REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Improving Affordability in the Health Insurance Exchanges
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, "Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization." The policy states that "our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care." In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on improving affordability in the individual health insurance marketplace, and Council on Medical Service Report 3, "Ensuring Marketplace Competition and Health Plan Choice."

The Council believes that there is an opportunity to improve affordability in the health insurance exchanges through extending eligibility for premium tax credits, as well as increasing tax credit amounts for some individuals who are already eligible for them. Extending eligibility for advance premium tax credits to 500 percent of the federal poverty level (FPL) would assist individuals with incomes between 400 and 500 percent FPL to obtain coverage, consistent with Policy H-165.848 on individual responsibility. Another key mechanism to improve health insurance affordability, help balance the individual market risk pool and increase coverage rates among young adults is the provision of "enhanced" tax credits to young adults, which provides those aged 19 to 35 who are eligible for advance premium tax credits with "enhanced" premium tax credits—eg, an additional $50 per month for those ages 19-30, the amount declining to age 35.

The Council recognizes that the effectiveness of premium tax credits as a mechanism to improve health insurance affordability relies on individuals who are eligible for such assistance being aware of their eligibility. Toward that end, the Council recommends adequate funding for and expansion of outreach efforts to increase public awareness of premium tax credits to not only increase the number of people who are insured, but also help to balance the individual market risk pool by increasing overall marketplace enrollment.

The elimination of the federal individual mandate penalty has the potential to cause not only premium increases and coverage losses, but increased market instability starting in 2019. States have the opportunity for innovation to maximize the number of individuals covered and stabilize health insurance premiums. In particular, the Council is encouraged by activities and discussions on the state level pursuing state-level individual mandates, auto-enrollment and/or reinsurance, and believes those mechanisms hold great promise in improving coverage rates and market stability.

The Council is encouraged by the success of the Affordable Care Act's (ACA) reinsurance program as well as state reinsurance programs under Section 1332 waiver authority in reducing premiums in comparison to what they otherwise would have been. By partially reimbursing plans for the costs of their high-risk enrollees, reinsurance would help stabilize premiums for all individuals with ACA marketplace coverage, while protecting patients with pre-existing conditions. Therefore, the Council recommends the establishment of a permanent federal reinsurance program. Taken together, the Council believes its policy recommendations will provide the AMA with consistent guidance for advocating for our patients.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-18

Subject: Improving Affordability in the Health Insurance Exchanges

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, "Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization." The policy states that "our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care."

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on improving affordability in the individual health insurance marketplace, and Council on Medical Service Report 3, "Ensuring Marketplace Competition and Health Plan Choice."

This report provides background on recent premium increases in the Affordable Care Act (ACA) individual health insurance marketplaces and their associated impact on health plan affordability**,** outlines potential approaches to improve affordability in the ACA marketplaces, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Premiums in ACA marketplaces rose significantly in many counties across the country from 2017 to 2018, due to factors including health insurer uncertainty about payment of cost-sharing reductions (CSRs) and enforcement of the individual mandate, lower insurer participation in the marketplaces, as well as more characteristic factors contributing to annual increases, including health care costs and trends. Depending on the county of residence and eligibility for premium tax credits, however, not all individuals have faced increases in their premiums from 2017 to 2018. For example, for a 40 year-old, unsubsidized premiums for the lowest-cost bronze, silver and gold plans increased nationally by an average of 17 percent, 32 percent and 18 percent respectively between 2017 and 2018. Premiums for silver plans experienced larger increases than bronze and gold plans as a result of insurer and state strategies employed in response to the termination of CSR payments.[1] For those consumers who enrolled in coverage via the healthcare.gov platform during the 2017 and 2018 open enrollment periods, the average premium before the application of any tax credit increased from $476 in 2017 to $621 in 2018.[2]

Even though the federal government has stopped reimbursing insurers for CSRs, insurers are still required under the ACA to offer CSRs to individuals with incomes up to 250 percent of the federal

poverty level (FPL) who enroll in silver plans. Insurers, depending on the state in which they offer plans, responded to the termination of CSR payments in one of four main ways in setting premiums for the 2018 plan year:

- Increasing premiums only for silver plans offered inside the marketplace, because CSRs are only available for these plans;
- Increasing premiums for all silver plans, including those offered inside and outside the marketplace;
- Increasing premiums for all ACA-compliant individual market plans, including those offered inside and outside the marketplace; and
- Not adjusting premiums at all in response to the termination of CSR payments, though this strategy was very uncommon.[3]

Partially as a result of insurer responses to termination of CSR payments, for individuals who are eligible for premium tax credits, subsidized premiums are often lower in 2018 than 2017. Of note, of those consumers who selected or were automatically reenrolled in an ACA marketplace plan during open enrollment this year, 83 percent received a tax credit to lower their premiums.[4] The amount of premium tax credits an individual receives is based on the cost of the second lowest cost silver (benchmark) plan available to them. In 2018, for states using the healthcare.gov platform, the average monthly premium for the benchmark plan for a 27 year-old increased by 37 percent ($411) compared to 2017 ($300). Such increases in benchmark plan premiums have yielded much higher tax credit amounts for many individuals. For states using the healthcare.gov platform, the average premium tax credit for individuals with 2017 coverage was estimated to increase by 45 percent from 2017 to 2018, from $382 to $555.[5] For consumers who enrolled in plans during the 2018 open enrollment period in states using the healthcare.gov platform and received a tax credit to lower their premiums, the average premium tax credit was $550. Among these consumers with a premium tax credit, the tax credit covered approximately 86 percent of the total premium on average. After the application of the tax credit, the average premium was $89 per month.[6] With higher premium tax credit amounts, gold plans became much more affordable, with bronze plans oftentimes having very low or no premiums. In some counties, the premium of the lowest-cost gold plan was even cheaper than the lowest-cost silver plan.

Looking ahead to 2019, resulting from the elimination of the individual mandate penalty due to enactment of tax reform legislation, individuals will become uninsured, and premiums will increase. In fact, the Congressional Budget Office has projected that repealing the individual mandate, starting in 2019, would cause the number of individuals with health insurance coverage to decrease by four million in 2019 and 13 million in 2027. At the same time, average premiums in the nongroup market would increase by approximately 10 percent in most years of the coming decade.[7]

APPROACHES TO IMPROVE AFFORDABILITY IN THE INDIVIDUAL MARKETPLACE

State-Level Individual Mandates and Auto-Enrollment

In light of the elimination of the federal individual mandate penalty, states have begun contemplating approaches to prevent the projected coverage losses and the level of premium increases anticipated in 2019. While the individual mandate of Massachusetts remains in place, some states are moving forward with individual mandate requirements, with the status and substance of such discussions varying by locality. For example, the New Jersey legislature approved the New Jersey Health Insurance Market Preservation Act, which would institute an

individual mandate penalty in the state that largely resembles that of the ACA.[8] The Council notes that state approaches to instituting state-level individual mandates, as well as auto-enrollment, depend on whether a state has an income tax and the extent to which a state operates its own health insurance marketplace.

The auto-enrollment option is also being considered in some states, to be either implemented separately from or in concert with a state-level individual mandate. For example, in Maryland, the Protect Maryland Health Care Act of 2018 has been introduced, which, if enacted into law, would give uninsured residents who would otherwise be charged an individual mandate penalty a choice: pay the penalty, or instead use the penalty amount as a down payment to assist them in purchasing health insurance coverage. If there are plans available that cost no more than any applicable federal premium tax credit amount and the down payment, consumers would be enrolled in such plans. If there are no "zero premium" plans available, the down payment would be placed into an escrow account that accumulates interest, which could then be used to purchase health insurance coverage during the following open enrollment period. If consumers do not select a plan by the end of open enrollment, and a "zero premium" plan has become available to them, they will be auto-enrolled in such coverage. Otherwise, their down payment would be deposited into the newly established Maryland Insurance Stabilization Fund, and be applied toward such initiatives as reinsurance.[9,10]

State and Federal Reinsurance Programs

The recommendations of Council on Medical Service Report 4-I-17 established Policy H-165.842[3], which prefers reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. State and federal reinsurance programs have been shown to be effective in yielding premium reductions, in comparison to what they otherwise would have been. On the federal level, the ACA's temporary reinsurance program helped stabilize premiums in the individual marketplace during the early years of ACA implementation. The program provided payments to plans that enrolled higher-cost individuals whose costs exceeded a certain threshold, also known as an attachment point, up to the reinsurance cap.[11] To fund the ACA's transitional reinsurance program, insurers and third party administrators paid $63 per enrollee per year in 2014, $44 in 2015 and $27 in 2016. These investments in reinsurance yielded premium reductions. For example, in 2014, the $10 billion reinsurance fund, the result of the $63 per enrollee per year contributions, was estimated to reduce premiums by 10 to 14 percent. The American Academy of Actuaries has stated that a permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums.[12]

States are also using ACA Section 1332 waivers to fund state reinsurance programs. Through an approved 1332 waiver, Alaska was able to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP covers claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. Accordingly, premiums are 20 percent lower this year in the average plan on the individual market than they would have been absent the waiver.[13] Other states have moved forward with implementing more traditional state reinsurance programs through Section 1332 waivers. For example, due to an approved 1332 waiver, premiums in Oregon were lower this year in comparison to what they would have otherwise been.[14]

In the 115th Congress, federal legislation has been introduced to provide funding for reinsurance programs. In the Senate, Senators Susan Collins (R-ME) and Bill Nelson (D-FL) introduced S 1835, the Lower Premiums Through Reinsurance Act of 2017, which would allow states to leverage Section 1332 waivers to apply and receive funding for reinsurance or invisible high-risk

pool programs. The legislation would provide $5 billion in total for funding, split evenly between fiscal years 2018 and 2019.[15]

In the House of Representatives, Congressmen Ryan Costello (R-PA) and Collin Peterson (D-MN) introduced HR 4666, the Premium Relief Act of 2017, which would establish the Patient and State Stability Fund, which would provide up to $30 billion from 2019 to 2021 for the Secretary of Health and Human Services (HHS) to allocate at his discretion to be used for defined, outlined purposes, including reinsurance. If states do not apply for funding and administer their own programs under the bill, a federal reinsurance program would be established in said states by default. The legislation would also provide for reimbursements to insurers for CSR payments retroactively for the last quarter of 2017, as well as for 2019 and 2020.[16]

HR 3311/S 1354, the Individual Health Insurance Marketplace Improvement Act, has been introduced by Senator Thomas Carper (D-DE) and Congressman James Langevin (D-RI). If enacted into law, the legislation would create a permanent federal reinsurance program. The reinsurance program would provide payments to health plans to cover 80 percent of insurance claims incurred by plan enrollees between $50,000 and $500,000 from 2018-2020, and between $100,000 and $500,000 in 2021 and beyond.[17,18]

There was also debate to include funding for reinsurance as part of HR 1625, the Consolidated Appropriations Act of 2018. However, ultimately such funding for reinsurance was not included in the final package.

Expansion of Eligibility for Premium Tax Credits

Under the ACA, eligible individuals and families with incomes between 100 and 400 percent FPL (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges. The size of premium credits is based on household income relative to the cost of premiums for the benchmark plan, which is the second-lowest-cost silver plan offered on the exchange. The premium credit thereby caps the percentage of income that individuals pay for their premiums.

Individuals and families with incomes over 400 percent FPL are left without any premium assistance. The Council notes that the policy of our AMA in support of an individual responsibility requirement (Policy H-165.848) states that once a system of refundable, advanceable tax credits inversely related to income is implemented, that individuals and families earning less than 500 percent FPL should be required to obtain coverage. Extending advanceable premium tax credits to those with incomes above 400 percent FPL would not only cause some individuals with incomes between 400 and 500 percent FPL to be able to afford and obtain health insurance coverage, but would also be highly consistent with Policy H-165.848.

Enhanced Premium Tax Credits for Young Adults

In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with “enhanced” premium tax credits—eg, an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio. Smaller amounts could be provided to individuals between ages 30–35. Under this policy option, the total credit, including the “enhanced” tax credit, could not exceed the cost of the second-lowest-cost silver plan available to them. Modeling of “enhanced” premium tax credits projects that individual market enrollment

would increase by one million with the proposal in place.[19] Of note, this approach to expanding coverage among young adults would cost less to the federal government than changing the age rating ratio from 3:1 to 5:1, as the latter would cause premiums for older adults to increase, as well as the associated premium tax credit amounts. Significantly, changing the age rating would cause some older adults to become uninsured; whereas with "enhanced" premium tax credits, individual market enrollment among older adults would remain largely unchanged.[20,21]

Improved Outreach About Premium Subsidies

In August 2017, the Centers for Medicare & Medicaid Services announced that it would be spending $10 million on educational activities targeted at new and returning marketplace enrollees for the open enrollment period for the 2018 plan year,[22] which represented a 90 percent cut from the $100 million spent on ACA-related advertising in 2017.[23] In addition, federal spending on the ACA's navigator program, which provides outreach, education and enrollment assistance to consumers eligible for marketplace coverage as well as Medicaid, was cut 40 percent.[24] However, states operating their own health insurance marketplaces and navigator programs continued to dedicate financial resources to outreach and educational activities, as did some non-profit entities. It has been suggested that the difference in resources dedicated to outreach and education between states operating their own marketplaces and states that relied on healthcare.gov impacted enrollment successes in the marketplaces for 2018. For example, in the 16 states and DC with state-based marketplaces, 2018 plan signups during the open enrollment period stayed consistent with that of 2017, with a very slight increase. On the other hand, in the 34 states that fully relied on the federal healthcare.gov platform, total plan signups decreased by more than five percent in comparison to 2017.[25]

At the same time, of the 27.5 million nonelderly people who were uninsured in 2016, 7.9 million were eligible for premium tax credits to purchase coverage through the marketplace. Data suggest that there remains a lack of awareness about premium tax credits and other financial assistance that may be available, as well as confusion about eligibility rules.[26] The Council notes that for individuals who are eligible for premium tax credits but remain uninsured, improved outreach and education about premium subsidies and their coverage options in the marketplace will be critical to increase the number of people who are insured, and may help to balance the individual market risk pool by increasing marketplace enrollment.

RELEVANT AMA POLICY

Over the course of the past couple of years, the Council has developed and presented reports specifically addressing improving health insurance affordability. CMS Report 4-I-17 focused on essential health benefits and the relative merits of high-risk pools versus reinsurance. The resulting policies, H-165.846[3] and H-165.842[3], oppose the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; oppose waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. CMS Report 8-I-15 established Policy H-165.828, which supports legislation or regulation to fix the "family glitch;" supports allowing workers and their families to be eligible for subsidized exchange coverage if their employer coverage has premiums high enough to make them exempt from the individual mandate; encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and

supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.

Policy H-165.841 supports the overall goal of ensuring that every American has access to affordable high quality health care coverage. Policy H-165.845 states that health insurance coverage should be equitable, affordable, and sustainable. Policy H-165.838 supports insurance market reforms that expand choice of affordable coverage. Policy H-165.920 supports individual tax credits as the preferred method for people to obtain health insurance coverage. Policy H-165.865 states that tax credits should be refundable; inversely related to income; large enough to ensure that health insurance is affordable for most people; fixed-dollar amounts for a given income and family structure; and advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs. Policy H-373.998 states that health reform plans should effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

Policy H-165.848 supports a requirement that individuals and families who can afford health insurance be required to obtain it, using the tax structure to achieve compliance. The policy advocates a requirement that those earning greater than 500 percent FPL obtain a minimum level of catastrophic and preventive coverage. Only upon implementation of tax credits or other coverage subsidies would those earning less than 500 percent FPL be subject to the coverage requirement. Policy H-165.856 supports health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. In CMS Report 9-A-11, "Covering the Uninsured and Individual Responsibility," the Council gave thoughtful consideration to alternatives to requiring individual responsibility, including the imposition of penalties for late enrollment, similar to Medicare Part D. The Council found that analyses fail to prove that such alternatives would be as effective in covering the uninsured and promoting a balanced risk pool of individuals between those who are sick and those who are healthy as an individual responsibility requirement.

Addressing state innovation, Policy D-165.942 advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives: a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care; b) ensure and maximize patient choice of physician and private health plan; and c) include reforms that eliminate denials for pre-existing conditions.

DISCUSSION

With almost 12 million Americans enrolled in coverage offered through health insurance exchanges this year, the Council affirms that progress has been made on a long-standing policy priority of the AMA—supporting the purchase of individually selected and owned health insurance coverage with use of refundable and advanceable tax credits inversely related to income. However, the Council remains concerned with the premium increases experienced in the health insurance marketplaces from their launch in the 2014 plan year, and at the same time recognizes that such increases primarily impact those who are not eligible for premium tax credits. The Council believes that there is an opportunity to extend eligibility for advance premium tax credits which are inversely related to income consistent with Policy H-165.865 to 500 percent of FPL, which would

assist individuals with incomes between 400 and 500 percent FPL to obtain coverage, consistent with Policy H-165.848 on individual responsibility.

The Council recognizes that the effectiveness of premium tax credits as a mechanism to improve health insurance affordability relies on individuals who are eligible for such assistance being aware of it. It is noteworthy that of the 27.5 million nonelderly people who were uninsured in 2016, 7.9 million were eligible for premium tax credits to purchase coverage through the marketplace. There is a clear opportunity to improve awareness about premium tax credits and other financial assistance that may be available to enrollees, as well as clear up confusion about eligibility rules. Accordingly, the Council recommends adequate funding for and expansion of outreach efforts to increase public awareness of premium tax credits to not only increase the number of people who are insured, but also help to balance the individual market risk pool by increasing overall marketplace enrollment.

Another key mechanism to help balance the individual market risk pool and increase coverage rates is the provision of "enhanced" tax credits to young adults. This proposal, which provides those aged 19 to 35 who are eligible for advance premium tax credits with "enhanced" premium tax credits—eg, an additional $50 per month for those ages 19-30, the amount declining to age 35—has been projected to spur increases in young adult enrollment in the marketplace. Importantly, this policy recommendation maintains the current premium tax credit structure which is inversely related to income and as such is highly consistent with AMA policy. The Council notes that, as outlined in long-standing Policy H-165.920 and Policy H-165.828, eliminating or capping the employee tax exclusion for employment-based insurance could be used as a funding stream for the mechanisms proposed to improve health insurance affordability in this report.

The elimination of the federal individual mandate penalty has the potential to cause not only premium increases and coverage losses, but increased market instability starting in 2019. An opportunity exists for state innovation to maximize the number of individuals covered and stabilize health insurance premiums. In particular, the Council is encouraged by activities and discussions on the state level pursuing state-level individual mandates, auto-enrollment and/or reinsurance, and believes those mechanisms hold great promise moving forward.

Finally, the Council is encouraged by the success of the ACA's reinsurance program as well as state reinsurance programs under Section 1332 waiver authority in reducing premiums in comparison to what they otherwise would have been. By partially reimbursing plans for the costs of their high-risk enrollees, reinsurance would help stabilize premiums for all individuals with ACA marketplace coverage, while protecting patients with pre-existing conditions. Therefore, the Council is recommending the establishment of a permanent federal reinsurance program. Upon the program's launch, it will be essential to monitor and evaluate the program's impact on premiums.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and that the remainder of the report be filed:

1. That our American Medical Association (AMA) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (New HOD Policy)

2. That our AMA support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level. (New HOD Policy)

3. That our AMA support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (New HOD Policy)

4. That our AMA encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. (New HOD Policy)

5. That our AMA support the establishment of a permanent federal reinsurance program. (New HOD Policy)

Fiscal Note: Less than $500.

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