

Health Care Financing Reform

What's on the Table? The AMA and CMA Proposals

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In the last issue of the *CSA Bulletin*, Dr. Steffie Woolhandler¹ argued for a single payer national health system; I responded² that such a proposal was fatally flawed and suggested a more workable approach to health care reform in America such as an incremental one like that advocated by Dr. Donald Palmisano for the AMA.³ To continue to inform CSA members concerning this critical ongoing socioeconomic and political debate, it is useful to compare and contrast the principles and specifics of the AMA position with the new plan now being proffered by the CMA.^{4,5,6} These proposals are driven by the enormous problem of the uninsured in America: 45 million people, 15 percent of the U.S. population, are uninsured, an increase of nearly 4 million since 2000. In California, 7 million people, 20 percent of the population, are uninsured.

The Evolution of Our System

Our national health care system, largely financed through the private sector, grew out of incentives initiated during World War II. Sixty years ago health care insurance premiums were—and still are—fully deductible to the employers and also a tax-free benefit to employees. Thus employees get tax-free compensation while employers save payroll taxes. Employees are insulated from the true costs of health care, creating a sense of entitlement for “free” and over-utilized health care services.

However, retirees and the unemployed had no health insurance coverage, being excluded from employer-based health insurance. For this reason, the Social Security Act Amendments of 1965 established Medicare to insure America's seniors, and Medicaid to finance services for some of the low-income population.

The concept of Medicaid began as coverage for everyone below the Federal Poverty Line (FPL), but it had a major design flaw, namely state eligibility controls. The federal government set broad eligibility and coverage guidelines that the states could exceed at their discretion; federal matching percentages vary by state and costs are entirely open-ended. Ninety percent of costs (\$305 billion in 2004) are presently paid out for only four categories: obstetrics, pediatrics, HIV, and nursing homes (greater than \$100 billion in 2005).⁴ Medicaid costs are careening out of control, and yet 20 million very low income Americans are currently uninsured.

Medicare was envisioned as the single payer system for seniors, with guaranteed coverage starting at age 65, and an initial taxpayer-recipient ratio of 10-15:1. This

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reflected a broad base of workers taxed to pay for the care of pre-baby boom recipients. There was a blank check for physician and hospital charges, as well as medical education, and many additional benefits have been added every year for 40 years. During this period (1956-1997), the taxpayer-recipient ratio declined progressively (3.3:1 by 1997, the same now, and projected to be 2.1:1 by 2030).⁷ The program faced potential bankruptcy as early as the mid-1980s. 1984 saw the advent of hospital price controls, as well as a doubling of payroll taxes. By 1989, physician price controls had begun. Medical device price controls and the uncapping of payroll taxes started in the early 1990s. Finally, in 1997, the Balanced Budget Act was passed, and Americans were bequeathed the Sustainable Growth Rate Update Formula, whereby the original Medicare Volume Performance Standards (MVPS) targets were replaced with a political fix, which has produced a completely predictable chronic and insoluble Medicare funding gap. The Centers for Medicare and Medicaid Services estimates that without federal corrective legislation, the 2006 Medicare physician fee schedule update will be a **negative** 4.3 percent, with additional five percent annual negative updates yearly through 2012, clearly an unsustainable scenario with inevitable grave consequences for patients' access to care.

Prior to physician price controls, Medicare paid usual, customary and reasonable (UCR) fees, but with the advent of the Resource-Based Relative Value System fee schedule adopted in 1992, UCR physician fees escalated as they cost-shifted Medicare shortfalls to other private insurers. Anesthesiologists are particularly sensitive to this issue because the Medicare conversion factor for anesthesiologists was erroneously underestimated. This mistake has compounded over the years, reducing the Medicare anesthesia conversion factor to less than 38 percent of the commercial contracted rates, compared to an average of 80 percent for other physicians.

The AMA Proposal

Not just the uninsured, but also all non-elderly individuals, are targeted by the AMA plan. The physician-patient relationship and continuity of care are preserved. The AMA's proposal develops from three fundamental principles:

1. Tax credits to encourage the purchase of health insurance;
2. Individual choice and personal ownership of health insurance policies; and
3. Facilitation of new and innovative health insurance markets which should expand choice, portability, and competition for premium dollars.

Tax Credits

The *tax deductibility* of employer-based health insurance would be replaced with *tax credits* (possibly contingent upon coverage for each family member) which are

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inversely related to income and which are advanceable, such that they may be used to buy insurance before federal tax returns are filed.

The existing federal *tax deductibility* of employer health insurance premiums and other payments provides an economic benefit largely to “relatively wealthy employed individuals and their families.” Those without employer coverage and those in low income tax brackets derive little tax benefit to encourage purchase of health insurance. The “total federal tax subsidy for employer health benefits [was] estimated to be \$188.5 billion” in 2004.³ This “subsidy” averaged \$1,492 overall per family, \$2,780 for families with income of \$100,000 or more, and only \$102 for families with less than \$10,000 income.

The AMA proposes *tax credits* indexed to income to replace deductions of employer-based health benefits, but employer spending on employee health insurance would still be fully deductible as a business expense. Credits would be large enough to ensure health insurance affordability for most people, targeting subsidies to those who would not be insured without them. This would reduce uncompensated care in the system. Credits could be used to refund those who purchased insurance and advanceable, perhaps with a voucher, to those who need it to purchase insurance. Originally the AMA plan would have removed all individual tax deductibility for health benefits from the federal tax code, but the AMA House of Delegates amended this to having a cap on deductions instead.

Individual Choice and Ownership of Health Insurance Policies

In the AMA plan, each person would own their own health insurance policy and employer plans would be merely one of several options for group coverage, allowing individuals to match their own choices better with their own individual preferences and values.

Choice produces satisfaction with care and also increases access. Ratings to compare insurance plans produce no consequences if there is little choice, as in the current employer-based system. The Federal Employees Health Benefits Program (FEHBP) is a good example of “individualized group insurance,” wherein considerable information and choice is available on plan performance, benefits, and premiums. Ratings of the FEHBP are high, with only 5 percent of enrollees changing plans each year, and many individuals “remain for decades with the same choice of plans and providers.”³

Moving toward the notion of defined contribution and away from defined benefit would produce an evolution in personally owned insurance in which the economic costs to the workers become explicit. Less first dollar coverage produces price

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consciousness and cost control. Insurers would be further incentivized to measure and demonstrate value. Employers would have more predictable costs of providing health benefits in a defined contribution scenario.

New Health Insurance Markets

Under the AMA plan, the range of offerings for health insurance policies would be facilitated by market incentives and reforms; individual choice would increase.

The AMA proposes allowing private-sector employees and individuals to use tax credits to purchase coverage in state health benefit systems. States could permit small group purchasing arrangements, association plans, and other markets. To expand coverage in non-employer group markets, exemptions similar to the Employee Retirement Income Security Act (ERISA) could be granted (e.g., exemptions from state mandated benefits, taxes on premiums, purchasing pool size minimums, and rating laws), while still safeguarding state and federal patient protection regulations. Also guaranteed issue and strict community rating with extensive benefit mandates could cure adverse selection bias, albeit at the cost of higher premiums and reduced numbers of insured. High-risk individuals might need subsidies, or insurers might be given risk-related subsidies. Reforms and incentives could stimulate Medical Savings Accounts and other consumer-driven plans, while the Internet could reduce the costs of administering multiple plans and multiple choices. Small-group purchasing arrangements could help small firms negotiate with more plans and offer more choices to employees. What would evolve would be new markets for individuals and non-employer groups, in addition to employer-based plans, such that competition for premium dollars would increase and coverage could become more affordable, particularly for those with pre-existing conditions.

AMA Conclusions

The cornerstones of the AMA’s proposal to expand insurance coverage are consumer choice, limiting the role of the government and “avoiding a ‘one size fits all’ approach to coverage.” Palmisano calls upon policy makers to “be aware of the siren song of single payer advocates,” cautioning that “experience with these systems has exposed the many drawbacks for patients and physicians.” He argues for funding sufficient for 95 percent of the U.S. population to be covered by a program of tax credits and enrolling Medicaid eligible uninsured.

The CMA Plan

The CMA has stepped up to promote its own proposal for health care financing reform. Without a fix, the CMA foresees collapse of the safety net for emergency and trauma care, with the result that fewer patients will pay their bills and ul-

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mately more physicians and hospitals will be driven out of business. In September 2004, the CMA House of Delegates and Board of Directors adopted a series of resolutions,⁸ which as a whole represent a proposal to develop consensus as a meaningful first step toward a solution.

The underlying principle is to expand meaningful health insurance coverage to the largest number of currently uninsured Americans without impacting state or federal budgets. The declared top priority is to eliminate the fear of being bankrupted by catastrophic illness, while also including U.S. Public Health Service-approved clinical prevention coverage such as well-child and prenatal care, as well as screening mammograms, for example. The goal of the CMA Proposal is not to solve every problem with one sweeping set of reform measures, but rather to “begin to provide most efficiently the highest quality care to the most people.”^{4,5}

Mandates

The CMA has deduced that some sort of mandate will be required to ensure universal access to care.

One option for a mandate is a single payer system. Dr. Woolhandler has floated this proposal at the national level and Senator Kuehl has done so in Sacramento, but it suffers from the considerable risk that medical decisions will be reduced to politics: rationing services not logically, but politically. Such a scenario has until now been a non-starter for the majority of voters. Moreover, despite calls for a “Canada Deluxe” system, the CMA argues that the Canadian system is actually more expensive than assumed, if costs are adjusted for demographics, accounting practices, hospital infrastructure, the tort system, and the care of seniors.⁴

A second option is for employer mandates, an approach championed by the CMA not so long ago. Proposition 166, a 1994 measure based upon the largely successful legislation for employer mandates in Hawaii and backed by CMA at considerable cost, failed with the voters. SB 2, a 2003 measure providing for a more limited version of employer mandates, initially applying only to employers with 50 or more employees, passed and was signed into law by Governor Gray Davis in November 2003. Although it was predicted to have only a modest impact, it would have resulted in payroll tax increases of up to 40 percent in some business sectors, and, before it took effect, Proposition 72 repealed it by a margin of 50.5 percent to 49.5 percent in November 2004. The CMA has concluded that there is no employer mandate that business will not fight, and Governor Arnold Schwarzenegger is absolutely clear about his support for reducing the costs of doing business in California.

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We are left with an individual mandate with sliding-scale tax credits for those with lower incomes as the only viable approach to advance the goal of universal access to meaningful care.

The CMA plan is offered as an incremental approach to change. It mandates insurance coverage for all, but seeks only to ensure catastrophic coverage and basic public-health type screenings and services. There is a gap of what happens between screening and catastrophe which is purposefully not addressed, but the liability for that gap is set at approximately \$3,000, considerably less than the liability many now have who are uninsured or underinsured. It finances its plan by markedly curtailing tax deductions for a segment of the population which is generally employed, “relatively well-off,” and well insured. It provides a mechanism to cover the uninsured and delivers this sound bite: “We could cover the vast majority of the currently uninsured population with no net impact on the state or federal budgets. The top priorities would be bankruptcy prevention and preventative care, not free office visits and free meds.”⁴

Specifics of the CMA Plan

The 45 million uninsured fall into four groups, defined as follows:

Group I	5 million, incomes > 400% of FPL
Group II	10 million, age < 18 and SCHIP eligible
Group III	10 million employed at 200-400% FPL
Group IV	20 million truly low income

Group I: There would be an individual mandate to obtain catastrophic coverage, paired with market reforms like guaranteed issue and “community rating” of insurance plans, to mitigate the adverse selection bias discussed earlier. The mandate could be enforced through the tax code, wherein a form that verifies health insurance could reduce a significant tax liability. The estimated cost to the taxpayers in the aggregate is \$0, although the cost to individuals could be significant.

Group II: Federal SCHIP (State Children’s Health Insurance Program, called Healthy Families in California) monies would be used to cover all children at an estimated cost of \$10 billion.

Group III: There would be tax subsidies for lower income employed individuals, with the minimum coverage required to be catastrophic plus prevention. Tax credits could be refundable, paid only after proof of purchase of insurance, or could be allocated directly, perhaps with a voucher, to a health care broker on behalf of an individual taxpayer. The estimated cost is \$20 billion, \$2,000 for each individual, 10 million individuals.

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Group IV: This group is comprised of the truly indigent, many homeless, many mentally ill, for whom tax credits and any kind of complexity just will not work. The proposal is to bolster the safety net for these individuals, using multi-disciplinary public health approaches including community health centers that could be open 24/7. The estimated cost is \$20 billion.

Show Me the Money

Fifty billion dollars in additional funds is required to insure these 45 million uninsured. The relatively affluent uninsured, those in Group I, pay out of their own pockets for their insurance and thus do not require additional federal dollars. Furthermore, existing federal SCHIP dollars, which are available but have not been put to use, should be mined to help to insure all children. The balance of the \$50 billion needed to cover groups II, III, and IV could be raised by capping the deductibility of “employer-based coverage [one-third of the \$150 billion income tax subsidy] at 110 percent of the value of the local average plan (the ‘excess’ benefit).”

The winners with this health care financing reform plan are: 30 to 35 million uninsured Americans and those who at present are obliged to give them uncompensated care; all American children; all emergency service practitioners; all current payers for the uninsured; and business, which avoids additional taxes and additional mandates. The losers are a subset of Americans with relatively high incomes and relatively expensive medical benefits. The CMA declares that society as a whole must determine whether the \$50 billion needed to cover enormous numbers of the uninsured is best allocated to do so, or whether it is better to subsidize the insurance benefits of Americans who are well-insured **and** relatively well paid. The estimated deductible for catastrophic coverage is estimated to be \$3,000. Certainly this seems substantial, but it is a major improvement over totally uncapped individual liability.

How the CMA Proposal Differs from the AMA Proposal

The AMA plan is an attempt, based upon philosophic principles, to reinvent our system within the context of a market economy. It does not mandate or guarantee insurance coverage, but it incentivizes individuals to act rationally in response to changes in the tax code; it goes beyond targeting the uninsured and seeks to use tax incentives to control costs. Potentially individuals could use their credits for something other than to purchase health insurance. It is a big picture plan and does not fill in the precise details. It estimates a cost of up to \$65 billion to maximize increased insurance coverage, but it does not offer a mechanism for funding.

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For the CMA, the priorities are: to insure for catastrophic care, to ensure that no one goes bankrupt from health care costs, and to insure for preventative care as per USPHS standards. It is financed by reducing some of the tax preferences for the health benefits of a subset of Americans who are already well insured.

These proposals for health care financing reform by our large professional medical associations have some common principles, but some different priorities and mechanisms of change. They share a perspective that the growing ranks of the uninsured is a fundamental problem that must be addressed, and a core tenet that a single payer national health system cannot be the answer. They both conclude that enhancements in insurance markets must be enacted to permit any meaningful changes, and both recognize that new money in the form of a redistribution of income mediated through the tax structure will be required.

Note: Proposals for health care financing reform in America have been discussed before in the CSA Bulletin,^{9,10,11} and many more have been analyzed in detail elsewhere.^{12,13,14}

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