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POSITION PAPER

Improving the Patient Protection and Affordable Care Act's Insurance Coverage Provisions: A Position Paper From the American College of Physicians

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The coverage reforms of the Patient Protection and Affordable Care Act have fundamentally changed the U.S. health care system. The law's health insurance regulations, which include protections for persons with preexisting conditions, have made health insurance more accessible. The premium tax credit and cost-sharing subsidies have made nongroup coverage more affordable. The essential health benefit package and coverage for preventive services without cost sharing have made insurance more comprehensive. Perhaps most important, the Medicaid expansion extended coverage to millions of low-income adults. Despite these gains, more needs to be done to bring the United States closer to achieving universal coverage. In this position paper, the American College of Physicians recommends action to enhance and expand eligibility for health insurance financial subsidies; stabilize health insurance marketplaces; provide sustained funding for outreach, education, and enrollment assistance activities; test and implement a mechanism to encourage enrollment; expand Medicaid in all states; and establish a public insurance option to increase competition.

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The American College of Physicians (ACP) has long endorsed policies to achieve universal health insurance coverage (1) and supported passage of the Patient Protection and Affordable Care Act (ACA) in 2010. The ACP has since offered recommendations on how to improve the law and has strongly opposed its repeal. The ACA has extended comprehensive health insurance coverage to millions of persons, but many remain uninsured or underinsured. This position paper reviews the ACA's progress, identifies its shortcomings, and offers official policy recommendations on how the law may be improved. This executive summary provides a synopsis of the position paper. The entire background and rationale may be found in the **Appendix** (available at Annals.org).

The ACA was signed into law in 2010, and the major provisions for expanding coverage took effect in 2014. In 2016, the uninsured rate reached a historic low of 8.8%, with Medicaid expansion states experiencing the deepest reductions; in 2017 and early 2018, the uninsured rate remained at 8.8% (2–4). Roughly 10.6 million persons selected or reenrolled in a 2018 plan through the health insurance marketplace and paid their first month's premium, a slight increase from 2017 (5). More than 12 million newly eligible persons were covered by Medicaid in September 2017, the most recent data available (6). Despite impressive improvements in insurance status, access to care, and economic security measures, the ACA is imperfect and several repeal efforts and poor stewardship threaten to exacerbate the law's problems.

The ACA faced several problems in its early years. The rollout of the online federal health insurance marketplace was fraught with technical issues (7). Underfunding and the temporary nature of 2 risk stabilization programs led to premium spikes and contributed to the demise of Consumer Operated and Oriented Plans (also known as CO-OPs) in many states (8), and the Government Accountability Office raised concerns about premium tax credit enrollment fraud (9). Recent actions that may have a pernicious effect on the law include elimination of the individual mandate penalty starting in 2019, regulations to expand the availability of insurance products that are not required to abide by the law's market regulations, exemptions to the contraceptive coverage requirement for entities with religious and moral objections, and continued uncertainty about the fate of cost-sharing reduction (CSR) payments. The federal government also approved Medicaid waivers that require enrollees to work or be otherwise engaged in the community, which could force sick and economically vulnerable enrollees out of the program and create new administrative and paperwork burdens for physicians and their patients (10). Other problems are a product of the law's design, including limits on premium tax credit and CSR eligibility. Although a recent report indicates that the number of uninsured persons remained steady in the first 3 months of 2018 (4), the Congressional Budget Office (CBO) projects that the number of uninsured will rise from 32 million to 35 million during 2019 to 2028 (11).

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METHODS

This position paper was drafted by the Health and Public Policy Committee of the ACP, which is charged with addressing issues that affect the health care of the U.S. public and the practice of internal medicine and its subspecialties. The authors reviewed available studies, reports, and surveys on the ACA from PubMed, Google Scholar, relevant news articles, policy documents, Web sites, and other sources, including *Health Affairs*, *Annals of Internal Medicine*, *New England Journal of Medicine*, and the Kaiser Family Foundation. The authors largely excluded sources that were published before the ACA's major insurance coverage provisions went into effect in 2014. Recommendations were based on reviewed literature and input from the ACP's Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and Council of Subspecialty Societies. The position paper and related recommendations were reviewed and approved by the Health and Public Policy Committee in September 2018 and the Board of Regents in on 3 November 2018. Financial support for the development of this position paper comes exclusively from the ACP operating budget.

RECOMMENDATIONS

1. Immediate efforts are necessary to strengthen the Patient Protection and Affordable Care Act (ACA) and prepare for transformational reform of the nation's health care system that will achieve truly universal health coverage.

2. The eligibility requirements for premium tax credits and cost sharing should be redesigned to enhance individual market insurance affordability. Specifically, the 400% federal poverty level premium tax credit eligibility cap should be eliminated, and the amount of premium tax credits for all income levels should be enhanced.

3. The federal government should stabilize the marketplace by establishing a permanent reinsurance program. The federal government should not prohibit the practice of "silver loading," where insurers raise silver-tier plan premiums to an amount equal to what they would have received if cost-sharing reduction reimbursements were distributed. Also, steps should be taken by federal and state regulators to limit the sale of individual market plans that do not comply with ACA regulations, including extended short-term, limited-duration plans; association health plans; and "grandmothered" off-marketplace plans.

4. Sustained funding is needed for dedicated outreach, consumer assistance, and education to promote open enrollment, provide in-person and virtual enrollment assistance, and respond to inquiries from the community.

5. Federal and/or state governments should ensure that all individuals enroll in coverage by developing an auto-enrollment program, a penalty for failing to enroll upon eligibility, an individual mandate, or some combination of these approaches. Exemptions for financial hardship and residing in a non–Medicaid expansion state, among others, should be applied.

6. The American College of Physicians reaffirms support for Medicaid expansion. All states should fully expand Medicaid eligibility and should not apply financially burdensome premiums or cost-sharing requirements, lock-out periods, benefit cuts, or mandatory work or community engagement policies that have the effect of reducing enrollment among vulnerable individuals.

7. To encourage market competition, Congress should enact legislation to authorize the development of a public insurance plan to ensure enrollees have access to a variety of coverage options in their area. Potentially, the public option could be expanded to serve as a stepping stone to universal coverage.

CONCLUSION

The ACA has made health insurance accessible and affordable for millions of Americans, but many remain uninsured or burdened with unaffordable coverage. For policymakers, the pragmatic proposals offered here will require substantial political will and funding. If these proposals are fully implemented, coverage and market stability problems will probably remain. However, adopting these policies will be a step toward realizing what has been an unachievable goal: affordable, comprehensive insurance for all. To accomplish true universal coverage, a concerted effort must be made to transform the U.S. health care system into one that attains universal coverage in a less costly and complex way.

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Appendix: Background and Rationale

How the ACA Has Affected Patients

Insurance coverage increases access to medical care, use of preventive services, and treatment and management of chronic diseases; enhances financial security; and improves health outcomes, among other benefits (12). Before implementation of the ACA's major coverage provisions in 2014, a total of 47 million Americans were uninsured and nearly half of them had been without coverage for 5 or more years, according to a Kaiser Family Foundation survey (13). Eighty percent of these uninsured persons did not have the option for employer-based insurance, and most of those who did said it was not affordable. Just over half of uninsured persons had a usual source of care, and only one third reported having a regular doctor.

The ACA seeks to make coverage more accessible and affordable through a range of regulations that pertain to nearly all individual and small group insurance plans, including guaranteed issue and renewability, prohibitions on preexisting condition exclusions, premium rating rules, and limits on out-of-pocket costs. Such plans are required to cover an essential health benefit package providing 10 categories of services, including ambulatory services, prescription drugs, maternity care, and treatment for mental health and substance use disorder. Actuarial value requirements ensure a minimum generosity of coverage, with bronze-level coverage having lower premiums and higher cost sharing and platinum-level coverage having higher premiums and lower cost sharing. Premium tax credits are available to certain persons with incomes between 100% to 400% of the federal poverty level (FPL), and CSR payments that reduce out-of-pocket costs are available to those with incomes from 100% to 250% FPL. The law establishes health insurance marketplaces through which persons can shop for and purchase comprehensive health insurance. It also authorizes funding for enrollment-related education and outreach.

The law initiated an unprecedented expansion of the Medicaid program, extending eligibility to most persons with incomes up to 138% FPL. A 2012 U.S. Supreme Court ruling made the Medicaid expansion optional for states, and as of November 2018, a total of 36 states and the District of Columbia have adopted expanded eligibility.

The ACA Has Greatly Reduced the Number of Uninsured Persons and Improved Access to Care

Emerging evidence shows that the ACA is improving access to coverage and use of medical care, especially for persons eligible for premium tax credits and CSR subsidies and those residing in Medicaid expansion states. A 2018 quasi-experimental study found that among previously uninsured persons who enrolled in marketplace-based subsidized insurance, rates of coverage, outpatient and inpatient care visits, prescription drug use, and diagnosis of hypertension increased (14).

A 2017 review found that insurance coverage rates greatly improved among low-income adults, members of ethnic minority groups, childless adults, and young adults (15). The review also found early improvements in affordability and use, particularly of outpatient care and preventive services. Disparities in access-to-care measures between whites and African Americans and Latinos, including the share of adults who went without care because of cost and the share of adults without a usual source of care, diminished from 2013 to 2015 (16). Duration of time without insurance declined among nonelderly persons as well (17).

Before the ACA's Medicaid expansion, a randomized controlled trial of Oregon Medicaid enrollees found that Medicaid coverage improved self-reported health status, decreased the probability of positive screening for depression, and reduced financial stress related to medical care; however, it did not have a significant effect on blood pressure, cholesterol levels, or glycated hemoglobin measures (18). The evidence suggests that Medicaid expansion has had mostly beneficial coverage and economic effects. According to a Kaiser Family Foundation review, expansion "has had largely positive impacts on coverage; access to care, utilization, and affordability; and economic outcomes including impacts on state budgets, uncompensated care costs for hospitals and clinics, and employment and the labor market . . . Overall, these findings suggest potential for gains in coverage and access as well as economic benefits to states and providers in the remaining non-expansion states" (19). The ACA coverage provisions also have improved financial well-being

among the Medicaid expansion population, including reductions in the number and amount of third-party collections (20). A study of 2 expansion states (Kentucky and Arkansas) and a nonexpansion state (Texas) found that expansion was associated with increases in the use of outpatient and preventive care, better health care quality, and lower emergency department use compared with the nonexpansion state (21). However, a study of 14 Medicaid expansion and 11 nonexpansion states concluded that emergency department visits rose among the Medicaid expansion population (22). Despite initial concerns about the erosion of employer-based insurance as a result of the ACA, job-based insurance participation remains robust, including in states that expanded Medicaid (23). Little evidence exists that crowdout (that is, uninsured persons or persons enrolled in private insurance selecting Medicaid coverage over private insurance) occurred after the start of Medicaid expansion in 2014 (24).

Before the ACA was implemented, many individual market health plans did not cover maternity care, treatment for mental health and substance use disorder, or prescription drugs (25). The essential health benefit requirement has effectively ensured that individual market coverage is comprehensive and includes these important coverage categories. Up to 133 million nonelderly Americans have preexisting conditions, including high blood pressure, behavioral health disorders, and high cholesterol levels (26). Preexisting conditions are prominent in many areas of the United States. For example, 38% of persons in the Charleston, West Virginia, area have a preexisting condition for which they probably would have been denied coverage before the ACA prohibited coverage exclusions (27). Before the ACA, diabetes and congestive heart failure were considered declinable conditions in the medically underwritten individual market. Simply being pregnant was grounds to deny coverage. The ACA has ensured that people with preexisting conditions can enroll in coverage, are not subject to higher premiums because of their preexisting condition, and have comprehensive benefits. Further, the structure of the premium tax credit, which limits the out-of-pocket premium cost to a percentage of income, insulates subsidized enrollees from hefty premium increases.

The ACA Has Made Impressive Gains in Various Areas, but Considerable Gaps and Problems With the Law Persist and May Worsen

Coverage Gaps

The ACA has not achieved universal coverage. According to a Kaiser Family Foundation report, 54% of the 27.5 million persons who were uninsured in 2016 were eligible for assistance: 7.8 million were eligible for premium tax credits, and 7.0 million were adults or children eligible for Medicaid or another public program. The remaining uninsured persons were ineligible for coverage because of immigration status (3.9 million), had an offer of employer-sponsored insurance (3.7 million), were ineligible for subsidized coverage because of their income but were eligible to buy marketplace-based insurance (2.9 million), or were in the coverage gap (2.2 million), meaning that they qualified for Medicaid but resided in a nonexpansion state and did not have sufficient income to qualify for premium tax credits to purchase marketplace-based insurance (28).

Expensive or Insufficient Coverage

In a 2016 survey of uninsured persons, 45% of respondents reported high cost as the reason for remaining without coverage (29). Because the law's health insurance subsidies and Medicaid expansion target low- and moderate-income persons, individual market coverage is unaffordable for many higher-income persons who are ineligible for premium tax credits (that is, those with an annual income of $100 400 for a family of 4 in 2018). Low-income persons with subsidized coverage may have trouble accessing care because of high deductibles; deductibles for silver- and gold-level plans increased from 2017 to 2018 (15, 30). Forty-four percent of persons with individual market plans, including marketplace-based plans, were underinsured in 2016 (31). Evidence suggests that underinsured persons have more barriers to receiving recommended health care than those with adequate insurance (32). The affordability problem is particularly acute in states that have not expanded Medicaid. In a survey taken in the first quarter of 2017, nearly 70% of uninsured respondents residing in nonexpansion states cited cost as a reason for not enrolling in insurance, compared with 59% in expansion states (33).

Limited Choice of Physicians and Other Health Care Professionals

More marketplace-based plans are offering narrow provider networks in the 2018 plan year. Seventy-three percent of marketplace-based plans involved a health maintenance organization or exclusive provider organization, 2 insurance models that limit the selection of physicians and hospitals available to enrollees (30). Although narrow network plans may have lower premiums (34), their presence might trigger adverse selection in broad network plans, reducing options for patients who prefer or need a wider choice of providers (35).

The Public Remains Confused or Unaware of the Law's Status

Surveys show that the public remains perplexed about the status of the law and concerned about its future. In a January 2018 tracking poll, most respon-

dents reported seeing or hearing little to nothing about the 2018 open enrollment period (36). In addition, 17% of the respondents believed that the ACA had been repealed. Half the respondents to a March 2018 survey believed that the individual insurance market was "collapsing" (37). Nearly 60% of marketplace enrollees were concerned that no insurance companies would be offering coverage in their area in the future.

Insurer Participation

Insurer participation in the health insurance marketplace is strong in some areas of the country and tepid in others. According to the Kaiser Family Foundation, an average of 5 insurers participated in each state's marketplace in 2014 and an average of 6 participated in 2015 (38). However, some insurers opted to exit the exchanges in 2016 and 2017. Many that remained substantially increased premiums, in part because of heavy losses and the phasing out of the reinsurance program (39). Insurer participation may have a substantial effect on premiums: A 29-year-old single nonsmoker could purchase the second least expensive silver-tier plan for 50% less in an area with 2 or more insurers than in an area with a single insurer (40). Data indicate that the financial performance of individual market insurers improved in the first half of 2018; however, concern has been raised that recent changes, including the repeal of the individual mandate penalty and loosening of regulations regarding non–ACA-compliant plans, may threaten market stability (41, 42).

Eligibility Verification Problems

According to a December 2017 report from the U.S. Government Accountability Office, about 1% of the 8 million enrollments for subsidized coverage in federal marketplace plans in plan year 2015 may have been improper or fraudulent (43). Of that 1%, about 43 000 enrollees had an open or unresolved inconsistency related to citizenship, national, or legal status; 33 000 had an inconsistency related to an open Social Security number; and 17 000 received or maintained subsidized coverage after their reported death.

Recommendations

1. Immediate efforts are necessary to strengthen the Patient Protection and Affordable Care Act (ACA) and prepare for transformational reform of the nation's health care system that will achieve truly universal health coverage.

Following up on a long-standing pledge, the Republican-controlled 115th Congress and President Trump made several efforts in 2017 to repeal and replace the ACA. Their efforts were unsuccessful, but they did eliminate the individual mandate penalty starting in 2019, which may lead to reduced enrollment and increased premiums, according to the CBO. The administration also cut funding for advertising and outreach, shortened the open enrollment period, and proposed several regulations that would dilute federal oversight of the market and facilitate proliferation of non–ACA-compliant insurance products. Cost-sharing reduction payments were canceled in late 2017, raising the threat of disruption (42). Despite rising premiums and shrinking insurer participation in some areas, effectuated enrollment (that is, persons who enrolled and paid the first month's premium) in 2018 may have increased slightly. This may be attributed to many insurers silver-loading CSR payments (raising the premium for silver-tier plans to an amount equal to what they would have received if CSR reimbursements were distributed), which had the positive effect of increasing the generosity of premium tax credits and taking the sting out of premium spikes. Unsubsidized enrollees, however, bore the full burden of higher out-of-pocket costs.

The ACA should be redesigned to bring the nation closer to universal coverage. The current structure, with its unaffordable premiums for persons who are ineligible for premium subsidies, coverage gaps, and tepid insurer participation, prevents the law from achieving that goal. The following recommendations are intended to encourage enrollment, increase insurer participation, and create more choice and market competition in the individual market and Medicaid program. About one fifth of uninsured persons are undocumented immigrants, a group explicitly barred from purchasing marketplace-based insurance. The ACP supports allowing undocumented immigrants to purchase private insurance using their own funds and calls for increasing funding to health clinics that provide services regardless of insurance status. In addition, many states have yet to expand their Medicaid programs, leaving more than 2 million people in coverage gap limbo. These issues present major barriers to achieving universal coverage.

2. The eligibility requirements for premium tax credits and cost sharing should be redesigned to enhance individual market insurance affordability. Specifically, the 400% federal poverty level premium tax credit eligibility cap should be eliminated, and the amount of premium tax credits for all income levels should be enhanced.

Recent surveys indicate that most uninsured persons remain without coverage because they cannot afford it (37). A survey of uninsured persons in California, a Medicaid expansion state with a robust state-operated health insurance marketplace, found that 47% of respondents did not have coverage because it was too expensive or unaffordable (44). According to exit surveys by the Centers for Medicare & Medicaid Services (CMS), 46% of persons who canceled their marketplace-based insurance coverage before paying their first month's premium did so because of cost (45).

Eighty percent of marketplace enrollees are worried or somewhat worried that copays and deductibles will become so high that they will be unable to get the health care they need or that premiums will no longer be affordable (37).

Unsubsidized persons are severely affected by premium spikes because they pay for premiums out of pocket. Removing the 400% FPL eligibility "cliff" for the premium tax credit is one way to protect middle-income persons and families from dramatic premium hikes and amplify enrollment. An issue brief by the RAND Corporation and The Commonwealth Fund estimates that removing the 400% FPL eligibility threshold would increase the number of newly insured persons by 1.2 million, including 900 000 with incomes over 400% FPL and 200 000 with incomes below 400% FPL who would enter the market because the policy would reduce premiums by balancing the risk pool (46). Another 400 000 previously insured persons would gain a tax credit under the policy. The change would primarily affect persons aged 50 to 64 years. Incentivizing eligible healthy persons to enter or remain in the health insurance marketplace is crucial to ensuring the vitality of the individual market, especially with the availability of cheap, non–ACA-compliant, extended short-term, limited-duration (STLD) insurance coverage.

The number of persons aged 18 to 34 years enrolled in marketplace-based coverage decreased slightly in 2018 (47). High deductibles and out-of-pocket costs remain a major concern for enrollees. In a 2016 position paper, the ACP recommended enhancing the generosity of financial subsidies by tying premium tax credit levels to the second least expensive gold-tier health plan and expanding eligibility for cost-sharing subsidies (48). Affordability may be increased by exempting chronic care management services from cost sharing (49). Premium tax credits should be more generous. A proposal from RAND and The Commonwealth Fund estimates that if premium tax credits were enhanced to reduce out-of-pocket premium costs to 1.79% to 8.5% rather than 2.09% to 9.95% of income, individual marketplace enrollment would increase by 1.4 million; in concert with extending tax credits to persons with incomes over 400% FPL, enrollment might rise by 3.4 million (50). Other options include increasing the premium tax credit for persons aged 19 to 30 years by a fixed amount each month.

3. The federal government should stabilize the marketplace by establishing a permanent reinsurance program. The federal government should not prohibit the practice of "silver loading," where insurers raise silver-tier plan premiums to an amount equal to what they would have received if cost-sharing reduction reimbursements were distributed. Also, steps should be taken by federal and state regulators to limit the sale of individual market plans that do not comply with ACA regulations, including extended short-term, limited-duration plans; association health plans; and "grandmothered" off-marketplace plans.

Overall, the performance of insurers in the individual market was on a stronger foundation in plan year 2018, with market profitability on the upswing (51). However, in several states, premiums rose and insurer participation in the health insurance marketplace dwindled (52, 53). Forty-eight percent of counties had 3 or more insurers offering marketplace-based plans in 2018, compared with 58% of counties in 2017 and 85% in 2016 (54). Premiums in plan year 2019 seem to be higher than they would have been without the repeal of the individual mandate penalty and the expansion of plans that do not comply with ACA insurance regulations (55).

Silver Loading

The ACA requires the federal government to reimburse insurers for CSR payments that compensate for lowering the amount of deductibles, coinsurance, and copayments for premium tax credit recipients with incomes up to 250% FPL. In October 2017, the Trump administration announced it would not reimburse insurers for CSR expenses, causing fear that CSR expenses would be passed onto consumers in the form of higher premiums. In response, many insurers included the cost of CSRs in silver-tier plan premiums. This had the effect of increasing premium subsidies, which are based on the cost of premiums for the second least expensive silver-tier plan and other factors, hence the term *silver loading*. As a result, premium subsidies for many enrollees were more generous than if silver loading had not occurred. In some markets, zero-premium bronze-tier plans were available and gold-tier plan premiums were lower than silver-tier premiums (56). The administration hinted that it would prohibit silver loading in the 2019 plan year because of the cost to the federal government and the effect on unsubsidized persons, who face higher costs (57). Although silver loading is an imperfect tool, ACP recommends that it be permitted as a way to make health insurance more affordable for enrollees, along with strategies to provide financial assistance to higher-income persons.

Noncompliant Plans

Some states allow insurers to sell plans that do not comply with ACA regulations, leading to high premiums for marketplace plan enrollees. Iowa, a state that once had a competitive health insurance marketplace, has experienced a contraction in the number of participating insurers. The reason is that 60% of people with individual market coverage are enrolled in a plan that does not meet ACA regulations, including grandfathered plans (coverage in effect before 2010 that cannot be newly issued) and grandmothered plans (cover-

age issued after 2010 but before 2014) (58). If Iowa insurers had phased out grandfathered plans and the state had prohibited grandmothered plans in 2015, marketplace plan premiums would have dropped by an estimated 8% to 18%, depending on how many persons switched to ACA-compliant coverage (59). Marketplace enrollment in Washington state rose by 8% in 2018, largely because insurers stopped offering off-marketplace plans in several areas (56).

Allowing the sale of noncompliant plans segments the risk pool and leads to higher premiums for marketplace-based coverage. Starting in 2019, Iowa will allow the state farm bureau and Wellmark Blue Cross Blue Shield to offer coverage that does not meet ACA requirements, triggering concerns that marketplace-based plan premiums will increase as healthy persons select the less comprehensive off-marketplace plans. Likewise, Idaho proposed to allow the sale of noncompliant plans but was blocked from doing so by CMS. The federal government has approved a proposal to allow the sale of extended STLD plans and has broadened access to association health plans, both of which are allowed to skirt ACA regulations. The CBO estimates that 2 million persons will enroll in extended STLD insurance plans starting in 2023 (60). The report finds that the combined effect of expanding the duration of STLD plans and access to association health plans would cause premiums for ACA-compliant individual and small group market plans to increase by 2% to 3% in most years. Federal and state regulators should take action to block noncompliant plans and encourage enrollment in coverage that meets ACA requirements. The ACP recommends that the federal regulations on association health plans and extended STLD policies be reversed. Until that happens, state regulators should take action to ban or at least curb the sale of these products, such as by limiting the duration of short-term plans, prohibiting plans from discriminating on the basis of health status and other factors, and penalizing insurance agents and brokers who mislead consumers about such coverage (61).

Reinsurance and Other Market Stabilization Programs

The ACA established risk adjustment, risk corridors, and reinsurance, a 3-pronged mechanism to stabilize premiums, balance risk, and protect against risk selection and adverse selection (62). The risk adjustment mechanism transfers payments between insurers on the basis of medical claims costs so that insurers with higher-than-expected medical claims receive higher compensation and those with lower-than-expected claims receive less compensation (62). Risk corridors intend to prevent insurers from setting premiums too high by requiring those with claims lower than a predetermined target to pay into a fund. The funds are then distributed to insurers with claims that are above the target. The reinsurance program provides financial protection for health plans with high-cost enrollees. The risk adjustment program is permanent, but the risk corridors and reinsurance programs ended in 2016. A permanent reinsurance program, as found in the Medicare Part D program, should be created to help stabilize the market and encourage insurer participation. Evidence shows that risk-sharing programs have been effective (63). Some states have received waivers from CMS to draw federal funding to support state-based reinsurance programs, which have successfully reduced premiums in Alaska, Minnesota, and other states (64).

4. Sustained funding is needed for dedicated outreach, consumer assistance, and education to promote open enrollment, provide in-person and virtual enrollment assistance, and respond to inquiries from the community.

The ACA was signed into law in 2010. Eight years later, much of the public remains confused about or unaware of its major coverage provisions. The ACA created the Navigator program and other community-based initiatives to provide education, outreach, and enrollment assistance, but the federal government slashed funding for the program in 2017 and 2018 (65). Nationally, federal funding for Navigators dropped 84% from 2016 to 2018 (66). The administration also cut funds to advertise open enrollment and shortened the open enrollment period, which may have contributed to declines in rates of marketplace-based plan coverage (67). In October 2017, just before the 2018 open enrollment period, President Trump declared the law to be "dead" (68) and news reports predicted "rampant public confusion" before the 2018 open enrollment period (69).

Millions of persons are eligible for public insurance or subsidized marketplace insurance but remain uninsured, which may partially be the result of a lack of awareness about the availability of affordable coverage options and confusion about the status of the ACA (70). Insurers and state and federal governments must fund efforts to promote the ACA's coverage programs, especially during open enrollment. State and local health departments also may be able to provide outreach and enrollment assistance (71, 72). Persons who receive enrollment assistance from a Navigator or other application helper are more likely to obtain coverage than those who do not; therefore, Navigator grants and other outreach and educational initiatives need sustained, sufficient funding to carry out their mission of reducing confusion and expanding understanding of what the law has to offer (73). Further, resources may be best directed toward persons who are eligible for Medicaid or premium tax credits and CSRs but are not enrolled in coverage (74). School-based enrollment ini-

tiatives and outreach through workplaces, the court system, and non–health-related public benefit programs may be options to reach the remaining uninsured. Survey data show that the volume of television commercials for federally sponsored health insurance is associated with persons shopping for and enrolling in marketplace-based insurance (75). Television advertising, social media, and other marketing efforts should communicate about open enrollment.

5. Federal and/or state governments should ensure that all individuals enroll in coverage by developing an auto-enrollment program, a penalty for failing to enroll upon eligibility, an individual mandate, or some combination of these approaches. Exemptions for financial hardship and residing in a non–Medicaid expansion state, among others, should be applied.

Critics of the individual mandate argue that it has been ineffective because of a low financial penalty and weak enforcement (76). An analysis by Frean and colleagues (77, 78) found that the individual mandate's exemptions and penalties had "little impact on coverage rates" in 2014 and 2015, possibly because of the penalty amount and limited consumer understanding of the mandate, although the mandate may have encouraged persons not subject to the penalty to enroll in coverage to comply with the law. A large majority of enrollees report purchasing coverage to protect against high medical bills or to achieve peace of mind rather than to avoid the individual mandate penalty (79). Less than 10% of insured adults say they will not keep their insurance in 2019 because of the individual mandate's repeal (67). Other evidence shows that the individual mandate has increased coverage rates. It may have driven the higher-income unsubsidized population (those with incomes over 400% FPL) to enroll in coverage, suggesting that the policy increased the number of nonelderly persons with insurance "by at least several million in 2016" (80). An analysis of empirical evidence on the effect of the individual mandate found that mandates increase health insurance enrollment, especially among younger and healthier persons (81). Stakeholders view the individual mandate as an unpopular but necessary means to encourage enrollment, especially among healthy persons. The CBO estimated that repeal of the individual mandate would result in a 10% increase in average individual market premium costs (82). One report concluded that if all states implemented a state-level individual mandate, marketplace premiums would fall by nearly 12% on average in 2019 and the number of uninsured would drop by almost 4 million in 2019 and 7.5 million in 2022 (83).

Alternative mechanisms to spur enrollment should be tested and implemented. An analysis of individual mandate alternatives concluded that auto-enrollment would not achieve as high an insurance coverage rate as a mandate (84). However, proponents of auto-enrollment cite opt-out 401(k) plans as evidence that it can be an effective way to encourage enrollment. Medicare Part B and D and some Medicaid programs use auto-enrollment (85). Other potential mechanisms include imposing a late penalty for failing to enroll, similar to the Medicare Part B penalty.

6. The American College of Physicians reaffirms support for Medicaid expansion. All states should fully expand Medicaid eligibility and should not apply financially burdensome premiums or cost-sharing requirements, lock-out periods, benefit cuts, or mandatory work or community engagement policies that have the effect of reducing enrollment among vulnerable individuals.

As outlined in the background section of this paper, expansion of the Medicaid program has resulted in major gains in health care access for millions of persons. However, many states have not expanded their Medicaid program, denying millions of low-income persons the chance to access affordable health care. Further, some states have used the Medicaid waiver process to establish onerous conditions for Medicaid eligibility. Arkansas expanded Medicaid through a private option program that allowed the Medicaid expansion population to enroll in private insurance using Medicaid funding. Access outcomes have been similar to those of Kentucky, which expanded eligibility through the traditional route (86). Among the most popular waiver proposals is a requirement that certain Medicaid enrollees and potential enrollees work, attend school, or be otherwise engaged in the community. Most nonelderly Medicaid enrollees are already working or would be exempt from work requirements because of disability or other reasons (87). Most enrollees report that Medicaid coverage enhances their ability to continue working and enables job seekers to look for employment (88, 89). Some evidence shows that work requirements would have only "modest impacts on job-searching behavior in this population" (90). Evidence from Arkansas shows that work requirements may have unintended consequences, including disenrolling persons who are working but unable or unaware that they need to report their work status to remain in the program (91). The ACP recommends that Medicaid expansion be implemented in a way that does not discourage enrollment or cause enrollees to disenroll, delay, or forgo care because of cost (92).

7. To encourage market competition, Congress should enact legislation to authorize the development of a public insurance plan to ensure enrollees have access to a variety of coverage options in their area. Potentially, the public option could be expanded to serve as a stepping stone to universal coverage.

Insurer participation has decreased in some areas of the country, with 8 states having only 1 insurer offering coverage in 2018. To provide more choice and

competition, persons eligible for marketplace-based coverage should have the option of enrolling in a public health insurance program. If proven viable, the public insurance option could potentially be opened to anyone seeking coverage. The Medicare Part D program features a fallback coverage option that triggers when an area does not have at least 1 standalone drug plan and at least 2 drug plans total. Because Part D participation has been robust, the fallback option has not been implemented. To expand options in the health insurance marketplaces, the federal government could establish a fallback plan in areas where 2 or fewer insurers are participating. This might be accomplished by opening enrollment to the Blue Cross Blue Shield Federal Employee Program's standard plan through a marketplace-specific risk pool separate from that of federal employees (93), or by borrowing aspects of Medicare's structure to build a new public option that conforms to recommendations outlined in the ACP position paper, "A Public Plan Option in a Health Insurance Connector" (94). The ACP also supports a Medicare buy-in option for persons aged 55 to 64 years (95).

A proposal introduced in the 115th Congress by Senators Tim Kaine (D-VA) and Michael Bennet (D-CO) would allow people to enroll in the "Medicare X" program, a public option–style marketplace-based insurance offering that uses Medicare's provider network and reimbursement policies but offers a modified benefit package that includes such categories as maternity care and pediatric services (96). The Medicare Trust Fund would not be affected. Initially, only persons residing in a county with 1 or 2 insurers participating in the individual insurance marketplace would be allowed to enroll; over time, the program would expand to individuals and small businesses in all counties. As currently devised, the proposal might conflict with ACP policy, because, for example, flawed aspects of the Medicare payment structure might be carried over to the Medicare X program.

As an alternative, a Medicaid buy-in proposal by Senator Brian Schatz (D-HI) would allow persons to purchase a Medicaid public insurance option alongside other marketplace-based coverage using their own funds, or premium tax credits and CSRs if applicable. Reimbursement rates for physicians and other health care professionals would be set at Medicare levels (97). This option would limit annual premiums for persons with incomes over 400% FPL at 9.5%, essentially eliminating the income eligibility cap for the premium tax credit. However, the appeal of Medicaid buy-in may be tempered because of political barriers (only Medicaid expansion states with low marketplace competition may be interested), hesitation among Medicaid managed care organizations to join the marketplace, and provider participation issues (98).

The CBO has considered a public option established and administered by the U.S. Department of Health and Human Services (99). Reimbursement rates for physicians and other providers would be 5% higher than Medicare rates and would increase incrementally over several years. Participation would be optional for physicians, hospitals, and others. Because provider reimbursement rates would be lower than those of commercial insurers, the CBO estimates that premiums would be up to 8% lower from 2016 to 2023 than those of private marketplace-based plans. Savings from administrative efficiencies and lower prescription drug prices also would be realized. Although premiums would be lower for some persons, the CBO estimates that lower reimbursements would diminish the quality of care delivered by providers. Further, the public option may attract higher-cost enrollees, leading to higher premiums to cover medical claims.

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