substantially expands the Child Tax Credit and supplements the earnings of families receiving the credit. Under the law, most Americans will receive $3,000 a year for each child ages 6-17, and $3,600 per year for each child under 6. The provision lasts one year and will be sent via direct deposit on a "periodic" basis. This provision represents a major expansion of the child tax credit, and the proposed "periodic" payments mirror a UBI payment.[23]

As the COVID-19 pandemic and its economic fallout continue, the US and society must consider the appropriate responses to not only the pandemic but also deepened and newly exposed financial inequities. The AMA is committed to following and analyzing the relevant research to confront these issues and propose solutions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 236-A-19, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy H-350.974, which states that the elimination of racial and ethnic disparities in health care are an issue of highest priority for the organization. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy H-290.986, which states that the Medicaid program is a safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy D-290.979, which directs the AMA to work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility as authorized by the Affordable Care Act. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy D-290.985, which encourages sufficient federal and state funding for Medicaid to support enrollment and the provision of appropriate services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-290.997 stating that greater equity in the Medicaid program should be achieved through creation of adequate payment levels to ensure broad access to care. (Reaffirm HOD Policy)

6. That our AMA encourage Universal Basic Income pilot studies to measure health outcomes and access to care for patients to increase data on the health effects of these programs. (New HOD Policy)

7. That our AMA actively monitor Universal Basic Income pilot studies that intend to measure participant health outcomes and access to care. (Directive to Take Action)

Fiscal Note: Less than $500.

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