REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-26)
Study of the Federal Employees Health Benefits Program (FEHBP)

EXECUTIVE SUMMARY

At the 2025 Annual Meeting, the House of Delegates adopted Policy D-185.906, which directs the American Medical Association (AMA) to conduct a thorough study of the Federal Employees Health Benefits Program (FEHBP) to understand its successes, failures, strengths and weaknesses, and compare it with AMA Policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform. This report, which is presented for information to the House of Delegates, discusses key features of the FEHBP, its role in health reform efforts, and relevant AMA policy.

The FEHBP provides health insurance coverage to more than eight million civilian federal workers, retirees, and their dependents (non-federal employees are ineligible) and is the largest employer-sponsored insurance program in the country. For decades, the FEHBP has been viewed by many as a highly successful program that offers robust health plan competition and choice. Other advantages include its comprehensive benefits package, generous federal contributions, and continuity of coverage into retirement. Limitations include the FEHBP's high and increasing costs as well as its limited eligibility.

Although various health reformers from across the political spectrum have pointed to the FEHBP as a model, health system reform proposals that are based on the FEHPB have diminished in recent years, perhaps due to the availability of exchange plan coverage under the Affordable Care Act and/or because the program is less competitive and more costly than it once was. The FEHBP is largely consistent with Policy H-165.881 as well as AMA policies emphasizing pluralism, choice, competition, and other essential health reform principles. Of note, AMA Policy H-165.846 supports using the FEHBP as a standard for assessing meaningful coverage. The Council emphasizes that this is only one such standard, and that the principles and guidelines embedded throughout AMA policy form the basis by which the AMA will continue to evaluate an array of health reform approaches, including proposals that may build upon the FEHBP or incorporate some of its features. That said, we do not necessarily view the FEHBP as the most promising solution to achieving universal coverage, primarily due to the program's limited eligibility and rising costs. We also believe that allowing the public to access FEHBP coverage would severely disrupt the program's risk pool, which has been key to its success over the years. Because the Council did not identify gaps in existing AMA policy that would preclude assessment of future reform proposals that are based in part or in full on the FEHBP, we make no policy recommendations at this time.

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-26

Subject: Study of the Federal Employees Health Benefits Program (FEHBP)

Presented by: Betty Chu, MD, MBA, Chair

At the 2025 Annual Meeting, the American Medical Association (AMA) House of Delegates (HOD) adopted Policy D-185.906, "Study of the Federal Employee Health Benefit Plan [sic] (FEHBP)," which asks the following:

> Our AMA will conduct a thorough study of the FEHBP to understand the successes and failures, strengths and weaknesses of the program and determine how the FEHBP compares with AMA policy H-165.881 to see whether it might be an appropriate model to achieve private and public health system reform, with a report back to the A-26 Meeting of our House of Delegates.

Under Policy H-165.881, our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. This report, which is presented as information to the HOD, discusses the FEHBP and its advantages, limitations, and consistency with AMA health reform policy.

BACKGROUND

The FEHBP provides health insurance coverage to approximately 8.2 million civilian federal workers, retirees, and their dependents, or roughly 2.4 percent of the U.S. population.[1] As such, it is the largest employer-sponsored insurance (ESI) program in the country.[2] Established in 1960, in an era when many large private employers had begun offering health benefits, the intent of the FEHBP was to provide better benefits to federal employees, help them understand and compare plan options, and organize annual enrollment.[3]

Administered by the U.S. Office of Personnel Management (OPM), the FEHBP is governed by federal law that authorizes OPM to contract with qualified health insurers to offer a variety of plan types, primarily including fee-for-service (FFS) plans (most of which have a preferred provider organization [PPO] component), health maintenance organization (HMO) plans, and high-deductible health plans.[4] Similar to other private health plans, FEHBP offerings must comply with Affordable Care Act (ACA) benefits rules and requirements regarding minimum essential benefits, prohibitions on annual and lifetime limits, and other consumer protections enshrined in the 2010 law. Even so, the FEHBP is subject to fewer Department of Health and Human Services regulations than ACA marketplace, Medicare, or Medicaid plans and likewise receives less attention from Congress, interest groups, and health policy stakeholders.[5]

The basic rules of the FEHBP are outlined in federal statute and regulations, which give OPM relatively broad authority to administer the program and contract with plans.[6] In a typical cycle, OPM sends a "call letter" to insurers in the spring and then meets with each carrier to negotiate

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premiums, benefits, and payments for the next plan year.[7] The administrative structure of the FEHBP has been described as "diffuse," in that OPM works in coordination with the many health plans with which it contracts as well as more than a hundred federal agency employment offices.[8] Enrollment in the FEHBP is managed by federal agency personnel offices that oversee participation in accordance with OPM rules and procedures. The intent is to help workers enroll in coverage; unlike other federal health programs, OPM as the administrator does not engage in public purchasing or provider rate setting.[9]

Like other types of ESI, both the federal government and enrollees contribute towards the costs of FEHBP coverage. The federal government's share of premiums, known as the "fair share" formula and governed by statute, is intended to keep federal contributions consistent, regardless of the plan selected by an employee.[10] Generally, the government pays about 72 percent of the average premium across all plans (sometimes more, sometimes less) and will pay no more than 75 percent of a particular plan's premium.[11]

Premiums are designed to cover health care costs, plans' administrative expenses and profits, and OPM's administrative costs.[12] In reviewing health plans to be offered under the FEHBP, OPM considers the ability of plans to provide reasonable access to and choice of primary and specialty medical care throughout the service area. Participating health plans must be open to all workers, and no one can be denied coverage due to pre-existing conditions. OPM policy states that all participating carriers must be committed to the following:

1. Ensuring enrollees have access to good health care benefits;
2. Striving to keep premiums affordable;
3. Ensuring enrollees have access to quality provider networks;
4. Providing competitive health care choices for consumers;
5. Strengthening information for consumers so they can be more involved and responsible for their own health care decisions;
6. Being well managed and financially secure;
7. Providing efficient and effective contract administration;
8. Ensuring the timely and accurate submission of actuarial data and financial accounting information;
9. Maintaining compliance with laws, regulations, contract requirements and administrative guidance at all times; and
10. Guaranteeing that enrollee and government resources are protected.[13]

Importantly, eligibility for the FEHBP is limited to civilian federal employees, federal retirees, White House staff, and cabinet members. Per the ACA, members of Congress and their staffs are required to purchase coverage through an ACA exchange in order to receive a government contribution. Similar to other ESI programs, FEHBP-eligible individuals can enroll themselves and their family members in FEHBP plans within 60 days of being hired; during an open enrollment period; or within a specific timeframe of experiencing a qualified live event, such as a marriage, divorce or the birth or adoption of a new baby.[14] According to OPM, the FEHBP enrollee population reflects the demographics of the federal workforce: the median age of active employees is 47; approximately 42 percent of enrollees in the FEHBP and Postal Service Health Benefits Program are over the age of 50; and around 11 percent are younger than 30. When retiree demographics are considered together with the active workforce, the average age of FEHBP enrollees is around 60.[15]

Advantages of the FEHBP

Policy D-185.906 directed the AMA to study the successes and strengths of the FEHBP, which we describe as "advantages." For decades, the FEHBP has been viewed by many as a highly successful program. When compared to other types of coverage, its advantages include the following:
Robust, structured choice of plans: The FEHBP provides a broad range of plan options to enrollees, generally between 10 and 20 plans in each geographic market,[16] and—in 2026—offers a total of 132 plan options from 47 participating insurers.[17] Despite having a catalogue of available plans that is more robust than plan choices available at many private workplaces, only about five percent of FEHBP enrollees opt to change plans in a given year.[18] Moreover, the FEHBP has become more concentrated over the years such that, in 2015, Blue Cross Blue Shield (BCBS) had become the largest carrier for FEHBP enrollees in 98 percent of all U.S. counties.[19] This concentration translates to decreased competition and gives BCBS plans considerable influence when it comes to pricing of FEHBP plans. Of note, in 2025 approximately two-thirds of federal workers were enrolled in BCBS plans.[20]

Comprehensive benefits package and patient protections: Most FEHBP plans offer comprehensive coverage, including preventive services at no cost when received from a preferred provider. Notably, GLP-1 medications are currently covered by FEHBP. Additionally, there are no waiting periods or coverage restrictions based on pre-existing conditions.

Generous federal contributions: Federal contributions towards FEHBP plans are not based on employee income. Rather, the federal government pays 72 to 75 percent of the average premium across all plans with employees responsible for the remainder. In comparison, according to KFF's Employer Health Benefits Survey (which includes data from both public and private employers) in 2025 employers contributed on average 84 percent of single coverage premiums and 74 percent of family plan premiums.[21]

Continuity of coverage: Unlike most private employer plans, the FEHBP provides continuity of coverage to federal workers and retirees. FEHBP enrollees are able to maintain their coverage when transitioning to other federal jobs/agencies, and can continue FEHBP coverage into retirement. Because many private employers no longer offer retiree health coverage, continuity of coverage into retirement should be considered a particularly valuable FEHBP perk.

Less attention from Congress, regulators: Unlike other federal health programs, the FEHBP is somewhat insulated from policymakers and stakeholders and receives less attention from Congress and regulators than other federal health programs. In Congress, the program falls under the jurisdiction of the House Oversight and Accountability Committee and Senate Committee on Homeland Security and Government Affairs instead of the health and tax committees that oversee most Congressional health care matters.

Limitations of the FEHBP

Limitations of the FEHBP include the following:

High and Increasing costs: The main shortcoming of the FEHBP is that its health coverage is expensive, and costs are rising. In 2026, employees and retirees are expected to contribute 12.3 percent more, on average, towards their premiums after incurring a 13.5 percent increase in premium contributions in 2025.[22] The average premium increase overall in 2026 is 10.2 percent, down from 11.2 percent in 2025, while the federal contribution increased 9.2 percent in 2026, down from 10.1 percent in 2025.[23] The program's recent double-digit increases may generally be

higher than premium cost increases at many private firms, whose average premium contributions vary by firm size, industry, and other factors.

OPM has stated that premium increases this year are due in part to an aging workforce; the use of expensive prescription medications, especially GLP-1 drugs; and increased behavioral health spending. [24,25] Health policy experts have also highlighted higher hospital prices as a contributor.[26] OPM states that it routinely compares FEHBP premium costs to other large employers, although detailed benchmarking was not included in its benefits highlights for the current plan year. In last year's benefits highlights, OPM asserted that the FEHBP's overall average premium increase (11.2 percent) was similar to premium increases at comparable large employers, citing the California Public Employees' Retirement System —the second largest purchaser of public employee health benefits (after the federal government)—which saw average premiums increase by 10.8 percent.[27] OPM also cited the Large Employer Health Strategy Survey, conducted by the Business Group on Health, which found that large employers projected an average premium increase of eight percent for plan year 2025.[28]

Limited eligibility: An obvious but important drawback of the FEHBP as a reform model is its eligibility parameters, which limit enrollment to federal employees and retirees and their dependents, thus ensuring the overall stability of its risk pool.

Choice overload: Too much choice and not enough information to help guide enrollee decision-making may make it difficult for some federal employees to understand how different plans could impact their costs and access to care. Choice overload has also been cited as a challenge in other insurer markets, including ACA exchanges.

Susceptibility to changes in administration priorities: Given the White House's oversight of federal agencies, including OPM, the FEHBP may be more susceptible to changes intended to align the program with administration priorities. For example, coverage for some gender-affirming care for people of all ages was removed from the FEHBP following an executive order by President Trump.[29]

ROLE OF THE FEHBP IN HEALTH REFORM EFFORTS

Various health reformers have pointed to the FEHBP as a model almost since its inception, although considerations of the program were more frequent during the pre-ACA era and less so in recent years. Of note, proposals from across the political spectrum have been based in part on the FEHBP's framework, including the *Healthy Americans Act*—proposed in 2007 and 2009 by Senators Wyden and Bennett to establish universal health care—and the *FEHBP for All Act*, first introduced in 2011 by Representative Darrell Issa to repeal the ACA and open up the FEHBP to everyone. Importantly, the Issa bill kept the traditional FEHBP program intact to prevent adverse selection from negatively affecting the risk pool.

The FEHBP as a Model for National Health Insurance

In the 1990s, calls for the public to be able to purchase the same health coverage as members of Congress, who prior to the ACA were typically enrolled in the FEHBP, led to an array of proposals to open the FEHBP to the public and treat it as national health insurance. Back then, the FEHBP was widely praised as providing excellent coverage at low administrative cost. Not surprisingly, federal employees and their unions vehemently opposed such legislation, which they believed would significantly increase their premium costs. Moreover, the complexities involved in implementing such proposals became apparent when, for example, the OPM director at the time

commented that the FEHBP is "a wonderful working model, but it cannot be instantly duplicated."[30] More modest proposals to open the FEHBP to uninsured people and/or small businesses were also debated, and President Clinton's health package—released in 1995—included a provision allowing small businesses to buy into the program.[31]

The FEHBP as a Model for Restructuring Medicare

Also in the 1990s, several proposals to restructure the Medicare program based in part on the FEHBP were considered by various stakeholders because, at that time, the FEHBP was viewed as more successful than Medicare at controlling spending while offering robust choice and achieving high participant satisfaction.[32] In 1995, Stuart Butler and a colleague from the Heritage Foundation proposed reforming Medicare by adopting the FEHBP's choice and competition features and by, among other things, transforming it from an entitlement to a defined contribution program (though the FEHBP is not strictly a defined contribution model) and providing vouchers that enrollees could put towards a private plan of their choosing.[33] A few years later, a provision in the Balanced Budget Act of 1997, called Medicare+Choice, established Medicare Part C by authorizing the participation of private plans, thus launching the initial phase of what is now known as Medicare Advantage (MA).[34] The Medicare Modernization Act of 2003 further modified plan payments in Part C and established the Part D prescription drug program, which also incorporated the FEHBP's "managed competition" structure.[35,36]

The FEHBP as a Model for the ACA, Public Option Proposals

The idea of the FEHBP as a model for national health insurance was also debated in the years leading up to passage of the ACA, although some analysts cautioned against opening it up to non-federal workers in order to prevent disrupting the program's stable risk pool. In the end, President Obama rejected calls to open the FEHBP to the public in favor of carefully-designed insurance exchanges.[37]

The ACA also adopted some protections that had previously been provided to FEHBP enrollees, such as the prohibition on coverage restrictions based on health status. In 2009, a spinoff of the FEHBP that would authorize OPM with overseeing national health plans (outside of the FEHBP) was discussed as a potential replacement for the public option that was included in legislation passed by the House of Representatives. However, neither a public option nor an FEHBP spinoff-type option was included in the Senate bill or final ACA package.

Leveraging health plan FEHBP participation to address counties lacking individual market insurers (known as bare counties) was a key component of a bipartisan proposal to improve the ACA in 2017. This proposal would have required, as a condition of continued participation in the FEHBP, the two largest FEHBP insurers in a county to offer at least one silver plan through the federal exchange in all counties that would otherwise be bare.

In an effort to build upon the ACA's existing structure, a new coverage option for exchanges that would allow the public to enroll in the FEHBP has also been suggested.[38] Perhaps due to feasibility and/or cost concerns as well as existing FEHBP eligibility restrictions, such proposals have not gained much traction. Instead, most proposals put forward in Congress to establish a public option on ACA exchanges have been tied to Medicare or Medicaid payment rates in order to keep costs down, since the intent of a public option is to offer good coverage that costs less than other competing plans. Likewise, at the time this report was written, none of the states implementing a public option had adopted an approach that would allow the public to enroll in either the FEHBP or state employee health plan. Instead, public option laws in Washington, Colorado, and Nevada aim

to lower premiums and decrease overall health costs by either capping provider payments (Washington), establishing premium reduction targets (Nevada), or both—setting premium targets with the authority to reduce provider payments if the targets are not met (Colorado).[39] Several other states have considered various public option proposals and may, in the future, explore leveraging their state's employee benefits plan to increase available exchange plan offerings.

AMA POLICY

Longstanding policy (Policy H-165.846) has supported using federal guidelines, such as those under the FEHBP, as a standard for assessing meaningful health insurance coverage. As previously noted, Policy H-165.881 states that our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. Additional policies referencing the FEHBP include:

- Policy H-165.825, which supports 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. To clarify, this policy 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.

- Policy H-180.961, which encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the FEHBP.

Policies addressing ESI, including Policies H-165.828 and H-165.843, are also relevant to the FEHBP as it is the largest ESI provider in the country. For decades, AMA policy has advocated for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes receive the largest credits (e.g., Policies H-165.920 and H-165.865). Additional AMA health reform policies relevant to this report include:

- Policy H-165.838, which 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. This policy further commits the AMA to achieving health reforms that include numerous components, including health insurance coverage for all Americans; insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions; and assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials.

- Policy H-165.823, which advocates for a pluralistic health care system—which may include a public option—that focuses on increasing equity and access, is cost-conscious, and reduces burden on physicians. This policy establishes standards for supporting a public option and for supporting auto-enrollment in health insurance coverage.

- Policy H-165.985, which reaffirms core AMA health reform principles, including free market competition; freedom of patients to select and change physicians or health plans; freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, and to participate or not participate in a particular plan or method of payment; and full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.

DISCUSSION

Although the FEHBP has often been cited as a model for providing robust health plan competition and choice at reasonable cost, the Council finds that expanding the program broadly is not a viable strategy for increasing coverage and patient choice. Proposals incorporating the FEHBP in health system reforms have diminished in recent years, possibly due to the availability of exchange plan coverage under the ACA and/or because the FEHBP is less competitive and more costly than it once was. In comparing the FEHBP to other types of coverage, the Council found that the structure of the FEHBP does not substantially differ from the ACA marketplace or large employer plans, though the catalog of FEHBP plan options may be larger in some areas, its risk pool may be more stable than that of the ACA market, and FEHBP coverage may be continued into retirement. Unlike the 1960s when the FEHBP was created, most health plans must now meet certain standards and requirements, which has narrowed the differences between the FEHBP and other coverage types.

FEHBP consumer protections and benefit packages are generally comprehensive, as evidenced by the FEHBP's coverage of GLP-1 medications for obesity; however, they are not necessarily more generous than some large private employer offerings. In terms of cost, true comparisons between the FEHBP and other types of coverage would require detailed analysis at the local level; however, the Council points to recent double-digit increases in federal worker premium costs. Of note, the Council also recognizes that significant federal workforce reductions since 2025 may impact the FEHBP as soon as next year in ways that are not yet understood. For example, it is not clear how the FEHBP risk pool will be affected and whether some carriers may opt to exit the program in areas like Washington, DC that have experienced substantial decreases in staffing.

The Council believes that the FEHBP is largely consistent with Policy H-165.881 as well as AMA policies emphasizing pluralism, choice, competition, and other essential health reform principles. In particular, the FEHBP provides a broad array of competing plan options and a standardized employer contribution, both of which encourage consumer choice and plan competition. That said, we do not necessarily view the FEHBP as the most promising solution to achieving universal coverage, primarily due to its limited eligibility and rising costs. Additionally, premium contributions for federal workers are not tied to their household incomes; rather, the federal government pays between 72 and 75 percent of worker premiums, amounts that do not increase or decrease based on income. This feature of the FEHBP could be viewed as inconsistent with AMA policy advocating for the use of tax credits that are inversely related to income, so that patients with the lowest incomes receive the largest credits.

After studying the FEHBP as a reform model and hearing from a program expert, the Council concluded that opening up the FEHBP to the public would seem unwise in that it would severely disrupt the program's stable risk pool, which has been one of the keys to its success over the years. Though an expanded FEHBP would provide generous coverage and a robust choice of plans, FEHBP plans are relatively expensive and the costs of an expanded or open program would be high, potentially making it less affordable. That said, future reforms may continue to adopt certain features of the FEHBP, just as the ACA, MA, and Part D programs have done.

The Council also underscores that AMA Policy H-165.846—first adopted in 1997 and most recently reaffirmed in 2019—supports using the FEHBP as a standard for assessing meaningful coverage. We emphasize that this is only one such standard, and that the principles and guidelines embedded throughout the AMA's large compendium of policy form the basis by which the AMA will continue to evaluate and engage in advocacy around a broad array of health reform approaches, including proposals that may build upon the FEHBP or incorporate some of its features.

CONCLUSION

Having decided against recommending new AMA policy supportive of expanding eligibility for the FEHBP to non-federal workers—which would threaten that program's sustainability—the Council did not identify gaps in existing AMA policy that would preclude assessment of future reform proposals that are based in part or in full on the FEHBP. Therefore, the Council makes no policy recommendations at this time.

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Council on Medical Service Report 2-A-26
Study of the Federal Employees Health Benefits Program (FEHBP)
Policy Appendix

Expanding Choice in the Private Sector H-165.881
Our American Medical Association (AMA) will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee's health plan choice and expanded individual selection and ownership of health insurance where plans are truly accountable to patients. (BOT Rep. 23, A-97; Reaffirmed BOT Rep. 6, A-98; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmation: A-19)

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:
A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.
D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.
2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.
3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) 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. (CMS Rep. 7, A-07; Reaffirmation I-07; Reaffirmation A-09; Reaffirmed: Res. 103, A-09; Reaffirmation I-09; Reaffirmed: CMS Rep. 3, I-09; Reaffirmed: CMS Rep. 2, A-11; Appended: CMS Rep. 2, A-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed: CMS Rep. 1, I-12; Reaffirmed: CMS Rep. 3, A-13; Reaffirmed in lieu of Res. 812, I-13; Reaffirmed: CMS Rep. 6, I-14; Reaffirmed: CMS Rep. 6, I-15; Appended: CMS Rep. 04, I-17; Reaffirmed in lieu of: Res. 101, A-19)

Medical Care for Patients with Low Incomes H-165.855
It is the policy of our American Medical Association that:
1. states be allowed the option to provide coverage to their Medicaid beneficiaries who are nonelderly and nondisabled adults and children with the current Medicaid program or with premium tax credits that are refundable, advanceable, inversely related to income, and administratively simple for patients, exclusively to allow patients and their families to purchase coverage through programs modeled after the state employee purchasing pool or the Federal Employee Health Benefits Program (FEHBP) with minimal or no cost-sharing obligations based on income. Children qualified for Medicaid must also receive Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program benefits and have no cost-sharing obligations.

2. in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, Children's Health Insurance Program, and exchange plans.
3. to support the development of a safety net mechanism, allow for the presumptive assessment of eligibility and retroactive coverage to the time at which an eligible person seeks medical care.
4. tax credit beneficiaries should be given a choice of coverage, and that a mechanism be developed to administer a process by which those who do not choose a health plan will be assigned a plan in their geographic area through auto-enrollment until the next enrollment opportunity. Patients who have been auto-enrolled should be permitted to change plans any time within 90 days of their original enrollment.
5. state public health or social service programs should cover, at least for a transitional period, those benefits that would otherwise be available under Medicaid, but are not medical benefits per se.
6. as the nonelderly and nondisabled populations transition into needing chronic care, they should be eligible for sufficient additional subsidization based on health status to allow them to maintain their current coverage.
7. our American Medical Association encourages the development of pilot projects or state demonstrations, including for children, incorporating the above recommendations. (Modify Current HOD Policy)
8. our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects. (CMS Rep. 1, I-03; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation I-07; Modified: CMS Rep. 1, A-12; Reaffirmed in lieu of Res. 101, A-13; Reaffirmed: CMS Rep. 02, A-16; Reaffirmation: A-18;Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21; Reaffirmed: CMS Rep. 3, A-22; Reaffirmed: CMS Rep. 5, I-23)

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) 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; (2) 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; and (3) 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. (CMS Rep. 03, A-18; Reaffirmed: CMS Rep. 01, I-20)

Defining Levels of Health Insurance Coverage H-180.961
Our AMA strongly encourages the National Association of Insurance Commissioners to develop standards and a uniform disclosure format applicable to health plans and policies offered in the general insurance market, taking into consideration the benefit definitions and disclosure format used by plans participating in the Federal Employees Health Benefits Plan program; and supports the enactment of federal and/or state legislation requiring the use by health plans of standardized uniform disclosure formats that have had appropriate input by medical organizations. (CMS Rep. 9, A-97; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17)

Health Insurance Affordability H-165.828

1. Our AMA supports modifying the eligibility criteria for premium credits and cost-sharing subsidies for those offered employer-sponsored coverage by lowering the threshold that determines whether an employee's premium contribution is affordable to the level at which premiums are capped for individuals with the highest incomes eligible for subsidized coverage in Affordable Care Act (ACA) marketplaces.
2. Our AMA supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," thus determining the eligibility of family members of workers for premium tax credits and cost-sharing reductions based on the affordability of family employer-sponsored coverage and household income.
3. Our AMA encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
4. Our AMA supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch" and individuals who forego cost-sharing subsidies despite being eligible.
5. Our AMA supports additional education regarding deductibles and cost-sharing at the time of health plan enrollment, including through the use of online prompts and the provision of examples of patient cost-sharing responsibilities for common procedures and services.
6. Our AMA supports efforts to ensure clear and meaningful differences between plans offered on health insurance exchanges.
7. Our AMA supports clear labeling of exchange plans that are eligible to be paired with a Health Savings Account (HSA) with information on how to set up an HSA.
8. Our AMA supports the inclusion of pregnancy as a qualifying life event for special enrollment in the health insurance marketplace.
9. Our AMA supports that the ACA eligibility firewall not apply to individuals offered employer-sponsored coverage whose household incomes are at or below 200 percent of the federal poverty level, so they can receive federal premium tax credits and cost-sharing assistance if they opt to enroll in a marketplace health plan as an affordable alternative to their employer-based plan.
10. Our AMA supports incrementally lifting the ESI firewall with continual monitoring and consideration of insurance marketplace stability, if and only if there is documentation that marketplace insurance pays sufficiently to ensure physician practice sustainability, and other relevant parameters, with the goal of maximizing the number of individuals able to freely choose the health insurance plan that is best for themselves and their families.
11. Our AMA supports any incremental lifting of the firewall must be paired with a pause to review the relevant parameters, and the ability to pause permanently, or reverse if disruptive effects are detected.
12. Our AMA advocates that physician payments by health insurers participating in the ACA marketplace be sustainable, reflect the full cost of practice and the value of the care provided, include inflation-based updates, and pay fair and equitable rates. (CMS Rep. 8, I-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmation: A-17; Reaffirmed: CMS Rep. 09, A-19; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed in lieu of: Res. 101, A-19; Reaffirmed: CMS Rep. 01, I-20; Reaffirmed: CMS Rep. 2, I-20; Modified: CMS Rep. 3, I-21; Appended: Res. 701, I-21; Reaffirmed: Res. 826, I-24; Appended: CMS Rep. 02, A-25)

Trends in Employer-Sponsored Health Insurance H-165.843
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. provide employees with user-friendly information regarding their eligibility for subsidized ACA marketplace plans based on their offer of employer-sponsored insurance;
d. 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. offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
f. support increased fairness and uniformity in the health insurance market; and
g. promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care. (CMS Rep. 4, I-07; Reaffirmed: CMS Rep. 01, A-17; Modified: CMS Rep. 02, A-25)

Individual Health Insurance H-165.920
Our AMA:
(1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services;
(2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access;
(3) actively supports the principle of the individual's right to select a health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will:
(a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes;
(b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly;
(c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and
(d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes;

(4) will identify any further means through which universal coverage and access can be achieved;
(5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it;
(6) supports the individual's right to select a health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage;
(7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons;
(8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures;
(9) supports legislation requiring a “maintenance of effort” period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan;
(10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage;
(11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one;
(12) supports a replacement of the present federal income tax exclusion from employees’ taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax;
(13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees’ federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and
(14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured.
(15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. (BOT Rep. 41, I-93; CMS Rep. 11, I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99; Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed: CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03; Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Modified: CMS Rep. 3, A-06; Reaffirmed in lieu of Res. 105, A-06; Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed in lieu of: Res. 805, I-17; Modified: Speakers Rep. 02, I-24)