

REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-23)
Health Care Marketplace Plan Selection
Informational Report

EXECUTIVE SUMMARY

At the 2022 Interim Meeting, the House of Delegates adopted Policy D-165.933, “Health Care Marketplace Plan Selection.” This policy directs the American Medical Association (AMA) to re-evaluate and study the effectiveness of the current plan options in the health care marketplace to adequately provide choice and competition, especially in communities in close proximity to multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023 Annual Meeting. This report, which is presented for information to the House of Delegates, provides updated information on insurer competition in health insurance exchanges, insurer concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally, the report summarizes key AMA policies that strongly support competition and choice in the health insurance marketplace.

Insurer participation in the Affordable Care Act (ACA) marketplace has increased for five consecutive years, enrollment has surpassed 16 million people, and the exchanges are generally functioning well. Still, the Council recognizes that insurer participation in the marketplace remains lower today than in 2015, when it was at its highest, and the share of plans offered by large insurers has been steadily growing in recent years. Many insurer exchange markets remain highly concentrated, as evidenced by data compiled in the AMA’s most recent edition of *Competition in Health Insurance: A Comprehensive Study of U.S. Markets*. The Council shares the sentiment of many physicians that insufficient competition in the ACA marketplace remains concerning in many areas. Importantly, health insurance markets are local; across states, there is significant variation in the number of insurers and plans offered in ACA exchanges and, within states, there may be differences in insurer participation in rural and urban regions.

The Council finds that the concerns raised in Policy D-165.933 are addressed by Policies H-165.825, H-165.839, H-165.838, H-165.846, H-180.946, H-165.856, and H-180.947. We identify no gaps in existing AMA policy and make no recommendations at this time. However, the Council believes network adequacy, which is key to maintaining healthy competition and choice in the marketplace, remains problematic and is worthy of additional study. The Council has begun looking at the need for stronger network adequacy standards for ACA, Medicare Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-23

Subject: Health Care Marketplace Plan Selection

Presented by: Lynn Jeffers, MD, Chair

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2 Marketplace Plan Selection.” This policy directs the American Medical Association (AMA) to
3 re-evaluate and study the effectiveness of the current plan options in the health care marketplace to
4 adequately provide choice and competition, especially in communities in close proximity to
5 multiple states (insurance markets) and submit a report to the AMA House of Delegates at the 2023
6 Annual Meeting. This report, which is presented for information to the House of Delegates,
7 provides updated information on insurer competition in health insurance exchanges, insurer
8 concentration in exchange markets, and policies impacting the marketplace in 2023. Additionally,
9 the report summarizes AMA policy that strongly supports competition and choice in the health
10 insurance marketplace.

11

12 BACKGROUND

13

14 The intent of individual health insurance exchanges required under the Affordable Care Act (ACA)
15 is to broaden coverage through a patient-friendly market and ensure healthy competition among
16 plans. Products sold in the ACA marketplace are required to be certified as qualified health plans
17 (QHPs); and as a condition of QHP certification, insurers—or issuers—must meet certain standards
18 and requirements designed to protect patients while encouraging health plan competition and
19 choice. Robust competition among issuers participating in the insurance exchanges is essential to
20 health plan affordability and choice, as evidenced by research showing that the participation of
21 additional insurers on an exchange is associated with lower premiums and, conversely, regions
22 with fewer insurers have higher premiums.¹ Across states, there is significant variation in the
23 number of insurers and plans offered in ACA exchanges and, within states, there may be
24 differences in insurer participation in rural and urban areas.

25

26 INSURER PARTICIPATION IN HEALTH INSURANCE EXCHANGES

27

28 Insurer participation in the marketplace has been an ongoing concern since the ACA exchanges
29 began operating and have gone up and down in the ensuing years in response to marketplace
30 regulations and insurers entering and exiting the market. After a period of decreasing insurer
31 participation between 2016 and 2018 (participation was at its highest in 2015), 2023 marks the fifth
32 consecutive year of increases in the number of insurers offering ACA marketplace plans. In fact,
33 most people shopping for coverage on an exchange must navigate through scores of offerings
34 before choosing a health plan that best meets their needs and budget, a process that can be both
35 daunting and confusing. This year, consumers using the federal exchange through HealthCare.gov
36 will have, on average, more than 113 QHPs to choose from, up from over 60 plan options in 2021
37 and just over 25 options in 2019.² An issue brief released by the Office of Health Policy for the
38 Assistant Secretary for Planning and Evaluation (ASPE) showed that, in 2021, nearly three-
39 quarters of HealthCare.gov users had more than 60 plan options to choose from, and over a quarter
40 selected from more than 160 plans.³ Within a specific metal tier (i.e., bronze, silver, gold, or

1 platinum), or even within a particular metal tier and a specific issuer, consumers in many areas can
 2 still have an abundance of plan options from which to choose.

3
 4 In the 33 marketplaces using the HealthCare.gov platform, the Centers for Medicare & Medicaid
 5 Services (CMS) has announced that there is greater choice of insurers in 2023 with only one
 6 percent of enrollees having access to a single QHP issuer, the lowest in marketplace history.⁴ The
 7 Center for Consumer Information and Insurance Oversight (CCIIO) has reported that, in
 8 HealthCare.gov states, 92 percent of enrollees have three or more insurers from which to choose
 9 this year compared to 89 percent of enrollees in 2022. There are 220 total insurers participating in
 10 HealthCare.gov states, an increase of seven from 2022, and the average enrollee has access to
 11 between six and seven issuers, and over 113 QHPs.⁵ A CCIIO [map](https://www.cms.gov/files/document/py2023-county-coverage-map.pdf)
 12 (<https://www.cms.gov/files/document/py2023-county-coverage-map.pdf>) of Plan Year 2023
 13 exchange insurers, which includes federally-facilitated exchange data as well as self-reported data
 14 (updated as of October 2022) from the 18 states operating their own exchanges, shows that only
 15 three percent of counties (93) have a single insurer while 25 percent (771) have two insurers and
 16 remaining counties have three or more insurers on the exchange. This contrasts with 2018 when
 17 over half (51.3 percent) of counties had a single carrier, a percentage that decreased to just over 35
 18 percent of counties in 2019, 24 percent in 2020, nine percent in 2021, five percent in 2022, and
 19 three percent in 2023 (see appendix). County level data is important to measuring competition in
 20 the ACA marketplace because many insurers offer plans in some parts of a state but not others, and
 21 because health plans are priced and offered locally.

22
 23 A brief from the Robert Wood Johnson Foundation explains that although insurer participation in
 24 the ACA marketplace increased significantly between 2019 and 2021, such increases were more
 25 moderate in 2022 and relatively small in 2023.⁶ This year, large increases in insurer participation
 26 were seen in only a small number of states, including a few non-expansion states, as insurers
 27 continue to focus on areas where more uninsured people live. Although Georgia had a large
 28 increase in new plan offerings in 2022, the increase in that state was much smaller in 2023 when
 29 Texas had the most new offerings.⁷ Importantly, the share of plans offered by large health insurers,
 30 including Blues plans, UnitedHealthcare, Cigna, CVS/Aetna, Centene, and Molina, increased in the
 31 marketplace while the share of smaller insurers, such as regional and provider-sponsored plans,
 32 decreased from 45 percent in 2022 to 40 percent in 2023.⁸ Furthermore, the large national insurers
 33 have tended to take over where smaller companies, including Bright Health and Oscar Health, have
 34 exited markets. It is also notable that the Medicaid managed care companies Centene and Molina
 35 have been steadily increasing their footprints on the exchanges.

36
 37 **INSURER CONCENTRATION IN EXCHANGE MARKETS**

38
 39 The 2022 edition of the AMA's *Competition in Health Insurance: A Comprehensive Study of U.S.*
 40 *Markets* notes that there have been large changes over time in exchange market concentration and
 41 some volatility in exchange insurers' market shares and rankings. According to the study's
 42 analysis, there were large increases in average market concentration in the exchanges between 2015
 43 and 2018, annual decreases thereafter, and a notably large decrease between 2020 and 2021 that
 44 was widespread across metropolitan statistical areas (MSAs). The AMA study found that, at the
 45 MSA level in 2021, at least one insurer had a market share of 30 percent in 98 percent of exchange
 46 markets; in 73 percent of markets, one insurer had a market share of 50 percent; and in 39 percent
 47 of markets, an insurer had a market share of 70 percent.⁹ Turning to the national level, Anthem had
 48 the largest share of the exchange market in 2014 and 2015 but fell to sixth largest in 2021 while
 49 Centene, which had a smaller share of the exchange market in earlier years, had the largest market
 50 share (15 percent) in 2021.¹⁰

1 Concerns over the years regarding insufficient competition in the individual health care
 2 marketplace have led some thought leaders, as well as state and federal policy makers, to put
 3 forward a range of proposals to ensure marketplace coverage options, including the creation of a
 4 public option. Concerns with public option proposals have previously been addressed at length by
 5 the Council on Medical Service in [Council Report 3-A-18](#) and [Council Report 1-Nov.-20](#). Policy
 6 experts have also suggested leveraging Federal Employees Health Benefits Program (FEHBP)
 7 health plan participation as a solution to prevent bare counties in the marketplaces, which is
 8 consistent with Policy H-165.825. In addition to discussing a public option and establishing policy
 9 that supports requiring the largest two FEHBP insurers in counties that lack a marketplace plan to
 10 offer at least one silver-level marketplace plan as a condition of FEHBP participation, Policy
 11 H-165.825—established via [Council on Medical Service Report 3-A-18](#)—supports health plans
 12 offering coverage options for individuals and small groups competing on a level playing field,
 13 including providing coverage for pre-existing conditions and essential health benefits. This policy
 14 also opposes the sale of health insurance plans in the individual and small group markets that do
 15 not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits
 16 and their associated protections against annual and lifetime limits, and out-of-pocket expenses,
 17 except in the limited circumstance of short-term limited-duration insurance offered for no more
 18 than three months.

19
 20 A primary purpose of regulations governing the health insurance marketplace has been to help
 21 ensure that insurers are competing and operating on an even playing field in which all insurers and
 22 plans must play by the same rules. The AMA advocates that exchanges need to offer choices to
 23 patients to spur competition and that mechanisms to facilitate competition in health insurance
 24 should ensure that critical patient protections remain in place, including the ban on pre-existing
 25 condition exclusions as well as critical cost protections guaranteed in the ACA (e.g., annual cap on
 26 out-of-pocket expenses). The AMA strongly believes that an important federal role remains to
 27 ensure that proposals to foster competition in health insurance also promote ACA marketplace
 28 stability and a balanced risk pool and do not lead to adverse selection in the marketplace.¹¹

29
 30 NETWORK ADEQUACY

31
 32 AMA policy and advocacy also underscores that a plan’s provider network is an important factor in
 33 maintaining healthy competition and choice and, as such, the AMA consistently advocates for
 34 stronger network adequacy standards for QHPs, including those offered through federally
 35 facilitated exchanges. The AMA believes that state regulators should have flexibility to regulate
 36 their provider networks but also maintains that there is a critical need for a minimum federal
 37 network adequacy standard that includes quantifiable standards, especially in light of inaction in
 38 many states to update network adequacy requirements. The AMA has also advocated that CMS
 39 implement additional qualitative standards to measure network adequacy and better evaluate access
 40 to timely and appropriate care for enrollees in QHP plans.¹²

41
 42 In response to CMS’ proposed rulemaking on benefits and payment parameters under the ACA for
 43 2024, the AMA strongly supported CMS’ inclusion of wait time requirements into the
 44 measurement of network adequacy. The AMA believes this, and other quantitative standards are
 45 critical to determining if a network can serve the needs of its enrollees. Often network physicians
 46 may appear to be available but may not be accepting new patients at all or have a lengthy wait time
 47 for obtaining an appointment that makes it impossible to see them in a timely manner. Wait time
 48 requirements could help address these issues. The AMA also urged CMS to consider additional
 49 tools to measure compliance beyond insurer attestation, including audits, secret shopper programs,
 50 and patient surveys.¹³

1 SALE OF HEALTH INSURANCE ACROSS STATE LINES

2
3 The issue of permitting the sale of health insurance across state lines has been debated by the
4 House of Delegates several times over the years, with proponents arguing that this would spur
5 competition, choice, and affordability and others maintaining that any such allowances could
6 motivate insurers to incorporate in states with less insurance regulation, putting important patient
7 and provider protections at risk. Under AMA Policy H-180.946, established in 2017, the AMA
8 would support the sale of health insurance across state lines, including multistate compacts, when
9 patient and provider protection laws are consistent with and enforceable under the laws of the state
10 in which the patient resides. These protections include not weakening any state's laws or
11 regulations involving network adequacy and transparency; fair contracting and claims handling;
12 prompt payment for physicians; regulation of unfair health insurance market products and
13 activities; rating and underwriting rules; grievance and appeals procedures; and fraud. The
14 sentiment of AMA policy is that patients purchasing an out-of-state policy should retain the right to
15 bring a claim against an insurer in a state court in the state in which the patient resides.

16
17 Because a state's insurance regulator cannot enforce another state's laws or regulate beyond its
18 borders, consumer protections and other regulations must be clearly defined when interstate health
19 insurance sales are permitted. It is unclear whether insurers would even be interested in selling
20 products in new markets across state lines where other carriers are already competing. When
21 interstate health insurance sales were debated at the federal level in 2017, a handful of states had
22 laws allowing such sales; however, out-of-state issuers were not drawn to these markets, primarily
23 due to the costs and other challenges associated with developing provider networks in another state.
24 Some stakeholders, including the American Academy of Actuaries and the National Association of
25 Insurance Commissioners, have cautioned that interstate sales will neither increase competition nor
26 decrease premium pricing but could have unintended consequences related to consumer protections
27 and adverse selection.¹⁴

28
29 ADDITIONAL POLICIES IMPACTING THE MARKETPLACE IN 2023

30
31 *Extension of Enhanced Premium Tax Credit Subsidies:* The Inflation Reduction Act, signed into
32 law in August 2022, extends through 2025 the enhanced premium tax credits that were made
33 available to eligible consumers under the American Rescue Plan Act of 2021. This advanceable
34 and refundable credit, which the AMA supports, reduces the premium contribution for families
35 with incomes between 100 and 150 percent of the federal poverty level (FPL) to zero and provides
36 subsidies to 90 percent of consumers selecting marketplace plans. Partly as a result, enrollment in
37 marketplace plans has reached record highs, surpassing 16 million during the open enrollment
38 period that ran until mid-January 2023 for most exchanges.¹⁵ Additionally, the enhanced subsidies
39 significantly increase affordability of marketplace plans and will improve the stability of the
40 exchange market if healthier people enroll.¹⁶

41
42 *Special Enrollment Opportunity (SEP) for Consumers Losing Medicaid/CHIP Coverage:* The
43 Consolidated Appropriations Act of 2023 decoupled the Medicaid continuous enrollment
44 requirement from the public health emergency (PHE) end date and permitted state eligibility
45 redeterminations of Medicaid/CHIP enrollees to begin as early as March 2023. Although it is not
46 yet known how many individuals will be disenrolled as states undertake these mass
47 redeterminations, major disruptions in coverage are anticipated and many people could become
48 uninsured. Importantly, CMS established a SEP for consumers losing Medicaid/CHIP coverage due
49 to the unwinding of the continuous enrollment requirement. This SEP, which allows individuals
50 and families to enroll in marketplace plans, if eligible, outside of the annual open enrollment
51 period, runs between March 31, 2023 and July 31, 2024 and presents a significant enrollment

1 opportunity for the exchanges.¹⁷ The Council addressed the mass redeterminations and strategies
2 for preventing coverage losses in [Council Report 03-A-22](#).

3
4 *Fixing the “Family Glitch:”* The AMA long supported fixing the “family glitch” and was
5 accomplished this year by regulations allowing family members of workers offered affordable self-
6 only coverage to gain access to subsidized ACA marketplace coverage. Under the new rule, it was
7 anticipated that nearly one million Americans would see their coverage become more affordable.¹⁸

8
9 *Requiring Standardized Plan Options:* To address “choice overload” and increase transparency, in
10 2023, CMS began requiring issuers offering QHPs on HealthCare.gov to offer standardized benefit
11 plans for every product, metal level, and geographic area. In comment letters to CMS, the AMA
12 has supported this change which will help highlight clear and meaningful differences between
13 plans, simplify consumer choice, and improve the plan selection process.¹⁹

14 15 AMA POLICY

16
17 As previously noted, Council on Medical Service Report 3-A-18 established Policy H-165.825,
18 which added to the AMA’s strong body of policy on marketplace competition and health plan
19 choice. Policy H-165.839 outlines principles for the operation of health insurance exchanges,
20 including that: health insurance exchanges should maximize health plan choice for individuals and
21 families purchasing coverage; health plans participating in the exchange should provide an array of
22 choices, in terms of benefits covered, cost-sharing levels, and other features; and federal authority
23 or oversight of health insurance exchanges must respect the role of state insurance commissioners
24 with regard to ensuring protections for patients and physicians. Additionally, this policy supports
25 using the open marketplace model for any health insurance exchange to increase competition and
26 maximize patient choice of health plans.

27
28 Policy H-165.838 supports health reform initiatives that are consistent with long-standing AMA
29 policies on pluralism, freedom of choice, freedom of practice, and universal access for patients.
30 This policy also states that insurance coverage options offered in a health insurance exchange be
31 self-supporting; have uniform solvency requirements; not receive special advantages from
32 government subsidies; include payment rates established through meaningful negotiations and
33 contracts; not require provider participation; and not restrict enrollees’ access to out-of-network
34 physicians. Support for fixing the ACA’s “family glitch” is addressed by Policy H-165.828, which
35 also supports efforts to ensure clear and meaningful differences between plans offered on health
36 insurance exchanges.

37
38 Principles to guide in the evaluation of the adequacy of health insurance coverage options are
39 outlined in Policy H-165.846, including that: any insurance pool or similar structure designed to
40 enable access to age-appropriate health insurance coverage must include a wide variety of coverage
41 options from which to choose; existing federal guidelines regarding types of health insurance
42 coverage should be used as a reference when considering if a given plan would provide meaningful
43 coverage; and mechanisms must be in place to educate patients and assist them in making informed
44 choices. This policy also opposes waivers of essential health benefits (EHB) requirements that lead
45 to the elimination of EHB categories and their associated protections. Policy H-165.865 states that
46 in order to qualify for a tax credit for the purchase of individual health insurance, the health
47 insurance purchased must provide coverage for hospital care, surgical and medical care, and
48 catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the U.S. Code.

49
50 Network adequacy is addressed in Policy H-285.908, which supports state regulators as the primary
51 enforcer of network adequacy requirements. This policy supports requiring health insurers to

1 submit and make publicly available, at least quarterly, reports to state regulators that provide data
 2 on several measures of network adequacy. Policy H-180.946 supports the selling of insurance
 3 across state lines that ensure that certain patient and provider protection laws are consistent with
 4 and enforceable under the laws of the state in which the patient resides. Additionally, Policy
 5 H-180.946 states that patients purchasing an out-of-state policy should retain the right to bring a
 6 claim in a state court in the state in which the patient resides.

7
 8 Policy H-165.856 supports greater national uniformity of market regulation across health insurance
 9 markets, geographic location, or type of health plan. Under this policy, state variation in market
 10 regulation is permissible so long as states demonstrate that departures from national regulations
 11 would not drive up the number of uninsured, and so long as variations do not hamper the
 12 development of multi-state group purchasing alliances or create adverse selection. Under Policy
 13 D-165.971, the AMA will support an association health plan that safeguards state and federal
 14 patient protection laws, including those state regulations regarding fiscal soundness and prompt
 15 payment. Policy D-180.986 encourages local, state, and federal regulatory authorities to
 16 aggressively pursue action against “sham” health insurers.

17
 18 Policy H-180.947 opposes consolidation in the health insurance industry that may result in
 19 anticompetitive markets. Antitrust reform is an AMA priority under Policy D-383.990, which
 20 directs the AMA to continue to: aggressively advocate for a level playing field for negotiations
 21 between physicians and health insurers; advocate to the Federal Trade Commission and
 22 Department of Justice for more flexible and fair treatment of physicians and for greater scrutiny for
 23 insurers; continue to develop and publish objective evidence of the dominance of health insurers
 24 through its study, *Competition in Health Insurance*; and identify consequences of the concentration
 25 of market power by health plans.

26
 27 DISCUSSION

28
 29 Insurer participation in the ACA marketplace has increased for five consecutive years, although a
 30 smaller increase was seen in 2023. Additionally, record numbers of individuals have signed up for
 31 coverage in the exchanges, which seem to be functioning well. Enrollment is likely being
 32 influenced this year by 1) the Inflation Reduction Act’s extension of enhanced premium tax credit
 33 subsidies for marketplace plans, through 2025, and 2) the disenrollment of individuals no longer
 34 eligible for Medicaid/CHIP, some of whom may be eligible for subsidized ACA plans. Still, the
 35 Council recognizes that insurer participation in the marketplace remains lower today than in 2015,
 36 when it was at its highest, and the share of plans offered by large insurers has been steadily
 37 growing in recent years. Additionally, many insurer exchange markets remain highly concentrated,
 38 as evidenced by data compiled in the AMA’s most recent edition of *Competition in Health
 39 Insurance: A Comprehensive Study of U.S. Markets*. Importantly, health insurance markets are
 40 local; across states, there is significant variation in the number of insurers and plans offered in
 41 ACA exchanges and, within states, there may be differences in insurer participation in rural and
 42 urban regions. The Council shares the sentiment of many physicians that insufficient competition
 43 in the ACA marketplace remains concerning in many areas.

44
 45 The Council also recognizes that the AMA has been a longstanding advocate for health insurance
 46 coverage for all Americans, as well as pluralism, freedom of choice, freedom of practice and
 47 universal access for patients. The [AMA’s plan to cover the uninsured](#), updated annually with new
 48 policy and metrics on the uninsured, lays out key calls for action to not only maintain, but build
 49 upon, the coverage gains that have been achieved under the ACA. This plan guides ongoing AMA
 50 federal and state advocacy on health reform policy priorities. Importantly, increasing insurer
 51 competition, maximizing health plan choice, and strengthening and ensuring the sustainability of

1 the ACA marketplace remain key AMA priorities. The Council has presented several reports in
2 recent years to establish and update AMA policy on these issues, including:

- 3
- 4 • [Council on Medical Service Report 4-I-17](#), Health Insurance Affordability: Essential
5 Health Benefits and Subsidizing the Coverage of High-Risk Patients;
- 6 • [Council on Medical Service Report 3-A-18](#), Ensuring Marketplace Competition and Health
7 Plan Choice;
- 8 • [Council on Medical Service Report 2-A-18](#), Improving Affordability in the Health
9 Insurance Exchanges;
- 10 • [Council on Medical Service Report 2-A-19](#), Covering the Uninsured under the AMA
11 Proposal for Reform;
- 12 • [Council on Medical Service Report 1-Nov.-20](#), Options to Maximize Coverage under the
13 AMA Proposal for Reform; and
- 14 • [Council on Medical Service Report 3-Nov.-21](#), Covering the Remaining Uninsured.
- 15

16 Additionally, the Council highlights the following AMA policies addressing the issues raised in
17 Policy D-165.933 and exemplifying the AMA's strong support for insurer competition and health
18 plan choice:

- 19
- 20 • Policy H-165.825, which offers solutions to ensuring marketplace competition and health
21 plan choice;
- 22 • Policy H-165.839, which supports using the open marketplace model for any health
23 insurance exchange and states that exchanges should maximize health plan choice;
- 24 • Policy H-165.838, under which insurance coverage options offered in an exchange should
25 be self-supporting and have uniform solvency and other requirements;
- 26 • Policy H-165.846, which outlines principles to guide in the evaluation of health insurance
27 coverage options;
- 28 • Policy H-180.946, which supports the selling of insurance across state lines, including
29 multistate compacts, when patient and provider protection laws are consistent with and
30 enforceable under the laws of the state in which the patient resides;
- 31 • Policy H-165.856, which supports greater uniformity of market regulation across health
32 insurance markets, geographic location, or type of health plan; and
- 33 • Policy H-180.947, which opposes consolidation in the health insurance industry that may
34 result in anticompetitive markets.
- 35

36 CONCLUSION

37
38 During the development of this report, the Council did not identify gaps in existing AMA policy on
39 competition and choice and, therefore, makes no policy recommendations at this time. However,
40 the Council believes network adequacy, which is key to maintaining healthy competition and
41 choice in the exchanges, is an issue that remains problematic and is worthy of additional study.
42 Relatedly, the Council is concerned about the ability of patients to see certain physicians who are
43 listed by plans as in-network but for whom, in reality, access is limited. Accordingly, the Council
44 has begun looking at the need for stronger network adequacy standards for ACA, Medicare
45 Advantage, and Medicaid plans and will present a report on this topic at the 2023 Interim Meeting.

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⁴ *Ibid.*

⁵ CMS *supra* note 2.

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⁷ *Ibid.*

⁸ *Ibid.*

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¹⁰ *Ibid.*

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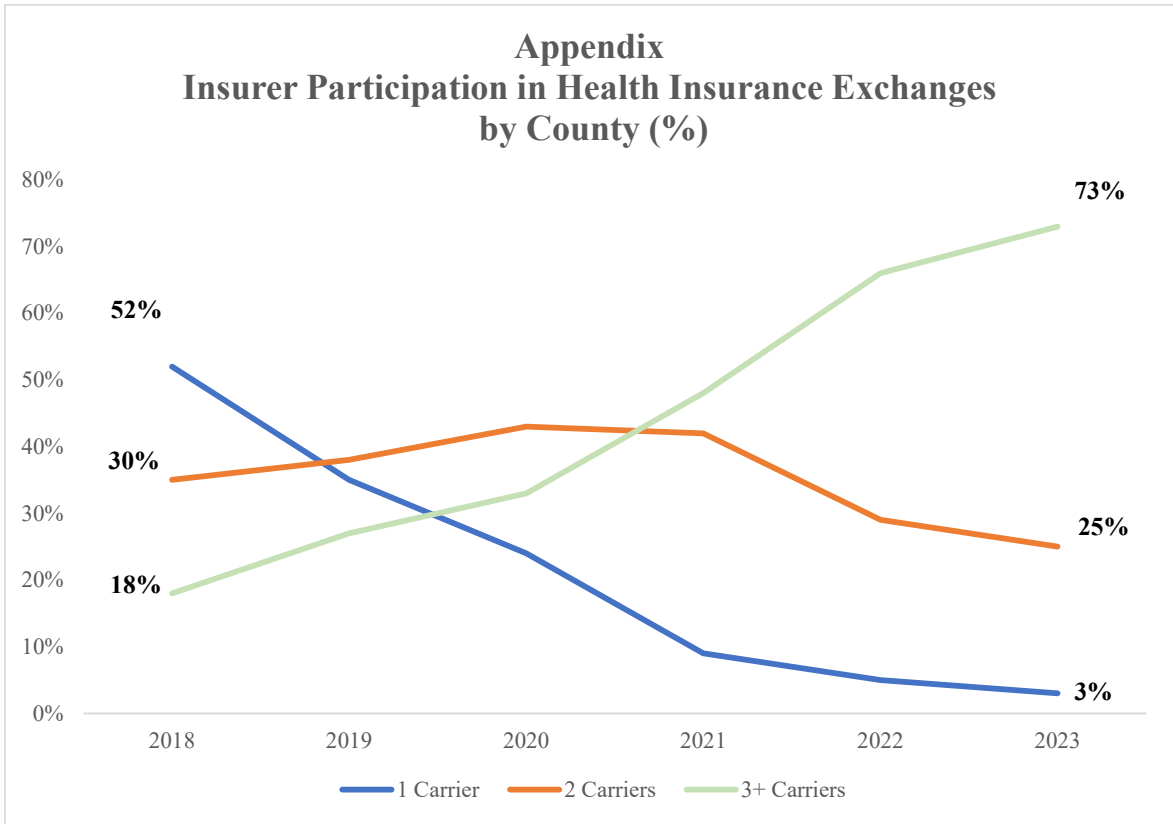
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¹⁹ AMA *supra* note 15.



Centers for Medicare & Medicaid Services. Center for Consumer Information and Insurance Oversight (CCIIO). County by County Plan Year 2018-2023 Insurer Participation in Health Insurance Exchanges.
Kaiser Family Foundation. Insurer Participation on the ACA Marketplaces, 2014-2021.
Values may not add up to 100% due to rounding.