



Expanding
Health
Insurance:
The AMA
Proposal
for Reform

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Introduction

The American Medical Association (AMA) has long championed the idea that every American should have health insurance. Despite a sustained period of economic prosperity and substantial job creation throughout the past decade, an increasing portion of the United States population does not have health insurance. The uninsured often defer obtaining medical care and preventive services, jeopardizing their health and the healthy development of their children and potentially adding to the complications and cost of their treatment once they do seek care. This booklet details the AMA proposal for reforming private health insurance in the United States. It presents a number of steps that can be taken to assure that individuals are fully enabled to obtain health insurance of their choice. The proposal is aligned with the AMA's long-range policy goal of transforming the country's health care from a system that is primarily responsive to employers to one that is primarily responsive to patients.

In particular, the AMA proposes a health care financing system to address the alarming number of uninsured Americans in a manner that will result in increased choice and that contains the following benefits:

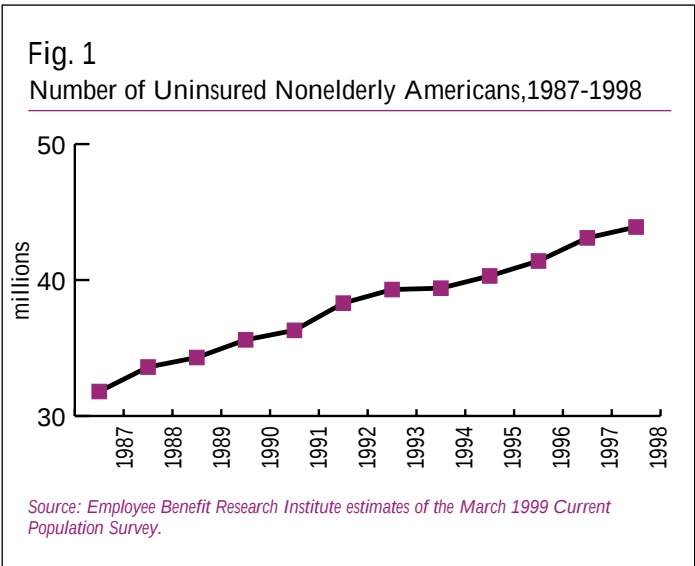
- Provide health insurance for those who are currently uninsured.
- Enable individuals to choose and control coverage for themselves and their families.
- Correct the current inequity in the tax code, so that the tax treatment of health insurance expenditures is more favorable to those with low incomes than to those with high incomes.
- Create a health insurance market that offers products that are affordable for individuals and families.

The AMA proposal to increase the number of Americans with health insurance coverage is financially sustainable for the nation and puts patients first in choosing health insurance that meets their needs. Only a few fundamental changes need be made to establish the legal and regulatory framework for a vastly improved market for health insurance. Those who are satisfied with the coverage they have now will be able to maintain that coverage. Moreover, people will be permitted to pursue alternatives if they are uninsured or if they are not satisfied with their current coverage. The changes and their rationale are described in the remainder of this booklet.

The AMA proposal to increase the number of Americans with health insurance coverage is financially sustainable for the nation and puts patients first in choosing health insurance that meets their needs.

I. The Rising Number of Uninsured Americans

From 1987 to 1998, the number of nonelderly Americans who were uninsured rose steadily from 31.8 million to 43.9 million (Figure 1). The largest subgroups of the uninsured tend to be younger, employed in smaller firms, and making relatively low wages.



The increase in the number of uninsured Americans has captured considerable national attention, particularly as the country has been experiencing a prolonged period of economic prosperity. Accordingly, health insurance coverage has played an increasingly important role in congressional and presidential campaigns, as well as in ongoing political debate. Today, a number of legislative proposals would change the tax treatment of health insurance to make it easier for people to obtain insurance outside of the predominantly employment-based system.

The AMA proposal for reducing the number of uninsured persons would change the financing of private health insurance in a manner that encourages and enables individuals to purchase the coverage of their choice, with a tax treatment that does not discourage lower-income individuals from obtaining coverage, as does the current system. The two main elements of the AMA proposal are as follows:

- Establish a system of refundable tax credits for the purchase of health insurance that are inversely related to income.

The increase in the number of uninsured Americans has captured considerable national attention.

- Create widespread opportunities for alternative markets for affordable health insurance, so that groups other than employers are able to pool risk and individuals have more choices.

The AMA proposal increases the fairness of taxation on health insurance. Its principal goal is to expand health insurance coverage by redirecting the current subsidy of employer-sponsored coverage toward those who need it most. The AMA proposal allows for the continuation of employment-based insurance in the private sector, while encouraging new sources of health insurance that would be available for both the uninsured and the currently insured. The Medicaid program and Children's Health Insurance Program (CHIP) could be modeled similarly to provide greater beneficiary choice by providing a tax credit or voucher for recipients to use in selecting their own health plans.

Past attempts to overhaul private sector health insurance have failed. State-imposed insurance regulations have tended to make individually purchased insurance both more affordable by regulating private insurance rates and more comprehensive by mandating coverage of an increasing array of benefits. However, such regulations have contributed to the counterproductive effect of adding to the numbers of the uninsured. Public programs for the poor and near poor, such as Medicaid and CHIP, are not designed to provide coverage to all of those who are currently uninsured. However, these public programs can and should be made more effective in enrolling eligible beneficiaries to address the growing number of our nation's uninsured children.

The vast majority of the uninsured in the United States are employed.

II. The Current Employment-Based System

Coverage provided through employment dominates the private sector. In 1998, just 6.5% of the nonelderly population had individually purchased coverage, whereas 64.9% had employment-based coverage. Another 14.3% had some form of coverage through the public sector, while 18.4% of the nonelderly population went uninsured. The current individual market for health insurance is regulated in a manner that makes it an inaccessible alternative to many people who would otherwise seek coverage on their own.

Increased health care expenditures throughout the latter half of the century encouraged employers, as well as public sector payers, to seek ways to control costs. Managed care

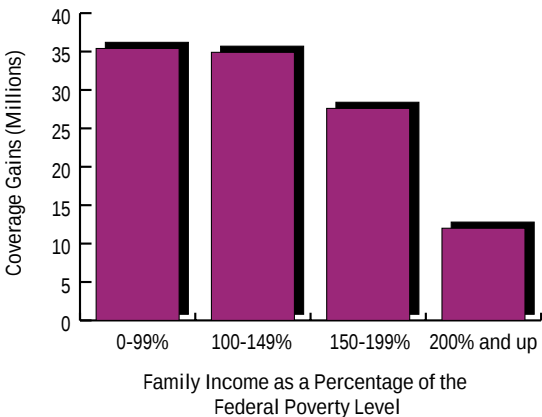
was embraced as a means of doing so. The system served the nation well until the mid-1980s, when the number of non-elderly Americans with employment-based coverage began to fall and the country began to experience a continued rise in the number of uninsured Americans.

In many ways, the failure of the employment-based system to ensure health insurance coverage is related to the cost-cutting techniques of managed care. Many managed care practices have created a strong public outcry, giving rise to a significant focus on patient rights in the congressional and state elections of 2000. The tremendous rise in health care costs was not anticipated until decades after employment-based health insurance had become entrenched as an entitled benefit expectation, which directly resulted from hastily devised post World War II tax policy.

The current tax treatment of health insurance creates a number of gross inequities and distortions in the health insurance market.

A clear indication of the failure of the employment-based foundation for private sector coverage is the fact that the majority of the uninsured are employed. According to 1998 estimates from the Employee Benefit Research Institute, 83% of the uninsured lived in families headed by workers; 61% were full-year, full-time workers, and 22% were part-time and/or seasonal workers. Only 17% of the uninsured were in families in which the family head was not employed. The relatively low proportion of total uninsured individuals with a non-working head of household is due primarily to the large proportion of this group enrolled in Medicaid, CHIP, and/or Medicare. Figure 2 shows that the prevalence of being uninsured is highest among those just above the federal poverty level.

Fig. 2
Percentage Uninsured among Nonelderly Population by Family Income, 1998



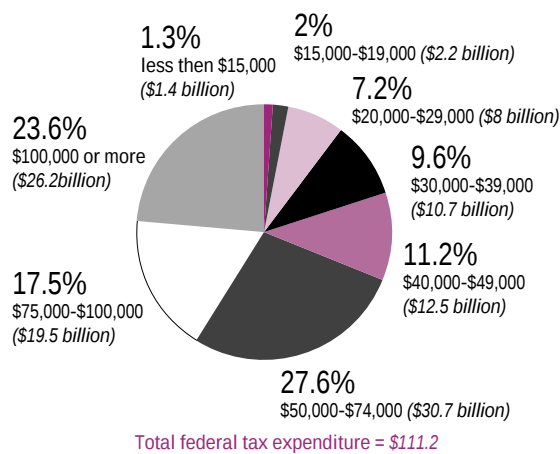
Source: Employee Benefit Research Institute estimate of the March 1999 Current Population Survey.

Currently, the government subsidizes the purchase of health insurance by excluding from an individual's or family's taxable income expenditures on health insurance—but only if insurance is obtained through an employer, and only on that portion of the premium paid for by the employer. Those who are self-employed can now take a partial tax deduction if they purchase their own health insurance, and by 2003 they will be able to deduct 100% of their insurance costs. No tax break is given to other individuals who purchase their own health insurance, such as workers whose employers do not offer coverage.

The self-employed and others who purchase their coverage on the current individual market face premiums that are significantly higher than for coverage negotiated by employers. The current inequitable tax treatment of individually purchased health insurance puts it at a great disadvantage in the market, and perpetuates the employment-based health insurance system. Furthermore, it often leads workers with employment-based insurance to want coverage for all ordinary, routine, and inexpensive health care needs because routine expenditures can be made tax-free through the benefit system, a major cause of over-insurance and excessive growth in health care expenditures.

Perhaps most disturbing is that the current tax exclusion provides the largest tax subsidy for those with the highest income, making it socially inequitable. By being skewed toward higher incomes, the current subsidy is an inherently ineffective approach to encouraging coverage among those who are most likely to go without coverage: those with low incomes. In a recent analysis of the cost of the health insurance tax exemption, it was estimated that the value of tax exemption per average family was \$1,031. However, for families earning \$100,000 or more the value was \$2,357 and for families earning less than \$15,000 the value was only \$71 (Sheils and Hogan, 1999). Furthermore, higher-income employees tend to choose more generous, expensive plans, thereby obtaining larger amounts of subsidy. Figure 3, created by the Lewin Group, illustrates the regressive nature of the current tax exclusion by showing that about one-fourth of the health insurance subsidy goes to the 10% of American families earning \$100,000 or more.

Fig. 3
Distribution of Federal Health Benefits Tax Expenditures, By Family Income, 1998



Source: Lewin Group estimates using the Health Benefits Simulation Model (HBSM). Reprinted with permission from *Health Affairs*, "Cost of Tax-Exempt Health Benefits in 1998," Vol.18, No.3, 176-181, Copyright 1999, 'Project HOPE' <http://projhope.org/HA>.

The AMA proposal would expand health insurance coverage by redirecting the current tax subsidy.

The AMA proposal would expand health insurance coverage by redirecting the current subsidy of health insurance from the higher to lower income groups who are most likely to be uninsured for financial reasons, and creating a market with risk pooling mechanisms that offer an alternative to employment-based coverage.

III. The AMA Proposal— Expanding Health Insurance

The two main elements of the AMA proposal for expanding health insurance coverage are:

- Establishing income-related, refundable tax credits for purchasing health insurance; and
- Creating opportunities for alternative markets for health insurance/health expense coverage –Health Insurance Marts (also referred to as voluntary choice cooperatives, insurance marts, health insurance purchasing groups).

A. Establishing Tax Credits for the Purchase of Health Insurance

The existing tax exclusion for employer expenditures on health insurance would be replaced with a refundable tax credit to all individuals or families who purchase health insurance. Under the current system, individuals obtain tax benefits simply by virtue of the fact that their employers' expenditures on health insurance are not included as taxable income. Under the AMA's proposed system, employer contributions to health insurance would be reported as taxable income and individuals would take a portion of spending for health insurance as tax credits to be directly subtracted from their tax bills.

The AMA believes that expanding health insurance coverage through the use of tax credits should be guided by the following principles:

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

This principle provides a strong incentive for people to purchase health insurance voluntarily. It makes tax subsidies for insurance independent of employment or an employer's health benefit offerings, and ensures that the subsidy is used for the purchase of health insurance. A minimum of stipulations and restrictions should be imposed on health insurance products beyond requiring that they broadly cover standard medical services and provide catastrophic protection in order to maximize the affordability of basic coverage, and to permit maximum flexibility for developing insurance choices that meet the needs of various groups of consumers, whether through a traditional insurance or managed care plan or a medical savings account (MSA).

Tax credits should be refundable.

The tax credit should be refundable to those who purchase health insurance, but who have tax liability less than the value of the tax credit. This principle is particularly essential for low-income individuals and families that are more likely to be uninsured in the absence of tax subsidies.

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

This principle provides greater subsidy to those with lower incomes. As previously noted, the current tax exclusion provides a greater subsidy to individuals in higher tax brackets. Further, those families that earn too little to owe any income tax currently get no tax subsidy on health insurance. Inversely relating tax credits to income targets the tax subsidy toward those who would otherwise be most likely to be uninsured, and conserves budgetary resources.

A consequence of moving from the current, regressive subsidy to tax credits that are inversely related to income is that members of upper income groups will lose some or all of their current subsidy. However, this reduction in subsidy will have several offsetting effects. First, redirecting the subsidy to lower income groups will achieve coverage more efficiently by reducing the amount of uncompensated care. Because uncompensated care is ultimately paid for through higher taxes and higher premiums, expanded coverage confers financial benefits to upper income groups. Second, market competition under individually owned health insurance will lead to greater price and quality competition among insurers, greater individual choice of plans, and lower premiums for all income groups. Third, to the extent that some employers no longer offer health insurance to their employees, economists expect they will compensate employees with higher wages and salaries in order to remain competitive in labor markets.

The most likely methods of structuring tax credits under this principle are to tie the amount of tax credits to individual and family federal income, or to multiples of the federal poverty level (e.g., 100%, 200%, 300%). Another method of targeting tax credits to lower income groups is to impose an income cutoff for eligibility for tax credits. As noted later in this booklet, simulations of alternative tax credit scenarios show that restricting eligibility to the lowest income categories reduces cost per newly insured and increases coverage for any given level of new federal spending. Making the tax credit progressive has little negative impact on coverage as long as the credit is sufficient to cover a substantial portion of the premium costs for individuals in the low income categories.

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

In combination with the preceding principle that tax credits be inversely related to income, this principle

acknowledges the need for tax credits that are large enough to empower virtually all individuals to obtain and maintain health insurance. A comparison of AMA tax credit simulations suggests that the credit must be sufficient to cover a substantial portion of the premium costs for individuals in the low-income categories. At the lowest income levels the credit must approach 100% of the premium.

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

This principle discourages overinsurance. If the size of the credit does not vary with the amount of health insurance expenditure, as recommended by the AMA's next principle, there is an implicit cap equal to the amount of the highest tax credit. However, if a tax credit proposal in which the credits vary with the level of insurance premiums becomes viable, it should cap the credits to prevent overinsurance.

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

This principle provides an incentive for individuals to be cost-conscious and discourages overinsurance by making the size of credits independent of health insurance expenditures. The current system provides a greater subsidy with increases in health insurance expenditures, thereby encouraging overinsurance. Relating tax credits to health insurance expenditures would also significantly increase the administrative complexity of the system.

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

This principle would ensure that tax credits generally mirror the pricing structure of health insurance premiums for individuals and families. Premiums for family policies tend to be less than the sum of premiums for individual members. In general, the larger the group, the easier it is to predict costs, thereby reducing the “cost of risk” to the insurer.

In the event that some family members have insurance not purchased by the family (e.g., CHIP, Medicaid or Medicare), those family members would be excluded from the determination of family size for purposes of establishing the size of tax credits. Adhering to this principle would simplify the structure and administration of the tax credits.

How Will the Individual Health Insurance Market Change?

Compared with group insurance, individual policies are generally much more expensive because they are not subsidized, and because they lack the substantial cost savings of pooling risk and reducing administrative overhead. For these reasons, employment-based coverage is effectively the only choice that most Americans have.

Delinking the tax benefit of health insurance coverage from employment is an important first step in expanding individuals' options for obtaining affordable coverage. Both the size and the extent of the individually purchased health insurance market will increase dramatically. The AMA's proposed change in the tax treatment of health insurance expenditures would also make it easier for employers to offer benefits through a defined contribution approach rather than a defined benefit approach, benefiting employers with further potential savings and workers with enhanced choice of health benefits.

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

This principle encourages maximum coverage. In the absence of this requirement, individuals might "game" the system by purchasing coverage only for themselves and not their healthy children, waiting to seek coverage for the children only when they experience a need for health care.

Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Medical Savings Account, and not for out-of-pocket health expenditures.

This principle limits the tax credits to the purchase of health insurance coverage. Allowing tax credits to be used for out-of-pocket health expenses would encourage excess consumption of health care services, may necessitate the development of detailed rules regarding which out-of-pocket health expenses should qualify for credits, and may dilute the incentive to purchase health insurance. In general, for a given "budget" of tax credits, subsidizing direct health expenditures means there will be smaller subsidies available for health insurance. Separate subsidies should be developed and/or considered for those individuals whose out-of-pocket health spending is atypically high due to chronic disease or health catastrophe.

B. Creating Alternative Markets

The second major element of the AMA's vision for expanding access to health insurance coverage is creating new opportunities for individuals to pool risks and obtain "group" insurance. The AMA recognizes that the existing individual health insurance market is financially inaccessible to many individuals, particularly those who most need comprehensive coverage. In fact, the cost of health insurance in the current individual market is inflated precisely because it is subject to adverse selection by individuals who do not have access to employment-based coverage, but who anticipate significant health care expenses. A large portion of those who have neither employment-based nor individual coverage are young and healthy individuals who believe they can risk "going bare."

Therefore, the AMA supports federal legislation enabling the formation of Health Insurance Markets by affinity groups that could include coalitions of small employers, unions, trade associations, health insurance purchasing coopera-

tives, farm bureaus, fraternal organizations, chambers of commerce, churches and religious groups, and ethnic coalitions. Prototypes already exist in the form of Multiple Employer Welfare Associations (MEWAs) and some internet-based health insurance companies.

Groups serving as Health Insurance Marts would be encouraged to create competitive alternative insurance plans by being exempted from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws. In order to promote true portability of coverage, savings inherent in group coverage, and choice, emphasis would be placed on the formation of Health Insurance Marts by organizations that are regional or national in scope, and on assuring that such pools offer a choice of plans.

Both Health Insurance Marts and employers offering a choice of plans should be encouraged to contain or compensate for adverse selection among available plans by using such mechanisms as risk adjustment across plans, reinsurance pools, and limiting enrollment and disenrollment opportunities through limited open-enrollment periods and multiple-year policy contracts. These measures would enhance access to insurance by those with preexisting conditions, the disabled, and the chronically ill by reducing incentives to insurers to avoid such high-risk individuals.

C. Five Simulated Tax Credit Scenarios

The AMA Center for Health Policy Research has used modeling techniques to assess the impact of alternative tax credit proposals on insurance coverage, the federal budget, private health insurance expenditures, and other key aspects of the health system. The estimated impacts of five health insurance tax credit scenarios were analyzed in a simulation model that incorporates behavioral relationships among key economic variables influencing the demand for coverage. The key outcome variables from the simulations include the change in coverage, the change in federal spending, and changes in the distributional measures of the tax subsidy.

It needs to be stressed that the tax credit simulation estimates reflect measures of behavioral responses in the current system, which may differ significantly from the responses in a fully implemented individually selected and owned health insurance system. In addition, the five scenarios were developed for illustrative purposes only and

Employment-based insurance would continue to the extent that the market demands it, and new sources of health insurance would open up for employees, children, and the general uninsured population.

Tax credit simulations indicate that the AMA proposal would be effective at expanding coverage with a modest federal commitment.

The AMA Tax Credit Simulation Project

The AMA Tax Credit Simulation Project, developed by the AMA Center for Health Policy Research, incorporates state-of-the-art modeling techniques. The Center holds workshops on simulation methodologies and estimates with health economists and other experts. Additional information on the AMA's tax credit analysis is available in the Tax Credit Simulation Project Technical Report, June 2000, Discussion Paper 00-1

none should be viewed as representing the AMA proposal per se.

None of the five simulated scenarios achieves 100% coverage, and full coverage is defined as insuring 95% of the population. In fact, even in countries that purport to have systems of “universal coverage,” there are individuals who remain uninsured.

The size of the tax credits in the five modeled scenarios ranged from \$900 for individual coverage and \$1,800 for family coverage, to more generous scenarios featuring \$2,000 for individual coverage and \$4,000 for family coverage. Two scenarios were modeled without regard for income level, with one at the lower tax credit rate (scenario A) and the other at the higher rate (scenario B). The scenario involving a low tax credit level for all individuals regardless of income would expand coverage to an estimated 16.2 to 18.6 million persons and require an additional \$29 to \$41 billion in federal spending. The same scenario with the higher tax credit would increase coverage by an estimated 22 to 24 million persons for an additional \$124 to \$146 billion in federal spending.

The other three scenarios would provide the full tax credit only for incomes up to \$10,000, with the credit declining by \$200 for individuals and \$400 for families per income category up to a cap of \$75,000 (scenarios C and D) or \$100,000 (scenario E), at which point there is no credit. Scenarios D and E assume 95% (or full) participation rates for individuals in the \$0 - \$10,000 and \$10,000 - \$20,000 income brackets, in part to recognize the significant income effects the tax credits create at lower income levels. These three scenarios, in which the credits are inversely related to income, would result in between 18 and 26 million more persons with coverage at a cost of between \$31 and \$65 billion in new federal spending. Figure 4 tabulates the estimated impacts of each of the five tax credit scenarios considered.

Fig. 4 Summary of Five Tax Credit Scenarios—Impacts on Coverage and Spending

Impacts	A	B	C	D	E
Coverage Gains (millions)	16.2-18.6	21.7-24.3	17.9-19.9	24.3-25.4	25.4-26.4
Remaining Uninsured (millions)	25.7-28.1	20-22.6	24.4-26.4	18.9-20.0	17.9-18.9
Percentage of Population Remaining Uninsured	9.1%-10.0%	7.1%-8.0%	8.7%-9.4%	6.7%-7.1%	6.4%-6.7%
New Federal Spending (billion \$)	\$28.8-\$40.8	\$124.4-\$146.4	\$31.1-\$48.7	\$39.1-\$55.8	\$45.9-\$65.0
Cost per Newly Insured	\$1,776-\$2,194	\$5,726-\$6,032	\$1,807-\$2,442	\$1,607-\$2,204	\$1,810-\$2,464
After-tax Premium as a Percent of Income, Income \$0-\$50,000	4.7%-11.9%	0%-4.9%	0%-7.3%	0%-7.3%	0%-7.3%

Source: Division of Economic and Statistical Research, American Medical Association, March 2000.

Excluding scenario B, in which all income levels received the larger credit at an additional cost of \$124 to \$146 billion, the results of the simulations suggest that the cost of approaching full coverage requires \$30 billion to \$60 billion in new federal spending, with the estimates of the added insured persons ranging from 16 million to over 26 million people. The three scenarios that provide full credits for the lowest income levels and declining amounts at higher income levels substantially redirect spending toward lower income groups and away from higher income groups. The impact of each tax credit scenario on coverage is presented in Figure 5 and the impact of each on federal spending is presented in Figure 6.

Fig. 5 Range of Coverage Gains

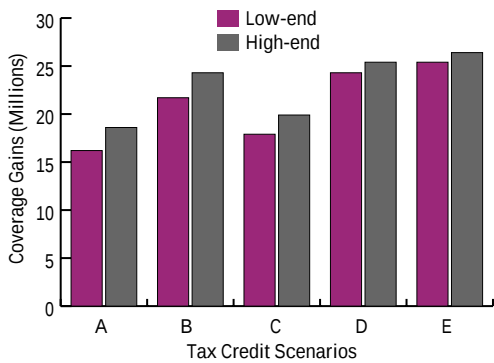
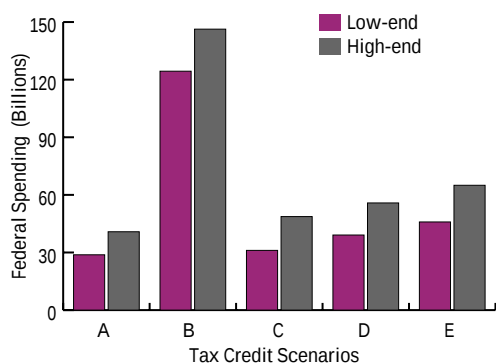


Fig. 6 Range of New Federal Spending



Source: Division of Economic and Statistical Research, American Medical Association, March 2000.

Comparing the results from the last three scenarios with scenario B, which provides the full credit at all income levels, suggests that making the tax credit progressive has little negative impact on coverage as long as the credit is sufficient to cover a substantial portion of the premium costs for individuals in the low income categories. Compared to a neutral tax credit, a progressive tax credit significantly reduces the federal spending necessary to reach a desired coverage level. These scenarios suggest that a cap based on income level is effective in increasing coverage and holding down cost.

D. Advantages of the AMA Proposal

When compared with alternative proposals for expanding health insurance coverage to the uninsured, the AMA proposal has several advantages, even when the comparison is with other “tax credit” proposals. These advantages, addressed below, include fairness, choice, universality, affordability, and fiscal soundness.

The AMA proposal also is well suited to incremental changes, although the impact of revising the tax treatment of health insurance expenditures would be profound. The AMA has given particular care to ensuring that vulnerable populations do not risk losing their coverage during the transition to a more equitable system of private health insurance coverage.

Fairness

The AMA proposal is fair in several respects. In contrast to the current system, everyone could receive a tax benefit for purchasing insurance regardless of employment status. Unlike the existing tax exclusion for employment-based insurance, a refundable tax credit for the purchase of health insurance could enhance access to health insurance for the self-employed and those whose employers do not offer health insurance, as well as those who are disadvantaged economically or by health risk. Because the tax credit applies whether the individual obtains insurance through the employer or elsewhere, the AMA proposal increases insurance portability for those in the labor market.

Compared with the current tax exclusion, the AMA proposed system of tax credits is a more equitable approach to subsidizing health insurance because it would be targeted to those who need it most. With the tax credit inversely related to income, not only would those with low incomes have the ability to purchase coverage, but also those with middle and upper incomes would have a safety net in the event of catastrophic health or financial events. Compared with the current system, the AMA proposal provides the simple assurance that the sick poor in society would have improved access to needed care, since the current tax exemption provides little, if any, assistance to this group.

The AMA proposal increases portability... and assures that the sick poor in society would have improved access to needed care.

Expanded Coverage

Recognizing that no approach, even a compulsory one, will achieve 100% universal coverage, the AMA favors using strong tax incentives to increase access to health insurance without resorting to individual or employer mandates. One tax-based approach would be to make the tax credit contingent on the purchase of health insurance, so that if insurance were not purchased, the credit would be forfeited. Although this would have no effect on persons who prefer to go uninsured, it would encourage the majority of the population who recognize the value of health insurance to obtain coverage in order to qualify for the tax credit. A more coercive tax-based approach would be to assess a tax penalty equal to the premium of some minimal insurance on individuals who filed tax returns or presented for care without evidence of having health insurance, with the penalty funds used to enroll such individuals in a “fall-back” plan. Tax-based incentives to purchase insurance, coupled with a greater tax credit to low-income persons to assist them in obtaining health insurance would lead to virtual universal coverage.

Tax-based incentives to purchase insurance, coupled with a greater tax credit to low-income persons, would lead to virtual universal coverage.

Increased Choice

Today, most employees are offered only one health plan, and some are not offered health insurance at all. The tax system puts employers in the unnatural position of negotiating the type of coverage, benefits, and premiums of plans on behalf of a diverse group of individuals, often with widely varying needs and preferences. Under the AMA proposal, individuals would have a wider choice of health insurance options because they could purchase insurance through any number of sources. Insurance would be offered both by many employers and by Health Insurance Marts that would offer multiple health insurance plans.

Patient Empowerment

The AMA proposal will empower patients and strengthen the patient–physician relationship. Individual ownership of health insurance is necessary to allow patients to assert their desires in how care is delivered. Patients are more likely than employers to change plans due to dissatisfaction with plan performance, so plans will have to try harder to remain competitive. Plans also may find it harder to deny services recommended by physicians, because the plans would no longer be able to defer to the benefit selections of employers. Under individually owned insurance, patients

can more easily switch from plans that fail to recognize the medical decisions reached by patients and their physicians, such as when a service recommended by a physician is denied by the plan.

Affordability for Individuals

Individual choice will force health plans to compete on the basis of price, plan features, and quality.

Compared with the current system of private health insurance dominated by employment-based coverage, the combination of changing the tax treatment of health insurance expenditures and creating new opportunities for pooling risks would potentially result in lower health insurance premiums for a variety of reasons. First, tax incentives would be structured to induce most people to purchase health insurance, thus reducing both the tax burden and the premium padding of insurers that currently is necessary to pay for uncompensated care. Second, individual choice will force plans to compete on the basis of price, plan features, and quality. Faced with competition in the individual market, plans will face pressure to provide coverage that is responsive to the concerns of individuals, rather than employers. Third, a tax credit capped at a certain limit of health expenditures would reduce the current incentive of those with higher incomes to over-insure.

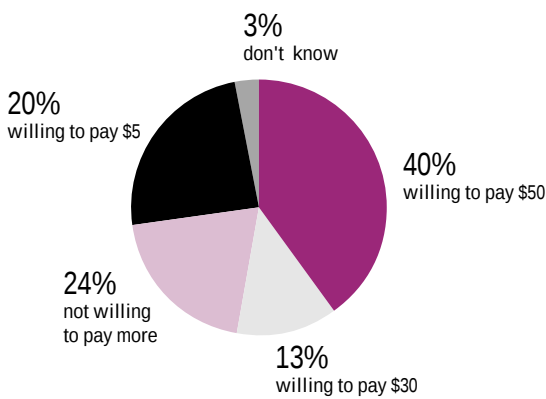
Fiscal Soundness

In contrast to other proposals for insuring more Americans, the AMA proposal ensures near universal coverage in a fiscally responsible manner. The AMA proposal is financially feasible precisely because of the tax changes that are recommended. In 1998, the federal government provided close to \$66 billion per year in tax subsidies for health insurance through the tax exclusion of employment-based insurance. (Sheils and Hogan, 1999). This is tax revenue that the government foregoes by not counting employee health benefits as taxable income. By eliminating the tax exclusion, the federal government could offer up to \$66 billion in tax credits and still remain budget neutral.

Providing health insurance coverage to the 44 million people who are currently uninsured will require significant public commitment. As the AMA simulations show, accounting for the \$66 billion in new tax dollars, the federal government would need to provide between \$39 billion and \$65 billion in new funding to provide nearly full coverage of approximately 93%. To the extent that additional funding resources become available, the number of the uninsured could possibly decline even more.

A December 1999 survey by the Kaiser Family Foundation and the Harvard School of Public Health found that 73% of registered voters were willing to pay more per month in higher premiums or taxes to increase the number of Americans who have health insurance coverage. Figure 7 shows the level of increased financial commitment respondents indicated they were willing to make.

Fig. 7
Percentage of Voters Willing to Pay More per Month to Expand Health Insurance Coverage



Source: Kaiser Family Foundation/Harvard School of Public Health, *National Survey on Health Care and the 2000 Elections*, January 19, 2000.

With such a high level of public concern and commitment, combined with the current surplus environment, it is inconceivable to not take positive steps toward enabling more people to become insured.

It is important to keep in mind, however, that no approach, even a compulsory one, will achieve 100% universal coverage. Nations that have instituted individual or employer mandates to purchase health insurance generally approach but do not achieve 100% universal coverage. Because there will always be some uninsured individuals, it is important that vulnerable populations continue to be supported through safety net mechanisms.

“Protecting Vulnerable Populations”

The AMA proposal is fundamentally sensitive to the needs of low-income individuals. Core principles of the proposal include structuring tax credits to be refundable and inversely related to income, both of which were developed to expand coverage among those most likely to be uninsured.

For low-income persons who cannot afford the monthly out-of-pocket premium costs, the AMA proposes that existing organizations, such as a local welfare agency, could verify income status, issue a voucher for the cost of coverage, and receive the tax credits due individuals, thus providing “up-front” funds for purchasing coverage.

At the same time, the AMA believes various other programs and concepts will be needed to maintain a safety net for vulnerable patients.

Expanding Outreach and Enrollment of Medicaid and CHIP Eligibles:

Some 5 million children and adults in low income families are eligible for coverage under these public sector programs, but are not enrolled. The AMA strongly supports the current national and state efforts to increase outreach efforts to enroll these individuals in the appropriate programs.

(continued on pg 18)

(Protecting Vulnerable Populations, continued)

Community Rating Bands:

The AMA supports the use by states of rating bands, or limits on the extent to which premiums for individual policies can vary around the average premium in a geographic location or insurance market. Rating bands allow premiums to vary by such factors as health status, gender, and age, but limit variation from the average premium.

State Risk Pools:

The AMA has long advocated for the establishment of state risk pools, in which all health care underwriters in each state would participate in a risk pooling program to provide coverage, at a premium slightly higher than the standard group rate, to those who are unable to obtain such coverage because of medical considerations, as well as those with medically standard risks who lack group coverage and are unable to afford private individual health insurance.

Conclusion

The AMA believes that individually owned health insurance, accomplished with fundamental changes in the current tax and individual insurance market systems, would provide the best opportunity to reverse the growth in the number of the uninsured, while also increasing the health plan choices of those Americans who are currently insured. The present exclusion of employer-sponsored insurance costs from taxable income inequitably provides more help to higher income individuals. As proposed by the AMA, an income-related refundable credit would provide greater assistance to those who need it the most, such as individuals with lower incomes. It is a fair and simple approach to reform.

The AMA proposal retains a market-based approach to health insurance coverage, while addressing the multitude of problems caused by the current system of health care financing. In addition to a staggering rise in the number of uninsured individuals, the current system is marked by growing costs, and patient and physician discontent. The AMA proposal seeks equity in the tax treatment of health insurance by providing tax credits inversely related to income. It seeks to empower patients, and strengthen the patient-physician relationship, by providing individuals with a greater choice of health plans and direct ownership of coverage.

Most importantly, the AMA proposal promises to expand health insurance coverage to nearly all Americans, in a manner that is affordable for individuals and fiscally sound for the nation.