REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-25)
Reconsidering the Affordable Care Act (ACA) Eligibility Firewall
(Resolution 103-A-23)
(Reference Committee A)

EXECUTIVE SUMMARY

As highlighted in this report, employer-sponsored health insurance (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. A provision in the Affordable Care Act (ACA), colloquially referred to as "the firewall," prohibits workers with "affordable" and "adequate" ESI offers from receiving premium tax credits to purchase marketplace plans.

The main concerns from Council on Medical Service about eliminating the firewall abruptly and fully include the potential impacts on physician payment and practice sustainability, employer behavior and ESI stability, and federal expenditures, since allowing millions of people to opt out of ESI coverage and into the ACA marketplace could prove to be prohibitively expensive, while also disrupting both ESI and ACA markets. Instead, the Council recommends an incremental approach to reducing the affordability threshold that prioritizes workers most in need. As such, we believe it makes the most sense to support a firewall policy change that targets individuals and families with the lowest incomes who could benefit the most from ACA premium tax credits and cost-sharing subsidies that are not available under ESI. Accordingly, the Council recommends that it be the policy of our AMA 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. We believe this recommendation is an appropriate first step in addressing ESI affordability challenges while at the same time preserving physician practice sustainability, stability in the ESI market, and limits on federal spending increases.

Because ESI enrollees with lower incomes are more likely to report difficulties covering the costs of medical care and may not know if they are subject to the firewall, 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.

To address physician payment concerns, the Council also recommends advocating that physician payments by 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 no less than prevailing Medicare rates.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-25

Subject: Reconsidering the Affordable Care Act (ACA) Eligibility Firewall (Resolution 103-A-23)

Presented by: Stephen Epstein, MD, MPP, Chair

Referred to: Reference Committee A

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

Health Insurance Affordability H-165.828[1]
~~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 that which applies to the exemption from the individual mandate of the Affordable Care Act (ACA).~~Our AMA advocates for the elimination of the employer-sponsored insurance firewall such that no individual would be ineligible for premium tax credits and cost-sharing assistance for marketplace coverage solely on the basis of having access to employer-sponsored health insurance.

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

Options to Maximize Coverage Under the AMA Proposal for Reform H-165.823[2]
2. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
~~b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.~~
b~~e~~. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
c~~d~~. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
d~~e~~. The public option is financially self-sustaining and has uniform solvency requirements.

ef. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
fg. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits—at no or nominal cost.

Council on Medical Service Report 2-A-24 was referred back to the Council to ensure that the recommendations maximize patient access to care while protecting physician practice revenue and sustainability. This report discusses employer-sponsored insurance (ESI) affordability, explains the ACA affordability threshold (known as the "firewall"), summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Almost a decade and a half after enactment of the ACA, employer-sponsored insurance ESI continues to be the dominant source of health coverage for Americans under 65 years of age. In 2023, 164.7 million people under age 65, or 60 percent of the non-elderly population, had health insurance coverage through an employer.[1] Although ESI is the most common type of health insurance, coverage varies significantly by income as well as race and ethnicity. While 84 percent of individuals with incomes at or above 400 percent of the federal poverty level (FPL) had ESI, it covered fewer than one-quarter of individuals with incomes below 200 percent FPL. Additionally, larger percentages of white and Asian people have ESI while individuals who are African American and Latino are less likely to have employer-based coverage.[2,3]

Overall, most Americans appear satisfied with employment-based coverage. According to KFF's survey of consumer experiences with health insurance, in 2023, 80 percent of adults with ESI and 73 percent of those with ACA marketplace coverage rated their health coverage as "excellent" or "good" although people in poorer health gave more negative ratings across all plan types. Regardless of health status, enrollees in marketplace plans were most likely to rate their experiences with health insurance as fair or poor.[4] Ninety-three percent of workers responding to a 2022 poll sponsored by the U.S. Chamber of Commerce expressed high rates of satisfaction with ESI, with a large majority (89 percent) expressing a preference for ESI over other types of coverage.[5] Eighty percent of respondents to this survey ranked health insurance as the most important workplace benefit provided to them, and a majority cited "affordability" and "high quality" as ESI's most critical features.[6]

Although ESI is popular, it has become increasingly costly for employers and employees, especially small firms and lower-income workers. According to 2024 data from the KFF Employer Health Benefits Survey:

- Fifty-four percent of all firms offered health benefits, including almost all (98 percent) large employers (those with 200 or more workers) and just over half (53 percent) of smaller firms (those with three to 199 workers). Eight percent of firms with at least 50 employees that offer health benefits offer a plan that has a narrow provider network.[7]
- Seventy-five percent of eligible employees took up coverage when it was offered to them, a slight decrease from 2013 (80 percent) and a more sizeable decrease from 2003 (84 percent). Across both firms that offer health benefits and those that do not, more than half (54 percent) of workers have employer coverage.[8]
- Annual health insurance premiums averaged $8,951 for individual coverage and $25,572 for family coverage, six and seven percent more than last year, respectively. In comparison, the

Bureau of Labor Statistics found that wages increased 4.5 percent while inflation grew by 3.2 percent. Notably, premiums for family coverage have increased 24 percent over the last five years while, during the same time period, inflation has risen 23 percent and wages have increased 28 percent. Workers pay, on average, $1,368 annually for individual coverage and $6,296 toward the cost of family premiums.

- Seventy-six percent of firms offering coverage offered only one type of plan. Large firms were significantly more likely to offer more than one plan type than small firms.
- Almost half (48 percent) of covered employees are enrolled in preferred provider organizations (PPOs), the most common plan type offered. Twenty-seven percent of covered workers are enrolled in a high-deductible health plan (HDHP) with savings option.[9]

ESI Affordability

To manage costs, many employer-based plans include substantial deductibles and other out-of-pocket cost-sharing that, together with premium contributions, increase employee health costs and impact affordability.[10] The comparability of ESI and ACA marketplace plan affordability is complicated by differences among enrollees across plans; differences in plan design and regulatory requirements; and enrollee tax savings. In a 2024 report, the U.S. Government Accountability Office (GAO) found that average premiums for employer plans in 2022 were lower than average premiums for marketplace plans. However, after accounting for employer contributions to workers' premiums and federal premium tax credits for marketplace plans, average worker premium contributions to ESI plans were higher than average enrollee premium contributions to marketplace plans.[11] A report from The Commonwealth Fund and Urban Institute found that, prior to the American Rescue Plan Act of 2021 (ARPA) enhancements to marketplace premium tax credits, adults with nongroup coverage reported higher average premiums and health care costs than ESI enrollees and were more likely to report foregoing health care and having problems affording care.[12]

According to KFF's 2024 Employer Health Benefits Survey, the average annual deductible for employees with single coverage was $1,787, a figure that has held relatively steady over the last five years but is 47 percent higher than the average deductible amount 10 years ago.[13] Overall, nearly a third of employees (32 percent) had plan deductibles of $2,000 or more, including half of workers at small firms, whose average annual deductible was $2,575 compared to $1,538 for employees of larger firms.[14]

High-Deductible Health Plans: Not only are deductible amounts rising, but more workers are now covered by high-deductible health plans (HDHPs), which typically have higher deductibles and lower premiums when compared to traditional plans. Such plans generally require patients to pay the full cost of health services and medications until deductibles are met. Although an HDHP's lower premium may be attractive to some people, the responsibility for out-of-pocket expenses becomes problematic when deductibles are too high for enrollees to afford and patients are unable to cover their costs. Not surprisingly, studies have found that reductions in health spending achieved through HDHPs are primarily due to patients simply receiving less medical care as they become more cost-conscious when seeking services.[15] As previously highlighted by the Council on Medical Service (Council on Medical Service Report 2-Nov-20, Mitigating the Negative Effects of High-Deductible Health Plans), the imposition of greater consumer cost-sharing is frequently used to ensure that those receiving health care services "have skin in the game," and as a lever to minimize premium growth.

Over the years, HDHPs have become a more common ESI offering. Among workers with HDHPs, 52 percent had plans with Health Savings Accounts (HSAs) while eight percent participated in

plans with Health Reimbursement Arrangements (HRAs), figures that varied considerably between high and low wage employees. Among workers in the lowest 25 percent wage category, 32 percent had plans with HSAs and 12 percent had HRAs. Among workers in the highest 25 percent wage category, 66 percent had plans with HSAs and seven percent had HRAs.[16] Theoretically, lower premiums may result in higher wages that may help offset the risk associated with HDHPs.

Small Employer Coverage: Health coverage is especially challenging for small business, whose employees frequently pay more for health coverage. According to the Commonwealth Fund, these workers generally contribute a greater share of premium costs and have larger deductible amounts than large-firm employees.[17] KFF has also highlighted the lack of affordable family coverage options for workers at smaller firms employing fewer than 200 people. These employees pay on average $8,334 towards family coverage premiums each year with a quarter paying at least $12,000 annually, not including deductibles and other cost-sharing expenses.[18]

Lower-Income Employees and Affordability: Several analyses have pointed out that workers with lower incomes are disproportionately burdened by ESI costs and usually pay a greater share of income toward employer plan premiums and other out-of-pocket expenses.[19, 20, 21] A KFF analysis of data from its 2023 survey of consumer experiences with health insurance found that adults with incomes below 200 percent FPL who have ESI were significantly more likely than higher-income peers to report difficulties paying for medical care; treatment delays and declines in health due to insurance problems, such as prior authorization; dissatisfaction with the availability and quality of health providers in their plan's network; and more difficulty comparing plans and signing up for coverage.[22] Additional KFF research from 2022 found that, on average, families with incomes below 200 percent FPL pay approximately 10.4 percent of income toward health care premiums and out-of-pocket expenses (7.7 percent for premiums) while those with incomes at or above 400 percent FPL pay about 3.5 percent toward premiums and medical expenses (2.3 percent for premiums).[23] Though employers could utilize health benefit design strategies to address affordability issues facing lower-income workers, few seem to do so; in 2022, 10 percent of large firms reportedly had programs that lowered premium costs for lower-income employees while only five percent reported programs to lower their cost-sharing expenses.[24] COBRA coverage is often too costly an option for workers who are leaving a job.

Though many workers mistakenly think otherwise, they—not the firms they work for—pay the majority of ESI costs, both directly through contributions and indirectly through wage adjustments made to cover employers' health care costs.[25] Building on the literature linking growth in health insurance costs to stagnant wages, a 2023 *JAMA* analysis suggests a likely association between increased premium costs for workers with ESI family coverage and decreased earnings and increased income inequality.[26] Because workers earning lower wages contribute a greater share of income toward ESI premiums, the analysis posits that making employer plans more affordable for lower-wage workers could help address earnings inequality. This study also identified large disparities in premium costs as a percentage of income by race (African American and Latino families paid higher percentages of earnings toward premium costs than white families), and found that over 30 years, families with ESI may have cumulatively lost, on average, more than $125,000 in earnings due to increases in premium costs.[27]

ACA Provisions on Affordability and Employer Shared Responsibility

Though not nearly as dominant as ESI, ACA marketplace plans have become a growing source of health coverage; in January 2025, more than 23 million people had enrolled in marketplace plans, up from 11 million in 2020.[28] Under the ACA, individuals are not eligible for marketplace premium tax credits if they are eligible for "minimum essential coverage," which is broadly

defined to include Medicare, Medicaid, and other public programs as well as ESI. Accordingly, individuals with offers of coverage from an employer do not qualify for ACA marketplace subsidies unless their ESI offer is deemed either unaffordable or inadequate. In 2025, an employer plan was considered unaffordable if an employee's premium contribution exceeded 9.02 percent of that person's household income.[29] To be considered adequate, a plan must cover at least 60 percent of average costs (actuarial value); anything less is deemed inadequate.[30] The ACA provision making workers with affordable and adequate ESI offers ineligible to receive premium tax credits to purchase marketplace coverage is colloquially referred to as "the firewall." This affordability threshold was established to address multiple concerns with the landmark legislation; namely, to prevent disruption to the ESI market and prevent prohibitive increases in federal spending (for marketplace subsidies) while preserving ESI as the principal source of health coverage in this country. Notably, the affordability threshold changes from year to year based on a methodology that considers rates of premium growth and income growth.

As explained in a 2014 Council on Medical Service Report on the future of ESI, the ACA aimed to build upon the ESI framework and provide low-income, non-elderly individuals without access to ESI with either Medicaid coverage or subsidized private coverage offered through the nongroup marketplace. As such, provisions in the ACA statute included incentives and penalties intended to prevent disruption to the ESI market. For example, to incentivize employers to continue offering coverage, the ACA contained an "employer shared responsibility" provision, also called the "employer mandate," which requires employers with 50 or more full-time employees to either offer affordable minimum essential coverage to full-time employees and their dependents or pay a penalty to the Internal Revenue Service (IRS).[31] Under this provision, employers face two potential penalties:

- If an employer does not offer minimum essential coverage to at least 95 percent of its full-time employees and dependents, and at least one employee receives a premium tax credit for coverage offered through an ACA exchange, the employer faces a penalty that is based on all full-time employees (except 30), including those who have ESI or coverage from another source. In 2024, the penalty was $2,970 per employee.[32]
- If an employer offers coverage to at least 95 percent of its employees but at least one employee obtains a premium tax credit for ACA coverage due to the employer's coverage not being "affordable" or "adequate," the employer must pay a penalty for each employee who receives the premium tax credit. In 2024, the penalty is $4,460 per employee.[33]

AMA Policy on the ACA Affordability Threshold

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

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

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

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

> … modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered ESI 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 ACA coverage.

Federal Subsidies for ACA Premium Tax Credits and Cost-Sharing

In 2023, the federal government subsidized coverage obtained through the ACA marketplaces and the Basic Health Program (BHP) at a cost of $92 billion.[34] This figure includes ARPA federal subsidy enhancements for premium tax credits and cost-sharing reductions that were extended through 2025 by the Inflation Reduction Act (IRA), which decreased the maximum required contribution for previously eligible enrollees and extended eligibility to people with incomes exceeding 400 percent FPL, effectively reducing premium costs by 44 percent, on average.[35] Prior to ARPA, required premium contribution percentages ranged from about two percent of household income for people with poverty level income to nearly 10 percent of income for people with incomes between 300 to 400 percent FPL; people earning more than 400 percent FPL were not eligible for premium tax credits.[36] This year, as shown in Table 1, required premium contribution percentages range from zero for people with less than 150 percent FPL to 8.5 percent for those making around 400 percent FPL or more.

Table 1: Required Individual Contribution Percentage for 2025[37]

Household income percentage of Federal poverty line:	% at start of range	% at top of range
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%

The more generous federal subsidies have made marketplace plan premiums much more affordable while targeting the largest premium tax credits to people most in need. Notably, more than 90 percent of the 21 million people enrolled in marketplace coverage in 2024 received subsidies that lowered their premium amounts. If the subsidies are not extended beyond 2025, many people will face substantial premium increases, making marketplace coverage less affordable and less attractive as an insurance option. According to the Congressional Budget Office (CBO), without a permanent extension of the premium tax credits, healthier people will leave the ACA marketplace and premiums will rise for remaining enrollees by an estimated 4.3 percent in 2026, 7.7 percent in 2027, and 7.9 percent, on average, over the 2026-2034 period. The CBO also estimates that the number of uninsured people will increase by 2.2 million in 2026, 3.7 million in 2027, and 3.8 million on average between 2026 and 2034.[38] The Urban Institute projects that expiration of the enhanced subsidies will cause four million people to lose health insurance, especially in states that have not adopted Medicaid expansion.[39] According to the Commonwealth Fund, the loss of enhanced subsidies after 2025 would also cause significant economic harm to states, including job losses to health providers and other economic sectors.[40]

Premium tax credits for ACA marketplace coverage are calculated by subtracting the required contribution from the actual cost of the "benchmark" (second-lowest-cost silver) plan, though the credit can be applied toward any marketplace plan except catastrophic coverage.[41] People with incomes below 250 percent FPL also receive subsidies for cost-sharing expenses that are based on income, so that people with incomes between 100 and 150 percent FPL receive the most generous subsidies.[42] These cost-sharing reductions are only available to those enrolled in silver plans. According to the CBO, in 2023 the average federal subsidy per ACA marketplace/BHP enrollee was $5,990,[43] although the range of subsidy amounts is considerable.

Federal Subsidies for ESI

For many decades, the U.S. tax code has provided a sizeable tax benefit to both employers and employees by excluding premium contributions towards ESI from federal income and payroll taxes. As ESI premiums have risen over the years, so has the tax benefit. The amount of an individual's subsidy depends on that person's marginal tax rate that would be owed if employer-paid premiums were taxed as wages. Accordingly, people with greater incomes and higher marginal tax rates receive larger federal ESI subsidies than people with lower-incomes and lower tax rates.[44] According to the CBO, the average federal subsidy per ESI enrollee in 2023 was $2,170.[45]

In part due to the enhanced subsidies for marketplace enrollees established by ARPA and extended by the IRA, several analysts have observed a growing disparity between federal subsidies that help defray ACA marketplace plan costs, and subsidies for ESI coverage. To illustrate this expanding gap, a 2024 American Enterprise Institute (AEI) paper calculated the value of subsidies that would be received by a family of four with $75,000 in income, depending on whether they purchased ESI or marketplace coverage. According to AEI, if the family enrolled in an employer-based plan, their tax subsidy would be around $4,100, compared to the more than $15,000 in federal premium subsidies the family would be eligible for if enrolled in a marketplace plan.[46] Other analyses have noted that workers with lower incomes may be contributing more for an employer-based plan than they would pay for coverage under a subsidized marketplace plan, and that it could be financially advantageous for these workers to move to the marketplace.[47] However, lower-income workers, including those with incomes at or below 200 percent of FPL ($30,120 for an individual; $62,400 for a family of four), cannot enroll in marketplace coverage if they have an offer of ESI. Without the firewall, and if current subsidy enhancements are extended, workers earning less than 150

percent of FPL would be eligible for zero premium silver plans in the ACA marketplace as well as generous cost-sharing reductions. Employees making 200 percent of FPL would also be eligible for cost-sharing reductions and their premium contributions would be capped at two percent of household income.[48] Thus, lower-income workers at or below 200 percent of FPL may find more affordable coverage on the marketplace, depending on how much they must pay for premiums, deductibles and copayments under their ESI plan.

Importantly, some lower-income employees who would be financially incentivized to enroll in a marketplace plan if the firewall is repealed might opt to retain ESI coverage if they are satisfied with their plan and able to see the physicians they want in a timely manner. The Centers for Medicare & Medicaid Services has previously acknowledged the proliferation of narrow networks among ACA exchange plans, and several studies have demonstrated varying degrees of challenges facing marketplace enrollees attempting to access in-network providers, most commonly mental health specialists. A 2020 *JAMA* study found that provider networks were broader in ESI plans and narrower in marketplace plans but that networks may also be limited in lower-quality employer plans.[49] The Council has previously observed that, while marketplace plans may be attractive to some people because their premium prices are lower, purchasers may not be aware that a plan's provider network could be narrower and that they may have trouble getting needed care from in-network physicians, hospitals, and other providers. Therefore, some workers with ESI coverage who would become newly eligible for marketplace subsidies if the firewall is repealed may decide to keep their employer plan to avoid possible care disruptions and to preserve relationships with their treating physicians. Depending on income and a range of other factors, this could be true for some employees who utilize more services and medications or who have a family member on their plan who has a health condition that requires timely access to specialty care.

POLICY OPTIONS ADDRESSING ESI AFFORDABILITY

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

American Enterprise Institute (AEI): A 2020 paper published by AEI recognizes both the value of ESI to many Americans as well as its flaws, including rising costs for both employers and employees. AEI asserts that ESI is worth preserving and suggests tax reforms as the centerpiece of a framework for a more stable ESI system, including the provision of a tax benefit for employers that would be applied to employee premiums. According to AEI, such firm-level tax credits could be structured to provide greater support to lower-income employees but less support to those with higher incomes.[50]

Bipartisan Policy Center (BPC): A 2022 BPC report recognized that ESI is less affordable for lower-wage workers but suggests that fully eliminating the firewall would be quite costly for the federal government. Instead, BPC recommended that Congress adjust the affordability threshold to align with the percentage cap on premium contributions for marketplace plans.[51] As discussion of broad tax cut extensions (and the need to pay for them) intensified late last year, BPC suggested

that the ESI tax exclusion be capped at the 80th percentile of premiums, or around $10,000 for single plans and $30,000 for family plans.[52]

Center on Budget and Policy Priorities (CBPP): A 2019 CBPP analysis acknowledged that eliminating the firewall would improve equity but concluded that a full repeal would be too costly to recommend. Instead, the CBPP suggested strengthening the standards for employer coverage offers, such as by raising the minimum value standard (from 60 to 70 percent) or establishing more robust benefit standards for ESI plans.[53]

Commonwealth Fund: A 2020 analysis found that, depending on marketplace subsidy amounts in place, between six and 13 percent of people with ESI would pay lower premium amounts if they were able to switch to marketplace plans. Importantly, the paper pointed out that people with the lowest incomes would benefit the most from lower marketplace premiums, as would African American, Latino, American Indian and Alaska Native individuals. According to the brief, much is unknown about potential employer responses to elimination of the firewall, including whether firms will incentivize sicker workers to move to exchange plans or stop offering coverage altogether.[54] A 2024 Commonwealth Fund paper on automatic enrollment in health insurance posits that 1.2 million people with incomes below 150 percent of FPL and 6.5 million people with income between 150 percent and 200 percent of FPL would become eligible for marketplace subsidies if the firewall were eliminated. The analysis states that "most" of these newly eligible individuals currently have ESI although some are paying full premiums for nongroup plans.[55]

Congressional Budget Office (CBO): In 2020, the CBO estimated that approximately 25 percent of workers with ESI would become eligible for marketplace subsidies if the firewall was repealed. For 20 percent of those newly eligible, post-subsidy premiums for marketplace plans would be lower than ESI premiums, thus making the nongroup market an attractive option. The CBO maintained that, although firms would respond differently to a lifting of the firewall, most of the savings incurred would likely be passed on to employees and adverse selection would be minimized.[56]

Urban Institute: Urban Institute data presented to the Council and published by The Commonwealth Fund estimated that eliminating the firewall would decrease ESI coverage by two percent or less, meaning approximately 1.8 million people would transition out of ESI, with most of these workers shifting to marketplace coverage. Urban Institute's modeling assumes that most workers would stay enrolled in ESI coverage because ESI tax benefits are substantial. In this scenario, federal spending on marketplace premium tax credits would increase by $17.8 billion, or 18 percent; state spending would increase by $460 million; employer spending on premium contributions would decrease $8.1 billion; and households would save $4.4 billion per year in health spending. This study also projected that 1.4 million fewer people would be uninsured if the firewall was eliminated, including 0.4 million people between 138 percent and 200 percent of the poverty line, 0.8 million people between 200 percent and 400 percent of the poverty line, and 0.1 million people above 400 percent of the poverty line. It is estimated that this would save an estimated $1.5 billion in uncompensated care costs. The study also noted additional benefits may occur from elimination of the ESI firewall due to elimination of red tape that will make it easier for individuals who already qualify for PTCs to actually receive those benefits.[57]

RELEVANT AMA POLICY

Policy H-165.829 encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health

insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges. Among its many provisions, Policy H-165.920 supports:

- A system where individually owned health insurance is the preferred option but employer-provided coverage is still available to the extent the market demands it;
- An 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; and
- A replacement of the present federal income tax exclusion from employee's taxable income of employer-provided insurance coverage with tax credits for individuals and families.

Under Policy H-165.851, the AMA supports incremental steps toward financing individual tax credits for the purchase of health insurance, including but not limited to capping the tax exclusion for employment-based health insurance. Policy H-165.843 encourages employers to promote greater individual choice and ownership of plans; enhance employee education regarding how to choose health plans that meet their needs; and support increased fairness and uniformity in the health insurance market. Policy H-185.918 further encourages employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) collaborate with employees to understand their health insurance preferences and needs, (c) tailor benefit designs to the health insurance preferences and needs of their employees, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year. Policy H-165.881 advocates for equal-dollar contributions by employers irrespective of an employee's health plan choice. Policy H-165.854 supports Health Reimbursement Arrangements (HRAs)—account-based health plans that employers can offer to reimburse employees for their medical expenses—as one mechanism for empowering patients to have greater control over health care decision-making. Under Policy D-165.971, the AMA will work to ensure that any Association Health Plan Programs safeguard state and federal patient protection laws.

Policy H-165.824 supports improving affordability in health insurance exchanges by expanding eligibility for premium tax credits beyond 400 percent FPL; increasing the generosity of premium tax credits; expanding eligibility for cost-sharing reductions; and increasing the size of cost-sharing reductions. Policy H-165.828, which as previously noted addresses the affordability threshold (firewall), also supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability. This policy further supports education regarding deductibles, cost-sharing, and Health Savings Accounts (HSAs).

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

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. To expand coverage to all Americans, the AMA has 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. ESI continues to be the dominant source of health coverage for people under 65 years of age, and most people enrolled in employer coverage seem satisfied with it. Still, the Council acknowledges that because of shortcomings inherent to the ESI system—including equity and affordability concerns, and rising costs—it does not work well for everyone, especially workers with lower incomes and those employed by smaller firms.

As explained in this report, people with higher earnings receive larger federal ESI subsidies than their lower-income peers, and lower-income people pay a greater share of earnings towards ESI. The Council recognizes that federal tax benefits available to ESI subscribers facing the greatest affordability challenges are not nearly as generous as the enhanced subsidies currently available to lower-income individuals enrolled in ACA marketplace plans. However, the affordability "firewall" makes employees with "affordable" ESI offers ineligible for federal subsidies to purchase ACA plans. To illustrate, an employee of a big box retailer earning 200 percent of FPL or less could pay up to 9.02 percent of his income towards "affordable" ESI. However, if he was eligible to move to the ACA marketplace, his premium contributions would be capped at two percent of income and he would also be eligible for cost-sharing subsidies. Under Policy H-165.828[1]), the AMA supports lowering the affordability threshold (firewall) to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage (currently 8.5 percent).

During the development of this report, the Council reviewed the literature and heard from experts presenting an array of views regarding the potential impacts of fully eliminating the firewall, which is the policy change requested by referred Resolution 103-A-23. The Council found that estimates varied regarding how many workers would transition from ESI to exchange plans if the firewall was repealed. Therefore, we cannot predict with certainty how coverage patterns and payments to physicians would be affected. The Council's revised recommendations reflect, in part, our concerns regarding the harms that significant coverage transitions out of ESI and into ACA plans could have on physician payment and the sustainability of physician practices. Although payment rates in the nongroup market tend to vary, they are generally lower than rates paid by ESI plans. In fact, a study published in 2024 found that, in 2021, marketplace nongroup insurers paid health providers substantially less than employer small-group plans. Even though the study found that marketplace rates were generally higher than Medicare payments,[58] the Council is aware that in some states marketplace plan payments barely exceed, or are even lower than, Medicare rates. In the current environment of Medicare and Medicaid physician payment inadequacies, the Council recognizes that significant shifts from ESI to the ACA marketplace could have deleterious effects on physician practices, adding to their considerable burdens and threatening their viability.

The Council is also concerned about potential employer responses to a repeal of the firewall, which cannot be predicted and will likely vary, with some firms possibly shifting certain employees to the marketplace or ceasing to offer health coverage altogether, and without assurances that employer savings would be passed along to workers. Still, we understand that the firewall is problematic for lower-income workers who may be contributing more for an employer plan than they would pay for marketplace coverage and for people working for small employers whose ESI costs have become increasingly expensive. Given the enhanced subsidies for premium tax credits and cost-sharing reductions available under current law, it is likely that at least some employees with incomes at or below 200 percent of FPL—whose premium contributions for exchange plans would be capped at two percent of income—would find marketplace coverage significantly more affordable than their ESI plan. However, if the more generous premium tax credits are allowed to expire at the end of this year, the cost of marketplace coverage will rise, potentially making ACA plans less attractive. Even among employees who would benefit financially from transitioning to the marketplace, some may opt to retain ESI coverage if they are satisfied with that plan, concerned

about the network breadth of exchange plans, or interested in preserving relationships with their treating physicians.

If the firewall was eliminated, the Council is also concerned about the potential costs that would be incurred by the federal government, which already spends upwards of $1.8 trillion on health insurance subsidies—across all coverage programs—each year.[59] Allowing potentially millions of ESI enrollees to access ACA marketplace subsidies could prove to be prohibitively expensive. We cannot estimate the exact costs of eliminating the firewall, which would depend on how many workers ultimately move to exchange plans, but expect it could total tens of billions of dollars or more per year. We believe that budgetary considerations may make the full repeal option unrealistic, financially, and also politically since it would be unpopular with ESI proponents, including employers (and employees) who value and want to preserve the ESI tax exclusion.

For all of these reasons, the Council decided to recommend an incremental approach to reducing the affordability threshold so that it first benefits workers most in need, after which the effects of this change on coverage patterns, federal and consumer health spending, and employer behavior could be monitored. At this time, we support a firewall policy change that targets employees with the lowest incomes who could benefit the most from ACA premium tax credit and cost-sharing subsidies not available under ESI. Accordingly, the Council recommends that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the FPL, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan. We believe this recommendation is an appropriate first step to addressing ESI affordability challenges among the lowest-wage workers while at the same time preserving physician practice sustainability, stability in the ESI market, and limits on federal spending increases. We recommend 200 percent of the FPL since it represents workers most in need and, as the studies cited in this report note, more data are available for individuals with incomes at this threshold. Furthermore, we believe that defining the affordability threshold by a percentage of FPL should make it easier for employees to determine whether they are eligible for ACA subsidies. To protect employees and their ability to choose a health plan that best meets their needs, the Council maintains that some level of employer shared responsibility requirements will need to continue so that employers do not push workers to the marketplace involuntarily or stop offering ESI to certain income groups.

Because ESI enrollees with lower incomes 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 recognizes that employers are already required to provide employees with notice about the ACA marketplace and that, depending on income and ESI offer, they may be eligible for lower-cost coverage in the marketplace. However, it may be challenging for some employees to determine whether they are eligible for marketplace subsidies without tools to help them do so.

To address physician payment concerns, the Council also recommends advocating that physician payments by 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 no less than prevailing Medicare rates. This policy mirrors other AMA physician payment policies and is critical to ensuring physician practice sustainability.

RECOMMENDATIONS

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

1. That it be the policy of our American Medical Association (AMA) that the Affordable Care Act (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. (New HOD Policy)

2. That our AMA support incrementally lifting the employer-sponsored health insurance 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. (New HOD Policy)

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

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

   Our AMA encourages employers to:
   a) promote greater individual choice and ownership of plans;
   b) implement plans to improve affordability of premiums and/or cost-sharing, especially expenses for employees with lower incomes and those who may qualify for Affordable Care Act marketplace plans based on affordability criteria, while promoting meaningful coverage and the application of vital consumer and provider protections, such as prompt pay and network adequacy requirements;
   c) ~~help employees determine if their employer coverage offer makes them ineligible or eligible for federal marketplace subsidies~~ provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
   ~~b~~d) ~~enhance employee education regarding available health plan options and how to choose health plans that meet their needs~~ provide employees with information regarding available health plan options, including the plan's cost, network breadth, and prior authorization requirements, which will help them choose a plan that meets their needs;
   ~~e~~e) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
   ~~d~~f) support increased fairness and uniformity in the health insurance market; and
   ~~e~~g) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (Modify HOD Policy)

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

Fiscal Note: Less than $500.

REFERENCES

[1] KFF. Employer-Sponsored Health Insurance 101. May 2024. Available at: https://www.kff.org/health-policy-101-employer-sponsored-health-insurance/?utm_campaign=KFF-Health-Policy-101&utm_source=pdf&utm_medium=pdf&utm_term=eshi&entry=table-of-contents-introduction.
[2] *Ibid*.
[3] Straw Tara. Trapped by the Firewall: Policy Changes Are Needed to Improve Health Coverage for Low-Income Workers. Center on Budget and Policy Priorities. December 3, 2019. Available at: https://www.cbpp.org/research/trapped-by-the-firewall-policy-changes-are-needed-to-improve-health-coverage-for-low-income
[4] KFF. Survey of Consumer Experiences with Health Insurance. June 15, 2023. Available at: https://www.kff.org/private-insurance/poll-finding/kf-survey-of-consumer-experiences-with-health-insurance/
[5] U.S. Chamber of Commerce. New poll of American workers reveals tremendous value placed on workplace health benefits. December 15, 2022. Available at: https://www.uschamber.com/health-care/new-poll-of-american-workers-reveals-tremendous-value-placed-on-workplace-health-benefits
[6] *Ibid*.
[7] KFF. 2024 Employer Health Benefits Survey. 2024. Available at: https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf
[8] *Ibid*.
[9] *Ibid*.
[10] KFF. Employer-Sponsored Health Insurance 101. May 2024. Available at: https://files.kff.org/attachment/health-policy-101-employer-sponsored-health-insurance.pdf
[11] U.S. Government Accountability Office. Comparison of Employer-Sponsored Plans to Healthcare.gov Marketplace Plans. November 2024. Available at: https://www.gao.gov/assets/gao-25-106798.pdf.
[12] Urban Institute and The Commonwealth Fund. Health Care Affordability in Employer versus Private Nongroup Coverage before ARPA. October 2024. Available at: https://www.urban.org/research/publication/health-care-affordability-employer-versus-private-nongroup-coverage-arpa.
[13] KFF. Employer-Sponsored Health Insurance 101. May 2024.
[14] *Ibid*.
[15] Rajender Agarwal, Olena Mazurenko, Nir Menachemi. High-Deductible Health Plans Reduce Health Care Cost And Utilization, Including Use Of Needed Preventive Services. Health Affairs. October 2017. Available at: https://doi.org/10.1377/hlthaff.2017.0610
[16] Bureau of Labor Statistics, U.S. Department of Labor. Health care plan provisions for private industry workers in the United States, 2023. Available at: https://www.bls.gov/ebs/publications/health-care-plan-provisions-for-private-industry-workers-2023.htm#/ebs/publications/health-care-plan-provisions-for-private-industry-workers-2023.htm#tabs-4
[17] The Commonwealth Fund. Trends in Employer Health Insurance Costs, 2014–2023: Coverage Is More Expensive for Workers in Small Businesses. December 10, 2024. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2024/dec/trends-employer-health-insurance-costs-2014-2023.
[18] Altman Drew. Family Health Insurance Is No Longer Affordable Through Small Employers. KFF. November 28, 2023. Available at: https://www.kff.org/health-costs/perspective/family-health-insurance-is-no-longer-affordable-through-small-employers/
[19] Straw, *supra* note 3.
[20] Hager K, Emanuel E, and Mozaffarian D. Employer-Sponsored Health Insurance Premium Cost Growth and Its Association with Earnings Inequality Among US Families. JAMA Network Open January 16, 2024. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2813927
[21] The Peterson Center on Healthcare and KFF. Health System Tracker: How affordability of employer coverage varies by family income. March 10, 2022. Available at: https://www.healthsystemtracker.org/brief/how-affordability-of-health-care-varies-by-income-among-

people-with-employer-coverage/#Average%20share%20of%20family%20income%20going%20toward%20employer-based%20health%20insurance%20premium%20contributions%20and%20out-of-pocket%20costs,%202020

[22] KFF. Lower Income Adults with Employer Sponsored Insurance Face Unique Challenges with Coverage Compared to Higher Income Adults. December 19, 2023. Available at: https://www.kff.org/private-insurance/issue-brief/lower-income-adults-with-employer-sponsored-insurance-face-unique-challenges-with-coverage-compared-to-higher-income-adults/

[23] *Ibid*.

[24] KFF *supra* note 13.

[25] Capretta James C. The Widening Gap between ACA and ESI Subsidies. AEI Ideas, January 29, 2024. Available at: https://www.aei.org/economics/the-widening-gap-between-aca-and-esi-subsidies/

[26] Hager *supra* note 21.

[27] *Ibid*.

[28] Centers for Medicare & Medicaid Services. Marketplace 2025 Open Enrollment Period Report: National Snapshot. January 8, 2025. Available at: https://www.cms.gov/newsroom/fact-sheets/marketplace-2025-open-enrollment-period-report-national-snapshot-1

[29] 26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability. Available at: https://www.irs.gov/pub/irs-drop/rp-24-35.pdf

[30] Congressional Research Service. Health Insurance Premium Tax Credit and Cost-Sharing Reductions. Updated February 14, 2024. Available at: https://crsreports.congress.gov/product/pdf/R/R44425

[31] Internal Revenue Service (IRS). Webpage: Employer Shared Responsibility Provisions. Available at: https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions

[32] Internal Revenue Service. Webpage: Employer shared responsibility provisions. Available at: https://www.irs.gov/affordable-care-act/employers/employer-shared-responsibility-provisions

[33] *Ibid*.

[34] Congressional Budget Office (CBO). Federal Subsidies for Health Insurance: 2023 to 2033. September 2023. Available at: https://www.cbo.gov/system/files/2023-09/59273-health-coverage.pdf

[35] KFF. Inflation Reduction Act Health Insurance Subsidies: What is Their Impact and What Would Happen if They Expire? July 26, 2024. Available at: https://www.kff.org/affordable-care-act/issue-brief/inflation-reduction-act-health-insurance-subsidies-what-is-their-impact-and-what-would-happen-if-they-expire/

[36] KFF. Explaining Health Care Reform: Questions About Health Insurance Subsidies. October 6, 2023. Available at: https://www.kff.org/affordable-care-act/issue-brief/explaining-health-care-reform-questions-about-health-insurance-subsidies/#:~:text=This%20%E2%80%9Crequired%20individual%20contribution%E2%80%9D%20is,household%20income%20(Table%202).

[37] 26 CFR 601.105: Examination of returns and claims for refund, credit, or abatement; determination of correct tax liability. Available at: https://www.irs.gov/pub/irs-drop/rp-24-35.pdf

[38] Congressional Budget Office. Letter to Senators Wyden and Shaheen and Representatives Neal and Underwood on the Effects of Not Extending the Expanded Premium Tax Credits for the Number of Uninsured People and Growth in Premiums. December 5, 2024. Available at: https://www.cbo.gov/system/files/2024-12/59230-ARPA.pdf.

[39] Urban Institute. Four Million People Will Lose Health Insurance If Premium Tax Credit Enhancements Expire in 2025. November 14, 2024. Available at: https://www.urban.org/urban-wire/four-million-people-will-lose-health-insurance-if-premium-tax-credit-enhancements-expire.

[40] The Commonwealth Fund. The Cost of Eliminating the Enhanced Premium Tax Credits. March 3, 2025. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2025/mar/cost-eliminating-enhanced-premium-tax-credits.

[41] *Ibid*.

[42] *Ibid*.

[43] CBO *supra* note 34.

[44] *Ibid*.

[45] *Ibid*.

[46] Capretta *supra* note 25.

[47] Straw *supra* note 3.

[48] Banthin J, Skopec L, and Ramchandani U. Improving Affordability of Insurance for Consumers by Eliminating the Firewall Between Employer and Individual Markets. Commonwealth Fund, June 2024.

Available at: https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/improving-affordability-insurance-consumers-eliminating-firewall.

[49] Graves JA, Nshuti L, Everson J et al. Breadth and Exclusivity of Hospital and Physician Networks in US Insurance Markets. *JAMA Network Open*. December 17, 2020. Available at: https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774285

[50] Capretta James C. The Future of Employer-Sponsored Health Insurance. AEI Economic Perspectives. November 2020. Available at: https://www.aei.org/wp-content/uploads/2020/12/The-Future-of-Employer-Sponsored-Health-Insurance.pdf?x91208

[51] Bipartisan Policy Center. Improving and Strengthening Employer-Sponsored Insurance. October 2022. Available at: https://bipartisanpolicy.org/wp-content/uploads/2022/10/BPC-Improving-and-Strengthening-Employer-Sponsored-Insurance-Oct-2022.pdf

[52] Bipartisan Policy Center. Paying the 2025 Tax Bill: Employer-Sponsored Health Insurance. December 2024. Available at: https://bipartisanpolicy.org/explainer/paying-the-2025-tax-bill-employer-sponsored-health-insurance/

[53] Straw *supra* note 3.

[54] The Commonwealth Fund. Removing the Firewall Between Employer Insurance and the ACA Marketplaces: Who Could Benefit? December 15, 2020. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2020/dec/removing-firewall-employer-insurance-aca-marketplaces

[55] The Commonwealth Fund. Automatic Enrollment in Health Insurance: A Pathway to Increased Coverage for People with Low Income. March 11, 2024. Available at: https://www.commonwealthfund.org/publications/fund-reports/2024/mar/automatic-enrollment-health-insurance-pathway-increased-coverage

[56] Congressional Budget Office. Answers to Questions for the Record Following a Hearing Conducted by the Senate Committee on the Budget on CBO's Budget Projections. December 18, 2020. Available at: https://www.cbo.gov/publication/56912

[57] Banthin J, Skopec L and Ramchandani, U. Improving the Affordability of Insurance by Eliminating the Firewall Between Employer and Individual Markets. The Commonwealth Fund. June 2024. Available at: https://www.commonwealthfund.org/publications/issue-briefs/2024/jun/improving-affordability-insurance-consumers-eliminating-firewall.

[58] Hanson C, McCarthy I, Molloy E, and Stockley K. Providers Paid Substantially Less By Marketplace Nongroup Insurers Than By Employer Small-Group Plans, 2021. *Health Affairs*. November 20, 2024.

[59] Congressional Budget Office Testimony before the Senate Subcommittee on Health, Committee on Energy and Commerce. January 31, 2024. Available at: https://d1dth6e84htgma.cloudfront.net/Chapin_White_Witness_Testimony_01_31_2024_1318e7a8de.pdf