2022 and Beyond: AMA's Plan to Cover the Uninsured

As millions of Americans have gained coverage resulting from the Affordable Care Act (ACA) and the American Rescue Plan Act (ARPA), 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. Affordable coverage options available due to the ACA – subsidized ACA marketplace coverage and the Medicaid expansion – are more critical than ever, serving as a needed safety net during the COVID-19 pandemic.

At a time of record enrollment in ACA coverage, the AMA calls for action this year to not only maintain, but build upon, the coverage gains that have been achieved. We as a nation cannot take steps back and lose ground in our efforts to cover the uninsured.

The AMA plan to cover the uninsured and improve affordability focuses on five 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 who remain uninsured who are ineligible for ACA's premium tax credits due to having an "affordable" offer of employer coverage
4. People who remain uninsured because they fall into the ACA's "coverage gap"
5. People who remain uninsured who are ineligible for ACA financial assistance due to immigration status

Who Are the Uninsured?

In 2020, nearly 60 percent of nonelderly Americans had employer-sponsored health insurance coverage, 20 percent had Medicaid coverage, and 6 percent had non-group coverage. In 2020, 27.4 million nonelderly individuals (10.2 percent) were uninsured, holding relatively steady from the 27 million (10 percent) who were uninsured in 2018. Data indicate that the uninsured rate has decreased during the COVID-19 pandemic, due to the temporary ACA improvements included in the American Rescue Plan Act, continuous Medicaid enrollment, state Medicaid expansions, and the 2021 special enrollment period for ACA marketplaces.

Overall, people of color are at greater risk of being uninsured than White people. People of color accounted for 63 percent of the nonelderly uninsured population in 2020, despite comprising 44 percent of the nonelderly population. Hispanic individuals made up 40 percent of the nonelderly uninsured population in 2020, with non-Hispanic White individuals comprising 37 percent, and Black individuals accounting for 15 percent.

Nearly half of the nonelderly uninsured in 2020 had family incomes below 200 percent of the federal poverty level (FPL). In 2022, 200 percent FPL is $27,180 for an individual and $55,500 for a family of four. Most of the nonelderly uninsured live in working families, due, in part, to the fact that health insurance is not often offered with jobs that low-income individuals have.

Most of the nonelderly uninsured are eligible for ACA financial assistance, either in the form of premium tax credits or Medicaid/CHIP. 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 has historically been cited as a reason for being uninsured – 74 percent of nonelderly adults in 2019 said they were uninsured because coverage was not affordable. One in three insured adults reported it was difficult to afford to

pay their deductible. In addition, approximately one in four insured adults reported difficulties in paying the cost of health insurance premiums monthly, as well as the cost sharing associated with physician visits and prescription drugs. Overall, approximately 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 2022 open enrollment period, the average premium was $585 per month before any application of premium tax credits. However, premiums were reduced significantly for those eligible for premium tax credits, which constitute most ACA marketplace enrollees – the average premium tax credit for all consumers was $505 per month. Overall, the average premium after the application of premium tax credits was $133 per month. In the employer market, in 2021, the average annual employee contribution for self-only coverage was estimated to be $1,299, while the average annual employee contribution for family coverage was estimated to be $5,969.

Once covered, individuals can face high deductibles and other cost-sharing responsibilities. In 2022, assessing the states with federally facilitated or partnership exchanges, the average deductible in plans with combined medical and prescription drug deductibles was $7,051 for bronze plans and $4,753 for silver plans. Cost-sharing reductions bring down the deductibles of silver plans for individuals who are eligible. As a result, in 2022, the average deductible for a silver plan was reduced to $146 for individuals with incomes between 100 and 150 percent FPL, $756 for those with incomes between 150 and 200 percent FPL, and $3,215 for those with incomes between 200 and 250 percent FPL.

For the 85 percent of covered employees that had a general annual deductible in 2021, the average annual deductible for employee-only coverage was $1,669. Aggregate annual deductibles for employer-sponsored family coverage were higher, ranging from $3,000 for preferred provider organization (PPO) plans, to $4,705 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

Nearly four in 10 of the remaining nonelderly uninsured in 2020 are eligible for ACA's premium tax credits. Reasons for this population remaining uninsured include simply not being aware of the financial assistance available to them under the ACA, which has since been temporarily enhanced by the American Rescue Plan Act through the end of 2022. In addition, for those not eligible for significant premium and cost-sharing assistance, premiums and cost-sharing responsibilities continue to be viewed as unaffordable.

The AMA urgently calls for ARPA subsidies, which increase the generosity of premium tax credits to improve premium affordability and incentivize tax credit eligible individuals to get covered, to be extended beyond 2022. Generally, individuals and families with incomes above 100 percent FPL (133 percent in Medicaid expansion states) are eligible for 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.

ARPA temporarily – for 2021 and 2022 – lowered the cap on the percentage of income individuals are required to pay for premiums of the

benchmark plan. If action is not taken to extend these ARPA subsidies beyond 2022, premiums could double for millions of exchange plan enrollees, with the steepest premium increases to be experienced by those with the lowest incomes. Such premium increases will impact whether current exchange plan enrollees stay covered, and may cause them to switch to a plan with higher deductibles and cost-sharing requirements. The AMA supports measures to permanently increase the generosity of premium tax credits, 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 permanently eliminating the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent FPL past 2022. The American Rescue Plan Act temporarily eliminated the subsidy cliff for two years; approximately 3.7 million people gained subsidy eligibility thanks to this ARPA provision. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL ($51,520 for an individual and $106,000 for a family of four based on 2021 federal poverty guidelines) are now capped at 8.5 percent of their income. Without a permanent elimination of the subsidy cliff, individuals and families with higher incomes will again be ineligible for any financial assistance in the form of premium tax credits, even if the income differential above 400 percent FPL is minimal. In addition, if the subsidy cliff is not eliminated beyond 2022, the impacts of other ACA improvements, including fixing the "family glitch," will be more limited.

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. Generally, 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. Looking ahead, 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.

The AMA supports states and/or the federal government pursuing auto-enrollment for those individuals who qualify for zero-premium marketplace coverage. Eligible individuals and families with incomes between 100 and 150 percent FPL (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. Others remain eligible for zero-premium bronze or silver plans, after the application of any subsidies. Therefore, the targeted use of auto-enrollment for the population eligible for zero-premium marketplace coverage has the potential to achieve significant coverage gains. Notably, auto-enrollment could also be used to help minimize coverage losses following the end of the COVID-19 public health emergency. For those who lose their employer-sponsored health insurance coverage, state unemployment insurance systems could be leveraged to facilitate enrollment in no- or low-cost health insurance for which the newly unemployed are eligible.

The AMA supports continued adequate funding for and expansion of outreach efforts to increase public awareness of ACA's premium tax credits. The AMA welcomes the extensive outreach and education efforts by the Biden administration and state-run marketplaces that have played a vital role in driving higher enrollment in ACA coverage, including among members of historically marginalized and

minoritized communities. Such outreach and education efforts have been essential in light of the ACA enhancements included in ARPA, which made premium tax credits more generous, and available to more people. Adequately funding and expanding outreach efforts not only increases the number of people who are insured, but also helps to balance the individual market risk pool by increasing overall marketplace enrollment.

AMA Plan: Cover Uninsured Eligible for Medicaid or CHIP

Seven million of the remaining nonelderly uninsured in 2020 are eligible for Medicaid or CHIP. Of this number, 4.2 million were adults and 2.8 million are children. Nearly two-thirds of the nonelderly uninsured eligible for Medicaid/CHIP are people of color, and three-quarters are in working families. Reasons for this population remaining uninsured include lack of awareness of eligibility or assistance in enrollment.

The AMA supports states and/or the federal government pursuing auto-enrollment for those individuals who qualify for Medicaid/CHIP. Auto-enrolling individuals who qualify for Medicaid or CHIP coverage at no cost to them would lead to significant coverage gains among the nation's lowest-income adults and children.

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.

AMA Plan: Make Coverage More Affordable for People Not Eligible for ACA's Premium Tax Credits Due to Having an "Affordable" Offer of Employer Coverage

While the American Rescue Plan Act temporarily extended premium tax credit eligibility to those with higher incomes, some individuals with an offer of "affordable" employer-sponsored health insurance coverage remain ineligible for assistance provided by ACA's premium tax credits due to how "affordability" was defined in the ACA and subsequent regulations. Without needed financial assistance, this population can continue to face unaffordable premiums and remain uninsured.

The AMA welcomes regulatory action to fix 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 generally is much more expensive than employee-only coverage. The average employee contribution for self-only coverage was estimated to be $1,299 in 2021, while the average contribution for family coverage was estimated to be $5,969. The "family glitch" leaves more than five million people – families of workers – 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 9.61 percent of their income for family coverage. Accordingly, these families face a difficult choice between paying very high premiums for the coverage options available to them, or going uninsured.

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 9.61 percent of income in 2022. 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, especially considering that premiums of the second-lowest-cost silver plan are now capped at 8.5 percent of income for individuals with the highest incomes eligible for subsidized ACA marketplace coverage.

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 2022 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 24.1 percent average decrease in premiums for 2022.

AMA Plan: Cover Individuals Who Fall into ACA's "Coverage Gap"

More than two million of the remaining nonelderly uninsured in 2020 find 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. Approximately 60 percent of individuals who fall into the coverage gap are people of color. Three of four individuals who fall into the coverage gap reside in four states – Florida, Georgia, North Carolina and Texas. Approximately two-thirds of individuals in the coverage gap are in working families, with half working themselves. Without access to Medicaid or heavily subsidized marketplace coverage, the uninsured in the coverage gap simply do not have access to affordable coverage options.

The AMA encourages all states to expand Medicaid eligibility to 133 percent FPL. To date, 38 states and DC have adopted the Medicaid expansion, with 12 states not adopting the expansion. States that have not yet expanded Medicaid are now eligible for a five-percentage-point increase in their traditional Federal Medical Assistance Percentage Rate (FMAP) for two years if they implement the expansion. This incentive would provide additional funds to states that newly expand Medicaid, applicable to a large share of their Medicaid population and spending. In the near term, the five-percentage-point increase would be in addition to the current 6.2-percentage-point increase in the match rate provided under the Families First Coronavirus Response Act (FFCRA) pursuant to the COVID-19 public health emergency. Importantly, states that newly expand would also receive a 90 percent federal match for the expansion population. The AMA believes that states that newly expand Medicaid should be made eligible for three years of full federal funding.

The AMA advocates that any federal approach to cover uninsured individuals who fall into the "coverage gap" make health insurance coverage available to this population at no or nominal cost, with significant cost-sharing protections. In order to ensure that states that implemented Medicaid expansions maintain their expansions, any federal approach to close the "coverage gap" should also provide current Medicaid expansion states with additional incentives.

The AMA advocates that any public option to expand health insurance coverage must be made available to uninsured individuals who fall into the "coverage gap" at no or nominal cost. The AMA believes that the primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition. And, for those individuals who fall into the "coverage gap" in states that do not expand Medicaid, a public option has the potential to finally provide them with an affordable coverage option.

That being said, physician payments under any public option must be established through meaningful negotiations and contracts. Physician payments under any public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option. A public option must be financially self-sustaining, have uniform solvency requirements, and not receive advantageous government subsidies in comparison to those provided to other health plans.

AMA Plan: Provide Coverage Options to Uninsured Ineligible for ACA Financial Assistance Due to Immigration Status

Nearly four million of the nonelderly uninsured are ineligible for ACA financial assistance due to their immigration status. Overall, lawfully present and undocumented immigrants were significantly more likely to be uninsured than citizens in 2020. Among the nonelderly population, 26 percent of lawfully present immigrants and 42 percent of undocumented immigrants were uninsured, compared to eight percent of citizens. Critically, noncitizen children are more likely to be uninsured than citizen children.

The AMA supports extending eligibility to purchase ACA marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. Undocumented immigrants are not eligible to purchase coverage through the ACA marketplaces, even if they pay the full cost because they are not eligible for subsidies. In addition, they are not eligible to enroll in Medicaid or CHIP. These eligibility restrictions for Medicaid, CHIP and marketplace coverage also extend to individuals with Deferred Action for Childhood Arrivals (DACA) status, as they are not considered lawfully present and remain ineligible for coverage options, according to rules issued by the Centers for Medicare and Medicaid Services.

The AMA recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. With the current coverage restrictions facing undocumented immigrants, some states and localities have established programs to provide coverage to certain groups of immigrants regardless of immigration status, without the use of federal funds.

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 the adoption of mechanisms to maximize coverage gains under the ACA, including individual mandates and/or auto-enrollment in health insurance coverage. To mitigate any adverse impacts of the zeroing out of the federal individual mandate penalty due to the enactment of tax reform legislation, the AMA supports reinstituting a federal individual mandate penalty, as well as states enacting their own individual mandates. The AMA also believes that auto-enrolling individuals who qualify for zero-premium marketplace coverage or Medicaid/CHIP in health insurance coverage has the potential to improve the coverage reach of the ACA. Auto-enrollment could also be used to help minimize coverage losses following the end of the COVID-19 public health emergency.

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 2022 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 2022 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.