REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (I-15)
Health Insurance Affordability
(Resolution 120-A-15)
(Reference Committee J)

EXECUTIVE SUMMARY

With the implementation of the Affordable Care Act (ACA) well underway, the Council on Medical Service spent the past year reviewing the substantial body of American Medical Association (AMA) policy pertaining to the AMA proposal for reform. The Council has concluded that the preponderance of AMA policy regarding coverage, choice and access remains relevant. However, in its review, the Council identified policy gaps with respect to affordability of coverage. In addition, at the 2015 Annual Meeting, the House of Delegates referred Resolution 120, which asked that our AMA study how high deductible, high maximum out-of-pocket insurance policies "affect health care costs in the immediate and distant future so that we may learn whether this actually increases total cost of care over time by delaying early treatment and secondary prevention efforts."

The Council believes that there is an opportunity to provide millions of workers and their families with access to affordable coverage offered on health insurance exchanges. As a first step, the Council recommends making changes to how affordable coverage is being defined in ACA implementation. Changing the threshold that determines the affordability of employer-sponsored coverage will give affected employees access to exchange coverage, which in many cases is more affordable than the coverage provided by their employer. The Council also recommends that the AMA support legislation or regulation to fix the ACA's "family glitch," which would therefore determine the affordability of employer-sponsored coverage with respect to the cost of family-based or employee-only coverage, whichever is relevant.

Realizing that navigating health plan choices available on health insurance exchanges may be potentially difficult for patients, the Council supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. There should also be clear labeling of exchange plans that are eligible to be paired with health savings accounts (HSAs) with information on how to set up an HSA. Further, the Council believes that additional assistance is needed during the health plan enrollment process to ensure patients are able to base their enrollment decision not solely on the cost of the premium, but rather on the total cost of care.

The Council is concerned that patients who forego cost-sharing subsidies by enrolling in a bronze plan may have difficulties affording any care they need, which can result in them avoiding or delaying needed care. The Council recognizes that there may be a role for HSAs to assist patients who forego cost-sharing subsidies by enrolling in a bronze plan. The AMA should encourage 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 an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy.

Existing policy has supported capping the tax exclusion for employment-based insurance as an incremental step toward financing individual tax credits for the purchase of health insurance – a key provision of the AMA proposal for reform. In that spirit, as ACA implementation moves forward, the Council believes that capping the employee tax exclusion for employment-based insurance can be used as a funding stream of proposals to improve health insurance affordability.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-I-15

Subject: Health Insurance Affordability
(Resolution 120-A-15)

Presented by: Robert E. Hertzka, MD, Chair

Referred to: Reference Committee J
(Jeffrey P. Gold, MD, Chair)

The American Medical Association (AMA) proposal to cover the uninsured and expand choice, used in AMA advocacy leading up to and following the enactment of the Affordable Care Act (ACA) and highlighted in AMA's Voice for the Uninsured campaign, is based on a number of policies developed and/or refined by the Council on Medical Service, and adopted by the House of Delegates, during the 1990s and 2000s. The proposal removes the bias towards employment-based insurance and promotes a system of individually selected and owned health insurance coverage, using tax credits, individual responsibility, and other market regulations to maximize coverage gains, make coverage affordable, and ensure patient choice of health plan and physicians.

With the implementation of the ACA well underway, the Council spent the past year reviewing the substantial body of AMA policy pertaining to the AMA proposal for reform. The Council has concluded that the preponderance of AMA policy regarding coverage, choice and access remains relevant. However, in its review, the Council identified policy gaps with respect to affordability of coverage.

At the 2015 Annual Meeting, the House of Delegates referred Resolution 120, "High Deductible, High Coinsurance Policies," which was introduced by the Wisconsin Delegation and assigned to the Council for study. Resolution 120-A-15 asked:

> That our American Medical Association study how high deductible, high maximum out-of-pocket insurance policies affect health care costs in the immediate and distant future so that we may learn whether this actually increases total cost of care over time by delaying early treatment and secondary prevention efforts.

This report outlines policy gaps and opportunities with respect to defining affordability as well as the affordability of exchange coverage, summarizes relevant AMA policy and presents policy recommendations.

DEFINING AFFORDABILITY

The definition of affordable coverage is not consistent within the ACA, with noteworthy differences existing between the definition of affordable coverage pertaining to exemption from the individual mandate, and eligibility for premium and cost-sharing subsidies. The inconsistencies in how affordable coverage has been defined in ACA implementation have left millions of Americans ineligible for premium tax credits to purchase coverage through health insurance exchanges. In

addition, opportunities exist to improve the affordability of coverage purchased through health insurance exchanges, especially regarding exchange plan deductibles and cost-sharing.

Exemption from the Individual Mandate

Beginning in 2014, the ACA required most individuals to obtain minimum acceptable coverage for themselves and their dependents or pay a tax penalty. Exemptions from the requirement to purchase health insurance are available to those who qualify for a religious exemption, American Indians, those who have been uninsured for less than three months, undocumented immigrants, incarcerated individuals, and those deemed unable to afford health insurance. Individuals are exempt from the individual mandate if the lowest-priced coverage available to them would cost more than 8.05 percent of their household income in 2015, the threshold over which coverage is determined to be unaffordable. Dependents are exempt from the individual mandate as well if the premium of the lowest cost family coverage, including employer-sponsored coverage, is more than 8.05 percent of their household income.

Eligibility for Premium and Cost-Sharing Subsidies

Individuals eligible for premium and cost-sharing subsidies to purchase coverage on health insurance exchanges include US citizens, legal immigrants, and employees who are offered an employer plan that does not have an actuarial value of at least 60 percent or if the employee share of the premium exceeds 9.56 percent of income in 2015. As such, individuals offered employer-sponsored coverage with premiums for self-only coverage equaling 9.25 percent of household income would be exempt from the individual mandate because their coverage would be deemed unaffordable with respect to application of the individual mandate, but at the same time they would not be eligible to receive premium and cost-sharing subsidies to purchase exchange coverage because their premium contribution for self-only coverage through their employer would be considered affordable. This affordability misalignment prevents a segment of workers from accessing coverage that would in many instances be more affordable on health insurance exchanges, considering roughly 17 million workers who are offered employer coverage have incomes low enough to qualify for cost-sharing subsidies if they would be otherwise eligible.[1]

Family Glitch

In determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. 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 is estimated to be $1,290 in 2015, while the average contribution for family-based coverage is estimated to be $4,874.[2] 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 9.56 percent of their income for family coverage. There is also the potential for workers and families affected by the glitch to remain uninsured, especially considering that low-income families

are disproportionately affected. The Agency for Healthcare Research and Quality has estimated that 10.5 million adults and children may fall within the "family glitch."[3]

AFFORDABILITY OF EXCHANGE COVERAGE

Consistent with longstanding AMA policy supporting the provision of refundable and advanceable tax credits that are inversely related to income, eligible low-income individuals and families qualify for subsidized coverage offered on health insurance exchanges. Individuals and families with incomes just above Medicaid levels to 250 percent of the federal poverty level (FPL) qualify for both premium tax credits and cost-sharing subsidies, while individuals and families with incomes between 250 and 400 percent FPL qualify only for premium tax credits. In 2015, the federal poverty level is $11,770 for an individual and $24,250 for a family of four.[4] In 2016, approximately 13.8 million individuals will be eligible for both premium and cost-sharing subsidies, with an additional 9.4 million individuals eligible solely for premium tax credits.[5]

Premium Tax Credits

Eligible individuals and families with incomes between 100 and 400 percent FPL (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium credits to purchase coverage on health insurance exchanges. The size of premium credits is based on household income relative to the cost of premiums for the reference plan, which is the second-lowest-cost silver plan offered on the exchange. The premium credit as such caps the percentage of income that an individual pays for their premiums. Examples of maximum monthly health insurance premiums for the second-lowest-cost silver plan in federally facilitated and partnership exchanges for single adults include $20 for an adult at 100 percent FPL, $123 for an adult at 200 percent FPL, and $279 for an adult at 300 percent FPL.[6]

However, individuals eligible for premium subsidies can also choose to purchase other levels of coverage. The bronze plan, which represents minimum creditable coverage, covers 60 percent of benefit costs including out-of-pocket limits that cannot be more than $6,600 for individuals and $13,200 for families in 2015. The percentage of benefit costs covered increases to 70 percent in the silver plan, 80 percent in the gold plan, and 90 percent in the platinum plan. If individuals eligible for premium subsidies choose a higher-level plan (gold, platinum), they would be responsible for paying the difference between the costs of the higher-level plan and the second-lowest cost silver plan. All subsidy-eligible individuals can also choose to pay less for a bronze plan, which would have higher deductibles and cost-sharing.

Cost-Sharing Subsidies

In addition, individuals and families with incomes between 100 and 250 percent FPL (133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies to purchase coverage on health insurance exchanges. Individuals eligible for cost-sharing subsidies must be enrolled in a silver plan. Cost-sharing subsidies effectively raise the actuarial value (percent of benefit costs covered) of the silver plan, leading patients to face lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. The average annual value of cost-sharing subsidies per eligible individual is projected to be $479 in 2016, ranging from an average of $217 for those with incomes between 200 and 250 percent FPL, to an average of $693 for those with incomes above Medicaid levels but below 150 percent FPL.[5] However, individuals eligible for cost-sharing subsidies forego such subsidies if they enroll in a bronze plan to save on premiums. More than 2 million individuals enrolled in exchange plans in 2015 who are eligible for cost-sharing subsidies are not receiving them because they did not select a qualifying silver plan.[7]

Average Deductibles and Out-of-Pocket Limits by Plan Type
Federally Facilitated and Partnership Exchanges[8,9]

		Silver Plan – by Income			
	Standard Silver Plan	Above Medicaid to 150% FPL	150-200% FPL	200-250% FPL	Bronze Plan
Deductible	$2,556	$229	$737	$2,077	$5,328
Out-of-Pocket Limit	$5,826	$881	$1,692	$4,624	$6,359

High-Deductible Health Plans

Related to the intent of referred Resolution 120-A-15, the Council recognizes that low-income individuals who enroll in bronze plans may have difficulties affording the medical care they need. However, individuals with higher incomes are more likely to be able to absorb the costs associated with high-deductible health plans. Overall, from January to March of 2015, 4.4 percent of the US population failed to obtain needed medical care due to cost, a decline from 5.9 percent in 2013.[10] Forty percent of health plan enrollees in the non-group market (both ACA-compliant and non-compliant plans) have a plan with a deductible of $1,500 or more for an individual or 3,000 or more for a family.[11] Fourteen million Americans ages 19 to 64 who were insured all year in 2014 had deductibles equal to five percent or more of their income. These individuals with deductibles equal to five percent or more of their income were more likely to report not getting needed medical care because of cost, as well as having issues with medical bills than those with lower or no deductibles.[12] Among households with incomes between 100 and 250 percent FPL, the income eligibility range for cost-sharing subsidies, only 32 percent have enough liquid financial assets to meet deductible amounts of $1,200 for individuals and $2,400 for families, while one in five can meet deductible amounts of $2,500 for individuals and $5,000 for families.[13] According to the Commonwealth Fund Health Care Affordability Tracking Survey conducted September to October 2014, approximately two-thirds of privately insured individuals with incomes between 100 percent and 199 percent FPL reported it was difficult to afford their deductibles, with half of those with incomes between 200 percent and 399 percent FPL reporting difficulties. Almost half of privately insured adults with incomes below 200 percent FPL reported avoiding medical care when sick, avoiding necessary specialist visits, not filling prescriptions and skipping medical tests due to their copayments and coinsurance.[14]

RELEVANT AMA POLICY

Policy H-165.841 supports the overall goal of ensuring that every American has access to affordable high quality health care coverage. Policy H-165.845 states that health insurance coverage should be equitable, affordable, and sustainable. Policy H-165.838 supports insurance market reforms that expand choice of affordable coverage. Policy H-165.865 states that the size of tax credits should be large enough to ensure that health insurance is affordable for most people. Policy H-373.998 states that health reform plans should effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

Policy H-165.839 states that health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage, with participating health plans providing an array of choices, in terms of benefits covered, cost-sharing levels and other features. Policy H-165.852 strongly supports HSAs maintaining their role in the health insurance marketplace as an option for patients. Policies H-165.845, H-373.998, H-165.838, H-165.846, H-320.968 and H-165.985

support patient choice of health plan, as well as the provision of full and clear information to consumers on the provisions and benefits offered by health plans. Policy H-373.994 outlines guidelines for patient navigator programs. Policy H-165.846 states that mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and excluded services. The policy also states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations, which aligns with Policy H-165.865, which states that the size of premium credits should be large enough to ensure that health insurance is affordable for most people.

Policy H-165.920 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. Policy H-165.851 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. The Council notes that capping the tax exclusion for employment-based insurance is different from the excise tax on high cost employer-sponsored coverage that was included in the ACA, also known as the "Cadillac tax." Starting in 2018, employer-sponsored health benefits will be subject to the excise tax if their total value—including employers' and employees' tax-excluded contributions for health insurance premiums and contributions made through health reimbursement arrangements (HRAs), flexible spending accounts (FSAs), or HSAs—is greater than $10,200 for single coverage and $27,500 for other than self-only coverage in 2018.[15] The amount of the excise tax will be equal to 40 percent of the difference between the total cost of health benefits for an employee and the applicable threshold amount. Rather, capping the tax exclusion for employment-based coverage would impose a limit to which employer and worker contributions for an employee's health insurance and other health care costs (FSAs, HRAs, and HSAs) could be excluded from an employee's taxable income.

DISCUSSION

As millions of Americans have enrolled in coverage offered through health insurance exchanges, the Council affirms that progress has been made on a long-time policy priority of the AMA—expanding access to affordable, quality health insurance coverage. According to Census Bureau findings released in September 2015, the uninsured rate decreased from 13.3 percent, or 41.8 million individuals in 2013 to 10.4 percent, or 33 million individuals in 2014.[16] However, there is an opportunity to provide millions of workers and their families with access to premium credits and cost-sharing subsidies to purchase affordable coverage on health insurance exchanges, who are currently not eligible for subsidized exchange coverage due to how affordable coverage has been defined as the ACA has been implemented. First, aligning the definitions of affordability of coverage with respect to being exempt from the individual mandate (premium > 8.05 percent of income), and eligibility for premium tax credits if offered employer-sponsored coverage (premium > 9.56 percent of income), will prevent situations in which workers are ineligible for subsidized exchange coverage, despite only having access to employer-sponsored coverage with premiums high enough to make them exempt from the individual mandate. In addition, the ACA's "family glitch" has left many children and other family members being considered ineligible for premium tax credits to purchase coverage on health insurance exchanges, because the affordability of employer-sponsored coverage is only based on the cost of employee-only coverage, ignoring the cost of family coverage. Without fixing the "family glitch," families will continue to be in the position of choosing between unaffordable employer-sponsored coverage or face a penalty under the individual responsibility requirement for failing to have coverage. While the cost of fixing the "family glitch" depends on the actual regulatory or legislative approach selected, the Urban

Institute has estimated that the cost of its proposed approach to address the "family glitch" through regulatory changes would be $78 billion over 10 years.[2]

The intent of health insurance exchanges is to provide a patient-friendly market for patients to purchase health insurance, as well as increase the competition among plans based on quality and price. In general, patients have to navigate through many health plans to make the right choice that responds to their health care needs and budgetary realities. A Department of Health and Human Services study that analyzed the exchange market in 35 states showed that patients have an average of 40 health plans to choose from for 2015 coverage, including catastrophic plans. On average, there are 15 silver plans available, 12 bronze, 9 gold, 2 platinum and 2 catastrophic.[17] However, there is notably wide variation in the number of health plans to choose from in each rating area; some rating areas offer very limited health plan choice, whereas there are some rating areas with well over 100 plans available. Realizing that navigating health plan choices available on health insurance exchanges may be potentially difficult for patients, the Council supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. There should also be clear labeling of exchange plans that are HSA eligible with information on how to set up an HSA.

The Council believes that additional assistance is needed during the health plan enrollment process to ensure patients are able to base their enrollment decision not solely on the cost of the premium, but rather on the total cost of care. At the time that this report was written, the Centers for Medicare & Medicaid Services was developing an Out-of-Pocket Cost Comparison Tool to show patients looking for coverage in federally facilitated exchanges estimates of total spending (to include premiums and cost-sharing) across the health insurance plans available to them. While the Council believes that such a tool is a key first step, there is also a need for additional education regarding deductibles and cost-sharing at the time of enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services. With additional education, patients will have a greater understanding of the impact of enrolling in plans with higher deductibles, co-payments and co-insurance.

Individuals and families with incomes between 100 and 250 percent FPL (133 and 250 percent FPL in Medicaid expansion states) – the population eligible for cost-sharing subsidies – have a choice when selecting a health plan on the exchange. They can purchase a subsidized silver plan that due to cost-sharing subsidies has lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts than would otherwise be available. Or, they can forego the cost-sharing subsidy and enroll in a bronze plan, which may have a lower premium, but higher deductibles. The Council is concerned that patients who forego cost-sharing subsidies by enrolling in a bronze plan may have difficulties affording any care they need, which can result in them avoiding or delaying needed care. While the Council does not want to limit health plan choice, the Council recognizes that there may be a role for HSAs to assist patients who forego cost-sharing subsidies by enrolling in a bronze plan. The AMA should encourage 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 an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Therefore, in cases when individuals forego cost-sharing subsidies by enrolling in a bronze plan, they would have some contributions in their HSAs to help finance the medical care they need. Unspent HSA funds will rollover from year to year, creating greater protection against high deductibles.

Existing policy has supported capping the tax exclusion for employment-based insurance as an incremental step toward financing individual tax credits for the purchase of health insurance – a key provision of the AMA proposal for reform. The Council notes that in some proposals released

to date, capping the tax exclusion would effectively replace the "Cadillac tax" of the ACA. Building off of existing policy that recognizes that providing affordable health insurance to individuals in the US has a cost, the Council believes that, as ACA implementation moves forward, capping the employee tax exclusion for employment-based insurance can be used as a funding stream to improve health insurance affordability, including for individuals impacted by the "family glitch," individuals who forego cost-sharing subsidies despite being eligible, and individuals impacted by the inconsistency in affordability definitions.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 120-A-15, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support 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). (New HOD Policy)

2. That our AMA support 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. (New HOD Policy)

3. That our AMA encourage 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. (New HOD Policy)

4. That our AMA support 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. (New HOD Policy)

5. That our AMA support 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. (New HOD Policy)

6. That our AMA support efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges. (New HOD Policy)

7. That our AMA support 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. (New HOD Policy)

Fiscal Note: Less than $500.

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