REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-24)
Improving Affordability of Employment-Based Health Coverage
(Resolution 103-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

To expand coverage to all Americans, the American Medical Association has long advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. As highlighted in this report, ESI remains the dominant source of health coverage in this country and most people seem satisfied with it. However, because of shortcomings inherent to the ESI system—namely equity and affordability concerns, and rising costs—it does not work well for everyone. Some workers, especially those with lower incomes, may be contributing more for an employer plan than they would pay for subsidized marketplace coverage because a provision in the Affordable Care Act (ACA), known as the firewall, prohibits workers with affordable ESI offers from receiving premium tax credits to purchase marketplace plans.

The Council's main concerns about eliminating the firewall abruptly and in full include the potential impacts on ESI stability, which may not be wholly understood, and potential costs to the federal government, since allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively expensive. Instead, the Council supports incrementally reducing the affordability threshold so that it benefits workers most in need, and then monitoring the effects of this change over time. Accordingly, the Council recommends amending Policy H-165.828[1] to support lowering the threshold that determines whether an employee's premium contribution is affordable to the maximum percentage of income they would be required to pay, after accounting for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan).

Additional recommendations are intended to strengthen the quality and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council also recommends supporting efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-24

Subject: Improving Affordability of Employment-Based Health Coverage (Resolution 103-A-23)

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

At the June 2023 Annual Meeting, the House of Delegates referred Resolution 103, which was sponsored by the Medical Student Section and asked the American Medical Association (AMA) to: (1) recognize the inefficiencies and complexity of the employer-sponsored health insurance system and the existence of alternative models that better align incentives to facilitate access to high quality health care; (2) support movement toward a health care system that does not rely on employer-sponsored health insurance and enables universal access to high quality health care; (3) amend Policy H-165.828[1], "Health Insurance Affordability," by addition and deletion to read as follows:

Health Insurance Affordability H-165.828[1]
~~1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

and (4) amend Policy H-165.823[2] by deletion to read as follows:

Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~
b~~e~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.

ef. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
fg. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report discusses policy options for addressing employer-sponsored health insurance (ESI) affordability, summarizes relevant AMA policy, and presents recommendations.

BACKGROUND

Almost a decade and a half after enactment of the ACA, ESI continues to be the dominant source of health coverage for Americans under 65 years of age. In 2023, the Congressional Budget Office (CBO) estimated that 155 million people under age 65—or 57.3 percent of the nonelderly population—had health insurance coverage through their employer, a number the CBO predicts will remain steady through 2025 and increase in the years thereafter.[1] Although ESI is the most common type of health insurance, coverage varies significantly by income as well as race and ethnicity. While nearly all individuals with incomes at or above 400 percent of the federal poverty level (FPL) have ESI, it covers just over half of people with incomes between 150 to 400 percent FPL and fewer than one-quarter of individuals with incomes below 150 percent FPL.[2] Additionally, larger percentages of white and Asian people have ESI while individuals who are African American and Latino are less likely to have employer-based coverage, raising equity concerns.[3,4]

Overall, most Americans appear satisfied with employment-based coverage.[5] According to KFF's survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and 73 percent of those with marketplace coverage rated their health coverage as "excellent" or "good" although people in poorer health gave more negative ratings across all plan types. Regardless of health status, enrollees in marketplace plans were most likely to rate their experiences with health insurance as fair or poor.[6] Ninety-three percent of workers responding to a 2022 poll sponsored by the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority (89 percent) expressing a preference for ESI over other types of coverage.[7] Eighty percent of respondents to this survey ranked health insurance as the most important workplace benefit provided to them, and a majority cited "affordability" and "high quality" as ESI's most critical features.[8]

Although ESI is popular, it has become increasingly costly for employers and employees, especially small firms and lower-income workers. According to 2023 data from the KFF's Employer Health Benefits Survey:

- Fifty-three percent of all firms offered health benefits, down slightly from five years ago (57 percent). Almost all (98 percent) large employers (those with 200 or more workers) offered coverage to at least some workers while just over half (53 percent) of smaller firms (those with three to 199 workers) did so.
- Seventy-five percent of eligible employees took up coverage when it was offered to them, a slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent).[9]
- Annual health insurance premiums averaged $8,435 for individual coverage and $23,968 for family coverage, a seven percent increase over 2022. Notably, premiums for family coverage

have increased on average 22 percent since 2018 and 47 percent since 2013. Workers pay, on average, $6,575 annually toward the cost of family premiums.

- Most (77 percent) firms offered only one type of plan, and PPOs were the most common plan type offered. Large employers were more likely than smaller firms to offer more than one plan.[10]

In addition to premium contributions, most workers with ESI are responsible for cost-sharing expenses, including plan deductibles, copayments, and coinsurance. According to KFF's 2023 Employer Health Benefits Survey, the average annual deductible for employees with single coverage was $1,735, a figure that has increased more than 50 percent over the course of 10 years.[11] Overall, nearly a third of employees had plan deductibles of $2,000 or more, including almost half (47 percent) of workers at small firms, whose average annual deductible was $2,434 compared to $1,478 for employees of larger firms.[12]

ESI Affordability

KFF has also highlighted the lack of affordable family coverage options for workers at smaller firms employing fewer than 200 people. These employees pay on average $8,334 towards family coverage premiums each year with a quarter paying at least $12,000 annually, not including deductibles and other cost-sharing expenses.[13] A KFF analysis of data from its 2023 survey of consumer experiences with health insurance found that adults with incomes below 200 percent FPL who have ESI were significantly more likely than higher-income peers to report difficulties paying for medical care; treatment delays and declines in health due to insurance problems, such as prior authorization; dissatisfaction with the availability and quality of health providers in their plan's network; and more difficulty comparing plans and signing up for coverage.[14]

Several analyses have pointed out that workers with lower incomes are disproportionately burdened by ESI costs and usually pay a greater share of income toward employer plan premiums and other out-of-pocket expenses.[15] [16] [17] KFF research from 2022 found that, on average, families with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent for premiums).[18] More workers (over 20 percent, according to a 2019 KFF survey) [19] are covered by high-deductible plans, which can present additional challenges to lower-income employees even if a health savings account or health reimbursement account option is available to them. Though employers could utilize health benefit design strategies to address affordability issues facing lower-income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that lowered premium costs for lower-income employees while only five percent reported programs to lower their cost-sharing expenses.[20] COBRA coverage may also be too costly for some workers who are leaving a job.

Though many workers mistakenly think otherwise, they—not the firms they work for—pay the majority of ESI costs, both directly through contributions and indirectly through wage adjustments made to cover employers' health care costs.[21] Building on the literature linking growth in health insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between increased premium costs for workers with ESI family coverage and decreased earnings and increased income inequality.[22] Because workers earning lower wages contribute a greater share of income toward ESI premiums, the analysis posits that making employer plans more affordable for lower-wage workers could help address earnings inequality. This study also identified large disparities in premium costs as a percentage of income by race (African American and Latino families paid higher percentages of earnings toward premium costs than white families), and found

that over 30 years, families with ESI may have cumulatively lost, on average, more than $125,000 in earnings due to increases in premium costs.[23]

ACA Provisions on Affordability and Employer Shared Responsibility

Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible for "minimum essential coverage," which is broadly defined to include Medicare, Medicaid, and other public programs as well as ESI. Accordingly, individuals with offers of coverage from an employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either unaffordable or inadequate. In 2023, an employer plan was considered unaffordable if an employee's premium contribution exceeded 9.12 percent of that person's household income. This percentage threshold is adjusted annually for inflation and is 8.39 percent in 2024.[24] To be considered adequate, a plan must cover at least 60 percent of average costs (actuarial value); anything less is deemed inadequate.[25] The ACA provision making workers with affordable and adequate ESI offers ineligible to receive advance premium tax credits to purchase marketplace coverage is colloquially referred to as "the firewall." This affordability threshold was established to address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI market and prevent prohibitive increases in federal spending (for marketplace subsidies) while preserving ESI's position as the principal source of health coverage in this country.

As explained in a 2014 Council on Medical Service Report on the future of ESI, the ACA aimed to build upon the ESI framework and provide low-income, non-elderly individuals without access to ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup marketplace. As such, provisions in the ACA statute included incentives and penalties intended to prevent disruption to the ESI market. For example, to incentivize employers to continue offering coverage, the ACA contained an "employer shared responsibility" provision, also called the "employer mandate," which requires employers with 50 or more full-time employees to either offer affordable minimum essential coverage to full-time employees and their dependents or pay a penalty to the Internal Revenue Service (IRS).[26] Under this provision, employers face two potential penalties:[27]

- If an employer does not offer minimum essential coverage to at least 95 percent of its full-time employees and dependents, and at least one employee receives a premium tax credit for coverage offered through an ACA exchange, the employer faces a penalty that is based on all full-time employees (except 30), including those who have ESI or coverage from another source. In 2024, the penalty is $2,970 per employee.[28]
- If an employer offers coverage to at least 95 percent of its employees but at least one employee obtains a premium tax credit for ACA coverage due to the employer's coverage not being "affordable" or "adequate," the employer must pay a penalty for each employee who receives the premium tax credit. In 2024, the penalty is $4,460 per employee.[29]

AMA Policy on the ACA Affordability Threshold

In the early years of ACA implementation, a 2015 Council on Medical Service report on health insurance affordability recommended making changes to how affordable coverage is defined under the law in order to provide more workers and their families with access to marketplace plans when those plans are more affordable than employer plans. This report established Policy H-165.828, which included several provisions calling for the ACA's "family glitch" to be fixed and capping the tax exclusion for ESI as a funding stream to improve insurance affordability. Policy H-165.828[1] as originally written (prior to being amended in 2021) established AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to that which applies to the exemption from the individual mandate of the ACA.

In 2015 when this policy was adopted, individuals were deemed exempt from the ACA's individual mandate—which was repealed in 2017—if the lowest-priced coverage available to them cost more than 8.05 percent of their household income. The same year, individuals with employer coverage offers were eligible for ACA marketplace plan premium tax credits if their ESI premium contributions exceeded 9.56 percent of income. The aforementioned Policy H-165.828[1] was crafted to align the definitions of affordability with respect to being exempt from the individual mandate (>8.05 percent) and premium tax credit eligibility for individuals with ESI offers (>9.56 percent).

Policy H-165.828[1] was amended via adoption of the recommendations in a 2021 Council on Medical Service report to address new inconsistencies between the definition of affordability pertaining to premium tax credit eligibility and provisions in the American Rescue Plan Act of 2021 (ARPA), which extended eligibility for premium subsidies to people with incomes greater than 400 percent FPL and capped premiums for those with the highest incomes at 8.5 percent of their income. ARPA increased the generosity of premium tax credits and lowered the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan for everyone. At the time the report was written, in 2021, employer coverage with an employee share of the premium less than 9.83 percent of income was considered "affordable." To open the door to premium tax credit eligibility to individuals with ESI premiums that were above the maximum affordability threshold applied to subsidized marketplace plans, Policy H-165.828[1] was amended to establish AMA support for:

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized ACA coverage.

Federal Subsidies for ACA Premium Tax Credits/Cost-Sharing and ESI Tax Benefits

In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and the Basic Health Program (BHP) at a cost of $92 billion.[30] This figure includes ARPA federal subsidy enhancements for premium tax credits and cost-sharing reductions that were extended through 2025 by the Inflation Reduction Act (IRA). Prior to ARPA, required premium contribution percentages ranged from about two percent of household income for people with poverty level income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL; people earning more than 400 percent FPL were not eligible for premium tax credits.[31] This year, as shown in Table 1, required premium contribution percentages range from zero for people with less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

Table 1: Required Individual Contribution Percentage for 2024[32,33]

Household income percentage of Federal poverty line:	% at start of range	% at top of range
Less than 150%	0.00%	0.00%
At least 150% but less than 200%	0.00%	2.00%
At least 200% but less than 250%	2.00%	4.00%
At least 250% but less than 300%	4.00%	6.00%

At least 300% but less than 400%	6.00%	8.50%
At least 400% and higher	8.50%	8.50%

Premium tax credits for ACA marketplace coverage are calculated by subtracting the required contribution from the actual cost of the "benchmark" plan, though the credit can be applied toward any marketplace plan except catastrophic coverage.[34] People with incomes below 250 percent FPL also receive subsidies for cost-sharing expenses that are based on income, so that people with incomes between 100 and 150 percent FPL receive the most generous subsidies.[35] These cost-sharing reductions are only available to those enrolled in silver plans. According to the CBO, in 2023 the average federal subsidy per ACA marketplace/BHP enrollee was $5,990.[36] The range of subsidy amounts is considerable, with small subsidy amounts provided to people with incomes around 400 or more percent of the FPL and subsidies worth around $15,000 for families with the lowest incomes.

The federal government subsidizes ESI via tax benefits provided to employers and employees that exclude premium contributions from federal income and payroll taxes. The amount of an individual's subsidy depends on that person's marginal tax rate that would be owed if employer-paid premiums were taxed as wages. Accordingly, people with greater incomes and higher marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower tax rates.[37] According to the CBO, the average federal subsidy per ESI enrollee in 2023 was $2,170.[38]

In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended by the IRA, several analysts have observed the growing disparity between federal subsidies that help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies that would be received by a family of four with $75,000 in income, depending on whether they purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-based plan, their tax subsidy would be around $4,100, compared to the more than $15,000 in federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.[39] Other analyses have noted that workers with lower incomes may be contributing more for an employer-based plan than they would pay for coverage under a subsidized marketplace plan, and that it would be financially advantageous for these workers to move to the marketplace.[40]

Some employees who would be financially incentivized to enroll in a marketplace plan if the firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services (CMS) has previously acknowledged the proliferation of narrow networks among ACA exchange plans, and several studies have demonstrated varying degrees of challenges facing marketplace enrollees attempting to access in-network providers, most commonly mental health specialists. A 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in marketplace plans but that networks may also be limited in lower-quality employer plans.[41] The Council has previously observed that, while marketplace plans may be attractive to some people because their premium prices are lower, purchasers may not be aware that a plan's provider network could be narrower and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their employer plan to avoid possible care disruptions and to preserve relationships with their treating physicians. Depending on income and a range of other factors, this could be true for some employees who utilize more services and medications or who have a family member on their plan who has a health condition that requires timely access to specialty care.

POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

During the development of this report, the Council reviewed papers from a broad spectrum of organizations and also met with subject matter experts who suggested a range of approaches to improving affordability in ESI and nongroup markets. Review of the literature uncovered a handful of data analyses and a range of conflicting opinions on the best way forward. The studies generally agreed that lifting the firewall would increase access to lower cost insurance for people with low incomes. However, they differed in their assessment of the percent of the population that would move from ESI to the ACA marketplace, the impact of employer behavior, and their willingness to support increased federal health spending. These studies are summarized below in alphabetical order.

American Enterprise Institute (AEI): A 2020 paper published by AEI recognizes both the value of ESI to many Americans as well as its flaws, including rising costs for both employers and employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of a framework for a more stable ESI system, including the provision of a tax benefit for employers that would be applied to employee premiums. According to AEI, such firm-level tax credits could provide greater support to lower-income employees but less support to those with higher incomes.[42]

Bipartisan Policy Center (BPC): A 2022 BPC report recognizes that ESI is less affordable for lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the federal government. Instead, BPC recommends that Congress adjust the affordability threshold to align with the percentage cap on premium contributions for marketplace plans.[43]

Center on Budget and Policy Priorities (CBPP): A 2019 CBPP analysis acknowledged that eliminating the firewall would improve equity but concluded that a full repeal would be too costly to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more robust benefit standards for ESI plans.[44]

Commonwealth Fund: A 2020 analysis found that, depending on marketplace subsidy amounts in place, between six and 13 percent of people with ESI would pay lower premium amounts if they were able to switch to marketplace plans. Importantly, the paper pointed out that people with the lowest incomes would benefit the most from lower marketplace premiums, as would African American, Latino, American Indian and Alaska Native individuals. According to the brief, much is unknown about potential employer responses to elimination of the firewall, including whether firms will incentivize sicker workers to move to exchange plans or stop offering coverage altogether.[45]

A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2 million people with incomes below 150 percent of FPL and 6.5 million people with income between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if the firewall were eliminated. The analysis states that “most” of these newly eligible individuals currently have ESI although some are paying full premiums for nongroup plans.[46]

Congressional Budget Office (CBO): In 2020, the CBO estimated that approximately 25 percent of workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained

that, although firms would respond differently to a lifting of the firewall, most of the savings incurred would likely be passed on to employees and adverse selection would be minimized.[47]
Urban Institute: Data presented to the Council but not yet published at the time this report was written estimated that eliminating the firewall would decrease ESI coverage by two percent or less, increase federal spending by about $20 billion, decrease the number of uninsured individuals, slightly increase provider revenue, and decrease employer spending and household spending.[48]

RELEVANT AMA POLICY

Policy H-165.829 encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges. Among its many provisions, Policy H-165.920 supports:

- A system where individually owned health insurance is the preferred option but employer-provided coverage is still available to the extent the market demands it;
- An individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer-provided coverage; and
- A replacement of the present federal income tax exclusion from employee's taxable income of employer-provided insurance coverage with tax credits for individuals and families.

Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. Policy H-165.843 encourages employers to promote greater individual choice and ownership of plans; enhance employee education regarding how to choose health plans that meet their needs; and support increased fairness and uniformity in the health insurance market. Policy H-165.881 advocates for equal-dollar contributions by employers irrespective of an employee's health plan choice. Policy H-165.854 supports Health Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to reimburse employees for their medical expenses—as one mechanism for empowering patients to have greater control over health care decision-making.

Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. Policy H-165.828, which as previously noted addresses the affordability threshold (firewall), also supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability.

Policy H-165.823 supports a pluralistic health care system and advocates that eligibility for premium tax credit and cost-sharing assistance to purchase a public option be restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits. This policy sets additional standards for supporting a public option and states that it shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid at no or nominal cost.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. As ESI continues to be the dominant source of health coverage for people under 65 years of age, most people who have employment-based coverage seem satisfied with it. Still, the Council acknowledges that because of shortcomings inherent to the ESI system—including equity and affordability concerns, and rising costs—it does not work well for everyone, especially workers with lower incomes and those at smaller firms paying for costly family coverage.

As explained in this report, people with higher earnings receive larger federal ESI subsidies than their lower-income peers and employees with lower incomes pay a greater share of earnings towards ESI expenses. The Council recognizes that federal tax benefits available to ESI subscribers most in need are not nearly as generous as the enhanced subsidies available to many low- and moderate-income individuals enrolled in ACA marketplace plans. Because the disparity between subsidy amounts for people with ESI and those with marketplace coverage has widened as marketplace subsidies have increased and ESI costs have continued to grow, the Council agrees that it is an appropriate time to revisit AMA policy on the firewall (Policy H-165.828[1]), which supports lowering the affordability threshold to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).

During the development of this report, the Council reviewed the literature and heard from experts holding an array of views on the potential impacts of fully eliminating the firewall, which is the policy change requested by referred Resolution 103-A-23. Although the Council cannot estimate with certainty how many people would switch from ESI to exchange plans over time if the firewall was repealed, the impact on coverage patterns could be significant. Even less is known about potential employer responses to a repeal, which cannot be predicted and will likely vary, with some firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage altogether, and without assurances that employer savings would be passed along to workers. Still, we understand that the firewall is problematic for some employees, including lower-income workers who may be contributing more for an employer plan than they would pay for marketplace coverage and those whose firms offer little to no choice of health plans. Even among employees who would benefit financially from transitioning to the marketplace, some may opt to retain ESI coverage if they are satisfied with that plan, concerned about the network breadth of exchange plans, or interested in preserving relationships with their treating physicians.

The impact of eliminating the firewall on physician payment rates is also difficult to predict, since payment rates in the nongroup market tend to vary, though they are generally lower than rates paid in the ESI market. The Council's main concerns about eliminating the firewall abruptly and in full include the potential impacts on ESI stability, which may not be wholly understood, and the potential substantial costs that would be incurred by the federal government, which already spends upwards of $1.8 trillion on health insurance subsidies—across all coverage programs—each year.[49] Allowing all ESI enrollees access to ACA marketplace subsidies might prove to be prohibitively expensive. We cannot estimate the exact costs of eliminating the firewall, which would depend on how many workers ultimately move to exchange plans but the costs easily total tens of billions of dollars or more per year, especially if enhanced federal marketplace subsidies remain in place after

2025. We believe that budgetary considerations may make the full repeal option unrealistic, financially, and also politically since it would be unpopular with ESI proponents, including employers using health coverage offers as recruiting tools. For these reasons, the Council supports incrementally reducing the affordability threshold so that it benefits workers most in need, and then monitoring the effects of this change on coverage patterns, federal and consumer health spending, and employer behavior. Accordingly, the Council recommends amending Policy H-165.828[1] to support lowering the threshold that determines whether an employee's premium contribution is affordable to the maximum percentage of income they would be required to pay, after accounting for subsidies, towards premiums for an ACA benchmark plan (second-lowest-cost silver plan). The Council is optimistic that this change, if enacted, may also encourage some employers to offer more affordable coverage in order to keep attracting workers.

The Council also suggests additional recommendations that are intended to strengthen the quality and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are more likely to report difficulties covering the costs of medical care and who may not know if they are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to: 1) implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of ESI; and 3) provide employees with information regarding available health plan options, including the plans' cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs. The Council recognizes that employers are already required to provide employees with notice about the ACA marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost coverage in the marketplace. However, it may be challenging for some employees to determine whether they are eligible for marketplace subsidies without tools to help them do so.

The Council also notes that large employers are subject to a 60 percent actuarial value standard compared to the 70 percent standard required of silver plans on the marketplace (an 80 percent actuarial standard is required for gold plans; 60 percent for bronze). Notably, marketplace plans are also subject to more rigorous essential health benefits standards. To address these disparities in standards, the Council recommends general support for efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards. Finally, the Council recommends reaffirmation of AMA policies most relevant to this report: Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance; and Policy H-165.920, which supports principles related to individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it.

RECOMMENDATIONS

The Council on Medical Service recommends that the following recommendations be adopted in lieu of Resolution 103-A-23, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition and deletion to read:

   Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the ~~level at which~~

~~premiums are capped for individuals with the highest incomes eligible for subsidized coverage~~ maximum percentage of income they would be required to pay towards premiums after accounting for subsidies ~~in~~ for an Affordable Care Act (ACA) marketplace~~s~~ benchmark plan. (Modify HOD Policy)

2. That our AMA amend Policy H-165.843 by addition and deletion to read:

Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria;
c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
~~c~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
~~d~~f) support increased fairness and uniformity in the health insurance market; and
~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)

3. That our AMA support efforts to strengthen employer coverage offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards, like those required of nongroup marketplace plans. (New HOD Policy)

4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance. (Reaffirm AMA Policy)

5. That our AMA reaffirm Policy H-165.920, which supports individually purchased and owned health insurance coverage as the preferred option, although employer-provided coverage is still available to the extent the market demands it, and other principles related to health insurance. (Reaffirm AMA Policy)

Fiscal Note: Less than $500.

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Appendix

Policies Recommended for Amendment and Reaffirmation

Health Insurance Affordability H-165.828
1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace. (CMS Rep. 8, I-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmation: A-17 Reaffirmed: CMS Rep. 09, A-19 Reaffirmed: CMS Rep. 02, A-19 Reaffirmed in lieu of: Res. 101, A-19 Reaffirmed: CMS Rep. 01, I-20 Reaffirmed: CMS Rep. 2, I-20 Modified: CMS Rep. 3, I-21 Appended: Res. 701, I-21)

Trends in Employer-Sponsored Health Insurance H-165.843
Our AMA encourages employers to:
a) promote greater individual choice and ownership of plans;
b) enhance employee education regarding how to choose health plans that meet their needs;
c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
d) support increased fairness and uniformity in the health insurance market; and
e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (CMS Rep. 4, I-07 Reaffirmed: CMS Rep. 01, A-17)

Expanding Choice in the Private Sector H-165.881
Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by

employers irrespective of an employee's health plan choice and mexpanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97 Reaffirmed BOT Rep. 6, A-98 Reaffirmation A-02 Reaffirmed: CMS Rep. 4, A-12 Reaffirmation: A-19)

Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;
(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a “maintenance of effort” period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;

(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93 CMS Rep. 11, I-94 Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5, I-97 Res. 212, I-97 Appended and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3,
A-02 Reaffirmed: CMS Rep. 3, I-02 Reaffirmed: CMS Rep. 3, A-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07 Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11 Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17)