

2020 and Beyond: AMA's Plan to Cover the Uninsured

As millions of Americans have gained coverage resulting from the Affordable Care Act (ACA), progress has been made on a long-standing policy priority of the American Medical Association (AMA) – expanding access to and choice of affordable, quality health insurance coverage. Instead of abandoning the ACA and threatening the stability of coverage for those individuals who are generally satisfied with their coverage, the AMA believes that now is the time to invest not only in fixing the law, but also in improving it. Improving the ACA appropriately targets providing coverage to the uninsured population, rather than upending the health insurance coverage of most Americans. Modifications to the law could also improve the affordability of coverage for those who cite costs as a barrier to accessing the care they need.

The AMA plan to cover the uninsured and improve affordability focuses on four main targets:

1. People eligible for ACA's premium tax credits who remain uninsured
2. People eligible for Medicaid or the Children's Health Insurance Program (CHIP) who remain uninsured
3. People that remain uninsured who are ineligible for ACA's premium tax credits
4. People with low incomes that remain uninsured and are ineligible for Medicaid

Who Are the Uninsured?

Nearly 60 percent of nonelderly Americans have employer-sponsored health insurance coverage, 22 percent have Medicaid coverage, and 7 percent have non-group coverage. In 2018, 27.9 million nonelderly individuals (10.4 percent) were uninsured, an increase from the 27.4 million (10.2 percent) who were uninsured in 2017. Of note, 2017 was the first year the uninsured rate

increased since the enactment of the ACA; 2018 marked the second straight year.

Approximately half of the nonelderly uninsured have family incomes below 200 percent of the federal poverty level (FPL). In 2020, 200 percent FPL is \$25,520 for an individual and \$52,400 for a family of four. Most of the nonelderly uninsured are in working families, partly due to the fact that health insurance is not often offered with jobs that low-income individuals have.

Significantly, more than half of the nonelderly uninsured (57 percent) were eligible for ACA financial assistance, either in the form of premium tax credits or Medicaid/CHIP, in 2018. Therefore, it remains imperative to craft public policy solutions to cover the uninsured based on eligibility for premium tax credits, or Medicaid/CHIP.

Problems with Affordability

Cost is frequently cited as a reason for being uninsured - 45% of nonelderly adults in 2018 said they were uninsured because costs were too high. In addition, in 2019, one in three insured adults reported it was difficult to afford to pay their deductible, with approximately one in four insured adults reporting difficulties in affording to pay the cost of health insurance premiums monthly, as well as the cost sharing associated with physician visits and prescription drugs. Overall, roughly half of US adults reported they or a family member delayed or skipped needed health care or dental care in the past year due to cost.

Premium costs can serve as a factor contributing to individuals being uninsured, as well as in their health plan selection, potentially driving individuals to select plans with lower premiums, but higher deductibles and cost-sharing responsibilities. For the 2020 open enrollment period for the 38 states with federally facilitated or partnership exchanges, the average premium was \$595 per month before any application of premium tax credits. But, premiums were reduced

significantly for those eligible for premium tax credits, which constitute most of ACA marketplace enrollees – the average monthly premium for these individuals was \$89. In the employer market, in 2019 the average annual employee contribution for self-only coverage was estimated to be \$1,242, while the average annual employee contribution for family coverage was estimated to be \$6,015.

Once covered, individuals can face high deductibles and other cost-sharing responsibilities. In 2020, assessing the states with federally facilitated or partnership exchanges, the average deductible in plans with combined medical and prescription drug deductibles is \$6,506 for bronze plans and \$4,544 for silver plans. Cost-sharing reductions bring down the deductibles of silver plans for individuals who are eligible. As a result, in 2020, the average deductible for a silver plan is reduced to \$209 for individuals with incomes between 100 and 150 percent FPL, \$762 for those with incomes between 150 and 200 percent FPL, and \$3,268 for those with incomes between 200 and 250 percent FPL.

For the 82 percent of covered employees that had a general annual deductible in 2019, the average annual deductible for employee-only coverage was \$1,655. Aggregate annual deductibles for employer-sponsored family coverage were higher, ranging from \$2,883 for preferred provider organization (PPO) plans, to \$4,779 for high-deductible plans with a tax-preferred savings option.

Therefore, the AMA believes that proposals to cover the uninsured need to include provisions to improve health insurance affordability, including for those who have difficulties affording their deductibles and other cost-sharing responsibilities, and individuals and families whose employer-sponsored coverage is unaffordable.

AMA Plan: Cover Uninsured Eligible for ACA's Premium Tax Credits

In 2018, 9.2 million of the non-elderly uninsured were eligible for ACA's premium tax credits.

Reasons for this population remaining uninsured include premiums and cost-sharing responsibilities for available plans being viewed as unaffordable, as well as individuals simply not being aware of the financial assistance available to them under the ACA.

The AMA supports adequate funding for and expansion of outreach efforts to increase public awareness of ACA's premium tax credits. In recent years, there have been significant federal funding cuts to ACA-related advertising, limiting educational activities targeted at new and returning marketplace enrollees for the open enrollment period. 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, has been cut drastically. The AMA believes 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. Adequately funding and expanding outreach efforts will not only increase the number of people who are insured, but also will help to balance the individual market risk pool by increasing overall marketplace enrollment.

The AMA supports increasing the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered. Currently, 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 tax 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 tax credit thereby caps the percentage of income that individuals pay for their premiums. The generosity of premium tax credits can be increased by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan.

The AMA supports providing enhanced premium tax credits to 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—such as 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.

The AMA supports expanding the eligibility for and increasing the size of cost-sharing reductions. Currently, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads to lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. Extending eligibility for cost-sharing reductions beyond 250 percent FPL, and increasing the size of cost-sharing reductions, will lessen the cost-sharing burdens many individuals face, which impact their ability to access and afford the care they need.

AMA Plan: Cover Uninsured Eligible for Medicaid or CHIP

In 2018, 6.7 million of the nonelderly uninsured were eligible for Medicaid or CHIP. Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment. The imposition of Medicaid work requirements also has the potential to cause individuals eligible for Medicaid to be uninsured.

The AMA supports increasing and improving Medicaid/CHIP outreach and enrollment. Successful outreach and enrollment strategies that states have deployed to achieve and maintain coverage gains include developing and implementing broad marketing and outreach campaigns; providing, training and supporting in-person assisters; and developing and implementing streamlined eligibility and

enrollment systems that can coordinate with other programs.

The AMA opposes Medicaid work requirements. The AMA believes that Medicaid work requirements will negatively affect access to care and lead to significant negative consequences for individuals’ health and well-being. The AMA is especially concerned about interrupting the continuity of care for patients who are subject to the requirements, and with the coverage losses experienced and projected in states that have moved forward with Medicaid work requirements. Studies show that most individuals who would lose their coverage under Medicaid work requirements will do so due to increased administrative burdens, versus not meeting the actual work requirements.

AMA Plan: Make Coverage More Affordable for People Not Eligible for ACA’s Premium Tax Credits

In 2018, 5.7 million of the nonelderly uninsured were ineligible for financial assistance under the ACA, either due to their income, or because they have an offer of “affordable” employer-sponsored health insurance coverage. Without the assistance provided by ACA’s premium tax credits, this population can continue to face unaffordable premiums and remain uninsured.

The AMA supports eliminating the subsidy “cliff,” thereby expanding eligibility for premium tax credits beyond 400 percent FPL. In 2020, the premiums of the second lowest cost silver plan for individuals with incomes at 400 percent FPL (\$49,960 for an individual and \$103,000 for a family of four based on 2019 federal poverty guidelines) are capped at 9.78 percent of their income. Meanwhile, individuals and families with higher incomes are not eligible for any financial assistance in the form of premium tax credits, even if the income differential is minimal.

The AMA supports the establishment of a permanent federal reinsurance program, and the use of Section 1332 waivers for state reinsurance programs. Reinsurance provides payments to plans that enroll higher-cost

individuals whose costs exceed a certain threshold, also known as an attachment point, up to a defined reinsurance cap. Reinsurance plays a role in stabilizing premiums by reducing the incentive for insurers to charge higher premiums across the board in anticipation of higher-risk people enrolling in coverage.

The temporary reinsurance program in place during the early years of Affordable Care Act (ACA) implementation – 2014-16 – helped stabilize premiums in the individual health insurance marketplace. For example, in 2014, insurers received reinsurance payments once an enrollee’s costs exceeded \$45,000 (attachment point), covering 80 percent of enrollee costs up to \$250,000 (reinsurance cap). The \$10 billion reinsurance fund for 2014, the result of the \$63 per enrollee per year contributions, was estimated to reduce premiums by 10 to 14 percent.

Section 1332 waivers have also been approved to provide funding for state reinsurance programs. As a result, premiums are lower in 2020 in the individual market in these states than what they otherwise would have been. For example, the Oregon Reinsurance Program reduced individual market rates by 6 percent, while Colorado’s reinsurance program contributed to a 20.2 percent average decrease in premiums for 2020.

The AMA supports lowering the threshold that determines whether an employee's premium contribution is “affordable,” allowing more employees to become eligible for premium tax credits to purchase marketplace coverage. Individuals eligible for premium and cost-sharing subsidies to purchase coverage on health insurance exchanges include US citizens, legal immigrants, and employees who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.78 percent of income in 2020. As a result, some employees, especially those with lower incomes, are caught in a situation where the employer-sponsored coverage available to them is not affordable, yet they are not eligible for premium tax credits to purchase marketplace coverage. This affordability misalignment prevents a segment of workers

from accessing coverage that would in many instances be more affordable on health insurance exchanges.

The AMA supports fixing the ACA’s “family glitch.” In determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA’s “family glitch,” does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. The average employee contribution for self-only coverage was estimated to be \$1,242 in 2019, while the average contribution for family coverage was estimated to be \$6,015. The “family glitch” leaves many workers and their families ineligible to receive premium and cost-sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they would likely have to pay well over 9.78 percent of their income for family coverage. There is also the potential for workers and families affected by the glitch to remain uninsured, especially considering that low-income families are disproportionately affected.

AMA Plan: Expand Medicaid to Cover More People

In 2018, 2.3 million of the nonelderly uninsured found themselves in the coverage gap – not eligible for Medicaid, and not eligible for tax credits because they reside in states that did not expand Medicaid. Without access to Medicaid, these individuals do not have a pathway to affordable coverage.

The AMA encourages all states to expand Medicaid eligibility to 133 percent FPL. To date, 36 states and DC have implemented the Medicaid expansion, with 14 states not adopting the expansion. To incentivize expansion decisions, states that newly expand Medicaid should be made eligible for three years of full federal funding.

AMA Plan: Reverse Actions That Negatively Impacted Health Insurance Gains

The AMA is highly concerned that recent legislative and regulatory actions have negatively impacted the health insurance achievements of the ACA. Steps need to be taken to reverse these actions to ensure that coverage gains under the ACA can be maximized, and individuals are enrolled in insurance coverage that guarantees coverage of pre-existing conditions.

The AMA supports reinstating a federal individual mandate penalty. In the interim, the AMA encourages states to enact their own individual mandates. The AMA is concerned with any coverage losses and premium increases that are the result of the elimination of the individual mandate penalty due to enactment of tax reform legislation. Importantly, moving forward, the enactment of an individual mandate penalty will be critical to ensure that proposals to build upon the ACA are able to maximize coverage gains.

The AMA opposes the sale of health insurance plans in the individual and small group markets that do not guarantee: a) pre-existing condition protections; and b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months. Unlike ACA marketplace plans, short-term limited duration insurance (STLDI) plans do not have to comply with the market reforms and consumer protections of the ACA. As such, STLDI plans can deny coverage or charge higher premiums based on health status; exclude coverage for pre-existing conditions; impose annual or lifetime limits; have higher out-of-pocket limits than the ACA maximums; not cover essential health benefit categories; rescind coverage; and not comply with medical loss ratio requirements. Limiting STLDI coverage would help reinstate the original purpose of STLDI – to serve as a very temporary bridge between plans offering meaningful coverage, thereby preventing

destabilization of the ACA marketplaces and ensuring individuals are in health plans that cover pre-existing conditions.

AMA's Commitment to Covering the Uninsured in 2020 and Beyond

The AMA has long advocated for health insurance coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice, and universal access for patients. The AMA remains committed to improving health insurance coverage and health care access so that patients receive timely, high quality care, preventive services, medications and other necessary treatments. In 2020 and beyond, steps must be taken to cover the uninsured and improve affordability, so our patients are able to secure affordable and meaningful coverage, and access the care that they need.