REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Ensuring Marketplace Competition and Health Plan Choice
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, "Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization." The policy states that "our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care." In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on ensuring marketplace competition and health plan choice and specifically reviews approaches to a public option, and Council on Medical Service Report 2, "Improving Affordability in the Health Insurance Exchanges."

The Council is concerned with the potential for some state and federal activities to lead to market segmentation, with healthier individuals enrolling in skimpier plans, and with individuals who for health and other reasons enroll in plans following Affordable Care Act (ACA) requirements. As a result of such adverse selection, there will likely be increased costs for individuals in plans following ACA requirements, resulting from sicker risk pools. To strengthen and ensure the sustainability of the individual health insurance marketplace, the Council supports health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits. In the same light, the Council believes that the AMA should not support coverage options that are exempted from such mandated benefits. As such, the Council is recommending the reaffirmation of Policy D-180.986 concerning "sham" health insurers.

The Council agrees with the sentiment of many physicians that insufficient competition in the ACA marketplaces remains an issue to be addressed. However, the Council is concerned that public option proposals that rely on Medicaid and/or Medicare payment rates and/or tie physician participation in Medicare and/or Medicaid to a public option could negatively impact physician practices and physician practice sustainability, as well as patient access to care and choice of health plan. As such, the Council recommends the reaffirmation of Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

To ensure patients are not left without coverage options in the marketplaces, consistent with the recommendation of a wide array of policy experts across the political spectrum, the Council recommends that our AMA support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. This strategy, unlike some others advocating for a public option, enables patient choice of private health plans, ensures physician freedom of practice, does not require physician participation, and recognizes the value of payment rates being established through meaningful negotiations and contracts.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-18

Subject: Ensuring Marketplace Competition and Health Plan Choice

Presented by: Paul A. Wertsch, MD, Chair

Referred to: Reference Committee A
(Jonathan D. Leffert, MD, Chair)

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, "Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization." The policy states that "our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care."

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on ensuring marketplace competition and health plan choice and specifically reviews approaches to a public option, and Council on Medical Service Report 2, "Improving Affordability in the Health Insurance Exchanges."

This report provides background on health plan choice and competition in the Affordable Care Act (ACA) marketplaces, highlights regulatory and legislative activity that could have marketplace impacts, outlines various approaches to ensuring marketplace coverage options, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

This year, there is an average of 3.5 insurers participating in each state's ACA health insurance marketplace, ranging from one insurer in Alaska, Delaware, Iowa, Mississippi, Nebraska, Oklahoma, South Carolina, and Wyoming, to 12 insurers in New York. Approximately 26 percent of marketplace enrollees, living in 52 percent of counties, have only one insurer on the marketplace from which to select plans. Conversely, roughly half of enrollees, living in 18 percent of counties, have a choice of three or more insurers. Within states, there are differences between rural and urban areas as to insurer participation in the marketplace. For 2018, counties in metropolitan areas have on average two insurers participating in the marketplace, whereas non-metro counties have 1.6 insurers participating on average. In 2017, 87 percent of marketplace enrollees lived in counties in metropolitan areas.[1]

Plans that are sold in the ACA marketplaces are required to be certified as qualified health plans (QHPs). As a condition of QHP certification, QHP insurers must provide at least one silver (covers 70 percent of benefit costs) and one gold level plan (covers 80 percent of benefit costs).[2] Therefore, at a minimum, consumers in counties with one insurer are expected to have at least two plans from which to choose. Data show, however, that there is wide variation in the number of unique plans

offered, even in counties with one or two insurers participating in the marketplace. In 2017, in states using the healthcare.gov platform, counties with a single insurer participating had between two and 28 unique plan offerings with the average nearing 11. In counties with two insurers participating, there were between four and 61 unique plans to choose from, with 16 plans being the approximate average.[3,4]

REGULATORY ACTIVITY IMPACTING MARKETPLACES

Association Health Plan Proposed Rule

Proposed federal regulations have been released this year, which, if finalized, could impact the competition in and stability of ACA marketplaces. In January, the Department of Labor (DOL) released a proposed rule regarding Association Health Plans (AHPs) in response to Presidential Executive Order 13813 (Promoting Healthcare Choice and Competition Across the United States).[5] The proposed rule interprets the term "employer" to include self-employed and sole-proprietors for purposes of becoming an employer member of an AHP, which is important to the risk pool of the ACA marketplaces.

Under the proposed rule, AHPs with 51 or more "employees" can offer health insurance that qualifies as large group coverage to all of its employer members. Large group coverage does not have to comply with many of the ACA's consumer protections. These protections include providing 10 essential health benefit (EHB) categories – including maternity care, prescription drugs, and mental health and substance use disorder services – that the ACA requires of insurance sold to individuals and small businesses; prohibiting varying rates based on gender, age, occupation, and group size; having a single risk pool for all enrollees to set premium rates; and risk adjustments of claims. Importantly, key cost protections guaranteed in the ACA, such as the annual cap on out-of-pocket costs and the ban on annual and lifetime limits, are only applicable to services considered EHBs.

Concerns have been raised that by enabling self-employed individuals and sole-proprietors to have access to AHP group coverage, the proposed rule has the potential to lead to healthy self-employed individuals enrolling in AHP coverage rather than ACA marketplace coverage. As a result of such adverse selection, individuals in plans following ACA requirements are expected to face higher premiums, resulting from sicker risk pools.[6,7,8] At the same time, the Council notes, self-employed individuals enrolling in AHP coverage could be without guaranteed coverage of EHBs and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Such coverage could be potentially problematic for individuals with pre-existing conditions, or enrollees who become sick over the course of the plan year.

Short-Term Limited Duration Plan Proposed Rule

In February, also in response to Presidential Executive Order 13813, the Departments of Health and Human Services (HHS), Labor, and Treasury issued a proposed rule addressing the regulation of short-term, limited duration insurance (STLDI) coverage. Unlike ACA marketplace plans, STLDI plans do not have to comply with the market reforms and consumer protections of the ACA. As such, STLDI plans can deny coverage or charge higher premiums based on health status; exclude coverage for pre-existing conditions; impose annual or lifetime limits; have higher out-of-pocket limits than the ACA maximums; not cover EHB categories; rescind coverage; and not comply with medical loss ratio requirements. Currently, STLDI coverage can only be offered for three months at a time, and if individuals enroll in STLDI plans for more than three months, they may have to pay the individual mandate penalty. By limiting STLDI coverage to three months, the

purpose of STLDI plans was to serve as a bridge between coverage in plans offering meaningful coverage.[9] Under the proposed rule, however, STLDI coverage could again be offered for periods up to 364 days, with the potential for consumers to reapply for coverage at the end of the 364-day period.

In the proposed rule, the agencies outlined the following potential benefits and costs:

- "Increased access to affordable health insurance for consumers unable or unwilling to purchase Patient Protection and Affordable Care Act (PPACA)-compliant plans, potentially resulting in improved health outcomes for them;
- "Increased choice at lower cost and increased protection (for consumers who are currently uninsured) from catastrophic health care expenses for consumers purchasing short-term, limited-duration insurance;
- "Potentially broader access to health care providers compared to PPACA-compliant plans for some consumers;
- "Reduced access to some services and providers for some consumers who switch from PPACA-compliant plans;
- "Increased out-of-pocket costs for some consumers, possibly leading to financial hardship; and,
- "Worsening of States' individual market single risk pools and potential reduced choice for some other individuals remaining in those risk pools."[10]

State-Level Activities: Idaho and Iowa

In January, Idaho Governor Butch Otter issued Executive Order No. 2018-02, "Restoring Choice in Health Insurance for Idahoans," which directed "the Idaho Department of Insurance to approve options that follow all State-based requirements, even if not all PPACA requirements are met, so long as the carrier offering the option also offers an exchange-certified alternative in Idaho."[11] As a result, the Idaho Insurance Department director issued an insurance bulletin recognizing and outlining the requirements of such plans. As outlined in the bulletin, state-based plans could have pre-existing condition exclusions for individuals without continuous qualifying coverage within 63 days of the plan's effective date. In addition, such plans would not be required to cover all EHB categories required under the ACA, have the ability to impose annual limits of $1 million, and not be required to abide by the out-of-pocket maximums outlined in the ACA. While enrollees in state-based and ACA-compliant plans would be considered to be in the same risk pool, premiums for state-based plans could vary based on age (5:1 instead of 3:1 ratio), tobacco use and health status.[12] In response, the Centers for Medicare & Medicaid Services (CMS) issued a letter to Idaho regarding its bulletin, stating that that the agency has reason to believe that Idaho would be failing to substantially enforce the provisions of the ACA. If Idaho fails to enforce the ACA, CMS stated that it has the authority to enforce the provisions of the law on behalf of the state. At the same time, CMS also stated that Idaho could potentially modify its proposal to offer state-based plans under the exception for STLDI coverage.[13]

In Iowa, legislation has been signed into law that will allow the Iowa Farm Bureau Federation to offer health insurance plans that would not, under law, be considered to be insurance. As such, the plans would not have to comply with ACA benefit standards and consumer protections, including prohibitions on pre-existing condition exclusions and denials, essential health benefits and age rating. In addition, they would not be subject to customary state regulations pertaining to health insurance, including those pertaining to rate review and solvency.[14,15] The Council notes that the state of Tennessee has a similar law in place.

VARIOUS APPROACHES TO ENSURE MARKETPLACE COVERAGE OPTIONS

Concerns about insufficient competition on the marketplaces and affordability have led thought leaders, as well as federal and state legislators and gubernatorial candidates, to put forward proposals to ensure marketplace coverage options, including the creation of a public option. Approaches to a public option vary in many respects. For example, while some proposals would require provider participation in a public option, others would allow providers to choose whether or not they want to participate in the plan offerings put forth in the event of bare counties. There are also different approaches to provider payment: through negotiation, or being tied to Medicare or Medicaid payment levels. In addition, while some public option proposals would build upon the Medicaid or Medicare programs, other proposals would use private health plans to ensure marketplace competition.

Federal and State Legislative Approaches

In the 115th Congress, federal legislation has been introduced addressing a public option. Congressman Peter DeFazio (D-OR) has introduced HR 1307, the Public Option Deficit Reduction Act, which would require the Secretary of HHS to offer a public option on the marketplaces. The public option envisioned in HR 1307 would comply with requirements for plans offered through marketplaces, including requirements related to benefits, benefit levels, provider networks, notices, consumer protections, and cost sharing. In addition, it would offer bronze, silver and gold plans, with the option to also offer platinum plans. Premiums would be geographically adjusted, and set at a level sufficient to fully finance the costs of the health benefits provided, administrative costs, and a contingency margin. Provider payment rates would be at Medicare rates, with the Secretary of HHS modifying payment rates in order to accommodate payment for services not otherwise covered in Medicare, including well-child visits. For the first three years, payment rates would be five percent higher than Medicare in order to incentivize provider participation. Medicare participating providers would also be considered to be providers in the public option unless they opt out. The bill appropriates funding for the establishment of the public health insurance option, which HHS must repay over 10 years.[16]

Senator Brian Schatz (D-HI) and Congressman Ben Ray Luján (D-NM) introduced S 2001/HR 4129, the State Public Option Act. If enacted into law, the legislation would give states the option to establish a Medicaid buy-in plan for residents regardless of income. Interestingly, for individuals ineligible for premium tax credits, their premiums cannot exceed 9.5 percent of household income. If these individuals were to enroll in other plans on state ACA marketplaces, their premiums would not be capped as a percentage of their income. In terms of physician payment rates, the State Public Option Act would make permanent a payment increase to Medicare levels for a range of primary care providers.[17,18] These bills are similar to Assembly Bill 374 that passed the Nevada legislature, but was vetoed by the governor in June 2017. Other states have also considered a Medicaid buy-in approach, including Massachusetts and Minnesota.[19]

Senator Debbie Stabenow (D-MI) has introduced S 1742, the Medicare at 55 Act, which would provide an option for individuals age 55 to 64 to buy into Medicare or Medicare Advantage.[20] Similarly, Congressman Brian Higgins (D-NY) introduced HR 3748, the Medicare Buy-In and Health Care Stabilization Act of 2017, which would allow individuals age 50 and 64 to buy into Medicare.[21] Under both bills, premiums would be based on estimating the average, annual per capita amount for benefits and administrative expenses that would be payable under Parts A, B, and D (including, as applicable, under Part C) for the buy-in populations. Notably, individuals would be able to apply premium tax credits and cost-sharing reductions toward the purchase of such coverage. These proposals are alternatives to more comprehensive proposals that would allow all

individuals to buy into Medicare, or provide Medicare for all (eg, S. 1804, the Medicare for All Act of 2017, introduced by Senator Bernie Sanders [I-VT]).

Congresswoman Dita Titus (D-NV) introduced HR 4394, the Bare County Buy-in Act of 2017, which would require the Secretary of HHS to make available a public option for health insurance coverage for individuals residing in an area without any marketplace plan options. The public option would consist of a silver-level plan that provides coverage for essential health benefits. Providers who participate in Medicare or Medicaid would be considered to be participating providers in the public option unless they opt out. While the legislation states that the Secretary of HHS should establish provider payment rates through negotiated agreements, the bill also stipulates that if the Secretary and health care providers are unable to reach a negotiated agreement, that Medicare fee-for-service (FFS) payment rates should be used.[22]

Leveraging FEHBP to Ensure Marketplace Plan Choice

The Federal Employees Health Benefits Program (FEHBP) provided health insurance coverage to approximately 8.2 million federal employees, retirees, and their dependents in 2016. By entering into contracts with qualified health insurance carriers, the US Office of Personnel Management (OPM) offers through FEHBP two primary types of plans – FFS plans (most of which have a preferred provider organization component) and health management organization (HMO) plans. While FFS plans are offered nationwide to all enrollees, HMO plans offer coverage in certain geographic areas. In reviewing health plans to be offered under FEHBP, OPM considers the ability of plans to provide reasonable access to and choice of primary and specialty medical care throughout the service area.

In 2015, the median number of FEHBP plan offerings in a county was 24, most of which were nationwide FFS plans available in all counties. However, despite this level of choice of health plan, FEHBP enrollment is highly concentrated. The median county market share held by the largest FEHBP carrier was 72 percent in 2015, with the market share of the largest three carriers being 90 percent. Blue Cross Blue Shield Association (BCBSA), which offers two nationwide FFS plans, was the largest FEHBP carrier in 98 percent of counties in 2015. BCBSA's two nationwide FFS plans vary based on factors including premiums and provider network breadth. The Government Employees Health Association, Inc., which also offers nationwide FFS plans, held the second or third largest market share in 77 percent of counties in 2015. Kaiser Permanente, which offers HMO plans, was the third largest FEHBP carrier in 2015.[23]

Leveraging health plan FEHBP participation has been included in a leading proposed solution to prevent bare counties in the marketplaces. Tim Jost, a health law expert who is Emeritus Professor at the Washington and Lee University School of Law and contributor to the Health Affairs Blog, proposed that, in the short term, "the largest two FEHBP insurers in any county should be required as a condition of continued participation in the program to offer at least one silver-level plan though the federal exchange in all counties that would otherwise be without coverage. These plans should be eligible for premium tax credits and could otherwise charge actuarially appropriate premiums."[24] Jost's proposal was cited in a bipartisan agreement to fix the ACA released in 2017, notably supported by Joseph Antos (American Enterprise Institute); Stuart Butler (The Brookings Institution); Lanhee Chen (Hoover Institution, Stanford University, Romney-Ryan 2012); John McDonough (Harvard University, Senator Ted Kennedy); Ron Pollack (Families USA); Sara Rosenbaum (George Washington University, former MACPAC chair); Grace-Marie Turner (Galen Institute); Vikki Wachino (Former Director, Center for Medicaid and CHIP Services); and Gail Wilensky (former HCFA Administrator and Deputy Assistant to President G HW Bush).[25]

RELEVANT AMA POLICY

Policy H-165.838 supports health system reform initiatives that are consistent with long-standing AMA policies on pluralism, freedom of choice, freedom of practice, and universal access for patients. The policy also states that insurance coverage options offered in a health insurance exchange should be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. Policy H-165.839 states that health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage.

Regarding meaningful coverage, Policy H-165.846 states that existing federal guidelines regarding types of health insurance coverage (eg, Title 26 of the US Tax Code and FEHBP regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. The policy also advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any EHB package for children; opposes the removal of categories from the EHB package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Policy H-165.865 states 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 US Code.

Addressing AHPs, Policy D-165.971 supports any AHPs that safeguard state and federal patient protection laws, including those state regulations regarding fiscal soundness and prompt payment. Similarly, Policy H-180.946 supports the selling of insurance across state lines that ensure that patient and provider protection laws are consistent with and enforceable under the laws of the state in which the patient resides. Relevant to both AHPs and STLDI plans, while Policy H-165.856 supports the removal of barriers to the formation and operation of group purchasing alliances, the policy also calls for greater national uniformity of market regulation regardless of type of sub-market, geographic location, or type of health plan, and raises concerns with adverse selection.

Policy D-180.986 states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers. By contrast, Policy H-165.882 supports federal legislation to encourage the formation of small employer and other voluntary choice cooperatives by exempting insurance plans offered by such cooperatives from selected state regulations regarding mandated benefits, premium taxes, and small group rating laws, while safeguarding state and federal patient protection laws.

Regarding a Medicare buy-in, Policy H-330.896 supports restructuring age-eligibility requirements and incentives to match the Social Security schedule of benefits. Concerning Medicaid, Policy D-290.979 states that the AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent of the federal poverty level (FPL), or 138 percent FPL including the income disregard, as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver health care services more effectively, even as coverage is expanded.

DISCUSSION

In light of long-standing AMA policy (Policy H-165.856) advocating for greater national uniformity of market regulation across health insurance markets, and recognizing that departures from such uniform regulation should not create adverse selection, the Council believes it is essential that health plans competing to enroll individuals operate on a level playing field with the same rules applying to all plans. The Council is concerned with the potential for certain state and federal activities to lead to market segmentation, with healthier individuals enrolling in skimpier plans, and with individuals who for health and other reasons enrolling in plans following ACA requirements. As a result of such adverse selection the risk pools will likely be less healthy and there will likely be increased costs for individuals in plans following ACA requirements.

The AMA has long supported efforts to maximize health plan choices for individuals seeking coverage. However, it is imperative that state and federal consumer protection laws be maintained, AMA's key principles on health system reform be upheld, and patients have meaningful health insurance coverage options. AMA policy opposes denials and exclusions due to pre-existing conditions, and recognizes the protection that EHB coverage provides against out-of-pocket expenses, and annual and lifetime limits.

To strengthen and ensure the sustainability of the individual health insurance marketplace, upon which AMA's proposal for reform relies, the Council supports health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and EHBs. In the same light, the Council believes that the AMA should not support coverage options that are exempted from such mandated benefits, due to their negative impact on marketplace stability, risk pools and plan affordability, resulting from adverse selection. As such, the Council recommends the reaffirmation of Policy D-180.986, which states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers, and the rescission of Policy H-165.882, as it has been superseded by Policy D-180.986 and other AMA policies, and predates the ACA. The Council also recommends rescinding Policy D-165.934, which calls for the study that has been accomplished by the development of this report.

The Council agrees with the sentiment of many physicians that insufficient competition in the ACA marketplaces remains an issue to be addressed. However, the Council is concerned that public option proposals that rely on Medicaid and/or Medicare payment rates and/or tie physician participation in Medicare and/or Medicaid to a public option could negatively impact physician practices and physician practice sustainability, as well as patient access to care and choice of health plan. As such, the Council recommends the reaffirmation of Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.

To ensure patients are not left without coverage options in the marketplaces, consistent with the recommendation of a wide array of policy experts across the political spectrum, the Council recommends that our AMA support requiring the largest two FEHBP insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. The Council notes that this proposal would not allow individuals to buy-in to FEHBP plans. Rather, individuals in otherwise bare counties would have the choice of at least two silver plans that abide by ACA requirements, offered by the two largest FEHBP insurers in their county. Importantly, this proposal, unlike some others advocating for a public option, enables patient

choice of private health plans, ensures physician freedom of practice, does not require physician participation, and recognizes the value of payment rates being established through meaningful negotiations and contracts.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits. (New HOD Policy)

2. That our AMA oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: a) pre-existing condition protections; and b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months. (New HOD Policy)

3. That our AMA reaffirm Policy H-165.838, which states that health insurance coverage options offered in a health insurance exchange should be self-supporting; have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. (Reaffirm HOD Policy)

4. That our AMA support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation. (New HOD Policy)

5. That our AMA reaffirm Policy D-180.986, which states that our AMA will encourage local, state, and federal regulatory authorities to aggressively pursue action against "sham" health insurers. (Reaffirm HOD Policy)

6. That AMA Policy H-165.882 be rescinded. (Rescind HOD Policy)

7. That AMA Policy D-165.934 be rescinded. (Rescind HOD Policy)

Fiscal Note: Less than $500.

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