

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Covering the Remaining Uninsured
(Resolution 123-J-21)
(Reference Committee A)

EXECUTIVE SUMMARY

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The Council analyzed the remaining uninsured post-ARPA to assess whether new American Medical Association (AMA) policy is needed targeting select segments of the remaining uninsured. After reviewing AMA policy as well as health reform legislation and regulation at the state and federal levels, the Council sees an opportunity to further maximize coverage rates and improve affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for Affordable Care Act (ACA) financial assistance due to falling into the coverage gap, immigration status, or having an “affordable” offer of employer coverage.

The Council is highly concerned about the more than two million uninsured who fall into ACA’s coverage gap. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, and protect against current expansion states from dropping their Medicaid expansions.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/Children’s Health Insurance Program. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for undocumented immigrants and Deferred Action for Childhood Arrivals recipients, but also recognize state and local efforts to provide coverage to immigrants regardless of immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an “affordable” employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA’s “family glitch,” to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

The Council recognizes there is strong interest in the House of Delegates in how best to cover the population ages 60-64. In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. The AMA proposal for reform, as well as the recommendations of this report, strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-N-21

Subject: Covering the Remaining Uninsured
(Resolution 123-J-21)

Presented by: Asa Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

1 With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of
2 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The nation has witnessed
3 record enrollment in Affordable Care Act (ACA) coverage, via coverage offered on ACA
4 marketplaces and under the Medicaid expansion, as well as through the Special Open Enrollment
5 Period that recently ended. Resulting from the ARPA, a significant proportion of the uninsured is
6 now eligible for ACA financial assistance, either in the form of premium tax credits to purchase
7 marketplace coverage, or Medicaid. However, some segments of the uninsured population continue
8 to be left behind, with potential negative effects on their health outcomes and financial security, as
9 well as systemwide impacts resulting from how their care is provided and financed. After
10 reviewing American Medical Association (AMA) policy as well as health reform legislation and
11 regulation at the state and federal levels, the Council concluded that new and innovative AMA
12 policy is needed targeting select segments of the uninsured population.

13
14 Subsequently, at the June 2021 Special Meeting of the House of Delegates, Resolution 123,
15 Medicare Eligibility at Age 60, was referred. Introduced by the Medical Student Section,
16 Resolution 123 asked that our AMA advocate that the eligibility threshold to receive Medicare as a
17 federal entitlement be lowered from age 65 to age 60. The Board of Trustees assigned this item to
18 the Council on Medical Service for a report back to the House of Delegates.

19
20 This report provides background on the ACA improvements included in the ARPA; outlines the
21 AMA proposal for reform; analyzes the need for new AMA policy to improve the coverage rates
22 for each segment of the post-ARPA uninsured; examines the uninsured population ages 60 to 64
23 and evaluates potential pathways to increase coverage to this population, including lowering the
24 Medicare eligibility age; and presents policy recommendations.

25
26 **BUILDING UPON THE ACA: THE AMERICAN RESCUE PLAN ACT**

27
28 The ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible
29 individuals and families with incomes between 100 and 400 percent of the federal poverty level
30 (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with
31 refundable and advanceable premium credits that are inversely related to income to purchase
32 coverage on health insurance exchanges. However, consistent with Policy H-165.824, the ARPA
33 eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with
34 incomes above 400 percent FPL (\$51,040 for an individual and \$104,800 for a family of four based
35 on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals
36 eligible for premium tax credits include individuals who are offered an employer plan that does not

1 have an actuarial value of at least 60 percent (i.e., 60 percent of benefit costs covered) or if the
 2 employee share of the premium exceeds 9.83 percent of income in 2021.

3
 4 Also consistent with Policy H-165.824, ARPA increased the generosity of premium tax credits for
 5 two years, lowering the cap on the percentage of income individuals are required to pay for
 6 premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost
 7 silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of
 8 their income. Notably, resulting from the changes, eligible individuals and families with incomes
 9 between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in
 10 Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of
 11 2022. In addition, individuals receiving unemployment compensation who qualify for exchange
 12 coverage are eligible for a zero-premium silver plan in 2021.

13
 14 Individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250
 15 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a
 16 silver plan, which reduces their deductibles, out-of-pocket maximums, copayments and other cost-
 17 sharing amounts. The only change ARPA made to cost-sharing reduction eligibility and generosity
 18 was targeted to those receiving unemployment compensation. Individuals receiving unemployment
 19 compensation in 2021 who qualify for exchange coverage and enroll in a silver plan—regardless of
 20 income—are eligible for substantial cost-sharing reductions.

21
 22 At the time that this report was written, 38 states and the District of Columbia had adopted the
 23 Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals
 24 with incomes up to 133 percent FPL.¹ ARPA included new incentives for states to implement
 25 Medicaid expansions. States that have not yet expanded Medicaid are now eligible for a five-
 26 percentage-point increase in their traditional Federal Medical Assistance Percentage Rate (FMAP)
 27 for two years if they newly implement the Medicaid expansion, applicable to a large share of their
 28 Medicaid population and spending. In the near term, the new five-percentage-point increase would
 29 be in addition to the current 6.2-percentage-point increase in the match rate provided under the
 30 Families First Coronavirus Response Act (FFCRA) pursuant to the COVID-19 public health
 31 emergency. Importantly, states that newly expand would also receive a 90 percent federal match
 32 for the expansion population.

33
 34 THE AMA PROPOSAL FOR REFORM

35
 36 Covering the uninsured and improving health insurance affordability have been long-standing goals
 37 of the AMA. Since the enactment of the ACA, the AMA proposal for reform has continued to
 38 evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in
 39 the current coverage environment. The AMA proposal for reform focuses on expanding health
 40 insurance coverage to four main population targets:

- 41
 42 1. Individuals eligible for ACA’s premium tax credits who remain uninsured (11 million);
 43 2. Individuals eligible for Medicaid or the Children’s Health Insurance Program (CHIP) who
 44 remain uninsured (7.3 million);
 45 3. People who remain uninsured who are ineligible for ACA’s premium tax credits due to an
 46 offer of “affordable” employer-sponsored coverage (3.5 million); and
 47 4. People with low incomes who remain uninsured and are ineligible for Medicaid (2.2
 48 million).²

1 By appropriately targeting the provision of coverage to the uninsured population, the AMA
 2 proposal for reform has aimed to make significant strides in covering the remaining uninsured and
 3 providing health insurance to millions more Americans:

- 4
- 5 • Premium tax credits would be available to individuals without an offer of “affordable”
 6 employer coverage, with no upper income limit (Policy H-165.824).
- 7 • Individuals currently caught in the “family glitch” and unable to afford coverage offered
 8 through their employers for their families would become eligible for ACA financial
 9 assistance based on the premium for family coverage of their employer plan (Policy H-
 10 165.828). Currently, in determining eligibility for premium tax credits, coverage for family
 11 members of an employee is considered to be affordable as long as employee-only coverage
 12 is affordable. The employee-only definition of affordable coverage pertaining to employer-
 13 sponsored coverage, commonly referred to as ACA’s “family glitch,” does not take into
 14 consideration the cost of family-based coverage, which commonly is much more expensive
 15 than employee-only coverage. As a result, the “family glitch” leaves many workers and
 16 their families ineligible to receive premium and cost-sharing subsidies to purchase
 17 coverage on health insurance exchanges, even though in reality they would likely have to
 18 pay well over 9.83 percent of their income for family coverage.
- 19 • To help employees currently having difficulties affording coverage, the threshold used to
 20 determine the affordability of employer coverage would be lowered, which would make
 21 more people eligible for ACA financial assistance based on income (Policy H-165.828).
- 22 • The generosity of premium tax credits would be increased to improve premium
 23 affordability, by tying premium tax credit size to gold-level instead of silver-level plan
 24 premiums, and/or lowering the cap on the percentage of income individuals are required to
 25 pay for premiums of the benchmark plan (Policy H-165.824).
- 26 • Young adults facing high premiums would be eligible for “enhanced” tax credits based on
 27 income (Policy H-165.824).
- 28 • Eligibility for cost-sharing reductions would be expanded to help more people with the
 29 cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
- 30 • The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens
 31 many individuals with low incomes face, which impact their ability to access and afford
 32 the care they need (Policy H-165.824).
- 33 • A permanent federal reinsurance program would be established, to address the impact of
 34 high-cost patients on premiums (Policy H-165.842).
- 35 • State initiatives to expand their Medicaid programs will continue to be supported. To
 36 incentivize expansion decisions, states that newly expand Medicaid would still be eligible
 37 for three years of full federal funding (Policies D-290.979 and H-290.965).
- 38 • Public options would be explored as potential pathways to provide health insurance
 39 coverage to uninsured individuals who fall into the “coverage gap” at no or nominal cost,
 40 provided that they meet the standards outlined in Policy H-165.823.
- 41 • To maximize coverage rates, the AMA would support the auto-enrollment of individuals
 42 who qualify for zero-premium marketplace coverage or Medicaid/CHIP in health insurance
 43 coverage, and continue to support the use of individual mandate penalties at the state and
 44 federal levels (Policies H-165.823, H-165.824 and H-165.848).
- 45 • To improve coverage rates of individuals eligible for either ACA financial assistance or
 46 Medicaid/CHIP but who remain uninsured, the AMA would support investments in
 47 outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971,
 48 H-290.982 and D-290.982).
- 49 • States would continue to have the ability to test different innovations to cover the
 50 uninsured, provided such experimentations: a) meet or exceed the projected percentage of

1 individuals covered under an individual responsibility requirement while maintaining or
 2 improving upon established levels of quality of care; b) ensure and maximize patient
 3 choice of physician and private health plan; and c) include reforms that eliminate denials
 4 for pre-existing conditions (Policy D-165.942).

5
 6 NEED FOR NEW AMA POLICY TO ADDRESS THE POST-ARPA UNINSURED: FILLING IN
 7 URGENT POLICY GAPS

8
 9 While the exact number of the uninsured is in flux due to the COVID-19 pandemic and resulting
 10 changes in employment and eligibility for either ACA premium assistance or Medicaid, Kaiser
 11 Family Foundation (KFF) released estimates that offer a profile of the post-ARPA uninsured. Of
 12 note, these estimates are based on 2019 American Community Survey data; the time delay may
 13 affect overall numbers, but these estimates are still expected to provide a representative overview
 14 of the uninsured population. Overall, KFF estimates that 28.9 million nonelderly individuals are
 15 uninsured.³ The Council has analyzed the remaining uninsured post-ARPA to assess whether new
 16 AMA policy is needed targeting select segments of the remaining uninsured. The Council's
 17 analysis concluded that how to best cover three segments of the uninsured population is currently
 18 not sufficiently addressed in AMA policy and AMA's plan to cover the uninsured: the uninsured
 19 who are ineligible for ACA financial assistance due to falling into ACA's coverage gap, the
 20 uninsured who are ineligible for ACA financial assistance due to immigration status, and the
 21 uninsured ineligible for ACA financial assistance due to having an offer of affordable employer
 22 coverage. Critically, without the implementation of policy solutions for these populations, many
 23 will be left without any affordable coverage options.

24
 25 *Uninsured Ineligible for ACA Financial Assistance Due to Falling into ACA's Coverage Gap*

26
 27 Resulting from states not implementing the Medicaid expansion provided for under the ACA, more
 28 than two million of the nonelderly uninsured find themselves in the coverage gap—not eligible for
 29 Medicaid, and not eligible for premium tax credits because they reside in states that did not expand
 30 Medicaid.⁴ Approximately 60 percent of individuals who fall into the coverage gap are people of
 31 color. Three of four individuals who fall into the coverage gap reside in four states—Florida,
 32 Georgia, North Carolina and Texas.⁵ Of note, an additional 1.8 million uninsured adults in non-
 33 expansion states with incomes between 100 and 133 percent FPL are currently eligible for
 34 premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage but would
 35 become eligible for Medicaid if their state implemented the Medicaid expansion.⁶

36
 37 Medicaid eligibility for adults in states that did not expand their Medicaid programs is quite
 38 limited. The median limit for parents in these states is 40 percent FPL. Childless adults—regardless
 39 of income—remain ineligible for Medicaid in nearly all states that did not expand their Medicaid
 40 programs. Significantly, childless adults make up more than three of four individuals who fall into
 41 the coverage gap. Overall, approximately half of individuals who fall into the coverage gap have
 42 incomes under 50 percent FPL, which amounts to \$6,440 per year for an individual, or \$537 per
 43 month.⁷

44
 45 Approximately two-thirds of individuals in the coverage gap are in working families, with half
 46 working themselves.⁸ Overall, individuals who fall in the coverage gap are in households in which
 47 workers earn low wages, work part-time, or are not consistently employed. Without access to
 48 Medicaid or heavily subsidized marketplace coverage, the uninsured in the coverage gap simply do
 49 not have access to affordable coverage options. For example, in 2021, the national average
 50 unsubsidized premium for a 40-year-old non-smoker seeking coverage on ACA marketplaces was
 51 \$436 per month for the lowest-cost silver plan and \$328 per month for a bronze plan. This is

1 equivalent to roughly 80 percent of income for those at the lower income range of the coverage gap
 2 (below 40 percent FPL), and nearly a third of income for those with incomes closer to the poverty
 3 line.⁹

4
 5 Assessment of the Need for New AMA Policy

6
 7 Policy D-290.979 states that our AMA will work with state and specialty medical societies in
 8 advocating at the state level in support of Medicaid expansion. Policy H-290.965 supports states
 9 that newly expand Medicaid being made eligible for three years of full federal funding. Policy
 10 H-290.966 encourages policymakers at all levels to focus their efforts on working together to
 11 identify realistic coverage options for adults currently in the coverage gap; encourages states that
 12 are not participating in the Medicaid expansion to develop waivers that support expansion plans
 13 that best meet the needs and priorities of their low income adult populations; and encourages the
 14 Centers for Medicare & Medicaid Services (CMS) to review Medicaid expansion waiver requests
 15 in a timely manner, and to exercise broad authority in approving such waivers, provided that the
 16 waivers are consistent with the goals and spirit of expanding health insurance coverage and
 17 eliminating the coverage gap for low-income adults. Policies H-165.920 and H-165.865 advocate
 18 for the promotion of individually selected and owned health insurance using refundable and
 19 advanceable tax credits that are inversely related to income so that patients with the lowest incomes
 20 will receive the largest credits. Policy H-165.855 encourages state demonstrations to provide
 21 coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid
 22 beneficiaries to obtain private health insurance. Policy H-165.823 states that any public option shall
 23 be made available to uninsured individuals who fall into the “coverage gap” in states that do not
 24 expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty
 25 level, which is the lower limit for premium tax credit eligibility—at no or nominal cost.

26
 27 At the time that this report was written, there were three main pathways to provide coverage to the
 28 uninsured who fall into the coverage gap. One strategy, as past COVID-19 relief bill provisions
 29 aimed to do, would be to provide more incentives to states to adopt ACA’s Medicaid expansion.
 30 The Council notes that, at this juncture, it is unclear whether additional financial incentives would
 31 cause any additional states to expand Medicaid. Another strategy would be to extend eligibility for
 32 premium tax credits and cost-sharing reductions to individuals with incomes below the poverty
 33 line, the current floor for eligibility. Lastly, the establishment of a federal Medicaid-like program or
 34 another type of public option has been discussed to cover those individuals who fall in the coverage
 35 gap in non-expansion states. While the AMA has policy relevant to each of the leading legislative
 36 approaches to provide individuals in the coverage gap with a source of health insurance coverage,
 37 the Council believes that new policy is needed to address the affordability of coverage offered
 38 under any federal approach to provide coverage to this population, as well as the impacts of any
 39 intervention on states that have already expanded Medicaid. The Council believes that there is a
 40 need for new policy to ensure that any federal approach targeted at the uninsured who fall in the
 41 coverage gap makes health insurance coverage available to this population at no or nominal cost,
 42 with significant cost-sharing protections. In addition, the Council believes that it is critical for any
 43 federal approach to address the coverage gap protect against current expansion states from
 44 dropping their Medicaid expansions.

45
 46 *Uninsured Ineligible for ACA Financial Assistance Due to Immigration Status*

47
 48 Almost four million of the nonelderly uninsured are ineligible for ACA financial assistance due to
 49 their immigration status.¹⁰ Overall, lawfully present and undocumented immigrants were
 50 significantly more likely to be uninsured than citizens in 2019. Among the nonelderly population,
 51 25 percent of lawfully present immigrants and 46 percent of undocumented immigrants were

1 uninsured, compared to nine percent of citizens. Critically, noncitizen children are more likely to
2 be uninsured than citizen children.¹¹

3
4 The higher uninsured rate among noncitizens is partially rooted in eligibility restrictions for
5 Medicaid, CHIP and ACA marketplace coverage. Currently, many qualified non-citizens, including
6 many lawfully permanent residents or green card holders, face a five-year waiting period after
7 receiving qualified immigration status before becoming eligible for Medicaid and CHIP.
8 Populations exempt from the five-year waiting period include refugees, asylees and lawfully
9 permanent residents who used to be refugees or asylees. States currently have the option to
10 eliminate the five-year waiting period for lawfully present children and pregnant women without a
11 qualified immigration status. At the time this report was written, 35 states have extended coverage
12 to affected children, with half of states having done so for impacted pregnant women.¹²

13
14 An alternative to coverage for lawfully present immigrants who are affected by the five-year
15 waiting period or do not have a qualified immigration status is to seek coverage on ACA
16 marketplaces and receive subsidies for coverage. These lawfully present immigrants with incomes
17 below the poverty line are eligible to receive premium tax credits and cost-sharing reductions to
18 purchase ACA marketplace coverage even if they are ineligible for Medicaid based on their
19 immigration status. Lawfully present immigrants with incomes between 100 and 400 percent of
20 FPL are eligible for premium tax credits and cost-sharing reductions to purchase coverage if they
21 are not eligible for other coverage.

22
23 However, undocumented immigrants are not eligible to purchase coverage through the ACA
24 marketplaces, even if they pay the full cost because they are not eligible for subsidies. In addition,
25 they are not eligible to enroll in Medicaid or CHIP. These eligibility restrictions for Medicaid,
26 CHIP and marketplace coverage also extend to individuals with Deferred Action for Childhood
27 Arrivals (DACA) status, as they are not considered lawfully present and remain ineligible for
28 coverage options, according to rules issued by CMS. With these restrictions in place, some states
29 and localities have established programs to provide coverage to certain groups of immigrants
30 regardless of immigration status, without the use of federal funds.

31 32 Assessment of the Need for New AMA Policy

33
34 Policy H-290.983 opposes federal and state legislation denying or restricting lawfully present
35 immigrants Medicaid and immunizations. Policy H-440.903 directs the AMA to actively lobby
36 federal and state governments to restore and maintain funding for public health care benefits for all
37 lawfully present immigrants. Policy H-350.957 advocates for policies to make available and
38 effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees
39 or asylees. Policy H-440.876 opposes any policies, regulations or legislation that would criminalize
40 or punish physicians and other health care providers for the act of giving medical care to patients
41 who are undocumented immigrants; opposes any policies, regulations, or legislation requiring
42 physicians and other health care providers to collect and report data regarding an individual
43 patient's legal resident status; and opposes proof of citizenship as a condition of providing health
44 care. Policy D-440.985 states that our AMA shall assist states on the issue of the lack of
45 reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a
46 national level.

47
48 The Council believes that existing policy sufficiently addresses the need to provide health
49 insurance coverage to lawfully present immigrants and has enabled the AMA to advocate in
50 support of removing the five-year waiting period for lawfully present immigrants to enroll in
51 Medicaid/CHIP. The Council is cognizant that proper knowledge surrounding eligibility for

1 benefits is key to eligible immigrants enrolling in Medicaid, CHIP or marketplace coverage. The
2 Council believes that existing policy addressing outreach and enrollment assistance for
3 Medicaid/CHIP coverage, and financial assistance to purchase marketplace coverage, is sufficient
4 to address this barrier to enrollment in coverage. However, there remains a gap in AMA policy that
5 provides an avenue for undocumented immigrants and DACA recipients to access coverage
6 options. There is a need for AMA policy in support of allowing undocumented immigrants and
7 DACA recipients to purchase unsubsidized coverage on ACA marketplaces, with the guarantee that
8 health plans and ACA marketplaces will not collect and/or report data regarding enrollee
9 immigration status. Without that guarantee in place, fear of immigration enforcement could
10 preclude a segment of the immigrant population from enrolling in coverage. AMA policy also may
11 be needed to address state and local initiatives to provide coverage to immigrants regardless of
12 their immigration status; existing policy only addresses the reimbursement for the care provided to
13 undocumented immigrants.

14
15 *Uninsured Ineligible for ACA Financial Assistance Due to Having an Affordable Offer of Employer*
16 *Coverage*

17
18 Approximately 3.5 million of the nonelderly uninsured are ineligible for ACA's premium tax
19 credits because they have an "affordable" offer of employer-sponsored insurance coverage.¹³ To be
20 considered "affordable," employer coverage must have an actuarial value of at least 60 percent and
21 the employee share of the premium must be less than 9.83 percent of income in 2021. Notably,
22 following the enactment of ARPA into law, inconsistencies now exist between the definition of
23 affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those
24 offered employer coverage, and the percentage of income at which premiums are capped for
25 individuals with the highest incomes eligible for subsidized marketplace coverage. Premiums of the
26 second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are
27 capped at 8.5 percent of their income. But employer coverage with an employee share of the
28 premium less than 9.83 percent of income is considered to be "affordable."
29

30 In determining eligibility for premium tax credits, coverage for family members of an employee is
31 considered to be affordable as long as employee-only coverage is affordable. Defining the
32 affordability of employer coverage based on the premium contribution for employee-only
33 coverage, and not family-based coverage, is rooted in ambiguity within the ACA as to how
34 affordability is defined for family members of employees offered employer-sponsored coverage.
35 As a result, the Joint Committee on Taxation interpreted the law to base the definition of employer-
36 sponsored coverage solely on the cost of employee-only coverage; this interpretation was
37 ultimately adopted in regulations issued by the Internal Revenue Service. The employee-only
38 definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred
39 to as ACA's "family glitch," does not take into consideration the cost of family-based coverage,
40 which commonly is much more expensive than employee-only coverage. The average employee
41 contribution for self-only coverage was estimated to be \$1,243 in 2020, while the average
42 contribution for family coverage was estimated to be \$5,588.¹⁴
43

44 The "family glitch" leaves many families of workers ineligible to receive premium and cost-
45 sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they
46 would likely have to pay well over 9.83 percent of their income for family coverage. Overall, 5.1
47 million individuals fall into ACA's family glitch, more than half of whom are children. Of this
48 number, 4.4 million are currently covered by an employer plan, 315,000 are enrolled in
49 unsubsidized individual market coverage, and 451,000 are uninsured.¹⁵ A study from 2016
50 estimated that, on average, families who fall into the family glitch spent 15.8 percent of their
51 incomes on employer-sponsored coverage.¹⁶

1 Assessment of the Need for New AMA Policy

2
 3 Policy H-165.828 supports modifying the eligibility criteria for premium credits and cost-sharing
 4 subsidies for those offered employer-sponsored coverage by lowering the threshold that determines
 5 whether an employee’s premium contribution is affordable to that which applies to the exemption
 6 from the individual mandate of the ACA. Existing AMA policy, therefore, does not take into
 7 consideration the inconsistency between the definition of affordable coverage pertaining to
 8 eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the
 9 percentage of income at which premiums are capped for individuals with the highest incomes
 10 eligible for subsidized marketplace coverage. The Council believes that this inconsistency should
 11 be rectified.

12
 13 Policy H-165.828 also supports legislation or regulation, whichever is relevant, to fix the ACA’s
 14 “family glitch,” thus determining the affordability of employer-sponsored coverage with respect to
 15 the cost of family-based or employee-only coverage. However, current discussions surrounding
 16 fixing ACA’s family glitch are exploring a different solution to fixing the glitch, which would in
 17 effect decouple the worker from their family in determining eligibility for premium tax credits to
 18 purchase coverage. As such, a spouse and/or child in a family offered “affordable” employee-only
 19 coverage but unaffordable family coverage would become eligible for premium subsidies to
 20 purchase marketplace coverage. The worker, meanwhile, would remain only eligible for the
 21 employee-only employer-sponsored coverage, not premium subsidies to purchase coverage on the
 22 ACA marketplaces. Because employees would not be newly eligible for premium tax credits, there
 23 would be no impact on liability for employers under the employer mandate, as the mandate is only
 24 applicable if an employee receives subsidies, not their family members.

25
 26 Under this option, the family would be covered by at least two different health plans and would be
 27 responsible for the premiums associated with each plan, including that associated with the
 28 employee-only employer-sponsored coverage as well as that associated with the marketplace plan.
 29 Accordingly, not all families would necessarily be better off switching from their employer-
 30 sponsored family plan. However, many families would be better off, even those that may still need
 31 to pay more than 9.83 percent of their income for coverage of their entire family between
 32 employer-sponsored and marketplace plan premiums. It has been estimated that families switching
 33 from their employer plans would save approximately \$400 per person in premiums on average,
 34 with families with incomes below 200 percent FPL saving \$580 per person. Overall, while some
 35 currently covered by employer-sponsored coverage would transition to marketplace or
 36 Medicaid/CHIP coverage under this approach to fixing the family glitch, it also has been projected
 37 to cover nearly 200,000 uninsured individuals impacted by ACA’s family glitch.¹⁷

38
 39 POST-ARPA UNINSURED POPULATIONS FOR WHOM AMA POLICY IS SUFFICIENT:
 40 LOOKING AHEAD

41
 42 The Council’s analysis concluded that AMA policy sufficiently addresses how best to cover three
 43 segments of the post-ARPA uninsured population: the uninsured eligible for ACA premium tax
 44 credits, the uninsured eligible for Medicaid, and the uninsured who have an affordable ACA
 45 marketplace plan available to them without the need for any subsidy. That being said, the Council
 46 underscores the need for AMA policy to be implemented to cover these populations, ranging from
 47 ramping up outreach and enrollment assistance, to making additional improvements to ACA’s
 48 premium tax credits and cost-sharing subsidies, to implementing auto-enrollment for those eligible
 49 for zero-premium marketplace plans or Medicaid.

1 *Uninsured Eligible for ACA Premium Tax Credits*

2
 3 Eleven million of the nonelderly uninsured are eligible for premium tax credits, at least six million
 4 of whom are eligible for zero-premium marketplace plans.¹⁸ Of those individuals eligible for zero-
 5 premium marketplace plans, approximately 1.3 million have incomes below 150 percent FPL
 6 (\$19,140 for an individual and \$39,300 for a family of four based on 2020 federal poverty
 7 guidelines) and are eligible for zero-premium silver plans with cost-sharing reductions that result in
 8 their deductibles being reduced to an average of \$177 and thus resembling platinum-level
 9 coverage¹⁹ (90 percent of benefit costs covered). Individuals receiving unemployment
 10 compensation in 2021 who qualify for exchange coverage and enroll in a silver plan—regardless of
 11 income—are also eligible for substantial cost-sharing reductions that also cause their coverage to
 12 resemble that of a platinum plan. Even with the additional premium assistance provided for in the
 13 ARPA, a segment of the uninsured eligible for premium tax credits may not see the benefit in
 14 getting covered if they cannot afford their deductibles, copayments, and other cost-sharing
 15 responsibilities.

16
 17 Assessment of the Need for New AMA Policy

18
 19 Under Policy H-165.824, (1) there would be adequate funding for and expansion of outreach
 20 efforts to increase public awareness of advance premium tax credits; (2) the generosity of premium
 21 tax credits would be increased to improve premium affordability, by tying premium tax credit size
 22 to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of
 23 income individuals are required to pay for premiums of the benchmark plan; (3) young adults
 24 facing high premiums would be eligible for “enhanced” tax credits based on income; (4) eligibility
 25 for cost-sharing reductions would be expanded to help more people with the cost-sharing
 26 obligations of the plan in which they enroll; (5) the size of cost-sharing reductions would be
 27 increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact
 28 their ability to access and afford the care they need; and (6) the subsidy “cliff” would be
 29 eliminated. Policy H-165.823 highlights the potential for auto-enrollment as a strategy to cover the
 30 more than six million individuals eligible for zero-premium marketplace plans who remain
 31 uninsured.

32
 33 As such, the Council believes that existing AMA policy is sufficient to address how best to cover
 34 uninsured individuals eligible for premium tax credits. Policy H-165.823 would provide a pathway
 35 for the six million uninsured individuals eligible for zero-premium coverage to become insured.
 36 Policy H-165.824 would enable the AMA to not only advocate to make the ARPA enhancements—
 37 improved premium tax credit generosity and ACA subsidy cliff elimination—permanent, but would
 38 support advocacy efforts to take additional steps to make premiums more affordable for the
 39 uninsured who are subsidy-eligible, as well as tackle barriers posed by deductibles and cost-sharing
 40 requirements. The policy also recognizes that uninsured individuals eligible for premium tax
 41 credits can only enroll in subsidized coverage if they are aware that they are eligible, which is why
 42 outreach efforts are so critical.

43
 44 *Uninsured Eligible for Medicaid*

45
 46 More than seven million of the nonelderly uninsured are eligible for Medicaid/CHIP, which
 47 includes adults in the Medicaid expansion population and populations eligible for Medicaid/CHIP
 48 under pre-ACA rules but who have not enrolled.²⁰ The reasons for this group remaining uninsured
 49 remain multifaceted, ranging from not being aware of their eligibility for coverage, to perceived
 50 stigma associated with public coverage, to facing barriers to enrollment, including those which are
 51 administrative or technical in nature.

1 Assessment of the Need for New AMA Policy

2
3 To improve coverage rates of individuals eligible for Medicaid/CHIP but who remain uninsured,
4 AMA policy supports investments in outreach and enrollment assistance activities (Policies H-
5 290.976, H-290.971, H-290.982 and D-290.982). Policy H-165.823 states that individuals should
6 only be auto-enrolled in health insurance coverage if they are eligible for coverage options that
7 would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment
8 would, therefore, include individuals eligible for Medicaid/CHIP.

9
10 As such, the Council believes that existing AMA policy is sufficient to address how best to cover
11 uninsured individuals eligible for Medicaid. Policy H-165.823 would provide a mechanism through
12 which the uninsured who are Medicaid-eligible would be able to gain coverage via auto-
13 enrollment. Until auto-enrollment for Medicaid-eligible individuals is able to be implemented,
14 investments in outreach and enrollment assistance activities will be essential to get this segment of
15 the uninsured covered.

16
17 *Uninsured Who Have an Affordable Marketplace Plan Available to Them*

18
19 More than one million of the nonelderly uninsured have an affordable ACA marketplace plan
20 available to them with an unsubsidized benchmark premium that is less than 8.5 percent of their
21 household income without a premium tax credit, making them ineligible for ACA financial
22 assistance.²¹ Of note, this segment of the uninsured has higher incomes, but removing ACA's
23 subsidy cliff still does not make them eligible for premium assistance.

24
25 Assessment of the Need for New AMA Policy

26
27 Policy H-165.824 supports lowering the cap on the percentage of income individuals are required
28 to pay for premiums of the benchmark plan. Policy H-165.848 supports a requirement that
29 individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for
30 catastrophic health care and evidence-based preventive health care, using the tax structure to
31 achieve compliance.

32
33 The Council notes that a segment of this population could potentially become eligible for premium
34 tax credits if the cap on premiums as a percentage of income were lowered even further than what
35 the ARPA accomplished. That being said, using a policy "stick" to get this population covered may
36 be necessary, including a state and/or federal individual mandate penalty. Accordingly, the Council
37 believes that existing AMA policy is sufficient to address how best to cover this segment of the
38 uninsured population.

39
40 COVERING THE UNINSURED AGES 60 TO 64

41
42 Following the referral of Resolution 123 at the June 2021 Special Meeting of the House of
43 Delegates, the Council examined the segment of the uninsured ages 60 to 64 to ascertain what
44 improvements, if any, need to be made to AMA's proposal for reform to ensure that this population
45 has a pathway to coverage, and to assess the merits of lowering the Medicare eligibility age to age
46 60. Of the 20.8 million individuals ages 60 to 64 in the US, 56.3 percent are enrolled in employer-
47 sponsored coverage, 14.5 percent are enrolled in Medicaid, 11.3 percent are enrolled in non-group
48 coverage, 10.1 percent are enrolled in other public coverage (e.g., Medicare and military coverage),
49 and 7.8 percent are uninsured.²²

1 Of the uninsured ages 60 to 64, nearly half are eligible for premium tax credits. Further, nearly 20
 2 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to
 3 having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven
 4 percent are ineligible for ACA financial assistance due to immigration status.²³

5
 6 *Assessment of the Need for New AMA Policy*

7
 8 The Council notes that the earlier sections of this report address how existing AMA policy pertains
 9 to each segment of the uninsured population ages 60 to 64. For the uninsured eligible for premium
 10 tax credits, making premium tax credit assistance more generous, and expanding eligibility for and
 11 improving the generosity of cost-sharing subsidies, will be highly beneficial. The Council
 12 understands that when this population is able to enroll in ACA marketplace coverage, affordable
 13 cost-sharing levels will be critical so they will be able to access the care they need. The Council
 14 believes that subsidized ACA marketplace coverage with improved cost-sharing assistance is the
 15 preferable option to cover this segment of the uninsured population ages 60 to 64, especially
 16 considering that most current traditional Medicare beneficiaries are enrolled in supplemental
 17 insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more
 18 comprehensive cost-sharing protections than what is offered in the traditional Medicare program.
 19 Subsidized ACA marketplace assistance would also become available to some of the uninsured
 20 ages 60-64 currently ineligible due to having an affordable offer of employer coverage under
 21 current AMA policy, as well as recommendations for new policy proposed in this report.

22
 23 For uninsured individuals ages 60 to 64 who are eligible for zero-premium marketplace coverage,
 24 as well as the 20 percent of the uninsured eligible for Medicaid, the Council believes that auto-
 25 enrollment again can be used as a mechanism to provide health insurance to these individuals at no
 26 cost to them. Existing AMA policy, and recommendations for new policy in this report, applicable
 27 to the uninsured who fall in the coverage gap, and ineligible for ACA financial assistance due to
 28 immigration status, would also pertain to those ages 60 to 64.

29
 30 The Council also recognizes the role Policy H-330.896 plays in improving the consistency between
 31 Medicare and Social Security eligibility. The policy supports restructuring Medicare's age-
 32 eligibility requirements and incentives to match the Social Security schedule of benefits. However,
 33 lowering the age to become eligible for Medicare from 65 to 60 is not consistent with the intent of
 34 Policy H-330.896, and is projected to have unintended consequences.

35
 36 While lowering the age of Medicare eligibility to 60 could cover many of the uninsured in the 60-
 37 64 age bracket, the Council believes that the AMA proposal for reform, as well as the
 38 recommendations of this report, provide a better pathway to get this age cohort of the uninsured
 39 covered without causing significant health system changes and potential negative impacts to
 40 physicians, hospitals, and other entities. For example, lowering the age of Medicare eligibility to 60
 41 has been projected by KFF to also have the potential to shift nearly 12 million individuals with
 42 employer coverage and 2.4 million with non-group coverage into Medicare.²⁴ Such a shift would
 43 notably impact the payer mix of physician practices. At the same time, only one-third of the
 44 approximately 1.6 million uninsured in this age cohort remains ineligible for premium tax credits to
 45 purchase marketplace coverage, or Medicaid, because they do not qualify for ACA financial
 46 assistance due to an affordable offer of employer coverage, falling into the coverage gap, or due to
 47 immigration status. Accordingly, the Council believes that the AMA proposal for reform can cover
 48 this population without the unwanted policy tradeoffs that lowering the Medicare eligibility age
 49 would present.

1 The Council recognizes that there are equity considerations associated with each alternative to
 2 cover the uninsured ages 60 to 64, and those associated with lowering the Medicare eligibility age
 3 must be examined. While lowering the Medicare eligibility age to 60 would open the door to
 4 Medicare to individuals aged 60-64, doing so would notably eliminate subsidized marketplace
 5 coverage eligibility for these individuals, potentially increasing their cost of coverage. They still
 6 would, however, be able to choose to remain on their employer-sponsored coverage. In light of the
 7 premium tax credit enhancements included in the ARPA, lower-income individuals currently
 8 enrolled in a marketplace plan may have the potential to face higher premiums in traditional
 9 Medicare. In addition, considering that half of the uninsured ages 60 to 64 are eligible for premium
 10 tax credits, the Council believes that they should not lose access to the most affordable coverage
 11 pathway available to them—critical for those with the lowest incomes. Avalere found that current
 12 marketplace subsidies are consistently more generous for lower-income individuals than the
 13 subsidies available to Medicare beneficiaries.²⁵ Accordingly, the Council believes that improving
 14 the generosity of premium tax credits and cost-sharing reductions, and making cost-sharing
 15 reductions available to more people, as outlined in AMA policy, provides low-income uninsured
 16 ages 60 to 64 with a more preferable choice of coverage option than lowering the Medicare
 17 eligibility age to 60.

18
 19 Overall, lowering the Medicare eligibility age to 60 has been projected to cost \$200 billion over ten
 20 years.²⁶ The aforementioned shift in coverage from employer coverage to Medicare shifts a large
 21 share in health spending to the federal budget. While certain proposals to date reiterate that
 22 lowering the Medicare eligibility age to 60 would be funded by general revenues, they would still
 23 need a pay-for. Proposals to lower the Medicare eligibility age to 60 could also threaten the fiscal
 24 stability of the Medicare Trust Fund. Notably, the Council emphasizes that the AMA proposal for
 25 reform would not only have a smaller fiscal footprint over a ten-year period, but also would not
 26 negatively impact the Medicare Trust Fund. The potential for other unintended consequences of
 27 lowering the Medicare eligibility age must be assessed, including on graduate medical education
 28 (GME).

29
 30 Finally, the Council is highly concerned that lowering the Medicare eligibility age to 60 would
 31 negatively impact the payer mix of physician practices. It is expected that lowering the Medicare
 32 eligibility age to 60 would lower the revenues for physicians, hospitals, and other providers
 33 delivering care to the 60-64 age cohort. Physician and hospital payment rates from private plans
 34 tend to be higher than those paid by Medicare, with the difference between the two increasing over
 35 time.²⁷

36
 37 **DISCUSSION**

38
 39 The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order
 40 to cover the remaining uninsured. The enactment of the ARPA into law has provided a preview as
 41 to what ACA improvements, many of which reflect the AMA proposal for reform, can accomplish.
 42 The Council underscores that Policy H-165.824 supports making the ARPA changes to the ACA
 43 permanent—increasing the generosity of premium tax credits as well as eliminating ACA’s subsidy
 44 “cliff.” However, the Council is cognizant that more needs to be done to cover the uninsured
 45 eligible for premium tax credits and Medicaid, as well as the uninsured already eligible for an
 46 affordable ACA marketplace plan without any subsidy. Policy H-165.823, by outlining the
 47 potential for auto-enrollment for the segment of the uninsured eligible for coverage options that
 48 would be of no cost to them after the application of any subsidies, provides a coverage pathway for
 49 the 7.3 million uninsured individuals eligible for Medicaid/CHIP and the six million eligible for
 50 zero-premium marketplace coverage. Until auto-enrollment is enacted for these populations, the
 51 Council believes that outreach and enrollment assistance efforts will be absolutely critical, so

1 individuals are aware that they are eligible for premium tax credits or Medicaid/CHIP and receive
2 any necessary assistance to enroll in coverage. Outreach and enrollment assistance efforts are also
3 vital to facilitate the enrollment of immigrants eligible for ACA financial assistance in health
4 insurance coverage.

5
6 Policy H-165.824 also contains highly important provisions to improve the affordability of not only
7 the premiums for individuals who remain uninsured despite being eligible for premium tax credits
8 as well as those who already have access to an affordable marketplace plan, but also deductibles
9 and other cost-sharing obligations. A component of the uninsured may not see the benefit to
10 enrolling in coverage if they know they will not be able to afford the cost-sharing responsibilities
11 of the plan in which they can enroll. In addition, uninsured individuals already eligible for
12 affordable ACA marketplace coverage without any subsidy may need the “stick” of an individual
13 mandate penalty to get coverage, advocated for in Policies H-165.848 and Policy H-165.824.

14
15 However, the Council sees an opportunity to further maximize coverage rates and improve
16 coverage affordability under the AMA proposal for reform by either amending existing policy, or
17 establishing new policy, impacting the uninsured ineligible for ACA financial assistance due to
18 falling into the coverage gap, immigration status, or having an affordable offer of employer
19 coverage. The Council is highly concerned about the more than two million uninsured who fall into
20 ACA’s coverage gap. It has been the hope of the Council that, following existing AMA policy, the
21 states that have not yet expanded their Medicaid programs would do so, and enjoy the associated
22 significant, positive financial incentives. With policy alternatives emerging to cover this segment
23 of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing
24 reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like
25 program or other public option, the Council underscores that Policies H-165.838 and H-165.823
26 recommended for reaffirmation collectively constitute a critical baseline for any federal approach
27 to cover the uninsured who fall in the coverage gap to meet. In addition, the Council recommends
28 new policy to advocate that any approach to cover the uninsured who fall into the coverage gap
29 ensure this population has access to affordable, quality coverage, and protect against current
30 expansion states from dropping their Medicaid expansions. These new policies, as well as existing
31 policy outlining standards that any public option to expand health insurance coverage must meet,
32 supersede Policy H-290.966, which is recommended to be rescinded.

33
34 Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy
35 H-290.983 already enables the AMA to advocate in support of removing the five-year waiting
36 period for lawfully present immigrants to enroll in Medicaid/CHIP. However, additional policy is
37 needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for
38 undocumented immigrants and DACA recipients, but to recognize state and local efforts to provide
39 coverage to immigrants regardless of immigration status. In implementing initiatives to improve
40 the coverage rates of immigrants, the Council believes it is critical that entities overseeing these
41 programs do not collect and/or report data regarding enrollee immigration status.

42
43 The Council believes that additional policy options must be pursued to make coverage more
44 affordable to individuals and families offered an “affordable” employer-sponsored plan which, in
45 reality, is actually not affordable to them. To do so, the Council recommends the amendment of
46 Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing
47 reductions to those facing an employer plan premium that is above the maximum affordability
48 threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the
49 amendment of the policy to enable the AMA to support additional solutions to fix ACA’s “family
50 glitch,” to ensure that more families of workers are able to become eligible for subsidized ACA
51 marketplace coverage.

1 In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the
2 AMA proposal for reform, as well as the recommendations of this report, are preferable to other
3 options, including lowering the Medicare eligibility age to 60. Current AMA policy and these
4 recommendations strongly target each segment of the uninsured population ages 60 to 64, without
5 causing health system disruptions. The Council still believes there is a role for Policy H-330.896,
6 which supports restructuring age-eligibility requirements and incentives of Medicare to match the
7 Social Security schedule of benefits. The Council finds lowering the Medicare eligibility age to 60
8 has multiple downsides:

- 9
- 10 • Individuals ages 60 to 64 would lose access to health plan choices, including subsidized
- 11 ACA marketplace coverage.
- 12 • As current ACA marketplace subsidies are consistently more generous for lower-income
- 13 individuals than the subsidies available to Medicare beneficiaries, lower-income
- 14 individuals currently enrolled in a marketplace plan may have the potential to face higher
- 15 premiums in traditional Medicare.
- 16 • The level of benefits under Medicare differs from options currently available to individuals
- 17 ages 60 to 64, underscoring why most current, traditional Medicare beneficiaries are also
- 18 enrolled in supplemental insurance.
- 19 • The projected crowd-out of millions of individuals from employer-sponsored and other
- 20 private coverage to Medicare has the potential to negatively impact the payer mix of
- 21 physician practices and hospitals.
- 22 • Physician and hospital payment rates from private plans tend to be higher than those paid
- 23 by Medicare, with the difference between the two increasing over time.
- 24

25 The Council believes its recommendations address gaps in AMA policy with respect to covering
26 the uninsured—including those ages 60 to 64—necessary to ensure that our patients are able to secure
27 affordable and meaningful coverage and access the care that they need. There is now an
28 opportunity to build upon the ACA and ARPA to cover more of the uninsured. The Council affirms
29 that our AMA is well-positioned to move forward in its advocacy efforts in support of coverage of
30 the uninsured, guided by policy and its resulting plan to cover the uninsured, which will include the
31 recommendations of this report.

32 33 RECOMMENDATIONS

34
35 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
36 123-J-21, and that the remainder of the report be filed.

- 37
- 38 1. That our American Medical Association (AMA) advocate that any federal approach to cover
- 39 uninsured individuals who fall into the “coverage gap” in states that do not expand Medicaid—
- 40 having incomes above Medicaid eligibility limits but below the federal poverty level, which is
- 41 the lower limit for premium tax credit eligibility—make health insurance coverage available to
- 42 uninsured individuals who fall into the coverage gap at no or nominal cost, with significant
- 43 cost-sharing protections. (New HOD Policy)
- 44
- 45 2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into
- 46 the coverage gap provide states that have already implemented Medicaid expansions with
- 47 additional incentives to maintain their expansions. (New HOD Policy)
- 48
- 49 3. That our AMA support extending eligibility to purchase Affordable Care Act (ACA)
- 50 marketplace coverage to undocumented immigrants and Deferred Action for Childhood

- 1 Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will
2 not collect and/or report data regarding enrollee immigration status. (New HOD Policy)
3
- 4 4. That our AMA recognize the potential for state and local initiatives to provide coverage to
5 immigrants without regard to immigration status. (New HOD Policy)
6
- 7 5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying
8 or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD
9 Policy)
10
- 11 6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:
12
- 13 a. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing
14 subsidies for those offered employer-sponsored coverage by lowering the threshold that
15 determines whether an employee's premium contribution is affordable to ~~that which applies~~
16 ~~to the exemption from the individual mandate of the~~ level at which premiums are capped
17 for individuals with the highest incomes eligible for subsidized coverage in Affordable
18 Care Act (ACA) marketplaces.
- 19 b. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's
20 "family glitch," thus determining the eligibility of family members of workers for premium
21 tax credits and cost-sharing reductions based on the affordability of family employer-
22 sponsored coverage with respect to the cost of family-based or employee-only coverage
23 and household income. ... (Modify Current HOD Policy)
24
- 25 7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and
26 specialty medical societies in advocating at the state level in support of Medicaid expansion.
27 (Reaffirm HOD Policy)
28
- 29 8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid
30 being made eligible for three years of full federal funding. (Reaffirm HOD Policy)
31
- 32 9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health
33 insurance coverage if they are eligible for coverage options that would be of no cost to them
34 after the application of any subsidies, including zero-premium marketplace coverage and
35 Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public
36 option to expand health insurance coverage must meet. (Reaffirm HOD Policy)
37
- 38 10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options
39 offered in a health insurance exchange should be self-supporting, have uniform solvency
40 requirements; not receive special advantages from government subsidies; include payment
41 rates established through meaningful negotiations and contracts; not require provider
42 participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD
43 Policy)
44
- 45 11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and
46 expansion of outreach efforts to increase public awareness of advance premium tax credits; (2)
47 providing young adults with enhanced premium tax credits while maintaining the current
48 premium tax credit structure which is inversely related to income; (3) state innovation,
49 including considering state-level individual mandates, auto-enrollment and/or reinsurance, to
50 maximize the number of individuals covered and stabilize health insurance premiums without
51 undercutting any existing patient protections; (4) eliminating the subsidy "cliff," thereby

- 1 expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level
2 (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-
3 sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD
4 Policy)
5
- 6 12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which
7 support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm
8 HOD Policy)
9
- 10 13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and
11 families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic
12 health care and evidence-based preventive health care, using the tax structure to achieve
13 compliance. (Reaffirm HOD Policy)
14
- 15 14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as
16 the recommendations of this report. (Rescind HOD Policy)
17
- 18 15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-
19 eligibility requirements and incentives to match the Social Security schedule of benefits.
20 (Reaffirm HOD Policy)

Fiscal note: Less than \$500.

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