

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

EXECUTIVE SUMMARY

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

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

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

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-24

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

Presented by: Sheila Rege, MD, Chair

Referred to: Reference Committee A

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

9  
10 Health Insurance Affordability H-165.828[1]

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

18  
19 and (4) amend Policy H-165.823[2] by deletion to read as follows:

20  
21 Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]

22 2. Our AMA will advocate that any public option to expand health insurance coverage must meet  
23 the following standards:

24 a. The primary goals of establishing a public option are to maximize patient choice of health plan  
25 and maximize health plan marketplace competition.

26 ~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is~~  
27 ~~restricted to individuals without access to affordable employer-sponsored coverage that meets~~  
28 ~~standards for minimum value of benefits.~~

29 ~~b.~~ b. Physician payments under the public option are established through meaningful negotiations  
30 and contracts. Physician payments under the public option must be higher than prevailing Medicare  
31 rates and at rates sufficient to sustain the costs of medical practice.

32 ~~c.~~ c. Physicians have the freedom to choose whether to participate in the public option. Public option  
33 proposals should not require provider participation and/or tie participation in Medicare, Medicaid  
34 and/or any commercial product to participation in the public option.

35 ~~d.~~ d. The public option is financially self-sustaining and has uniform solvency requirements.

1 ef. The public option does not receive advantageous government subsidies in comparison to those  
 2 provided to other health plans.

3 fg. The public option shall be made available to uninsured individuals who fall into the “coverage  
 4 gap” in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but  
 5 below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal  
 6 cost.

7  
 8 The Board of Trustees assigned this item to the Council on Medical Service for a report back to the  
 9 House of Delegates. This report discusses policy options for addressing employer-sponsored health  
 10 insurance (ESI) affordability, summarizes relevant AMA policy, and presents recommendations.

11  
 12 **BACKGROUND**

13  
 14 Almost a decade and a half after enactment of the ACA, ESI continues to be the dominant source  
 15 of health coverage for Americans under 65 years of age. In 2023, the Congressional Budget Office  
 16 (CBO) estimated that 155 million people under age 65—or 57.3 percent of the nonelderly  
 17 population—had health insurance coverage through their employer, a number the CBO predicts  
 18 will remain steady through 2025 and increase in the years thereafter.<sup>1</sup> Although ESI is the most  
 19 common type of health insurance, coverage varies significantly by income as well as race and  
 20 ethnicity. While nearly all individuals with incomes at or above 400 percent of the federal poverty  
 21 level (FPL) have ESI, it covers just over half of people with incomes between 150 to 400 percent  
 22 FPL and fewer than one-quarter of individuals with incomes below 150 percent FPL.<sup>2</sup>  
 23 Additionally, larger percentages of white and Asian people have ESI while individuals who are  
 24 African American and Latino are less likely to have employer-based coverage, raising equity  
 25 concerns.<sup>3,4</sup>

26  
 27 Overall, most Americans appear satisfied with employment-based coverage.<sup>5</sup> According to KFF’s  
 28 survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and  
 29 73 percent of those with marketplace coverage rated their health coverage as “excellent” or “good”  
 30 although people in poorer health gave more negative ratings across all plan types. Regardless of  
 31 health status, enrollees in marketplace plans were most likely to rate their experiences with health  
 32 insurance as fair or poor.<sup>6</sup> Ninety-three percent of workers responding to a 2022 poll sponsored by  
 33 the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority  
 34 (89 percent) expressing a preference for ESI over other types of coverage.<sup>7</sup> Eighty percent of  
 35 respondents to this survey ranked health insurance as the most important workplace benefit  
 36 provided to them, and a majority cited “affordability” and “high quality” as ESI’s most critical  
 37 features.<sup>8</sup>

38  
 39 Although ESI is popular, it has become increasingly costly for employers and employees,  
 40 especially small firms and lower-income workers. According to 2023 data from the KFF’s  
 41 Employer Health Benefits Survey:

- 42
- 43 • Fifty-three percent of all firms offered health benefits, down slightly from five years ago (57  
 44 percent). Almost all (98 percent) large employers (those with 200 or more workers) offered  
 45 coverage to at least some workers while just over half (53 percent) of smaller firms (those with  
 46 three to 199 workers) did so.
  - 47 • Seventy-five percent of eligible employees took up coverage when it was offered to them, a  
 48 slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent).<sup>9</sup>
  - 49 • Annual health insurance premiums averaged \$8,435 for individual coverage and \$23,968 for  
 50 family coverage, a seven percent increase over 2022. Notably, premiums for family coverage

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

- 3 • Most (77 percent) firms offered only one type of plan, and PPOs were the most common plan  
 4 type offered. Large employers were more likely than smaller firms to offer more than one  
 5 plan.<sup>10</sup>

6  
 7 In addition to premium contributions, most workers with ESI are responsible for cost-sharing  
 8 expenses, including plan deductibles, copayments, and coinsurance. According to KFF's 2023  
 9 Employer Health Benefits Survey, the average annual deductible for employees with single  
 10 coverage was \$1,735, a figure that has increased more than 50 percent over the course of 10  
 11 years.<sup>11</sup> Overall, nearly a third of employees had plan deductibles of \$2,000 or more, including  
 12 almost half (47 percent) of workers at small firms, whose average annual deductible was \$2,434  
 13 compared to \$1,478 for employees of larger firms.<sup>12</sup>

14  
 15 ESI Affordability

16  
 17 KFF has also highlighted the lack of affordable family coverage options for workers at smaller  
 18 firms employing fewer than 200 people. These employees pay on average \$8,334 towards family  
 19 coverage premiums each year with a quarter paying at least \$12,000 annually, not including  
 20 deductibles and other cost-sharing expenses.<sup>13</sup> A KFF analysis of data from its 2023 survey of  
 21 consumer experiences with health insurance found that adults with incomes below 200 percent FPL  
 22 who have ESI were significantly more likely than higher-income peers to report difficulties paying  
 23 for medical care; treatment delays and declines in health due to insurance problems, such as prior  
 24 authorization; dissatisfaction with the availability and quality of health providers in their plan's  
 25 network; and more difficulty comparing plans and signing up for coverage.<sup>14</sup>

26  
 27 Several analyses have pointed out that workers with lower incomes are disproportionately  
 28 burdened by ESI costs and usually pay a greater share of income toward employer plan premiums  
 29 and other out-of-pocket expenses.<sup>15 16 17</sup> KFF research from 2022 found that, on average, families  
 30 with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care  
 31 premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or  
 32 above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent  
 33 for premiums).<sup>18</sup> More workers (over 20 percent, according to a 2019 KFF survey)<sup>19</sup> are covered  
 34 by high-deductible plans, which can present additional challenges to lower-income employees even  
 35 if a health savings account or health reimbursement account option is available to them. Though  
 36 employers could utilize health benefit design strategies to address affordability issues facing lower-  
 37 income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that  
 38 lowered premium costs for lower-income employees while only five percent reported programs to  
 39 lower their cost-sharing expenses.<sup>20</sup> COBRA coverage may also be too costly for some workers  
 40 who are leaving a job.

41  
 42 Though many workers mistakenly think otherwise, they—not the firms they work for—pay the  
 43 majority of ESI costs, both directly through contributions and indirectly through wage adjustments  
 44 made to cover employers' health care costs.<sup>21</sup> Building on the literature linking growth in health  
 45 insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between  
 46 increased premium costs for workers with ESI family coverage and decreased earnings and  
 47 increased income inequality.<sup>22</sup> Because workers earning lower wages contribute a greater share of  
 48 income toward ESI premiums, the analysis posits that making employer plans more affordable for  
 49 lower-wage workers could help address earnings inequality. This study also identified large  
 50 disparities in premium costs as a percentage of income by race (African American and Latino  
 51 families paid higher percentages of earnings toward premium costs than white families), and found

1 that over 30 years, families with ESI may have cumulatively lost, on average, more than \$125,000  
 2 in earnings due to increases in premium costs.<sup>23</sup>

3 ACA Provisions on Affordability and Employer Shared Responsibility  
 4

5 Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible  
 6 for “minimum essential coverage,” which is broadly defined to include Medicare, Medicaid, and  
 7 other public programs as well as ESI. Accordingly, individuals with offers of coverage from an  
 8 employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either  
 9 unaffordable or inadequate. In 2023, an employer plan was considered unaffordable if an  
 10 employee’s premium contribution exceeded 9.12 percent of that person’s household income. This  
 11 percentage threshold is adjusted annually for inflation and is 8.39 percent in 2024.<sup>24</sup> To be  
 12 considered adequate, a plan must cover at least 60 percent of average costs (actuarial value);  
 13 anything less is deemed inadequate.<sup>25</sup> The ACA provision making workers with affordable and  
 14 adequate ESI offers ineligible to receive advance premium tax credits to purchase marketplace  
 15 coverage is colloquially referred to as “the firewall.” This affordability threshold was established to  
 16 address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI  
 17 market and prevent prohibitive increases in federal spending (for marketplace subsidies) while  
 18 preserving ESI’s position as the principal source of health coverage in this country.  
 19

20 As explained in a [2014 Council on Medical Service Report](#) on the future of ESI, the ACA aimed to  
 21 build upon the ESI framework and provide low-income, non-elderly individuals without access to  
 22 ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup  
 23 marketplace. As such, provisions in the ACA statute included incentives and penalties intended to  
 24 prevent disruption to the ESI market. For example, to incentivize employers to continue offering  
 25 coverage, the ACA contained an “employer shared responsibility” provision, also called the  
 26 “employer mandate,” which requires employers with 50 or more full-time employees to either offer  
 27 affordable minimum essential coverage to full-time employees and their dependents or pay a  
 28 penalty to the Internal Revenue Service (IRS).<sup>26</sup> Under this provision, employers face two potential  
 29 penalties:<sup>27</sup>  
 30

- 31 • If an employer does not offer minimum essential coverage to at least 95 percent of its full-  
 32 time employees and dependents, and at least one employee receives a premium tax credit  
 33 for coverage offered through an ACA exchange, the employer faces a penalty that is based  
 34 on all full-time employees (except 30), including those who have ESI or coverage from  
 35 another source. In 2024, the penalty is \$2,970 per employee.<sup>28</sup>
- 36 • If an employer offers coverage to at least 95 percent of its employees but at least one  
 37 employee obtains a premium tax credit for ACA coverage due to the employer’s coverage  
 38 not being “affordable” or “adequate,” the employer must pay a penalty for each employee  
 39 who receives the premium tax credit. In 2024, the penalty is \$4,460 per employee.<sup>29</sup>  
 40

41 AMA Policy on the ACA Affordability Threshold  
 42

43 In the early years of ACA implementation, a [2015 Council on Medical Service report](#) on health  
 44 insurance affordability recommended making changes to how affordable coverage is defined under  
 45 the law in order to provide more workers and their families with access to marketplace plans when  
 46 those plans are more affordable than employer plans. This report established Policy H-165.828,  
 47 which included several provisions calling for the ACA’s “family glitch” to be fixed and capping  
 48 the tax exclusion for ESI as a funding stream to improve insurance affordability. Policy H-  
 49 165.828[1] as originally written (prior to being amended in 2021) established AMA support for:  
 50

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

5  
 6 In 2015 when this policy was adopted, individuals were deemed exempt from the ACA’s individual  
 7 mandate—which was repealed in 2017—if the lowest-priced coverage available to them cost more  
 8 than 8.05 percent of their household income. The same year, individuals with employer coverage  
 9 offers were eligible for ACA marketplace plan premium tax credits if their ESI premium  
 10 contributions exceeded 9.56 percent of income. The aforementioned Policy H-165.828[1] was  
 11 crafted to align the definitions of affordability with respect to being exempt from the individual  
 12 mandate (>8.05 percent) and premium tax credit eligibility for individuals with ESI offers (>9.56  
 13 percent).

14  
 15 Policy H-165.828[1] was amended via adoption of the recommendations in a [2021 Council on](#)  
 16 [Medical Service report](#) to address new inconsistencies between the definition of affordability  
 17 pertaining to premium tax credit eligibility and provisions in the American Rescue Plan Act of  
 18 2021 (ARPA), which extended eligibility for premium subsidies to people with incomes greater  
 19 than 400 percent FPL and capped premiums for those with the highest incomes at 8.5 percent of  
 20 their income. ARPA increased the generosity of premium tax credits and lowered the cap on the  
 21 percentage of income individuals are required to pay for premiums of the benchmark (second-  
 22 lowest-cost silver) plan for everyone. At the time the report was written, in 2021, employer  
 23 coverage with an employee share of the premium less than 9.83 percent of income was considered  
 24 “affordable.” To open the door to premium tax credit eligibility to individuals with ESI premiums  
 25 that were above the maximum affordability threshold applied to subsidized marketplace plans,  
 26 Policy H-165.828[1] was amended to establish AMA support for:

27  
 28 ... modifying the eligibility criteria for premium credits and cost-sharing subsidies for  
 29 those offered ESI by lowering the threshold that determines whether an employee’s  
 30 premium contribution is affordable to the level at which premiums are capped for  
 31 individuals with the highest incomes eligible for subsidized ACA coverage.

32  
 33 Federal Subsidies for ACA Premium Tax Credits/Cost-Sharing and ESI Tax Benefits

34  
 35 In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and  
 36 the Basic Health Program (BHP) at a cost of \$92 billion.<sup>30</sup> This figure includes ARPA federal  
 37 subsidy enhancements for premium tax credits and cost-sharing reductions that were extended  
 38 through 2025 by the Inflation Reduction Act (IRA). Prior to ARPA, required premium contribution  
 39 percentages ranged from about two percent of household income for people with poverty level  
 40 income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL;  
 41 people earning more than 400 percent FPL were not eligible for premium tax credits.<sup>31</sup> This year,  
 42 as shown in Table 1, required premium contribution percentages range from zero for people with  
 43 less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

44  
 45 Table 1: Required Individual Contribution Percentage for 2024<sup>32,33</sup>

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

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

1 Premium tax credits for ACA marketplace coverage are calculated by subtracting the required  
 2 contribution from the actual cost of the “benchmark” plan, though the credit can be applied toward  
 3 any marketplace plan except catastrophic coverage.<sup>34</sup> People with incomes below 250 percent FPL  
 4 also receive subsidies for cost-sharing expenses that are based on income, so that people with  
 5 incomes between 100 and 150 percent FPL receive the most generous subsidies.<sup>35</sup> These cost-  
 6 sharing reductions are only available to those enrolled in silver plans. According to the CBO, in  
 7 2023 the average federal subsidy per ACA marketplace/BHP enrollee was \$5,990.<sup>36</sup> The range of  
 8 subsidy amounts is considerable, with small subsidy amounts provided to people with incomes  
 9 around 400 or more percent of the FPL and subsidies worth around \$15,000 for families with the  
 10 lowest incomes.

11  
 12 The federal government subsidizes ESI via tax benefits provided to employers and employees that  
 13 exclude premium contributions from federal income and payroll taxes. The amount of an  
 14 individual’s subsidy depends on that person’s marginal tax rate that would be owed if employer-  
 15 paid premiums were taxed as wages. Accordingly, people with greater incomes and higher  
 16 marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower  
 17 tax rates.<sup>37</sup> According to the CBO, the average federal subsidy per ESI enrollee in 2023 was  
 18 \$2,170.<sup>38</sup>

19  
 20 In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended  
 21 by the IRA, several analysts have observed the growing disparity between federal subsidies that  
 22 help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this  
 23 expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies  
 24 that would be received by a family of four with \$75,000 in income, depending on whether they  
 25 purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-  
 26 based plan, their tax subsidy would be around \$4,100, compared to the more than \$15,000 in  
 27 federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.<sup>39</sup>  
 28 Other analyses have noted that workers with lower incomes may be contributing more for an  
 29 employer-based plan than they would pay for coverage under a subsidized marketplace plan, and  
 30 that it would be financially advantageous for these workers to move to the marketplace.<sup>40</sup>

31  
 32 Some employees who would be financially incentivized to enroll in a marketplace plan if the  
 33 firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to  
 34 see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services  
 35 (CMS) has previously acknowledged the proliferation of narrow networks among ACA exchange  
 36 plans, and several studies have demonstrated varying degrees of challenges facing marketplace  
 37 enrollees attempting to access in-network providers, most commonly mental health specialists. A  
 38 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in  
 39 marketplace plans but that networks may also be limited in lower-quality employer plans.<sup>41</sup> The  
 40 Council has previously observed that, while marketplace plans may be attractive to some people  
 41 because their premium prices are lower, purchasers may not be aware that a plan’s provider  
 42 network could be narrower and that they may have trouble getting needed care from in-network  
 43 physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would  
 44 become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their  
 45 employer plan to avoid possible care disruptions and to preserve relationships with their treating  
 46 physicians. Depending on income and a range of other factors, this could be true for some  
 47 employees who utilize more services and medications or who have a family member on their plan  
 48 who has a health condition that requires timely access to specialty care.

1 POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

2  
 3 During the development of this report, the Council reviewed papers from a broad spectrum of  
 4 organizations and also met with subject matter experts who suggested a range of approaches to  
 5 improving affordability in ESI and nongroup markets. Review of the literature uncovered a handful  
 6 of data analyses and a range of conflicting opinions on the best way forward. The studies generally  
 7 agreed that lifting the firewall would increase access to lower cost insurance for people with low  
 8 incomes. However, they differed in their assessment of the percent of the population that would  
 9 move from ESI to the ACA marketplace, the impact of employer behavior, and their willingness to  
 10 support increased federal health spending. These studies are summarized below in alphabetical  
 11 order.

12  
 13 *American Enterprise Institute (AEI)*: A 2020 paper published by AEI recognizes both the value of  
 14 ESI to many Americans as well as its flaws, including rising costs for both employers and  
 15 employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of  
 16 a framework for a more stable ESI system, including the provision of a tax benefit for employers  
 17 that would be applied to employee premiums. According to AEI, such firm-level tax credits could  
 18 provide greater support to lower-income employees but less support to those with higher  
 19 incomes.<sup>42</sup>

20  
 21 *Bipartisan Policy Center (BPC)*: A 2022 BPC report recognizes that ESI is less affordable for  
 22 lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the  
 23 federal government. Instead, BPC recommends that Congress adjust the affordability threshold to  
 24 align with the percentage cap on premium contributions for marketplace plans.<sup>43</sup>

25  
 26 *Center on Budget and Policy Priorities (CBPP)*: A 2019 CBPP analysis acknowledged that  
 27 eliminating the firewall would improve equity but concluded that a full repeal would be too costly  
 28 to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage  
 29 offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more  
 30 robust benefit standards for ESI plans.<sup>44</sup>

31  
 32 *Commonwealth Fund*: A 2020 analysis found that, depending on marketplace subsidy amounts in  
 33 place, between six and 13 percent of people with ESI would pay lower premium amounts if they  
 34 were able to switch to marketplace plans. Importantly, the paper pointed out that people with the  
 35 lowest incomes would benefit the most from lower marketplace premiums, as would African  
 36 American, Latino, American Indian and Alaska Native individuals. According to the brief, much is  
 37 unknown about potential employer responses to elimination of the firewall, including whether  
 38 firms will incentivize sicker workers to move to exchange plans or stop offering coverage  
 39 altogether.<sup>45</sup>

40  
 41 A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2  
 42 million people with incomes below 150 percent of FPL and 6.5 million people with income  
 43 between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if  
 44 the firewall were eliminated. The analysis states that “most” of these newly eligible individuals  
 45 currently have ESI although some are paying full premiums for nongroup plans.<sup>46</sup>

46  
 47 *Congressional Budget Office (CBO)*: In 2020, the CBO estimated that approximately 25 percent of  
 48 workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For  
 49 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower  
 50 than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained



1 that, although firms would respond differently to a lifting of the firewall, most of the savings  
 2 incurred would likely be passed on to employees and adverse selection would be minimized.<sup>47</sup>  
 3 *Urban Institute*: Data presented to the Council but not yet published at the time this report was  
 4 written estimated that eliminating the firewall would decrease ESI coverage by two percent or less,  
 5 increase federal spending by about \$20 billion, decrease the number of uninsured individuals,  
 6 slightly increase provider revenue, and decrease employer spending and household spending.<sup>48</sup>  
 7

8 RELEVANT AMA POLICY  
 9

10 Policy H-165.829 encourages the development of state waivers to develop and test different models  
 11 for transforming employer-provided health insurance coverage, including giving employees a  
 12 choice between employer-sponsored coverage and individual coverage offered through health  
 13 insurance exchanges, and allowing employers to purchase or subsidize coverage for their  
 14 employees on the individual exchanges. Among its many provisions, Policy H-165.920 supports:  
 15

- 16 • A system where individually owned health insurance is the preferred option but employer-  
 17 provided coverage is still available to the extent the market demands it;
- 18 • An individual’s right to select his/her health insurance plan and to receive the same tax  
 19 treatment for individually purchased coverage, for contributions toward employer-provided  
 20 coverage, and for completely employer-provided coverage; and
- 21 • A replacement of the present federal income tax exclusion from employee’s taxable  
 22 income of employer-provided insurance coverage with tax credits for individuals and  
 23 families.  
 24

25 Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax  
 26 credits for the purchase of health insurance, including but not limited to capping the tax exclusion  
 27 for employment-based health insurance. Policy H-165.843 encourages employers to promote  
 28 greater individual choice and ownership of plans; enhance employee education regarding how to  
 29 choose health plans that meet their needs; and support increased fairness and uniformity in the  
 30 health insurance market. Policy H-165.881 advocates for equal-dollar contributions by employers  
 31 irrespective of an employee’s health plan choice. Policy H-165.854 supports Health  
 32 Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to  
 33 reimburse employees for their medical expenses—as one mechanism for empowering patients to  
 34 have greater control over health care decision-making.  
 35

36 Policy H-165.824 supports improving affordability in health insurance exchanges by expanding  
 37 eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium  
 38 tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing  
 39 reductions. Policy H-165.828, which as previously noted addresses the affordability threshold  
 40 (firewall), also supports capping the tax exclusion for employment-based health insurance as a  
 41 funding stream to improve health insurance affordability.  
 42

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

## 1 DISCUSSION

2  
3 The AMA has long supported health system reform alternatives that are consistent with AMA  
4 policies concerning pluralism, freedom of choice, freedom of practice, and universal access for  
5 patients. To expand coverage to all Americans, the AMA has advocated for the promotion of  
6 individually selected and owned health insurance; the maintenance of the safety net that Medicaid  
7 and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market  
8 demands it. As ESI continues to be the dominant source of health coverage for people under 65  
9 years of age, most people who have employment-based coverage seem satisfied with it. Still, the  
10 Council acknowledges that because of shortcomings inherent to the ESI system—including equity  
11 and affordability concerns, and rising costs—it does not work well for everyone, especially  
12 workers with lower incomes and those at smaller firms paying for costly family coverage.  
13

14 As explained in this report, people with higher earnings receive larger federal ESI subsidies than  
15 their lower-income peers and employees with lower incomes pay a greater share of earnings  
16 towards ESI expenses. The Council recognizes that federal tax benefits available to ESI subscribers  
17 most in need are not nearly as generous as the enhanced subsidies available to many low- and  
18 moderate-income individuals enrolled in ACA marketplace plans. Because the disparity between  
19 subsidy amounts for people with ESI and those with marketplace coverage has widened as  
20 marketplace subsidies have increased and ESI costs have continued to grow, the Council agrees  
21 that it is an appropriate time to revisit AMA policy on the firewall (Policy H-165.828[1]), which  
22 supports lowering the affordability threshold to the level at which premiums are capped for  
23 individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).  
24

25 During the development of this report, the Council reviewed the literature and heard from experts  
26 holding an array of views on the potential impacts of fully eliminating the firewall, which is the  
27 policy change requested by referred Resolution 103-A-23. Although the Council cannot estimate  
28 with certainty how many people would switch from ESI to exchange plans over time if the firewall  
29 was repealed, the impact on coverage patterns could be significant. Even less is known about  
30 potential employer responses to a repeal, which cannot be predicted and will likely vary, with some  
31 firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage  
32 altogether, and without assurances that employer savings would be passed along to workers. Still,  
33 we understand that the firewall is problematic for some employees, including lower-income  
34 workers who may be contributing more for an employer plan than they would pay for marketplace  
35 coverage and those whose firms offer little to no choice of health plans. Even among employees  
36 who would benefit financially from transitioning to the marketplace, some may opt to retain ESI  
37 coverage if they are satisfied with that plan, concerned about the network breadth of exchange  
38 plans, or interested in preserving relationships with their treating physicians.  
39

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

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

12  
13 The Council also suggests additional recommendations that are intended to strengthen the quality  
14 and affordability of ESI. To help address the needs of ESI enrollees with lower incomes, who are  
15 more likely to report difficulties covering the costs of medical care and who may not know if they  
16 are firewalled, the Council recommends amending Policy H-165.843 to encourage employers to: 1)  
17 implement programs that improve affordability of ESI premiums and/or cost-sharing; 2) provide  
18 employees with user-friendly information regarding their eligibility for subsidized ACA  
19 marketplace plans based on their offer of ESI; and 3) provide employees with information  
20 regarding available health plan options, including the plans' cost, network breadth, and prior  
21 authorization requirements, which will help them choose a plan that meets their needs. The Council  
22 recognizes that employers are already required to provide employees with notice about the ACA  
23 marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost  
24 coverage in the marketplace. However, it may be challenging for some employees to determine  
25 whether they are eligible for marketplace subsidies without tools to help them do so.

26  
27 The Council also notes that large employers are subject to a 60 percent actuarial value standard  
28 compared to the 70 percent standard required of silver plans on the marketplace (an 80 percent  
29 actuarial standard is required for gold plans; 60 percent for bronze). Notably, marketplace plans are  
30 also subject to more rigorous essential health benefits standards. To address these disparities in  
31 standards, the Council recommends general support for efforts to strengthen employer coverage  
32 offerings, such as by requiring a higher minimum actuarial value or more robust benefit standards.  
33 Finally, the Council recommends reaffirmation of AMA policies most relevant to this report:  
34 Policy H-165.881, which directs the AMA to pursue strategies for expanding patient choice in the  
35 private sector by advocating for greater choice of health plans by consumers, equal-dollar  
36 contributions by employers irrespective of an employee's health plan choice, and expanded  
37 individual selection and ownership of health insurance; and Policy H-165.920, which supports  
38 principles related to individually purchased and owned health insurance coverage as the preferred  
39 option, although employer-provided coverage is still available to the extent the market demands it.

#### 40 41 RECOMMENDATIONS

42  
43 The Council on Medical Service recommends that the following recommendations be adopted in  
44 lieu of Resolution 103-A-23, and that the remainder of the report be filed.

- 45  
46 1. That our American Medical Association (AMA) amend Policy H-165.828[1] by addition  
47 and deletion to read:

48  
49 Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing  
50 subsidies for those offered employer-sponsored coverage by lowering the threshold that  
51 determines whether an employee's premium contribution is affordable to the level at which

1 ~~premiums are capped for individuals with the highest incomes eligible for subsidized~~  
2 ~~coverage maximum percentage of income they would be required to pay towards premiums~~  
3 ~~after accounting for subsidies in for an Affordable Care Act (ACA) marketplaces~~  
4 ~~benchmark plan. (Modify HOD Policy)~~  
5

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

7  
8 Our AMA encourages employers to:

9 a) promote greater individual choice and ownership of plans;

10 b) implement plans to improve affordability of premiums and/or cost-sharing, especially  
11 expenses for employees with lower incomes and those who may qualify for Affordable  
12 Care Act marketplace plans based on affordability criteria;

13 ~~c) help employees determine if their employer coverage offer makes them ineligible or~~  
14 ~~eligible for federal marketplace subsidies provide employees with user-friendly~~  
15 ~~information regarding their eligibility for subsidized ACA marketplace plans based on their~~  
16 ~~offer of employer-sponsored insurance;~~

17 ~~bd) enhance employee education regarding available health plan options and how to choose~~  
18 ~~health plans that meet their needs provide employees with information regarding available~~  
19 ~~health plan options, including the plan's cost, network breadth, and prior authorization~~  
20 ~~requirements, which will help them choose a plan that meets their needs;~~

21 ee) offer information and decision-making tools to assist employees in developing and  
22 managing their individual health care choices;

23 ~~df) support increased fairness and uniformity in the health insurance market; and~~

24 eg) promote mechanisms that encourage their employees to pre-fund future costs related to  
25 retiree health care and long-term care. (Modify HOD Policy)  
26

- 27 3. That our AMA support efforts to strengthen employer coverage offerings, such as by  
28 requiring a higher minimum actuarial value or more robust benefit standards, like those  
29 required of nongroup marketplace plans. (New HOD Policy)  
30

- 31 4. That our AMA reaffirm Policy H-165.881, which directs the AMA to pursue strategies for  
32 expanding patient choice in the private sector by advocating for greater choice of health  
33 plans by consumers, equal-dollar contributions by employers irrespective of an employee's  
34 health plan choice and expanded individual selection and ownership of health insurance.  
35 (Reaffirm HOD Policy)  
36

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

Fiscal Note: Less than \$500.

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## **Appendix**

### **Policies Recommended for Amendment and Reaffirmation**

#### **Health Insurance Affordability H-165.828**

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

#### **Trends in Employer-Sponsored Health Insurance H-165.843**

Our AMA encourages employers to:

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

#### **Expanding Choice in the Private Sector H-165.881**

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

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

### **Individual Health Insurance H-165.920**

Our AMA:

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



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