

Reference Committee B

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Resolution(s)

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 11-A-17

Subject: Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee B
(Alethia Morgan, MD, Chair)

1 INTRODUCTION

2
3 At the 2016 Annual Meeting, The House of Delegates (HOD) adopted Policy D-478.970,
4 “Physician-Patient Text Messaging and Non-HIPAA Compliant Electronic Messaging,” which
5 asks that:

6
7 Our American Medical Association study the medicolegal implications of text messaging and
8 other non-HIPAA-compliant electronic messaging between physicians, patients, and members
9 of the health care team, with report back at the 2017 Annual Meeting.

10
11 Our AMA develop patient-oriented educational materials about text messaging and other non-
12 HIPAA-compliant electronic messaging communication between physicians, patients, and
13 members of the health care team.

14
15 This report outlines federal requirements for text messaging and other electronic messaging
16 communications that convey patient information. It notes that using such technology is not barred
17 by federal privacy and security laws but entails certain risks that should be weighed and
18 considered. The report also emphasizes the importance of patient consent when using these tools
19 and highlights ongoing efforts to clarify appropriate uses of communicating via text or electronic
20 messaging.

21
22 BACKGROUND

23
24 As technology has developed, communication by text and other electronic messaging has become
25 extremely common. Physicians, other health care workers and patients are part of this trend and are
26 using these tools more and more often. For example, one study found that the majority of
27 physicians use text messaging, and that it was the preferred form of communication among
28 members of the health care team for patient related care.¹

29
30 Using electronic messaging can offer numerous advantages for clinical care since it is usually fast
31 and efficient. Many patients also value the ability to communicate with their health care providers
32 via text due to their access to and familiarity with a cell phone’s texting capabilities since texting is
33 readily available on their cell phones. Patients now ask that their health information be sent to them
34 in this form.

1 Many health professionals also prefer to communicate with their co-workers via text rather than
2 paging. As a comparison, one-way paging does not allow a recipient to directly respond to a
3 message's sender. While some clinicians have access to two-way paging, this technology still
4 requires additional steps or use of an entirely separate device that is in addition to the health care
5 worker's phone. Further, since pagers generally do not include address book functionality, the risk
6 of sending a paged message to an unintended recipient is greatly increased compared to using a cell
7 phone's address book to select a text message recipient.

8
9 Texting and other forms of electronic messaging, however, have specific and unique risks that
10 should be considered before being used. For example, pagers typically do not store any data
11 directly on the paging device whereas the information in texts is stored and typically remains
12 accessible on a person's phone. Text messages often can also be viewed on a phone's home screen,
13 allowing anyone near the phone to see the messages without the need to enter a password. Texting
14 networks also have less broadcast power than pagers, which make the signals less reliable,
15 especially in cases of emergencies.

16
17 Physicians and patients are often not aware of the full risks associated when communicating via
18 text or electronic messaging. Many are also confused about what is or is not permitted by law, what
19 limitations are placed on these forms of communication, and how to manage the unique risks when
20 using texting or electronic messaging. The following sections of this report provide background on
21 the legal requirements and other considerations that may be relevant when using texting or
22 electronic messaging to communicate with patients or across the health care team.

23 24 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) 25 PROTECTIONS

26 27 *Safeguards for text or electronic messaging to patients and the health care team*

28
29 Guidance on the use of text and electronic messaging has typically advised against their use
30 because of privacy and security concerns, including potential HIPAA violations. Caution was
31 recommended because of the lack of encryption, the fact that the vendor/wireless carrier can store
32 text messages, and the inability for the sender to know with certainty that the message is received
33 by the intended recipient.² Ultimately, unencrypted text messaging, without additional safeguards,
34 continues to pose these risks and is generally not recommended for communicating Protected
35 Health Information (PHI). PHI is defined as information that identifies the individual or for which
36 there is a reasonable basis to believe it can be used to identify the individual and relates to:

- 37
38 • the individual's past, present, or future physical or mental health or condition;
39 • the provision of health care to the individual; or
40 • the past, present, or future payment for the provision of health care to the individual.³

41
42 Under HIPAA, messages that contain PHI, whether sent among members of the health care team or
43 to patients, generally require sufficient safeguards to ensure the confidentiality, integrity, and
44 security of the information.⁴ New advances in technology, however, have addressed some of these
45 concerns and have created forms of encrypted texts and electronic messaging. The U.S.
46 Department of Health and Human Services (HHS) Office of the National Coordinator for Health
47 Information Technology (ONC) directly addressed texting in a frequently asked question (FAQ). In
48 its response, ONC notes that physicians and other providers who plan to use text to communicate
49 PHI with patients or other health care providers should adhere to the HIPAA Security Rule,
50 including performing a risk analysis and utilizing a secure communication platform on approved
51 mobile devices.⁵

1 To implement appropriate safeguards, physicians and other providers should consult with legal
2 counsel and information technology security experts to understand their obligations under the
3 HIPAA Security Rule. In general terms, HIPAA requires that physicians and other covered entities
4 conduct a risk assessment to determine potential privacy and security vulnerabilities when
5 communicating PHI electronically.⁶ This assessment does not prescribe specific actions that must
6 be taken to secure information. Instead, practices must consider their resources and capabilities to
7 take reasonable and appropriate precautions when communicating via text or electronic
8 messaging.⁷ To provide additional clarity, HHS has developed specific security and privacy
9 guidance on when and how to use mobile phones while still maintaining appropriate privacy and
10 security standards.⁸

11
12 Following the Security Rule, however, is only the first step in ensuring that text messaging can be
13 used when communicating PHI. Other considerations that the physician and practice should
14 evaluate when deciding if texting is appropriate include patient consent and liability risks. AMA
15 policy provides additional general guidance on these issues and is discussed in more detail below.

16
17 *Emailing, texting and electronic messaging when the patient has consented or initiated*
18 *communications*

19
20 While using a secure texting platform is generally considered a best practice to communicate PHI,
21 there may be circumstances where a patient asks for or initiates a non-secure text. The HIPAA
22 Privacy Rule provides a patient with the right to request and have a health care provider
23 communicate with him or her by the patient's preferred means, if it is reasonable for the provider to
24 do so.⁹ HHS clarified that this right allows a patient to request that a physician communicate with
25 him or her electronically and that the physician may agree to the patient's request if the physician
26 uses reasonable safeguards to avoid unintentional disclosures.¹⁰

27
28 HHS further explained that physicians are permitted to send information via unencrypted emails if
29 they have advised the individual of the risk and the recipient still prefers this method of
30 communication.¹¹ Such a warning may allow the patient to weigh the risk of unintentional
31 disclosure against the ease of using an unsecured form of communication. HHS clarified that it
32 does not expect the physician or covered entity to educate the patient about encryption or
33 information security but merely explain that there is some level of risk of exposure to a third party.
34 If the patient is notified of this risk, and still consents to using this manner of communication,
35 covered entities mitigate the risk of unauthorized access of the PHI. Furthermore, the covered
36 entity is not responsible for safeguarding the information once it is delivered to the individual.¹² It
37 is recommended that a physician obtain written consent prior to initiating communications with a
38 patient.

39
40 If a patient initiates communications with a provider using email, HHS noted that the health care
41 provider can assume (unless the patient has explicitly stated otherwise) that this form of
42 communication is acceptable to the individual.¹³ If the provider feels the patient may not be aware
43 of the possible risks of using unencrypted communication, or has concerns about potential liability,
44 the provider can alert the patient of those risks, and let the patient decide whether to continue the
45 communications.¹⁴

46
47 TELEPHONE CONSUMER PROTECTION ACT (TCPA)

48
49 The TCPA also places requirements on certain text messages or calls. Specifically, the TCPA
50 requires prior opt-in written consent for the delivery of marketing text messages and prior opt-in
51 oral consent for the delivery of non-marketing or informational text messages.¹⁵ The TCPA also

1 governs the use of an autodialer (defined broadly to include any device that is *capable* of randomly
2 dialing a number without human intervention, which has been interpreted to cover most desk
3 phones and smart phones) and on the use of prerecorded voice technologies when calling cell
4 phones. Prior written opt-in consent is required for placing an autodialed or prerecorded marketing
5 call to a cell phone; prior opt-in oral consent is required for placing an autodialed or prerecorded
6 informational call to a cell phone. The TCPA also imposes requirements on the use of prerecorded
7 technologies to landlines.¹⁶ For more details about the TCPA requirements, including the do-not-
8 contact and consent provisions, time-of-day restrictions, opt-out requirements, and other
9 restrictions, entities can review the materials on the law available from the Federal
10 Communications Commission. Please note that states impose separate and often superseding
11 restrictions on the use of autodialing and prerecorded technologies and placement of telemarketing
12 calls.

13

14 INSTITUTIONAL POLICIES & LOCAL RESTRICTIONS

15

16 While HIPAA allows the use of text and electronic communications in compliance with the
17 HIPAA requirements as described above, hospital policies, institutional guidance, and state or local
18 laws may ban or place additional limitations on the use of these communication tools. Such
19 additional restrictions are unique to each facility and jurisdiction and must be considered when
20 communicating with either patients or among health care team members. These laws and policies
21 may require additional protections for certain types of patient information (e.g., substance abuse,
22 mental health). They may also require that physicians undergo training, use certain devices, follow
23 procedures in case of a potential breach, and may impose penalties or disciplinary actions.

24

25 As an example of institutional guidelines, The Joint Commission has repeatedly changed its policy
26 with respect to text messaging. In its most recent guidance, issued in December 2016, The Joint
27 Commission concluded that all health care organizations should have policies prohibiting the use of
28 unsecured text messaging for communicating PHI. Furthermore, even the use of secured text is not
29 permitted for orders.¹⁷ Physicians should therefore ensure that they consider institutional policies as
30 well as local laws before communicating via text and electronic messaging, even when messages
31 do not contain PHI.

32

33 GUIDANCE ON TEXT MESSAGING AND ELECTRONIC COMMUNICATIONS

34

35 To help guide physicians and other providers on the appropriate use of text and electronic
36 messaging, HHS has developed several tools, including a [website](#) devoted to appropriately securing
37 mobile devices.¹⁸ This guidance, which is available for free, includes tips on how to develop mobile
38 device policies, advice on how to secure and protect health information, a list of FAQs, and
39 instructional videos. In addition, the HHS Office of Civil Rights [website](#) contains a number of tools
40 related to HIPAA that help physicians conduct risk assessments and other actions required to
41 protect electronically-sent PHI. The AMA anticipates that additional guidance on texting will be
42 available later this year to provide greater clarity on how HIPAA applies to this form of
43 communication.

44

45 As instructed by the second section of Policy D-478.970, the AMA is also developing patient-
46 oriented educational materials about text and electronic messaging. The AMA anticipates
47 publishing this education information via AMA Wire later this year.

1 CURRENT AMA POLICY

2
3 As mentioned previously, additional considerations beyond federal and local laws should also be
4 considered before texting either with the health care team or directly with patients. These concerns
5 include privacy, liability, confidentiality, as well as ways to mitigate potential risks. Our AMA has
6 adopted Policy, H-478.997, "Guidelines for Patient-Physician Electronic Mail" on communicating
7 with patients via e-mail that would also guide text and other electronic communications.
8 Specifically, this policy highlights the importance of informing patients about privacy issues when
9 using these modes of communication and encourages use of a patient-clinician agreement to ensure
10 informed consent when communicating in this manner. It also notes precautions that should be
11 taken when using e-mail that would equally apply in the context of text messaging, such as
12 avoiding group messaging where recipients are visible to each other.

13
14 More general guidance on how to manage communications and disclosure of patient information to
15 ensure privacy and confidentiality is included in AMA Policies H-140.989, H-315.983, H-315.978,
16 and H-320.994. These policies note that holders of health record information should be responsible
17 for reasonable security measures and the importance of patient consent and education when
18 disclosing and protecting patient information.

19
20 CONCLUSION

21
22 When communicating PHI with patients and amongst the health care team, HIPAA allows health
23 care providers to text utilizing a secure communication platform if providers comply with the
24 HIPAA Privacy and Security Rule and other applicable federal and local laws. AMA policy,
25 however, notes physicians should also consider institutional, local and other requirements, patient
26 consent, and liability risks before engaging in this practice.

27
28 RECOMMENDATION

29
30 The Board of Trustees recommends that AMA Policy H-478.997 be amended by addition to read
31 as follows, and that the remainder of the report be filed.

32
33 Policy H-478.997, "Guidelines for Patient-Physician Electronic Mail"

34
35 New communication technologies must never replace the crucial interpersonal contacts that are the
36 very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet
37 communication should be used to enhance such contacts. Furthermore, before using electronic mail
38 or other electronic communication tools, physicians should consider Health Information Portability
39 and Accountability Act (HIPAA) requirements as well as related AMA policy on privacy and
40 confidentiality, including Policies H-315.978 and H-315.989. Patient-physician electronic mail is
41 defined as computer-based communication between physicians and patients within a professional
42 relationship, in which the physician has taken on an explicit measure of responsibility for the
43 patient's care. These guidelines do not address communication between physicians and consumers
44 in which no ongoing professional relationship exists, as in an online discussion group or a public
45 support forum.

46
47 (1) For those physicians who choose to utilize e-mail for selected patient and medical practice
48 communications, the following guidelines be adopted.

1 Communication Guidelines:

- 2
- 3 (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- 4 (b) Inform patient about privacy issues.
- 5 (c) Patients should know who besides addressee processes messages during addressee's usual
- 6 business hours and during addressee's vacation or illness.
- 7 (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of
- 8 e-mail communications with patients.
- 9 (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity
- 10 of subject matter (HIV, mental health, etc.) permitted over e-mail.
- 11 (f) Instruct patients to put the category of transaction in the subject line of the message for filtering:
- 12 prescription, appointment, medical advice, billing question.
- 13 (g) Request that patients put their name and patient identification number in the body of the
- 14 message.
- 15 (h) Configure automatic reply to acknowledge receipt of messages.
- 16 (i) Send a new message to inform patient of completion of request.
- 17 (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- 18 (k) Develop archival and retrieval mechanisms.
- 19 (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to
- 20 each other. Use blind copy feature in software.
- 21 (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- 22 (n) Append a standard block of text to the end of e-mail messages to patients, which contains the
- 23 physician's full name, contact information, and reminders about security and the importance of
- 24 alternative forms of communication for emergencies.
- 25 (o) Explain to patients that their messages should be concise.
- 26 (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients
- 27 to come in to discuss or call them.
- 28 (q) Remind patients when they do not adhere to the guidelines.
- 29 (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-
- 30 mail relationship.

31

32 Medicolegal and Administrative Guidelines:

- 33 (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This
- 34 should be discussed with and signed by the patient and documented in the medical record. Provide
- 35 patients with a copy of the agreement. Agreement should contain the following:
- 36 (b) Terms in communication guidelines (stated above).
- 37 (c) Provide instructions for when and how to convert to phone calls and office visits.
- 38 (d) Describe security mechanisms in place.
- 39 (e) Hold harmless the health care institution for information loss due to technical failures.
- 40 (f) Waive encryption requirement, if any, at patient's insistence.
- 41 (g) Describe security mechanisms in place including:
- 42 (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and
- 43 at home.
- 44 (i) Never forwarding patient-identifiable information to a third party without the patient's express
- 45 permission.
- 46 (j) Never using patient's e-mail address in a marketing scheme.
- 47 (k) Not sharing professional e-mail accounts with family members.
- 48 (l) Not using unencrypted wireless communications with patient-identifiable information.
- 49 (m) Double-checking all "To" fields prior to sending messages.
- 50 (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term
- 51 applicable to paper records.

- 1 (o) Commit policy decisions to writing and electronic form.
2
3 (2) The policies and procedures for e-mail be communicated to all patients who desire to
4 communicate electronically.
5
6 (3) The policies and procedures for e-mail be applied to facsimile communications, where
7 appropriate.
8
9 (4) The policies and procedures for e-mail be applied to text and electronic messaging using a
10 secure communication platform, where appropriate.

Fiscal Note: Less than \$500.

REFERENCES

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- ² HHS. FAQ. Can you use texting to communicate health information, even if it is to another provider or professional? Available at <https://www.healthit.gov/providers-professionals/faqs/can-you-use-texting-communicate-health-information-even-if-it-another-p> Last visited February 2017.
- ³ 45 C.F.R. § 160.103.
- ⁴ 45 C.F.R. § 164.306.
- ⁵ HHS. FAQ. Can you use texting to communicate health information, even if it is to another provider or professional? Available at <https://www.healthit.gov/providers-professionals/faqs/can-you-use-texting-communicate-health-information-even-if-it-another-p> Last visited February 2017.
- ⁶ 45 C.F.R. § 164.308(a)(1)(ii)(A).
- ⁷ HHS. Summary of the HIPAA Security Rule. Available at <https://www.hhs.gov/hipaa/for-professionals/security/laws-regulations/index.html> Last visited March 2017.
- ⁸ HHS. Your Mobile Device and Health Information Privacy and Security. Available at <https://www.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security> Last visited February 2017.
- ⁹ See 45 C.F.R. § 164.522(b).
- ¹⁰ HHS. FAQ 570. Does the HIPAA Privacy Rule Permit Health Care Providers to Use E-mail to Discuss Health Issues and Treatment with Their Patients? Available at <https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html> Last visited February 2017.
- ¹¹ HHS. Breach Notification Final Rule, 78 Fed. Reg. 5566, 5634 (Jan. 25, 2013).
- ¹² HHS. Breach Notification Final Rule, 78 Fed. Reg. 5566, 5634 (Jan. 25, 2013).
- ¹³ HHS. FAQ 570. Does the HIPAA Privacy Rule Permit Health Care Providers to Use E-mail to Discuss Health Issues and Treatment with Their Patients? Available at <https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html>
- ¹⁴ HHS. FAQ 570. Does the HIPAA Privacy Rule Permit Health Care Providers to Use E-mail to Discuss Health Issues and Treatment with Their Patients? Available at <https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html> Last visited February 2017.
- ¹⁵ See 42 U.S.C. § 227.
- ¹⁶ Federal Communications Commission. Telemarketing and Robocalls. Available at <https://www.fcc.gov/general/telemarketing-and-robocalls>
- ¹⁷ The Joint Commission. Clarification: Use of Secure Text Messaging for Patient Care Orders Is Not Acceptable Available at https://www.jointcommission.org/clarification_use_of_secure_text_messaging/
- ¹⁸ HHS. Your Mobile Device and Health Information Privacy and Security. Available at <https://www.healthit.gov/providers-professionals/your-mobile-device-and-health-information-privacy-and-security>

APPENDIX – CURRENT AMA POLICY

Policy H-478.997, “Guidelines for Patient-Physician Electronic Mail”

New communication technologies must never replace the crucial interpersonal contacts that are the very basis of the patient-physician relationship. Rather, electronic mail and other forms of Internet communication should be used to enhance such contacts. Patient-physician electronic mail is defined as computer-based communication between physicians and patients within a professional relationship, in which the physician has taken on an explicit measure of responsibility for the patient's care. These guidelines do not address communication between physicians and consumers in which no ongoing professional relationship exists, as in an online discussion group or a public support forum.

(1) For those physicians who choose to utilize e-mail for selected patient and medical practice communications, the following guidelines be adopted.

Communication Guidelines:

- (a) Establish turnaround time for messages. Exercise caution when using e-mail for urgent matters.
- (b) Inform patient about privacy issues.
- (c) Patients should know who besides addressee processes messages during addressee's usual business hours and during addressee's vacation or illness.
- (d) Whenever possible and appropriate, physicians should retain electronic and/or paper copies of e-mail communications with patients.
- (e) Establish types of transactions (prescription refill, appointment scheduling, etc.) and sensitivity of subject matter (HIV, mental health, etc.) permitted over e-mail.
- (f) Instruct patients to put the category of transaction in the subject line of the message for filtering: prescription, appointment, medical advice, billing question.
- (g) Request that patients put their name and patient identification number in the body of the message.
- (h) Configure automatic reply to acknowledge receipt of messages.
- (i) Send a new message to inform patient of completion of request.
- (j) Request that patients use autoreply feature to acknowledge reading clinicians message.
- (k) Develop archival and retrieval mechanisms.
- (l) Maintain a mailing list of patients, but do not send group mailings where recipients are visible to each other. Use blind copy feature in software.
- (m) Avoid anger, sarcasm, harsh criticism, and libelous references to third parties in messages.
- (n) Append a standard block of text to the end of e-mail messages to patients, which contains the physician's full name, contact information, and reminders about security and the importance of alternative forms of communication for emergencies.
- (o) Explain to patients that their messages should be concise.
- (p) When e-mail messages become too lengthy or the correspondence is prolonged, notify patients to come in to discuss or call them.
- (q) Remind patients when they do not adhere to the guidelines.
- (r) For patients who repeatedly do not adhere to the guidelines, it is acceptable to terminate the e-mail relationship.

Medicolegal and Administrative Guidelines:

- (a) Develop a patient-clinician agreement for the informed consent for the use of e-mail. This should be discussed with and signed by the patient and documented in the medical record. Provide patients with a copy of the agreement. Agreement should contain the following:

- (b) Terms in communication guidelines (stated above).
- (c) Provide instructions for when and how to convert to phone calls and office visits.
- (d) Describe security mechanisms in place.
- (e) Hold harmless the health care institution for information loss due to technical failures.
- (f) Waive encryption requirement, if any, at patient's insistence.
- (g) Describe security mechanisms in place including:
- (h) Using a password-protected screen saver for all desktop workstations in the office, hospital, and at home.
- (i) Never forwarding patient-identifiable information to a third party without the patient's express permission.
- (j) Never using patient's e-mail address in a marketing scheme.
- (k) Not sharing professional e-mail accounts with family members.
- (l) Not using unencrypted wireless communications with patient-identifiable information.
- (m) Double-checking all "To" fields prior to sending messages.
- (n) Perform at least weekly backups of e-mail onto long-term storage. Define long-term as the term applicable to paper records.
- (o) Commit policy decisions to writing and electronic form.

(2) The policies and procedures for e-mail be communicated to all patients who desire to communicate electronically.

(3) The policies and procedures for e-mail be applied to facsimile communications, where appropriate.

Policy H-140.989, "Informed Consent and Decision-Making in Health Care"

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the patient.

(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that

information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.

Policy H-315.983, "Patient Privacy and Confidentiality"

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information:
 - (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged;
 - (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability;
 - (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled;
 - (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure.
2. Our AMA affirms:
 - (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients,
 - (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and
 - (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law.
3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals.
 - (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible.
 - (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms.
 - (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information.
 - (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure.
4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review.
5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use.
6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained.
7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual.
8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable

and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end.

9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures.
10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB.
11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures
12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights.
13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance.
15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands.
16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine.
17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing.
18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes.

19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls.
20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes.

Policy H-315.978, "Privacy and Confidentiality"

Our AMA policy is that where possible, informed consent should be obtained before personally identifiable health information is used for any purpose. However, in those situations where specific informed consent is not practical or possible, either (1) the information should have identifying information stripped from it or (2) an objective, publicly accountable entity must determine that patient consent is not required after weighing the risks and benefits of the proposed use. Re-identification of personal health information should only occur with patient consent or with the approval of an objective, publicly accountable entity.

Policy H-320.994, "Confidentiality"

Our AMA believes that:

- (1) there has been an erosion of the confidential relationships between the patient and health professional, which has resulted from growing outside demands for the information shared in this relationship for the purpose of patient care;
- (2) there is a need to sensitize the public to the intrusions into confidential medical information which can result from increased demands for accountability - in substantiating health insurance claims, in litigation, and in medical care evaluation;
- (3) much of the erosion has emanated from the public, and properly so; however, an over-emphasis on society's right to know, at the expense of the individual's right to privacy and confidentiality, has resulted and a better balance is needed;
- (4) one important contribution to restoring such balance would be greater education of patients and the public as to the full range of purposes for which confidential information is used, the policies governing the release of such information, and the individual's rights with respect thereto.

Policy H-315.989, "Confidentiality of Computerized Patient Records"

The AMA will continue its leadership in protecting the confidentiality, integrity, and security of patient-specific data; and will continue working to ensure that computer-based patient record systems and networks, and the legislation and regulations governing their use, include adequate technical and legal safeguards for protecting the confidentiality, integrity, and security of patient data.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 13-A-17

Subject: Closing Gaps in Prescription Drug Monitoring Programs
(Resolution 232-A-16)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee B
(Alethia Morgan, MD, Chair)

1 INTRODUCTION

2
3 At the 2016 Annual Meeting, the House of Delegates referred Resolution 232-A-16, “Closing Gaps
4 in Prescription Drug Monitoring Programs,” introduced by the Alabama Delegation, which asked:

5
6 That our American Medical Association advocate for the inclusion of all controlled substance
7 prescriptions, regardless of their private, public, military or governmental source, in the
8 reporting requirements for Prescription Drug Monitoring Programs (PDMP); and

9
10 That our AMA advocate for the inclusion of all controlled substances administered or
11 dispensed by opioid treatment programs in the reporting requirements for Prescription Drug
12 Monitoring Programs (PDMP).

13
14 During reference committee hearings considerable testimony supported using PDMPs to inform
15 physicians’ decision making when considering whether to prescribe controlled substances. Many
16 commented that when PDMPs contain relevant, timely information that is available at the point of
17 care, PDMPs can provide helpful information. Testimony was clear, however, that many state
18 PDMPs are less than optimal for a variety of reasons, including that information from opioid
19 treatment providers (OTPs), the Veterans Health Administration (VHA) and other sources are not
20 always included in PDMPs.

21
22 The reference committee agreed that PDMPs can be most helpful when they contain all relevant
23 information. Testimony also raised important issues regarding patient privacy, including that OTPs
24 must comply with the strict privacy requirements under 42 CFR Part 2 governing disclosure of
25 patient records, and that state PDMPs may not all meet those requirements. This report provides an
26 update on PDMP functionality, relevant state legislative issues, and makes a number of
27 recommendations.

28
29 DISCUSSION

30
31 Physician use of PDMPs continues to increase. In fact, an AMA survey of state PDMP
32 administrators found that queries by health care professionals to state PDMPs increased from
33 60.7 million in 2014 to more than 85 million in 2015 – a 40 percent increase.¹ Interestingly, some
34 of the largest increases were seen in states that did not mandate prescribers to check a PDMP. This
35 included California, which saw an increase in use from 3.6 million in 2014 to 6.2 million in 2015;
36 Florida, which saw an increase from 1.5 million in 2014 to 4.1 million in 2015; and Oklahoma,

1 which saw an increase from 1.1 million in 2014 to 2.9 million in 2015. California and Oklahoma
2 have since passed mandates for prescribers to check the PDMP under certain circumstances, and
3 other states currently are considering new mandates requiring use of the PDMP.

4
5 One reason for these increases is the fact that mandates to check PDMPs have been enacted in
6 many states in recent state legislative sessions. At the same time, the technology supporting
7 PDMPs has improved in many states, including the development of more readable interfaces, more
8 relevant information being provided on screen, and increased speed of accessing the PDMP itself.
9 While these improvements may not reflect every practice setting or physician's experience, the
10 trend is generally positive in terms of increased physician use of PDMPs. The Board notes,
11 however, that it remains inconclusive whether or how the new mandates have reduced opioid
12 related mortality or improved pain care on a broad scale.

13
14 Regarding Resolution 232-A-16, two of the important issues with respect to the data contained in a
15 PDMP are: (1) the substances monitored by a PDMP; and (2) the frequency of data entered into the
16 PDMP. According to the National Alliance for Model State Drug Laws,² 14 states monitor
17 Schedule II-IV Controlled Substances, while the rest of the states monitor Schedule II-V
18 Controlled Substances. With respect to the frequency of pharmacies and other dispensers reporting
19 data to the PDMP,³ the range is between "real time" at the point of dispensing to monthly
20 reporting. Thirty-two states and the District of Columbia have a 24-hour reporting requirement.

21
22 Addressing the merits of whether a state should include all controlled substances or only Schedule
23 II-IV raises multiple issues. As noted above, increased use of PDMPs is generally viewed as a
24 positive trend in terms of physicians seeking more information on which to make more informed
25 prescribing decisions. Yet, those increases have occurred in "mandate" and "non-mandate" states
26 as well as states with requirements to check for all controlled substances and for only Schedule II-
27 IV. To better understand the outcomes of including different schedules of controlled substances in
28 a state PDMP, and to help better inform AMA advocacy, your Board recommends a careful review
29 of the literature and outcomes that PDMPs have on opioid-related mortality, treatment decisions,
30 pain care, and other measures to be determined in consultation with the AMA Task Force to
31 Reduce Opioid Abuse (Task Force).

32
33 The benefits to such a review include that this review would likely be one of the first of its kind to
34 be carried out by physician organizations. With some states now looking to only require a check of
35 the PDMP for prescriptions for opioids and benzodiazepines,⁴ and other states considering various
36 permutations of when to check a PDMP – and what to check it for – the Board recommends these
37 decisions be informed by data. Compiling this data will afford AMA the opportunity to provide the
38 Federation and policymakers with objective data on which further decisions can be made.

39
40 In addition, available information suggests that few U.S. Department of Veterans Affairs (VA)
41 pharmacies report information to the state PDMP.⁵ This runs counter to trends for states to require
42 real time data entry by dispensers. In recent history, only Oklahoma had a 24-hour data entry
43 requirement. As noted above, 32 states and the District of Columbia have a 24 hour/1 business day
44 requirement.⁶ In addition, more than 40 states now are sharing interstate information through the
45 InterConnect program of the National Association of Boards of Pharmacy,⁷ which is supported by
46 the AMA. As state PDMP technology improves, combined with more frequent data reported by
47 state-licensed pharmacies, it would benefit both dispensers and prescribers if information about
48 controlled substances dispensed by VA pharmacies were included in state PDMPs. Therefore the
49 Board recommends that the AMA advocate that VA pharmacies report prescription information
50 required by the state into the respective state PDMP. This will help ensure that physicians and other

1 health care professionals who check a PDMP have the benefit of more comprehensive information
2 from prescriptions dispensed in the state.

3
4 Moreover, having VA pharmacies submit information to state PDMPs, would support ongoing VA
5 efforts to have PDMPs serve as clinical support tools. VHA Directive 1306,⁸ issued
6 October 19, 2016, stated:

7
8 It is VHA policy that state PDMP databases are queried for VHA patients who are receiving
9 prescriptions for controlled substances as outlined in this policy on a minimum of an annual
10 basis and that the results of queries are documented in the VA medical record. State PDMP
11 databases will be queried prior to initiating therapy with a controlled substance and more often
12 when clinically indicated.

13
14 VHA Directive 1306 also notes that a VA health care professional may not be licensed in the state
15 where he or she practices. For the purposes of this report, that means that the health care
16 professional may not be eligible to register for – or use – the state PDMP. This is one of the gaps
17 that could be addressed through state legislation or regulation: specifically authorizing all
18 physicians and other health care professionals to be eligible to register for and authorized to use the
19 state PDMP. Therefore, to help VA physicians use the information in state PDMPs, your Board
20 recommends that VA physicians and other health care professionals employed by the VA be
21 allowed to access the state PDMP in the state in which they are practicing, even if not licensed in
22 the state.

23
24 The final issue to address is the role of patient privacy, including that OTPs must comply with the
25 strict privacy requirements under 42 CFR Part 2 governing disclosure of patient records, and that
26 state PDMPs may not all meet those requirements. This was one of the issues that the Substance
27 Abuse and Mental Health Services Administration (SAMHSA) was considering in proposed
28 revisions to the Confidentiality of Alcohol and Drug Abuse Patient Records regulations at
29 42 CFR part 2. The AMA and others commented on the need to ensure a proper balance between
30 appropriate disclosures to qualified entities and ensuring the privacy and confidentiality of patients
31 with substance use disorders.⁹

32
33 In the final rule, SAMHSA specifically declined to “address issues pertaining to e-prescribing and
34 Prescription Drug Monitoring Programs (PDMPs) in the NPRM because they were not ripe for
35 rulemaking at the time due to the state of technology and because the majority of part 2 programs
36 are not prescribing controlled substances electronically.”¹⁰ On one hand, this could mean that
37 SAMHSA did not want to combine discussion of e-prescribing and PDMPs. It also is possible that
38 SAMHSA is monitoring each issue separately. In either case, SAMHSA has not clarified whether
39 opioid treatment programs and other substance use disorder treatment programs may share
40 dispensing information with state-based PDMPs. Therefore, your Board recommends that the
41 AMA seek further clarification on this issue.

42 43 RECOMMENDATIONS

44
45 The Board recommends that the following be adopted in lieu of Resolution 232-A-16, and that the
46 remainder of the report be filed.

- 47
48 1. That our AMA conduct a literature review of available data showing the outcomes of PDMPs
49 on opioid-related mortality and other harms; improved pain care; and other measures to be
50 determined in consultation with the AMA Task Force to Reduce Opioid Abuse. (Directive to
51 Take Action)

- 1 2. That our AMA advocate that U.S. Department of Veterans Affairs pharmacies report
2 prescription information required by the state into the state PDMP. (Directive to Take Action)
3
- 4 3. That our AMA advocate for physicians and other health care professionals employed by the
5 VA to be eligible to register for and use the state PDMP in which they are practicing even if
6 the physician or other health care professional is not licensed in the state. (Directive to Take
7 Action)
8
- 9 4. That our AMA seek clarification from SAMHSA on whether opioid treatment programs and
10 other substance use disorder treatment programs may share dispensing information with state-
11 based PDMPs. (Directive to Take Action)

Fiscal Note: Less than \$500.

REFERENCES

¹ From January to June 2016, the AMA sent inquiries to every state PDMP administrator. The AMA received data from 42 states; 6 states either did not respond or said they are not able to provide information; and three states (the District of Columbia, Missouri and Pennsylvania) did not have functional PDMPs.

² National Alliance for Model State Drug Laws, "Substances Monitored by PMP."
<http://www.namsdl.org/library/8D7261F8-E47D-B6A5-DD0CAFA98FEA4846/>

³ National Alliance for Model State Drug Laws, "Frequency of Data Reporting."
<http://www.namsdl.org/library/9ADAAF18-D321-1AE6-90D7B256F05CEDEC/>

⁴ See for example, legislation in Louisiana and Maryland.

⁵ See, for example, this state map from the Prescription Drug Monitoring Program Training and Technical Assistance Center at Brandeis University: http://www.pdmpassist.org/pdf/VA_pharmacies_reporting.pdf

⁶ National Alliance for Model State Drug Laws, "Frequency of Data Reporting"
<http://www.namsdl.org/library/9ADAAF18-D321-1AE6-90D7B256F05CEDEC/>

⁷ National Association of Boards of Pharmacy, PMP InterConnect. Available at: https://nabp.pharmacy/wp-content/uploads/2017/01/PMPMap_-10-25-16.pdf

⁸ https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&ved=0ahUKEWjS6orakpSAhUHyoMKHY6bDEMQFggcMAA&url=https%3A%2F%2Fwww.va.gov%2Fvhapublications%2FViewPublication.asp%3Fpub_ID%3D3283&usg=AFQjCNFN3cQDSPNwzBm5f1_simBrih6PKg&cad=rja

⁹ AMA to Acting Director Kana Enomoto, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. April 11, 2016.

¹⁰ Federal Register, Jan. 18, 2017. <https://www.federalregister.gov/documents/2017/01/18/2017-00719/confidentiality-of-substance-use-disorder-patient-records>

REPORT OF THE BOARD OF TRUSTEES

B of T Report 14-A-17

Subject: Medicare Part B Double Dipping
(Resolution 209-A-16)

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee B
(Alethia Morgan, MD, Chair)

1 INTRODUCTION

2
3 At the 2016 Annual Meeting, the House of Delegates (HOD) referred Resolution 209-A-16,
4 “Medicare Part B Double Dipping,” for report back at the 2017 Annual Meeting. This resolution
5 was introduced by the New York Delegation and asked that:

6
7 Our American Medical Association seek legislation to stop the practice by the federal
8 government of deducting Medicare Part B coverage costs from the Social Security checks of
9 retirees, as well as from salaries individuals may earn after they draw on social security
10 benefits.

11
12 During the hearing on this resolution, Reference Committee B heard mixed testimony. While there
13 was testimony supportive of the drafter’s intentions, others pointed out that the premise of the
14 resolution that the government is “double dipping,” as described in the whereas clauses, is
15 inaccurate and does not occur. This report discusses the difference between deductions for
16 Medicare Part A from employee paychecks and Medicare Part B premiums from Social Security
17 benefit checks.

18 19 BACKGROUND

20
21 Medicare is a federal insurance program that pays for health care services for individuals aged 65
22 and older and certain disabled people. There are four parts: Part A (Hospital Insurance), which
23 covers inpatient hospital services, skilled nursing care, hospice care, and some home health
24 services; Part B (Supplementary Medical Insurance), which covers physician services, outpatient
25 services, and some home health and preventive services; Part C, Medicare Advantage, which is a
26 private plan option; and Part D, which covers outpatient prescription drug benefits. This report will
27 focus on Parts A and B.

28
29 Generally, Medicare beneficiaries aged 65 or older are automatically entitled to Part A if they or
30 their spouse paid Medicare payroll taxes for at least 40 quarters (10 years) on their earnings. The
31 Part A trust fund is primarily funded by a 2.9 percent payroll tax on earnings (employees and
32 employers each pay 1.45 percent; those self-employed pay the full 2.9 percent). Employees with
33 annual incomes greater than \$200,000 single/\$250,000 joint are subject to an additional 0.9 percent
34 on income over these amounts. Similar to Social Security taxes, Medicare Part A payroll taxes are
35 based on earnings—i.e., there is no age limit and deductions continue even after an individual
36 becomes eligible for Medicare.

1 Under Part B, most Medicare beneficiaries pay a monthly premium that is deducted from their
2 monthly Social Security checks. Most of the Part B trust fund (75 percent) is funded through
3 federal government general revenues, while 25 percent is funded by beneficiary premiums. Part B
4 enrollees whose premiums are not deducted from Social Security (or Railroad Retirement, or Civil
5 Service Retirement) monthly benefits, or paid by Medicaid, must pay premiums directly to the
6 Centers for Medicare & Medicaid Services.

7
8 DISCUSSION

9
10 Resolution 209 asks that our AMA prevent the federal government from deducting Medicare Part
11 B from the salaries individuals may earn after they become eligible to draw on Social Security
12 benefits. However, as explained above, a Medicare beneficiary's share of the Part B premium is not
13 financed through employee payroll taxes, it generally is deducted from the beneficiary's Social
14 Security check. Also, to the extent that a Medicare beneficiary continues to work, or returns to
15 work, after becoming eligible for Medicare benefits, the Medicare payroll taxes that are deducted
16 from the beneficiary's (employee's) paycheck go to fund the Medicare Part A trust fund, which is
17 used to pay for Medicare Part A benefits.

18
19 Resolution 209 states in the whereas clauses that "Medicare Part B is deducted from Social
20 Security their checks," and "once they return to work, Medicare Part B is also deducted from their
21 paychecks, meaning the government is 'double dipping'." However, as discussed above, these
22 paycheck deductions go to fund the Part A trust fund, not the beneficiary's share of the Part B
23 premium. While it is true that some portion of a beneficiary's federal income tax would be used to
24 fund the federal government's general revenue expenditures, which would include funding 75
25 percent of Medicare Part B premiums, federal income tax deductions do not appear to be the focus
26 of this resolution. The Board, therefore, recommends that Resolution 209-A-16 not be adopted.

27
28 RECOMMENDATION

29
30 The Board of Trustees recommends that Resolution 209-A-16 not be adopted and the remainder of
31 the report be filed.

Fiscal Note: Less than \$500.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 22-A-17

Subject: Council on Legislation Sunset Review of 2007 House Policies

Presented by: Patrice A. Harris, MD, MA, Chair

Referred to: Reference Committee B
(Alethia Morgan, MD, Chair)

1 At its 1984 Interim Meeting, the House of Delegates established a sunset mechanism for House
2 policies (Policy G-600.110, “AMA Policy Database”). Under this mechanism, a policy established
3 by the House ceases to be viable after 10 years unless action is taken by the House to retain it.
4

5 The objective of the sunset mechanism is to help ensure that the American Medical Association
6 (AMA) Policy Database is current, coherent, and relevant. By eliminating outmoded, duplicative,
7 and inconsistent policies, the sunset mechanism contributes to the ability of the AMA to
8 communicate and promote its policy positions. It also contributes to the efficiency and
9 effectiveness of House of Delegates deliberations.
10

11 At its 2002 Annual Meeting, the House modified Policy G-600.110 to change the process through
12 which the policy sunset review is conducted. The process now includes the following steps:
13

- 14 • In the spring of each year, the House policies that are subject to review under the policy sunset
15 mechanism are identified.
- 16 • Using the areas of expertise of the AMA councils as a guide, the staffs of the AMA councils
17 determine which policies should be reviewed by which councils.
- 18 • For the Annual Meeting of the House, each council develops a separate policy sunset report
19 that recommends how each policy assigned to it should be handled. For each policy it reviews,
20 a council may recommend one of the following actions: (a) retain the policy; (b) rescind the
21 policy; or (c) retain part of the policy. A justification must be provided for the recommended
22 action on each policy.
- 23 • The Speakers assign the policy sunset reports for consideration by the appropriate reference
24 committees.
25

26 Although the policy sunset review mechanism may not be used to change the meaning of AMA
27 policies, minor editorial changes can be accomplished through the sunset review process.
28

29 In this report, the Board of Trustees presents recommendations from the Council on Legislation on
30 the disposition of the House policies that were assigned to it. The Council’s recommendations on
31 policies are presented in the Appendix to this report.
32

33 RECOMMENDATION

34
35 The Board of Trustees recommends that the House of Delegates policies listed in Appendix 1 to
36 this report be acted upon in the manner indicated and the remainder of this report be filed.

**APPENDIX 1
RECOMMENDED ACTIONS ON 2007 HOUSE POLICIES**

Policy Number	Title	Text	Recommendation
H-60.948	Child Protection Legislation	The AMA opposes legislation that would: (1) hinder, obstruct or weaken investigations of suspected child and adolescent abuse, and (2) hamper or interfere with child protection statutes. Citation: (Sub. Res. 219, I-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-60.949	Opposition to Parental Rights Amendments	The AMA opposes state or federal legislative proposals (sometimes but not always known as “Parental Rights Amendments”) that might give parents the right under law to harm a child or adolescent, and educate its members and the public regarding the potentially dangerous effects such initiatives represent to the public health and particularly to the health of our children. Citation: (BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-60.962	Enforcement of Child Labor Laws	The AMA will work in conjunction with all appropriate organizations and specialty societies to enhance physician awareness of the problems and dangers associated with the illegal employment of children. Citation: (Sub. Res. 222, I-92; Reaffirmed by BOT Rep. 24, A-97; Reaffirmed: BOT Rep. 33, A-07)	Retain – This policy remains relevant.
H-120.944	Standards, Laws, and Regulations Addressing Pain Medications and Medical Practice	1. AMA policy is that states should examine their pain policies and seek to improve them, based on the Federation of State Medical Boards Model Policy and/or criteria established by the Wisconsin Pain & Policies Study Group. 2. AMA policy is that the impact of state-based prescription drug monitoring programs on medical care, including appropriate pain management, should be evaluated. 3. Our AMA will urge the Drug Enforcement Administration to work with physician organizations and other relevant stakeholders to reconstruct a document similar to "Prescription Pain Medications: Frequently Asked Questions and Answers for Health Care Professionals and Law Enforcement Personnel" to serve as a legitimate resource for physicians, regulators, and law enforcement personnel. Citation: (CSAPH Rep. 6, A-07)	Retain in part – The first clause is covered by Policy H-120.960, “Protection for Physicians Who Prescribe Pain Medication,” and the third clause is covered by D-120.985, “Education and Awareness of Opioid Pain Management Treatments, Including Responsible Use of Methadone,” which covers the focus on education resources. The second clause remains relevant.

H-125.982	Medicare Part D Modifications	<p>Our AMA will seek necessary federal legislative changes to:</p> <ul style="list-style-type: none"> a. have all pharmacy benefit programs participating in Medicare Part D offer at least one program that eliminates the coverage gap; and b. require that all pharmacy benefit programs participating in Medicare Part D inform the enrollees of lower cost/generic alternatives for each prescribed medication. <p>Citation: (Res. 130, A-07)</p>	Retain – This policy remains relevant.
H-125.993	Legislation Prohibiting Therapeutic Substitution	<p>It is the policy of the AMA to: (1) oppose the establishment of a system at the federal or state level premised on therapeutic interchangeability of prescription drugs and formularies, since it will inevitably interfere with the ability of the patient's physician to assure that the medication prescribed is dispensed to the patient; (2) encourage and assist all states in passing legislation prohibiting the practice of therapeutic substitution; and (3) provide education to physicians and the general public that therapeutic substitution is not equal to generic substitution and provide information about the potential dangers of therapeutic substitution.</p> <p>Citation: (Sub. Res. 161, A-90; Reaffirmed by Sub. Res. 501, A-95; Reaffirmed: BOT Rep. 9, I-97; Reaffirmed: CSAPH Rep. 3, A-07)</p>	Retain – This policy remains relevant.
H-130.950	Emergency Medical Treatment and Active Labor Act (EMTALA)	<p>Our AMA: (1) will seek revisions to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementing regulations that will provide increased due process protections to physicians before sanctions are imposed under EMTALA;</p> <ul style="list-style-type: none"> (2) expeditiously identify solutions to the patient care and legal problems created by current Emergency Medical Treatment and Active Labor Act (EMTALA) rules and regulations; (3) urgently seeks return to the original congressional intent of EMTALA to prevent hospitals with emergency departments from turning away or transferring patients without health insurance; and. (4) strongly opposes any regulatory or legislative changes that would further increase liability for failure to comply with ambiguous EMTALA requirements. <p>Citation: (Sub. Res. 214, A-97; Reaffirmation I-98; Reaffirmation A-99; Appended: Sub. Res. 235 and Reaffirmation A-00; Reaffirmation A-07)</p>	Retain – This policy remains relevant.

H-130.967	Action Regarding Illegal Aliens	Our AMA supports the legislative and regulatory changes that would require the federal government to provide reasonable payment for federally mandated medical screening examinations and further examination and treatment needed to stabilize a condition in patients presenting to hospital emergency departments, when payment from other public or private sources is not available. Citation: (BOT Rep. MM, A-89; Reaffirmed by BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)	Retain – This policy remains relevant.
H-135.944	Further Limit of Asbestos in the United States	Our AMA supports legislation further restricting the use of asbestos in the United States. Citation: Res. 215, A-07	Retain – This policy remains relevant.
H-140.945	Code Status Requirement for Nursing Home Residents	The AMA opposes any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. The AMA urges other medical agencies and associations to oppose any legislative or regulatory attempts that would allow a nursing home facility to require that a patient consent to a DNR order as a condition of admission unless that facility is limited to palliative care. Citation: (Res. 236, I-97; Reaffirmed: CEJA Rep. 7, A-07)	Retain – This policy remains relevant.
H-145.991	Gun Control	The AMA supports using its influence in matters of health to effect passage of legislation in the Congress of the U.S. mandating a national waiting period that allows for a police background and positive identification check for anyone who wants to purchase a handgun from a gun dealer anywhere in our country. Citation: (Sub. Res. 34, I-89; Reaffirmed: BOT Rep. 8, I-93; Reaffirmed: BOT Rep. 50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)	Retain – This policy remains relevant.
H-145.992	Waiting Period Before Gun Purchase	The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S. Citation: (Res. 171, A-89; Reaffirmed: BOT Rep.50, I-93; Reaffirmed: CSA Rep. 8, A-05; Reaffirmation A-07)	Retain – This policy remains relevant.
H-145.993	Restriction of Assault Weapons	Our AMA supports appropriate legislation that would restrict the sale and private ownership of inexpensive handguns commonly referred to as “Saturday night specials,” and large clip, high-rate-of-fire automatic and semi-automatic	Retain – This policy remains relevant.

		<p>firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon. Citation: (Sub. Res. 264, A-89; Reaffirmed: BOT Rep. 50, I-93; Amended: Res.215, I-94; Reaffirmed: CSA Rep. 6, A-04; Reaffirmation A-07)</p>	
H-145.999	Gun Regulation	<p>Our AMA supports stricter enforcement of present federal and state gun control legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm. Citation: (Sub. Res. 31, I-81; Reaffirmed: CLRPD Rep. F, I-91; Amended: BOT Rep. I-93-50; Reaffirmed: Res. 409, A-00; Reaffirmation A-07)</p>	Retain – This policy remains relevant.
H-160.956	Federal Funding for Safety Net Care for Undocumented Aliens	<p>Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens. Citation: (Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07)</p>	Retain – This policy remains relevant.
H-175.976	Physician Protections in Fraud Data Bank Program	<p>Our AMA will take all necessary actions to oppose and rescind the Health Care Integrity and Protection Data Bank. If not possible to repeal the establishment of the data bank, the AMA should take steps to protect the legal due process rights of practitioners. Citation: (Sub. Res. 803, A-99; Reaffirmation I-07)</p>	Rescind – The Health Care Integrity and Protection Data Bank is no longer operational and has been superseded by the National Practitioner Data Bank. (NPDB). AMA policies on the NPDB, including H-355.975 Opposition to the National Practitioner Data Bank, now address these concerns.
H-175.982	Due Process for Physicians	<p>It is the policy of the AMA to review current legislation governing fraud and abuse investigations and propose additional legislation and/or regulations as necessary and be prepared to take legal action in order to assure physicians due process in the conduct of fraud and abuse investigations.</p> <p>Our AMA requests the United States Department of Justice to establish a specific procedure for audit of a physician's office records which includes, but is not limited to, the following: (1) Patient care in the physician's office must not be interrupted during the course of the audit;</p>	Retain – This policy remains relevant.

		<p>(2) Patient ingress and egress must not be hindered during the course of an audit;</p> <p>(3) Normal telephonic communication must not be interrupted during the course of an audit; and</p> <p>(4) Normal routine of physician's care of patients in hospital or at home must not be interrupted.</p> <p>AMA policy is to pursue legislative, regulatory or other avenues to eliminate fines for inadvertent Medicare billing errors.</p> <p>Citation: (Sub. Res. 229, I-97; Reaffirmation A-99; Reaffirmation I-00; Reaffirmation I-01; Reaffirmed: Res. 12, A-06; Reaffirmation I-07)</p>	
H-260.966	CLIA Physician Office Laboratory Inspections	<p>The AMA will seek and support legislation which would amend Section 353 of the Public Health Service Act to exempt physicians' office laboratories, except for those which perform a pap smear (Papanicolaou's Smear) analysis, from the clinical laboratories requirements of that section; and if this is not possible, the AMA will seek legislation or modification in the Centers for Medicare & Medicaid Services regulations which would allow physicians' office laboratories which do not do cytology, which have no significant deficiencies on inspection thus triggering a "revisit," which have satisfactory proficiency testing performances, which have no complaints against the lab and which have not undergone any significant changes (i.e., new director), be allowed to perform a self-assessment study called the Alternative Quality Assessment Survey (AQAS) in lieu of the biannual on-site inspection.</p> <p>Citation: (Res. 212, A-97; Reaffirmed: BOT Rep. 33, A-07)</p>	Retain – This policy remains relevant.
H-270.984	Change in Bankruptcy Code	<p>The AMA supports the passage of an amendment to Section 523(a)(8) of the Bankruptcy Code, which would substitute the word "organization" for the word "institution."</p> <p>Citation: (Res. 45, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 33, A-07)</p>	Retain – This policy remains relevant.
H-270.987	Tax Law Changes	<p>The AMA supports: (1) correction of inequities in the Tax Reform Act of 1986, including (a) the excise penalty tax on excess retirement distribution; (b) the excise tax on excess retirement accumulation; (c) the requirement of 10-year plan participation; and (d) the requirement of plan participation by the specified percentage of all employees; and (2) re-establishment of IRA rules as under the previous law.</p> <p>Citation: (Sub. Res. 138, A-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: BOT Rep. 33, A-07)</p>	Retain – This policy remains relevant.

H-275.927	Medicare/ Medicaid Exclusion: Amendment of Definition of Conviction in Health Insurance Portability and Accountability Act	<p>1. It is AMA policy that a recovering physician who is convicted of a felony for an offense which relates to the “unlawful manufacture, distribution, prescription or dispensing of a controlled substance,” and in order to resolve criminal charges arising from personal substance abuse, has entered into a first offender, deferred adjudication or other such arrangement (42 USC § 1320a-7[i]), should not be excluded from the Medicare and Medicaid programs for a mandatory five years.</p> <p>2. Our AMA seeks legislation either to (a) delete this first offender, deferred adjudication definition of “conviction” from the statute, or (b) seek to exempt recovering providers from its application.</p> <p>Citation: (BOT Action in response to referred for decision Res. 215, I-97; Reaffirmed: CMS Rep. 9, A-07)</p>	Retain – This policy remains relevant.
H-275.940	Physician Impairment	<p>The AMA adopts the policy that, except in the case of summary suspension necessary to protect patients from imminent harm, no adverse action be taken against the privileges of a physician by a hospital, managed care organization or insurer based on a claim of physician impairment without a suitable due process hearing in accordance with medical staff bylaws to determine the facts related to the allegations of impairment and, where appropriate, a careful clinical evaluation of the physician.</p> <p>Citation: (Res. 701, I-97; Reaffirmed: CME Rep. 2, A-07)</p>	Retain – This policy remains relevant.
H-290.970	Federal Legislation on Access to Community- Based Services for People with Disabilities	<p>Our AMA strongly supports reform of the Medicaid program established under title XIX of the Social Security Act (42 U.S.C. 1396) to provide services in the most appropriate settings based upon the individual’s needs, and to provide equal access to community-based attendant services and supports.</p> <p>Citation: (Res. 917, I-07)</p>	Retain – This policy remains relevant.
H-305.941	Recognizing Dependent Care Expenses in Determining Medical Education Financial Aid	<p>AMA policy is to pursue changes to federal legislation or regulation, and specifically to the Higher Education Act, to change the cost of attendance definition for medical education to include costs for food, shelter, clothing and health care for all dependents, and for dependent care.</p> <p>Citation: (Res. 205, I-97; Reaffirmed: CME Rep. 2, A-07)</p>	Retain – This policy remains relevant.
H-315.975	Police, Payer, and Government Access to Patient	<p>(1) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, to define “health care operations”</p>	Retain – This policy remains relevant.

	<p>Health Information</p>	<p>narrowly to include only those activities and functions that are routine and critical for general business operations and that cannot reasonably be undertaken with de-identified information.</p> <p>(2) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that the Centers for Medicare & Medicaid Services (CMMS) and other payers shall have access to medical records and individually identifiable health information solely for billing and payment purposes, and routine and critical health care operations that cannot reasonably be undertaken with de-identified health information.</p> <p>(3) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation, that CMMS and other payers may access and use medical records and individually identifiable health information for non-billing, non-payment purposes and non-routine, non-critical health care operations that cannot reasonably be undertaken with de-identified health information, only with the express written consent of the patient or the patient's authorized representative, each and every time, separate and apart from blanket consent at time of enrollment.</p> <p>(4) Our AMA advocates vigorously, with respect to the final privacy rule or other privacy legislation that no government agency, including law enforcement agencies, be permitted access to medical records or individually identifiable health information (except for any discretionary or mandatory disclosures made by physicians and other health care providers pursuant to ethical guidelines or to comply with applicable state or federal reporting laws) without the express written consent of the patient, or a court order or warrant permitting such access.</p> <p>(5) Our AMA continues to strongly support and advocate a minimum necessary standard of disclosure of individually identifiable health information requested by payers, so that the information necessary to accomplish the intended purpose of the request be determined by physicians and other health care providers, as permitted under the final privacy rule.</p> <p>Citation: (Res. 246, A-01; Reaffirmation I-01; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, I-06; Reaffirmation A-07; Reaffirmed: BOT Rep. 19, A-07)</p>	
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<p>H-330.929</p>	<p>Lessening the Impact of New Legislation on Physicians: An Anti-Hassle Proposal</p>	<p>AMA policy is to promote and further strengthen the Practicing Physician Advisory Council (PPAC) whose purpose is to identify proposed changes and to recommend needed clarification of regulations and legislation that impact physicians and medical practices. Citation: (Res. 206, I-97; Reaffirmed: BOT Rep. 33, A-07)</p>	<p>Rescind: Section 3134(b)(2) of the Patient Protection and Affordable Care Act, repeals section 1860(a) of the Social Security Act (42 U.S.C. 1395ee(a)), which provided for the establishment of the Practicing Physicians Advisory Council.</p>
<p>H-435.949</p>	<p>Liability Relief for Physicians Who Volunteer at Free Clinics</p>	<p>Our AMA urges states to adopt legislation that provides for liability relief for volunteer physicians who serve at free clinics, deliver pro bono care, or volunteer in times of disaster.</p>	<p>Retain – This policy remains relevant.</p>
<p>H-435.951</p>	<p>Health Court Principles</p>	<p>AMA PRINCIPLES FOR HEALTH COURTS</p> <ul style="list-style-type: none"> - These principles are intended to serve as legislative guidelines for state medical associations and can be amended on an as needed basis. - Health courts should be structured to create a fair and expeditious system for the resolution of medical liability claims - with a goal of resolving all claims within one year from the filing date. - Health court judges should have specialized training in the delivery of medical care that qualifies them for serving on a health court. - Negligence should be the minimum threshold for compensation to award damages. - Health court judgments should not limit the recovery of economic damages, but non-economic damages should be based on a schedule. - Qualified experts should be utilized to assist a health court in reaching a judgment. - Health court pilot projects should have a sunset mechanism in place to ensure that participating physicians, hospitals, and insurers do not experience a drastic financial impact based on the new judicial format. <p>I. Health Court Structure</p> <p>Jurisdiction</p> <ul style="list-style-type: none"> - Health courts should only be established at the state or local level. - If a health court is established on a statewide or local basis, then it should be established within the state's trial court of general jurisdiction. Using the already established system would lessen the 	<p>Retain – This policy remains relevant.</p>

		<p>financial and administrative burden.</p> <ul style="list-style-type: none">- To capture all medical liability cases, a health court that is established as a statewide or local program should have exclusive jurisdiction over any lawsuit (contract or tort) which involves an injury arising from the alleged negligence of a health care provider.- Appeals should be handled within the health court system as well.- The jurisdiction's discovery rules should be modified to be consistent with the timeline for resolving a case before a health court.- Eventually, health courts should have expanded jurisdiction over the validity of advance directives, managed care independent review decisions, and other health law issues. <p>Trial Format</p> <ul style="list-style-type: none">- One option for a health court is to have a bench trial before a specially trained judge.- Another option is for a health court to have a jury trial under the authority of a specially trained judge.- Health courts utilizing a jury should provide juries with a specialized educational session on the basics of medical care delivery and the distinction between negligence and adverse outcomes as well as appropriate guidelines on the purpose of awarding non-economic damages. <p>Administrative Option</p> <ul style="list-style-type: none">- An administrative system (e.g. established by a hospital or insurer) should include many of the same requirements that the AMA supports for a health court established within a jurisdiction's standard judicial system.- Health court pilot programs established through an insurer or hospital should have jurisdiction over patients who choose to opt in to the system. <p>II. Health Court Judges</p> <p>Selection of Health Court Judges</p> <ul style="list-style-type: none">- Health court judges should be appointed by a health court task force.- The health court task force should be comprised of four physicians, four lawyers, and four laypersons.- The majority and minority leaders in each of the state's legislative chambers should pick one member from each category (i.e., house majority	
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		<p>leader would pick one physician, one lawyer, and one layperson for the task force. The house minority leader, the senate majority leader, and the senate minority leader would do the same.)</p> <ul style="list-style-type: none">- The health court task force chairmanship should rotate on an annual basis.- The majority and minority leaders in each legislative chamber should ask the state medical association for a list of health court task force candidates before making an appointment.- Governmental entities should adjust the term of a health court judge based on the length of terms in their state for other special courts. <p>Training for Health Court Judges</p> <ul style="list-style-type: none">- Health court judges should complete a judicial training program which provides an overview of medical and legal issues that often arise in medical liability cases.- The curriculum should be established by the health court task force.- The medical portion of the training program should include both in-classroom clinical training and an internship whereby the judge "shadows" a physician in different health care settings.- States and other government bodies with an existing judicial training program should have this office administer the special training program for judges assigned to the health court. <p>III. Health Court Procedure</p> <p>Threshold for Patient Compensation</p> <ul style="list-style-type: none">- Negligence must be proven for a patient to recover in a health court proceeding. <p>Damages</p> <ul style="list-style-type: none">- Economic damages should not be limited. Injured parties should be fully compensated for their economic losses.- Non-economic damage awards should be established by a schedule. Consistent injuries should result in consistent non-economic damage awards based on the schedule. The health court task force should establish the schedule.- One option for the schedule is to base it on type/severity of the injury. Another option is to have the schedule link non-economic damages awards to the amount of economic damages included in the judgment.- Punitive damages, if allowed, should not be	
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		<p>awarded unless the party alleging such damages meets the burden of producing clear and convincing evidence of oppression, fraud, malice, or the opposing party's intent to do harm.</p> <ul style="list-style-type: none"> - Health court judges should give jury instructions that provide clear delineations between the purposes of economic damages (for economic loss), non-economic damages (for pain and suffering), and punitive damages (for punishment to prevent future bad behavior). The instructions should also distinguish the different burden of proof needed for punitive damages. - Future damages should be paid on a periodic basis as authorized by a health court. <p>Other Procedural Issues</p> <ul style="list-style-type: none"> - Health courts should be designed to resolve claims within one year from the filing date. - Health courts should limit attorney's fees to maximize the award to the patient. - Collateral payment sources should be admissible as evidence in a health court proceeding. - Health court damage awards should include mandatory offsets for collateral payments for the same injury. - An affidavit/certificate of merit should be a prerequisite to filing a medical liability case before a health court. - A pre-trial screening panel should be utilized prior to the start of a trial before a health court. - The statute of limitations in a health court should be two years from the act or omission. - The period for suspending the application of state statutes of limitations for minors should be no more than six years after birth. The statute should include a three-year statute of repose from manifestation as well for minors. - In a health court proceeding, statements of sympathy, apology or regret made by a health care provider or their staff to an alleged victim or family of the victim relating to the discomfort, pain, suffering, injury, or death resulting from an unanticipated outcome of medical care should be inadmissible as evidence of an admission of liability or as evidence of an admission against interest. <p>IV. Medical Error Reporting</p> <p>Medical Error Reporting</p> <ul style="list-style-type: none"> - The AMA continually strives to advance efforts 	
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		<p>to improve patient safety through educational activities and all other available means to discover and promote “best practices” in the delivery of health care services. Toward this end, a health court system should encourage the reporting of medical errors.</p> <ul style="list-style-type: none">- The reporting system should be non-punitive, and it should be confidential and not subject to discovery in legal proceedings.- The medical error reporting system should collaborate with the Patient Safety Organization (PSO) (which will be established pursuant to the federal Patient Safety and Quality Improvement Act of 2005) in its state or region to encourage the efficient reporting and analysis of the data. <p>V. Experts</p> <p>Court Appointed Medical Experts</p> <ul style="list-style-type: none">- The health court task force should maintain a list of qualified medical experts from which a judge may select to help clarify or interpret medical testimony given in legal proceedings.- A health court judge should use and rely on the testimony of a court appointed medical expert.- A court appointed medical expert must, at a minimum, meet the same qualifications as the medical experts who testify on behalf of a party in the presiding lawsuit. <p>Party Expert Witnesses</p> <ul style="list-style-type: none">- Health courts should only allow medical expert witnesses to testify if the expert witness is licensed as a doctor of medicine or osteopathy.- An expert witness should be trained and experienced in the same field as the defendant or has specialty expertise in the disease process or procedure performed in the case.- An expert witness should be certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, or by a board with equivalent standards.- An expert witness should, within five years of the date of the alleged occurrence or omission giving rise to the claim, be in active medical practice in the same field as the defendant, or have devoted a substantial portion of his time teaching at an accredited medical school, or in university-based research in relation to the medical care and type of treatment at issue.	
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<p>H-435.973</p>	<p>Report of the Special Task Force on Professional Liability and the Advisory Panel on Professional Liability</p>	<p>(1) Medical Expert Witness Testimony: Courts should admit into evidence only expert medical testimony that is shown through a proper legal foundation to be based on (a) widely accepted theories of medical science or (b) theories that are supported by a respectable minority of experts in the field at issue. (2) Implementation of the “Loser Pays” Rule in Medical Liability Litigation: Responsibility for a prevailing party's legal expenses, including attorney fees, should not be shifted to a losing party in medical liability litigation unless (a) some provision is made for retrieving fees owed to a prevailing party from the losing party's attorney in the event the losing party has no available assets; (b) some provision is made to calculate fees owed to a plaintiff's attorney on the basis of the reasonable value of time expended, regardless of the existence of a contingency fee arrangement; (c) the rule is adopted that no losing party will be</p>	<p>Retain – This policy remains relevant.</p>

		<p>required to pay expenses including legal fees that exceed his or her own bill for such goods or services; and</p> <p>(d) other efforts are made as necessary to insure that the "loser pays" disincentive to pursue litigation applies equally to all parties. (3) Punitive Damages Awards: Punitive damages in medical liability cases should not be awarded unless the party alleging such damages meets the burden of producing clear and convincing evidence of the opposing party's intent to do harm. Citation: (BOT Rep. CC, I-91; Reaffirmed: BOT Rep. 9, I-99; Reaffirmed: BOT Rep. 13, A-07)</p>	
H-440.869	<p>Establishment of Model Legislation to Develop State Commission/ Taskforce to Eliminate Racial and Ethnic Health Care Disparities</p>	<p>Our AMA will develop model legislation and encourage and assist state and local medical societies to advocate for creation of statewide commissions to eliminate health disparities in each state. Citation: (Res. 914, I-07)</p>	<p>Retain in part – The directive to develop model legislation has been achieved. The remainder of this policy remains relevant.</p>
H-440.870	<p>Amending Child Restraint Laws</p>	<p>Our AMA supports: (1) federal legislation that increases law enforcement standards for child safety seat use in the United States; and (2) state and federal legislation that updates child car seat violation codes from a secondary to primary law. Citation: (Res. 913, I-07)</p>	<p>Retain – This policy remains relevant.</p>
H-440.874	<p>Support of Legislation Regarding Global and Domestic Tuberculosis Control</p>	<p>Our AMA supports federal legislation to increase resources for global and domestic TB control. Citation: (Res. 227, A-07)</p>	<p>Retain – This policy remains relevant.</p>
H-450.939	<p>Activities of the National Quality Forum</p>	<p>Our AMA will: (1) continue to advocate for the Physician Consortium for Performance Improvement as the measure developer for physician-level performance measurement; (2) continue to monitor the National Quality Forum's (NQF) activities to ensure physician representation and involvement in all activities and leadership; and (3) oppose any efforts to expand the NQF's mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement's principal role in the measure development process. Citation: (BOT Rep. 1, I-07)</p>	<p>Retain – This policy remains relevant.</p>

H-450.940	National Quality Forum	<p>Our AMA opposes any efforts to expand the National Quality Forum’s (NQF) mission to include measure development or other actions that would effectively limit or eliminate the Physician Consortium for Performance Improvement’s principal role in the measurement development process and will report on the ongoing activities of the NQF at the 2007 Interim Meeting. Citation: (Res. 230, A-07)</p>	<p>Rescind – The report referenced in this policy was completed and submitted to the HOD at the 2007 Interim Meeting as BOT Rep. 1. The recommendation in the report was adopted as Policy H-450.939, which supersedes this policy.</p>
H-450.944	Protecting Patients’ Rights	<p>Our AMA opposes Medicare pay-for-performance initiatives (such as value-based purchasing programs) that do not meet our AMA’s “Principles and Guidelines for Pay-for-Performance,” which include the following five Principles: (1) ensure quality of care; (2) foster the patient/physician relationship; (3) offer voluntary physician participation; (4) use accurate data and fair reporting; and (5) provide fair and equitable program incentives. Citation: (Sub. Res. 902, I-05; Reaffirmation A-06; Reaffirmation I-06; Reaffirmation A-07)</p>	<p>Retain – This policy remains relevant.</p>
H-450.962	National Committee for Quality Assurance	<p>The AMA: (1) promotes physician-developed guidelines for evaluating patient and physician satisfaction with plans, accreditation standards, utilization, quality and cost policies; and (2) will develop policy and medically appropriate guidelines for review of physician offices as promulgated by NCQA. Citation: (BOT Rep. 12, A-95; Reaffirmation I-96; Reaffirmed: CSAPH Rep. 3, A-07)</p>	<p>Rescind – The AMA does not develop guidelines for review of physicians’ offices so this is not relevant policy.</p>
H-450.964	National Committee for Quality Assurance	<p>The AMA believes that the National Committee for Quality Assurance (NCQA) is not an appropriate organization to determine criteria for physician credentialing. The AMA: (1) advocates for appropriate changes in the NCQA policies, standards, and accreditation procedures that are consistent with AMA policy (Reaffirmed in lieu of Res. 701, I-94); (2) urges NCQA to study ways of modifying its standards and accreditation procedures to reduce the potential burdens placed on physicians and their employees in responding to the on-site office review requests made by managed care organizations; (3) urges NCQA to ensure that managed care organizations are prohibited from requesting and reviewing medical records of patients who are not enrollees of the health plan of the managed care organization being surveyed by NCQA;</p>	<p>Rescind – The NCQA does not do physician credentialing, and therefore, this policy is no longer relevant.</p>

		<p>(4) urges NCQA to develop means of involving practicing physicians in NCQA's accreditation processes; and</p> <p>(5) urges NCQA to include physician satisfaction surveys of practicing physicians participating in managed care organizations as an additional measure of assessing the quality of managed care organizations under NCQA's accreditation processes.</p> <p>Citation: (BOT Rep. 6, A-94; Reaffirmed by Sub. Res. 722, I-96; Amended by Res. 710, A-97; Reaffirmed: CSAPH Rep. 3, A-07)</p>	
D-60.977	Exclusion of Homeless Children from Deficit Reduction Act Documentation Requirements	<p>Our AMA will advocate for exclusion of homeless infants, children, adolescents, and young adults from the requirements of the Deficit Reduction Act that they document their citizenship and identification under Section 6036 of the Deficit Reduction Act of 2006, "Improved Enforcement of Documentation Requirements."</p> <p>Citation: (Res. 120, A-07)</p>	Retain – This policy remains relevant.
D-100.980	One Fee, One Number	<p>Our AMA will work with the appropriate agencies to require only one federal DEA number that would be physician-specific and not site-specific.</p> <p>Citation: Res. 701, I-07)</p>	Retain – This policy remains relevant.
D-130.982	EMTALA -- Major Regulatory and Legislative Developments	<p>Our AMA: (1) continue to work with the Federal government to implement the EMTALA related recommendations of the Health and Human Services Advisory Committee on Regulatory Reform;</p> <p>(2) continue to work diligently to clarify and streamline the EMTALA requirements to which physicians are subject;</p> <p>(3) continue to work diligently with the Department of Health and Human Services (HHS) to further limit the scope of EMTALA, address the underlying problems of emergency care, and provide appropriate compensation and adequate funding for physicians providing EMTALA-mandated services;</p> <p>(4) request that HHS establish a public/private EMTALA Technical Advisory Group which could provide expertise and assistance to the HHS Secretary with respect to the EMTALA rules and interpretative guidelines and their application to hospitals and physicians until the problems of emergency care have been adequately addressed and resolved;</p> <p>(5) communicate to physicians its understanding that following inpatient admission of a patient initially evaluated in an emergency department and stabilized, care will not be governed by the</p>	Retain in part – Clauses (1) and (4) should be removed since the Health and Human Services Advisory Committee on Regulatory Reform is no longer operational and HHS did establish an EMTALA Technical Advisory Group, although its charter ended in 2007. Clauses 2 and 3 can be retained.

		EMTALA regulations. (6) continue strongly advocating to the Federal government that, following inpatient admission of a patient evaluated in an emergency department, where a patient is not yet stable, EMTALA regulations shall not apply. Citation: (BOT Rep. 17, I-02; Reaffirmation A-07)	
D-160.985	Establishment of a Federal Office of Men's Health	Our AMA encourages the establishment of an Office of Men's Health at the U.S. Department of Health and Human Services to coordinate awareness, outreach, and outcomes on men's health. Citation: (Res. 417, A-07)	Retain – This policy remains relevant.
D-290.983	Children's Rights to Receive Health Care Services Under the Medicaid Act	Our AMA will take all reasonable steps to introduce and pass legislation which would: (1) confirm, clarify and codify Congressional intent that Medicaid-eligible children have an enforceable right to receive Early Periodic Screening, Diagnosis, and Treatment services and a right to enforce the equal access provision; and (2) overturn the reasoning applied by the United States Court of Appeals for the Tenth Circuit in Oklahoma Chapter of the American Academy of Pediatrics v. Fogarty. Citation: (Res. 114, A-07)	Retain – This policy remains relevant.
D-305.966	Reinstatement of Economic Hardship Loan Deferment	Our AMA will actively work to reinstate the economic hardship deferment qualification criterion known as the "20/220 pathway," and support alternate mechanisms that better address the financial needs of post-graduate trainees with educational debt. Citation: (Res. 930, I-07)	Retain – This policy remains relevant.
D-380.996	Balance Billing for All Physicians	1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care. 2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts. 3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient. Citation: (Res. 925, I-07)	Retain – This policy remains relevant.

D-390.987	Medicare Payment For Critical Care Services	The AMA shall continue to aggressively pursue legislative changes to fix the Medicare physician payment update problem. CMS Rep. 4, I-02 Reaffirmation I-07)	Rescind – The Medicare physician payment update problem was fixed with the Medicare Access and CHIP Reauthorization Act of 2015.
D-400.999	Non-Medicare Use of the RBRVs	Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods;. (2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale; (3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies; (4) strongly oppose and protests any efforts by third party payers and other public programs to redefine the Centers for Medicare & Medicaid Services’ Medicare multiple surgery reduction policy <u>by reducing which reduces</u> payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS. Citation: (CMS Rep. 12, A-99; Reaffirmation I-03; Reaffirmation I-07)	Retain in part – The Centers for Medicare & Medicaid Services has implemented multiple surgery reduction policies, so clause (4) should be modified accordingly.
D-510.996	Military Care in the Public and Private Sector	Our AMA will use its influence to expedite quality medical care, including mental health care, for all military personnel and their families by developing a national initiative and strategies to utilize civilian health care resources to complement the federal health care systems. Citation: (Res. 444, A-07)	Retain – This policy remains relevant.

APPENDIX 2

AMA Policies Superseding Policies Recommended for Rescission

H-175.976 “Physician Protections in Fraud Data Bank Program”

Our AMA will take all necessary actions to oppose and rescind the Health Care Integrity and Protection Data Bank. If not possible to repeal the establishment of the data bank, the AMA should take steps to protect the legal due process rights of practitioners. (Sub. Res. 803, A-99; Reaffirmation I-07)

Policy H-355.975 “Opposition to the National Practitioner Data Bank”

1. Our AMA communicates to legislators the fundamental unfairness of the civil judicial system as it now exists, whereby a jury, rather than a forum of similarly educated peers, determines if a physician has violated the standards of care and such results are communicated to the National Practitioner Data Bank; and impresses on our national legislators that only when a physician has been disciplined by his/her state licensing agency should his/her name appear on the National Practitioner Data Bank.
2. Our AMA affirms its support for the Federation of State Medical Boards Action Data Bank and seeks to abolish the National Practitioner Data Bank.
3. Our AMA urges HHS to retain an independent consultant to (A) evaluate the utility and effectiveness of the National Practitioner Data Bank, (B) evaluate the confidentiality and security of the reporting, processing and distribution of Data Bank information, and (C) provide the findings and recommendations to the National Practitioner Data Bank Executive Committee and the General Accounting Office.
4. Our AMA will take appropriate steps to have Congress repeal Section 4752 (f) of OBRA 1990 requiring peer review organizations and private accreditation entities to report any negative action or finding to the Data Bank.
5. Our AMA seeks to amend the Health Care Quality Improvement Act of 1986 to allow a physician, at the time the physician notifies the Data Bank of a dispute, to attach an explanation or statement to the disputed report;
6. Our AMA opposes any legislative or administrative efforts to expand the Data Bank reporting requirements for physicians, such as the reporting of a physician who is dismissed from a malpractice suit without any payment made on his or her behalf, or to expand the entities permitted to query the Data Bank such as public and private third party payers for purposes of credentialing or reimbursement.
7. Our AMA (A) urges HHS to work with the Federation of State Medical Boards to refine its National Practitioner Data Bank breakdown of drug violation reporting into several categories; (B) urges the HHS to analyze malpractice data gathered by the Physician Insurance Association of America and recommend to Congress that a threshold of at least \$30,000 for the reporting of malpractice payments be established as soon as possible; (C) will continue to work with HHS to allow physicians an expanded time period to verify the accuracy of information reported to the Data Bank prior to its release in response to queries; (D) will work with HHS and the Office of Management and Budget to reduce the amount of information required on the request for information disclosure form and to improve the design of the form to allow for more efficient processing of information; and (E) will continue to work with HHS to improve its mechanism to distribute revisions and clarifications of Data Bank policy and procedure.
8. Our AMA will review questions regarding reportability to the Data Bank and will provide periodic updates on this issue to the AMA House of Delegates.

Policy H-355.977 “Reporting of Resident Physicians to the National Practitioner Data Bank”

1. Our AMA: (A) seeks opportunities to limit reports concerning residents to the National Practitioner Data Bank to only those situations where a final adverse action has been taken by a

medical licensing jurisdiction; (B) opposes attempts to extend reports concerning residents to the National Practitioner Data Bank beyond those covered in Item 1 of this policy; and (C) advocates for legislation amending, as appropriate, the NPDB reporting requirements regarding resident physicians to be consistent with this policy, and opposes the expansion of existing reporting requirements.

2. Our AMA: (A) fully supports the mandatory and prompt notification of residents by the appropriate hospital authority when they are named along with a hospital and/or others in the hospital in malpractice suits; (B) opposes the inclusion in the National Practitioner Data Bank of information on liability payments made on behalf of residents named in malpractice suits for incidents that occur during the required supervised activities of their residency training; (C) seeks the immediate suspension of the policy whereby information on residents named in malpractice suits for incidents which occur during the required supervised activities of their residency training is reported to the National Practitioner Data Bank when liability payments are made on their behalf; and (D) will work with the Association of American Medical Colleges and other interested parties to reinvigorate its efforts to successfully change National Practitioner Data Bank policy through legislative or other means in accordance with this policy.

3. Our AMA will continue to monitor the types of information reported about resident physicians to federal and state agencies, especially the National Practitioner Data Bank and state medical licensing boards.

Policy H-355.990 "National Practitioner Data Bank"

(1) The AMA shall continue to pursue vigorously remedial action to correct all operational problems with the National Practitioner Data Bank (NPDB). (2) The AMA requests that the Health Resources and Services Administration (a) prepare and disseminate to physician and hospital organizations a white paper addressing its plans to enhance the confidentiality/security provisions of the reporting and querying process no later than December 1992; (b) conduct a statistically valid sample of health care entities, other than hospitals, on the entity file to determine if entities that are not eligible to query under the statute and regulation have gained access to the NPDB information, and disseminate the results to the NPDB Executive Committee no later than December 1992; (c) implement appropriate steps to ensure and maintain the confidentiality of the practitioner's self-query reports no later than December 1992; (d) recommend to the Congress that small claims payments, less than \$30,000, no longer be reported to the NPDB and provide the Executive Committee members the opportunity to attach their comments on the report that goes to the Congress; (e) allow by January 1, 1993, the practitioner to append an explanatory statement to the disputed report; and (f) release the evaluation report, prepared by Dr. Mohammad Akhter, on the NPDB's first year of operation to the AMA by July 1992. (3) The AMA will reevaluate at the 1992 Interim Meeting the progress on these issues. If the preceding requests are not met by the established due date and the House of Delegates is not satisfied with the progress on these issues, the AMA will again reevaluate the implementation of Policy H-355.991.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 201
(A-17)

Introduced by: Resident and Fellow Section

Subject: Improving Drug Affordability

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, Recent media coverage of individual drugs such as sofosbuvir, epinephrine, naloxone
2 and pyrimethamine has highlighted the skyrocketing cost of medications in the U.S.^{1,2,3,4}; and
3
4 Whereas, These individual drug costs are not isolated phenomena but symbolic of a systemic
5 crisis of drug affordability with devastating consequences for our patients and our health care
6 system⁵; and
7
8 Whereas, Prices for 1,200 existing generic drugs increased 450%, on average, in a single year
9 (2013-2014); and
10
11 Whereas, Prices for 73 existing brand name drugs increased 75% or more since 2007; and
12
13 Whereas, The average price for oncology medications has doubled over the past decade, from
14 \$5,000 per month to \$10,000 per month; and
15
16 Whereas, Of the 12 oncology drugs approved by the FDA in 2013, 11 were priced at more than
17 \$100,000 per year; and
18
19 Whereas, Spending on specialty drugs is expected to more than quadruple from \$87 billion in
20 2012 to \$400 billion in 2020, if nothing is done to address current and future prices; and
21
22 Whereas, AMA Policy Pharmaceutical Cost H-110.987 states, “Our AMA encourages
23 prescription drug price and cost transparency among pharmaceutical companies, pharmacy
24 benefit managers (PBMs) and health insurance companies”; and
25
26 Whereas, Drug pricing transparency is a necessary but not sufficient first step in addressing
27 drug pricing affordability and increasing access to medicines; and
28
29 Whereas, Increasing drug affordability requires comprehensive legislation including
30 transparency, notification and enforcement provisions including but not limited to price gouging
31 provisions; therefore be it

1 RESOLVED, That our American Medical Association support drug price transparency legislation
 2 that requires pharmaceutical manufacturers to disclose, in a timely fashion, the basis for the
 3 prices of all prescription drugs, including but not limited to: (1) research and development costs
 4 paid by both the manufacturer and any other entity; (2) manufacturing costs; (3) advertising and
 5 marketing costs; (4) total revenues and direct and indirect sales; (5) unit price; (6) financial
 6 assistance provided for each drug including any discounts, rebates and/or prescription drug
 7 assistance; (7) any offshoring of either jobs or profits; (8) any reverse payment settlements; (9)
 8 payments to third parties--such as wholesalers, group purchasing organizations (GPOs),
 9 managed care organizations (MCOs), and pharmacy benefit management companies (PBMs)
 10 (New HOD Policy); and be it further
 11

12 RESOLVED, That our AMA support legislation that requires pharmaceutical manufacturers to
 13 provide public notice before increasing the wholesale price of any brand or specialty drug by
 14 10% or more each year or per course of treatment (New HOD Policy); and be it further
 15

16 RESOLVED, That our AMA support legislation that authorizes the Attorney General and/or the
 17 Federal Trade Commission to take legal action to address price gouging by pharmaceutical
 18 manufacturers and increase access to affordable drugs for patients (New HOD Policy); and be it
 19 further
 20

21 RESOLVED, That our AMA support the expedited review of generic drug applications and
 22 prioritize review of such applications when there is a drug shortage, no available comparable
 23 generic drug, or a price increase of 10% or more each year or per course of treatment. (New
 24 HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 02/20/17

References:

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2. "Behind the EpiPen Monopoly; Lobbying Muscle, Flailing Competition, Tragic Deaths," Kaiser Health News, Sept. 8, 2016. Available at <http://khn.org/news/behind-the-epipen-monopoly-lobbying-muscle-flailing-competition-and-tragic-deaths/>
3. "Price Soars for Key Weapon Against Heroin Overdoses," NPR, Sept. 10, 2015. Available at <http://www.npr.org/sections/health-shots/2015/09/10/439219409/naloxone-price-soars-key-weapon-against-heroin-overdoses>
4. "High Cost of Sovaldi Hepatitis C Drug Prompts a Call to Void Its Patents," New York Times, May 19, 2015. Available at <http://www.nytimes.com/2015/05/20/business/high-cost-of-hepatitis-c-drug-prompts-a-call-to-void-its-patents.html>
5. "The Soaring Cost of a Simple Breath," New York Times, Oct. 12, 2013. Available at <http://www.nytimes.com/2013/10/13/us/the-soaring-cost-of-a-simple-breath.html?pagewanted=all>

RELEVANT AMA POLICY

Pharmaceutical Cost H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting. (CMS Rep. 2, I-15; Reaffirmed in lieu of Res. 817, I-16)

Cost of Prescription Drugs H-110.997

Our AMA:

- (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
- (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
- (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
- (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
- (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
- (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
- (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients. (BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 530, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11)

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation. (CMS rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation A-14; Reaffirmed in lieu of Res. 229, I-14)

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs. (Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of Res. 817, I-16)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 202
(A-17)

Introduced by: Louisiana

Subject: Protect Individualized Compounding in Physicians' Offices

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Our AMA protects small practices from unfair government regulations, which could
2 limit access to care for our patients; and
3
4 Whereas, Small practices perform in-office compounding for treatments for certain patients who
5 benefit from these combinations; and
6
7 Whereas, Physicians are concerned that patients will be unable to receive needed medication if
8 small-level in-office compounding is eliminated; and
9
10 Whereas, The US Food and Drug Administration's (FDA) draft guidance on Insanitary
11 Conditions at Compounding facilities may have a significant impact on the practice of medicine;
12 and
13
14 Whereas, Our AMA noted that none of the 10 recent deaths from compounded drugs have
15 resulted from in-office physician compounding on a small scale; and
16
17 Whereas, There is pronounced frustration and concern that the FDA and Congress have not
18 addressed the negative consequences to patient access and health outcomes of limiting
19 in-office preparations of treatments; therefore be it
20
21 RESOLVED, That our American Medical Association strongly request the US Food and Drug
22 Administration (FDA) withdraw its draft guidance "Insanitary Conditions at Compounding
23 Facilities" and that no further action be taken by the agency until revisions to the USP Chapter
24 <797> on Sterile Compounding, have been finalized (Directive to Take Action); and be it further
25
26 RESOLVED, That our AMA work with the US Congress to adopt legislation that would preserve
27 physician office-based compounding as the practice of medicine and codify in law that
28 physicians compounding medications in their offices for immediate or subsequent use in the
29 management of their patients are not compounding facilities under the jurisdiction of the FDA.
30 (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/20/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 203
(A-17)

Introduced by: Missouri

Subject: AMA to Support Pharmaceutical Pricing Negotiation in US

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, The cost of medication in the US has risen by 11.3% in the last 12 months, despite
2 the inflation rate holding steady at 1%; and
3
4 Whereas, Nearly 17% of total US healthcare costs are spent on prescription medications; and
5
6 Whereas, Many previously inexpensive generics are no longer available alternatives, such as
7 the price of doxycycline increasing from 6 cents to \$3.36 per pill from 2012-2013; and
8
9 Whereas, Not surprisingly, data from the CDC shows that 1 in 10 Americans cannot afford to fill
10 their prescriptions and even more choose not to fill their prescriptions; and
11
12 Whereas, Physicians' offices spend countless hours dealing/hassling with insurance plan
13 changes, pharmacy changes, and patients' refusal to pay their increasing share of the
14 costs; and
15
16 Whereas, Buying medications from other countries is often unsafe or illegal; and
17
18 Whereas, The Federal government has already established cost setting programs on doctor and
19 hospital charges; and
20
21 Whereas, The Federal government via the Medicare Part D program, by paying a percentage of
22 costs rather than a set price, is a major contributor to the escalation of drug pricing;
23 therefore be it
24
25 RESOLVED, That our American Medical Association prioritize its support for the Centers for
26 Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable
27 medications covered by CMS. (New HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 04/25/17

RELEVANT AMA POLICY

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
 2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
- Res. 211, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 201, I-11 Appended: Res. 206, I-14
Reaffirmed: CMS Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127
(A-17)

Introduced by: Washington
Subject: Balance Billing State Regulation
Referred to: Reference Committee A
(John H. Armstrong, MD, Chair)

- 1 Whereas, Balance billing occurs when an out-of-network physician bills a patient for the
2 outstanding balance of the entire charge after the insurance company submits its portion of the
3 bill; and
4
5 Whereas, Median physician charges have been recently reported to vary greatly across the
6 nation and average 2.5 times higher than what Medicare pays (JAMA;317(3):315-317); and
7
8 Whereas, Nearly 7 in 10 of individuals with unaffordable out-of-network medical bills did not
9 know the health care provider was not in their plan's network at the time they received care; and
10
11 Whereas, The ACA requires health plans to provide coverage for out-of-network emergency
12 care services and apply in-network levels of cost sharing for emergency services, even if the
13 plan otherwise provides no out-of-network coverage; and
14
15 Whereas, CMS has issued rules to begin to address surprise medical bills for non-emergency
16 services for individuals covered by qualified health plans offered through the Health Insurance
17 Marketplace; and
18
19 Whereas, The National Association of Insurance Commissioners has proposed changes to its
20 health plan network adequacy model act to address surprise medical bills; and
21
22 Whereas, Most states are either contemplating or have passed balance billing limits or
23 mandatory dispute resolution processes between payers and providers in balance billing cases;
24 therefore be it
25
26 RESOLVED, That our American Medical Association report on the status of the various current
27 efforts across the country, including the many state legislative efforts, to limit non-Medicare
28 balance billing (Directive to Take Action); and be it further
29
30 RESOLVED, That our AMA develop model state legislation to assist its component members in
31 their advocacy efforts against current efforts to regulate balance billing (Directive to Take
32 Action); and be it further
33
34 RESOLVED, That the Board of Trustees report back to the House of Delegates at the 2017
35 Interim Meeting according to AMA Policy D-380.996. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/25/17

RELEVANT AMA POLICY

Balance Billing for All Physicians D-380.996

1. Our AMA will devote the necessary political and financial resources to introduce national legislation at the appropriate time to bring about implementation of Medicare balance billing and to introduce legislation to end the budget neutral restrictions inherent in the current Medicare physician payment structure that interferes with patient access to care.
2. This national legislation will be designed to pre-empt state laws that prohibit balance billing and prohibit inappropriate inclusion of balance billing bans in insurance-physician contracts.
3. Our AMA will develop model language for physicians to incorporate into any insurance contracts that attempt to restrict a physician's right to balance bill any insured patient.
4. Our AMA Board of Trustees will report back to our AMA House of Delegates electronically by March 15, 2008 and at every HOD meeting its progress toward the completion of all of these goals.

Res. 925, I-07

Medicare Balance Billing D-390.985

Our AMA will work on behalf of physicians to regain the right to balance bill Medicare patients for the full reasonable fees as they determine appropriate.

Res. 119, A-03 Reaffirmation A-04 Reaffirmation A-06 Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06 Modified: CMS Rep. 01, A-16

Medicare Balance Billing D-390.986

Our American Medical Association: (1) advocate that physicians be allowed to balance bill Medicare recipients to the full amount of their normal charge with the patient responsible for the difference between the Medicare payment and the physician charges; (2) seek introduction of national legislation to bring about implementation of balance billing of Medicare recipients; and (3) further advocate that such federal laws and regulations pre-empt state laws that prohibit balance billing.

Res. 713, I-02 Reaffirmation A-04 Reaffirmation A-06 Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06 Reaffirmed: CMS Rep. 5, I-12

Balance Billing H-385.991

Our AMA supports the right of the physician to balance bill a patient for any care given, regardless of method of payment, where permissible by law or contractual agreement.

Sub. Res. 128, I-83 Reaffirmed: CLRPD Rep. 1, I-93 Reaffirmed: Sub. Res. 704, A-01 Reaffirmation A-04 Reaffirmation A-05 Reaffirmation A-06 Reaffirmed per BOT Action in response to referred for decision Res. 236, A-06 Reaffirmed: CMS Rep. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 205
(A-17)

Introduced by: Washington

Subject: Limiting Medicare Part D Enrollee Costs

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Medicare Part D is a voluntary outpatient prescription drug benefit for people enrolled
2 in Medicare that covers nearly 41 million Medicare beneficiaries; and
3
4 Whereas, Medicare Part D helps to reduce out-of-pocket drug spending for enrollees, which is
5 especially important to those with modest incomes or very high drug costs; and
6
7 Whereas, Average Medicare Part D premiums are rapidly rising, more plans are charging
8 coinsurance rather than flat copayments for covered brand-name drugs, and the pace of rising
9 out-of-pocket costs for their Part D coverage is nearly double that of Part A and Part B; and
10
11 Whereas, Medicare Part D has no limiting charge or out-of-pocket limits; and
12
13 Whereas, Prescription drug plan rules frequently leave Part D enrollees without coverage, and
14 therefore exposed to excessive and sometime abusive charges; and
15
16 Whereas, Medicaid prices are set by law at the lower end of a discounted price scale or the
17 lowest price anyone is able to negotiate; and
18
19 Whereas, The VA negotiates prices, receives mandatory rebates and maintains a National Drug
20 Formulary; and
21
22 Whereas, The Medicare Modernization Act of 2003 (MMA), which established Medicare Part D,
23 included a ban on such negotiation and required Medicare to pay for all approved drugs;
24 therefore be it
25
26 RESOLVED, That our American Medical Association advocate for a Medicare Part D limiting
27 charge for prescription medications (Directive to Take Action); and be it further
28
29 RESOLVED, That our AMA advocate for a Medicare Part D annual out-of-pocket limit. (Directive
30 to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/25/17

RELEVANT AMA POLICY

Prescription Drug Prices and Medicare D-330.954

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
 2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
- Res. 211, A-04 Reaffirmation I-04 Reaffirmed in lieu of Res. 201, I-11 Appended: Res. 206, I-14
Reaffirmed: CMS Rep. 2, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 206
(A-17)

Introduced by: Washington

Subject: MACRA and the Independent Practice of Medicine

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) seeks to
2 create innovative, value-based reimbursement models; and
3
4 Whereas, Successful quality reporting will continue to be a challenge for specialties, especially
5 those that work in the hospital setting; and
6
7 Whereas, With MACRA quality reporting, physicians providing care for a sicker patient
8 population in a hospital are not differentiated clearly from outpatient providers, so that absent
9 appropriate risk adjustment methodologies, hospitalists will routinely be at a disadvantage under
10 MACRA scoring; and
11
12 Whereas, Hospitalists primarily work in groups with shift-based schedules, thus sharing care of
13 patients, and the use of individual identifiers may not be a sufficiently effective method for
14 differentiating patterns of quality in care delivery across hospital systems; and
15
16 Whereas, Hospital-based physicians have little or no influence or control over whether their
17 facility participates in an Advanced Alternative Payment Model; and
18
19 Whereas, There may be a disincentive for physicians to care for sicker patients as such patients
20 may adversely affect the physicians' quality scores; therefore be it
21
22 RESOLVED, That our American Medical Association advocate for appropriate scoring
23 adjustments for physicians treating high-risk beneficiaries in the MACRA program (New HOD
24 Policy); and be it further
25
26 RESOLVED, That our AMA study if MACRA creates a disincentive for physicians to provide
27 care to sicker Medicare patients. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/25/17

RELEVANT AMA POLICY

MIPS and MACRA Exemption H-390.838

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Res. 208, I-16

Preserving Patient Access to Small Practices Under MACRA D-390.949

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.

2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.

3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Res. 243, A-16

Developing Measures for Good Access to Care H-450.930

1. Our AMA will collaborate with the appropriate organizations to support specialty-designed measures of access to care that ensure physicians have the measures they need to be successful under the Medicare Access and Chip Reauthorization Act (MACRA).

2. Our AMA encourages the Centers for Medicare and Medicaid Services (CMS) to use specialty society-developed access to care measures for the Clinical Practice Improvement incentives rather than CMS-generated measures of access.

Res. 102, A-16

Measurement of Drug Costs to Assess Resource Use Under MACRA H-385.911

Our AMA will work with Congress and the Centers for Medicare and Medicaid Services to exempt all Medicare Part B and Part D drug costs from any current and future resource use measurement mechanisms, including those that are implemented as part of the Merit-Based Incentive Payment System or resource use measurement used by an Alternative Payment Model to assess payments or penalties based on the physician's performance and assumption of financial risk, unless a Physician Focused Alternative Payment Model (incorporating such costs) is proposed by a stakeholder organization and participation in the model is not mandatory.

Res. 218, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 207
(A-17)

Introduced by: Washington
Subject: Sky Rocketing Drug Prices
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, An analysis by *Consumer Reports* found that the practice by pharmaceutical
2 companies of raising drug prices on new and old medications is common and widespread, with
3 about 32 million Americans being adversely affected by price hikes
4 (<http://www.consumerreports.org/drugs/cure-for-high-drug-prices/>); and
5
6 Whereas, The bipartisan Senate Aging Committee Report of December 2016 describes a
7 pattern whereby pharmaceutical companies typically purchase decades-old, off-patent and
8 previously affordable drugs, and then raise prices by staggering amounts
9 (<https://www.collins.senate.gov/sites/default/files/DP%20Report.pdf>); and
10
11 Whereas, Turing raised the price of Darprim, used in treating toxoplasmosis infection, by 5,000
12 percent--from \$13.50 a pill to \$750 per pill, and Valeant raised the prices of two off-patent drugs,
13 Cuprimine and Syprine, from about \$500 to about \$24,000 for a 30-day supply; and
14
15 Whereas, Some pharmaceutical companies acquire a sole-sourced “gold standard” drug for
16 which there is a small but desperate market, with little or no action by those companies to
17 improve on the drug or invest in further development, but will create a “closed distribution
18 system” to prevent competition and raise the price of the drug; and
19
20 Whereas, An increase in drug prices can make a drug unaffordable to patients, undermining
21 their quality of life, with increases in patients’ cost share acting as a barrier to medication
22 compliance, particularly for patients who need these drugs to treat life-threatening diseases
23 such as cancer; and
24
25 Whereas, Several companies have stopped making older generic drugs on which patients have
26 come to depend, such as hydroxychloroquine, because the drugs are no longer sufficiently
27 profitable; and
28
29 Whereas, In 2015 California enacted a law capping consumers’ out of pocket drug costs at \$250
30 for a single prescription drug per month, or \$500 for certain high-deductible plans; and
31
32 Whereas, There exists a government “march-in” right whereby if there is a problem with the
33 public’s access to a drug (either a supply shortage or an exorbitant price) and if the drug was
34 developed using taxpayer money, then the Department of Health and Human Services has the
35 right to force the company to allow another manufacturer to make generic versions that are
36 cheaper for the consumer; and
37
38 Whereas, The nation’s largest insurers, Medicare and Medicaid, are not allowed to negotiate
39 prices and under federal law must pay for all approved drugs; and

1 Whereas, Prescription drugs (not including IV drugs) now comprise an estimated 9.8% of
2 national health expenditures compared to 19/9% for physician and clinical services ([Health,
3 United States, 2015, table 94](#)); and
4

5 Whereas, There is bipartisan support to incentivize entry into the market of competing generic
6 manufacturers when generic drug price increases become abusive to patient out of pocket
7 costs; and
8

9 Whereas, The higher the cost of the medication (and co-pay), the poorer the adherence to the
10 medication because patients cannot afford to take their medications; therefore be it
11

12 RESOLVED, That our American Medical Association strongly advocate for policies, regulations
13 and legislation that protect patients from sky rocketing exorbitant prices for previously affordable
14 drugs (Directive to Take Action); and be it further
15

16 RESOLVED, That our AMA advocate for an “out of pocket” maximum dollar amount for total
17 drug costs for our patients not to exceed \$500 per month. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/25/17

RELEVANT AMA POLICY

Cost of Prescription Drugs H-110.997

Our AMA:

(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;

(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;

(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;

(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;

(5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;

(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and

(7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

BOT Rep. O, A-90 Sub. Res. 126 and Sub. Res. 503, A-95 Reaffirmed: Res. 502, A-98 Reaffirmed: Res. 520, A-99 Reaffirmed: CMS Rep. 9, I-99 Reaffirmed: CMS Rep.3, I-00 Reaffirmed: Res. 707, I-02 Reaffirmation A-04 Reaffirmed: CMS Rep. 3, I-04 Reaffirmation A-06 Reaffirmed in lieu of Res. 814, I-09 Reaffirmed in lieu of Res. 201, I-11

Pharmaceutical Cost H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
 2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
 3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
 4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
 5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
 6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
 7. Our AMA supports legislation to shorten the exclusivity period for biologics.
 8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
 9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients, and will report back to the House of Delegates regarding the progress of the drug pricing advocacy campaign at the 2016 Interim Meeting.
- CMS Rep. 2, I-15 Reaffirmed in lieu of: Res. 817, I-16

Reducing Prescription Drug Prices D-110.993

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

CMS Rep. 3, I-04 Modified: CMS Rep. 1, A-14 Reaffirmation A-14 Reaffirmed in lieu of Res. 229, I-14

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
 2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
 3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
 4. Our AMA supports measures that increase price transparency for generic prescription drugs.
- Sub. Res. 106, A-15 Reaffirmed: CMS 2, I-15 Reaffirmed in lieu of: Res. 817, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 208
(A-17)

Introduced by: Medical Student Section

Subject: Housing Provision and Social Support to Immediately Alleviate Chronic Homelessness in the United States

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The January 2015 point-in-time count identified 564,708 people experiencing
2 homelessness in the United States, including 96,275 chronically homeless people;¹ and
3
4 Whereas, Homeless individuals suffer from drastically increased incidence of HIV/ AIDS,
5 tuberculosis, hepatitis, exposure-related health conditions, substance abuse, mental illness
6 (especially schizophrenia), and other chronic and infectious diseases;² and
7
8 Whereas, Homelessness creates barriers to continuity of care and adherence to prescribed
9 treatment regimens for patients, in part because of the transient and unstable nature of their
10 living situations, leading to poor management of chronic illnesses like diabetes and
11 hypertension;² and
12
13 Whereas, Homeless persons utilize a disproportionate share of health care resources, with
14 higher rates of hospitalization and emergency department use than the general population,
15 partially due to lack of access to primary and preventative care;² and
16
17 Whereas, The Housing First model of addressing chronic homelessness is an evidence-based
18 method that provides immediate, low-barrier permanent housing without treatment or behavioral
19 preconditions;³ and
20
21 Whereas, The Housing First model provides social support services, as needed on a voluntary
22 basis, to help individuals experiencing chronic homelessness remain stably housed and meet
23 behavioral health needs;³ and

¹ National Alliance to End Homelessness. The State of Homelessness in America. <http://www.endhomelessness.org/page/-/files/2016%20State%20Of%20Homelessness.pdf>. Published 2016. Accessed March 18, 2017.

² Baggett, T. and O'Connell, J. Healthcare of homeless persons in the United States. In: UpToDate, Schwenk, TL (Ed), UpToDate, Waltham, MA. Accessed March 18, 2017.

³ United States Interagency Council on Homelessness. Housing First. <https://www.usich.gov/solutions/housing/housing-first>. Updated January 17, 2017. Accessed March 18, 2017.

⁴ Sadowski, L. et al. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults. *JAMA*. 2009;300(17): 1771-1778.

⁵ Collins, S. et al. Suicidality among chronically homeless people with alcohol problems attenuates following exposure to housing first. *Suicide Life Threat Behav*. 2016 Apr 8.

⁶ Ly, A. and Latimer, E. Housing first impact on costs and associated cost offsets: a review of the literature. *Can J Psychiatry*. 2015 Nov;60(11):475-87.

⁷ Larimer, M. et al. Health Care and Public Service Use and Costs Before and After Provision of Housing for Chronically Homeless Persons With Severe Alcohol Problems. *JAMA*. 2009;301(13):1349-1357.

⁸ Tsemberis, S. et al. Housing first, consumer choice, and harm reduction for homeless individuals with a dual diagnosis. *American Journal of Public Health*. 2004 Apr;94(4):651-6.

⁹ State of Utah (2015). Comprehensive report on homelessness. <https://jobs.utah.gov/housing/scso/documents/homelessness2015.pdf>

¹⁰ Denver Human Services (2016). Denver's road home. <https://www.denvergov.org/content/denvergov/en/denver-human-services/community/denvers-road-home.html>

1 Whereas, The implementation of a Housing First approach decreased hospitalizations by 29%,
2 hospital days by 29%, and emergency department visits by 24% in homeless adults with chronic
3 medical illnesses;⁴ and

4
5 Whereas, Those who are receiving stable housing under a Housing First model experience
6 reduced severity and clinical significance of suicidal ideation;⁵ and

7
8 Whereas, The overall costs to society of implementing a Housing First model are offset by the
9 reduced costs of utilization of public services, including savings in emergency department visits,
10 hospitalizations, and housing shelter expenses;^{6,7} and

11
12 Whereas, The Housing First model has been successfully implemented in several United States
13 cities, including New York, Chicago, Denver, and Salt Lake City;^{4,8,9,10} therefore be it

14
15 RESOLVED, That our AMA amend Policy H-160.903 by addition to read as follows:

16
17 H-160.903, Eradicating Homelessness

18
19 Our American Medical Association: (1) supports improving the health outcomes and
20 decreasing the health care costs of treating the chronically homeless through clinically
21 proven, high quality, and cost effective approaches which recognize the positive impact
22 of stable and affordable housing coupled with social services; (2) will work with state
23 medical societies to advocate for legislation implementing stable, affordable housing and
24 appropriate voluntary social services as a first priority in the treatment of chronically-
25 homeless individuals, without mandated therapy or services compliance; and (3)
26 supports the appropriate organizations in developing an effective national plan to
27 eradicate homelessness. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 04/28/17

RELEVANT AMA POLICY:

Financial Barriers to Health Care Access E-11.1.4

The Mentally Ill Homeless H-160.978

Eradicating Homelessness H-160.903

Caring for the Poor H-160.961

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 209
(A-17)

Introduced by: New York

Subject: Reduce Physician Practice Administrative Burden

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Physicians have become more and more burdened with increasing federal and state
2 unfunded regulation and mandates over the past decade; and
3
4 Whereas, Electronic Health Records implementation and Meaningful Use (MU) requirements
5 that condition a portion of Medicare payment have failed to meet their intended goal of
6 facilitating improved care quality and/or clinical outcomes; and
7
8 Whereas, Quality measure reporting including Physician Quality Reporting System (PQRS) has
9 not been associated with relevant outcome measurement or improved quality; and
10
11 Whereas, The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) eliminated the
12 flawed Medicare Sustained Growth Rate formula, but it also incorporated many detrimental
13 regulatory and punitive elements on physician practices that had been included in the PQRS
14 and MU reporting systems; and
15
16 Whereas, Alternative payment models including Accountable Care Organization (ACO's),
17 Health Homes, and chronic disease management model have not consistently demonstrated
18 program savings; and
19
20 Whereas, These mandates, most of it unfunded, make it extremely difficult for a physician to
21 start his/her own practice in today's environment; and
22
23 Whereas, The increased administrative burden associated with compliance with these programs
24 imposes significant physical, mental, and financial stress on many physician practices; and
25
26 Whereas, Studies have demonstrated that these requirements significantly reduce patient-
27 physician direct contact time and interfere with the physician-patient relationship; and
28
29 Whereas, Such administrative burden reduces patient access to available physician care in
30 various care settings and models; therefore be it
31
32 RESOLVED, That our American Medical Association advocate to repeal the law that conditions
33 a portion of a physician's Medicare payment on compliance with the Medicare Merit-Based
34 Incentive Payment System (MIPS) and Alternative Payment Models (APM) programs (New
35 HOD Policy); and be it further
36
37 RESOLVED, That, should full repeal not be achievable, our AMA advocate for legislation and/or
38 regulation to significantly reduce the administrative burdens and penalties associated with
39 compliance with the MIPS and APM programs. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000
Received: 04/28/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 210
(A-17)

Introduced by: New York

Subject: Violation of HIPAA Electronic Transaction Standards by Insurer

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, When insurers deny claims improperly, physicians suffer severe financial
2 consequences--and this improper behavior by insurers needs to be recognized and stopped,
3 with penalties if possible; and
4

5 Whereas, As a prime example: A number of major insurers failed for several months to upload
6 the October 1, 2016, version of ICD-10 (which is significantly different from the original ICD-10
7 of October 1, 2015)--so that claims from those months were improperly denied and physicians
8 were forced to resubmit them; and
9

10 Whereas, Some insurers even required the physicians to appeal the claims, even though the
11 errors were the insurers'; and
12

13 Whereas, The affected practices experienced undue hardships, and the insurers should be held
14 accountable; and
15

16 Whereas, To hold the insurers accountable, it is significant to note that they were in violation of
17 the HIPAA Electronic Transaction Standards, one of which requires insurers to process claims
18 using the appropriate ICD-10 codes (if not, the insurer is "ripe for complaint"); and
19

20 Whereas, The CMS Office of E-Health Standards & Services--which, in the past, has acted on
21 other HIPAA EDI (Electronic Data Interchange) issues--has asked to be informed of these
22 violations, and has encouraged physicians to file complaints about them; therefore be it
23

24 RESOLVED, That our American Medical Association present information on ICD-10 improper
25 claim denials to the Centers for Medicare and Medicaid Services (CMS) and its Office of E-
26 Health Standards & Services, to determine whether the insurers' failure to properly update their
27 claims processing systems has constituted a violation of the HIPAA Electronic Transaction
28 Standards and should trigger disciplinary or corrective actions to prevent these occurrences in
29 the future. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/28/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 211
(A-17)

Introduced by: New York

Subject: Sale of Health Insurance Across State Lines

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, The McCarran-Ferguson Act of 1945 guides that the business of insurance be
2 regulated by individual states and that it is in the public's best interest that states regulate this
3 industry; and
4
5 Whereas, The Financial Modernization Act of 1999 (Gramm-Leach-Bliley) reaffirms that states
6 should regulate the business of insurance; and
7
8 Whereas, Individual states are more directly aligned to address and protect the consumers with
9 stringent licensing requirements, product regulations, financial regulations, and marketing
10 regulations; and
11
12 Whereas, Individual states provide essential consumer protection with the support of the
13 National Association of Insurance Commissioners (NAIC); and
14
15 Whereas, Individual states have firmly established services geared to interact with the
16 consumer, including toll-free hotlines, websites, special consumer service units, etc.; and
17
18 Whereas, Individual states are more sensitive to, and can more easily respond to, local
19 consumer needs; and
20
21 Whereas, Individual state governance of health insurance sales provides significant state
22 revenues and jobs; and
23
24 Whereas, Disruption of state regulations of health insurance sales can negatively affect doctor
25 patient relationships, promote medical tourism and disrupt the robust local provider market
26 place infrastructure; and
27
28 Whereas, Distance and breadth of interstate regulations, by far-removed-regulators, prevents
29 quick and timely legal remedies available at the state level for consumer protection via the
30 voting preferences of policy holders; therefore be it
31
32 RESOLVED, That our American Medical Association oppose federal and state legislative
33 proposals that would permit the sale of health insurance products in a state that does not
34 comply with that state's law and regulations. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/28/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 212
(A-17)

Introduced by: American College of Legal Medicine

Subject: Advocacy for Seamless Interface Between Physician Electronic Health Records, Pharmacies and Prescription Drug Monitoring Programs to be Created and Financed by the Commercial EHR and Dispensing Program Providers

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, Prescription opioid usage is at epidemic levels in the United States of America,
2 opioids having been, either alone or in combination, the cause of the unintentional deaths of too
3 many American citizens, including a number of well-known celebrities; and
4

5 Whereas, Physicians are but one component in the system of delivery wherein patients receive
6 medically necessary and appropriate drug products by way of paper or electronic prescription,
7 subsequently filled by a registered pharmacist, who provides another level of oversight to
8 assure that patients are receiving appropriate medications at appropriate doses in appropriate
9 numbers and at an appropriate dosing frequency; and
10

11 Whereas, The electronic health records (EHRs) which are now the norm for documentation of
12 health care provider encounters with patients including medications prescribed have interfaces
13 commonly linking these EHR systems with clinical laboratories, surgical pathology providers,
14 radiography providers and other clinical providers within a given hospital or health system; and
15

16 Whereas, Our AMA Policy H-95.928: Model State Legislation Promoting the Use of Electronic
17 Tools to Mitigate Risk with Prescription Opioid Prescribing states, in part: "1. Our AMA supports
18 the ability of prescription drug monitoring programs (PDMPs) to have the capability for
19 physicians to know when their patients have received a prescription for controlled substances
20 from multiple prescribers or multiple pharmacies within a short time frame" and "4. Our AMA will
21 advocate for the interoperability of state PDMPs with electronic health records (EHRs)"; and
22

23 Whereas, Our AMA Policy H-95.939, Development and Promotion of Single National
24 Prescription Drug Monitoring Program, states " Our American Medical Association (1) supports
25 the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically
26 appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly
27 integrated into the physician's normal workflow, and provide clinically relevant, reliable
28 information at the point of care; (3) supports the ability of physicians to designate a delegate to
29 perform a check of the PDMP, where allowed by state law; (4) encourages states to foster
30 increased PDMP use through a seamless registration process; (5) encourages all states to
31 determine how to use a PDMP to enhance treatment for substance use disorder and pain
32 management; (6) encourages states to share access to PDMP data across state lines, within
33 the safeguards applicable to protected health information; and (7) encourages state PDMPs to
34 adopt uniform data standards to facilitate the sharing of information across state lines"; and

1 Whereas, Our AMA Policy H-95.990 Drug Abuse Related to Prescribing Practice, Part 4, states:
2 “Our AMA opposes any federal legislation that would require physicians to check a prescription
3 drug monitoring program (PDMP) prior to prescribing controlled substances”; and
4

5 Whereas, Our AMA Task Force to Reduce Opioid Abuse has stated (in part): “When PDMPs
6 are fully funded, contain relevant, real-time data and are integrated into a workflow, they allow
7 physicians to access a patient’s prescription history for opioids and other controlled substances
8 quickly during the exam--or allow a delegate to access it prior to the exam. Determine
9 immediately whether patients received opioids and other controlled substances from other
10 providers and dispensers, both in and out of state. Evaluate and manage patients with
11 persistent pain more effectively. Create alerts when a patient reaches certain thresholds for
12 prescriptions, dosage or quantity”; and
13

14 Whereas, State Prescription Drug Databases/Prescription Drug Management Plans generally
15 interface from State to State, allowing some element of interstate monitoring of prescription drug
16 use by patients potentially crossing state lines; and
17

18 Whereas, Physicians are already overburdened with EHR and desk work¹ and should not have
19 the additional task of personally querying the PDMP with each prescription; and
20

21 Whereas, The American College of Legal Medicine is the largest specialty organization of
22 dually-degreed health care professionals and attorneys in the United States, having special
23 expertise in areas wherein medicine and law intersect, many of whom also prescribe opioids in
24 the course of direct patient care; therefore be it
25

26 RESOLVED, That our American Medical Association join the American College of Legal
27 Medicine to advocate federally-mandated interfaces between provider/dispenser electronic
28 health record systems in the clinical, hospital and pharmacy environments and state prescription
29 drug databases and/or prescription drug management plans (Directive to Take Action); and be it
30 further
31

32 RESOLVED, That our AMA advocate that the cost of generating these interfaces be borne by
33 the commercial EHR and dispensing program providers (Directive to Take Action); and be it
34 further
35

36 RESOLVED, That our AMA advocate that the interface should include automatic query of any
37 opioid prescription, from a provider against the state prescription drug database/prescription
38 drug management plan (PDMP) to determine whether such a patient has received such a
39 medication, or another Schedule II drug from any provider in the preceding ninety (90) days
40 (Directive to Take Action); and be it further
41

42 RESOLVED, That our AMA advocate that the prescriber and the patient’s EHR-listed
43 dispensing pharmacy should then be notified of the existence of the referenced patient in the
44 relevant PDMP database, the substance of the previous prescription(s) (including the
45 medication name, number dispensed and prescriber’s directions for use) in real time and prior to
46 the patient receiving such medication (Directive to Take Action); and be it further

¹ Ann. Intern. Med. 2016; 165:753-760doi1: 10.7326/M16-0961

1 RESOLVED, That our AMA advocate that the electronic record management program at the
2 pharmacy filling the relevant prescription, contemporaneously as it enters the filling of the
3 prescription by the pharmacist, likewise be required to automatically query the state PDMP as a
4 secondary mechanism to prevent inappropriate prescribing, forgery, duplication and/or too great
5 a frequency of use of the involved controlled medication (Directive to Take Action); and be it
6 further
7

8 RESOLVED, That our AMA work with ACLM and other concerned societies to urge Congress to
9 timely enact and implement such a statutory scheme supported by a workable and concise
10 regulatory framework, chiefly concentrating on the interfacing of all applicable electronic health
11 record and pharmaceutical dispensing systems with every individual state's PDMP, thereafter
12 designating a timeframe wherein all treating providers and dispensing pharmacists would be
13 required to perform such queries, in concert with the routine ordering of and filling of a controlled
14 substance to be used in the treatment of patients (Directive to Take Action); and be it further
15

16 RESOLVED, That our AMA advocate that oversight of the appropriate prescribing of and filling
17 of prescriptions for controlled substances remain with the involved individual federal and state
18 criminal law enforcement agencies, the involved state departments of health, or similar entities
19 and the involved relevant state provider and/or pharmacy licensure authorities (Directive to Take
20 Action); and be it further
21

22 RESOLVED, That our AMA advocate that statistics be maintained and reviewed on a periodic
23 basis by state PDMP personnel and relayed to state departments of health or agencies similarly
24 situated so as to identify and possibly treat those patients identified through this screening
25 mechanism as potential drug abusers and/or at risk of addiction. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/28/17

RELEVANT AMA POLICY

Model State Legislation Promoting the Use of Electronic Tools to Mitigate Risk with Prescription Opioid Prescribing H-95.928

1. Our AMA supports the ability of prescription drug monitoring programs (PDMPs) to have the capability for physicians to know when their patients have received a prescription for controlled substances from multiple prescribers or multiple pharmacies within a short time frame.
2. Our AMA will advocate to key stakeholders, including the National Association of State Controlled Substances Authorities, the National Association of Boards of Pharmacy, and the National Governors Association, to ensure that efforts to reduce Multiple Provider Events (MPEs) are done in a manner that supports continuity of care.
3. Our AMA will work with the Centers for Disease Control and Prevention (CDC), Substance Abuse and Mental Health Services Administration (SAMHSA) and other relevant federal agencies, to better understand the factors that lead to MPEs and develop medically and ethically appropriate strategies for reducing them.
4. Our AMA will advocate for the interoperability of state PDMPs with electronic health records (EHRs).
5. Our AMA will advocate for the Centers for Medicaid and Medicare Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to better incorporate feedback from physicians to focus on outcomes and focusing ONC certification on testing for product safety, security, usability, and interoperability.

BOT Rep. 03, I-16

Development and Promotion of Single National Prescription Drug Monitoring Program H-95.939

Our American Medical Association (1) supports the voluntary use of state-based prescription drug monitoring programs (PDMP) when clinically appropriate; (2) encourages states to implement modernized PDMPs that are seamlessly integrated into the physician's normal workflow, and provide clinically relevant, reliable information at the point of care; (3) supports the ability of physicians to designate a delegate to perform a check of the PDMP, where allowed by state law; (4) encourage states to foster increased PDMP use through a seamless registration process; (5) encourages all states to determine how to use a PDMP to enhance treatment for substance use disorder and pain management; (6) encourages states to share access to PDMP data across state lines, within the safeguards applicable to protected health information; and (7) encourages state PDMPs to adopt uniform data standards to facilitate the sharing of information across state lines.

BOT Rep. 12, A-15 Reaffirmed: BOT Rep. 5, I-15 Reaffirmation A-16

Drug Abuse Related to Prescribing Practices H-95.990

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.

B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;

B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;

C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and

D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. The Council on Science and Public Health will report at the 2012 Annual Meeting on the effectiveness of current drug policies, ways to prevent fraudulent prescriptions, and additional reporting requirements for state-based prescription drug monitoring programs for veterinarians, hospitals, opioid treatment programs, and Department of Veterans Affairs facilities.

4. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.

CSA Rep. C, A-81 Reaffirmed: CLRPD Rep. F, I-91 Reaffirmed: Sunset Report, I-01 Reaffirmed: CSAPH Rep. 1, A-11 Appended: Res. 907, I-11 Appended: Res. 219, A-12 Reaffirmation A-15 Reaffirmed: BOT Rep. 12, A-15 Reaffirmed: BOT Rep. 5, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 213
(A-17)

Introduced by: New York
Subject: Copying and/or Scanning Costs
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The Omnibus Rule "allows for the identification of labor costs for copying protected
2 health information whether in paper or electronic form, which can include a reasonable
3 cost-based fee for time spent creating and copying the file"; and
4
5 Whereas, In New York State the charges allowed for copying records are as follows:
6 pages 1+ : \$0.75 per page (Statute Sections 17 & 18 of Public Health Law (PHL)); and
7
8 Whereas, Public Health Law Statute Sections 17 & 18, passed in 1991, has been unchanged,
9 with enormous advancements in technology and its implementation into medical record
10 upkeep; and
11
12 Whereas, In neighboring New Jersey the charges are pages 1-100: \$1 per page, 100+: \$0.25
13 per page and a Search Fee of \$10.00; and
14
15 Whereas, Over 30 states have Search Fees which may be as high as \$82.87 (Texas); and
16
17 Whereas, Many physician practices with EMRs still have to scan their records into their system
18 before forwarding them to the requesting party; and
19
20 Whereas, More and more parties are requesting records in digital format and expect to avoid
21 the copying fee; and
22
23 Whereas, Physician practices in New York State have some of the highest costs in the nation
24 i.e., labor, taxes, etc.;
25
26 Whereas, Under the Federal HIPAA regulations, a medical practice may not impose a charge
27 for the cost of labor related to search and retrieval of patient's health information; and
28
29 Whereas, Even if New York State law could be amended to permit a search and retrieval fee,
30 such fee would nevertheless be prohibited under the Federal HIPAA regulations; and
31
32 Whereas, Accordingly, in order to change the law to permit a search and retrieval fee, it would
33 be necessary to amend the HIPAA regulations; therefore be it
34
35 RESOLVED, That our American Medical Association seek changes to the federal HIPAA
36 regulations so that charges related to providing patient records defer to state law when charges
37 to be imposed for searching, retrieval and other matters are determined. (Directive to Take
38 Action)

Fiscal Note: Modest – between \$1,000 – \$5,000
Received: 04/28/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 214
(A-17)

Introduced by: New York

Subject: Medical Liability Coverage Through the Federal Tort Claims Act

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Malpractice insurance coverage is a major expense for physicians throughout the
2 United States, but particularly in New York State; and
3
4 Whereas, The Centers for Medicare and Medicaid Services (CMS) and other federal and state
5 agencies are increasingly mandating specific measures that control the way physicians are able
6 to practice medicine; and
7
8 Whereas, The cost of providing quality health care is under tremendous scrutiny by all levels of
9 government; and
10
11 Whereas, Physicians following government quality and cost cutting measures should not incur
12 personal malpractice liability for unexpected outcomes; and
13
14 Whereas, Malpractice insurance for federally employed physicians is provided under the
15 malpractice insurance umbrella of the Federal Tort Claims Act; and
16
17 Whereas, Malpractice claims adjudicated through the Federal Tort Claims Act are
18 proportionately substantially fewer and lead to substantially lower payouts per claim than claims
19 covered by other malpractice insurance companies (especially in New York State); and
20
21 Whereas, The Medical Society of the State of New York adopted policy on this issue at the 2009
22 HOD but many more mandates have been put into effect since that time, changing the
23 landscape substantially which justifies revisiting; therefore be it
24
25 RESOLVED, That our American Medical Association seek legislation that would lead to
26 malpractice insurance coverage through the Federal Tort Claims Act for all physicians who
27 participate in Medicare and/or Medicaid and all federal insurance plans. (Directive to Take
28 Action)

Fiscal Note: Modest - \$1,000 - \$5,000

Received: 04/28/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 215
(A-17)

Introduced by: American Medical Group Association

Subject: Revisiting Exemptions for Reporting Peer-Reviewed Journal Articles and Medical Textbooks per the Sunshine Act

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, At the 2014 Annual Meeting, this House of Delegates approved Resolution 210 that
2 directed AMA to seek relief for physicians in making exempt, from the Sunshine Act's reporting
3 requirements , the provision of peer-reviewed journal articles and medical textbooks to
4 physicians; and
5
- 6 Whereas, AMA Washington Staff have worked diligently, during the length of 2014-2016, to
7 obtain administrative, then legislative relief from this unnecessary requirement; and
8
- 9 Whereas, The CMS and the Congress have both failed to administratively or legislatively
10 remedy this reporting requirement during the length of 2014 -2016, the following Whereas' of
11 Resolution 210 (A-14) have been updated to formulate the substance of this Resolution, as
12 follows:
13
- 14 Whereas, Section 6002 of the Affordable Care Act (ACA), known as the Sunshine Act, requires
15 manufacturers of drugs, devices, biological, or medical supplies under Medicare, Medicaid/CHIP
16 to report annually to the Secretary, DHHS, certain payments or other "transfers of value" to
17 physicians and teaching hospitals; and
18
- 19 Whereas, Certified and accredited continuing medical education programs are exempted from
20 these reporting requirements under the Sunshine Act; and
21
- 22 Whereas, Statutory exceptions within the Sunshine Act include "...educational materials that
23 directly benefit patients or are intended for patient use (Section 1128G(e)(10)(B)(iii))"; and
24
- 25 Whereas, The Final Rule (78 Fed Reg 9486) indicated that peer-reviewed journal articles and
26 medical textbooks (heretofore referred to as "non-exempted materials,") do not fall within the
27 statutory exceptions and thus makes the provision of these non-exempted materials to
28 physicians reportable events within the regulatory framework of the Act; and
29
- 30 Whereas, The information contained within these non-exempted materials are subjected to the
31 highest standards of medical review (i.e., peer review standards rigorously applied within these
32 non-exempted materials to ensure the integrity of the scientific process vis a vis strict standards
33 to ensure no due influence applied by outside parties such as manufacturers); and
34
- 35 Whereas, These non-exempted materials enhance a physician's direct care to patients (and,
36 therefore, are, by de facto, "educational materials that directly benefit patients..."); and
37
- 38 Whereas, Physicians should have unfettered access to the most current medical information to
39 help inform their clinical decision-making processes without concern for concomitant
40 administrative detractors, such as this particular reporting requirement in the Sunshine Act; and

1 Whereas, There are significant, costly, unnecessary and administratively time-consuming
2 difficulties inherent to tracking these non-exempted materials; and
3

4 Whereas, The value of non-exempted materials in this reportable requirement is being set at the
5 price paid by industry to acquire the reprints, which is in direct contradiction to the intent of the
6 Sunshine Act whose stated purpose is to determine the “transfer of value” to physicians and, for
7 which, there is no rational means to determine the actual value of these non-exempted
8 materials towards the care of patients; therefore be it
9

10 RESOLVED, That our American Medical Association work again, first, with the Centers for
11 Medicare and Medicaid Services (CMS) to administratively expand the Sunshine Act exception
12 (that covers “...educational materials that directly benefit patients or are intended for patient
13 use”) to include peer-reviewed journal articles and medical textbooks when provided to
14 physicians (Directive to Take Action); and be it further
15

16 RESOLVED, That if no redress is obtained from CMS, that our AMA work again, with the
17 Congress to, once and for all, legislatively expand the exception in ACA section
18 1128G(e)(10)(B)(iii) to include peer-reviewed journal articles and medical textbooks when
19 provided to physicians. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/02/17

RELEVANT AMA POLICY

Medical Textbooks and Peer-Reviewed Journal Reprints per the Sunshine Act D-140.958 - Our AMA will work, first, with the Centers for Medicare & Medicaid Services (CMS) to administratively expand the Sunshine Act exception that covers “...educational materials that directly benefit patients or are intended for patient use” to include medical textbooks and peer-reviewed journal articles provided to physicians; (given that such resources are, in fact, ‘continuing educational materials’ that assist physicians to become better informed about their clinical decision-making and thus “...directly benefit patients...”); and if no redress is obtained from CMS, our AMA will work with the Congress to legislatively expand the exception in ACA section 1128G(e)(10)(B)(iii) to include medical textbooks and peer-reviewed journal articles provided to physicians.
Res. 210, A-14

Physician Payments Sunshine Act H-140.848

1. Our AMA will continue its efforts to minimize the burden and unauthorized expansion of the Sunshine Act by the Centers for Medicare & Medicaid Services (CMS) and will recommend to the CMS that a physician comment section be included on the "Physician Payments Sunshine Act" public database.
2. Our AMA will lobby Congress to amend the Sunshine Act to limit transfer of value reporting to items with a value of greater than \$100.
Res. 233, A-12 Appended: Res. 222, A-14

A Declaration of Professional Responsibility H-140.900 - Our AMA adopts the Declaration of Professional Responsibility DECLARATION OF PROFESSIONAL RESPONSIBILITY: MEDICINE'S SOCIAL CONTRACT WITH HUMANITY

Preamble

Never in the history of human civilization has the well being of each individual been so inextricably linked to that of every other. Plagues and pandemics respect no national borders in a world of global commerce and travel. Wars and acts of terrorism enlist innocents as combatants and mark civilians as targets. Advances in medical science and genetics, while promising to do great good, may also be harnessed as agents of evil. The unprecedented scope and immediacy of these universal challenges demand concerted action and response by all.

As physicians, we are bound in our response by a common heritage of caring for the sick and the suffering. Through the centuries, individual physicians have fulfilled this obligation by applying their skills and knowledge competently, selflessly and at times heroically. Today, our profession must reaffirm its historical commitment to combat natural and man-made assaults on the health and well being of humankind. Only by acting together across geographic and ideological divides can we overcome such powerful threats. Humanity is our patient.

Declaration

We, the members of the world community of physicians, solemnly commit ourselves to: (1) Respect human life and the dignity of every individual. (2) Refrain from supporting or committing crimes against humanity and condemn any such acts. (3) Treat the sick and injured with competence and compassion and without prejudice. (4) Apply our knowledge and skills when needed, though doing so may put us at risk. (5) Protect the privacy and confidentiality of those for whom we care and breach that confidence only when keeping it would seriously threaten their health and safety or that of others. (6) Work freely with colleagues to discover, develop, and promote advances in medicine and public health that ameliorate suffering and contribute to human well-being. (7) Educate the public and polity about present and future threats to the health of humanity. (8) Advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being. (9) Teach and mentor those who follow us for they are the future of our caring profession. We make these promises solemnly, freely, and upon our personal and professional honor. CEJA Rep. 5, I-01 Reaffirmation A-07

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 216
(A-17)

Introduced by: Illinois

Subject: Electronically Prescribe Controlled Substances Without Added Processes

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The current processes by which controlled substances are prescribed differ from the
2 e-prescribing process, which provides convenience, safety and monitoring oversight of all other
3 prescribed medications; and
4
5 Whereas, These include archaic, cumbersome and error- and fraud-prone processes like paper
6 prescriptions, verbal/telephone orders and faxes; and
7
8 Whereas, The current use of multiple processes does not serve the goals of improving the
9 safety and efficiency of patient care, but rather serves the interests of those who benefit from
10 preserving the status quo; and
11
12 Whereas, The status quo adds complexity to the work of physician practices, increasing costs
13 and the risk of error as well as frustration and hassle; therefore be it
14
15 RESOLVED, That our American Medical Association advocate for full electronic prescribing of
16 all prescriptions, without additional cumbersome electronic verification, including Schedule 2-5
17 controlled substances, eliminating the need for “wet signed” paper prescriptions and faxes for
18 specific classes of prescriptions. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/01/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 217
(A-17)

Introduced by: Illinois
Subject: Inappropriate Requests for DEA Numbers
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The U.S. Drug Enforcement Administration (DEA) assigns physicians and health care
2 providers a unique number which is to be used when prescribing controlled substances; and
3
4 Whereas, The only entity authorized by the federal government to provide DEA numbers is the
5 National Technical Information Service; and
6
7 Whereas, Prescription narcotics are coming under greater scrutiny due to the number of annual
8 fatalities related to their use and abuse; and
9
10 Whereas, Illegal prescriptions could be a contributor to the problems relating to narcotic
11 misuse; and
12
13 Whereas, Federal and state governments should be enhancing efforts to make it more difficult
14 to illegally obtain narcotics; and
15
16 Whereas, The use of the DEA number has been expanded beyond its intended purpose as
17 stated above, and is often used by insurance companies and pharmacies, including mail-order
18 pharmacies, as a means of identifying providers for non-narcotic prescriptions and other
19 administrative requirements; and
20
21 Whereas, Greater accessibility of these numbers only serves to facilitate the ability to request
22 an illegal narcotic prescription; therefore be it
23
24 RESOLVED, That our American Medical Association create a national registry or database
25 where physicians can report inappropriate uses or requests for their DEA numbers (Directive to
26 Take Action); and be it further
27
28 RESOLVED, That our AMA educate or seek penalties for those entities requesting or requiring
29 use of DEA numbers outside of the prescribing of controlled substances (Directive to Take
30 Action); and be it further
31
32 RESOLVED, That our AMA encourage the federal government to monitor and shut down any
33 electronic means, including websites, that collect and distribute providers' DEA numbers, which
34 would serve to protect the public and minimize the "hassle factor" for physicians. (New HOD
35 Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/01/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 218
(A-17)

Introduced by: Illinois

Subject: Licensing of Electronic Health Records

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, Electronic health records (EHRs) have become an essential tool for physicians; and
2
3 Whereas, While federal regulations have addressed technology standards, they have
4 inadequately addressed product usability; and
5
6 Whereas, Many vendors have fallen far short of delivering user-friendly products; and
7
8 Whereas, Regulations have failed to provide effective feedback mechanisms to address
9 individual physician frustrations; and
10
11 Whereas, Patient care, convenience and safety are compromised by many current products;
12 and
13
14 Whereas, Many states license virtually every aspect of the health care ecosystem except EHRs;
15 and
16
17 Whereas, The state licensing in other industries imposes minimal requirements on products
18 (e.g., cars must have tail lights); and
19
20 Whereas, Licensed physicians and other health professionals should not be handicapped by
21 products that are ill-suited for proper care of their patients; therefore be it
22
23 RESOLVED, That our American Medical Association develop model legislation for licensing
24 electronic health records with a focus on ensuring system interoperability. (Directive to Take
25 Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/01/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 219
(A-17)

Introduced by: Medical Student Section

Subject: Integration of Drug Price Information into Electronic Medical Records

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

-
- 1 Whereas, Increasing patient shares of medication costs adversely affect patients' ability to
2 adhere to medication regimens, according to a recent literature review of 66 studies;¹ and
3
4 Whereas, Poor medication adherence has been linked to worse health outcomes and increased
5 preventable healthcare spending, estimated at an annual \$100 billion;^{1,2} and
6
7 Whereas, A study of 68 internal medicine residents revealed that only 5.9% of these physicians
8 agreed that they could access adequate cost of care information, while 86.8% agreed that better
9 knowledge of costs would change their ordering;³ and
10
11 Whereas, Increased physician awareness of drug prices changes their prescribing behavior and
12 reduces the cost burden on patients;⁴ and
13
14 Whereas, Electronic medical record point-of-care reminders have been offered as a solution to
15 containing excessive drug expenditures;⁵ and
16
17 Whereas, EMRs that incorporate drug pricing information have been shown to decrease the
18 average cost per unit of medication prescribed by over 30%, and improve adherence;^{6,7} and
19
20 Whereas, Existing AMA policies support increased drug cost containment, price transparency,
21 and awareness of patients' drug expenses through improved patient and physician education,
22 and policy reform (H-110.996, H-110.997, H-110.990, H-110.987, H-110.991 H-125.979, H-
23 110.988, H-373.998, D-330.954); and

¹ Eaddy, Michael T., Christopher L. Cook, Ken O'Day, Steven P. Burch, and C. Ron Cantrell. "How Patient Cost-Sharing Trends Affect Adherence and Outcomes: A Literature Review." *P & T: A Peer-Reviewed Journal for Formulary Management* 37, no. 1 (January 2012): 45–55.

² Marcum, Zachary A., Mary Ann Sevick, and Steven M. Handler. "Medication Nonadherence: A Diagnosable and Treatable Medical Condition." *JAMA* 309, no. 20 (May 22, 2013): 2105. doi:10.1001/jama.2013.4638.

³ Post, Jason, Darcy Reed, Andrew J. Halvorsen, Jeanne Huddleston, and Furman McDonald. "Teaching High-Value, Cost-Conscious Care: Improving Residents' Knowledge and Attitudes." *The American Journal of Medicine* 126, no. 9 (September 2013): 838–42. doi:10.1016/j.amjmed.2013.05.015.

⁴ Goetz, Celine, Stephen R. Rotman, George Hartoularos, and Tara F. Bishop. "The Effect of Charge Display on Cost of Care and Physician Practice Behaviors: A Systematic Review." *Journal of General Internal Medicine* 30, no. 6 (June 2015): 835–42. doi:10.1007/s11606-015-3226-5.

⁵ Kesselheim, Aaron S., Jerry Avorn, and Ameet Sarpatwari. "The High Cost of Prescription Drugs in the United States: Origins and Prospects for Reform." *JAMA* 316, no. 8 (August 23, 2016): 858. doi:10.1001/jama.2016.11237.

⁶ Newman, Kira L., Jay Varkey, Justin Rykowski, and Arun V. Mohan. "Yelp for Prescribers: A Quasi-Experimental Study of Providing Antibiotic Cost Data and Prescription of High-Cost Antibiotics in an Academic and Tertiary Care Hospital." *Journal of General Internal Medicine* 30, no. 8 (August 2015): 1140–46. doi:10.1007/s11606-015-3253-2.

⁷ Smith, Jaime Y., R. Scott Leslie, Bimal V. Patel, Clark Kucharski, Seth B. Joseph, and Max Sow. "E-Prescribing With Decision Support Is Associated With Improvements in Medication Adherence." *American Journal of Pharmacy Benefits* 8, no. 4 (August 17, 2016).

1 Whereas, Existing AMA policies support improvements of EMRs and electronic prescribing
2 systems, especially to increase data transparency, advance clinical practice, and better patient
3 care (H-406.987, D-120.944, G-615.035); therefore be it
4
5 RESOLVED, That our American Medical Association support the incorporation of estimated
6 patient out of pocket drug costs into electronic medical records in order to help reduce patient
7 cost burden (New HOD Policy); and be it further
8
9 RESOLVED, That our AMA collaborate with invested stakeholders, such as physician groups,
10 Electronic Medical Records (EMR) vendors, hospitals, insurers, and governing bodies to
11 integrate estimated out of pocket drug costs into electronic medical records in order to help
12 reduce patient cost burden. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 04/28/17

RELEVANT AMA POLICY:

Cost of Prescription Drugs H-110.996

Cost of Prescription Drugs H-110.997

Pharmaceutical Cost H-110.987

Price of Medicine H-110.991

Private Health Insurance Formulary Transparency H-125.979

Medical Information and Its Uses H-406.987

Improvement for Electronic Prescription Software D-120.944

Technology and the Practice of Medicine G-615.035

Drug Issues in Health System Reform H-100.964

Information Technology Standards and Costs D-478.996

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

Patient Information and Choice H-373.998

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 220
(A-17)

Introduced by: Medical Student Section
Subject: Accountability of 911 Emergency Services Funding
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, In 2011, the 19 states that submitted their call volume data to the National 911
2 Program collectively reported receiving 173,958,226 calls to 911, with responses ranging from
3 197,000 calls to 89,605,140 calls per state;¹ and
4
5 Whereas, About 70% of phone calls to 911 services are from cell phones, but the proportion of
6 911 cell phone calls that transmit location data varies depending on the service area from 10%
7 to 95% of calls made (i.e. 63% of cell phone calls to 911 in California did not transmit a location
8 in 2014);^{2,3} and
9
10 Whereas, Voice-centric 911 systems do not support text messaging, which would ease
11 communication for those with hearing or speech impairments;⁴ and
12
13 Whereas, Efforts to modernize 911 services to better serve cell phones have been impaired by
14 a lack of funding and regional coordination, which has prolonged the implementation timeline
15 and the transitional period to Next Generation 911 programs (during which legacy
16 communications capabilities must be maintained as well), thus further increasing costs;^{5,6} and
17
18 Whereas, Louisiana, Missouri and Nevada have no state-level 911 focus or coordination
19 mechanism;⁵ and
20
21 Whereas, In 2014, forty-eight states, the District of Columbia, American Samoa, the Navajo
22 Nation, and three Bureau of Indian Affairs offices collected \$2.53 billion in 911 fees and
23 charges, but eight states reported diverting or transferring 911 fees for purposes other than 911
24 services, with a total of \$223.4 million (approximately 8.8% of 911 fees collected) diverted or
25 transferred;⁷ and

¹ Review of Nationwide 911 Data Collection. National Highway Traffic Safety Administration
<http://www.911.gov/pdf/Current911DataCollection-072613.pdf>. Published July 2013.

² 911 Wireless Services. Federal Communications Commission. <https://www.fcc.gov/consumers/guides/911-wireless-services>.
Updated November 2, 2015.

³ Kelly J, Keefe B. 911's deadly flaw: Lack of location data. USA Today. <http://www.usatoday.com/story/news/2015/02/22/cellphone-911-lack-location-data/23570499/>

⁴ White Paper: A Next Generation 911 Cost Study: A Basis for Public Funding Essential to Bringing a Nationwide Next Generation 911 Network to America's Communications Users and First Responders. Federal Communications Commission. https://apps.fcc.gov/edocs_public/attachmatch/DOC-309744A1.pdf. Published September 2011.

⁵ Current State of 911 Funding and Oversight. Blue Ribbon Panel on 911 Funding. <http://www.911.gov/pdf/Current-State-911-Funding.pdf>. Published March 20, 2013.

⁶ Simpson, D. Achieving Next Generation 911 Goals. Federal Communications Commission. <https://www.fcc.gov/news-events/blog/2015/08/07/achieving-next-generation-911-goals>. Published August 7, 2015.

⁷ Seventh Annual Report to Congress: On State Collection and Distribution of 911 and Enhanced 911 Fees and Charges. Federal Communications Commission. https://transition.fcc.gov/pshs/911/Net%20911/NET911_Act_7thReport_to_Congress_123115.pdf. Published December 2015.

1 Whereas, In response to the Federal Communications Commission's 2014 report to Congress,
 2 the New Jersey Wireless Association commented that New Jersey's state and municipal Public
 3 Safety Answering Points (PSAPs) had not received any funds from the 911 Trust Fund since
 4 2009, despite those PSAPs handling the "vast majority" of 911 calls, and reported concerns that
 5 New Jersey would "never" be able to implement a new Emergency Services IP network, with
 6 only \$9,141 spent on Next Generation 911 programs in 2014;⁷ and
 7

8 Whereas, According to the Washington Association of Public-Safety Communications and
 9 National Emergency Number Association (APCO-NENA), the state of Washington has recently
 10 addressed its budget issues by "chang[ing] the language of the E911 [funding] statute to meet
 11 their funding needs," including diverting "\$2 [million for a] Department of Corrections narrow-
 12 banding radio project," "\$3.5 million . . . to fund computer system upgrades for the criminal
 13 history section of the Washington State Patrol," and "\$10.8 million to the Washington State
 14 Military Department for operating expenses";⁷ and
 15

16 Whereas, APCO-NENA has stated that the effect of the diversion of 911 funding in Washington
 17 has been to "at a minimum, extend the timeline for NG911 therefore causing additional
 18 unnecessary expenses and at a maximum, could damage the transition to the point of inability
 19 to implement";⁷ therefore be it
 20

21 RESOLVED, That our American Medical Association encourage federal guidelines and state
 22 legislation that protects against reallocation of 911 funding to unrelated services. (Directive to
 23 Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/02/17

RELEVANT AMA POLICY:

Cellular Phone Location of 911 Emergency Calls H-440.913 – The AMA encourages the development of 911 emergency cellular phone service locating systems; encourages that such locating systems be made available to the purchaser of a cellular phone for the benefit of the consumer; and urges appropriate state and federal agencies (e.g., the FCC) to facilitate universal access to 911 services via cellular telephones. Res. 421, A-96 Res. 223, A-97 Reaffirmed: CSAPH Rep. 3, A-07

[See also:](#)

The Future of Emergency and Trauma Care D-130.971 Trauma Center Efficacy H-130.977

Standards of Care During a Mass Casualty Event D-130.968

AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946

On-Site Emergency Care H-130.976

Emergency Preparedness D-130.974

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 221
(A-17)

Introduced by: New York
Subject: AMA Policy on American Health Care Act
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The United States healthcare system has been in a state of flux since the introduction
2 of PPACA; and
3
4 Whereas, The AMA chose to support PPACA in its early stages so that physicians could have
5 “a seat at the table” as policies were being negotiated; and
6
7 Whereas, The newly elected Congress and President of the United States recently proposed
8 the American Healthcare Act (AHCA), intended to replace PPACA; and
9
10 Whereas, Physicians and patients would benefit from having the AMA maintain its “seat at the
11 table” as any alternative to PPACA is developed; therefore be it
12
13 RESOLVED, That our American Medical Association engage in negotiations with the current
14 leadership of the United States to craft healthcare policy that is in keeping with AMA values.
15 (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/01/17

RELEVANT AMA POLICY

Evaluating Health System Reform Proposals H-165.888

1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
 - A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
 - B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
 - C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
 - D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
 - E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
 - F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
 - G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
 - H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and

substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.

Health System Reform Legislation H-165.838

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:

- a. Health insurance coverage for all Americans
- b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
- c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
- d. Investments and incentives for quality improvement and prevention and wellness initiatives
- e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
- f. Implementation of medical liability reforms to reduce the cost of defensive medicine
- g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange 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.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:

- a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
- b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
- c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
- d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
- e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
- f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.

See also:

Comprehensive Health System Reform H-165.847

Comprehensive Health System Reform H-165.841

Amend the Patient Protection and Affordable Care Act (PPACA) H-165.833

Universal Health Coverage H-165.904

Ensuring Quality in Health System Reform H-450.946

Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care D-165.935

Preventive Medical Care Coverage for All H-165.840

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 222
(A-17)

Introduced by: Oklahoma

Subject: Response to Burdensome Governmental Mandate

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The Centers for Medicare and Medicaid Services (CMS) replaced Meaningful Use,
2 Physician Quality Reporting System (PQRS), and the Value Based Modifier with the Merit
3 Based Incentive Payment System (MIPS); and
4
5 Whereas, MIPS was promised to be a simplified and more relevant payment and regulatory
6 program that would allow physicians to focus on quality and efficient care; and
7
8 Whereas, MIPS as promulgated by CMS is burdensome on physicians and an impediment to
9 high quality and efficient patient care; therefore be it
10
11 RESOLVED, That our American Medical Association, in the interest of patients and physicians,
12 encourage the Centers for Medicare and Medicaid Services, Congress and the Trump
13 Administration to revise the Merit Based Incentive Payment System to a simplified quality and
14 payment system, with significant input from practicing physicians, that focuses on easing
15 regulatory burden on physicians, allowing physicians to focus on quality patient care. (New HOD
16 Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/02/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 223
(A-17)

Introduced by: California

Subject: Tax Deductions for Direct-to-Consumer Advertising

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Direct-to-consumer (DTC) advertising spending by pharmaceutical companies has
2 risen sharply from \$791 million in 1999 to \$4.8 billion in 2006; and
3
- 4 Whereas, An analysis estimates that for every \$1 spent on DTC, advertising sales increase by
5 \$4.20, eliciting concerns that investing in advertising may undermine research and development
6 (R&D); and
7
- 8 Whereas, The three United States pharmaceutical companies that spend the most on R&D
9 spend on average 15.1% of their revenue on R&D; and
10
- 11 Whereas, A study that analyzed clopidogrel costs and utilization before and after
12 implementation of a \$350 million, 4-year DTC advertising campaign found that DTC advertising
13 did not significantly change the number of units dispensed per 1000 enrollees, and that there
14 was a statistically significant, sustained increase in cost per unit that resulted in an additional
15 \$207 million in total pharmacy expenditures; and
16
- 17 Whereas, Patients who see DTC advertising are more likely to discuss specific medications with
18 their doctor, and evidence suggests that patient requests impact physician decisions and may
19 lead to over-prescribing and/or inappropriate prescribing; and
20
- 21 Whereas, U.S. prescription pharmaceutical sales in 2014 totaled \$373.9 billion, an increase of
22 13.1% from the previous year; and
23
- 24 Whereas, DTC advertising is banned in all developed nations except for the United States and
25 New Zealand; and
26
- 27 Whereas, Despite multiple AMA resolutions that support banning DTC advertising for
28 prescription drugs, controlled drugs, and medical devices, DTC marketing persists to this day;
29 and
30
- 31 Whereas, The Internal Revenue Code states that “ordinary and necessary” business expenses
32 are tax deductible, permitting pharmaceutical companies to deduct DTC advertising costs for
33 prescription medications; and
34
- 35 Whereas, Removing pharmaceutical company tax incentives for DTC advertising will further
36 discourage the practice without infringing upon First Amendment rights and increase
37 government revenue; and

1 Whereas, In 2009, Congress unsuccessfully attempted twice to remove tax deductions for
2 pharmaceutical DTC advertising and projected \$37 billion in government tax revenue over 10
3 years; therefore be it
4

5 RESOLVED, That our American Medical Association support legislation to prohibit costs for
6 direct-to-consumer advertising of prescription medications, medical devices, and controlled
7 drugs to be considered deductible business expenses for tax purposes. (New HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 05/03/17

RELEVANT AMA POLICY

Direct-to-Consumer Advertising (DTCA) of Prescription Drugs and Implantable Devices H-105.988

... 11. That our AMA supports eliminating the costs for DTCA of prescription drugs as a deductible business expense for tax purposes. ...

BOT Rep. 38 and Sub. Res. 513, A-99 Reaffirmed: CMS Rep. 9, Amended: Res. 509, and Reaffirmation I-99 Appended & Reaffirmed: Sub. Res. 503, A-01 Reaffirmed: Res. 522, A-02 Reaffirmed: Res. 914, I-02 Reaffirmed: Sub. Res. 504, A-03 Reaffirmation A-04 Reaffirmation A-05 Modified: BOT Rep. 9, A-06 Reaffirmed in lieu of Res. 514, A-07 BOT Action in response to referred for decision: Res. 927, I-15 Modified: BOT Rep. 09, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 224
(A-17)

Introduced by: California
Subject: Medicare Prepayment and RAC Audit Reform
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Medicare Administrative Contractors (MACs) are increasingly using prepayment
2 audits to unnecessarily postpone/deny payment of claims and hassle physicians; and
3
4 Whereas, The current web-based system for submitting appeals is prone to error and cannot be
5 relied upon, resulting in the need to submit appeals/supporting documentation by U.S. mail
6 return receipt; and
7
8 Whereas, MACs currently advise against sending in documents for more than one Date of
9 Service at a time as there have been several instances where grouped appeals have been
10 overlooked/lost and this results in duplication of supporting documents; and
11
12 Whereas, Reviewers of claims frequently interpret Medicare LCDs and NCDs in ways that are
13 contradictory to nationally published guidelines, thereby forcing physicians into an appeal
14 process that may take up to two years to reverse; and
15
16 Whereas, In contrast to RAC audits, prepayment audits have minimal regulations to control
17 overly aggressive review; and
18
19 Whereas, This results in physicians using more Advanced Beneficiary Notices (ABNs) which
20 unfairly increases the cost of health care to patients; and
21
22 Whereas, Nearly half of the RAC audit findings are overturned by an Administrative Law Judge
23 when a physician appeals which demonstrates that the program is not working; and
24
25 Whereas, Medicare may unfairly recoup alleged physician overpayments prior to the final
26 determination of a physician appeal which does not provide due process for physicians; and
27
28 Whereas, Medicare uses an extrapolation formula to determine the number of overpayments
29 that is not based on a statistically valid number of claims and it includes outliers; and
30
31 Whereas, Physicians are not reimbursed for excessive and costly documentation requests; and
32
33 Whereas, Penalties should be imposed on auditors for inaccurate findings to ensure there is
34 more accountability on the auditors, and auditors should be incentivized to educate physicians
35 so there is opportunity for physicians to be appropriately educated about billing mistakes, if any;
36 therefore be it

1 RESOLVED, That our American Medical Association formally request that Medicare employ
2 rules for prepayment audits that are at least as protective as the Random Audit Contractor
3 (RAC) rules for physicians, and that our AMA continue to advocate for reforms to the audit
4 process, including giving great weight to the treating physician's determination of medical
5 necessity (Directive to Take Action); and be it further
6

7 RESOLVED, That our AMA propose to Medicare that there be a mechanism by which
8 prepayment audit denials can be resolved via the telephone or other electronic communications
9 (Directive to Take Action); and be it further
10

11 RESOLVED, That our AMA continue its current legislative and regulatory efforts to reform the
12 Medicare RAC and Prepayment Audit process for physicians by eliminating or improving the
13 extrapolation formula, requiring physician reviewers within the same subspecialty, providing
14 payment for costly documentation requests, prohibiting recoupment of physician payment until
15 the appeals process is final, imposing penalties on auditors for inaccurate findings, and
16 incentivizing the auditors to perform more physician education. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/03/17

RELEVANT AMA POLICY

Creating a Fair and Balanced Medicare and Medicaid RAC Program D-320.991

1. Our AMA will continue to monitor Medicare and Medicaid Recovery Audit Contractor (RAC) practices and recovery statistics and continue to encourage the Centers for Medicare and Medicaid Services (CMS) to adopt new regulations which will impose penalties against RACs for abusive practices.

2. Our AMA will continue to encourage CMS to adopt new regulations which require physician review of all medical necessity cases in post-payment audits, as medical necessity is quintessentially a physician determination and judgment.

3. Our AMA will encourage CMS to discontinue the denial of payments or imposition of negative action during an audit due to the absence of specific words in the chief complaint when the note provides adequate documentation of the reason for the visit and services rendered.

4. Our AMA will assist states by providing recommendations regarding state implementation of Medicaid RAC rules and regulations in order to lessen confusion among physicians and to ensure that states properly balance the interest in overpayment and underpayment audit corrections for Recovery Contractors.

5. Our AMA will petition CMS to amend CMS' rules governing the use of extrapolation in the RAC audit process, so that the amended CMS rules conform to Section 1893 of the Social Security Act Subsection (f) (3) - Limitation on Use of Extrapolation; and insists that the amended rules state that when an RAC initially contacts a physician, the RAC is not permitted to use extrapolation to determine overpayment amounts to be recovered from that physician by recoupment, offset, or otherwise, unless (as per Section 1893 of the Social Security Act) the Secretary of Health and Human Services has already determined, before the RAC audit, either that (a) previous, routine pre- or post-payment audits of the physician's claims by the Medicare Administrative Contractor have found a sustained or high level of previous payment errors, or that (b) documented educational intervention has failed to correct those payment errors.

6. Our AMA, in coordination with other stakeholders such as the American Hospital Association, will seek to influence Congress to eliminate the current RAC system and ask CMS to consolidate its audit systems into a more balanced, transparent, and fair system, which does not increase administrative burdens on physicians.

7. Our AMA will: (A) seek to influence CMS and Congress to require that a physician, and not a lower level provider, review and approve any RAC claim against physicians or physician-decision making, (B) seek to influence CMS and Congress to allow physicians to be paid any denied claim if appropriate services are rendered, and (C) seek the enactment of fines, penalties and the recovery of costs incurred in defending against RACs whenever an appeal against them is won in order to discourage inappropriate and illegitimate audit work by RACs.

8. Our AMA will advocate for penalties and interest to be imposed on the auditor and payable to the physician when a RAC audit or appeal for a claim has been found in favor of the physician.

Res. 215, I-11 Appended: Res. 209, A-13 Appended: Res. 229, A-13 Appended: Res. 216, I-13 Reaffirmed: Res. 223, I-13 Appended: Res. 213, I-16

Medicare Prepayment and Postpayment Audits H-330.921

1. AMA policy is that with respect to prepayment and postpayment audits by the Medicare program, the following principles guide AMA advocacy efforts:

- (a) The confidential medical record should be preserved as an instrument of clinical care, with strong confidentiality protections and, we oppose its use as an accounting document;
- (b) CMS should discontinue random prepayment audits of E&M services;
- (c) In lieu of prepayment audits, CMS should use focused medical review of outliers based on reviews of patterns of services, using an independent medical peer review process, where physicians practicing in the same specialty, review their peers;
- (d) No financial or legal penalties should be assessed based on one level of disagreement in E&M code assignment; and
- (e) CMS must stop the practice of requiring physicians to repay alleged Medicare overpayments before an actual appeal is rejected or a final administrative decision or a court order is rendered. Legislative relief will be sought if advocacy with CMS is not successful in this regard.

2. Our AMA advocates that all government recovery programs contain complete physician access to any data mining criteria and programs, that there is same-specialty/same-subspecialty physician review prior to denial of claims, and that any denial of claims be based on medical necessity review as determined by that same-specialty/same-subspecialty physician reviewer, and will explore options for increased reimbursement of physician costs related to government audits, including remedies available through the Equal Access to Justice Act.

3. Our AMA supports the enactment of federal legislation that requires fairness in the practice of conducting physicians' post-payment audits as contained in paragraph 1 above, and which would include the following:

- (a) The requirement for such audits to be reviewed by a physician board certified within the same specialty prior to any requirement for repayment by the audited physician
- (b) The requirement for the repayment to be placed in escrow until the appeals process is complete
- (c) The removal of any incentives that are based upon a percentage of recovery for contracted government auditors
- (d) The establishment of a mechanism for recovery of a practice's legal fees incurred for unsuccessful audits
- (e) The full disclosure of contract terms with audit contractors

Sub. Res. 801, A-98 Reaffirmed: Res. 804, I-98 Reaffirmed: Sub. Res. 815, I-00 Res. 815, I-09 Res. 816, I-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 225
(A-17)

Introduced by: Minority Affairs Section
Subject: Truth in Advertising
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, A June 2014 study by the American Medical Association found that 22% of patients
2 believe that a chiropractor is a medical doctor, Thirty five percent of patients believe that a
3 doctor of nursing practice is a medical doctor. Thirty percent of patients believe that a
4 psychologist is a medical doctor. Forty-two percent of patients believe that an optometrist is a
5 medical doctor, and seventy-four percent of patients believe a podiatrist is a medical doctor; and
6
7 Whereas, There are widespread differences regarding the training and qualifications required to
8 earn specialty and subspecialty certifications. There are differences in training and skills are
9 necessary to correctly detect, diagnose, and treat serious healthcare conditions that are
10 common in specialized care; and
11
12 Whereas, The increased public knowledge of board certification has resulted in the creation of
13 22 fake boards for profit or solely for the creation of credentials; and
14
15 Whereas, an April 2012 article in "Forbes" magazine notes that 41 percent of physicians would
16 choose a different specialty if they could make the choice over again, and a lack of professional
17 satisfaction may lead physicians to drastically change their practice specialty; therefore be it
18
19 RESOLVED, That our American Medical Association support clarity and truth in advertising by
20 requiring physicians to fully disclose board certification status, medical license restrictions as
21 permitted by law, residency and fellowship status, particularly with vulnerable patients such as
22 those treated in confined settings such as locked mental health institutions and correctional
23 settings and encourage restricting the use of the title "doctor" in closed settings to only medical
24 doctors. (New HOD Policy)

Fiscal Note: Minimal - less than \$1,000

Received: 05/03/17

References:

¹ Forbes Magazine (2012) "Why Do So Many Doctors Regret Their Job Choice?"
URL: <http://www.forbes.com/sites/susanadams/2012/04/27/why-do-so-many-doctors-regret-their-job-choice/#27404f677dab>

² Wisconsin Medical Society Policies:
PHY-015: Truth in Advertising; URL: <https://www.wisconsinmedicalsociety.org/policies/phy-015-truth-in-advertising/>

RELEVANT AMA POLICY

Physician Practice Drift H-410.951

Our AMA will: (1) continue to work with interested state and national medical specialty societies to advance truth in advertising legislation, and (2) continue to monitor legislative and regulatory activity related to physician practice drift.

BOT Rep. 5, A-13

Truthful Specialty Information H-405.985

Our AMA: (1) reaffirms its policy that: (a) individual character, training, competence, experience and judgment be the criteria for granting privileges in hospitals; (b) physicians representing several specialties can and should be permitted to perform the same procedures if they meet these criteria; (c) a physician who acquires new skills as a result of additional education or training should be given individual evaluation and the same consideration as a new physician applying for privileges; and (2) believes that advertising by physicians should comply with ethical opinion 5.02 of the Council of Ethical and Judicial Affairs.

Sub. Res. 11, I-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CME Rep. 2, A-10

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 226
(A-17)

Introduced by: Ohio

Subject: Direct American Medical Association to Ask CMS and HHS to Remove Practice Expense and Malpractice Expense from Publicly Reported Payments

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, The Centers for Medicare & Medicaid Services (CMS) annually releases physician
2 reimbursement to the public; and
3
4 Whereas, This information is widely quoted by the media, lawmakers, and others, and believed
5 to represent physician income; and
6
7 Whereas, Practice expense and malpractice expense are included in the publicly-quoted
8 amounts; and
9
10 Whereas, Practice expense and malpractice expense are rigorously determined and reviewed
11 by the American Medical Association Relative Value Update Committee, with CMS input, and
12 then approved by CMS and published in the federal register; and
13
14 Whereas, CMS maintains, and is aware of all the components of physician reimbursement, and
15 this data is publicly available on its web site; and
16
17 Whereas, This reimbursement is for overhead and is not income to the physician; and
18
19 Whereas, CMS has removed other practice expenses from the publicly-released data, such as
20 the cost of some office-administered drugs; and
21
22 Whereas, Practice expense and malpractice expense can account for over 50% of the value of
23 many services, including evaluation and management visits, and falsely inflates the income of
24 all physicians; therefore be it
25
26 RESOLVED, That our American Medical Association petition the Centers for Medicare &
27 Medicaid Services and the Office of Health & Human Services to remove practice expense and
28 malpractice expense from reimbursements reported to the public. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/03/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 227
(A-17)

Introduced by: Ohio

Subject: Improving Clinical Utility of Medical Documentation

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, Regulatory guidelines associate reimbursement with the presence of certain
2 quantities of components in documentation (e.g. review of systems, physical exam), even when
3 not clinically relevant; and
4
5 Whereas, Providers are encouraged to document more components, which can lead to copy
6 and pasting, leading to inaccuracies in documentation¹; and
7
8 Whereas, A survey of 1515 trainees in 24 specialties showed that 92% felt that documentation
9 obligations are excessive and 73% felt that this has had a negative impact on patient care²; and
10
11 Whereas, An observational study found physicians were most likely to first read the History and
12 Physical and Assessment and Plan components of a clinical document, suggesting the
13 non-utility of many components of current notes³; and
14
15 Whereas, Reimbursement mechanisms are more likely to emphasize value over quantity of care
16 in the future; therefore be it
17
18 RESOLVED, That our American Medical Association advocate for appropriate, effective, and
19 less burdensome requirements in the use of electronic health records. (Directive to Take Action)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/03/17

¹ Weis JM, Levy PC. Copy, paste, and cloned notes in electronic health records; prevalence, benefits, risks, and best practice recommendations. *Chest*. 2014;145(3):632-638. doi:10.1378/chest.13-0886.

² Christino MA, Matson AP, Fischer SA, Reinert SE, Digiovanni CW, Fadale PD. Paperwork versus patient care: a nationwide survey of residents' perceptions of clinical documentation requirements and patient care. *J Grad Med Educ*. 2013;5(4):600-604. doi:10.4300/JGME-D-12-00377.1.

³ Rizvi RF, Harder KA, Hultman GM, et al. A comparative observational study of inpatient clinical note-entry and reading/retrieval styles adopted by physicians. *Int J Med Inform*. 2016;90(2016):1-11. doi:10.1016/j.ijmedinf.2016.02.011.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 228
(A-17)

Introduced by: Maryland
Subject: Free Speech Applies to Scientific Knowledge
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The definition of science is “The intellectual and practical activity encompassing the
2 systematic study of the structure and behavior of the physical and natural world through
3 observation and experiment”;¹ and
4
5 Whereas, Science has been, is, and continues to be critical in advancing our knowledge in such
6 areas such as medications, vaccines, and climate change and can save lives;²⁻⁴ and
7
8 Whereas, The First Amendment of the U.S. is “Congress shall make no law abridging the
9 freedom of speech, or of the press”;⁵ and
10
11 Whereas, Scientific integrity policies are in place at multiple scientific agencies which were
12 initially put in place via a presidential memorandum instituted in 2009 that states “Political
13 officials should not suppress or alter scientific or technological findings and conclusions” and “If
14 scientific and technological information is developed and used by the Federal Government, it
15 should ordinarily be made available to the public”;⁶ and
16
17 Whereas, Currently there are no legal consequences for violating these scientific integrity
18 policies;⁷ and
19
20 Whereas, Recent policy changes suggest that disseminating scientific knowledge to the public
21 may be impeded⁸ which could have important public, policy, and ethical ramifications;⁹⁻¹⁰
22 therefore be it
23
24 RESOLVED, That our American Medical Association work with members of the U.S. Congress
25 and the Trump Administration to assure that scientific knowledge, data, and research will
26 continue to be protected and freely disseminated in accordance with the U.S. First Amendment
27 (Directive to Take Action); and be it further
28
29 RESOLVED, That our AMA oppose any federal policies, orders, laws, or directives that alter or
30 prevent the free dissemination of scientific and technological information and research that is by
31 right and law the property of the American people and support legal proceedings in opposition to
32 violations of scientific integrity policies. (New HOD Policy)

Fiscal Note: Modest - between \$1,000 - \$5,000

Received: 05/03/17

References:

¹ U.S. Constitution: First Amendment. https://www.law.cornell.edu/constitution/first_amendment. Accessed 25 January 2017.

² Understanding Science: how science *really* works: What has science done for you

lately? http://undsci.berkeley.edu/article/whathassciencedone_01. Accessed 25 January 2017.

³ Five Important Reasons to Vaccinate Your Child. https://www.vaccines.gov/more_info/features/five-important-reasons-to-vaccinate-your-child.html. Accessed 25 January 2017.

⁴ NASA. Global Climate Change: Vital Signs of the Planet: Facts. <http://climate.nasa.gov/evidence/>. Accessed 25 January 2017.

⁵ U.S. Constitution: First Amendment. https://www.law.cornell.edu/constitution/first_amendment. Accessed 25 January 2017.

⁶ American Institute of Physics. Obama Signs Presidential Memorandum on Scientific Integrity. <https://www.aip.org/fyi/2009/obama-signs-presidential-memorandum-scientific-integrity>. Accessed 25 January 2017.

⁷ Koerth-Baker M. Trump Finds the Weak Spot in Obama's Protections for Scientists. <https://fivethirtyeight.com/features/trump-finds-the-weak-spot-in-obamas-protections-for-scientists/>. Accessed 25 January 2017.

⁸ Stein S, Sheppard K. Federal Workers Told to Halt External Communication in First Week under Trump. http://www.huffingtonpost.com/entry/trump-communication-freeze_us_58878b3ae4b0441a8f7114e2. Accessed 25 January 2017.

⁹ AAAS. AAAS Responds to Moves to Halt EPA and USDA Public Communications. https://www.aaas.org/news/aaas-responds-moves-halt-epa-and-usda-public-communications?utm_source=twitter&utm_medium=news_tweet_button&utm_content=aaas-responds-moves-halt-epa-and-usda-public-communications&utm_campaign=aaasorg_news. Accessed 25 January 2017.

¹⁰ Sunlight Foundation. Reports of Federal Government Agencies Directed Not to Communicate with the American Public. <https://sunlightfoundation.com/list-of-federal-government-agencies-told-not-to-communicate-with-the-public/>. Accessed 25 January 2017.

RELEVANT AMA POLICY

Freedom of Speech in Medical Information H-475.987

The AMA opposes the Multi-District Litigation (MDL) pertaining to pedicle screws because it impedes the progress of medical science and the availability of the highest quality care for patients; and opposes any and all actions that interfere with the free and unfettered exchange of medical information.

Res. 510, A-97 Reaffirmed: CSAPH Rep. 2, A-08

National Human Genome Research Institute H-460.962

Our AMA endorses the scientific and medical objectives of the National Human Genome Research Institute and asks appropriate medical and scientific organizations to (1) encourage worldwide support, including monetary support, of advances in human genome research; (2) promote the free and open exchange of sequence information among nations; and (3) express their hope that the information obtained from this international scientific research effort will be used solely for the benefit of mankind.

Res. 279, A-90 Reaffirmed: Sunset Report, I-00 Modified: CSAPH Rep. 1, A-10

See also:

University-Industry Cooperative Research Ventures H-460.981

Government Interference in Patient Counseling H-373.995

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 229
(A-17)

Introduced by: American Academy of Facial Plastic and Reconstructive Surgery
American Academy of Neurology
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Society for Gastrointestinal Endoscopy
American Society of Echocardiography
American Society of Neuroimaging
American Urological Association
Congress of Neurological Surgeons
North American Spine Society
Society for Cardiovascular Angiography and Interventions
American Society of Plastic Surgeons

Subject: Medicare's Appropriate Use Criteria Program

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The Protecting Access to Medicare Act (PAMA) of 2014 (P.L. 113-93) requires
2 clinicians to consult Appropriate Use Criteria (AUC) prior to ordering certain advanced
3 diagnostic imaging services; and
4

5 Whereas, The RAND evaluated the Medicare appropriate use criteria (AUC) imaging
6 demonstration conducted by the Centers for Medicare and Medicaid Services (CMS) from
7 October 2011 through September 2013 and found a large proportion of orders could not be
8 linked to any criteria when providers entered patient characteristics into Clinical Decision
9 Support Mechanisms (CDSMs);¹ and
10

11 Whereas, The RAND recommended against expanding the use of AUC for imaging services to
12 a broader population of Medicare beneficiaries;² and
13

14 Whereas, The Government Accountability Office (GAO) identified several issues that are key to
15 the effective implementation of the imaging AUC program or any future expansion of the
16 program, including, but not limited to, designing CDSMs for ease of use; ensuring provider
17 confidence in appropriateness ratings and their underlying evidence; and allowing sufficient
18 preparation time for implementation,³ and

¹ Timbie et. al. Medicare Imaging Demonstration Final Evaluation: Considerations for Expansion of the Appropriate Use Criteria Program, RAND Corporation; 2014. http://www.rand.org/content/dam/rand/pubs/research_reports/RR700/RR706/RAND_RR706.pdf

² Id.

³ Considerations for Expansion of the Appropriate Use Criteria Program. United States Government Accountability Office Report to Congress; GAO-15-816. Sept. 2015. <http://www.gao.gov/assets/680/672856.pdf>

1 Whereas, The GAO reported that providers who participated in the AUC imaging demonstration
2 noted that all phases of the demonstration were too short to address the large number of
3 challenges related to successfully engaging providers and staff, aligning existing and new
4 workflow patterns, and introducing providers and staff to the CDSM software and guidelines.
5 The GAO furthermore reported that efforts to move forward rapidly during the demonstration
6 were confounded by CDSM software challenges beyond the control of participants and their
7 practices;⁴ and

8
9 Whereas, CMS has stated that qualification of CDSMs before June 30, 2017 is not feasible⁵;
10 and

11
12 Whereas, CMS has stated that it expects to implement the AUC consultation and reporting
13 requirements under section 1834(q)(4)(A) and (B) of the PAMA on January 1, 2018⁶, allowing
14 six months for clinicians to acquire and implement in their practices a CDSM; and

15
16 Whereas, Section 1834(q)(1)(C) of PAMA defines the applicable imaging services for which
17 AUC consultation is required as those for which there is at least one free mechanism available
18 for AUC consultation; and

19
20 Whereas, CMS recognizes it is more likely that CDSMs available free of charge may initially
21 begin as web-based tools⁷; and

22
23 Whereas, The GAO notes that in the AUC imaging demonstration, providers using web-based
24 or stand-alone software applications experienced frustration with the lack of integration between
25 the CDSM and their electronic health record (EHR) system and experienced workflow
26 inefficiencies⁸; and

27
28 Whereas, The acquisition and implementation of a CDSM that integrates with the clinician's
29 EHR system may be cost prohibitive or hampered by EHR vendor readiness, thereby increasing
30 administrative burden on clinicians who must use a free web-based tool to consult AUC; and

31
32 Whereas, CMS has acknowledged the number of clinicians affected by the program is
33 "massive," crossing almost every medical specialty and having a particular impact on primary
34 care physicians since their scope of practice can be vast⁹; and

35
36 Whereas, The PAMA directs CMS to require, beginning Jan. 1, 2020, prior authorization for
37 ordering professionals who are identified as outliers in AUC adherence; and

38
39 Whereas, Prior authorization for advanced imaging services is a contradiction to established
40 AMA policy against the use of prior authorization in other parts of the Medicare program¹⁰; and

⁴Considerations for Expansion of the Appropriate Use Criteria Program. United States Government Accountability Office Report to Congress; GAO-15-816. Sept. 2015. <http://www.gao.gov/assets/680/672856.pdf>

⁵ Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80419

⁶ Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80419; pg. 80425

⁷ Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80414.

⁸Considerations for Expansion of the Appropriate Use Criteria Program. United States Government Accountability Office Report to Congress; GAO-15-816. Sept. 2015. <http://www.gao.gov/assets/680/672856.pdf>

⁹ Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule. CMS-1654-F. Federal Register/Vol. 81, No. 220; pg. 80424

¹⁰ AMA Policy D-330.933; <https://searchpf.ama-assn.org/SearchML/searchDetails.action?uri=%2FAMADoc%2Fdirectives.xml-0-1071.xml>

1 Whereas, The Medicare AUC Program is expected to be implemented in 2018 during the
2 continued transition to the new Quality Payment Program, which requires significant clinician
3 practice resources; and
4

5 Whereas, The AUC Program is an independent, stand-alone program that is largely
6 unnecessary since AUC consultation is inherent within the Merit-Based Incentive Payment
7 System and alternative payment models, both which hold clinicians accountable for quality and
8 patient outcomes, as well as for resource use, including the use of diagnostic tests and
9 procedures; and
10

11 Whereas, The Medicare AUC Program lacks a patient outcomes or quality component;
12 therefore be it
13

14 RESOLVED, That our American Medical Association advocate to delay the effective date of the
15 Medicare AUC Program until the Centers for Medicare & Medicaid can adequately assess how
16 the Quality Payment Program affects the use of advanced diagnostic imaging (Directive to Take
17 Action); and be it further
18

19 RESOLVED, That our AMA call upon Congress and the Administration to revisit the necessity
20 and value of the Medicare AUC Program given the establishment of the Quality Payment
21 Program. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/09/17

RELEVANT AMA POLICY

Restoring High Quality Care to the Medicare Part D Prescription Drug Program D-330.933

Our AMA will:

- a. work to eliminate prior authorizations under the Medicare Part D Prescription Drug Program which undermine a physician's best medical judgment;
- b. work with the Centers for Medicare and Medicaid Services (CMS) to enforce the Medicare Part D Prescription Drug Program statutory requirement that all Part D plans include at least two drugs proven to be equally effective in each therapeutic category or pharmacologic class, if available, to be used by the physician in deciding the best treatment options for their patients;
- c. work with CMS to place reasonable copays in the Medicare Part D Prescription Drug Program;
- d. work with other interested parties to simplify the CMS prior authorization process such that a diagnosis or reason written on the prescription should be accepted as documentation for non formulary request; and
- e. work with CMS to develop a one-page form for physicians and patients to utilize in appealing a prescription coverage denial.

Res. 106, A-07 Reaffirmation A-08 Reaffirmation A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 230
(A-17)

Introduced by: Michigan

Subject: CMS Reimbursement Guidelines for Teaching Physician Supervision

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, To submit a claim for a minor procedure, defined as requiring less than five minutes,
2 the Centers for Medicare and Medicaid Services (CMS) requires the supervising physician to be
3 present in the room for the entire procedure when performed by a resident¹; and
4
5 Whereas, For longer, major procedures, CMS requires the supervising physician to be present
6 only for key portions of the procedure, not the entire procedure; and
7
8 Whereas, The Accreditation Council for Graduate Medical Education Common Program
9 Requirements call for graduated supervision of residents with progressive authority and
10 responsibility and conditional independence² in order to ensure that resident supervision is
11 optimized to provide both high quality patient care and resident training; therefore be it
12
13 RESOLVED, That our American Medical Association recommend that the Centers for Medicare
14 and Medicaid Services change its policy to allow reimbursement for minor procedures
15 performed by residents as long as the supervising physician is present for the key portions of
16 the minor procedure. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

RELEVANT AMA POLICY

Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries H-390.999

When a physician assumes responsibility for the services rendered to a patient by a resident or an intern, the physician may ethically bill the patient for services which were performed under the physician's personal observation, direction, and supervision.

CMS Rep. H, A-77 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report, A-00 Reaffirmed: CMS Rep. 6, A-10

CMS Documentation Guidelines for Teaching Physicians H-315.982

The AMA will work with the CMS to: (1) reduce the redundant and burdensome documentation for teaching physicians; (2) accept documentation by the physician team under the supervision of a teaching physician if it collectively meets all CMS documentation requirements; and (3) accept a statement of the teaching physician's level of participation in patient care as sufficient or adequate documentation.

Res. 861, A-98 Reaffirmed: CME Rep. 2, A-08

¹ CMS Manual System. Pub 100-04 Medicare Claims Processing. Transmittal 2303. 100.1.2 Surgical Procedures

² ACGME Common Program Requirements. VI. D. Supervision of Residents,
http://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/CPRs_07012016.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 231
(A-17)

Introduced by: Michigan
Subject: Naloxone Price Increase
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, Naloxone is an opioid antagonist available as a reversal agent for opioid overdoses¹;
2 and
3
4 Whereas, States have worked extremely hard to increase access to naloxone by passing
5 legislation in 40 states that offer clinicians various levels of immunity from criminal or civil
6 prosecution for third-party prescriptions; and
7
8 Whereas, In 42 states, criminal or civil immunity is granted to bystanders who possess or use
9 illegal drugs when they provide emergency services to someone who has overdosed, including
10 administering naloxone or calling emergency responders²; and
11
12 Whereas, 40 states have passed legislation allowing access to naloxone via standing
13 prescription orders at pharmacies, pharmacist prescription authority, or collaborative practice
14 agreements²; and
15
16 Whereas, The price of naloxone products has increased significantly since 2009: Injectable or
17 intranasal, 1 mg-per-milliliter vial (2 mL) manufactured by Amphastar increased from \$20.34
18 (2009) to \$39.60 (2016); 0.4 mg-per-milliliter vial (10 mL) manufactured by Hospira increased
19 from \$62.29 (2012) to \$142.49 (2016); and the auto-injector, two-pack of single-use prefilled
20 auto-injectors (Evzio) manufactured by Kaleo increased from \$690.00 (2014) to \$4,687.50
21 (2017)²; and
22
23 Whereas, Naloxone bulk purchasing programs -- modeled after federal government purchasing
24 of vaccines -- could help reduce the price of naloxone for communities, as seen with the
25 Massachusetts bulk purchasing program that reduced the price for both first-responders and
26 municipalities; and
27
28 Whereas, Wisconsin, New York, and Ohio also have negotiated rebate programs with the
29 pharmaceutical manufacturers^{2,3,4}; and
30
31 Whereas, The US federal government could use federal law 28 U.S.C. section 1498, which
32 permits contracts with manufacturers to produce cheaper generic formulations of patented
33 products for federal use during public health emergencies, to negotiate for lower drug prices as
34 done with ciprofloxacin during the 2001 anthrax threat^{2,5}; and

¹ <https://www.samhsa.gov/medication-assisted-treatment/treatment/naloxone>

² <http://www.nejm.org.proxy.lib.wayne.edu/doi/full/10.1056/NEJMp1609578>

³ <http://www.sciencedirect.com/science/article/pii/S0749379700002105>

⁴ http://www.masslive.com/politics/index.ssf/2016/11/state_bulk_buying_of_anti-over.html

⁵ <http://content.healthaffairs.org/content/35/5/791.full>

1 Whereas, Increased competition through introduction of generic options could lower drug prices
2 and could be accomplished by incentivizing generic development with accelerated approval and
3 waived fees or importing international generic drugs that meet US Food and Drug
4 Administration (FDA) standards^{2,6}; and

5 Whereas, Making naloxone an over-the-counter drug (as discussed by the FDA previously)
6 would attract additional manufacturers, due to easier FDA authorization, which could reduce
7 prices^{2,7}; therefore be it

8

9 RESOLVED, That our American Medical Association amend existing AMA Policy, H-95.932,
10 "Increasing Availability of Naloxone," by addition and deletion as follows:

11

12 1. Our AMA supports legislative, ~~and regulatory, and national advocacy~~ efforts ~~that to~~
13 increase access to affordable naloxone, including but not limited to collaborative
14 practice agreements with pharmacists and standing orders for pharmacies and, where
15 permitted by law, community based organizations, law enforcement agencies,
16 correctional settings, schools, and other locations that do not restrict the route of
17 administration for naloxone delivery. (Modify Current HOD Policy)

Fiscal Note: Minimal – less than \$1,000

Received: 05/11/17

RELEVANT AMA POLICY

Study OTC Availability of Naloxone D-95.974

1. Our AMA encourages manufacturers or other qualified sponsors to pursue the application process for over the counter approval of naloxone with the Food and Drug Administration.

2. Our AMA will study and report back at the 2016 Annual Meeting on ways to expand the access and use of naloxone to prevent opioid-related overdose deaths.

Res. 909, I-15

Increasing Availability of Naloxone H-95.932

1. Our AMA supports legislative and regulatory efforts that increase access to naloxone, including collaborative practice agreements with pharmacists and standing orders for pharmacies and, where permitted by law, community based organizations, law enforcement agencies, correctional settings, schools, and other locations that do not restrict the route of administration for naloxone delivery.

2. Our AMA supports efforts that enable law enforcement agencies to carry and administer naloxone.

3. Our AMA encourages physicians to co-prescribe naloxone to patients at risk of overdose and, where permitted by law, to the friends and family members of such patients.

4. Our AMA encourages private and public payers to include all forms of naloxone on their preferred drug lists and formularies with minimal or no cost sharing.

5. Our AMA supports liability protections for physicians and other health care professionals and others who are authorized to prescribe, dispense and/or administer naloxone pursuant to state law.

6. Our AMA supports efforts to encourage individuals who are authorized to administer naloxone to receive appropriate education to enable them to do so effectively.

BOT Rep. 22, A-16

See also:

Prevention of Opioid Overdose D-95.987

⁶ <http://www.ajhp.org.proxy.lib.wayne.edu/content/72/17/1426.1.long>

⁷ http://www.mccaskill.senate.gov/imo/media/doc/SCA_Mylan_6_3_16.pdf

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 232
(A-17)

Introduced by: Michigan
Subject: Create MACRA Opt-Out Option
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, The Centers for Medicare and Medicaid Services has instituted provisions of the
2 Medicare Access and CHIP Reauthorization Act (MACRA) for quality payment for physicians;
3 and
4
5 Whereas, MACRA by design will produce winners and losers with practices that could lose up to
6 9 percent in 2022; and
7
8 Whereas, Small practices do not have the infrastructure or the budget to spend on a
9 complicated program such as MACRA; therefore be it
10
11 RESOLVED, That our American Medical Association work with the Centers for Medicare and
12 Medicaid Services to permit solo practitioners and small practices to opt-out of the Medicare
13 Access and CHIP Reauthorization Act completely in order to protect their financial viability.
14 (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

RELEVANT AMA POLICY

MIPS and MACRA Exemption H-390.838

Our AMA will advocate for an exemption from the Merit-Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) for small practices.

Res. 208, I-16

Preserving Patient Access to Small Practices Under MACRA D-390.949

1. Our AMA will urge the Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and to further reduce the MACRA requirements for ALL physicians' practices to provide additional flexibility, reduce the reporting burdens and administrative hassles and costs.

2. Our AMA will advocate for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.

3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek additional exemptions or flexibilities for those practices.

Res. 243, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 233
(A-17)

Introduced by: American Academy of Dermatology
American Society for Dermatologic Surgery Association
American College of Mohs Surgery
American Society of Dermatopathology
Society for Investigative Dermatology
Wisconsin

Subject: Regulation of Physician Assistants

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

-
- 1 Whereas, The physician assistant profession was originally created in the mid 1960's to serve
2 as a support role to physicians to help alleviate primary care shortages; and
3
4 Whereas, The physician assistant profession was designed to function under the direction of a
5 duly qualified licensed physician; and
6
7 Whereas, Existing AMA Policy H-160.947, "Physician Assistants and Nurse Practitioners,"
8 states that the extent of the involvement of a physician assistant in the assessment and
9 implementation of treatment should be determined by the supervising physician; and
10
11 Whereas, Additional AMA Policy H-35.989, "Physician Assistants," states that a physician
12 assistant's utilization should be approved by the medical licensing board; and
13
14 Whereas, Physicians are ultimately responsible for the scope of the physician assistant's
15 duties; and
16
17 Whereas, Physicians are licensed, regulated, and disciplined by state medical licensing and
18 regulatory bodies; and
19
20 Whereas, Currently, the majority of states authorize medical licensing and regulatory bodies to
21 license, regulate, and discipline physician assistants; therefore be it
22
23 RESOLVED, That our American Medical Association advocate in support of maintaining the
24 authority of medical licensing and regulatory boards to regulate the practice of medicine through
25 oversight of physicians, physician assistants and related medical personnel (New HOD Policy);
26 and be it further
27
28 RESOLVED, That our AMA oppose legislative efforts to establish autonomous regulatory
29 boards meant to license, regulate, and discipline physician assistants outside of the existing
30 state medical licensing and regulatory bodies' authority and purview. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000
Received: 05/11/17

RELEVANT AMA POLICY

Physician Assistants H-35.989

(1) The AMA opposes legislation to increase public funding for programs to train physician assistants and supports a careful reevaluation of the need for public funding at the time that present legislative authorities expire.

(2) A physician assistant should provide patient care services only in accord with the medical practice act and other applicable state law, and such law should provide that the physician assistant's utilization by a physician or group of physicians be approved by the medical licensing board. A licensed physician or group of physicians seeking to utilize a physician assistant should submit to the medical licensing board an application for utilization that identifies: the qualifications and experience of the physician assistant, the qualifications and experience of the supervising physician and a description of his or her practice, and a description of the manner and the health care settings in which the assistant will be utilized, and the arrangements for supervision by the responsible physician. Such an application should also specify the number of physician assistants that the physician or group of physicians plans to employ and supervise. A physician assistant should be authorized to provide patient care services only so long as the assistant is functioning under the direction and supervision of a physician or group of physicians whose application for utilization has been approved by the medical licensing board. State medical licensing boards, in their review of applications for utilization of a physician assistant, should take special care to insure that the proposed physician assistant functions not be of a type which: (a) would unreasonably expand the professional scope of practice of the supervising physician, (b) cannot be performed safely and effectively by the physician assistant, or (c) would authorize the unlicensed practice of medicine.

(3) The physician assistant should function under the direction of and supervision by a duly qualified licensed physician. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise that amount of control or supervision over a physician assistant which is appropriate for the maintenance of quality medical care and in accord with existing state law and the rules and regulations of the medical licensing authority. Such supervision in most settings includes the personal presence or participation of the physician. In certain instances, such as remote practice settings, where the physician assistant may function apart from the supervising physician, such remote function (if permitted by state law) should be approved by the state medical licensing board on an individual basis. Such approval should include requirements for regular reporting to the supervising physician, frequent site visits by that physician, and arrangements for immediate communication with the supervising physician for consultation at all times. The physician assistant may serve the patients of the supervising physician in all types of health care settings, including but not limited to: physician's office, ambulatory or outpatient facility, clinic, hospital, patient's home, long-term care facility or nursing home. The state medical licensing board should determine on an individual basis the number of physician assistants that a particular physician may supervise or a group of physicians may employ.

(4) While it is preferable and desirable that the physician assistant be employed by a physician or group of physicians so as to ensure appropriate physician supervision in the interests of the patient, where a physician assistant is employed by a hospital, the physician assistant must provide patient care services in accordance with the rules and procedures established by the organized medical staff for utilization of physician-employed physician assistants functioning in that institution, and under the direction and supervision of a designated physician who has been approved by the state medical licensing board to supervise that physician assistant in accordance with a specific utilization plan and who shall be directly responsible as the attending physician for the patient care services delegated to his physician assistant.

(5) The AMA opposes legislation or proposed regulations authorizing physician assistants to

make independent medical judgments as to the drug of choice for an individual patient.

(6) In view of an announced interest by HHS in considering national legislation which would override state regulatory systems for health manpower, the AMA recommends that present Association policy supporting state prerogatives in this area be strongly reaffirmed.

BOT/CME/CMS Joint Rep., I-80 Reaffirmed: CLRPD Rep. B, I-90 Reaffirmation A-99

Reaffirmed: CME Rep. 2, A-09 Reaffirmed: BOT Rep. 9, I-11

Physician Assistants and Nurse Practitioners H-160.947

Our AMA will develop a plan to assist the state and local medical societies in identifying and lobbying against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.

The suggested Guidelines for Physician/Physician Assistant Practice are adopted to read as follows (these guidelines shall be used in their entirety):

(1) The physician is responsible for managing the health care of patients in all settings.

(2) Health care services delivered by physicians and physician assistants must be within the scope of each practitioner's authorized practice, as defined by state law.

(3) The physician is ultimately responsible for coordinating and managing the care of patients and, with the appropriate input of the physician assistant, ensuring the quality of health care provided to patients.

(4) The physician is responsible for the supervision of the physician assistant in all settings.

(5) The role of the physician assistant in the delivery of care should be defined through mutually agreed upon guidelines that are developed by the physician and the physician assistant and based on the physician's delegatory style.

(6) The physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.

(7) The extent of the involvement by the physician assistant in the assessment and implementation of treatment will depend on the complexity and acuity of the patient's condition and the training, experience, and preparation of the physician assistant, as adjudged by the physician.

(8) Patients should be made clearly aware at all times whether they are being cared for by a physician or a physician assistant.

(9) The physician and physician assistant together should review all delegated patient services on a regular basis, as well as the mutually agreed upon guidelines for practice.

(10) The physician is responsible for clarifying and familiarizing the physician assistant with his/her supervising methods and style of delegating patient care.

BOT Rep. 6, A-95 Reaffirmed: Res 240 and Reaffirmation A-00 Reaffirmed: Res. 213, A-02

Modified: CLRPD Rep. 1, A-03 Reaffirmed: BOT Rep. 9, I-11 Reaffirmed: Joint CME-CMS Rep., I-12 Reaffirmed: BOT Rep. 16, A-13

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 234
(A-17)

Introduced by: American Academy of Neurology
American College of Rheumatology
The Endocrine Society

Subject: Protections for Patients with Genetic Conditions

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

-
- 1 Whereas, The Preserving Employee Wellness Programs Act¹ (H.R.1313) has been introduced
2 in the 115th Congress; and
3
4 Whereas, The legislation would reward employees who voluntarily provide personal and family
5 genetic information to their employers as part of workplace wellness programs by offering
6 discounts on insurance premiums and other financial incentives; and
7
8 Whereas, Provisions of this legislation explicitly remove privacy protections of the Genetic
9 Information Nondiscrimination Act of 2008 (GINA) and the Americans with Disabilities Act of
10 1990 (ADA) for genetic tests conducted as part of voluntary workplace wellness programs; and
11
12 Whereas, Employees who refuse to provide their personal genetic and health information or that
13 of their family members will face higher costs for employer-sponsored health insurance than
14 those who do provide this information; and
15
16 Whereas, If enacted, the Preserving Employee Wellness Programs Act would undermine
17 existing protections for privacy and introduce unnecessary ethical dilemmas into the employer-
18 employee relationship; therefore be it
19
20 RESOLVED, That our American Medical Association actively oppose the Preserving Employee
21 Wellness Programs Act (Directive to Take Action); and be it further
22
23 RESOLVED, That our AMA support efforts to preserve nondiscrimination protections
24 established by the Genetic Information Nondiscrimination Act and the Americans with
25 Disabilities Act. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

RELEVANT AMA POLICY

Genetic Discrimination and the Genetic Information Nondiscrimination Act H-65.969

Our AMA: (1) strongly opposes discrimination based on an individual's genetic information; (2) will pursue and support legislation intended to provide robust and comprehensive protections against genetic discrimination and misuse of genetic information; and (3) supports education for health care providers and patients on the protections against genetic discrimination currently afforded by federal and state laws. CSAPH Rep. 7, A-13

¹ United States Congress. H.R.1313 Preserving Employee Wellness Programs Act. <https://www.congress.gov/bill/115th-congress/house-bill/1313>

Patient Privacy and Confidentiality H-315.983

1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; and (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure. 2. Our AMA affirms: (a) that physicians and medical students who are patients are entitled to the same right to privacy and confidentiality of personal medical information and medical records as other patients, (b) that when patients exercise their right to keep their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate concealment, and (c) that physicians and medical students should not be required to report any aspects of their patients' medical history to governmental agencies or other entities, beyond that which would be required by law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms that authorize access should be explicit about to whom access is being granted and for what purpose, and should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical information should be given access to such information only through a court order. This court order for disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence, that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law enforcement authority cannot be satisfied by non-identifiable health information or by any other information; and that the law enforcement need for the information outweighs the privacy interest of the individual to whom the information pertains. These records should be subject to stringent security measures. 10. Our AMA must guard against the imposition of unduly restrictive barriers to patient records that would impede or prevent access to data needed for medical or public health research or quality improvement and accreditation activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where personal identification is essential for the collation of data, review of identifiable data should not take place without an institutional review board (IRB) approved justification for the retention of identifiers and the consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of identifiable patients' medical information may violate principles of informed consent and patient confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment. If other uses are to be made of the information, patients must first give their uncoerced permission after being fully informed about the purpose of such disclosures. 12. Our AMA, in collaboration with other professional organizations, patient advocacy groups and the public health community, should continue its advocacy for privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for disclosure of identifiable patient medical information between physicians and the health plans of which they are a part, and securing appropriate physicians' control over the disposition of information from their patients' medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned. 14. Disclosure of personally identifiable patient information to public health physicians and departments is appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. BOT Rep. 9, A-98 Reaffirmation I-98 Appended: Res. 4, and Reaffirmed: BOT Rep. 36, A-99 Appended: BOT Rep. 16 and Reaffirmed: CSA Rep. 13, I-99 Reaffirmation A-00 Reaffirmed: Res. 246 and 504 and Appended Res. 504 and 509, A-01 Reaffirmed: BOT Rep. 19, I-01 Appended: Res. 524, A-02 Reaffirmed: Sub. Res. 206, A-04 Reaffirmed: BOT Rep. 24, I-04 Reaffirmed: BOT Rep. 19, I-06 Reaffirmation A-07 Reaffirmed: BOT Rep. 19, A-07 Reaffirmed: CEJA Rep. 6, A-11 Reaffirmed in lieu of Res. 705, A-12 Reaffirmed: BOT Rep. 17, A-13 Modified: Res. 2, I-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 235
(A-17)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island, Vermont

Subject: Towards Eliminating ERISA State Preemption of Health Plan Liability

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, A strategic goal of our AMA is improving patient outcomes; and
2
3 Whereas, The Employee Retirement Income Security Act (ERISA), a comprehensive federal
4 statute enacted in 1974 to ensure the fiscal integrity of pension plans, applies to health benefit
5 plans as well; and
6
7 Whereas, ERISA became a pivotal piece of legislation because, to a large extent, it prevented
8 states from regulating the activities of employee health benefit plans¹; and
9
10 Whereas, Empirical research has found a correlation between higher payor denial rates and
11 profits²; and
12
13 Whereas, In today's health care delivery climate, the decision by a health plan not to cover a
14 particular service generally means that the patient will not receive the service; adverse effects
15 on the patient's health may result (as noted by the Supreme Court in *Pegram v Herdrich*¹; and
16
17 Whereas, The ERISA preemption against state laws that "relate to" employee benefit plans has
18 elicited a large volume of litigation, and 10 states have enacted laws attempting to enhance the
19 ability of enrollees to sue health plans in state courts, but the U.S. Supreme Court has ruled
20 that negligence claims against employer-sponsored health plans are preempted by ERISA¹; and
21
22 Whereas, Compensation in cases filed under ERISA is limited to that available under contract
23 law (compensation equal to the value of the services required in the contract). Thus, even
24 though enrollees may suffer serious medical consequences as a result of the actions of their
25 health plans, they may sue only for the value of the services withheld or delayed¹; and
26
27 Whereas, Justice Ruth Bader Ginsburg, in her concurring opinion, suggested that congressional
28 action amending ERISA may be the only mechanism available to provide patients with adequate
29 compensation for damages incurred as a result of coverage decisions made by employer-
30 sponsored health plans, and Justice Ginsburg and Justice Breyer characterized the current
31 ERISA preemption regimes in the field of health care as unjust and tangled^{1,3}; and
32
33 Whereas, Additionally, Justice Ginsburg acknowledges that the Supreme Court has joined
34 together "an encompassing interpretation of ERISA's preemptive force with a cramped
35 construction of the 'equitable relief allowable under [section] 502(a)(3)," to create a "regulatory
36 vacuum" that in effect denies ERISA plan beneficiaries any tort damages against HMOs for
37 medical malpractice³; and

1 Whereas, The Supreme Court has afforded to managed care plans that cover enrollees
2 through an employee benefit plan a type of immunity that will do little to deter these providers
3 from disapproving requests to cover necessary but expensive health care services¹; and
4

5 Whereas, ERISA is a complicated area of the law that throws up many hurdles that stand
6 between employees (and their attorneys) and their insurance benefits if the insurance coverage
7 is provided as an employee benefit⁴; and
8

9 Whereas, ERISA limits the remedy of a claim in a benefits case to the benefits that should have
10 been paid under the plan, plus maybe attorneys' fees, but precludes other state law remedies,
11 such as claims for bad faith failure to pay an insurance claim, or fraud, and ERISA precludes
12 punitive damages or other state law remedies⁴; and
13

14 Whereas, ERISA limits discovery, limits damages to the amount due under the plan (plus
15 possibly attorneys' fees), often allows the insurer a deferential standard of review, limits
16 evidence to that information that was provided during the administrative appeals process, does
17 not allow for jury trials, and usually involves litigating in federal court⁴; and
18

19 Whereas, Plaintiffs' attorneys often avoid ERISA cases⁴; and
20

21 Whereas, Payors have little incentive to comply with the regulations by accurately processing
22 and properly approving claims in the first place by virtue of minimal to no penalties even if found
23 at fault in federal court²; and
24

25 Whereas, Proponents of ERISA in 1974 had little inkling that this law would become a major
26 factor in shaping the US health care delivery system, since employer-sponsored health plans
27 were a much smaller percentage of the health care system at the time¹; and
28

29 Whereas, Many attempts have been made to overturn ERISA preemption over many years
30 without substantial success, and our AMA has policy supporting objections to this law (see
31 policies listed below); and
32

33 Whereas, Legal scholars such as L. Darnell Weeden, B.A., J.D. have concluded: "Congress
34 should adopt a Patients' Bill of Rights (PBR) Law to wipe out the vast regulatory vacuum
35 created by ERISA's conflict and complete preemption rationales that leave patients without any
36 adequate legal remedy when an HMO's conduct is proximate. It is my sincere hope that one day
37 Congress will enact meaningful PBR legislation to protect all Americans from the bottom-line
38 oriented eligibility and treatment decisions made by big business HMOs and other greedy
39 corporate actors in the managed care industry"³; and
40

41 Whereas, The current constitution of the Executive and Legislative branches has opened a
42 significant opportunity for change in the existing healthcare system; therefore be it
43

44 RESOLVED, That our American Medical Association renew active advocacy for Executive and
45 Congressional action to amend the Employee Retirement Income Security Act (ERISA) to
46 eliminate the state preemption clause and provide patients with a less restrictive and/or less
47 burdensome process to seek adequate redress or compensation for damages incurred as a
48 result of coverage decisions made by employer-sponsored health plans (Directive to Take
49 Action); and be it further

- 1 RESOLVED, That our AMA reaffirm Policies H-285.945, H-285.915, D-385.984 and D-385.973.
- 2 (Reaffirm HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

References

¹ Fred J. Hellinger, PhD and Gary J. Young, PhD, JD; Am J Public Health. 2005 February; 95(2): 217–223. Health Plan Liability and ERISA: The Expanding Scope of State Legislation

² Katherine Vukadin; Yale Journal of Health Policy and Ethics. Volume 11, issue 2, article 3, 3/3/2013. Delayed and Denied.

Towards an effective ERISA Remedy for Improper Processing of Healthcare Claims

³ L. Darnell Weeden, B.A., J.D.: University of Pennsylvania Journal of Labor Employment Law. Vol. 7:3, 2005. Casenote: ERISA's preemption ruling prevents a patient from suing an HMO under state malpractice law: after Aetna Health Inc. V. Davila who will grant the working middle class a meaningful right to be heard.

⁴ Eric Buchanan & Associates, PLLC. Website: How to Tell if an Insurance Claim is Preempted by ERISA

RELEVANT AMA POLICY

Establishment of Liability of Managed Care Organizations H-285.945

Our AMA supports changes in federal law to prohibit the exemption from liability of managed care organizations, including ERISA plans, for damages resulting from their policies, procedures, or administrative actions taken in relation to patient care.

Sub. Res. 220, I-97 Reaffirmation A-99 Reaffirmed: BOT Rep. 18, I-00 Reaffirmation A-09

Reaffirmed in lieu of Res. 224, A-09 Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11

AMA Policy on ERISA H-285.915

1. Our AMA will seek, through amendment of the ERISA statute, through enactment of separate federal patient protection legislation, through enactment of similar state patient protection legislation that is uniform across states, and through targeted elimination of the ERISA preemption of self-insured health benefits plans from state regulation, to require that such self-insured plans: (a) Ensure that plan enrollees have access to all needed health care services; (b) Clearly disclose to present and prospective enrollees any provisions restricting patient access to or choice of physicians, or imposing financial incentives concerning the provision of services on such physicians; (c) Be regulated in regard to plan policies and practices regarding utilization management, claims submission and review, and appeals and grievance procedures; (d) Conduct scientifically based and physician-directed quality assurance programs; (e) Be legally accountable for harm to patients resulting from negligent utilization management policies or patient treatment decisions through all available means, including proportionate or comparative liability, depending on state liability rules; (f) Participate proportionately in state high-risk insurance pools that are financed through participation by carriers in that jurisdiction; (g) Be prohibited from indemnifying beneficiaries against actions brought by physicians or other providers to recover charges in excess of the amounts allowed by the plan, in the absence of any provider contractual agreement to accept those amounts as full payment; (h) Inform beneficiaries of any discounted payment arrangements secured by the plan, and base beneficiary coinsurance and deductibles on these discounted amounts when providers have agreed to accept these discounted amounts as full payment; (i) Be subject to breach of contract actions by providers against their administrators; and (j) Adopt coordination of benefits provisions applying to enrollees covered under two or more plans.

2. Our AMA will continue to advocate for the elimination of ERISA preemption of self insured health plans from state insurance laws consistent with current AMA policy.

CMS Rep. 6, I-96 Reaffirmation A-97 Reaffirmed: Rules and Cred. Cmt., I-97 Reaffirmed by Sub.

Res. 202, A-98 Reaffirmation I-98 Reaffirmation A-99 Reaffirmed: Res. 238, A-00 Renumbered:

CMS Rep. 7, I-05 Reaffirmed and Modified: Res. 223, I-10 Reaffirmed in lieu of Res. 235, A-11: BOT action in response to referred for decision Res. 235, A-11 Reaffirmed: CMS Rep. 6, A-12

ERISA Preemption and State Prompt Pay Laws D-385.984

- (1) Our AMA continue to actively work with constituent societies to advocate for strong prompt payment laws, as well as full enforcement and implementation of those laws.
- (2) Our AMA Advocacy Resource Center disseminate information to the Federation regarding the issue of Employee Retirement Income Security Act preemption and state prompt pay laws, including specific guidance for drafting legislation to best avoid preemption.
- (3) Our AMA continue to seek legal avenues for advancing the case against ERISA preemption of state prompt pay laws.
- (4) Our AMA monitor developments with regard to implementation of the U.S. Department of Labor claims processing regulation and provide information to the federation on any significant developments.

BOT Rep. 16, I-02 Reaffirmation A-10 Reaffirmed: CMS Rep. 6, A-12 Reaffirmation A-14

ERISA Plans and the United States Department of Labor D-385.973

1. Our AMA will seek federal legislation that would modify Employee Retirement Income Security Act law to incorporate a clause that addresses timely payment of medical claims of health care practitioners who provide treatment in good faith to the members of self-funded group employer-sponsored health plans.
2. When the federal law is amended, our AMA will work with the United States Department of Labor to devise and implement a formalized appeal process at the United States Department of Labor.

Res. 213, A-07 Reaffirmation A-10 Reaffirmed: CMS Rep. 6, A-12 Reaffirmation A-14

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 236
(A-17)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island, Vermont

Subject: Retail Price of Drugs Displayed in Direct-to-Consumer
Pharmaceutical Advertising

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, Direct-to-consumer advertising of prescription pharmaceuticals is designed to cause
2 patients to pressure physicians to prescribe certain medications¹; and
3
4 Whereas, Prescription rates of those medications advertised directly to consumers have
5 increased by 34.2% compared to a 5.1% increase in other pharmaceuticals²; and
6
7 Whereas, Direct-to-consumer advertising of prescription pharmaceuticals was illegal in the
8 United States until 1997 and is currently legal in only one other country, New Zealand³; and
9
10 Whereas, Prescription pharmaceuticals cost more in the United States than they do in any other
11 country⁴; and
12
13 Whereas, Prescription pharmaceuticals that are advertised directly to consumers tend to be the
14 newer and more expensive ones in their classes⁵, such as Humira and Enbrel--each of which
15 cost more than \$4,000 per month⁶; and
16
17 Whereas, Efforts to ban direct-to-consumer advertising of prescription pharmaceuticals have
18 thus far been unsuccessful⁷; and
19
20 Whereas, In a free enterprise system such as we have in the United States, the purchasing
21 public should be educated; therefore be it
22
23 RESOLVED, That our American Medical Association advocate to the applicable Federal
24 agencies (including the Food and Drug Administration, the Federal Trade Commission, and the
25 Federal Communications Commission) which regulate or influence direct-to-consumer
26 advertising of prescription drugs that such advertising should be required to state the
27 manufacturer's suggested retail price of those drugs. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

¹ Frosch DL, Krueger PM, Hornik RC, Cronholm PF, Barg FK. Creating demand for prescription drugs: A content analysis of television direct-to-consumer advertising. *The Annals of Family Medicine*. 2007; 5: 6.

² Sheehan K. *Controversies in Contemporary Advertising*. Thousand Oaks, CA: Sage Publications, 2003.

³ Lee VC. Direct-to consumer pharmaceutical advertising: therapeutic or toxic? *Pharmacy and Therapeutics*. 2011; 36(10): 669.

⁴ Whalen J. Why the US pays more than other countries for drugs. *Wall Street Journal*. December, 2015.

⁵ Russell J. Do drug ads help patients or lead to expensive treatments? *Chicago Tribune*. September 4, 2016.

⁶ Thomas K. In plan to cut cost of drugs, complications. *New York Times*. September 9, 2016.

⁷ AMA calls for ban on direct to consumer advertising of prescription drugs and medical devices. *AMA Newsroom*. November 17, 2015.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 237
(A-17)

Introduced by: Connecticut, Maine, Massachusetts, New Hampshire,
Rhode Island, Vermont

Subject: Protection of Clinician-Patient Privilege

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, A student who was gang-raped at the University of Oregon sued the university and
2 due to loopholes in the Family Educational Rights and Privacy Act (FERPA), the university was
3 able to access the student's treatment records from the student's counseling sessions to use
4 against her in court^{2,3,5,6,7,8,11,15}; and
5
6 Whereas, These privacy loopholes in FERPA have led to 1) students being reluctant to utilize
7 their campus health or counseling services and 2) students receiving advice from legal experts
8 advising them not to utilize their campus health or counseling services precisely because of
9 these privacy loopholes in FERPA^{2,11,15}; and
10
11 Whereas, The Standards for Privacy of Individually Identifiable Health Information of HIPAA do
12 not apply to Protected Health Information (PHI) that is considered part of a student's education
13 record¹³; and
14
15 Whereas PHI that is considered part of a student's education record is subject to FERPA unless
16 more rigorous state regulations apply^{7,11,13,14}; and
17
18 Whereas, FERPA defines education records as records that are 1) directly related to a student
19 and 2) maintained by an educational institution or by a party acting for the institution^{1,14}; and
20
21 Whereas, FERPA defines treatment records as records that are made or maintained by a health
22 care clinician employed or contracted by the educational institution and are only shared with
23 other clinicians^{1,14}; and
24
25 Whereas, Under normal circumstances, treatment records are excluded from the definition of
26 education records under FERPA and thus have additional privacy protections that education
27 records do not^{1,14}; and
28
29 Whereas, If treatment records are disclosed under one of the exceptions to written consent
30 under 34 CFR §99.31, including when legal action is initiated by either the student or the
31 educational institution, these additional privacy protections no longer apply and an educational
32 institution may disclose a student's treatment records without a court order or subpoena^{1,10,14};
33 and
34
35 Whereas, The Department of Education has determined that educational institutions may
36 disclose educational records to courts without a court order or consent from the parents or
37 student¹²; and

1 Whereas, Medical privacy is typically only breached when the patient sues a health care
 2 professional for malpractice in order to determine if the standard of care was met, and in such
 3 cases, the request to breach privacy would require either the patient to give written consent or
 4 the judge to issue a subpoena, as well as allowing the patient the opportunity to object to the
 5 request for a subpoena or to request that the court look at the private medical records in secret
 6 in the judge's chambers to determine which medical records are relevant^{2,10}; and
 7

8 Whereas, The Supreme Court of the United States has ruled that psychotherapist-patient
 9 privilege exists within the Federal Rules of Evidence because "the mere possibility of disclosure
 10 may impede the confidential relationship necessary for successful treatment"⁴; and
 11

12 Whereas, The policies of both the American Counseling Association and the American
 13 Psychological Association state that a therapist's records may only be disclosed under a court
 14 order¹²; therefore be it
 15

16 RESOLVED, That our American Medical Association advocate to the relevant national bodies
 17 for the clinician-patient privilege to be regulated according to the privacy protections in the
 18 Health Insurance Portability and Accountability Act of 1996 without regard to where care is
 19 received. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 – \$5,000

Received: 05/11/17

¹ Family Educational Rights and Privacy Act of 1974, 20 U.S.C. § 1232g (1974)

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³ Greif, A. (2015, February 19). University of Oregon, Dana Altman counter lawsuit against them by alleged sexual assault victim. Retrieved from http://www.oregonlive.com/ducks/index.ssf/2015/02/university_of_oregon_dana_altm.html

⁴ Jaffee v. Redmond, 518 U.S. 1 (1996)

⁵ Kingkade, T. (2015, January 8). Oregon basketball coach sued by alleged rape victim for ignoring player's sexual assault record. Retrieved from http://www.huffingtonpost.com/2015/01/08/university-oregon-lawsuit-sexual-assault_n_6440000.html

⁶ Kingkade, T. (2015, February 9). University of Oregon violated sexual assault victim's medical privacy, employees claim. Retrieved from http://www.huffingtonpost.com/2015/02/09/university-of-oregon-medical-privacy_n_6641920.html

⁷ Mangan, K. (2015, March 5). Just how private are college students' campus counseling records? The Chronicle of Higher Education. Retrieved from <http://www.chronicle.com/article/just-how-private-are-college/228229>

⁸ Martin, J. (2015, January 9). Student sues University of Oregon, coach over alleged gang-rape. Retrieved from <http://www.cnn.com/2015/01/09/justice/university-of-oregon-title-ix-lawsuit/index.html>

⁹ M.G.L. ch.71, § 34H

¹⁰ Peterson, K. (2015, March 18). When FERPA meets HIPAA. Retrieved from <http://home.campusclarity.com/when-ferpa-meets-hipaa/>

¹¹ Pryal, K. (2015, March 2). Raped on campus? Don't trust your college to do the right thing. Retrieved from <http://www.chronicle.com/article/raped-on-campus-don-t-trust/228093>

¹² Tucker, C. (2015, March 25). Lawsuit against University of Oregon highlights problems with FERPA. Retrieved from <http://m.dailyprincetonian.com/news/2015/03/lawsuit-against-university-of-oregon-highlights-problems-with-ferpa/>

¹³ United States Department of Health and Human Services. (2003). OCR privacy brief: summary of the HIPAA privacy rule

¹⁴ U.S. Department of Health and Human Services and U.S. Department of Education. (2008). Joint guidance on the application of the Family Educational Rights and Privacy Act (FERPA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to student health records.

¹⁵ White, M. (2015, March 5). Read the fine print: where FERPA and HIPAA leave your medical records at risk. Retrieved from <http://mthsusidelines.com/2015/03/read-the-fine-print-where-ferpa-and-hipaa-leave-your-medical-records-at-risk/>

¹⁶ 603 CMR 23.00

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 238
(A-17)

Introduced by: New Jersey

Subject: Limitation on Reports to the National Practitioner Data Bank
Unrelated to Patient Care

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, The legislative purpose establishing the National Practitioner Data Bank (NPDB) was
2 to create a record of physicians whose treatment resulted in harm, but there are no empirical
3 studies that demonstrate the NPDB produced any impact on the quality of patient care; and
4
5 Whereas, The regulations and NPDB Guidebook of reportable events now expands beyond the
6 goal and intended purpose of the legislation to include reports by hospitals and other entities of
7 physicians for reasons not related to patient care and who remain competent; and
8
9 Whereas, A chief purpose of the Health Care Quality Improvement Act was to protect patients
10 from physicians prone to giving subpar healthcare services and to report on physicians and
11 providers found to harm the public during the delivery of patient care or “health care services”.
12 See 42 U.S.C. § 11101; and
13
14 Whereas, Hospitals improperly report on physician applicants to medical staff for reasons not
15 related to patient care, but rather for administrative or eligibility reasons unrelated to
16 professional performance; and
17
18 Whereas, Reports to the NPDB damage reputations, negatively affect hospital privileges and
19 future employment opportunities and deprive wrongfully reported physicians of liberty and
20 property interests without due process; therefore be it
21
22 RESOLVED, That our American Medical Association formally request that the Health
23 Resources and Services Administration (HRSA) clarify that reports of medical staff appointment
24 denial by physicians are contingent upon competency issues related to physicians’ provision of
25 or failure to provide healthcare services that result in patient harm (Directive to Take Action);
26 and be it further
27
28 RESOLVED, That our AMA formally petition the Secretary of HHS to direct the HRSA to remove
29 the name of any physician from the National Practitioner Data Bank reported for reasons not
30 related to patient care that resulted in patient harm. (Directive to Take Action)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 239
(A-17)

Introduced by: Tennessee

Subject: AMA Support for Texting as Approved HIPAA Communication

Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

1 Whereas, Despite efforts to educate patients and physicians on the topic of protected health
2 information (PHI), some physicians and patients still choose to text PHI to each other during the
3 course of medical care in violation of HIPAA privacy and security regulations; and
4

5 Whereas, Smartphone apps and encrypted email accounts, while meeting the HIPAA definition
6 of safe communication, are too cumbersome, complicated, and expensive for the transfer of
7 PHI; and
8

9 Whereas, Technological advances in areas such as two-step authentication, secured Wi-Fi, and
10 business associate agreements with cloud businesses have substantially closed the gaps
11 between current smartphone text communication platforms and the definition of HIPAA secured
12 communications; and
13

14 Whereas, The AMA has a long-established history of advocacy in many areas of medicine,
15 including technological infrastructure issues such as the development of the HCFA 1500 form;
16 therefore be it
17

18 RESOLVED, That our American Medical Association collaborate with medical technology
19 companies and the federal government to improve texting platforms so that more commercially
20 available devices comply with HIPAA without having to utilize expensive and complex
21 encryption technology (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA advocate for the relaxation of HIPAA rules regulating the use of
24 commercially available devices to transfer protected health information. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 240
(A-17)

Introduced by: Texas
Subject: Minimum Federal Standards for Interstate Sale of Health Insurance
Referred to: Reference Committee B
(Alethia E. Morgan, MD, Chair)

- 1 Whereas, The interstate sale of health insurance across state lines is being discussed at the
2 federal level as it applies to replacing the Affordable Care Act; and
3
4 Whereas, The Affordable Care Act provides for the sale of health insurance across state lines if
5 states form interstate compacts; and
6
7 Whereas, State legislatures and insurance departments may not have consensus on how they
8 want domiciled insurance companies to be regulated; and
9
10 Whereas, States have different laws regarding health insurance mandated health benefits,
11 prompt pay guidelines for claims, financial protections, and network adequacy rules to name a
12 few; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for the establishment of
15 minimum federal standards on the interstate sale of health insurance, consistent with existing
16 AMA policy (New HOD Policy); and be it further
17
18 RESOLVED, That our AMA advocate that minimum federal standards should not weaken any
19 states' requirements on network adequacy, tort, financial protections, and other relevant
20 insurance plan regulations. (New HOD Policy)

Fiscal Note: Modest – between \$1,000 - \$5,000

Received: 05/11/17

RELEVANT AMA POLICY

Health Insurance Exchange Authority and Operation H-165.839

1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:

A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.

B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.

C) Physician and patient decisions should drive the treatment of individual patients.

D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.

E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate

support available to assist physicians with the implementation process.

F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.

2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.

CMS Rep. 3, I-09 Reaffirmation A-10 Reaffirmed in lieu of Res. 105, A-10 Appended: CMS Rep. 6, I-11 Reaffirmed in lieu of Res. 812, I-13 Reaffirmed: Sub. Res. 813, I-13

Comprehensive Health System Reform H-165.841

Our AMA supports the overall goal of ensuring that every American has access to affordable high quality health care coverage and will work with interested members of Congress to seek legislation consistent with AMA policy.

Sub. Res. 924, I-07 Reaffirmed: Res. 239, A-12

Educating the American People About Health System Reform H-165.844

Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. Res. 717, I-07 Reaffirmation A-09

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.

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

Comprehensive Health System Reform H-165.847

1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA.

2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.

Res. 613, A-06 Reaffirmation I-07 Res. 107, A-08

[See also:](#) Health Insurance Market Regulation H-165.856, Expanding Choice in the Private Sector H-165.881, Achieving Health Care Coverage for All D-165.974, Expanding Patient Choice in the Private Sector D-165.996, AMA Establishment of a Nationwide Federation of Physician Networks H-285.938