

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Options to Maximize Coverage under the AMA Proposal for Reform
(Resolution 113-A-19 and Resolution 114-A-19)
(Reference Committee A)

EXECUTIVE SUMMARY

The American Medical Association (AMA) proposal for reform has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans. However, the Council sees an opportunity to further maximize coverage rates and improve coverage affordability under the AMA proposal for reform by establishing new policy on a public option, as well as auto-enrollment in health insurance coverage. Of note, both approaches cannot be implemented without safeguards in place to protect patients, as well as physicians and their practices.

The Council is aware of the growing interest within the House of Delegates for our AMA to support a public option. However, the term “public option” has several different meanings, and blanket support for a public option without safeguards in place could have negative consequences for physicians and their practices. If all criteria established by the policy proposed by the Council in this report are met, there is the potential for our AMA to support a public option, as it would provide patients with another choice of health plan. As such, a primary goal of establishing a public option should be to maximize patient choice of health plan and maximize health plan marketplace competition. Importantly, eligibility for premium tax credit and cost-sharing assistance to purchase the public option needs to be restricted to individuals without access to affordable employer-sponsored coverage. Otherwise, physician practice payer mix and revenues could be significantly impacted, especially if payment rates under the public option are tied to or guided by Medicare and/or Medicaid payment rates. Regardless of the public option design, payment rates need to be established through meaningful negotiations and contracts and must not be tied to or guided by Medicare and/or Medicaid rates. Physician freedom of practice needs to also be at the forefront of assessing any public option proposal and, as such, public option proposals should not require provider participation, and/or tie a provider’s participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

The Council sees tremendous potential in the use of auto-enrollment to improve the coverage reach of the AMA proposal for reform, especially amid the COVID-19 pandemic. In 2018, 57 percent of the nonelderly uninsured population was eligible for financial assistance – either through Medicaid or the Children’s Health Insurance Program, or via premium tax credits to purchase marketplace coverage as provided for under the Affordable Care Act (ACA). Additionally, a substantial percentage of the newly unemployed are eligible for Medicaid or premium tax credits to purchase ACA marketplace coverage. As such, a significant number of uninsured Americans are currently eligible for no- or low-cost coverage but are not enrolled. The Council believes that states and the federal government should seriously consider the use of auto-enrollment to maximize coverage rates, alongside key improvements to the ACA as outlined in the AMA proposal for reform. As such, the Council proposes standards for states and/or the federal government to follow as they pursue auto-enrollment in health insurance coverage. The Council believes that, especially considering the coverage impacts of the COVID-19 pandemic, there needs to be a mechanism in AMA policy to ensure that the AMA proposal for reform can maximize its coverage potential and reach. Physicians have the responsibility to advocate for improving health insurance coverage and health care access so that patients receive timely, high quality care, preventive services, medications and other necessary treatments.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1, November 2020

Subject: Options to Maximize Coverage under the AMA Proposal for Reform
(Resolution 113-A-19 and Resolution 114-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

1 At the 2019 Annual Meeting, the House of Delegates referred two resolutions jointly sponsored by
2 the Washington and Connecticut Delegations, Resolutions 113 and 114; an alternate resolution
3 offered by Reference Committee A; and an amendment offered by the American College of
4 Physicians during House of Delegates floor consideration of the reference committee report item
5 addressing Resolutions 113 and 114. The Board of Trustees assigned these items to the Council on
6 Medical Service for a report back to the House of Delegates.

7
8 Resolution 113-A-19, Ensuring Access to Statewide Commercial Health Plans, asked that our
9 American Medical Association (AMA) study the concept of offering state employee health plans to
10 every state resident, including exchange participants qualifying for federal subsidies, and report
11 back to the House of Delegates this year; and advocate that State Employees Health Benefits
12 Program health insurance plans be subject to all fully insured state law requirements on prompt
13 payment, fairness in contracting, network adequacy, limitations or restrictions against high
14 deductible health plans, retrospective audits and reviews, and medical necessity.

15
16 Resolution 114-A-19, Ensuring Access to Nationwide Commercial Health Plans, asked that our
17 AMA advocate that Federal Employees Health Benefits Program (FEHBP) health insurance plans
18 should become available to everyone to purchase at actuarially appropriate premiums as well as be
19 eligible for federal premium tax credits; and advocate that FEHBP health insurance plans be
20 subject to all fully insured state law requirements on prompt payment, fairness in contracting,
21 network adequacy, limitations or restrictions against high deductible health plans, retrospective
22 audits and reviews, and medical necessity.

23
24 The alternate resolution proposed by Reference Committee A asked that our AMA study the
25 impacts of various approaches that offer a public option in addition to current sources of coverage,
26 private or public, including but not limited to a Medicare buy-in; a public option offered on health
27 insurance exchanges; and buying into either the FEHBP or a state employee health plan; and
28 reaffirm Policy H-165.838, which states that insurance coverage options offered in a health
29 insurance exchange be self-supporting; have uniform solvency requirements; not receive special
30 advantages from government subsidies; include payment rates established through meaningful
31 negotiations and contracts; not require provider participation; and not restrict enrollees' access to
32 out-of-network physicians.

33
34 The amendment offered during the House of Delegates' consideration of this item at the 2019
35 Annual Meeting asked that our AMA support various approaches that offer a public option in
36 addition to current sources of coverage, private or public, including but not limited to: (a)(i) a
37 Medicare buy-in; (ii) a public option offered on health insurance exchanges; and (iii) buying into

1 either the FEHBP or a state employee health plan; and (b) study the options to effectively
2 implement such approaches.

3
4 This report provides background on the AMA proposal for reform; summarizes potential
5 approaches to a public option; outlines how the use of auto-enrollment has the potential to
6 maximize coverage rates; and presents policy recommendations.

7 8 THE AMA PROPOSAL FOR REFORM

9
10 Covering the uninsured and improving health insurance affordability have been long-standing goals
11 of the AMA. Since the enactment of the Affordable Care Act (ACA), the AMA proposal for reform
12 has continued to evolve to ensure that AMA policy is able to address how to best cover the
13 remaining uninsured in the current coverage environment. In 2018, nearly 60 percent of nonelderly
14 Americans (153.8 million) had employer-sponsored health insurance coverage, 22 percent (57.9
15 million) had Medicaid coverage, and 7 percent (19.4 million) had non-group coverage, while 10.4
16 percent (27.9 million) remained uninsured.¹

17
18 Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the
19 federal poverty level (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) are
20 being provided with refundable and advanceable premium credits that are inversely related to
21 income to purchase coverage on health insurance exchanges. Individuals eligible for premium
22 credits include individuals who are offered an employer plan that does not have an actuarial value
23 of at least 60 percent or if the employee share of the premium exceeds 9.78 percent of income in
24 2020. In addition, individuals and families with incomes between 100 and 250 percent FPL
25 (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing
26 subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums,
27 copayments and other cost-sharing amounts. At the time that this report was written, 38 states and
28 the District of Columbia had adopted the Medicaid expansion provided for in the ACA, which
29 extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.²

30
31 The AMA proposal for reform focuses on expanding health insurance coverage to four main
32 population targets:

- 33
34 1. Individuals eligible for ACA's premium tax credits who remain uninsured (9.2 million in
35 2018);
36 2. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) who
37 remain uninsured (6.7 million in 2018);
38 3. People that remain uninsured who are ineligible for ACA's premium tax credits due to
39 income or an offer of "affordable" employer-sponsored coverage (5.7 million in 2018); and
40 4. People with low incomes that remain uninsured and are ineligible for Medicaid (2.3
41 million in 2018).³

42
43 By appropriately targeting the provision of coverage to the uninsured population, [the AMA](#)
44 [proposal for reform](#) as follows has the potential to make significant strides in covering the
45 remaining uninsured and providing health insurance to millions more Americans:

- 46
47 • Premium tax credits would be available to individuals without an offer of "affordable"
48 employer coverage, with no upper income limit (Policy H-165.824).
49 • Individuals currently caught in the "family glitch" and unable to afford coverage offered
50 through their employers for their families would become eligible for ACA financial
51 assistance based on the premium for family coverage of their employer plan (Policy

H-165.828). Currently, 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. As a result, 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.

- To help employees currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income (Policy H-165.828).
- The generosity of premium tax credits would be increased to improve premium affordability, 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 (Policy H-165.824).
- Young adults facing high premiums would be eligible for “enhanced” tax credits based on income (Policy H-165.824).
- Eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
- The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact their ability to access and afford the care they need (Policy H-165.824).
- A permanent federal reinsurance program would be established, to address the impact of high-cost patients on premiums (H-165.842).
- State initiatives to expand their Medicaid programs will continue to be supported. To incentivize expansion decisions, states that newly expand Medicaid would still be eligible for three years of full federal funding (Policies D-290.979 and H-290.965).
- To maximize coverage rates, the AMA would continue to support reinstating a federal individual mandate penalty, as well as state efforts to maximize coverage, including individual mandate penalties and auto-enrollment mechanisms (Policies H-165.848 and H-165.824).
- To improve coverage rates of individuals eligible for either ACA financial assistance or Medicaid/CHIP but who remain uninsured, the AMA would support investments in outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982).
- States would continue to have the ability to test different innovations to cover the uninsured, provided such experimentations: 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 (Policy D-165.942).

APPROACHES TO A PUBLIC OPTION

As evidenced by the House of Delegates’ discussion of this item at the 2019 Annual Meeting, the term “public option” can be interpreted to include different proposals to expand public coverage. In general, proposals to expand public coverage can range from creating a public option on health insurance exchanges, to allowing people to buy into Medicare or Medicaid. In addition, proposals have explored leveraging the FEHBP and state employee benefit plans to increase the plan offerings available to individuals seeking exchange coverage.

1 *Public Option on Exchanges*

2
3 In general, proposals put forward in Congress to establish a public option on the exchanges rely on
4 components of the Medicare program both for structure and to keep plan costs down. The public
5 option would be available to individuals and/or employers eligible to purchase such coverage.
6 Under these proposals, Medicare participating providers could potentially be required to participate
7 in the public option. Proposals differ in their approaches to provider opt-out provisions, and
8 whether providers in Medicaid would also be required to participate in the public option. Most
9 public option proposals would also base provider payment rates on Medicare, either extending
10 Medicare payment rates or using Medicare rates as a guide to establish payment levels. Individuals
11 who qualify for premium tax credits and cost-sharing subsidies could use such subsidies to
12 purchase the public option. All public option proposals would cover essential health benefits as
13 required under the ACA, with some proposals covering more benefits.

14
15 State public option proposals vary in their structure and scope, and how they leverage
16 Medicare/Medicaid payment rates, as well as state employee plans. For example, Washington's
17 public option, Cascade Care, which was enacted in 2019, aims to increase coverage options on
18 *Washington Healthplanfinder* by requiring the state health care authority to contract with one or
19 more health insurance carriers to offer a public option plan at the bronze, silver and gold levels by
20 January 1, 2021. At the time that this report was written, five insurance carriers had applied to offer
21 public option plans in a majority of counties across the state.⁴ Washington's public option is not a
22 fully public option governed exclusively by the state; rather, it is a blended public-private
23 approach. The state will contract with private insurers to administer the state-sponsored plan but
24 maintain control of the terms to manage cost.

25
26 Cascade Care carriers must cap payment of providers and facilities at a maximum of 160 percent of
27 Medicare rates but excluding pharmacy benefits. Payment for critical access hospitals and sole
28 community hospitals may not be less than 101 percent of Medicare's allowable cost. Of note,
29 payment for primary care services provided by physicians in family medicine, general internal
30 medicine, or pediatric medicine may not be less than 135 percent of the amount that Medicare pays
31 for the same or similar services.⁵ There is not a defined floor for payment for services provided by
32 specialists outlined in the law.

33
34 Importantly, the Council notes that adding a public option to health insurance exchanges may not
35 necessarily achieve significant additional coverage gains, compared to proposals to build upon the
36 ACA. Many of the proposals that aim to cover more people under the ACA are included in the
37 AMA proposal for reform. For example, the Urban Institute in October 2019 [modeled the coverage
38 and cost impacts of various health reform options](#). It found that, after implementing a range of
39 proposals to build upon and improve the ACA – including enhancing and extending subsidies for
40 marketplace coverage, establishing a permanent reinsurance program, restoring the ACA's
41 individual mandate, addressing the Medicaid eligibility gap in non-expansion states, and allowing
42 for limited Medicaid autoenrollment – 21.4 million individuals would be uninsured in 2020. When
43 a public option is added to these ACA improvement provisions, 21.3 million individuals would still
44 be uninsured in 2020. Under this scenario, adding a public option would not achieve meaningful
45 additional coverage gains, as the public option would only lower health insurance premiums for
46 individuals not eligible for subsidies in the nongroup market, which would be a smaller population
47 after the implementation of the aforementioned ACA improvements. That being said, adding a
48 public option was shown to meaningfully lower federal spending on subsidies for marketplace
49 coverage, as lower premiums, premised on lower provider payment rates, would lead to lower
50 premium tax credit amounts.⁶

1 Similarly, in [a March 2020 brief that assessed the impacts of various public option designs](#), the
2 Urban Institute found that “[a] public option’s largest effects are on government and private
3 spending—not on insurance coverage, unless paired with other reforms, such as enhanced premium
4 tax credits and strategies to provide subsidized coverage for more low-income adults in states that
5 have not expanded Medicaid eligibility.” As evidence of its finding, Urban Institute estimated that
6 introducing a public option into the nongroup market would cause a small decrease in the number
7 of uninsured Americans – ranging from approximately 155,000 to 230,000 in 2020.⁷

8
9 In May 2020, RAND Corporation released a report that assessed the impact of four public option
10 alternatives: 1) coverage offered off of the ACA marketplaces, with provider payment set at 79
11 percent of commercial rates; 2) coverage offered on the ACA marketplaces, with provider payment
12 set at 79 percent of commercial rates; 3) coverage offered on the ACA marketplaces, with provider
13 payment set at 93 percent of commercial rates; and 4) coverage offered on the ACA marketplaces,
14 with provider payment set at 93 percent of commercial rates, and eligibility for ACA’s premium
15 tax credits extended to 500 percent FPL. Overall, the RAND analysis found that changes to the
16 number of the uninsured resulting from the introduction of a public option in scenarios 2, 3 and 4
17 would be small, with the first alternative having the largest impact on the uninsured. Notably, there
18 was also a shift in enrollment from private individual market plans to public plans, due in large part
19 to the lower premium of the public option, driven by lower provider payment rates. The analysis
20 also showed that the introduction of a public option could reduce premium tax credit amounts and
21 increase premiums for private ACA marketplace plans. As such, while some individuals would be
22 better off with a public option, those who would be worse off would likely be those with lower
23 incomes who would be eligible for smaller premium tax credits as a result.⁸

24 25 *Broader Availability of a Public Option*

26
27 Proposals introduced in Congress would also leverage a public option that relies heavily on
28 Medicare and Medicaid payment rates to achieve near-universal coverage. Unlike federal and state
29 legislation that proposes offering a public option on ACA marketplaces, which would be available
30 only to marketplace participants and keep the ACA’s eligibility criteria for premium tax credits and
31 cost-sharing subsidies the same, more expansive public option proposals would also open up the
32 public option and eligibility for premium and cost-sharing assistance to individuals who are offered
33 affordable employer-sponsored coverage. As a result, these proposals to establish a public option
34 would be expected to cause crowd-out from employer-sponsored coverage, as well as higher
35 enrollment in the public option, which would impact the payer mix of physician practices. In
36 addition, as employer-sponsored health plans tend to have higher provider payment rates than
37 nongroup health plans, opening up a public option to individuals with employer-sponsored
38 coverage has the potential to significantly reduce provider revenues and cause disruptions in the
39 health care delivery system.⁹

40
41 For example, as an alternative to the traditional Medicare-for-All proposals, Representative Rosa
42 DeLauro (D-CT) introduced H.R. 2452, the Medicare for America Act of 2019. Unlike Medicare-
43 for-All, Medicare for America would allow large employers to continue providing health insurance
44 to their employees, if they provide gold-level coverage (i.e., 80 percent of benefits costs covered).
45 Alternatively, employers can direct their contributions for employee coverage toward paying for
46 premiums for Medicare for America. If employers continue to offer health insurance to their
47 employees, employees would have the ability to choose Medicare for America coverage instead of
48 their employer coverage. There would also be premiums and cost-sharing under Medicare for
49 America, but notably, there would be no deductibles. Premiums would be on a sliding scale based
50 on income, with individuals with incomes below 200 percent FPL having no premium, deductible
51 or out-of-pocket costs. Premiums overall would be capped at no more than eight percent of

1 monthly income. Individuals and families with incomes between 200 and 600 percent FPL would
 2 be eligible to receive subsidies to lower their premium contributions, with current Medicare
 3 beneficiaries either paying the premium for which they are responsible under Medicare, or that of
 4 Medicare for America, whichever is less expensive. Out-of-pocket maximums would also be
 5 applied on a sliding scale based on income, with the caps being \$3,500 for an individual and
 6 \$5,000 for families. Provider payment under Medicare for America would be based largely on
 7 Medicare and Medicaid rates, with increases in payment for primary care, mental and behavioral
 8 health, and cognitive services, and the Secretary being given the authority to establish a rate
 9 schedule for services currently not paid for under Medicare. Participating providers under Medicare
 10 or Medicaid would be considered to be participating providers under Medicare for America.^{10,11}
 11

12 In addition, former Vice President Joe Biden, the Democratic presidential nominee, in conjunction
 13 with Senator Bernie Sanders (I-VT), put forward the Biden-Sanders Unity Task Force
 14 recommendations, which included provisions related to a public option. The recommendations
 15 called for the establishment of a public option administered by the Centers for Medicare &
 16 Medicaid Services that would be available to individuals covered by employer-sponsored coverage
 17 (regardless of whether such coverage is affordable), those with individually purchased coverage,
 18 and the uninsured. Significantly, uninsured individuals who fall in the coverage gap – not eligible
 19 for Medicaid, and not eligible for tax credits because they reside in states that did not expand
 20 Medicaid – would be automatically enrolled in a premium-free public option, with the ability to opt
 21 out should they choose. The public option would also be a health plan choice for older members of
 22 the workforce, along with their employer-sponsored plan, and the ability to enroll in Medicare at
 23 the age of 60. The public option would be required to provide at least one plan choice without
 24 deductibles, would cover all primary care without any cost-sharing, and would negotiate prices
 25 with physicians and hospitals to control costs for other treatments and services, “just like Medicare
 26 does on behalf of older people.”¹²
 27

28 The Biden-Sanders Unity Task Force recommendations also called for leveraging a public option
 29 in the context of a health emergency, which would include the COVID-19 pandemic. First, when
 30 an individual’s eligibility for Consolidated Omnibus Budget Reconciliation Act (COBRA)
 31 coverage expires, the recommendations call for workers whose incomes would qualify them for a
 32 zero-premium public option to be automatically enrolled in the public option, with the ability to opt
 33 out. In addition, the recommendations support automatically enrolling in the public option
 34 individuals eligible for a zero-premium public option, and individuals enrolled in any social safety
 35 net program for low-income Americans, such as the Supplemental Nutrition Assistance Program
 36 (SNAP) and Temporary Assistance for Needy Families (TANF).¹³
 37

38 *Medicare Buy-In*

39
 40 Senator Debbie Stabenow (D-MI) introduced S. 470, the Medicare at 50 Act, and Congressman
 41 Brian Higgins (D-NY) introduced H.R. 1346, the Medicare Buy-In and Health Care Stabilization
 42 Act of 2019, both of which would enable individuals to buy in to Medicare at age 50. Premiums
 43 would be based on estimating the average, annual per capita amount for benefits and administrative
 44 expenses that would be payable under Parts A, B, and D for the buy-in populations. Notably,
 45 individuals enrolled in the buy-in would receive financial assistance similar to that which they
 46 would have received had they purchased a qualified health plan through the marketplace.^{14,15}
 47

48 RAND Corporation has modeled various approaches to a Medicare buy-in to assess the impacts of
 49 allowing individuals ages 50 to 64 to buy in to the Medicare program, including on total health
 50 insurance enrollment. Across all approaches to a Medicare buy-in analyzed by RAND, 2.8 to 7
 51 million older adults would enroll, with 6 million individuals enrolling under RAND’s base buy-in

1 scenario. This rate of take-up of a Medicare buy-in is due to the premiums for the buy-in being less
 2 expensive than plans offered on the individual market – the result of factors including the buy-in
 3 paying providers at Medicare rates. However, when these older adults exit the individual market,
 4 premiums for plans offered on the individual market increase, as the remaining risk pool is smaller,
 5 and comprised of less healthy and more expensive individuals considering their ages. Accordingly,
 6 the RAND analysis showed that a Medicare buy-in has little to no effect on total health insurance
 7 enrollment, as more older adults enrolling in health insurance pursuant to the establishment of the
 8 buy-in is countered by more younger adults becoming uninsured.¹⁶

9
 10 *Medicaid Buy-In*

11
 12 Senator Brian Schatz (D-HI) and Congressman Ben Ray Lujan (D-NM) introduced S. 489/H.R.
 13 1277, the State Public Option Act. The legislation would give states the option to establish a
 14 Medicaid buy-in plan for residents regardless of income. For individuals ineligible for premium tax
 15 credits, their premiums cannot exceed 9.5 percent of household income. However, if these
 16 individuals were to enroll in other plans on state ACA marketplaces, their premiums would not be
 17 capped as a percentage of their income. In terms of physician payment rates, the State Public
 18 Option Act would make permanent a payment increase to Medicare levels for a range of primary
 19 care providers.^{17,18} Understandably, this approach to a Medicaid buy-in is more likely to be taken
 20 up by states that have expanded Medicaid versus states that have not. Urban Institute, in analyzing
 21 this approach to a Medicaid buy-in, found that, while it may not have a meaningful impact in states
 22 with competitive markets, it could make a difference in states with limited insurer competition and
 23 high premiums.¹⁹

24
 25 As state Medicaid programs are different, Medicaid buy-in proposals can be expected to vary from
 26 state to state. For example, a Medicaid buy-in can be offered on the exchanges (potentially a
 27 Medicaid managed care plan), or a Medicaid-like program could be offered off of the exchanges.
 28 Such design differences could impact the ability of individuals to use ACA subsidies to purchase
 29 Medicaid buy-in coverage. Importantly, Medicaid buy-in proposals strive to not change the
 30 existing Medicaid program for those currently eligible and enrolled. Approaches to physician
 31 payment can vary as well, from using Medicaid or Medicare rates as a guide, to opening the door to
 32 negotiated rates. Several states are considering a Medicaid buy-in approach, including New
 33 Mexico, Delaware, Massachusetts and Oregon.

34
 35 *Leveraging the Federal Employees Health Benefits Program (FEHBP) and State Employee Benefit*
 36 *Plans*

37
 38 The FEHBP provides health insurance coverage to federal employees, retirees, and their
 39 dependents. By entering into contracts with qualified health insurance carriers, the US Office of
 40 Personnel Management (OPM) offers through FEHBP two primary types of plans – fee-for-service
 41 (FFS) plans (most of which have a preferred provider organization component) and health
 42 management organization (HMO) plans. While FFS plans are offered nationwide to all enrollees,
 43 HMO plans offer coverage in certain geographic areas. In reviewing health plans to be offered
 44 under FEHBP, OPM considers the ability of plans to provide reasonable access to and choice of
 45 primary and specialty medical care throughout the service area.

46
 47 Leveraging health plan FEHBP participation has been included in a leading proposed solution to
 48 prevent bare counties in the marketplaces. A 2017 bipartisan proposal to fix the ACA supported, in
 49 the short-term, requiring the two largest FEHBP insurers in any county to offer at least one silver-
 50 level plan through the federal exchange in all counties that would otherwise be without coverage as
 51 a condition of participation in FEHBP. These plans would be eligible for premium tax credits and

1 could otherwise charge actuarially appropriate premiums.²⁰ In addition, last Congress,
2 Representative Darrell Issa (R-CA) introduced legislation to allow individuals who are not federal
3 employees to enroll in FEHBP unless the individual is enrolled, or eligible to enroll, in a different
4 public health insurance program; or is a member of the uniformed services.²¹

5
6 Some states are exploring leveraging state employee benefit plans to bolster proposed public
7 options, or to increase exchange plan offerings available. For example, the public option legislation
8 passed in the state of Washington requires the state authority to submit a report to the legislature by
9 December 1, 2022, that addresses the impact on exchange market choices, affordability, and
10 stability of linking a carrier's ability to offer a state-contracted public option with their
11 participation in programs administered by the public employees' benefits board, the school
12 employees' benefits board, or the health care authority; and the impact on the exchange market of
13 requiring providers who participate in the aforementioned programs to participate in public option
14 plan networks.²² In addition, an option available to potentially increase exchange plan offerings is
15 to require plans that participate in state employee benefit plans to offer plans on the exchange.

16
17 *Relevant AMA Policy*

18
19 Policy H-165.838 states that insurance coverage options offered in a health insurance exchange
20 should be self-supporting; have uniform solvency requirements; not receive special advantages
21 from government subsidies; include payment rates established through meaningful negotiations and
22 contracts; not require provider participation; and not restrict enrollees' access to out-of-network
23 physicians. Policy H-165.825 states that the largest two FEHBP insurers in counties that lack a
24 marketplace plan should be required to offer at least one silver-level marketplace plan as a
25 condition of FEHBP participation.

26
27 Addressing a Medicare buy-in, Policy H-330.896 states that Medicare's age-eligibility
28 requirements and incentives should be restructured to match the Social Security schedule of
29 benefits. Concerning Medicaid expansion, Policy D-290.979 advocates working with interested
30 states to expand Medicaid eligibility in their states to 133 percent of the federal poverty level.

31
32 **ACHIEVING HIGHER COVERAGE RATES THROUGH AUTO-ENROLLMENT**

33
34 In 2018, 27.9 million nonelderly individuals (10.4 percent) were uninsured, an increase from the
35 27.4 million (10.2 percent) who were uninsured in 2017.²³ Nearly seven million of the nonelderly
36 uninsured were eligible for Medicaid or CHIP. More than nine million nonelderly individuals were
37 eligible for premium tax credits provided for under the ACA.²⁴ In December 2019, the Kaiser
38 Family Foundation estimated that, of the uninsured who could purchase coverage on health
39 insurance exchanges, 4.7 million are eligible to purchase a zero-premium bronze plan (i.e., 60
40 percent of benefits costs covered) after subsidies in 2020.²⁵

41
42 The elimination of the federal individual mandate penalty as a part of tax reform legislation enacted
43 in December 2017, as well as job losses amid the COVID-19 pandemic, raise the need to examine
44 alternative approaches to maximize coverage rates. Resulting from the reality that a significant
45 proportion of the uninsured and newly unemployed are eligible for no- or low-cost coverage
46 provided for under the ACA, auto-enrollment has emerged as a prominent policy option. Federal
47 and/or state auto-enrollment approaches could address auto-enrollment in marketplace coverage,
48 Medicaid/CHIP and employer coverage.

1 Any auto-enrollment program needs to address four policy challenges:

- 2
- 3 1. How to obtain eligibility information so uninsured individuals can be identified and
- 4 matched to coverage for which they are eligible, including Medicaid/CHIP and
- 5 marketplace coverage, as well as premium tax credits.
- 6 2. How to collect premiums, if applicable.
- 7 3. How to assign individuals to an insurance plan.
- 8 4. How to manage situations where individuals are auto-enrolled into coverage for which
- 9 they are not eligible, or remain uninsured despite believing they were enrolled in health
- 10 insurance coverage.²⁶
- 11

12 There are multiple approaches to auto-enrollment. First, states and/or the federal government can
13 pursue tax-based auto-enrollment, under which individuals at the time of tax filing would either
14 indicate whether or not they had health insurance coverage, and/or authorize the state or federal
15 entity to determine eligibility for Medicaid/CHIP, or free or low-cost health insurance offered on
16 the marketplaces. Once coverage determinations take place, auto-enrollment can occur that results
17 in coverage for the upcoming year or coverage could be applied retroactively. Under traditional
18 auto-enrollment programs, individuals could either be auto-enrolled in Medicaid/CHIP, as well as
19 no-premium bronze plans if they are eligible; a special enrollment period could be established for
20 individuals who qualify for premium tax credits for marketplace coverage; and/or targeted outreach
21 activities could be implemented to facilitate the health insurance enrollment of those eligible for
22 premium tax credits and Medicaid/CHIP.

23

24 For example, the Maryland Easy Enrollment Health Insurance Program, enacted in 2019, is taking
25 steps to use a tax-based approach to auto-enrollment. Under the first phase of the program,
26 individuals check a box on their tax return to indicate any uninsured household members, and then
27 have a choice of providing authorization to the state to share information from their tax return with
28 the state exchange to determine their eligibility for no- or low-cost insurance. If individuals grant
29 the state authorization, the state exchange makes a preliminary eligibility determination and sends
30 out a written notice to the household. While individuals must use traditional channels to sign up for
31 marketplace coverage, they are granted a special enrollment period so they can sign up for
32 coverage after tax filing, versus waiting for the next open enrollment period. In the second phase of
33 implementation, which commences January 2021, the state is striving for real-time eligibility
34 determinations; automatic Medicaid enrollment; and streamlined marketplace plan enrollment,
35 again coupled with the use of a special enrollment period.²⁷

36

37 Auto-enrollment in health insurance coverage could also be implemented retroactively. For
38 example, individuals uninsured at the time of tax filing could be considered covered by a “backstop
39 plan” for each month of the previous year they were uninsured. As a result, these individuals would
40 pay premiums retroactively for the backstop coverage, which would be income-adjusted. If they
41 accessed health care services during their time of being uninsured and retroactively covered by the
42 backstop plan, the backstop plan would pay their claims.

43

44 If disconnected from tax filing, auto-enrollment programs could also leverage existing state
45 systems, such as automobile registration and drivers’ license renewal, or could be implemented in
46 partnership with health care providers, clinics and hospitals. Relevant to the tens of millions of
47 Americans who are projected to lose their employer-sponsored health insurance coverage resulting
48 from the COVID-19 pandemic, state unemployment insurance systems could be leveraged to
49 facilitate enrollment in no- or low-cost health insurance for which the newly unemployed are
50 eligible.

1 *Relevant AMA Policy*

2
3 Policy H-165.824 encourages state innovation, including considering state-level individual
4 mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and
5 stabilize health insurance premiums without undercutting any existing patient protections. Policy
6 H-165.855 states that, should tax credits be given to Medicaid beneficiaries, that they be given a
7 choice of coverage, and that a mechanism be developed to administer a process by which those
8 who do not choose a health plan will be assigned a plan in their geographic area through auto-
9 enrollment until the next enrollment opportunity. The policy also stipulates that patients who have
10 been auto-enrolled should be permitted to change plans any time within 90 days of their original
11 enrollment.

12
13 DISCUSSION

14
15 The AMA proposal for reform has the potential to make significant strides in covering the
16 remaining uninsured and providing health insurance to millions more Americans. However, the
17 Council sees an opportunity to further maximize coverage rates and improve coverage affordability
18 under the AMA proposal for reform by establishing new policy on a public option, as well as auto-
19 enrollment in health insurance coverage. The Council stresses that both approaches cannot be
20 implemented without safeguards in place to protect patients, as well as physicians and their
21 practices.

22
23 The Council is aware of the growing interest within the House of Delegates for our AMA to
24 support a public option. However, the term “public option” has several different meanings, and
25 blanket support for a public option without safeguards in place could have negative consequences
26 for physicians and their practices. For example, public option proposals that allow individuals with
27 affordable employer coverage to qualify for premium and cost-sharing subsidies and enroll in a
28 public option could significantly change the payer mix of physician practices, especially if payment
29 rates under the public option are tied to or guided by Medicare and/or Medicaid payment rates.
30 Regardless of the public option design, payment rates need to be established through meaningful
31 negotiations and contracts and must not be tied to or guided by Medicare and/or Medicaid rates.
32 Physician freedom of practice needs to also be at the forefront of assessing any public option
33 proposal and, as such, public option proposals should not require provider participation, and/or tie a
34 provider’s participation in Medicare, Medicaid and/or any commercial product to participation in
35 the public option. Public options need to be financially self-sustaining and not receive
36 advantageous government subsidies, so they do not place stressors on other funding streams of
37 government health programs, such as the Medicare Trust Fund.

38
39 If all criteria established by the policy proposed by the Council in this report are met, there is the
40 potential for the AMA to support a public option, as it would provide patients with another choice
41 of health plan. As such, a primary goal of establishing a public option should be to maximize
42 patient choice of health plan and maximize health plan marketplace competition. The Council
43 recognizes public options could be designed in many ways, and as a result could have various
44 coverage and affordability impacts. Overall, with guardrails in place to protect patients and
45 physicians, the Council underscores that a public option should not be seen as a panacea to cover
46 the uninsured. The Council reiterates that, in the meantime, in the event of bare counties in the
47 ACA marketplaces, Policy H-165.825 supports that the largest two FEHBP insurers in counties that
48 lack a marketplace plan should be required to offer at least one silver-level marketplace plan as a
49 condition of FEHBP participation.

1 On the other hand, the Council sees tremendous potential in the use of auto-enrollment to improve
2 the coverage reach of the AMA proposal for reform, especially amid the COVID-19 pandemic. In
3 2018, 57 percent of the nonelderly uninsured was eligible for financial assistance – either through
4 Medicaid/CHIP, or via premium tax credits to purchase marketplace coverage as provided for
5 under the ACA. In addition, a substantial percentage of the newly unemployed are eligible for
6 Medicaid or premium tax credits to purchase ACA marketplace coverage. As such, a significant
7 number of uninsured Americans are currently eligible for no- or low-cost coverage but are not
8 enrolled. The Council believes that states and the federal government should seriously consider the
9 use of auto-enrollment to maximize coverage rates, alongside key improvements to the ACA as
10 outlined in the [AMA proposal for reform](#).

11
12 After providing consent to applicable state and/or federal entities to share their health insurance
13 status and tax data, the Council believes that individuals should only be auto-enrolled in health
14 insurance coverage if coverage options are available at no cost to them after any applicable
15 subsidies. As such, candidates for auto-enrollment would be individuals eligible for
16 Medicaid/CHIP or zero-premium marketplace coverage, unless they choose to opt out. Individuals
17 who are auto-enrolled should not be penalized if they are auto-enrolled into coverage for which
18 they are not eligible or remain uninsured despite believing they were enrolled in health insurance
19 coverage via auto-enrollment. Individuals eligible for zero-premium marketplace coverage should
20 be randomly assigned among plans with the highest actuarial value with a zero-dollar premium
21 option, and plans should be incentivized to offer pre-deductible coverage including physician
22 services to maximize the value of zero-premium plans to patients. Individuals enrolled in a zero-
23 premium bronze plan who would otherwise qualify for significant cost-sharing reductions if they
24 enrolled in a silver plan (70 percent of benefits costs covered) should be notified of their eligibility
25 for cost-sharing reductions, and what enrolling in a silver plan would mean in terms of differences
26 in out-of-pocket responsibilities, so they could be appropriately informed in advance of the
27 subsequent open enrollment period. In this scenario, to assist with out-of-pocket responsibilities of
28 the bronze plan into which they are enrolled in the meantime, the Council recommends
29 reaffirmation of Policy H-165.824, which supports these individuals having access to a health
30 savings account (HSA) partially funded by an amount determined to be equivalent to the cost-
31 sharing subsidy.

32
33 To facilitate health insurance enrollment of other individuals (eligible for coverage, but with a
34 premium after application of any subsidies), the Council also believes that there should be targeted
35 outreach promoting enrollment. In addition, states and/or the federal government should consider
36 establishing a special enrollment period for these individuals to enroll in the coverage of their
37 choosing so they do not have to wait until the next open enrollment period to get covered.

38
39 The Council believes that, in the absence of a federal individual mandate penalty and as millions of
40 Americans have lost their employer-sponsored health insurance coverage resulting from the
41 COVID-19 pandemic, there needs to be a mechanism in AMA policy to ensure that the AMA
42 proposal for reform can maximize its coverage potential and reach. Physicians have the
43 responsibility to advocate for improving health insurance coverage and health care access so that
44 patients receive timely, high quality care, preventive services, medications and other necessary
45 treatments. The Council believes its recommendations address gaps in AMA policy with respect to
46 covering the uninsured and improving affordability, which are necessary to ensure that our patients
47 are able to secure affordable and meaningful coverage, and access the care that they need.

1 RECOMMENDATIONS

2
3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 113-A-19, Resolution 114-A-19, the alternate resolution proposed by Reference Committee A, and
5 the amendment offered during the House of Delegates' consideration of item 9 of the report of
6 Reference Committee A, and that the remainder of the report be filed.

- 7
8 1. That our American Medical Association (AMA) advocate that any public option to expand
9 health insurance coverage must meet the following standards:
10
11 a. The primary goals of establishing a public option are to maximize patient choice of
12 health plan and maximize health plan marketplace competition.
13 b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public
14 option is restricted to individuals without access to affordable employer-sponsored
15 coverage that meets standards for minimum value of benefits.
16 c. Physician payments under the public option are established through meaningful
17 negotiations and contracts. Physician payments under the public option must be higher
18 than prevailing Medicare rates and at rates sufficient to sustain the costs of medical
19 practice.
20 d. Physicians have the freedom to choose whether to participate in the public option.
21 Public option proposals should not require provider participation and/or tie physician
22 participation in Medicare, Medicaid and/or any commercial product to participation in
23 the public option.
24 e. The public option is financially self-sustaining and has uniform solvency requirements.
25 f. The public option does not receive advantageous government subsidies in comparison
26 to those provided to other health plans.
27 g. The public option shall be made available to uninsured individuals who fall into the
28 "coverage gap" in states that do not expand Medicaid – having incomes above
29 Medicaid eligibility limits but below the federal poverty level, which is the lower limit
30 for premium tax credits – at no or nominal cost. (New HOD Policy)
31
32 2. That our AMA support states and/or the federal government pursuing auto-enrollment in health
33 insurance coverage that meets the following standards:
34
35 a. Individuals must provide consent to the applicable state and/or federal entities to share
36 their health insurance status and tax data with the entity with the authority to make
37 coverage determinations.
38 b. Individuals should only be auto-enrolled in health insurance coverage if they are
39 eligible for coverage options that would be of no cost to them after the application of
40 any subsidies. Candidates for auto-enrollment would, therefore, include individuals
41 eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium
42 marketplace coverage.
43 c. Individuals should have the opportunity to opt out from health insurance coverage into
44 which they are auto-enrolled.
45 d. Individuals should not be penalized if they are auto-enrolled into coverage for which
46 they are not eligible or remain uninsured despite believing they were enrolled in health
47 insurance coverage via auto-enrollment.
48 e. Individuals eligible for zero-premium marketplace coverage should be randomly
49 assigned among the zero-premium plans with the highest actuarial values.

- 1 f. Health plans should be incentivized to offer pre-deductible coverage including
2 physician services in their bronze and silver plans, to maximize the value of zero-
3 premium plans to plan enrollees.
- 4 g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing
5 reductions should be notified of the cost-sharing advantages of enrolling in silver
6 plans.
- 7 h. There should be targeted outreach and streamlined enrollment mechanisms promoting
8 health insurance enrollment, which could include raising awareness of the availability
9 of premium tax credits and cost-sharing reductions, and establishing a special
10 enrollment period. (New HOD Policy)
- 11
- 12 3. That our AMA reaffirm Policy H-165.825, which states that the largest two Federal Employees
13 Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan should be
14 required to offer at least one silver-level marketplace plan as a condition of FEHBP
15 participation. (Reaffirm HOD Policy)
- 16
- 17 4. That our AMA reaffirm Policy H-165.828, which encourages the development of
18 demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego
19 these subsidies by enrolling in a bronze plan, to have access to a health savings account
20 partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
21 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500

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