

Individual Mandate, AMA Policy, and the Affordable Care Act

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A lot of heated debate has occurred for a year now at the AMA House of Delegates regarding the individual mandate. Needless to say it is an extremely divisive and emotional issue. Sadly, some unfortunately state it is a moral issue, which further adds to the divisiveness that it creates.

The basic reasoning behind the mandate is simple: to make health care coverage affordable, all Americans must share in the cost by buying insurance. The mandate prevents “free riders” from seeking expensive medical treatment in emergency rooms and then passing on costs to the rest of us.

I believe there is a lot of misinformation is being spread and therefore I would like to provide some clarification.

Existing AMA Policy Associated with the Individual Mandate

AMA policy regarding individual responsibility has largely been unchanged for five years and only stipulates catastrophic coverage under specific situations. The policy states:

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)*

AMA also supports the principles of pluralism, freedom of choice, freedom of practice, and universal access for patients (H-165.888). The AMA maintains an unwavering opposition against the encroachment of government in the practice of medicine as well as any attempts to covertly change the American health care system to a government program with the subsequent loss of precious personal freedoms, including the right of physicians and patients to contract privately for health care without government interference (H-165-916).

So the AMA supports a qualified mandate for catastrophic coverage. Catastrophic coverage is a typically a private insurance product designed to improve access and prevent financial disaster from extensive medical care.

Recent AMA House of Delegate Actions Regarding the Individual Mandate

At the Interim 2010 AMA HOD, the AMA policy regarding the individual mandate was challenged and then voted down by an extremely slim margin. Because of the close vote and divisiveness of the issue, it was referred back to the board. At the most recent AMA HOD (Annual 2011, June 2011), the issue correctly was addressed again and resolutions on both sides were presented. The debate was extensive and heated, and this time by a small margin the policy was upheld. In the end and after an exhausted debate, the HOD by a 2 to 1 margin voted to close the debate.

Realizing that the Affordable Care Act (PPACA) differs from current AMA Policy, the June 2011 HOD also passed the following resolution:

Our American Medical Association will continue to advocate to achieve needed reforms of the many defects of the federal Patient Protection and law so as to protect the primacy of the physician-patient relationship. Our AMA will vigorously work to change the PPACA to accurately represent our AMA Policy.

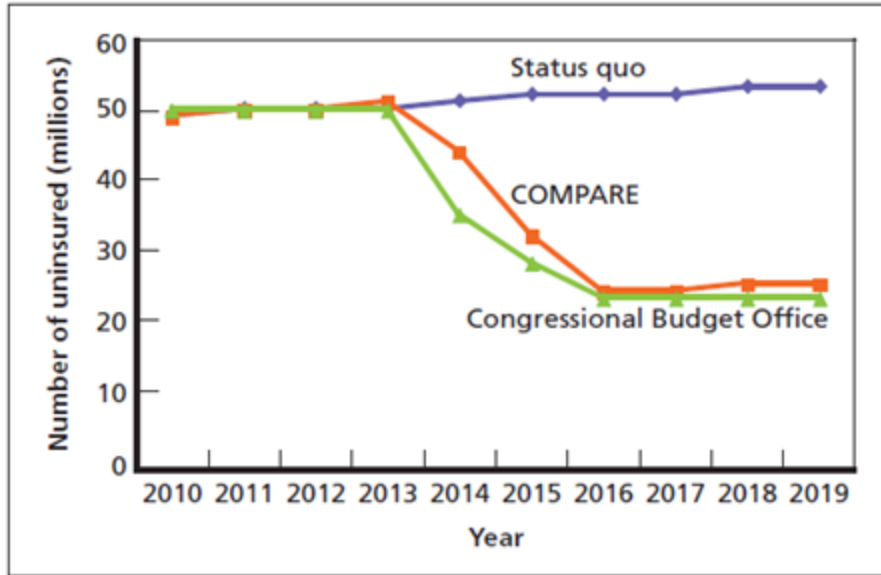
Accountable Care Act's Individual Mandate

The PPACA mandate requires U.S. citizens and legal residents to have qualifying health coverage. This differs from AMA policy in that under the PPACA, qualifying health coverage is extensive rather than catastrophic.

The PPACA individual mandate has been challenged in a number of federal courts since it would require citizens to purchase a product from a private company. In perhaps the most important case, 26 state attorneys general challenged the constitutionality of this provision. Regardless of this court's ruling, the mandate seems destined for the U.S. Supreme Court.

PPACA's Mandate Will Not Ensure Access for All

PPACA's individual mandate will not ensure coverage for all. In fact, projections by the Congressional Budget Office and Rand clearly state that only about half of the currently uninsured will get coverage.



RAND Compare Analysis 2010

A closer look into the Rand projections demonstrates that the vast majority of the uninsured gain coverage through state Medicaid programs and exchanges. Exchanges will be run by the states and will likely model the Basic Health Program.

Enrollment Projects (millions)

	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
<u>Status Quo</u>										
Medicaid/SCHIP	35	35	36	36	36	37	37	37	37	38
Employer-sponsored	153	153	154	154	154	155	155	155	156	156
Non-group	17	17	17	17	17	17	17	17	17	17
Other	15	15	15	15	16	16	16	16	16	16
Exchanges	0	0	0	0	0	0	0	0	0	0
Uninsured	49	50	50	51	51	52	52	52	53	53
<u>Under PPACA</u>										
Medicaid/SCHIP	35	35	36	36	41	45	49	49	50	50
Employer-sponsored	153	153	154	154	154	157	161	161	161	162
Non-group	17	17	17	17	5	1	0	0	0	0
Other	15	15	15	15	16	16	16	16	16	16
Exchanges	0	0	0	0	16	24	27	27	28	28
Uninsured	49	50	50	51	44	32	24	24	25	25

RAND Compare Analysis 2010

The states will be forced to dramatically expand coverage at a time when their current budgets are already stretched thin. Also, the assumption that private insurance coverage will grow is hotly disputed.

Employer Sponsored Coverage

Hidden inside the PPACA are a number of provisions that will likely dramatically reduce the employer sponsored coverage because of the unfavorable effect on premiums.

The original projections for premiums inflation by the CBO were relatively modest. The non-group individuals would see a small increase (13%) while the rest would see very little change.

In contrast, the Blue Cross Blue Shield Association predicts larger increase of around 20%. They specifically disagree with CBO estimates because:

1. *Guaranteed issue: Provisions that require insurance carriers to offer coverage to all who apply for it will draw more people with high expected medical costs into the market; it also creates risk that people will buy insurance only when they need it. Guaranteed issue will help provide access to insurance for high-risk people, but will increase average prices in the individual market.*
2. *Rating changes: Tighter age bands and the elimination of health status rating will also significantly increase premiums for younger and healthier people, while reducing premiums for the older and less healthy.*
3. *Minimum benefit requirements: The Senate bill mandates minimum benefit levels higher than those in many existing policies sold in the market. Ensuring adequate coverage is a logical goal of reform. But raising minimum benefit levels raises costs.*
4. *Expected medical costs of the uninsured: Consistent with the CBO and others who have evaluated the impact of reform, we believe the uninsured are healthier than the current total insured market. But we disagree with CBO's belief that the uninsured are healthier than the current individual market, which is significantly healthier than the total insured market. We estimate the uninsured, on average, will have medical claims about 20% higher than the current individual market.*

A recent survey conducted by management consultants McKinsey & Company found that when employers must decide whether to continue to offer health benefits to their employees in 2014, a significant portion plan to opt out. The firm surveyed more than 1,300 employers of all sizes, industries and locations. Overall, the survey found 30 percent of employers surveyed would “definitely” or “probably” stop offering employee health insurance after 2014. However, half of the employers with the strongest understanding of health care reform's changes said they will drop coverage and 60 percent said they will look for alternatives to traditional employer-provided health insurance.

If large numbers of employers drop coverage, the gains in coverage with Medicaid and the exchanges may be totally negated. The end result may be far more individuals either uninsured or covered under a government program.

Conclusion

The individual mandate is currently a very controversial issue. The AMA's supports individual responsibility, private expansion in coverage, pluralism, and choice. There are significant differences between the PPACA and current AMA policy.