REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (I-26)
Improving Marketplace Affordability through Premium Tax Credits
(Reference Committee J)

EXECUTIVE SUMMARY

At the 2025 Interim Meeting, the House of Delegates referred a clause proposed as an additional recommendation to Council on Medical Service Report 1, Health Savings Account Reform. The clause asked the American Medical Association to advocate using the expanded Affordable Care Act (ACA) premium tax credits (PTCs) as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts (HSA) or other cash savings accounts. This report describes ACA PTCs, the enhanced subsidies available from 2021 through 2025, and the potential impacts of redirecting PTCs into HSAs.

The expiration of the enhanced PTCs at the end of 2025 contributed to sharp premium increases and precipitous enrollment declines this year, raising concerns about less stable ACA marketplaces and more financial stress on patients, hospitals, and physicians. To address affordability concerns, some healthcare proposals have promoted redirecting federal marketplace premium subsidies through HSAs or HSA-type accounts. Although the Council has heard support in the House of Delegates for the flexible use of HSAs when they are voluntary, we understand that HSAs are regressive and could worsen economic and racial disparities if policies require that marketplace subsidies be placed into such accounts. Notably, most marketplace enrollment growth between 2021 and 2025 stemmed from lower-income enrollees, who the enhanced PTCs helped the most but who would be least likely to benefit from an HSA. The Council is also concerned that HSA-focused ACA reforms could incentivize greater enrollment shifts into cheaper but less comprehensive plans, including catastrophic plans that have deductibles this year of $10,600 for individual and $21,200 for family coverage. Although the Council maintains that HSAs should be available to individuals purchasing qualified marketplace plans on a voluntary basis, we believe that increased premium assistance within the existing ACA PTC structure will be critical as healthcare costs, and the cost of coverage, continue to rise. Therefore, the Council recommends supporting enhancements to ACA marketplace subsidies, including PTCs, without redirecting subsidies into HSAs.

Of note, in a year of significant declines in marketplace enrollment, a few states opted to use state funds to help subsidize coverage for residents who had lost federal premium support. Although the Council recognizes that states face serious fiscal challenges and difficult funding choices, we hope that many states will at least consider investing in marketplace subsidies for their residents with lower incomes. Therefore, the Council recommends encouraging states, when possible, to consider supplementing federal premium subsidies.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-I-26

Subject: Improving Marketplace Affordability through Premium Tax Credits

Presented by: A. Patrice Burgess, MD, Chair

Referred to: Reference Committee J

At the 2025 Interim Meeting, the House of Delegates referred a clause proposed as an additional recommendation to Council on Medical Service Report 1, Health Savings Account Reform. It states the following:

> Our American Medical Association (AMA) advocates for using the expanded Affordable Care Act (ACA) premium tax credits (PTC) as a vehicle for improving health insurance affordability rather than converting those subsidies to health savings accounts (HSA) or other cash savings accounts.

This report describes ACA PTCs, the enhanced subsidies available from 2021 through 2025, and the potential impacts of redirecting PTCs into HSAs; summarizes relevant AMA policy; and makes policy recommendations. The purview of this report is limited to PTCs and HSAs, and does not make recommendations for broader improvements to ACA affordability, which the Council continues to monitor.

BACKGROUND

Enrollment in the ACA marketplaces reached a record high of 24.3 million people in early 2025, more than double the 12 million individuals who were enrolled in 2021[1] when Congress increased the generosity of the ACA's PTCs as part of the American Rescue Plan Act (Public Law 117-2). The enhanced PTCs, which decreased the maximum required contribution for previously eligible enrollees and extended eligibility to people with incomes exceeding 400 percent of the federal poverty level (FPL), also led many enrollees to choose higher actuarial value plans that helped decrease their out-of-pocket expenses.[2]

As highlighted in a 2025 AMA Federation sign-on letter to congressional leadership, the enhanced PTCs increased the affordability of marketplace plans and drew in healthier people, thereby improving the risk pool and lowering premiums overall. Originally set to expire in 2022, the more generous subsidies were extended through 2025 by the Inflation Reduction Act (Public Law 117-169), and sunsetted at the end of that year when Congress did not extend them. Notably, both the American Rescue Plan Act and the Inflation Reduction Act were partisan bills that were enacted via the federal budget reconciliation process. The expiration of the enhanced PTCs, along with marketplace changes made by H.R. 1 (Public Law 119-21) and relevant rulemaking, have contributed to sharp premium increases and precipitous enrollment declines in 2026, raising concerns about less stable marketplaces and more financial stress on patients, hospitals, and physicians whose practice revenues could be negatively impacted.

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Healthcare proposals from the Trump Administration and Congress have promoted an expanded role for HSA-type accounts to address affordability concerns stemming from the expiration of the enhanced PTCs. An HSA is a tax-advantaged savings account that consumers enrolled in high-deductible health plans (HDHP) can use to set aside money, without paying taxes, for qualified medical expenses. Of note, HSAs do not constitute health coverage and, under current law, funds generally cannot be used to pay health plan premiums.

PREMIUM TAX CREDITS AND AFFORDABILITY

In addition to creating federally-regulated health insurance marketplaces, the ACA established federal subsidies, including PTCs that were intended to lower the cost of marketplace premiums for individuals with incomes up to 400 percent of the federal poverty level (FPL).[3] These credits can either be claimed at the end of the year when filing federal taxes, and then reconciled, or be paid in advance based on an enrollee's estimated income. Advance PTCs are paid directly to the insurer and applied to an enrollee's monthly premium.[4]

The ACA's eligibility limit around PTCs created a "subsidy cliff" by excluding people whose incomes exceeded 400 percent FPL by even a small amount from receiving federal subsidies. In 2021, as the costs of health coverage across markets continued to rise amid the COVID-19 pandemic, Congress enacted temporary federal ACA subsidy enhancements that were subsequently extended through 2025. These enhancements increased the value of subsidies, decreased the maximum required premium contribution for previously eligible enrollees, and extended eligibility for PTCs to people with incomes above 400 percent FPL. Because the PTCs effectively cap an eligible individual's premium liability at a percentage of household income, expanding PTC eligibility improved affordability for most people who depend on the ACA, including small business owners, self-employed people, gig workers, farmers, and early retirees. In 2025, for example, 92 percent of marketplace enrollees received advanced PTCs.[5]

After the enhanced PTCs expired at the end of 2025, the average marketplace premium more than doubled for a formerly subsidized individual who was no longer eligible for PTCs. As many consumers faced substantial premium increases in 2026 (average net premiums increased 58 percent from 2025),[6] marketplace coverage became less affordable and less attractive to some as an insurance option. During open enrollment for the 2026 plan year, initial sign-ups fell across a majority of states, and by 1.2 million people nationally.[7] Moreover, as premiums became due at the beginning of this year, a substantial number of enrollees dropped coverage instead of absorbing such large premium increases. By February 2026, effectuated enrollment in the ACA marketplaces—meaning those people who signed up for plans and maintained their coverage by making premium payments—had declined to 19.2 million individuals, down considerably from 2025 but still higher than pre-Covid era enrollment figures.[8] Fifty-state survey data from Manatt Health similarly highlighted enrollment declines and "buy-downs" to lower-value plans, especially in states using the federal platform (healthcare.gov). For example, silver plan selection, which allows lower-income people to qualify for cost-sharing assistance that is not available to individuals enrolled in other metal tiers, fell by 28 percent as many consumers switched to bronze and catastrophic plans.[9] Although every state except New Mexico experienced marketplace enrollment declines this year, some states (e.g., California, Colorado, Connecticut, Maryland, Massachusetts, and New Jersey) were able to mitigate the severity of the decreases by using state resources to at least partially make up for the loss of the enhanced federal subsidies.[10]

The full extent of attrition from ACA marketplaces had not yet been reported at the time this report was written; however, early estimates projected that enrollment would drop by 17 to 26 percent in 2026.[11] Such sizeable attrition, if it materializes, will negatively impact the risk pool if the people

dropping coverage tend to be younger and healthier. Changes to the risk pool could in turn destabilize the marketplaces in some states, causing further rate increases and less competition if insurers choose to exit the market. Early rate filings from plan issuers quickly signaled the potential for double-digit rate increases next year, on top of the significant increases in effect this year.[12] An analysis of preliminary rate filings in 16 states and DC found that insurers in most states had requested 10 to 20 percent premium increases for the 2027 plan year, on top of this year's rate increases. KFF estimates that between 2025 and 2027, marketplace premiums will increase by more than one-third, citing the expiration of the enhanced PTCs, Centers for Medicare & Medicaid Services (CMS) regulatory changes, and the rising cost of healthcare as contributing factors.[13]

The AMA has advocated against CMS marketplace changes that expanded less comprehensive coverage options and removed important network adequacy standards, among other provisions affecting marketplace affordability. In July 2026, a Federal District Court in Maryland issued a preliminary ruling and opinion in *City of Columbus v. Kennedy* (2026) that granted a stay of eight provisions in CMS rulemaking that were set to take effect for plan year 2027. Last year, the AMA also urged Congress not to allow the enhanced PTCs to expire, highlighting in an AMA Federation sign-on letter that extending the more generous subsidies would have continued to lower premiums across income levels, mitigated financial barriers to care, and sustained enrollment in the marketplaces. In addition to affordability concerns, the AMA argued that allowing the more generous subsidies to expire would reverse enrollment gains, increase the uninsured rate, and raise uncompensated care costs for hospitals and physician practices.

HEALTH SAVINGS ACCOUNTS (HSAs)

HSAs are closely tied to United States tax code and therefore must follow a complex web of guidelines and regulations governing their use. Pre-tax dollars can be saved in an HSA and the funds can be used at any time in a person's life to pay for co-pays, prescriptions, dental care, contacts and eyeglasses, bandages, x-rays, and other qualified medical expenses as defined by the Internal Revenue Service. Under current law, insurance premiums are generally not considered a qualified medical expense. Of note, once individuals turn 65, HSAs are treated similar to traditional retirement accounts.

The rationale behind the creation of HSAs in 2003 was that the accounts would incentivize people to choose HDHPs and therefore reduce health spending. In the years since, the use of these accounts has increased significantly, as has the number of goods and services that can be purchased using HSA funds, many of which are not typically covered by health plans.[14] Council on Medical Service Report 1-I-25 established new AMA policy (Policy H-165.818) intended to improve usability and flexibility for individuals who have HSAs. Importantly, this policy also decisively affirms that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability, such as PTCs. As highlighted in the Council's report, HSAs provide account owners with several tax advantages but are considered regressive because higher income people are more likely to use such accounts, exempt larger amounts, and navigate complex tax rules to maximum advantage.[15] Research also shows that HSAs are distributed unevenly across race and ethnicity, with Latino and Black individuals about half as likely to have HSAs as white and Asian individuals.[16] Finally, HSAs also tend to benefit patients who are healthy compared to those that have chronic care needs or substantial medical expenses.

High-Deductible Health Plans (HDHP)

Several Council reports have discussed HDHPs, which HSAs must be paired with and which typically have higher deductibles and lower premiums when compared to traditional health plans.

High-deductible plans generally require patients to pay the full cost of health services and medications until the high deductibles are met. Although an HDHP's lower premium may be attractive to some consumers, the responsibility for out-of-pocket expenses can become problematic when deductibles are too high for enrollees to afford and patients are unable to cover the cost of needed care. Not surprisingly, studies have found that reductions in health spending achieved through HDHPs are primarily due to patients simply receiving less medical care.[17]

An H.R. 1 (Public Law 119-21) provision allows ACA marketplace bronze and catastrophic plans to be treated as HSA-eligible HDHPs so that individuals who opt for these higher-deductible plans can take advantage of HSA tax and savings benefits. Regardless of actual deductible amounts, Policy H-165.828 supports bronze and silver plans being treated as HSA-qualified HDHPs, as long as appropriate guardrails are in place to ensure lower-income enrollees do not suffer financial hardships. As the Council noted in its 2025 report, HSAs can benefit some individuals but should not be considered a one size fits all approach, nor should they be considered a replacement for health insurance.

Proposals to Redirect ACA Subsidies into HSAs

In the months leading up to the expiration of enhanced PTCs at the end of last year, some Republicans in Congress proposed funneling subsidy amounts through HSAs or HSA-type accounts for eligible marketplace enrollees. For example, the Health Care Freedom for Patients Act (S. 3386), introduced by Senators Mike Crapo and Bill Cassidy, called for placement of enhanced subsidy amounts (but not baseline PTCs) into HSAs paired with bronze or catastrophic plans. Under this legislation, eligible individuals earning less than 700 percent FPL would receive $1,000 in an HSA if aged 18 to 49, and $1,500 if aged 50 to 64. Legislation introduced by Senator Rick Scott (R-FL) (S. 3264) would allow states to apply for waivers to place PTC and cost-sharing reduction amounts into HSA-type accounts called Trump Health Freedom Accounts. This bill would allow money in these accounts to be used for health plan premiums for any type of plan, including short-term limited duration policies, thus broadening the rules regarding qualifying medical expenses.[18] In January 2026, the Trump Administration announced the Great Healthcare Plan, which broadly proposes to "stop sending big insurance companies billions in extra taxpayer-funded subsidy payments and instead send that money directly to eligible Americans to allow them to buy the health insurance of their choice."[19] Although details of that plan were not yet available at the time this report was written, it may signal continued debate about using HSA-type accounts as a substitute for federal premium subsidies.

Channeling federal subsidies through HSAs in the ACA market could benefit both the healthiest enrollees whose spending on healthcare is relatively low, and those with the highest incomes who can afford high deductibles and out-of-pocket expenses. Presumably, these enrollees would be better able to set aside and roll over federal HSA contributions, allowing funds to grow tax free for future use. The availability of comprehensive coverage (e.g., bronze or silver plans) paired with HSAs could potentially incentivize such enrollees to keep marketplace coverage, which would improve the overall risk pool, although only catastrophic and bronze plans currently qualify as HDHPs. Proponents of HSA-focused options also argue that the accounts give patients more choice and control over their healthcare, incentivize consumers to price-shop and seek more value, and help HSA owners plan for future healthcare expenses.[20]

Under current law, plans that redirect federal premium subsidies into HSAs would reduce the total amount of federal premium assistance because HSA funds cannot be used to pay premiums. Since both the original and enhanced PTCs were designed to make marketplace premiums more affordable, plans substituting HSAs for PTCs may be viewed as pivoting away from the intended

purpose of direct premium assistance while shifting financial risk away from insurers and onto patients.

Redirecting subsidies into HSAs would also incentivize more consumers to choose cheaper, less comprehensive plans with deductibles so high that an unexpected illness could put them in financial straits. Notably, average bronze plan deductibles in 2026 are nearly $7,500; for catastrophic plans, deductibles are $10,600 for individuals and $21,200 for family coverage, the maximum allowed by the ACA,[21] sums that far exceed proposed federal contribution amounts for HSAs. Although such plans may work well for healthier and wealthier consumers, most marketplace enrollees are from lower- and middle-income households and are less likely to have sufficient disposable income to benefit from HSAs.[22] Thus, concerns have been raised that consumers incentivized to sign up for these plans may ultimately choose to delay or forego needed care if they cannot afford to pay for medical services before their high deductibles are met. Some enrollees in less comprehensive high-deductible plans may also incur increased medical debt. Furthermore, enrollment growth in bronze and especially catastrophic plans, even when paired with HSAs, could also make it more difficult for physician practices and other providers to be paid for services rendered, potentially increasing uncompensated care costs. Analysts have also expressed concern that, under a broad plan like Senator Scott's, healthier people could opt into less comprehensive plans (e.g., catastrophic or short-term limited duration plans) or not enroll at all, harming the risk pool and potentially destabilizing some marketplaces.[23]

AMA POLICY

Numerous AMA policies address the issues raised in the referred proposed recommendation, including policies supporting original and enhanced PTCs, and policies addressing HSAs and HDHPs.

PTCs, Enhanced PTCs: AMA policy supports the use of appropriately structured and adequately funded tax credits as the most effective mechanism for enabling uninsured individuals to obtain health insurance coverage (Policy H-180.951). Policy H-165.865 maintains that tax credits should be refundable and advanceable, and large enough to ensure that health insurance is affordable for most people. Under Policy H-165.824, the AMA supports improving affordability in health insurance exchanges by expanding eligibility for PTCs beyond 400 percent of the FPL (up to 500 percent of the FPL); increasing the generosity of PTCs; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. This policy also encourages state innovation, including consideration of state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize premiums without undercutting existing patient protections. Policy H-165.820 supports extending the enhanced PTCs established under the American Rescue Plan Act and the Inflation Reduction Act.

HSAs: Policy adopted by the House of Delegates in 2025 (Policy H-165.818) supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. Policy H-165.818 also supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans as well as some HSA flexibilities.

The AMA also has policy on how HSAs fit into the larger health insurance landscape. For example, Policy H-165.852(3) states that advocacy of HSAs continues to be incorporated prominently in AMA's campaign for health insurance reform, indicating the organization's commitment to improving HSAs, while Policy H-165.833 states that as part of the AMA's organizational goal of improving the ACA, the AMA will advocate to expand the use of HSAs.

Policy H-165.828 supports individual market bronze and silver plans being treated as HSA-qualified HDHPs, with appropriate guardrails in place to ensure low-income enrollees in these plans do not suffer financial hardships. This policy also 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 an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. Policy H-165.865 states that tax credits should be applicable only for the purchase of health insurance, including all components of a qualified HSA, and not for out-of-pocket health expenditures.

Policy H-165.852 supports legislation promoting the establishment and the use of HSAs and allowing the tax-free use of such accounts for healthcare expenses, including health, dental, vision, hearing, and long-term care insurance premiums and other costs of long-term care, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance. This policy also supports enhancing activities to educate patients about HSAs. Under Policy H-385.912, consumers should be able to use HSAs to access direct primary care.

Policy H-290.972 outlines principles for states to consider when deciding whether to offer HSA programs to Medicaid beneficiaries. These guidelines include, amongst other standards, making beneficiary participation voluntary, providing first-dollar coverage for preventive care, and allowing payments to non-Medicaid providers by beneficiaries to count towards deductibles and out-of-pocket spending limits. Under Policy D-165.962 the AMA will monitor pending regulations and take appropriate steps to ensure access to HSAs by all Medicare eligible individuals. Policy D-165.954 states that the AMA will monitor and support rigorous research on the impact of HSAs and health reimbursement arrangements on physician practices, and on levels and appropriateness of utilization, including preventive care, costs, and account savings.

HDHPs: Policy H-165.852 states that deductible limits for families should be the lower of either the individual or family combined deductible. Policy H-185.918 encourages strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. Policy D-180.979 encourages states and other stakeholders to monitor the growth of HDHPs to assess the impact of such plans on access to care, health outcomes, medical debt, and provider practice sustainability. This policy also advocates for the inclusion of health insurance contract provisions that permit network physicians to collect patient cost-sharing obligations at the time of service. Policy H-165.849 similarly opposes health plan requirements that require physicians to bill patients for out-of-pocket payments and do not allow physicians to collect these payments in a more efficient manner, such as collecting at point-of-service, establishing systems of electronic transfers from a patient's account, or offering cash discounts for expedited payment.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. Accordingly, the AMA has supported the right of individuals to choose the type of health coverage that best meets their needs, with an HDHP paired with an HSA being one such option. While supporting the use of HSAs for those who want them, AMA policy (Policy H-165.818) also underscores that HSAs should be complementary to—and not replace—health insurance coverage or other efforts to improve affordability, such as ACA PTCs.

In the ACA market, AMA policy supports treating bronze and silver plans as HSA-qualified HDHPs, with appropriate guardrails in place to ensure that lower-income enrollees do not suffer financial hardships (Policy H-165.828). Existing policy also supports tax credits that are large

enough to ensure that insurance is affordable for most people (Policy H-165.865), and expanding eligibility for PTCs beyond 400 percent FPL (Policy H-165.824).

The Council has heard support in the House of Delegates over the years for the flexible use of HSAs when they are voluntary. At the same time, we understand that HSAs can be regressive and could worsen economic and racial disparities if policies require that marketplace subsidies be placed into such accounts. Most marketplace enrollment growth between 2021 and 2025 stemmed from lower-income enrollees,[24] who the enhanced PTCs helped the most but who would be least likely to benefit from an HSA. The Council is also concerned that HSA-focused ACA reforms could incentivize even greater enrollment shifts into less comprehensive plans—including catastrophic and short-term limited duration plans—that provide less coverage, worsen healthcare affordability challenges, and cause patients to forego needed healthcare if they cannot afford their high deductibles. Furthermore, enrollment growth in marketplace high-deductible plans, even when paired with HSAs, could in turn increase physician's uncompensated care costs and/or add to patients' medical debt. Although the Council maintains that HSAs should be available to individuals purchasing qualified marketplace plans on a voluntary basis, we believe that increased premium assistance within the existing ACA PTC structure will be critical as healthcare costs, and the cost of coverage, continue to rise.

Although redirecting baseline or enhanced PTCs into HSAs or HSA-type accounts could benefit healthier marketplace enrollees and those with higher disposable incomes, the Council does not believe such policies would offset the loss of enhanced PTCs, lower costs for most marketplace consumers, or adequately mitigate affordability concerns. As previously noted, HSAs shift financial risk onto patients and should not be viewed as a replacement for federal premium assistance. Accordingly, the Council recommends that the AMA support enhancements to ACA marketplace subsidies, including PTCs, without redirecting subsidies into HSAs.

During the development of this report, the Council learned that a few states (e.g., California, Colorado, Connecticut, Maryland, Massachusetts, and New Jersey) used their own funds this year to help subsidize coverage in order to stabilize enrollment and improve affordability for residents who had lost federal premium support. In a time of general enrollment downturn, New Mexico actually increased enrollment in its marketplace by 17 percent by fully backfilling the lost federal enhanced subsidies, though it was the only state to fully make up for the expired enhanced PTCs.[25] Other states amended existing state subsidy programs to address a growing need for premium assistance, including Massachusetts, where an additional $250 million was invested and Connecticut, which spent an additional $51 million.[26] The Council recognizes that states cannot be expected to offset the loss of the enhanced federal PTCs, and that states face serious fiscal challenges and difficult funding choices due to federal cuts to Medicaid, SNAP, and other programs. However, since some states funded marketplace subsidies this year, we also believe that states should at least consider investing in marketplace subsidies, particularly for residents with the lowest incomes. Therefore, the Council recommends encouraging states, when possible, to consider supplementing federal ACA premium subsidies using state funds in order to stabilize enrollment and improve affordability. In addition, the Council recommends that the AMA reaffirm Policy H-165.818, which supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. Finally, the Council continues to study marketplace affordability and will present future policy recommendations to the House of Delegates as needed.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted and the remainder of the report be filed:

1. That our American Medical Association (AMA) advocate for enhancements to Affordable Care Act (ACA) marketplace subsidies, including premium tax credits, without redirecting subsidies into health savings accounts (HSAs). (New HOD Policy)

2. That our AMA encourage states, when possible, to supplement federal ACA premium subsidies using state resources in order to stabilize enrollment and improve affordability. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.818, which supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance, such as ACA premium tax credits. (Reaffirm HOD Policy)

Fiscal Note: Minimal

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[25] Pogue *supra* note 10.
[26] *Ibid*.

Council on Medical Service Report 5-I-26
Improving Marketplace Affordability through Premium Tax Credits
Policy Appendix

Health Savings Account Reform H-165.818

1. Our American Medical Association (AMA) supports permitting health savings account (HSA) contributions from family members, employers, or other designated individuals and not limiting HSA contributions to the owner of the high-deductible health plan, provided that annual Internal Revenue Service contribution limits are not exceeded.
2. Our AMA supports contributions to HSAs by individuals who are Medicare enrollees with support for external research and/or demonstration projects to determine how best those distributions can be spent, with special consideration for low-resource Medicare enrollees.
3. Our AMA supports external research and/or demonstration projects on the feasibility and tax integrity of transferring HSA funds between spouses and other family members.
4. Our AMA supports Affordable Care Act (ACA) premium tax credits designed to allow individuals to contribute to HSAs through the application of unused or residual credit amounts.
5. Our AMA supports education on the use of HSAs to Medicare beneficiaries and purchasers of ACA marketplace plans, including those purchasing bronze plans and how that plan compares to purchasing a silver plan with subsidies.
6. Our AMA supports the principle that HSAs are complementary to and do not replace health insurance coverage or other efforts to improve affordability of health insurance such as ACA premium tax credits. (CMS Rep. 01, I-25)

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
    i. 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; and
    ii. supports individual market bronze and silver plans, regardless of actual deductible amount, being treated as HSA-qualified high-deductible health plans, with appropriate guardrails in place (e.g., safe harbor provisions) to ensure low-income enrollees in these plans do not suffer financial hardships.
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.
9. Our AMA supports that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan.
10. Our AMA supports incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families.
11. Our AMA supports any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected.
12. Our AMA advocates that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay fair and equitable rates. (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; Reaffirmed: Res. 826, I-24; Appended: CMS Rep. 02, A-25; Modified: CMS Rep. 01, I-25)

Principles for Structuring a Health Insurance Tax Credit H-165.865
(1) AMA support for replacement of the present exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits will be guided by the following principles: (a) Tax credits should be contingent on the purchase of health insurance, so that if insurance is not purchased the credit is not provided. (b) Tax credits should be refundable. (c) The size of tax credits should be inversely related to income. (d) The size of tax credits should be large enough to ensure that health insurance is affordable for most people. (e) The size of tax credits should be capped in any given year. (f) Tax credits should be fixed-dollar amounts for a given income and family structure. (g) The size of tax credits should vary with family size to mirror the pricing structure of insurance premiums. (h) Tax credits for families should be contingent on each member of the family having health insurance. (i)Tax credits should be applicable only for the purchase of health insurance, including all components of a qualified Health Savings Account, and not for out-of-pocket health expenditures. (j) Tax credits should be advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs.
(2) It is the policy of our AMA that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the United States Code.
(3) Our AMA will support the use of tax credits, vouchers, premium subsidies or direct dollar subsidies, when designed in a manner consistent with AMA principles for structuring tax credits and when designed to enable individuals to purchase individually owned health insurance. (CMS

Rep. 4, A-00; CMS Rep. 5, A-00; Reaffirmation I-00; Reaffirmation A-02; Reaffirmation I-03; CMS Rep. 2, A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 01, A-24)

Improving Affordability in the Health Insurance Exchanges H-165.824

1. Our American Medical Association will:
    a. support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits.
    b. support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level.
    c. support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.
    d. encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections.
2. Our AMA supports:
    a. eliminating the subsidy “cliff”, thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL).
    b. increasing the generosity of premium tax credits.
    c. expanding eligibility for cost-sharing reductions.
    d. increasing the size of cost-sharing reductions. (CMS Rep. 02, A-18; Appended: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Res. 826, I-24)