REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (NOV-21)
Covering the Remaining Uninsured
(Resolution 123-J-21)
(Reference Committee A)

EXECUTIVE SUMMARY

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The Council analyzed the remaining uninsured post-ARPA to assess whether new American Medical Association (AMA) policy is needed targeting select segments of the remaining uninsured. After reviewing AMA policy as well as health reform legislation and regulation at the state and federal levels, the Council sees an opportunity to further maximize coverage rates and improve affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for Affordable Care Act (ACA) financial assistance due to falling into the coverage gap, immigration status, or having an "affordable" offer of employer coverage.

The Council is highly concerned about the more than two million uninsured who fall into ACA's coverage gap. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, hand protect against current expansion states from dropping their Medicaid expansions.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/Children's Health Insurance Program. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for undocumented immigrants and Deferred Action for Childhood Arrivals recipients, but also recognize state and local efforts to provide coverage to immigrants regardless of immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an "affordable" employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA's "family glitch," to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

The Council recognizes there is strong interest in the House of Delegates in how best to cover the population ages 60-64. In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. The AMA proposal for reform, as well as the recommendations of this report, strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-N-21

Subject: Covering the Remaining Uninsured (Resolution 123-J-21)

Presented by: Asa Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

With the enactment of the most recent COVID-19 relief bill, the American Rescue Plan Act of 2021 (ARPA), into law, the coverage dynamics in the US have shifted. The nation has witnessed record enrollment in Affordable Care Act (ACA) coverage, via coverage offered on ACA marketplaces and under the Medicaid expansion, as well as through the Special Open Enrollment Period that recently ended. Resulting from the ARPA, a significant proportion of the uninsured is now eligible for ACA financial assistance, either in the form of premium tax credits to purchase marketplace coverage, or Medicaid. However, some segments of the uninsured population continue to be left behind, with potential negative effects on their health outcomes and financial security, as well as systemwide impacts resulting from how their care is provided and financed. After reviewing American Medical Association (AMA) policy as well as health reform legislation and regulation at the state and federal levels, the Council concluded that new and innovative AMA policy is needed targeting select segments of the uninsured population.

Subsequently, at the June 2021 Special Meeting of the House of Delegates, Resolution 123, Medicare Eligibility at Age 60, was referred. Introduced by the Medical Student Section, Resolution 123 asked that our AMA advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates.

This report provides background on the ACA improvements included in the ARPA; outlines the AMA proposal for reform; analyzes the need for new AMA policy to improve the coverage rates for each segment of the post-ARPA uninsured; examines the uninsured population ages 60 to 64 and evaluates potential pathways to increase coverage to this population, including lowering the Medicare eligibility age; and presents policy recommendations.

BUILDING UPON THE ACA: THE AMERICAN RESCUE PLAN ACT

The ARPA represents the largest coverage expansion since the ACA. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the federal poverty level (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) have been provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. However, consistent with Policy H-165.824, the ARPA eliminated ACA's subsidy "cliff" for 2021 and 2022. As a result, individuals and families with incomes above 400 percent FPL ($51,040 for an individual and $104,800 for a family of four based on 2020 federal poverty guidelines) are eligible for premium tax credit assistance. Individuals eligible for premium tax credits include individuals who are offered an employer plan that does not

have an actuarial value of at least 60 percent (i.e., 60 percent of benefit costs covered) or if the employee share of the premium exceeds 9.83 percent of income in 2021.

Also consistent with Policy H-165.824, ARPA increased the generosity of premium tax credits for two years, lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark (second-lowest-cost silver) plan. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. Notably, resulting from the changes, eligible individuals and families with incomes between 100 and 150 percent of the federal poverty level (133 percent and 150 percent FPL in Medicaid expansion states) now qualify for zero-premium silver plans, effective until the end of 2022. In addition, individuals receiving unemployment compensation who qualify for exchange coverage are eligible for a zero-premium silver plan in 2021.

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 reduces their deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. The only change ARPA made to cost-sharing reduction eligibility and generosity was targeted to those receiving unemployment compensation. Individuals receiving unemployment compensation in 2021 who qualify for exchange coverage and enroll in a silver plan–regardless of income–are eligible for substantial cost-sharing reductions.

At the time that this report was written, 38 states and the District of Columbia had adopted the Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.[1] ARPA included new incentives for states to implement Medicaid expansions. 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 newly implement the Medicaid expansion, applicable to a large share of their Medicaid population and spending. In the near term, the new 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 PROPOSAL FOR REFORM

Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the ACA, the AMA proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage environment. The AMA proposal for reform focuses on expanding health insurance coverage to four main population targets:

1. Individuals eligible for ACA's premium tax credits who remain uninsured (11 million);
2. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) who remain uninsured (7.3 million);
3. People who remain uninsured who are ineligible for ACA's premium tax credits due to an offer of "affordable" employer-sponsored coverage (3.5 million); and
4. People with low incomes who remain uninsured and are ineligible for Medicaid (2.2 million).[2]

By appropriately targeting the provision of coverage to the uninsured population, the AMA proposal for reform has aimed to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Premium tax credits would be available to individuals without an offer of "affordable" employer coverage, with no upper income limit (Policy H-165.824).
- Individuals currently caught in the "family glitch" and unable to afford coverage offered through their employers for their families would become eligible for ACA financial 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 9.83 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 (Policy 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).
- Public options would be explored as potential pathways to provide health insurance coverage to uninsured individuals who fall into the "coverage gap" at no or nominal cost, provided that they meet the standards outlined in Policy H-165.823.
- To maximize coverage rates, the AMA would support the auto-enrollment of individuals who qualify for zero-premium marketplace coverage or Medicaid/CHIP in health insurance coverage, and continue to support the use of individual mandate penalties at the state and federal levels (Policies H-165.823, H-165.824 and H-165.848).
- 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).

NEED FOR NEW AMA POLICY TO ADDRESS THE POST-ARPA UNINSURED: FILLING IN URGENT POLICY GAPS

While the exact number of the uninsured is in flux due to the COVID-19 pandemic and resulting changes in employment and eligibility for either ACA premium assistance or Medicaid, Kaiser Family Foundation (KFF) released estimates that offer a profile of the post-ARPA uninsured. Of note, these estimates are based on 2019 American Community Survey data; the time delay may affect overall numbers, but these estimates are still expected to provide a representative overview of the uninsured population. Overall, KFF estimates that 28.9 million nonelderly individuals are uninsured.[3] The Council has analyzed the remaining uninsured post-ARPA to assess whether new AMA policy is needed targeting select segments of the remaining uninsured. The Council's analysis concluded that how to best cover three segments of the uninsured population is currently not sufficiently addressed in AMA policy and AMA's plan to cover the uninsured: the uninsured who are ineligible for ACA financial assistance due to falling into ACA's coverage gap, the uninsured who are ineligible for ACA financial assistance due to immigration status, and the uninsured ineligible for ACA financial assistance due to having an offer of affordable employer coverage. Critically, without the implementation of policy solutions for these populations, many will be left without any affordable coverage options.

Uninsured Ineligible for ACA Financial Assistance Due to Falling into ACA's Coverage Gap

Resulting from states not implementing the Medicaid expansion provided for under the ACA, more than two million of the nonelderly uninsured find themselves in the coverage gap–not eligible for Medicaid, and not eligible for premium tax credits because they reside in states that did not expand Medicaid.[4] 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.[5] Of note, an additional 1.8 million uninsured adults in non-expansion states with incomes between 100 and 133 percent FPL are currently eligible for premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage but would become eligible for Medicaid if their state implemented the Medicaid expansion.[6]

Medicaid eligibility for adults in states that did not expand their Medicaid programs is quite limited. The median limit for parents in these states is 40 percent FPL. Childless adults–regardless of income–remain ineligible for Medicaid in nearly all states that did not expand their Medicaid programs. Significantly, childless adults make up more than three of four individuals who fall into the coverage gap. Overall, approximately half of individuals who fall into the coverage gap have incomes under 50 percent FPL, which amounts to $6,440 per year for an individual, or $537 per month.[7]

Approximately two-thirds of individuals in the coverage gap are in working families, with half working themselves.[8] Overall, individuals who fall in the coverage gap are in households in which workers earn low wages, work part-time, or are not consistently employed. Without access to Medicaid or heavily subsidized marketplace coverage, the uninsured in the coverage gap simply do not have access to affordable coverage options. For example, in 2021, the national average unsubsidized premium for a 40-year-old non-smoker seeking coverage on ACA marketplaces was $436 per month for the lowest-cost silver plan and $328 per month for a bronze plan. This is

equivalent to roughly 80 percent of income for those at the lower income range of the coverage gap (below 40 percent FPL), and nearly a third of income for those with incomes closer to the poverty line.[9]

Assessment of the Need for New AMA Policy

Policy D-290.979 states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. Policy H-290.965 supports states that newly expand Medicaid being made eligible for three years of full federal funding. Policy H-290.966 encourages policymakers at all levels to focus their efforts on working together to identify realistic coverage options for adults currently in the coverage gap; encourages states that are not participating in the Medicaid expansion to develop waivers that support expansion plans that best meet the needs and priorities of their low income adult populations; and encourages the Centers for Medicare & Medicaid Services (CMS) to review Medicaid expansion waiver requests in a timely manner, and to exercise broad authority in approving such waivers, provided that the waivers are consistent with the goals and spirit of expanding health insurance coverage and eliminating the coverage gap for low-income adults. Policies H-165.920 and H-165.865 advocate for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits. Policy H-165.855 encourages state demonstrations to provide coverage to their Medicaid beneficiaries using subsidies that enable acute care Medicaid beneficiaries to obtain private health insurance. Policy H-165.823 states that any 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 credit eligibility–at no or nominal cost.

At the time that this report was written, there were three main pathways to provide coverage to the uninsured who fall into the coverage gap. One strategy, as past COVID-19 relief bill provisions aimed to do, would be to provide more incentives to states to adopt ACA's Medicaid expansion. The Council notes that, at this juncture, it is unclear whether additional financial incentives would cause any additional states to expand Medicaid. Another strategy would be to extend eligibility for premium tax credits and cost-sharing reductions to individuals with incomes below the poverty line, the current floor for eligibility. Lastly, the establishment of a federal Medicaid-like program or another type of public option has been discussed to cover those individuals who fall in the coverage gap in non-expansion states. While the AMA has policy relevant to each of the leading legislative approaches to provide individuals in the coverage gap with a source of health insurance coverage, the Council believes that new policy is needed to address the affordability of coverage offered under any federal approach to provide coverage to this population, as well as the impacts of any intervention on states that have already expanded Medicaid. The Council believes that there is a need for new policy to ensure that any federal approach targeted at the uninsured who fall in the coverage gap makes health insurance coverage available to this population at no or nominal cost, with significant cost-sharing protections. In addition, the Council believes that it is critical for any federal approach to address the coverage gap protect against current expansion states from dropping their Medicaid expansions.

Uninsured Ineligible for ACA Financial Assistance Due to Immigration Status

Almost four million of the nonelderly uninsured are ineligible for ACA financial assistance due to their immigration status.[10] Overall, lawfully present and undocumented immigrants were significantly more likely to be uninsured than citizens in 2019. Among the nonelderly population, 25 percent of lawfully present immigrants and 46 percent of undocumented immigrants were

uninsured, compared to nine percent of citizens. Critically, noncitizen children are more likely to be uninsured than citizen children.[11]

The higher uninsured rate among noncitizens is partially rooted in eligibility restrictions for Medicaid, CHIP and ACA marketplace coverage. Currently, many qualified non-citizens, including many lawfully permanent residents or green card holders, face a five-year waiting period after receiving qualified immigration status before becoming eligible for Medicaid and CHIP. Populations exempt from the five-year waiting period include refugees, asylees and lawfully permanent residents who used to be refugees or asylees. States currently have the option to eliminate the five-year waiting period for lawfully present children and pregnant women without a qualified immigration status. At the time this report was written, 35 states have extended coverage to affected children, with half of states having done so for impacted pregnant women.[12]

An alternative to coverage for lawfully present immigrants who are affected by the five-year waiting period or do not have a qualified immigration status is to seek coverage on ACA marketplaces and receive subsidies for coverage. These lawfully present immigrants with incomes below the poverty line are eligible to receive premium tax credits and cost-sharing reductions to purchase ACA marketplace coverage even if they are ineligible for Medicaid based on their immigration status. Lawfully present immigrants with incomes between 100 and 400 percent of FPL are eligible for premium tax credits and cost-sharing reductions to purchase coverage if they are not eligible for other coverage.

However, 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 CMS. With these restrictions in place, 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.

Assessment of the Need for New AMA Policy

Policy H-290.983 opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. Policy H-440.903 directs the AMA to actively lobby federal and state governments to restore and maintain funding for public health care benefits for all lawfully present immigrants. Policy H-350.957 advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees. Policy H-440.876 opposes any policies, regulations or legislation that would criminalize or punish physicians and other health care providers for the act of giving medical care to patients who are undocumented immigrants; opposes any policies, regulations, or legislation requiring physicians and other health care providers to collect and report data regarding an individual patient's legal resident status; and opposes proof of citizenship as a condition of providing health care. Policy D-440.985 states that our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.

The Council believes that existing policy sufficiently addresses the need to provide health insurance coverage to lawfully present immigrants and has enabled the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/CHIP. The Council is cognizant that proper knowledge surrounding eligibility for

benefits is key to eligible immigrants enrolling in Medicaid, CHIP or marketplace coverage. The Council believes that existing policy addressing outreach and enrollment assistance for Medicaid/CHIP coverage, and financial assistance to purchase marketplace coverage, is sufficient to address this barrier to enrollment in coverage. However, there remains a gap in AMA policy that provides an avenue for undocumented immigrants and DACA recipients to access coverage options. There is a need for AMA policy in support of allowing undocumented immigrants and DACA recipients to purchase unsubsidized coverage on ACA marketplaces, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status. Without that guarantee in place, fear of immigration enforcement could preclude a segment of the immigrant population from enrolling in coverage. AMA policy also may be needed to address state and local initiatives to provide coverage to immigrants regardless of their immigration status; existing policy only addresses the reimbursement for the care provided to undocumented immigrants.

Uninsured Ineligible for ACA Financial Assistance Due to Having an Affordable Offer of Employer Coverage

Approximately 3.5 million of the nonelderly uninsured are ineligible for ACA's premium tax credits because they have an "affordable" offer of employer-sponsored insurance coverage.[13] To be considered "affordable," employer coverage must have an actuarial value of at least 60 percent and the employee share of the premium must be less than 9.83 percent of income in 2021. Notably, following the enactment of ARPA into law, inconsistencies now exist between the definition of affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the percentage of income at which premiums are capped for individuals with the highest incomes eligible for subsidized marketplace coverage. Premiums of the second-lowest-cost silver plan for individuals with incomes at and above 400 percent FPL are capped at 8.5 percent of their income. But employer coverage with an employee share of the premium less than 9.83 percent of income is considered to be "affordable."

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. Defining the affordability of employer coverage based on the premium contribution for employee-only coverage, and not family-based coverage, is rooted in ambiguity within the ACA as to how affordability is defined for family members of employees offered employer-sponsored coverage. As a result, the Joint Committee on Taxation interpreted the law to base the definition of employer-sponsored coverage solely on the cost of employee-only coverage; this interpretation was ultimately adopted in regulations issued by the Internal Revenue Service. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. The average employee contribution for self-only coverage was estimated to be $1,243 in 2020, while the average contribution for family coverage was estimated to be $5,588.[14]

The "family glitch" leaves many 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 9.83 percent of their income for family coverage. Overall, 5.1 million individuals fall into ACA's family glitch, more than half of whom are children. Of this number, 4.4 million are currently covered by an employer plan, 315,000 are enrolled in unsubsidized individual market coverage, and 451,000 are uninsured.[15] A study from 2016 estimated that, on average, families who fall into the family glitch spent 15.8 percent of their incomes on employer-sponsored coverage.[16]

Assessment of the Need for New AMA Policy

Policy H-165.828 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 ACA. Existing AMA policy, therefore, does not take into consideration the inconsistency between the definition of affordable coverage pertaining to eligibility for premium and cost-sharing subsidies for those offered employer coverage, and the percentage of income at which premiums are capped for individuals with the highest incomes eligible for subsidized marketplace coverage. The Council believes that this inconsistency should be rectified.

Policy H-165.828 also supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage. However, current discussions surrounding fixing ACA's family glitch are exploring a different solution to fixing the glitch, which would in effect decouple the worker from their family in determining eligibility for premium tax credits to purchase coverage. As such, a spouse and/or child in a family offered "affordable" employee-only coverage but unaffordable family coverage would become eligible for premium subsidies to purchase marketplace coverage. The worker, meanwhile, would remain only eligible for the employee-only employer-sponsored coverage, not premium subsidies to purchase coverage on the ACA marketplaces. Because employees would not be newly eligible for premium tax credits, there would be no impact on liability for employers under the employer mandate, as the mandate is only applicable if an employee receives subsidies, not their family members.

Under this option, the family would be covered by at least two different health plans and would be responsible for the premiums associated with each plan, including that associated with the employee-only employer-sponsored coverage as well as that associated with the marketplace plan. Accordingly, not all families would necessarily be better off switching from their employer-sponsored family plan. However, many families would be better off, even those that may still need to pay more than 9.83 percent of their income for coverage of their entire family between employer-sponsored and marketplace plan premiums. It has been estimated that families switching from their employer plans would save approximately $400 per person in premiums on average, with families with incomes below 200 percent FPL saving $580 per person. Overall, while some currently covered by employer-sponsored coverage would transition to marketplace or Medicaid/CHIP coverage under this approach to fixing the family glitch, it also has been projected to cover nearly 200,000 uninsured individuals impacted by ACA's family glitch.[17]

POST-ARPA UNINSURED POPULATIONS FOR WHOM AMA POLICY IS SUFFICIENT: LOOKING AHEAD

The Council's analysis concluded that AMA policy sufficiently addresses how best to cover three segments of the post-ARPA uninsured population: the uninsured eligible for ACA premium tax credits, the uninsured eligible for Medicaid, and the uninsured who have an affordable ACA marketplace plan available to them without the need for any subsidy. That being said, the Council underscores the need for AMA policy to be implemented to cover these populations, ranging from ramping up outreach and enrollment assistance, to making additional improvements to ACA's premium tax credits and cost-sharing subsidies, to implementing auto-enrollment for those eligible for zero-premium marketplace plans or Medicaid.

Uninsured Eligible for ACA Premium Tax Credits

Eleven million of the nonelderly uninsured are eligible for premium tax credits, at least six million of whom are eligible for zero-premium marketplace plans.[18] Of those individuals eligible for zero-premium marketplace plans, approximately 1.3 million have incomes below 150 percent FPL ($19,140 for an individual and $39,300 for a family of four based on 2020 federal poverty guidelines) and are eligible for zero-premium silver plans with cost-sharing reductions that result in their deductibles being reduced to an average of $177 and thus resembling platinum-level coverage[19] (90 percent of benefit costs covered). Individuals receiving unemployment compensation in 2021 who qualify for exchange coverage and enroll in a silver plan–regardless of income–are also eligible for substantial cost-sharing reductions that also cause their coverage to resemble that of a platinum plan. Even with the additional premium assistance provided for in the ARPA, a segment of the uninsured eligible for premium tax credits may not see the benefit in getting covered if they cannot afford their deductibles, copayments, and other cost-sharing responsibilities.

Assessment of the Need for New AMA Policy

Under Policy H-165.824, (1) there would be adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) 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; (3) young adults facing high premiums would be eligible for "enhanced" tax credits based on income; (4) eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll; (5) 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; and (6) the subsidy "cliff" would be eliminated. Policy H-165.823 highlights the potential for auto-enrollment as a strategy to cover the more than six million individuals eligible for zero-premium marketplace plans who remain uninsured.

As such, the Council believes that existing AMA policy is sufficient to address how best to cover uninsured individuals eligible for premium tax credits. Policy H-165.823 would provide a pathway for the six million uninsured individuals eligible for zero-premium coverage to become insured. Policy H-165.824 would enable the AMA to not only advocate to make the ARPA enhancements–improved premium tax credit generosity and ACA subsidy cliff elimination–permanent, but would support advocacy efforts to take additional steps to make premiums more affordable for the uninsured who are subsidy-eligible, as well as tackle barriers posed by deductibles and cost-sharing requirements. The policy also recognizes that uninsured individuals eligible for premium tax credits can only enroll in subsidized coverage if they are aware that they are eligible, which is why outreach efforts are so critical.

Uninsured Eligible for Medicaid

More than seven million of the nonelderly uninsured are eligible for Medicaid/CHIP, which includes adults in the Medicaid expansion population and populations eligible for Medicaid/CHIP under pre-ACA rules but who have not enrolled.[20] The reasons for this group remaining uninsured remain multifaceted, ranging from not being aware of their eligibility for coverage, to perceived stigma associated with public coverage, to facing barriers to enrollment, including those which are administrative or technical in nature.

Assessment of the Need for New AMA Policy

To improve coverage rates of individuals eligible for Medicaid/CHIP but who remain uninsured, AMA policy supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). Policy H-165.823 states that individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/CHIP.

As such, the Council believes that existing AMA policy is sufficient to address how best to cover uninsured individuals eligible for Medicaid. Policy H-165.823 would provide a mechanism through which the uninsured who are Medicaid-eligible would be able to gain coverage via auto-enrollment. Until auto-enrollment for Medicaid-eligible individuals is able to be implemented, investments in outreach and enrollment assistance activities will be essential to get this segment of the uninsured covered.

Uninsured Who Have an Affordable Marketplace Plan Available to Them

More than one million of the nonelderly uninsured have an affordable ACA marketplace plan available to them with an unsubsidized benchmark premium that is less than 8.5 percent of their household income without a premium tax credit, making them ineligible for ACA financial assistance.[21] Of note, this segment of the uninsured has higher incomes, but removing ACA's subsidy cliff still does not make them eligible for premium assistance.

Assessment of the Need for New AMA Policy

Policy H-165.824 supports lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan. Policy H-165.848 supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance.

The Council notes that a segment of this population could potentially become eligible for premium tax credits if the cap on premiums as a percentage of income were lowered even further than what the ARPA accomplished. That being said, using a policy "stick" to get this population covered may be necessary, including a state and/or federal individual mandate penalty. Accordingly, the Council believes that existing AMA policy is sufficient to address how best to cover this segment of the uninsured population.

COVERING THE UNINSURED AGES 60 TO 64

Following the referral of Resolution 123 at the June 2021 Special Meeting of the House of Delegates, the Council examined the segment of the uninsured ages 60 to 64 to ascertain what improvements, if any, need to be made to AMA's proposal for reform to ensure that this population has a pathway to coverage, and to assess the merits of lowering the Medicare eligibility age to age 60. Of the 20.8 million individuals ages 60 to 64 in the US, 56.3 percent are enrolled in employer-sponsored coverage, 14.5 percent are enrolled in Medicaid, 11.3 percent are enrolled in non-group coverage, 10.1 percent are enrolled in other public coverage (e.g., Medicare and military coverage), and 7.8 percent are uninsured.[22]

Of the uninsured ages 60 to 64, nearly half are eligible for premium tax credits. Further, nearly 20 percent are eligible for Medicaid, 15 percent are ineligible for ACA financial assistance due to having an affordable offer of employer coverage, 10 percent fall in the coverage gap and seven percent are ineligible for ACA financial assistance due to immigration status.[23]

Assessment of the Need for New AMA Policy

The Council notes that the earlier sections of this report address how existing AMA policy pertains to each segment of the uninsured population ages 60 to 64. For the uninsured eligible for premium tax credits, making premium tax credit assistance more generous, and expanding eligibility for and improving the generosity of cost-sharing subsidies, will be highly beneficial. The Council understands that when this population is able to enroll in ACA marketplace coverage, affordable cost-sharing levels will be critical so they will be able to access the care they need. The Council believes that subsidized ACA marketplace coverage with improved cost-sharing assistance is the preferable option to cover this segment of the uninsured population ages 60 to 64, especially considering that most current traditional Medicare beneficiaries are enrolled in supplemental insurance through either a Medicare supplemental plan, Medicaid, or an employer to provide more comprehensive cost-sharing protections than what is offered in the traditional Medicare program. Subsidized ACA marketplace assistance would also become available to some of the uninsured ages 60-64 currently ineligible due to having an affordable offer of employer coverage under current AMA policy, as well as recommendations for new policy proposed in this report.

For uninsured individuals ages 60 to 64 who are eligible for zero-premium marketplace coverage, as well as the 20 percent of the uninsured eligible for Medicaid, the Council believes that auto-enrollment again can be used as a mechanism to provide health insurance to these individuals at no cost to them. Existing AMA policy, and recommendations for new policy in this report, applicable to the uninsured who fall in the coverage gap, and ineligible for ACA financial assistance due to immigration status, would also pertain to those ages 60 to 64.

The Council also recognizes the role Policy H-330.896 plays in improving the consistency between Medicare and Social Security eligibility. The policy supports restructuring Medicare's age-eligibility requirements and incentives to match the Social Security schedule of benefits. However, lowering the age to become eligible for Medicare from 65 to 60 is not consistent with the intent of Policy H-330.896, and is projected to have unintended consequences.

While lowering the age of Medicare eligibility to 60 could cover many of the uninsured in the 60-64 age bracket, the Council believes that the AMA proposal for reform, as well as the recommendations of this report, provide a better pathway to get this age cohort of the uninsured covered without causing significant health system changes and potential negative impacts to physicians, hospitals, and other entities. For example, lowering the age of Medicare eligibility to 60 has been projected by KFF to also have the potential to shift nearly 12 million individuals with employer coverage and 2.4 million with non-group coverage into Medicare.[24] Such a shift would notably impact the payer mix of physician practices. At the same time, only one-third of the approximately 1.6 million uninsured in this age cohort remains ineligible for premium tax credits to purchase marketplace coverage, or Medicaid, because they do not qualify for ACA financial assistance due to an affordable offer of employer coverage, falling into the coverage gap, or due to immigration status. Accordingly, the Council believes that the AMA proposal for reform can cover this population without the unwanted policy tradeoffs that lowering the Medicare eligibility age would present.

The Council recognizes that there are equity considerations associated with each alternative to cover the uninsured ages 60 to 64, and those associated with lowering the Medicare eligibility age must be examined. While lowering the Medicare eligibility age to 60 would open the door to Medicare to individuals aged 60-64, doing so would notably eliminate subsidized marketplace coverage eligibility for these individuals, potentially increasing their cost of coverage. They still would, however, be able to choose to remain on their employer-sponsored coverage. In light of the premium tax credit enhancements included in the ARPA, lower-income individuals currently enrolled in a marketplace plan may have the potential to face higher premiums in traditional Medicare. In addition, considering that half of the uninsured ages 60 to 64 are eligible for premium tax credits, the Council believes that they should not lose access to the most affordable coverage pathway available to them–critical for those with the lowest incomes. Avalere found that current marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries.[25] Accordingly, the Council believes that improving the generosity of premium tax credits and cost-sharing reductions, and making cost-sharing reductions available to more people, as outlined in AMA policy, provides low-income uninsured ages 60 to 64 with a more preferable choice of coverage option than lowering the Medicare eligibility age to 60.

Overall, lowering the Medicare eligibility age to 60 has been projected to cost $200 billion over ten years.[26] The aforementioned shift in coverage from employer coverage to Medicare shifts a large share in health spending to the federal budget. While certain proposals to date reiterate that lowering the Medicare eligibility age to 60 would be funded by general revenues, they would still need a pay-for. Proposals to lower the Medicare eligibility age to 60 could also threaten the fiscal stability of the Medicare Trust Fund. Notably, the Council emphasizes that the AMA proposal for reform would not only have a smaller fiscal footprint over a ten-year period, but also would not negatively impact the Medicare Trust Fund. The potential for other unintended consequences of lowering the Medicare eligibility age must be assessed, including on graduate medical education (GME).

Finally, the Council is highly concerned that lowering the Medicare eligibility age to 60 would negatively impact the payer mix of physician practices. It is expected that lowering the Medicare eligibility age to 60 would lower the revenues for physicians, hospitals, and other providers delivering care to the 60-64 age cohort. Physician and hospital payment rates from private plans tend to be higher than those paid by Medicare, with the difference between the two increasing over time.[27]

DISCUSSION

The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order to cover the remaining uninsured. The enactment of the ARPA into law has provided a preview as to what ACA improvements, many of which reflect the AMA proposal for reform, can accomplish. The Council underscores that Policy H-165.824 supports making the ARPA changes to the ACA permanent–increasing the generosity of premium tax credits as well as eliminating ACA's subsidy "cliff." However, the Council is cognizant that more needs to be done to cover the uninsured eligible for premium tax credits and Medicaid, as well as the uninsured already eligible for an affordable ACA marketplace plan without any subsidy. Policy H-165.823, by outlining the potential for auto-enrollment for the segment of the uninsured eligible for coverage options that would be of no cost to them after the application of any subsidies, provides a coverage pathway for the 7.3 million uninsured individuals eligible for Medicaid/CHIP and the six million eligible for zero-premium marketplace coverage. Until auto-enrollment is enacted for these populations, the Council believes that outreach and enrollment assistance efforts will be absolutely critical, so

individuals are aware that they are eligible for premium tax credits or Medicaid/CHIP and receive any necessary assistance to enroll in coverage. Outreach and enrollment assistance efforts are also vital to facilitate the enrollment of immigrants eligible for ACA financial assistance in health insurance coverage.

Policy H-165.824 also contains highly important provisions to improve the affordability of not only the premiums for individuals who remain uninsured despite being eligible for premium tax credits as well as those who already have access to an affordable marketplace plan, but also deductibles and other cost-sharing obligations. A component of the uninsured may not see the benefit to enrolling in coverage if they know they will not be able to afford the cost-sharing responsibilities of the plan in which they can enroll. In addition, uninsured individuals already eligible for affordable ACA marketplace coverage without any subsidy may need the "stick" of an individual mandate penalty to get coverage, advocated for in Policies H-165.848 and Policy H-165.824.

However, the Council sees an opportunity to further maximize coverage rates and improve coverage affordability under the AMA proposal for reform by either amending existing policy, or establishing new policy, impacting the uninsured ineligible for ACA financial assistance due to falling into the coverage gap, immigration status, or having an affordable offer of employer coverage. The Council is highly concerned about the more than two million uninsured who fall into ACA's coverage gap. It has been the hope of the Council that, following existing AMA policy, the states that have not yet expanded their Medicaid programs would do so, and enjoy the associated significant, positive financial incentives. With policy alternatives emerging to cover this segment of the uninsured, ranging from making them eligible for premium tax credits and cost-sharing reductions to purchase marketplace coverage, to establishing a standalone federal Medicaid-like program or other public option, the Council underscores that Policies H-165.838 and H-165.823 recommended for reaffirmation collectively constitute a critical baseline for any federal approach to cover the uninsured who fall in the coverage gap to meet. In addition, the Council recommends new policy to advocate that any approach to cover the uninsured who fall into the coverage gap ensure this population has access to affordable, quality coverage, and protect against current expansion states from dropping their Medicaid expansions. These new policies, as well as existing policy outlining standards that any public option to expand health insurance coverage must meet, supersede Policy H-290.966, which is recommended to be rescinded.

Addressing the uninsured ineligible for ACA financial assistance due to immigration status, Policy H-290.983 already enables the AMA to advocate in support of removing the five-year waiting period for lawfully present immigrants to enroll in Medicaid/CHIP. However, additional policy is needed not only to provide a coverage option via unsubsidized ACA marketplace coverage for undocumented immigrants and DACA recipients, but to recognize state and local efforts to provide coverage to immigrants regardless of immigration status. In implementing initiatives to improve the coverage rates of immigrants, the Council believes it is critical that entities overseeing these programs do not collect and/or report data regarding enrollee immigration status.

The Council believes that additional policy options must be pursued to make coverage more affordable to individuals and families offered an "affordable" employer-sponsored plan which, in reality, is actually not affordable to them. To do so, the Council recommends the amendment of Policy H-165.828, to open the door to eligibility for premium tax credits and cost-sharing reductions to those facing an employer plan premium that is above the maximum affordability threshold applied to subsidized ACA marketplace plans. In addition, the Council recommends the amendment of the policy to enable the AMA to support additional solutions to fix ACA's "family glitch," to ensure that more families of workers are able to become eligible for subsidized ACA marketplace coverage.

In assessing the options available to cover the uninsured ages 60 to 64, the Council finds that the AMA proposal for reform, as well as the recommendations of this report, are preferable to other options, including lowering the Medicare eligibility age to 60. Current AMA policy and these recommendations strongly target each segment of the uninsured population ages 60 to 64, without causing health system disruptions. The Council still believes there is a role for Policy H-330.896, which supports restructuring age-eligibility requirements and incentives of Medicare to match the Social Security schedule of benefits. The Council finds lowering the Medicare eligibility age to 60 has multiple downsides:

- Individuals ages 60 to 64 would lose access to health plan choices, including subsidized ACA marketplace coverage.
- As current ACA marketplace subsidies are consistently more generous for lower-income individuals than the subsidies available to Medicare beneficiaries, lower-income individuals currently enrolled in a marketplace plan may have the potential to face higher premiums in traditional Medicare.
- The level of benefits under Medicare differs from options currently available to individuals ages 60 to 64, underscoring why most current, traditional Medicare beneficiaries are also enrolled in supplemental insurance.
- The projected crowd-out of millions of individuals from employer-sponsored and other private coverage to Medicare has the potential to negatively impact the payer mix of physician practices and hospitals.
- Physician and hospital payment rates from private plans tend to be higher than those paid by Medicare, with the difference between the two increasing over time.

The Council believes its recommendations address gaps in AMA policy with respect to covering the uninsured–including those ages 60 to 64–necessary to ensure that our patients are able to secure affordable and meaningful coverage and access the care that they need. There is now an opportunity to build upon the ACA and ARPA to cover more of the uninsured. The Council affirms that our AMA is well-positioned to move forward in its advocacy efforts in support of coverage of the uninsured, guided by policy and its resulting plan to cover the uninsured, which will include the recommendations of this report.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 123-J-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate that any federal approach to cover 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 credit eligibility–make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections. (New HOD Policy)

2. That our AMA advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions. (New HOD Policy)

3. That our AMA support extending eligibility to purchase Affordable Care Act (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. (New HOD Policy)

4. That our AMA recognize the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status. (New HOD Policy)

5. That our AMA reaffirm Policy H-290.983, which opposes federal and state legislation denying or restricting lawfully present immigrants Medicaid and immunizations. (Reaffirm HOD Policy)

6. That our AMA amend Policy H-165.828 by addition and deletion to read as follows:

    a. 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 level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
    b. 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 ~~with respect to the cost of family-based or employee-only coverage~~ and household income. … (Modify Current HOD Policy)

7. That our AMA reaffirm Policy D-290.979, which states that our AMA will work with state and specialty medical societies in advocating at the state level in support of Medicaid expansion. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-290.965, which supports states that newly expand Medicaid being made eligible for three years of full federal funding. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-165.823, which supports auto-enrolling individuals in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies, including zero-premium marketplace coverage and Medicaid/Children's Health Insurance Program (CHIP); and outlines standards that any public option to expand health insurance coverage must meet. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy H-165.838, which states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-165.824, which supports: (1) adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits; (2) providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; (3) state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; (4) eliminating the subsidy "cliff," thereby

expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL); (5) increasing the generosity of premium tax credits; (6) expanding eligibility for cost-sharing reductions; and (7) increasing the size of cost-sharing reductions. (Reaffirm HOD Policy)

12. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support investments in Medicaid/CHIP outreach and enrollment assistance activities. (Reaffirm HOD Policy)

13. That our AMA reaffirm Policy H-165.848, which supports a requirement that individuals and families earning greater than 500 percent FPL obtain, at a minimum, coverage for catastrophic health care and evidence-based preventive health care, using the tax structure to achieve compliance. (Reaffirm HOD Policy)

14. That our AMA rescind Policy H-290.966, as it is superseded by Policy H-165.823 as well as the recommendations of this report. (Rescind HOD Policy)

15. That our AMA reaffirm Policy H-330.896, which supports restructuring Medicare age-eligibility requirements and incentives to match the Social Security schedule of benefits. (Reaffirm HOD Policy)

Fiscal note: Less than $500.

REFERENCES

[1] Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. July 23, 2021. Available at: https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.
[2] Rae M, Cox C, Claxton G, McDermott D and Damico A. How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured. Kaiser Family Foundation. March 25,h 2021. Available at: https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/.
[3] *Ibid.*
[4] *Ibid.*
[5] Garfield R, Damico A and Rudowitz R. Taking A Closer Look At Characteristics of People in the Coverage Gap. Kaiser Family Foundation. July 29, 2021. Available at: https://www.kff.org/policy-watch/taking-a-closer-look-at-characteristics-of-people-in-the-coverage-gap/.
[6] Rudowitz R, Garfield R and Levitt L. Filling the Coverage Gap: Policy Options and Considerations. Kaiser Family Foundation. April 22, 2021. Available at: https://www.kff.org/medicaid/issue-brief/filling-the-coverage-gap-policy-options-and-considerations/.
[7] Garfield, *supra* note 5.
[8] *Ibid.*
[9] Garfield R, Orgera K and Damico A. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. Kaiser Family Foundation. January 21, 2021. Available at: https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.
[10] Rae, *supra* note 2.
[11] Kaiser Family Foundation. Health Coverage of Immigrants. July 15, 2021. Available at: https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/.
[12] *Ibid.*
[13] Rae, *supra* note 2.

[14] KFF/HRET Employer Health Benefits Annual Survey. 2020. Available at: https://files.kff.org/attachment/Report-Employer-Health-Benefits-2020-Annual-Survey.pdf.
[15] Cox C, Amin K, Claxton G, and McDermott D. The ACA Family Glitch and Affordability of Employer Coverage. Kaiser Family Foundation. April 7, 2021. Available at: https://www.kff.org/health-reform/issue-brief/the-aca-family-glitch-and-affordability-of-employer-coverage/.
[16] Buettgens M, Dubay L, and Kenney G. Marketplace Subsidies: Changing The 'Family Glitch' Reduces Family Health Spending But Increases Government Costs. Health Affairs. 2016; 35(7): 1167–1175.
[17] Buettgens M and Banthin J. Changing the "Family Glitch" Would Make Health Coverage More Affordable for Many Families. Urban Institute. May 2021. Available at: https://www.urban.org/sites/default/files/publication/104223/changing-the-family-glitch-would-make-health-coverage-more-affordable-for-many-families_1.pdf.
[18] Rae, *supra* note 2.
[19] *Ibid.*
[20] *Ibid.*
[21] *Ibid.*
[22] Garfield R, Rae M and Rudowitz R. Coverage Implications of Policies to Lower the Age of Medicare Eligibility. Kaiser Family Foundation. May 21, 2021. Available at: https://www.kff.org/health-reform/issue-brief/coverage-implications-of-policies-to-lower-the-age-of-medicare-eligibility/.
[23] *Ibid.*
[24] *Ibid.*
[25] Whorley M, Cole M, Rosacker N, Carpenter E and Sloan C. Medicare Expansion Could Have a Mixed Impact on Premiums. Avalere. May 19, 2021. Available at: https://avalere.com/insights/medicare-expansion-could-have-a-mixed-impact-on-premiums.
[26] Committee for a Responsible Federal Budget. Understanding Joe Biden's 2020 Health Care Plan. August 31, 2020. Available at: https://www.crfb.org/papers/understanding-joe-bidens-2020-health-care-plan.
[27] Rae M, Cubanski J and Damico A. Health Spending for 60-64 Year Olds Would Be Lower Under Medicare Than Under Large Employer Plans. Kaiser Family Foundation. April 27, 2021. Available at: https://www.kff.org/medicare/issue-brief/health-spending-for-60-64-year-olds-would-be-lower-under-medicare-than-under-large-employer-plans/.