Reference Committee A

BOT Report(s)

40 Medicare Coverage of Services Provided by Proctored Medical Students

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REPORT OF THE BOARD OF TRUSTEES

B of T Report 40-A-18

Subject: Medicare Coverage of Services Provided by Proctored Medical Students (Resolution 812-I-17)

Presented by: Gerald E. Harmon, MD, Chair

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

At the 2017 Interim Meeting, the House of Delegates (HOD) referred Resolution 812-I-17, "Medicare Coverage of Services Provided by Proctored Medical Students," for report back at the 2018 Annual Meeting. This resolution was introduced by the Michigan Delegation and asked that:

> Our American Medical Association (AMA) amend Policy, H-390.999, "Payments to Physicians in Teaching Setting by Medicare Fiscal Intermediaries," by addition as follows:
>
> > When a physician assumes responsibility for the services rendered to a patient by a medical student, 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; and
> >
> > Our AMA work with the Centers for Medicare & Medicaid Services (CMS) to require coverage of medical services provided by medical students while under the physician's personal observation, direction, and supervision.

This report provides background on payments to physicians in teaching settings and medical students providing care.

BACKGROUND

In the *Guidelines for Teaching Physicians, Interns, and Residents,* CMS defines a student as an individual who participates in an accredited educational program (for example, medical school) that is not an approved Graduate Medical Education (GME) program and who is not considered an intern or a resident.[1] Medicare does not pay for any services furnished by these individuals. Specifically, CMS only reimburses for services provided by licensed physicians, which medical students are not.

In the *Guidelines,* CMS also states that "any contribution and participation of a student to the performance of a billable service must be performed in the physical presence of a teaching physician or resident in a service that meets teaching physician billing requirements."[2] However, CMS has clarified that, although under Medicare services by students are not billable, teaching physicians can involve students in services they perform, and to the extent that the medical student is involved in procedures under the personal supervision of a teaching physician who is performing the service, there is no prohibition against the teaching physician billing for these services.[3] Any contribution and participation of a student in the performance of a billable service must be

performed in the physical presence of a teaching physician or resident in service that meets teaching physician billing requirements.

During the reference committee hearing, there was testimony from the Council on Medical Education calling for Resolution 812 not to be adopted because of current CMS guidelines on teaching physicians, and the current restrictions on reimbursing only for services provided by licensed physicians.

DISCUSSION

In a teaching scenario, the teaching or supervising physician is making all of the medical decisions and is supervising any procedures performed by the medical student. Therefore, it is logical that the teaching or supervising physician will bill and be paid for the procedures or services. For billing purposes, the physician must also be the individual to document the procedure, including the medical student's participation.

In addition, Resolution 812-I-17 raises concerns because it would allow non-licensed medical students to bill for services. While the AMA has policy supporting payment for services rendered to a patient by a resident or an intern, who are licensed, it would be unprecedented to include medical students in this policy and advocate that CMS reimburse a non-licensed clinician.

Resolution 812-I-17 also raises liability concerns because it would allow physicians to bill for services performed solely by medical students. In order to ensure physicians are not exposed to increased liability, the AMA should not advocate that physicians be responsible for procedures that were performed by medical students who were not overseen by a teaching or supervising physician.

Finally, adoption of Resolution 812-A-17 could blur the line between the learning environment, where medical students pay tuition to cover the costs of being provided an education to become a physician, and the practice environment, where licensed physicians are compensated for providing their time and expertise educating medical students, as well as for treating patients. The Board's view is that these roles should remain separate.

RECOMMENDATION

The Board of Trustees recommends that Resolution 812-I-17 not be adopted and the remainder of the report be filed.

Fiscal Note: None.

REFERENCES

[1] Guidelines for Teaching Physicians, Interns, and Residents. Medicare Learning Network. March 2017. Viewed on January 24, 2018 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Teaching-Physicians-Fact-Sheet-ICN006437.pdf.
[2] Id.
[3] University of Washington Medicine Guidance Document. Billing for Procedures when Medical Students Participate. Viewed on January 25, 2018 at http://depts.washington.edu/comply/docs/MedStudentsAdvisory.pdf.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1-A-18

Subject: Council on Medical Service Sunset Review of 2008 AMA House Policies

Presented by: Paul A. Wertsch, MD, Chair

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

In 1984, the House of Delegates established a sunset mechanism for House policies (Policy G-600.110). Under this mechanism, a policy established by the House ceases to be viable after 10 years unless action is taken by the House to re-establish it.

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

Modified by the House on several occasions, the policy sunset process currently includes the following key steps:

- Each year, the House policies that are subject to review under the policy sunset mechanism are identified, and such policies are assigned to the appropriate AMA Councils for review.

- Each AMA Council that has been asked to review policies develops and submits a separate report to the House that presents recommendations on how the policies assigned to it should be handled.

- For each policy under review, the reviewing Council recommends one of the following alternatives: (a) retain the policy; (b) rescind the policy; or (c) retain part of the policy.

- For each recommendation, the Council provides a succinct but cogent justification for the recommendation.

- The Speakers assign the policy sunset reports for consideration by the appropriate reference committee.

RECOMMENDATION

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

That our American Medical Association (AMA) policies listed in the appendix to this report be acted upon in the manner indicated. (Directive to Take Action).

Appendix
Recommended Actions on 2008 Socioeconomic Policies

Policy #	Policy Title	Recommended Action and Rationale
D-70.955	Postoperative Care of Surgical Patients	Retain. Still relevant.
D-70.969	Discriminatory Payment Polices	Retain. Still relevant.
D-70.999	Diagnostic Procedural Coding System	Rescind. Directive accomplished. By CMS reporting mandate, this work was required to be, and in fact was, completed Oct 1, 2015. The recommendations in the policy were completed in the necessary timeframe to complete the physician roll-out of the new diagnostic code set.
D-125.995	Health Plan Coverage of Prescription Drugs	Rescind. Superseded by Policy D-120.988.
D-125.999	Health Plan Coverage for Over-the-Counter Drugs	Rescind. Superseded by Policy H-125.990.
D-155.992	Appropriate Hospital Charges	Rescind. Directive accomplished. Also superseded by Policy H-155.958, which was adopted via a 2009 Council on Medical Service report. The AMA sent a letter to the American Hospital Association with regard to the second Resolve.
D-160.944	Recognizing Transitions of Care for Performance Improvement	Rescind. Directive accomplished. The Physician Consortium for Performance Improvement (PCPI), in collaboration with the American College of Physicians, Society for Hospital Medicine, and the American Board of Internal Medicine Foundation, developed measures focusing on care transitions between the inpatient and outpatient settings. Additionally, the AMA participated in the AMDA task force to develop guidelines for transitional care in the long-term care continuum. Current guidelines are available at: https://paltc.org/product-store/transitions-care-cpg.
D-165.959	State-Based Demonstration Projects to Expand Health Coverage to the Uninsured	Rescind. Section 1332 of the Affordable Care Act established a new waiver supporting state innovation in order to enable states to experiment with and implement different models to provide health insurance coverage to their residents, with federal pass-through funding provided. As such, superseded by Policy H-165.826.
D-165.999	The Impact of Rapidly Developing Biotechnology on the Delivery of Medical Care	Rescind. Section 2 was accomplished via AMA advocacy in support of the Affordable Care Act. Section 1 was superseded by Policies H-450.938, D-478.966, D-478.976, H-478.985, D-478.977, and D-478.991.
D-180.984	Payer Measures for Private and Public Health Insurance	Retain. Still relevant.

Policy #	**Policy Title**	**Recommended Action and Rationale**
D-180.987	Elimination of Federal Government Discrimination Against Individuals Who Purchase Health Insurance	Rescind. Superseded by Policy H-165.920.
D-190.986	Provision of Payment Schedules and Methodology of Payment as Part of the Contracting Process	Rescind. Directive accomplished. The AMA added a category to the attorney expertise sheet for "Hospital Medical Staff Issues/Bylaws." It was provided to all members of AMA. Consulting link to indicate that they have this expertise. In addition, an updated Web site allowed physicians to search for attorneys and consultants by expertise. Now any new attorney member can indicate that they have expertise in this area.
D-210.997	Home Infusion Therapies	Retain. Still relevant.
D-220.972	Expanding Physician and Medical Staff Participation in Accreditation Surveys	Retain. Still relevant.
D-235.990	JCAHO Standard MS.1.20	Retain-in-part. Rescind (1) and (2), as superseded by the adoption of Standard MS.01.01.01. Amend (3[a]) as follows: Our AMA Commissioners to the Joint Commission: ~~(1) introduce and support language before the full JCAHO board such that Standard MS.1.20 clearly states there is a single document known as the "Medical Staff Bylaws" which must be approved by the voting members of the medical staff;~~ ~~(2) introduce and support language before the full JCAHO board such that JCAHO Standard MS.1.20 clearly states that the following components are to be an integral part of the medical staff bylaws:~~ ~~a. Application, reapplication, credentialing and privileging~~ ~~b. Fair hearing and appeal processes~~ ~~c. Selection, election and removal of medical staff officers~~ ~~d. The clinical criteria and standards which manage quality assurance and improvement, and utilization review~~ ~~e. Criteria and processing for privileging~~ ~~f. Qualification for appointment~~ ~~g. The structure of the medical staff~~ ~~h. The duties and privileges of medical staff categories~~ ~~i. The right to develop and adopt medical staff policies, procedures, rules, and regulations~~ ~~j. The right and ability of the medical staff as a group to retain and be represented by independent legal counsel at the medical staff's expense~~ ~~k. The right and ability to assess dues and to utilize the dues as the medical staff sees fit; and~~ (~~3~~ 1) continue to advocate: a. Any element of performance of Standard MS.~~1.20~~

Policy #	Policy Title	Recommended Action and Rationale
		01.01.01 must be retained in the medical staff bylaws and not in other documents such as rules and regulations or policies…
D-275.965	Optional Use of Social Security Numbers During the Council for Affordable Quality Health Care Credentialing Process	Retain. Still relevant.
D-330.926	Herpes Zoster Vaccines and Medicare Payment for the Vaccine and for Physician Administration of the Vaccine	Rescind. Directive accomplished. The AMA advocated with CMS as directed. Medicare Part D prescription drug plans and Medicare Advantage plans now provide coverage and payment for herpes zoster vaccines and its administration by physicians. Also superseded by Policies D-440.981 and H-440.875.
D-330.930	Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans	Retain-in-part. In 2010 Medicare ceased paying for CPT consultation codes. Providers now code for an evaluation and management (E&M) visit when appropriate. Modify policy to read as follows: (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation ~~(in the inpatient setting these encounters may be reported using the follow-up consultation codes in CPT and in the outpatient setting these encounters may be reported using the appropriate office or other outpatient setting codes)~~; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management, and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
D-330.951	Medicare Cost-Sharing	Retain. Still relevant.
D-335.984	Medicare Part B Contractor Changes	Rescind. Directive accomplished. AMA staff was in regular contact with CMS to address persistent and ongoing problems with Part B contractor performance in the areas of enrollment, claims processing, adequate customer service, and responsiveness to physicians.
D-340.999	Ensuring the Accuracy of Statistics Related to Physician Billing	Retain. Still relevant.
D-385.968	Support for Appropriate Billing and Payment Procedures by Physicians	Retain. Still relevant.
D-390.962	National Care Project Physician Input	Rescind. Directive accomplished. The AMA has had discussions with CMS about the importance of physician

Policy #	Policy Title	Recommended Action and Rationale
		input into the Post Acute CARE Project which evaluates costs and outcomes in post acute care provided in various facilities, including Skilled Nursing Facilities, Inpatient Rehabilitation Facilities and Home Health. We have also sent a letter urging the participation of physicians.
D-390.999	Universal Explanation of Medical Benefits Forms	Rescind. Superseded by Policy H-390.865 and AMA re-focus on adoption of the standard transaction for electronic remittance advice (a focus on encouraging an electronic version of a paper explanation of benefits). The AMA has undertaken significant activity to further the goal of adoption of the standard transaction for electronic remittance advice, including the development and publication of an educational toolkit available on the AMA website to help practices implement the standard electronic remittance advice transaction
D-400.986	The RUC: Recent Activities to Improve the Valuation of Primary Care Services	Retain. Still relevant.
D-406.994	Safeguard National Provider Identifier and Physician Privacy	Rescind. Directive accomplished. The AMA implemented a complaint form for physicians to register problems stemming from Medicare Administrative Contractor reforms and forwarded this information to CMS. The AMA also asked the states and specialties to forward any concerns they hear from the field so these issues can be tracked. The AMA continues to raise these concerns to CMS.
D-475.997	Postoperative Care of Surgical Patients	Retain. Still relevant.
H-25.998	Policy Recommendations in the Field of Aging	Retain. Still relevant.
H-70.938	Certified Professional Coders	Retain. Still relevant.
H-70.940	AMA Program to Readily Retrieve Billing Code Data by Payee within a Practice	Rescind. No longer relevant and superseded by Policy H-190.978.
H-70.946	Rebundling of Vaccine Codes	Retain. Still relevant.
H-70.948	Exclusion of Preoperative Services from Surgical Global Fee	Retain. Still relevant.
H-70.962	Changes in the Bundling of Medical Services by Managed Care Plans	Retain. Still relevant.
H-70.982	Primary Health Care Reimbursement Coding	Retain. Still relevant.
H-70.993	Uniform Use of CPT Coding	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-70.994	Coding of Physician and Non-Physician Services	Retain. Still relevant.
H-70.995	Collapsing the Codes	Retain. Still relevant.
H-120.947	Preserving Patients' Ability to Have Legally Valid Prescriptions Filled	Retain. Still relevant.
H-130.975	The Emergency Department and the Medical Staff	Retain. Still relevant.
H-155.963	Health System Expenditures	Retain. Still relevant.
H-160.930	Home Health Care	Retain. Still relevant.
H-160.951	Access to Primary Care Services	Retain. Still relevant.
H-165.847	Comprehensive Health System Reform	Rescind. Superseded by Policies H-165.904, H-165.920 and H-165.838.
H-165.861	Use of Federal Surpluses for Uninsured Americans	Retain. Still relevant.
H-165.877	Increasing Coverage for Children	Retain. Still relevant.
H-185.948	Health Insurance for Children	Rescind. Superseded by Policy H-165.848.
H-185.966	Physician-Performed Microscopy	Retain. Still relevant.
H-185.991	Uniform Definition of Experimental Procedures and Therapies	Rescind. Health Insurance Association of America no longer exists. Additionally, Policies H-450.935 and H-410.948 supersede in their provision for updating guidelines to reflect evolving evidence.
H-185.993	Third Party Encumbrances	Retain. Still relevant.
H-185.999	Multiple Coverage in Voluntary Health Insurance	Retain. Still relevant.
H-200.969	Definition of Primary Care	Retain. Still relevant.
H-205.998	Regionalization of Medical Services	Retain. Still relevant.
H-210.981	On-Site Physician Home Health Care	Retain. Still relevant.
H-210.994	Home Health Care	Retain. Still relevant
H-215.973	Emergent Care Adjacent to Hospitals	Retain. Still relevant.
H-215.991	Medicare Hospital Inspection and Certification Process	Retain. Still relevant.
H-220.933	Critical Relevancy of Medical Staff in JCAHO Standards	Rescind, superseded by the adoption of Leadership Standard LD.02.04.01.

Policy #	Policy Title	Recommended Action and Rationale
H-220.934	Conflicting Accreditation Standards Among Various Accreditors	Retain, amend as follows: Our AMA will work: (1) with ~~t~~The Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Centers for Medicare & Medicaid Services, state legislatures and regulating agencies, and other appropriate accrediting organizations, to ensure that there are no conflicts among the standards and their interpretation; (2) to ensure that accreditation remain in the private sector, and not become a function of government.
H-220.966	Future Directions of the JCAHO	Retain, amend as follows: The AMA urges ~~t~~The ~~JCAHO~~ Joint Commission, in any standards revision process, to make efforts to reduce burdensome and expensive administrative requirements imposed on health care providers that do not directly affect the quality of patient care.
H-225.956	Behaviors That Undermine Safety	Retain in part. Section 1 is still relevant, but the directive set forth in section 2 should be rescinded as accomplished. In December 2008, the AMA asked The Joint Commission to delay implementation of Joint Commission Standard LD.03.01.01, in part, because of its broad definition of disruptive behavior. The AMA also adopted its own Model Medical Staff Code of Conduct and continues to encourage organized medical staffs to adopt the AMA model code as part of their medical staff bylaws. 1. Our AMA adopted the following policies: A. The Medical Staff… B. The Hospital… ~~2. Our AMA Commissioners to the Joint Commission will urgently convey to The Joint Commission that a one-year moratorium on The Joint Commission Standard LD.03.01.01 is necessary to provide a feasible time frame for the medical staff to bring the medical staff bylaws into compliance with the Standard.~~
H-225.980	Hospital Medical Staff Section Representation on State Governing Boards	Retain. Still relevant.
H-225.982	Hospitals' Contractual Relationships with Health Plans	Retain. Still relevant.
H-230.968	Practice Limitations	Retain. Still relevant.
H-230.994	Encouragement of Open Hospital Medical Staffs	Retain. Still relevant.
H-235.999	Physicians Employed by Hospitals Required to be on Staff	Retain. Still relevant.
H-240.975	Realistic DRG Reimbursement	Retain. Still relevant.

Policy #	Policy Title	Recommended Action and Rationale
H-280.956	Medicare Prospective Payment System for Skilled Nursing Facilities	Retain. Still relevant.
H-285.913	Medicare Advantage Policies	Retain. Still relevant.
H-285.934	Physician Recredentialing by Managed Care Plans	Retain. Still relevant.
H-285.935	Patient Rights During Health Plan Sales	Retain. Still relevant.
H-285.938	AMA Establishment of a Nationwide Federation of Physician Networks	Retain. Still relevant.
H-285.946	Fair Physician Contracts	Retain. Still relevant.
H-285.953	Managed Care Organizations - Credentialing	Retain. Still relevant.
H-320.960	Secondary Utilization Review	Retain. Still relevant.
H-330.917	Medicare Reimbursements for Medications	Retain. Still relevant.
H-330.923	Medicare Toll-Free Number	Rescind. No longer relevant now that toll-free numbers are available and widely publicized by carriers.
H-330.926	Reform of CMS Technology Assessment Process	Rescind. The Medicare coverage policy envisioned by the policy has been accomplished.
H-330.936	Physician Ordering of Durable Medical Equipment and Home Health Services	Retain. Still relevant.
H-285.935	Patient Rights During Health Plan Sales	Retain. Still relevant.
H-285.938	AMA Establishment of a Nationwide Federation of Physician Networks	Retain. Still relevant.
H-335.994	CMS - Standards of Care, Hospital Admissions	Retain. Still relevant.
H-340.904	Quality Improvement Organization Program Status	Rescind. Superseded by Policy H-340.910.
H-340.910	Quality Improvement Organization Program Status	Retain. Still relevant.
H-340.968	Medicare Review	Retain. Still relevant.
H-345.986	Fifty Percent Copayment Requirement for Codes 290-310 Mental Disorders	Retain. Still relevant.
H-375.998	Review Committees for Medical Practices	Rescind. Superseded by Policies H-375.997 and H-375.962.

Policy #	Policy Title	Recommended Action and Rationale
H-380.984	The Role of Cash Payments in All Physician Practices	Retain. Still relevant.
H-380.991	Accurate Reporting of Physician Charges	Retain. Still relevant.
H-385.938	Most Favored Nation Clause within Insurance Contracts	Retain. Still relevant.
H-340.910	Quality Improvement Organization Program Status	Retain. Still relevant.
H-385.939	Hospital Billing on Behalf of Physicians	Retain. Still relevant.
H-385.942	CMS Use of Regulatory Authority to Implement Reimbursement Policy	Retain. Still relevant.
H-385.979	Reimbursement for Physicians in a Rehabilitation Setting	Retain. Still relevant.
H-390.865	Universal Explanation of Benefits Forms	Retain. Still relevant
H-390.870	Payment Denial Explanation on Medicare Benefit Statements	Retain. Still relevant.
H-390.879	Medicare Reimbursement for Multiple Physician's Visits on the Same Day Regardless of the Place of Service	Retain. Still relevant.
H-390.904	Timely Part B Medicare Payments to Physicians	Retain. Still relevant.
H-390.917	Consultation Follow-Up and Concurrent Care of Referral for Principal Care	Retain in part. In 2010 Medicare ceased paying for CPT consultation codes. Instead, providers may code for a patient evaluation and management (E&M) visit when appropriate. Modify policy to read as follows: (1) It is the policy of the AMA that: (a) the completion of a consultation may require multiple encounters after the initial consultative evaluation ~~(in the inpatient setting these encounters may be reported using the follow-up consultation codes in CPT and in the outpatient setting these encounters may be reported using the appropriate office or other outpatient setting codes)~~; and (b) after completion of the consultation, the consultant may be excused from responsibility of the care of the patient or may share with the primary care physician in concurrent care; he/she may also have the patient referred for care and thus become the principal care physician. (2) The AMA communicate the appropriate use of consultation, evaluation and management,

Policy #	Policy Title	Recommended Action and Rationale
		and office medical services codes to third party payers and advocate the appropriate reimbursement for these services in order to encourage high quality, comprehensive and appropriate consultations for patients.
H-390.947	Medicare Payment Policies/Requirement That Carriers Delay Processing Claims	Retain. Still relevant.
H-390.951	Medicare Deductibles and Co-Payments	Retain. Still relevant.
H-390.953	Medicare Payments for Physicians' Services in Puerto Rico	Retain. Still relevant.
H-400.945	Insurance Compensation When Medicare Rates Are Decreased	Retain. Still relevant.
H-400.946	Uncoupling Commercial Fee Schedules from Medicare Conversion Factors	Retain. Still relevant.
H-400.962	The AMA/Specialty Society RVS Update Process	Retain. Still relevant
H-410.969	Payer Use of Practice Parameters	Retain. Still relevant.
H-465.999	Certification of Rural Hospitals for Medicare	Retain. Still relevant.
H-480.954	National Agency for Technology Evaluations	Retain. Still relevant.

REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Improving Affordability in the Health Insurance Exchanges
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Annual Meeting, the House of Delegates adopted Policy D-165.934, "Studying Mechanisms Including a Public Option to Improve Health Insurance Marketplace Affordability, Competition and Stabilization." The policy states that "our American Medical Association (AMA) will study: (1) mechanisms to improve affordability, competition and stability in the individual health insurance marketplace; and (2) the feasibility of a public option insurance plan as a model as a part of a pluralistic health care system to improve access to care." In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on improving affordability in the individual health insurance marketplace, and Council on Medical Service Report 3, "Ensuring Marketplace Competition and Health Plan Choice."

The Council believes that there is an opportunity to improve affordability in the health insurance exchanges through extending eligibility for premium tax credits, as well as increasing tax credit amounts for some individuals who are already eligible for them. Extending eligibility for advance premium tax credits to 500 percent of the federal poverty level (FPL) would assist individuals with incomes between 400 and 500 percent FPL to obtain coverage, consistent with Policy H-165.848 on individual responsibility. Another key mechanism to improve health insurance affordability, help balance the individual market risk pool and increase coverage rates among young adults is the provision of "enhanced" tax credits to young adults, which provides those aged 19 to 35 who are eligible for advance premium tax credits with "enhanced" premium tax credits—eg, an additional $50 per month for those ages 19-30, the amount declining to age 35.

The Council recognizes that the effectiveness of premium tax credits as a mechanism to improve health insurance affordability relies on individuals who are eligible for such assistance being aware of their eligibility. Toward that end, the Council recommends adequate funding for and expansion of outreach efforts to increase public awareness of premium tax credits to not only increase the number of people who are insured, but also help to balance the individual market risk pool by increasing overall marketplace enrollment.

The elimination of the federal individual mandate penalty has the potential to cause not only premium increases and coverage losses, but increased market instability starting in 2019. States have the opportunity for innovation to maximize the number of individuals covered and stabilize health insurance premiums. In particular, the Council is encouraged by activities and discussions on the state level pursuing state-level individual mandates, auto-enrollment and/or reinsurance, and believes those mechanisms hold great promise in improving coverage rates and market stability.

The Council is encouraged by the success of the Affordable Care Act's (ACA) reinsurance program as well as state reinsurance programs under Section 1332 waiver authority in reducing premiums in comparison to what they otherwise would have been. By partially reimbursing plans for the costs of their high-risk enrollees, reinsurance would help stabilize premiums for all individuals with ACA marketplace coverage, while protecting patients with pre-existing conditions. Therefore, the Council recommends the establishment of a permanent federal reinsurance program. Taken together, the Council believes its policy recommendations will provide the AMA with consistent guidance for advocating for our patients.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-18

Subject: Improving Affordability in the Health Insurance Exchanges

Presented by: Paul A. Wertsch, MD, Chair

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

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

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. In response to Policy D-165.934, the Council is presenting two reports at the 2018 Annual Meeting: this one, which is focused on improving affordability in the individual health insurance marketplace, and Council on Medical Service Report 3, "Ensuring Marketplace Competition and Health Plan Choice."

This report provides background on recent premium increases in the Affordable Care Act (ACA) individual health insurance marketplaces and their associated impact on health plan affordability**,** outlines potential approaches to improve affordability in the ACA marketplaces, summarizes relevant AMA policy, and presents policy recommendations.

BACKGROUND

Premiums in ACA marketplaces rose significantly in many counties across the country from 2017 to 2018, due to factors including health insurer uncertainty about payment of cost-sharing reductions (CSRs) and enforcement of the individual mandate, lower insurer participation in the marketplaces, as well as more characteristic factors contributing to annual increases, including health care costs and trends. Depending on the county of residence and eligibility for premium tax credits, however, not all individuals have faced increases in their premiums from 2017 to 2018. For example, for a 40 year-old, unsubsidized premiums for the lowest-cost bronze, silver and gold plans increased nationally by an average of 17 percent, 32 percent and 18 percent respectively between 2017 and 2018. Premiums for silver plans experienced larger increases than bronze and gold plans as a result of insurer and state strategies employed in response to the termination of CSR payments.[1] For those consumers who enrolled in coverage via the healthcare.gov platform during the 2017 and 2018 open enrollment periods, the average premium before the application of any tax credit increased from $476 in 2017 to $621 in 2018.[2]

Even though the federal government has stopped reimbursing insurers for CSRs, insurers are still required under the ACA to offer CSRs to individuals with incomes up to 250 percent of the federal

poverty level (FPL) who enroll in silver plans. Insurers, depending on the state in which they offer plans, responded to the termination of CSR payments in one of four main ways in setting premiums for the 2018 plan year:

- Increasing premiums only for silver plans offered inside the marketplace, because CSRs are only available for these plans;
- Increasing premiums for all silver plans, including those offered inside and outside the marketplace;
- Increasing premiums for all ACA-compliant individual market plans, including those offered inside and outside the marketplace; and
- Not adjusting premiums at all in response to the termination of CSR payments, though this strategy was very uncommon.[3]

Partially as a result of insurer responses to termination of CSR payments, for individuals who are eligible for premium tax credits, subsidized premiums are often lower in 2018 than 2017. Of note, of those consumers who selected or were automatically reenrolled in an ACA marketplace plan during open enrollment this year, 83 percent received a tax credit to lower their premiums.[4] The amount of premium tax credits an individual receives is based on the cost of the second lowest cost silver (benchmark) plan available to them. In 2018, for states using the healthcare.gov platform, the average monthly premium for the benchmark plan for a 27 year-old increased by 37 percent ($411) compared to 2017 ($300). Such increases in benchmark plan premiums have yielded much higher tax credit amounts for many individuals. For states using the healthcare.gov platform, the average premium tax credit for individuals with 2017 coverage was estimated to increase by 45 percent from 2017 to 2018, from $382 to $555.[5] For consumers who enrolled in plans during the 2018 open enrollment period in states using the healthcare.gov platform and received a tax credit to lower their premiums, the average premium tax credit was $550. Among these consumers with a premium tax credit, the tax credit covered approximately 86 percent of the total premium on average. After the application of the tax credit, the average premium was $89 per month.[6] With higher premium tax credit amounts, gold plans became much more affordable, with bronze plans oftentimes having very low or no premiums. In some counties, the premium of the lowest-cost gold plan was even cheaper than the lowest-cost silver plan.

Looking ahead to 2019, resulting from the elimination of the individual mandate penalty due to enactment of tax reform legislation, individuals will become uninsured, and premiums will increase. In fact, the Congressional Budget Office has projected that repealing the individual mandate, starting in 2019, would cause the number of individuals with health insurance coverage to decrease by four million in 2019 and 13 million in 2027. At the same time, average premiums in the nongroup market would increase by approximately 10 percent in most years of the coming decade.[7]

APPROACHES TO IMPROVE AFFORDABILITY IN THE INDIVIDUAL MARKETPLACE

State-Level Individual Mandates and Auto-Enrollment

In light of the elimination of the federal individual mandate penalty, states have begun contemplating approaches to prevent the projected coverage losses and the level of premium increases anticipated in 2019. While the individual mandate of Massachusetts remains in place, some states are moving forward with individual mandate requirements, with the status and substance of such discussions varying by locality. For example, the New Jersey legislature approved the New Jersey Health Insurance Market Preservation Act, which would institute an individual mandate penalty in the state that largely resembles that of the ACA.[8] The Council notes

that state approaches to instituting state-level individual mandates, as well as auto-enrollment, depend on whether a state has an income tax and the extent to which a state operates its own health insurance marketplace.

The auto-enrollment option is also being considered in some states, to be either implemented separately from or in concert with a state-level individual mandate. For example, in Maryland, the Protect Maryland Health Care Act of 2018 has been introduced, which, if enacted into law, would give uninsured residents who would otherwise be charged an individual mandate penalty a choice: pay the penalty, or instead use the penalty amount as a down payment to assist them in purchasing health insurance coverage. If there are plans available that cost no more than any applicable federal premium tax credit amount and the down payment, consumers would be enrolled in such plans. If there are no "zero premium" plans available, the down payment would be placed into an escrow account that accumulates interest, which could then be used to purchase health insurance coverage during the following open enrollment period. If consumers do not select a plan by the end of open enrollment, and a "zero premium" plan has become available to them, they will be auto-enrolled in such coverage. Otherwise, their down payment would be deposited into the newly established Maryland Insurance Stabilization Fund, and be applied toward such initiatives as reinsurance.[9,10]

State and Federal Reinsurance Programs

The recommendations of Council on Medical Service Report 4-I-17 established Policy H-165.842[3], which prefers reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. State and federal reinsurance programs have been shown to be effective in yielding premium reductions, in comparison to what they otherwise would have been. On the federal level, the ACA's temporary reinsurance program helped stabilize premiums in the individual marketplace during the early years of ACA implementation. The program provided payments to plans that enrolled higher-cost individuals whose costs exceeded a certain threshold, also known as an attachment point, up to the reinsurance cap.[11] To fund the ACA's transitional reinsurance program, insurers and third party administrators paid $63 per enrollee per year in 2014, $44 in 2015 and $27 in 2016. These investments in reinsurance yielded premium reductions. For example, in 2014, the $10 billion reinsurance fund, the result of the $63 per enrollee per year contributions, was estimated to reduce premiums by 10 to 14 percent. The American Academy of Actuaries has stated that a permanent program to reimburse plans for the costs of their high-risk enrollees would reduce premiums.[12]

States are also using ACA Section 1332 waivers to fund state reinsurance programs. Through an approved 1332 waiver, Alaska was able to implement the Alaska Reinsurance Program (ARP) for 2018 and subsequent years. The ARP covers claims in the individual market for individuals with one or more of 33 identified high-cost conditions to help stabilize premiums. As a result, insurers relinquish both premiums received for such individuals as well as claims they would have paid absent the waiver. Accordingly, premiums are 20 percent lower this year in the average plan on the individual market than they would have been absent the waiver.[13] Other states have moved forward with implementing more traditional state reinsurance programs through Section 1332 waivers. For example, due to an approved 1332 waiver, premiums in Oregon were lower this year in comparison to what they would have otherwise been.[14]

In the 115th Congress, federal legislation has been introduced to provide funding for reinsurance programs. In the Senate, Senators Susan Collins (R-ME) and Bill Nelson (D-FL) introduced S 1835, the Lower Premiums Through Reinsurance Act of 2017, which would allow states to leverage Section 1332 waivers to apply and receive funding for reinsurance or invisible high-risk

pool programs. The legislation would provide $5 billion in total for funding, split evenly between fiscal years 2018 and 2019.[15]

In the House of Representatives, Congressmen Ryan Costello (R-PA) and Collin Peterson (D-MN) introduced HR 4666, the Premium Relief Act of 2017, which would establish the Patient and State Stability Fund, which would provide up to $30 billion from 2019 to 2021 for the Secretary of Health and Human Services (HHS) to allocate at his discretion to be used for defined, outlined purposes, including reinsurance. If states do not apply for funding and administer their own programs under the bill, a federal reinsurance program would be established in said states by default. The legislation would also provide for reimbursements to insurers for CSR payments retroactively for the last quarter of 2017, as well as for 2019 and 2020.[16]

HR 3311/S 1354, the Individual Health Insurance Marketplace Improvement Act, has been introduced by Senator Thomas Carper (D-DE) and Congressman James Langevin (D-RI). If enacted into law, the legislation would create a permanent federal reinsurance program. The reinsurance program would provide payments to health plans to cover 80 percent of insurance claims incurred by plan enrollees between $50,000 and $500,000 from 2018-2020, and between $100,000 and $500,000 in 2021 and beyond.[17,18]

There was also debate to include funding for reinsurance as part of HR 1625, the Consolidated Appropriations Act of 2018. However, ultimately such funding for reinsurance was not included in the final package.

Expansion of Eligibility for Premium Tax Credits

Under the ACA, eligible individuals and families with incomes between 100 and 400 percent FPL (133 and 400 percent in Medicaid expansion states) are being provided with refundable and advanceable premium tax credits to purchase coverage on health insurance exchanges. The size of premium credits is based on household income relative to the cost of premiums for the benchmark plan, which is the second-lowest-cost silver plan offered on the exchange. The premium credit thereby caps the percentage of income that individuals pay for their premiums.

Individuals and families with incomes over 400 percent FPL are left without any premium assistance. The Council notes that the policy of our AMA in support of an individual responsibility requirement (Policy H-165.848) states that once a system of refundable, advanceable tax credits inversely related to income is implemented, that individuals and families earning less than 500 percent FPL should be required to obtain coverage. Extending advanceable premium tax credits to those with incomes above 400 percent FPL would not only cause some individuals with incomes between 400 and 500 percent FPL to be able to afford and obtain health insurance coverage, but would also be highly consistent with Policy H-165.848.

Enhanced Premium Tax Credits for Young Adults

In order to improve insurance take-up rates among young adults and help balance the individual health insurance market risk pool, young adults ages 19 to 30 who are eligible for advance premium tax credits could be provided with “enhanced” premium tax credits—eg, an additional $50 per month—while maintaining the current premium tax credit structure which is inversely related to income, as well as the current 3:1 age rating ratio. Smaller amounts could be provided to individuals between ages 30–35. Under this policy option, the total credit, including the “enhanced” tax credit, could not exceed the cost of the second-lowest-cost silver plan available to them. Modeling of “enhanced” premium tax credits projects that individual market enrollment

would increase by one million with the proposal in place.[19] Of note, this approach to expanding coverage among young adults would cost less to the federal government than changing the age rating ratio from 3:1 to 5:1, as the latter would cause premiums for older adults to increase, as well as the associated premium tax credit amounts. Significantly, changing the age rating would cause some older adults to become uninsured; whereas with "enhanced" premium tax credits, individual market enrollment among older adults would remain largely unchanged.[20,21]

Improved Outreach About Premium Subsidies

In August 2017, the Centers for Medicare & Medicaid Services announced that it would be spending $10 million on educational activities targeted at new and returning marketplace enrollees for the open enrollment period for the 2018 plan year,[22] which represented a 90 percent cut from the $100 million spent on ACA-related advertising in 2017.[23] In addition, federal spending on the ACA's navigator program, which provides outreach, education and enrollment assistance to consumers eligible for marketplace coverage as well as Medicaid, was cut 40 percent.[24] However, states operating their own health insurance marketplaces and navigator programs continued to dedicate financial resources to outreach and educational activities, as did some non-profit entities. It has been suggested that the difference in resources dedicated to outreach and education between states operating their own marketplaces and states that relied on healthcare.gov impacted enrollment successes in the marketplaces for 2018. For example, in the 16 states and DC with state-based marketplaces, 2018 plan signups during the open enrollment period stayed consistent with that of 2017, with a very slight increase. On the other hand, in the 34 states that fully relied on the federal healthcare.gov platform, total plan signups decreased by more than five percent in comparison to 2017.[25]

At the same time, of the 27.5 million nonelderly people who were uninsured in 2016, 7.9 million were eligible for premium tax credits to purchase coverage through the marketplace. Data suggest that there remains a lack of awareness about premium tax credits and other financial assistance that may be available, as well as confusion about eligibility rules.[26] The Council notes that for individuals who are eligible for premium tax credits but remain uninsured, improved outreach and education about premium subsidies and their coverage options in the marketplace will be critical to increase the number of people who are insured, and may help to balance the individual market risk pool by increasing marketplace enrollment.

RELEVANT AMA POLICY

Over the course of the past couple of years, the Council has developed and presented reports specifically addressing improving health insurance affordability. CMS Report 4-I-17 focused on essential health benefits and the relative merits of high-risk pools versus reinsurance. The resulting policies, H-165.846[3] and H-165.842[3], oppose the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; oppose waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of high-cost and high-risk patients. CMS Report 8-I-15 established Policy H-165.828, which supports legislation or regulation to fix the "family glitch;" supports allowing workers and their families to be eligible for subsidized exchange coverage if their employer coverage has premiums high enough to make them exempt from the individual mandate; encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to a health savings account partially funded by an amount determined to be equivalent to the cost-sharing subsidy; and

supports capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability, including for individuals impacted by the inconsistency in affordability definitions, individuals impacted by the "family glitch," and individuals who forego cost-sharing subsidies despite being eligible.

Policy H-165.841 supports the overall goal of ensuring that every American has access to affordable high quality health care coverage. Policy H-165.845 states that health insurance coverage should be equitable, affordable, and sustainable. Policy H-165.838 supports insurance market reforms that expand choice of affordable coverage. Policy H-165.920 supports individual tax credits as the preferred method for people to obtain health insurance coverage. Policy H-165.865 states that tax credits should be refundable; inversely related to income; large enough to ensure that health insurance is affordable for most people; fixed-dollar amounts for a given income and family structure; and advanceable for low-income persons who could not afford the monthly out-of-pocket premium costs. Policy H-373.998 states that health reform plans should effectively provide universal access to an affordable and adequate spectrum of health care services, maintain the quality of such services, and preserve patients' freedom to select physicians and/or health plans of their choice.

Policy H-165.848 supports a requirement that individuals and families who can afford health insurance be required to obtain it, using the tax structure to achieve compliance. The policy advocates a requirement that those earning greater than 500 percent FPL obtain a minimum level of catastrophic and preventive coverage. Only upon implementation of tax credits or other coverage subsidies would those earning less than 500 percent FPL be subject to the coverage requirement. Policy H-165.856 supports health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability. In CMS Report 9-A-11, "Covering the Uninsured and Individual Responsibility," the Council gave thoughtful consideration to alternatives to requiring individual responsibility, including the imposition of penalties for late enrollment, similar to Medicare Part D. The Council found that analyses fail to prove that such alternatives would be as effective in covering the uninsured and promoting a balanced risk pool of individuals between those who are sick and those who are healthy as an individual responsibility requirement.

Addressing state innovation, Policy D-165.942 advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives: a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care; b) ensure and maximize patient choice of physician and private health plan; and c) include reforms that eliminate denials for pre-existing conditions.

DISCUSSION

With almost 12 million Americans enrolled in coverage offered through health insurance exchanges this year, the Council affirms that progress has been made on a long-standing policy priority of the AMA—supporting the purchase of individually selected and owned health insurance coverage with use of refundable and advanceable tax credits inversely related to income. However, the Council remains concerned with the premium increases experienced in the health insurance marketplaces from their launch in the 2014 plan year, and at the same time recognizes that such increases primarily impact those who are not eligible for premium tax credits. The Council believes that there is an opportunity to extend eligibility for advance premium tax credits which are inversely related to income consistent with Policy H-165.865 to 500 percent of FPL, which would

assist individuals with incomes between 400 and 500 percent FPL to obtain coverage, consistent with Policy H-165.848 on individual responsibility.

The Council recognizes that the effectiveness of premium tax credits as a mechanism to improve health insurance affordability relies on individuals who are eligible for such assistance being aware of it. It is noteworthy that of the 27.5 million nonelderly people who were uninsured in 2016, 7.9 million were eligible for premium tax credits to purchase coverage through the marketplace. There is a clear opportunity to improve awareness about premium tax credits and other financial assistance that may be available to enrollees, as well as clear up confusion about eligibility rules. Accordingly, the Council recommends adequate funding for and expansion of outreach efforts to increase public awareness of premium tax credits to not only increase the number of people who are insured, but also help to balance the individual market risk pool by increasing overall marketplace enrollment.

Another key mechanism to help balance the individual market risk pool and increase coverage rates is the provision of "enhanced" tax credits to young adults. This proposal, which provides those aged 19 to 35 who are eligible for advance premium tax credits with "enhanced" premium tax credits—eg, an additional $50 per month for those ages 19-30, the amount declining to age 35—has been projected to spur increases in young adult enrollment in the marketplace. Importantly, this policy recommendation maintains the current premium tax credit structure which is inversely related to income and as such is highly consistent with AMA policy. The Council notes that, as outlined in long-standing Policy H-165.920 and Policy H-165.828, eliminating or capping the employee tax exclusion for employment-based insurance could be used as a funding stream for the mechanisms proposed to improve health insurance affordability in this report.

The elimination of the federal individual mandate penalty has the potential to cause not only premium increases and coverage losses, but increased market instability starting in 2019. An opportunity exists for state innovation to maximize the number of individuals covered and stabilize health insurance premiums. In particular, the Council is encouraged by activities and discussions on the state level pursuing state-level individual mandates, auto-enrollment and/or reinsurance, and believes those mechanisms hold great promise moving forward.

Finally, the Council is encouraged by the success of the ACA's reinsurance program as well as state reinsurance programs under Section 1332 waiver authority in reducing premiums in comparison to what they otherwise would have been. By partially reimbursing plans for the costs of their high-risk enrollees, reinsurance would help stabilize premiums for all individuals with ACA marketplace coverage, while protecting patients with pre-existing conditions. Therefore, the Council is recommending the establishment of a permanent federal reinsurance program. Upon the program's launch, it will be essential to monitor and evaluate the program's impact on premiums.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (New HOD Policy)

2. That our AMA support expanding eligibility for premium tax credits up to 500 percent of the federal poverty level. (New HOD Policy)

3. That our AMA support providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income. (New HOD Policy)

4. That our AMA encourage state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. (New HOD Policy)

5. That our AMA support the establishment of a permanent federal reinsurance program. (New HOD Policy)

Fiscal Note: Less than $500.

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

EXECUTIVE SUMMARY

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

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

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

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

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-18

Subject: Ensuring Marketplace Competition and Health Plan Choice

Presented by: Paul A. Wertsch, MD, Chair

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

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

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

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

BACKGROUND

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

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

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

REGULATORY ACTIVITY IMPACTING MARKETPLACES

Association Health Plan Proposed Rule

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

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

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

Short-Term Limited Duration Plan Proposed Rule

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

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

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

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

State-Level Activities: Idaho and Iowa

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

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

VARIOUS APPROACHES TO ENSURE MARKETPLACE COVERAGE OPTIONS

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

Federal and State Legislative Approaches

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

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

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

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

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

Leveraging FEHBP to Ensure Marketplace Plan Choice

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

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

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

RELEVANT AMA POLICY

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

Regarding meaningful coverage, Policy H-165.846 states that existing federal guidelines regarding types of health insurance coverage (eg, Title 26 of the US Tax Code and FEHBP regulations) should be used as a reference when considering if a given plan would provide meaningful coverage. The policy also advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any EHB package for children; opposes the removal of categories from the EHB package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and opposes waivers of EHB requirements that lead to the elimination of EHB categories and their associated protections against annual and lifetime limits, and out-of-pocket expenses. Policy H-165.865 states that in order to qualify for a tax credit for the purchase of individual health insurance, the health insurance purchased must provide coverage for hospital care, surgical and medical care, and catastrophic coverage of medical expenses as defined by Title 26 Section 9832 of the US Code.

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

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

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

DISCUSSION

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

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

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

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

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

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

RECOMMENDATIONS

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

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

2. That our AMA oppose the sale of health insurance plans in the individual and small group markets that do not comply with Affordable Care Act requirements, including those related to pre-existing condition protections and essential health benefits, except in the limited circumstance of short-term limited duration insurance offered for no more than three months. (New HOD Policy)

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

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

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

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

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

Fiscal Note: Less than $500.

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REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (A-18)
Insulin Affordability
(Resolution 826-I-17)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2017 Interim Meeting, the House of Delegates referred Resolution 826, "Improving Affordability of Insulin," which was sponsored by the American Association of Clinical Endocrinologists and the Endocrine Society, and which directed the American Medical Association (AMA) to: (1) work with relevant medical specialty societies to convene a summit with participation by patients, clinicians, manufacturers, pharmacy benefit managers (PBMs), insurers and the appropriate federal representatives to highlight the dramatic increase in insulin costs and identify potential solutions; (2) pursue solutions to reduce patient cost sharing for insulin and ensure patients benefit from rebates at the point of sale; (3) work with health insurance companies and federal agencies to stabilize drug formularies and reduce non-medical switching by encouraging plans to cover insulin products at the same cost listed on a drug formulary throughout the entire plan year; (4) encourage insulin price and cost transparency among pharmaceutical companies, PBMs and health insurance companies; and (5) work with electronic medical record vendors and insurance companies to integrate current formularies and price information into all systems so physicians and patients can make informed decisions on insulin products to reduce cost burdens on patients. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting.

Approximately six million Americans use insulin, a drug that has experienced dramatic price increases over the past decade. High insulin prices impact stakeholders throughout the health care system, from patients to health plans/payers and PBMs. The Council notes that insulin is one of the many essential drugs across all categories of pharmaceuticals to recently experience remarkable price increases.

A variety of complicated factors contribute to increases in insulin prices, and this report examines opportunities to identify more affordable alternatives to high-priced insulin. The Council recommends supporting physician education initiatives focused on drug price and cost transparency and the cost-effectiveness of insulin therapies. Additionally, the Council recommends that our AMA disseminate relevant model state legislation and provide assistance, upon request, to state medical associations in support of legislative and regulatory efforts to improve drug price and cost transparency. Finally, the Council recommends that our AMA encourage the Federal Trade Commission and Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate.

In addition, the report describes extensive AMA policy and highly visible AMA advocacy that directly respond to the resolves of referred Resolution 826-I-17. Accordingly, the Council recommends reaffirmation of policies which support: monitoring the relationships between PBMs and the pharmaceutical industry; authorizing federal action to address price gouging and increase patient access to affordable drugs; prescription drug price and formulary transparency; value based insurance design and cost-sharing requirements that consider factors known to affect patient compliance; access to information about the out-of-pocket cost of prescription drugs; and continued collaboration with the Food and Drug Administration on controversial issues including drugs, biologics, and pharmaceuticals.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-A-18

Subject: Insulin Affordability
(Resolution 826-I-17)

Presented by: Paul A. Wertsch, MD, Chair

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

At the 2017 Interim Meeting, the House of Delegates referred Resolution 826, "Improving Affordability of Insulin," which was sponsored by the American Association of Clinical Endocrinologists (AACE) and the Endocrine Society (ES), and which directed the American Medical Association (AMA) to:

> (1) work with relevant medical specialty societies to convene a summit with participation by patients, clinicians, manufacturers, pharmacy benefit managers (PBMs), insurers and the appropriate federal representatives to highlight the dramatic increase in insulin costs and identify potential solutions; (2) pursue solutions to reduce patient cost sharing for insulin and ensure patients benefit from rebates at the point of sale; (3) work with health insurance companies and federal agencies to stabilize drug formularies and reduce non-medical switching by encouraging plans to cover insulin products at the same cost listed on a drug formulary throughout the entire plan year; (4) encourage insulin price and cost transparency among pharmaceutical companies, PBMs and health insurance companies; and (5) work with electronic medical record vendors and insurance companies to integrate current formularies and price information into all systems so physicians and patients can make informed decisions on insulin products to reduce cost burdens on patients.

The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2018 Annual Meeting. This report highlights insulin as one among the many prescription drugs to recently experience exceptional price increases, government and legal actions to address insulin affordability, opportunities to identify more affordable options for patients in need, and the strong ongoing efforts of the AMA to address affordability of pharmaceuticals. Finally, this report presents policy recommendations.

BACKGROUND

Approximately 30 million Americans have diabetes,[1] and approximately six million Americans use insulin.[2] As explained by the AACE and the ES, patients with type 1 diabetes need insulin for survival and frequently insulin is the only drug that can control the diabetes of patients with type 2 diabetes.[3] Insulin can be very expensive, and the price has increased dramatically over the course of the past decade. For example, the annual retail price of Humulin R (U-500) 500 units/mL—an insulin marketed by Eli Lilly and Company (Lilly)—increased from $2,487 at the end of 2005 to $15,860 by the end of 2015.[4] Humulin is one of six brand-name drugs that increased in price by 500 percent or more from 2006 to 2015.[5] In general, the mean price per milliliter of insulin increased almost 200 percent, from $4.34 per milliliter in 2002 to $12.92 per milliliter in 2013.[6]

High insulin prices impact stakeholders throughout the health care system. Of course, uninsured patients paying cash for their prescriptions are exposed directly to high insulin prices. Insured patients are also directly impacted by high insulin prices when they are still in the deductible period, when the drug prescribed is not covered by their insurance, when a nonpreferred formulary status for a particular insulin product leads to a higher patient cost-share, and when a Medicare Part D beneficiary is in the "donut hole."[7] As the number of patients enrolled in high-deductible health plans and Medicare Part D continues to rise, more patients will be vulnerable to significant drug prices. Insulin prices also impact health plans/payers and PBMs. The impact of insulin expenditures on Medicare and Medicaid has been noteworthy. For example, expenditures for just one long-acting insulin analogue, glargine, were the second largest of all Medicare expenditures in 2015.[8] In that year, Medicare Part D spent more than $4.3 billion and Medicaid spent more than $1.4 billion on glargine alone.[9]

Pharmaceutical manufacturers, PBMs and others in the pharmacy supply chain continue to blame each other for high drug prices,[10] but some have taken steps that may ameliorate the impact on patients. For example, Novo Nordisk has indicated that it would limit future annual price increase percentages to not exceed single digits, ensure that a lower-priced option for human insulin remains available, and continue support of copay assistance and patient assistance programs, which are described later in this report.[11]

At the same time, it is important to emphasize that insulin is one of the many essential drugs across all categories of pharmaceuticals—brand name, specialty, and generic—to experience remarkable price increases. For example, the brand name drug Wellbutrin XL, used to treat depression, experienced a price increase of 1,185 percent over a ten-year study period ending in 2015.[12] Over the same ten-year study period, the specialty drug Enbrel, used to treat inflammatory and immunological disorders, experienced a 172 percent price increase.[13] Finally, between 2010 and 2015, the generic drug divalproex sodium, an anticonvulsant, experienced a price increase of 450.6 percent.[14] The Council acknowledges that, as with insulin, if patients are not able to take these medications correctly due to affordability, complications can result.

GOVERNMENT AND LEGAL ACTIONS TO ADDRESS INSULIN AFFORDABILITY

The significant and complicated factors contributing to increases in insulin prices have led both state and federal governments, as well as private citizens, to take formal action. To date, at least five states and a federal prosecutor are demanding information from insulin manufacturers and PBMs.[15] In addition, prominent class-action attorneys are bringing lawsuits on behalf of patients.[16] For example, a class action complaint filed in Massachusetts in January 2017 points to evidence that, "In 13 instances since 2009, Sanofi and Novo Nordisk raised the benchmark prices of their long-acting analog insulins, Lantus and Levemir, in tandem, 'taking the same price increase down to the decimal point within a few days of each other'. . . Eli Lilly and Novo Nordisk have engaged in the same lock-step behavior with respect to their rapid-acting analog insulins, Humalog and Novolog."[17] The complaint further alleges that these pharmaceutical companies artificially inflated their list prices to secure positions on PBMs' formularies, with PBMs demanding higher rebates in exchange for including drugs on their preferred-drug lists.[18] Similarly, three of the main insulin manufacturers—Sanofi-Aventis, Novo Nordisk and Lilly—along with three of the largest PBMs—CVS Health, Express Scripts and OptumRx—are subject to a class action lawsuit, alleging that they together caused "rapid and lockstep price increases of more than 150 percent in insulin treatments."[19]

In addition, there has recently been legislative and regulatory action to improve insulin affordability. In November 2016, two US Senators requested that the Department of Justice (DOJ)

and the Federal Trade Commission (FTC) investigate possible collusion among insulin makers.[20] Concerns regarding PBMs became a theme in a February 2018 hearing by the House Energy and Commerce Subcommittee on Oversight and Investigations that was focused on concentration in the health care system.[21] Specifically relevant to this report, Ranking Member of the Subcommittee, Rep. Diana DeGette (D-Colo.), explored whether PBM consolidation contributed to higher prices for insulin.[22] Additionally, the Food and Drug Administration (FDA) is working to "improve transparency and encourage the development and submission of abbreviated new drug applications (ANDAs) in markets with limited competition."[23] To that end, it has developed a list identifying approved new drug application (NDA) drug products that are off-patent and off-exclusivity, and for which the FDA has not yet approved an ANDA. This list of applications was updated in December 2017, and it includes several insulin products (insulin human, insulin lispro protamine recombinant, and insulin lispro recombinant).[24] On the state level, in 2017, Nevada passed an act that requires the state's Department of Health and Human Services to compile a list of prescription drugs that it determines to be essential for treating diabetes.[25] The manufacturers and PBMs associated with essential diabetes drugs will have to submit annual reports to the state containing drug cost information,[26] which will be analyzed by the state and reported on its website.[27] However, pharmaceutical companies have begun challenging the Nevada law in court.[28]

OPPORTUNITIES TO IDENTIFY MORE AFFORDABLE ALTERNATIVES

Value-Based Insurance Design

Value-based insurance design (VBID) uses cost-sharing as a tool to encourage the use of specific "high-value services," which have been defined as those services that are clinically meaningful in the practice of medicine, improve quality of care or clinical outcomes for patients, and are usually standards of care as part of evidence-based guidelines or clinical care pathways.[29] Unlike traditional benefit designs that apply a standard set of cost-sharing requirements to all services and all patients, VBID determines coverage and cost-sharing rules based on an assessment of the clinical value of individual health care treatments or services.

Diabetes management is an especially strong example of VBID's potential. Aligning incentives to encourage blood glucose control prevents long-term complications from diabetes that can be physically and financially devastating to patients and the health care system. As AACE and ES have explained, without adequate control of diabetes, patients have a higher risk of developing microvascular complications such as blindness, kidney disease and nerve damage, and macrovascular complications including heart attacks and strokes.[30] A recent study used actuarial modeling to predict the financial impact of VBID for Medicare beneficiaries, and it used a design that incorporated targeted reductions in cost-sharing for select chronic conditions.[31] The study specifically focused on diabetes patients and included insulin and other glycemic-lowering agents among the high-value services targeted for reduced cost-sharing. The actuarial assumptions of this model indicated that removing cost-sharing for targeted high-value services would increase their use by five to 15 percent, and the fiscal impact of that additional spending would be partially offset by fewer inpatient stays and emergency department visits. The study found that for diabetes patients under this model, member cost-sharing would decrease, societal impact would be close to cost neutral, and the increase in cost to health plans would be "very modest."[32]

Recognizing its potential, VBID is gaining traction as an insurance design to improve affordability. The recently enacted Bipartisan Budget Act of 2018 incorporates the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which includes expansion of the Medicare Advantage Value-Based Insurance Design Model to all 50 states by no later than January 1, 2020.[33] The model allows Medicare Advantage plans the

flexibility to reduce cost-sharing or offer supplemental benefits to enrollees with specified chronic conditions, focusing on the services that are of highest clinical value to them. This Act demonstrates growing bipartisan support for the expanded role of VBID principles in public and private payers.

The Role of Biosimilars

Biosimilars may play a unique role in the insulin market. Currently, no insulin glargine products are licensed under the Public Health Service Act, so there is no "reference product" for a proposed biosimilar product. Instead, when Basaglar launched in December 2016, the FDA referred to it as "follow-on" insulin to the originator drug, Lantus. (This definitional confusion should resolve following a change to FDA law in 2020).[34] As with other drugs, the price patients will pay for Basaglar varies depending on their health insurance plan.[35] Additionally, Basaglar experienced uptake that varied based on patients' insurance type.[36] As of March 2017, Basaglar had achieved only approximately five percent market share. However, in the small portion of the market where insurance formularies preferred Basaglar to Lantus, it achieved approximately 50 percent market share.[37] Notably, this year, Basaglar is preferred in Medicare Part D plans, as well as other commercial plans.[38] Another key item to watch is a second follow-on insulin glargine, Lusduna, which gained tentative FDA approval in July 2017, but will not be issued final approval until a patent infringement suit, brought by Lantus' maker, Sanofi, concludes.[39] Due to stringent regulations and the cost of bringing "follow-on" or biosimilar insulins to market, some analysts expect that the mean price of insulin will not decrease as a result of "generic" competition.[40] In contrast, other analysts have speculated that once several follow-on insulin glargine products are actively competing with Lantus and its next-generation insulin glargine brand, discounts and rebates could mean savings of approximately 30 percent, as the market niche becomes saturated.[41]

The Role of Older Insulins

To avoid the high price of many insulin regimens, some physicians and analysts have advocated for use of older, less expensive insulins, when clinically appropriate to do so,[42] and this may vary among patients with type 1 and type 2 diabetes. As a general principle, the more severe the insulin deficiency (for type 1 and for some type 2 diabetes), "the more important it is to have considerable mimicry of normal physiology to successfully lower glucose and do so with safety. Although not superior in overall glycemic lowering efficacy compared to human insulin, the analogs . . . have gained progressive popularity despite their increased cost. Today, analogs used as basal bolus therapy are considered the standard of care for patients who have type 1 diabetes mellitus and are increasingly used in type 2 diabetes."[43]

In fact, the proportion of patients using more expensive, newer insulin analogs has substantially increased, even though data suggests that there is "little clinical benefit" to using insulin analog versus regular human insulin and neutral protamine Hagerdorn (NPH) for type 2 diabetes.[44] In 2000, 19 percent of privately insured adults with type 2 diabetes were using analog insulin, but by 2010, 96 percent of that population was using insulin analogs.[45] The older insulins, however, are still considered to be as effective as the analogs in controlling blood glucose for most patients with type 2 diabetes.[46] Moreover, a vial of NPH (N), human regular (R), or premixed 70/30 N/R insulin (Novolin N, R, or 70/30) can be obtained for as little as $25.[47] At the same time, given the substantial increase in use of insulin analogs since 2000, younger clinicians may not be as well versed in the use of older insulins, with many training programs no longer emphasizing the use of human insulins.[48] Accordingly, guidance and educational materials can help younger physicians become more comfortable with prescribing more affordable insulin alternatives.[49] Consistent with these recommendations, a recent study compared prescription drug spending in the US to nine

other high-income countries and found that US citizens consume a mix of drugs that include a high proportion of newer, more expensive medications without evidence of better health outcomes than the other nine countries examined.[50] The study observed that, unlike the US, the other nine countries have processes to assess not just whether a new drug is effective, but whether it is more effective than existing therapies, and sometimes, whether it is cost-effective.[51] A process for including cost-effectiveness in comparative effectiveness research for pharmaceuticals is consistent with AMA Policy H-110.986, which is detailed in the policy section below.

Improving Price Transparency

With timely, accurate information about what a specific prescription will cost a specific patient, physicians and patients will be in a stronger position to jointly develop optimal treatment plans. As detailed below, the AMA is engaged in significant activity, supported by longstanding policy, to advocate for improved prescription drug price transparency. Improved transparency at the point of sale may also help patients address affordability concerns.

Many health care industry stakeholders can potentially help improve insulin affordability. In November 2017, Surescripts announced a Real-Time Prescription Benefit to advance this goal. Surescripts is collaborating with six electronic health records (EHR) companies (representing 53 percent of the US physician base) and leveraging information from PBMs CVS Health and Express Scripts (representing nearly two-thirds of US patients), "to deliver patient-specific benefit and price information to providers in real time at the point of care. Once integrated with the EHR, the solution will also display therapeutic alternatives so that the prescriber and patient can collaborate in selecting a medication that is both clinically appropriate and affordable."[52] UnitedHealthcare and OptumRx are collaborating to provide a similar tool, specifically for their enrollees.[53] With PreCheck MyScript, before prescribing a medication, physicians can run a pharmacy trial claim to see how much a patient would be charged for a specific medication. The system will also provide lower-cost alternatives, when available.

In addition, pharmacists play an important role. Pharmacists may be aware of less expensive prescription drug options, but pharmacists can be prevented from informing patients of these options due to certain provisions in their contracts with PBMs.[54] For example, a drug formulary can require patients to spend more on a prescription copay than they would be charged if they purchased the drug without insurance.[55] So called "gag clauses" in pharmacy-PBM contracts can bar pharmacists from telling consumers about less expensive options, such as not using their insurance. Moreover, "clawback" provisions can allow PBMs to take back the difference between a higher copay amount and a lower negotiated rate. Bipartisan bills have recently been introduced in both the Senate[56] and the House[57] to prohibit these restrictions on pharmacies and pharmacists.

Additionally, financial assistance programs can help eligible patients, but as the ES has explained, these programs are often inaccessible or overly complicated for the patients who need them the most.[58] For example, the Novo Nordisk Savings Card can help patients save hundreds of dollars on their diabetes medication.[59] However, to be eligible for this program, patients must be enrolled in a commercial insurance plan (patients paying cash and those insured through any federal or state plan are ineligible).[60] Additionally, the discount only applies for up to 24 months, and is subject to maximum benefit limitations.[61] Sanofi-Aventis similarly offers a Sanofi Rx Savings Card, but it too carries eligibility restrictions that are not easily found on its website.[62] Finally, Lilly offers limited time offers for discounts on insulin products, but each offer is subject to eligibility requirements and differing expiration dates.[63]

Some patients may benefit from other forms of financial assistance, but this too is complicated. Patients without health insurance or without prescription drug coverage can apply for patient assistance programs, and the nonprofit NeedyMeds can help patients find programs that offer free or low-cost insulin for those who meet eligibility requirements.[64] Some patients who have prescription drug coverage, especially those with high deductible health plans, may find that cash and coupon prices can be lower than their insurance copay or coinsurance.[65] Websites like GoodRx can help patients find the lowest prices for their insulin.[66] However, companies that provide health insurance and prescription drug coverage have started instituting "copay accumulators," which can significantly impact patients' out-of-pocket costs when using drug coupons.[67] Previously, when patients used copay coupons to reduce the price they pay for their prescriptions, the value of those coupons counted toward their deductible or out-of-pocket maximum. However, the new copay accumulators will not count the coupons' value toward helping patients spend down their deductibles and out-of-pocket maximum. Accordingly, once patients use the full value of their drug coupons, they will be subject to more of the cost than they had been before.[68] Moreover, some insurance companies limit insured patients' abilities to use prescription coupons at all.[69]

AMA POLICY AND ADVOCACY

Extensive AMA policy and highly visible AMA advocacy directly respond to the resolves of referred Resolution 826-I-17 and continue to strive for greater prescription drug cost transparency and affordability.

AMA Policy

The Council agrees with the AACE and ES that a key issue in addressing insulin affordability is working toward reduced patient cost-sharing. AMA policy has historically strongly supported VBID, which can achieve reduced patient cost-sharing. For example, Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Policy H-185.939 outlines principles to guide the design and implementation of VBID programs, stating that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements, and that coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Supporting the role of physicians in engaging patients in joint decision-making to select an insulin regimen that appropriately balances clinical needs and cost-effectiveness, Policy H-450.938 stipulates that the cost of alternate interventions, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated. Moreover, the policy states, physicians should encourage their patients to participate in making value-based health care decisions.

AMA policy also supports value-based pricing for pharmaceuticals (Policy H-110.986). The policy specifically calls for value-based pricing processes that incorporate affordability criteria and that include cost-effectiveness analyses in comparative effectiveness research. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance. Finally, Policy H-125.977 advocates for economic assistance, including coupons and other discounts for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.

Another key to improving insulin affordability is improving price transparency. Consistent with Resolution 826-I-17 and ES recommendations,[70] Policy H-125.979 supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. Additionally, the AMA developed model state legislation entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year" (AMA Model Act), and it directly addresses the issue of stabilized formularies and cost transparency. The AMA Model Act specifically responds to Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs and health insurance companies. The policy also supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase, and legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients. In addition, the policy encourages 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. Also, Policy H-110.991 advocates for greater prescription drug price transparency at the pharmacy point of sale by: (1) advocating that both the retail price and the patient's copay be listed on prescription receipts, (2) pursuing legislation that would require pharmacies to inform patients of the cash price as well as the formulary price of any medication prior to purchase, and (3) opposing provisions in contracts between pharmacies and PBMs that would prohibit pharmacies from disclosing when a patient's copay is higher than the drug's cash price.

Physicians will be in a stronger position to help their patients with insulin affordability concerns if information systems can integrate price information, thus empowering physicians and patients to make informed decisions at the point of prescribing. The AMA Model Act also addresses the issue of timely decision support, consistent with Policy H-450.938, which states that physicians should have easy access to and review the best available data associated with costs at the point of decision-making, which necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. In addition, the policy calls for physicians to seek opportunities to improve their information technology infrastructures to include new and innovative technologies to facilitate increased access to needed and useable evidence and information at the point of decision-making. Related, Policy H-125.979 encourages PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide. Similarly, Policy H-110.990 supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can jointly decide on treatment.

Several AMA policies support the FDA's efforts to highlight drugs that are off-patent and off-exclusivity. Specifically, Policy H-100.980 supports a strong and adequately funded FDA to ensure that safe and effective medical products become available as efficiently as possible. The policy also states that our AMA will continue to work with the FDA on controversial issues concerning drugs, biologics and pharmaceuticals to try to resolve concerns of physicians. Related, Policy H-125.984 states that Congress should provide adequate resources to the FDA to continue to support an effective generic drug approval process. Finally, Policy H-125.980 supports FDA implementation of the Biologics Price Competition and Innovation Act of 2009 in a manner that places appropriate

emphasis on promoting patient access, protecting patient safety, and preserving market competition and innovation.

Also noteworthy are the many policies establishing a framework for the AMA's approach to improving drug pricing. For example, Policy H-110.998 urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs. Policy D-110.993 states that our AMA will 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. Policy H-110.992 states that the AMA will monitor the relationships between PBMs and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. Policy H-110.997 supports programs to contain the rising costs of prescription drugs that meet certain criteria, and encourages physicians to consider prescribing the least expensive drug.

Policy H-155.962 opposes the use of price controls in any segment of the health care industry, and continues to promote market-based strategies to achieve access to and affordability of health care goods and services. However, AMA policy makes a departure from its market-based approach to pharmaceutical pricing in Policy D-330.954, which supports federal legislation that gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs. The policy also states that our AMA will work toward eliminating the Medicare prohibition on drug price negotiation.

AMA Activity

AMA Model Legislation: The AMA Model Act referenced previously provides a template that state legislatures can modify to increase prescription drug cost transparency in a variety of ways, and it specifically advances many of the goals of Resolution 826-I-17 with regard to price and cost transparency, as well as integration into EHRs. Specifically, under the AMA Model Act, manufacturers of prescription medication available in any state that implements this act would be required to disclose a variety of their costs, as well as the amount of financial assistance they provide to patients; health insurers and PBMs operating in the state would be required to disclose any discounts or other financial consideration they received that affects the price and cost-sharing of covered medicines placed on a formulary. Consistent with ES recommendations,[71] the AMA Model Act would also authorize a pilot study to integrate transparency data at the point of care, with information such as medicines' formulary status, cost-sharing tier, patient out-of-pocket cost, and coverage restrictions (eg, prior authorization, step therapy, quantity limits) being integrated into the clinical and prescribing workflows of physicians and other health care providers in EHR or electronic prescribing systems. Finally, consistent with Policy H-110.991, the AMA prepared a new model bill that prohibits clawbacks and standard gag clauses in pharmacy-PBM contracts. Several states have enacted and/or are considering similar legislation, and with its new model bill, the AMA will advocate for greater nation-wide adoption of such policies.

AMA State and National Engagement: The AMA has been engaged in legislative and regulatory advocacy concerning prescription drug pricing and costs. For example, in December 2017, the AMA testified at a hearing of the Health Subcommittee of the House Committee on Energy and Commerce on examining the pharmaceutical supply chain. The AMA has been engaged at the National Association of Insurance Commissioners as it develops its Prescription Drug Benefit Management Model Act, including with regard to mid-year formulary changes. On the state level, in 2017, the AMA supported Assembly Bill 762 in New Jersey, which would help provide patients and the legislature with relevant information about the manufacturing, production, research and

development, advertising and other associated costs for prescription medications. Additionally, the AMA continues to urge state medical associations to have the AMA Model Act introduced.

AMA Grassroots Campaign: Pursuant to Policy H-110.987, and consistent with Resolution 826-I-17, in 2016, the AMA convened a Task Force on Pharmaceutical Costs, which met four times to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs. The Task Force agreed that increasing transparency among pharmaceutical companies, health plans and PBMs should be the first focus of the grassroots campaign, which led to the launch of the TruthinRx campaign in 2016. The goal of TruthinRx is to expose the opaque process that pharmaceutical companies, PBMs, and health plans engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency. To date, over 150,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency. Additionally, the *TruthinRx.org* website provides a template letter that website visitors can customize and directly send to their US Senators and US Representatives, calling on them to support increased transparency in prescription drug prices.[72] Finally, the Council notes that the *TruthinRx.org* website has content specifically addressing insulin pricing.[73] Coordinated with AMA model legislation, and state and national engagement, TruthinRx is continuously updated to reflect advances in AMA policy and pharmaceutical industry activities.

DISCUSSION

The Council lauds the sponsors of Resolution 826-I-17 for highlighting the price increases of insulin and shares the concerns that have led to class action lawsuits, state and federal actions, and congressional requests that the DOJ and FTC investigate possible collusion among insulin makers. The market factors contributing to the insulin price increases are complex and span the pharmaceutical supply chain. Pursuant to Policy H-110.992, the AMA is committed to monitoring the relationships between PBMs and the pharmaceutical industry and strongly discouraging arrangements that could cause a negative impact on the cost or availability of essential drugs. In addition, Policy H-110.987 supports legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients. Building upon these policies, the Council recommends that the AMA encourage the FTC and DOJ to monitor insulin pricing and market competition and take enforcement actions, as appropriate.

As demonstrated by the extensive policy and activity summarized in this report, the AMA is deeply committed to efforts to improve prescription drug affordability in general, and insulin affordability, in particular. In addition to supporting the FTC and DOJ, the AMA has established policy that supports the FDA as it strives to increase access to high quality generic and biosimilar drugs. Specifically, under Policy H-100.980, the AMA affirms its commitment to continuing to work with the FDA on controversial issues concerning drugs, biologics and pharmaceuticals to try to resolve concerns of physicians.

VBID presents a powerful opportunity to reduce patient cost-sharing for high-value services, such as diabetes treatment, and AMA policy strongly supports this model. Policy H-185.939 outlines principles to guide the design and implementation of VBID programs, including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Policy H-110.986 specifically supports value-based pricing for pharmaceuticals, and Policy H-155.960 encourages third-party payers to use targeted benefit design, with cost-sharing requirements determined based on the clinical value of a health care service, with consideration given to patient income and other factors known to impact compliance. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription

drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated; personal income, and other factors known to affect patient compliance. In addition, the policy supports joint physician-patient decision-making, encouraging the development and use of technology to enable physicians and patients to determine the actual price and out-of-pocket costs of prescription drugs prior to making prescribing decisions.

In recent years, the AMA has demonstrated an ongoing commitment to improving prescription drug price transparency. As detailed above, the TruthinRx campaign continues a powerful grassroots campaign for greater transparency in prescription drug pricing, and the AMA Model Act specifically responds to Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs, and health insurance companies. Moreover, pursuant to Policy H-110.987, the AMA supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each year or per course of treatment and provide justification for the price increase. Similarly supporting transparency and collaboration across the pharmacy supply chain, Policy H-125.979 supports AMA efforts to encourage PBMs, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing. In this way, health care technology and shared information can promote optimal physician-patient joint decision making. Together, these efforts are accomplishing the goals of Resolution 826-I-17. As a logical next step, the Council recommends that the AMA disseminate the model state legislation it has developed to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and PBMs that bar pharmacists from telling consumers about less expensive options, such as choosing to pay cash rather than using insurance, to purchase their medication. Moreover, the Council recommends that the AMA provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

The Council also thanks the AACE and the ES for their expertise and for calling attention to the need for training on the appropriate use of regular human insulin and neutral protamine Hagerdorn for post-graduate physicians, fellows, residents, and students. The Council recommends that the AMA support initiatives, such as those by AACE, ES, and other national medical specialty societies, that strive to fill this gap in continuing medical education. Similarly, to help physicians better understand the complex challenges their patients may face in paying for their medication, the Council recommends that the AMA support physician education regarding drug price and cost transparency and challenges that arise at the pharmacy.

As described above, it is important to continue to view insulin affordability within the context of the much broader issue of prescription drug affordability in the US. The AMA has a deep and longstanding commitment to improving patient access to affordable prescriptions. Recognizing that access to critical drugs across many critical disease states is jeopardized by high prices and continued price increases, the AMA has made a strategic decision to work toward broad-based reforms, rather than to examine one disease state or drug at a time. Otherwise, the AMA would be in a position to require individual summits and advocacy campaigns that are unique to each of the critical pharmaceutical challenges facing AMA members and their patients, which would not be a sustainable advocacy model. Accordingly, the Council's recommendations encourage continued AMA leadership on a broad strategy to address pharmaceutical pricing, while supporting initiatives to improve the affordability of insulin for our patients.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 826-I-17, and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate. (New HOD Policy)

2. That our AMA disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication. (Directive to Take Action)

3. That our AMA provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency. (Directive to Take Action)

4. That our AMA support physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale. (New HOD Policy)

5. That our AMA support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies and the appropriate use of regular human insulin and neutral protamine Hagerdorn (NPH). (New HOD Policy)

6. That our AMA reaffirm Policy H-110.992, which states that the AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies; supports drug price transparency legislation that requires public notice by pharmaceutical manufacturers when certain price increase triggers are reached; and supports legislation that authorizes the Attorney General and/or the FTC to take legal action to address price gouging by pharmaceutical manufacturers and increase patient access to affordable drugs. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-100.980, which states that the AMA will continue to work with the Food and Drug Administration on controversial issues, including those concerning drugs, biologics, and pharmaceuticals, to try to resolve concerns of physicians. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-125.979, which supports legislation or regulation to ensure that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policies H-185.939, H-155.960 and H-110.986 which support value based insurance design and value based pricing for pharmaceuticals. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-110.990 which supports cost-sharing requirements for prescription drugs that consider factors known to affect patient compliance and the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of prescription drugs prior to making prescribing decisions. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Reaffirmation

H-100.980 Food and Drug Administration
(1) AMA policy states that a strong and adequately funded FDA is essential to ensuring that safe and effective medical products are made available to the American public as efficiently as possible. (2) Our AMA: (a) continue to monitor and respond appropriately to legislation that affects the FDA and to regulations proposed by the FDA; (b) continue to work with the FDA on controversial issues concerning food, drugs, biologics, radioactive tracers and pharmaceuticals, and devices to try to resolve concerns of physicians and to support FDA initiatives of potential benefit to patients and physicians; and (c) continue to affirm its support of an adequate budget for the FDA so as to favor the agency's ability to function efficiently and effectively. (3) Our AMA will continue to monitor and evaluate proposed changes in the FDA and will respond as appropriate.
Policy Timeline Sub. Res. 548, A-92 BOT Rep. 32, A-95 BOT Rep. 18, A-96 Reaffirmed: BOT Rep. 7, I-01 Reaffirmation I-07

H-110.986 Incorporating Value into Pharmaceutical Pricing
1. Our AMA supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.
2. Our AMA supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research.
3. Our AMA supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.
Policy Timeline CMS Rep. 05, I-16 Reaffirmed in lieu of: Res. 207, A-17 Reaffirmed: CMS-CSAPH Rep. 01, A-17

H-110.987 Pharmaceutical Costs
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.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
Policy Timeline CMS Rep. 2, I-15 Reaffirmed in lieu of: Res. 817, I-16 Appended: Res. 201, A-17 Reaffirmed in lieu of: Res. 207, A-17 Modified: Speakers Rep. 01, A-17 Appended: Alt. Res. 806, I-17

H-110.990 Cost Sharing Arrangements for Prescription Drugs
Our AMA:
1. believes that cost-sharing arrangements for prescription drugs should be designed to encourage the judicious use of health care resources, rather than simply shifting costs to patients;
2. believes that cost-sharing requirements should be based on considerations such as: unit cost of medication; availability of therapeutic alternatives; medical condition being treated; personal income; and other factors known to affect patient compliance and health outcomes; and
3. supports the development and use of tools and technology that enable physicians and patients to determine the actual price and out-of-pocket costs of individual prescription drugs prior to making prescribing decisions, so that physicians and patients can work together to determine the most efficient and effective treatment for the patient's medical condition.
Policy Timeline CMS Rep. 1, I-07 Reaffirmation A-08 Reaffirmed: CMS Rep. 1, I-12 Reaffirmed in lieu of Res. 105, A-13 Reaffirmed in lieu of: Res. 205, A-17 Reaffirmed in lieu of: Res. 207, A-17

H-110.992 Study of Actions to Control Pharmaceutical Costs
Our AMA will monitor the relationships between pharmaceutical benefits managers and the pharmaceutical industry and will strongly discourage arrangements that could cause a negative impact on the cost or availability of essential drugs.
Policy Timeline Sub. Res. 114, A-01 Reaffirmed: Res. 533, A-03 Reaffirmed: CMS Rep. 4, A-13 Reaffirmed in lieu of Res. 229, I-14

H-125.979 Private Health Insurance Formulary Transparency
1. Our AMA will work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing.
2. Our AMA supports legislation or regulation that ensures that private health insurance carriers declare which medications are available on their formularies by October 1 of the preceding year, that formulary information be specific as to generic versus trade name and include copay responsibilities, and that drugs may not be removed from the formulary nor moved to a higher cost tier within the policy term.
3. Our AMA will develop model legislation (a) requiring insurance companies to declare which drugs on their formulary will be covered under trade names versus generic, (b) requiring insurance carriers to make this information available to consumers by October 1 of each year and, (c) forbidding insurance carriers from making formulary deletions within the policy term.
4. Our AMA will promote the following insurer-pharmacy benefits manager - pharmacy (IPBMP) to physician procedural policy: In the event that a specific drug is not or is no longer on the formulary when the prescription is presented, the IPBMP shall provide notice of covered formulary alternatives to the prescriber promptly so that appropriate medication can be provided to the patient within 72 hours.
5. Drugs requiring prior authorization, shall be adjudicated by the IPBMP within 72 hours of receipt of the prescription.
6. Our AMA (a) promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers nationwide, and (b) supports state medical societies in advocating for state legislation to ensure online access to up-to-date and accurate prescription drug formularies for all insurance plans.
7. Our AMA will continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits.
8. Our AMA will develop model state legislation on the development and management of pharmacy benefits.
Policy Timeline Sub. Res. 724, A-14 Appended: Res. 701, A-16 Appended: Alt. Res. 806, I-17

H-155.960 Strategies to Address Rising Health Care Costs
Our AMA:
(1) recognizes that successful cost-containment and quality-improvement initiatives must involve physician leadership, as well as collaboration among physicians, patients, insurers, employers, unions, and government;
(2) supports the following broad strategies for addressing rising health care costs: (a) reduce the burden of preventable disease;
(b) make health care delivery more efficient; (c) reduce non-clinical health system costs that do not contribute value to patient care; and
(d) promote “value-based decision-making” at all levels;
(3) will continue to advocate that physicians be supported in routinely providing lifestyle counseling to patients through: adequate third-party reimbursement; inclusion of lifestyle counseling in quality measurement and pay-for-performance incentives; and medical education and training;
(4) will continue to advocate that sources of medical research funding give priority to studies that collect both clinical and cost data; use evaluation criteria that take into account cost impacts as well as clinical outcomes; translate research findings into useable information on the relative cost-effectiveness of alternative diagnostic services and treatments; and widely disseminate cost-effectiveness information to physicians and other health care decision-makers;
(5) will continue to advocate that health information systems be designed to provide physicians and other health care decision-makers with relevant, timely, actionable information, automatically at

the point of care and without imposing undue administrative burden, including: clinical guidelines and protocols; relative cost-effectiveness of alternative diagnostic services and treatments; quality measurement and pay-for-performance criteria; patient-specific clinical and insurance information; prompts and other functionality to support lifestyle counseling, disease management, and case management; and alerts to flag and avert potential medical errors;
(6) encourages the development and adoption of clinical performance and quality measures aimed at reducing overuse of clinically unwarranted services and increasing the use of recommended services known to yield cost savings;
(7) encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. Consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance; and
(8) supports ongoing investigation and cost-effectiveness analysis of non-clinical health system spending, to reduce costs that do not add value to patient care.
(9) Our AMA will, in all reform efforts, continue to identify appropriate cost savings strategies for our patients and the health care system.
Policy Timeline CMS Rep. 8, A-07 Reaffirmed: CMS Rep. 7, A-08 Reaffirmed in lieu of Res. 828, I-08 Reaffirmation A-09 Reaffirmation I-09 Reaffirmation A-11 Reaffirmation I-11 Appended: Res. 239, A-12 Reaffirmed in lieu of Res. 706, A-12 Reaffirmed: CMS Rep. 1, I-12 Modified: CMS Rep. 2, A-13 Reaffirmed in lieu of Res. 122, A-15 Reaffirmed in lieu of: Res. 121, A-16 Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16 Reaffirmed in lieu of: Res. 712, A-17

H-185.939 Value-Based Insurance Design
Our AMA supports flexibility in the design and implementation of value-based insurance design (VBID) programs, consistent with the following principles: (a) Value reflects the clinical benefit gained relative to the money spent. VBID explicitly considers the clinical benefit of a given service or treatment when determining cost-sharing structures or other benefit design elements.
(b) Practicing physicians must be actively involved in the development of VBID programs. VBID program design related to specific medical/surgical conditions must involve appropriate specialists.
(c) High-quality, evidence-based data must be used to support the development of any targeted benefit design. Treatments or services for which there is insufficient or inconclusive evidence about their clinical value should not be included in any targeted benefit design elements of a health plan. (d) The methodology and criteria used to determine high or low-value services or treatments must be transparent and easily accessible to physicians and patients. (e) Coverage and cost-sharing policies must be transparent and easily accessible to physicians and patients. Educational materials should be made available to help patients and physicians understand the incentives and disincentives built into the plan design. (f) VBID should not restrict access to patient care. Designs can use incentives and disincentives to target specific services or treatments, but should not otherwise limit patient care choices. (g) Physicians retain the ultimate responsibility for directing the care of their patients. Plan designs that include higher cost-sharing or other disincentives to obtaining services designated as low-value must include an appeals process to enable patients to secure care recommended by their physicians, without incurring cost-sharing penalties. (h) Plan sponsors should ensure adequate resource capabilities to ensure effective implementation and ongoing evaluation of the plan designs they choose. Procedures must be in place to ensure VBID coverage rules are updated in accordance with evolving evidence. (i) VBID programs must be consistent with AMA Pay for Performance Principles and Guidelines (Policy H450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H450.941 and D285.972). Policy Timeline CMS Rep. 2, A13 Reaffirmed in lieu of Res. 122, A15 Reaffirmed in lieu of: Res. 121, A16 Reaffirmed: CMS Rep. 05, I-16 Reaffirmation I-16

JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE
AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH

CMS/CSAPH Joint Report A-18

Subject: Coverage for Colorectal Cancer Screening
(Resolution 822-I-17)

Presented by: Paul Wertsch, MD, Chair, Council on Medical Service
Robert A. Gilchick, MD, MPH, Chair, Council on Science and Public Health

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

At the 2017 Interim Meeting, the House of Delegates referred Resolution 822, "Elimination of All Cost-Sharing for Screening Colonoscopies," which was sponsored by the Georgia Delegation. The Board of Trustees assigned this item to the Council on Medical Service (CMS) and the Council on Science and Public Health (CSAPH) for a report back to the House of Delegates at the 2018 Annual Meeting. Resolution 822 asked: That the American Medical Association (AMA) develop model national policy that supports the voluntary removal of all cost-sharing associated with screening colonoscopies in all commercial and Medicare Advantage product lines and advocate for the adoption of these policies nationwide.

This report explains sources of confusion regarding insurance coverage for colorectal cancer screening (CRCS), summarizes relevant AMA policy and advocacy, and presents policy recommendations. The Councils developed this report in the context of a broader joint report they are preparing for the 2018 Interim Meeting regarding improving alignment of cost-sharing incentives for high-value services, such as CRCS.

BACKGROUND

The American Cancer Society estimates that colorectal cancer will be the third leading cause of cancer deaths among men and women in the US in 2018.[1] If a colorectal cancer patient is diagnosed with localized-stage disease, the five year survival rate is 90 percent, but unfortunately, only 39 percent of colorectal cancer patients are diagnosed at this early stage.[2] CRCS reduces colorectal cancer mortality both by decreasing the incidence of disease and by increasing the likelihood of survival.[3]

United States Preventive Services Task Force (USPSTF) CRCS Recommendation

In June of 2016, the USPSTF published a final recommendation on colorectal cancer screening. The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years.[4] The recommendation received an "A" grade, meaning that the USPSTF recommends the service and there is high certainty that the net benefit is substantial.

The screening methods examined by the USPSTF included stool based tests: guaiac-based fecal occult blood test (gFOBT), fecal immunochemical tests (FITs), and multitargeted stool DNA

testing (FIT-DNA) as well as direct visualization tests: colonoscopy, flexible sigmoidoscopy, CT colonography, and flexible sigmoidoscopy with FIT. The USPSTF noted that risks and benefits of different screening methods vary.[5] However, given the lack of evidence from head-to-head comparative trials that any of the screening strategies have a greater net benefit than the others, the USPSTF encourages clinicians to engage patients in informed decision-making about the screening strategy that would most likely result in completion, with high adherence over time, taking into consideration both the patient's preferences and local availability.[6]

Barriers to Screening

Despite the large body of evidence indicating the effectiveness of CRCS and the variety of screening options available,[7] one in three people are not up to date with CRCS.[8] Barriers to CRCS are more common among people with fewer financial resources, leading to disparities in care.[9] Moreover, there is substantial evidence that inadequate insurance coverage is associated with lower rates of screening.[10] Insurance coverage advances under the Affordable Care Act (ACA) tried to address under utilization rates of CRCS, but coverage of CRCS is uniquely complex, which poses barriers to care.

Coverage of CRCS, including colonoscopies, has been fraught with confusion and consternation for two key reasons. First, a colonoscopy is a rare example of how a single service can inherently incorporate screening, diagnosis, and treatment. In just one colonoscopy, an asymptomatic patient could be screened and one or more concerning polyp(s) removed for biopsy, making insurance coverage of CRCS uniquely confusing. This report both explains what leads to this confusion and makes recommendations regarding how the confusion can be ameliorated.

Second, CRCS suffers from misaligned incentives and expectations in much the same way as many other valuable preventive interventions. While CRCS is provided without cost-sharing for asymptomatic adults 50 years and older who are at average risk of colorectal cancer, it is arguably more valuable that higher-risk individuals be screened and with greater frequency to detect more likely instances of deadly disease at earlier stages. Moreover, for both clinical and financial reasons, a prudent approach can be to initiate CRCS with a non-invasive stool test, and only subject patients to invasive colonoscopies when the procedure is required for complete screening, diagnosis, and/or treatment. Patient cost-sharing models should encourage less invasive screening first, when appropriate, but they currently may not. Similar logic applies to other cancer screenings, management of chronic conditions, etc. This broader issue of aligning incentives for preventive interventions will be explored in detail in the aforementioned joint report of the CMS and the CSAPH at I-18.

Coverage Varies by Insurance

ACA – Commercial Insurance: The Councils previously considered preventive services in CMS/CSAPH Joint Report A-17, "Value of Preventive Services," and explained that the ACA tasked four expert organizations with identifying the preventive services that will be provided with no patient cost-sharing under all private, non-grandfathered health insurance plans. One of these expert organizations is the USPSTF, and the ACA mandates coverage of all of its "A" and "B" recommended services. Despite receiving an "A" recommendation from the USPSTF, implementation of the CRCS recommendation has resulted in confusion. Two key areas have raised concerns: (a) the population included in the no cost-share benefit and (b) the extent of the services included in the no cost-share benefit.

Regarding the population included in the no cost-share benefit, the USPSTF provides some guidance that clarifies implementation of its recommendation. The USPSTF did not review the evidence on screening populations at increased risk, so the recommendation does not speak to such patients. Specifically, the USPSTF states that its recommendation applies to:

> [A]symptomatic adults 50 years and older who are at average risk of colorectal cancer and who do not have a family history of known genetic disorders that predispose them to a high lifetime risk of colorectal cancer . . . , a personal history of inflammatory bowel disease, a previous adenomatous polyp, or previous colorectal cancer. When screening results in diagnosis of colorectal adenomas or cancer, patients are followed up with a surveillance regimen, and recommendations for screening no longer apply.[11]

The USPSTF guidance effectively eliminates vulnerable portions of the population from the valuable no cost-share screenings (eg, individuals who have an elevated risk of colorectal cancer, a history of previous adenomatous polyp, or who are otherwise being followed with a "surveillance regimen.") At the same time, the USPSTF also acknowledges the critical importance of CRCS for individuals at-risk: "[T]his recommendation applies to all racial/ethnic groups, with clear acknowledgment that efforts are needed to ensure that at-risk populations receive recommended screening, follow-up, and treatment."[12] With at-risk populations carved out of the USPSTF recommendation, it is not clear how the needed screening, follow-up, and treatment can be incentivized.

Regarding the extent of services included in the no cost-share benefit, the federal government seemed to recognize that the USPSTF recommendation was vulnerable to confusion when it issued clarifying guidance in 2013. Specifically, guidance prepared jointly by the Departments of Labor, Health and Human Services, and the Treasury (collectively, the Departments) state that cost-sharing may not be imposed when a polyp is removed during a screening colonoscopy pursuant to the USPSTF recommendation:

> Based on clinical practice and comments received from the American College of Gastroenterology, American Gastroenterological Association, American Society of Gastrointestinal Endoscopy, and the Society for Gastroenterology Nurses and Associates, polyp removal is an integral part of a colonoscopy. Accordingly, the plan or issuer may not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure. On the other hand, a plan or issuer may impose cost-sharing for a treatment that is not a recommended preventive service, even if the treatment results from a recommended preventive service.[13]

The Departments' guidance demonstrates how clinical insight from the physicians responsible for delivering a preventive intervention can lead to better alignment between clinical need and insurance coverage. Similarly, medical experts have described screening not as a single test, "but rather a cascade of events" – a stepwise continuum that may begin with a clinician's recommendation that an asymptomatic patient receive testing and conclude with the outcome of the test(s).[14] The Departments' guidance seems to reflect this "cascade of events" understanding, but confusion surrounding patient cost-sharing for CRCS persists, nevertheless.

While the USPSTF updated its screening for colorectal cancer recommendation in 2016, the updated recommendation hints at, but does not embrace, the "cascade of events" understanding of preventive screening. The recommendation expressly acknowledges that colonoscopy "represents the primary source of harms associated with CRCS,"[15] seemingly suggesting that less-invasive tests could represent a safe starting point for screening. Moreover, the recommendation acknowledges

that "with all screening methods, positive findings lead to follow-up colonoscopy."[16] To embrace screening that acknowledges a "cascade of events," the USPSTF could have specified that if a less-invasive screening test is used as a first line preventive method, and that initial test is positive, a colonoscopy should be used to complete the screening process. Including such explicit clarification in its recommendation would ensure that the entire "cascade of events" critical to effective CRCS is included among the ACA benefits provided without cost-sharing. The absence of this clarification contributes to the implementation challenges outlined below.

Medicare: Medicare provides significantly more detailed information about coverage of CRCS. However, as highlighted by HR 1017 and the AMA's support of that legislation, Medicare coverage differs critically from commercial coverage. Specifically, when a polyp or abnormal growth is removed during a colonoscopy, or when a biopsy is done of suspicious-looking tissue, the "screening" colonoscopy becomes "diagnostic," and although the Medicare Part B deductible is waived, beneficiaries are billed co-insurance of 20 percent of the cost of the procedure. This can lead to significant confusion, misaligned expectations, patient financial burden, and patient avoidance of CRCS.

Implementation Challenges

Given the complicated coding and payment rules surrounding CRCS, it is unsurprising that patients commonly find themselves billed for services they expected to be covered at no cost to them. As a result, health care providers, payers and government agencies can field a significant volume of questions and complaints.

The following are some situations where patients have reported being unexpectedly charged for elements of CRCS:

- If a patient receives a colonoscopy following a positive result in a stool test (such as gFOBT or FIT) or an abnormal double-contrast barium enema or CT colongraphy, patients may incur cost-sharing.
- If a patient is classified as "high-risk" for colorectal cancer, that patient's colonoscopy could incur cost-sharing, whereas the same procedure would be free of cost-sharing for an "average risk" peer.
- If a Medicare patient underwent what was thought to be a preventive screening colonoscopy (ie, no cost-sharing), and polyps were removed during the procedure, the patient may be surprised to incur cost-sharing.

Definition, Coding and Payment

There is significant confusion and inconsistency in how preventive interventions, particularly CRCS, are defined, coded and paid, potentially negatively impacting patient care. Whether a colonoscopy is called "screening," "diagnostic," or "therapeutic" can be subjective, and although such classification may not be clinically important, the classification can have a significant financial effect on the patient. Moreover, fear of financial burden may cause patients to forgo necessary care or force them to cope with adverse financial ramifications. Finally, without a common vocabulary that is universally understood among clinicians and payers (and effectively translated to patients), misunderstanding and misaligned expectations are a natural and unfortunate result.

AMA POLICY AND ADVOCACY

The AMA has established a priority of supporting evidence-based preventive services. Policy H-165.840 advocates for evidence-based prevention insurance coverage for all patients, and in all appropriate venues. Policy H-185.960 specifically advocates for health plan coverage of the full range of CRCS. Moreover, Policy D-330.950 supports Medicare coverage for a physician consultation prior to a screening colonoscopy. Echoing the "cascade of events" philosophy, Policy H-425.994 emphasizes the importance of only pursuing testing in patients when adequate treatment and follow-up can be arranged for identified abnormal conditions and risk factors.

Several AMA policies promote education of physicians and the public regarding the benefits of preventive interventions, the continued availability of such services, and insurance coverage of such services, including: H-165.848 supporting a requirement that preventive health care be included in the minimal coverage available to all families; H-425.986 encouraging communication and cooperation among physicians and public health agencies to address challenges in preventive medicine; and Ethical Opinion 8.11 encouraging physicians to keep current with preventive care guidelines. Finally, Policy H-450.938 sets forth Principles to Guide Physician Value-Based Decision-Making and specifically emphasizes that physicians should seek opportunities to integrate prevention, including, screening, testing and lifestyle counseling, into patient office visits.

Various AMA policies call for first-dollar coverage (payment exclusively by the health plan), including: H-185.969 regarding immunizations, D-330.935 regarding Medicare preventive service benefits, and H-290.972 regarding preventive coverage for health savings account holders in the Medicaid program. Policy D-425.992 demonstrates the potentially negative impact that limiting USPSTF recommended services can have on access to preventive care (in this case, access to screening mammography and prostate specific antigen [PSA] screening). At the same time, Policy H-165.856 calls for benefit mandates to be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

Several AMA policies directly support the goals articulated throughout this report. Specifically, Policy D-330.967 advocates for continued collaboration with national medical specialty societies and interest groups in the context of evidence-based recommendations regarding preventive services, especially for populations at high risk for a given condition. Similarly, Policy H-390.849 advocates for physician payment reform consistent with promoting improved patient access to high-quality, cost-effective care; promoting designs that incorporate input from the physician community; and providing patients with information and incentives to encourage appropriate utilization of preventive services. AMA policy also focuses specifically on the needs of Medicare beneficiaries in this context. Policy D-330.935 states that the AMA will collaborate with relevant stakeholders, including appropriate medical specialty societies, to actively promote to the public and the profession the value of Medicare-covered preventive services and it will support the expansion of first-dollar coverage for a preventive visit and required tests anytime within the first year of enrollment in Medicare Part B. Finally**,** Policy H-425.992 advocates for revision of current Medicare guidelines to include coverage of appropriate preventive medical services.

In addition, the AMA is engaged in advocacy initiatives to improve Medicare coverage of CRCS. On October 6, 2017, the AMA sent letters to Senator Sherrod Brown (D-OH) and Representative Charlie Dent (R-PA) in support of HR 1017, "Removing Barriers to Colorectal Cancer Screening Act of 2017." HR 1017 would level the playing field across ACA-compliant commercial health insurance plans and Medicare, waiving coinsurance under Medicare for CRCS, regardless of whether therapeutic intervention is required during the screening. The passage of HR 1017 would therefore address current significant barriers to care for the Medicare population.

DISCUSSION

The misaligned expectations surrounding coverage for CRCS drive toward three key opportunities for improvement: (1) pursue changes to benefit design that better align reduced cost-sharing with high-value services; (2) promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels; and (3) advocate for Medicare coverage consistent with ACA-compliant plan coverage.

Recognizing that much can be done to better align reduced cost-sharing with high-value services that prevent advanced disease, the CMS and CSAPH agreed to the development of a joint Council-initiated report for I-18, and this report will speak to the first opportunity referenced above. The I-18 CMS/CSAPH joint report will develop consistent and broadly applicable policy that addresses not only the CRCS concerns raised in Resolution 822, but also concerns about access to high-value preventive interventions in general. The Councils plan to expand upon their prior report regarding coverage for preventive services, and they are committed to advocating for changes to benefit design that better align reduced cost-sharing with high-value services.

The second opportunity referenced above is ripe for AMA educational leadership. The complexities in coding CRCS as a USPSTF-recommended preventive service vs. “surveillance” for ACA-compliant plans, and “screening” vs. “diagnostic” for Medicare plans, necessitate reliable coding guidance. The Councils acknowledge that there is currently conflicting guidance issued by credible specialty organizations on this topic. The AMA, as the authority on CPT, is in a unique position to issue educational materials that can be seen as a source of truth in aligning CRCS clinical scenarios to the proper CPT codes for billing. Accordingly, per Recommendation 7, the AMA will collaborate with physicians who specialize in CRCS to develop a coding guide to help physicians correctly bill various CRCS scenarios. A component of this coding guide will encourage specialist physicians to develop additional educational materials consistent with the guide and encourage both the health care provider and public health communities to continue efforts to educate the public about the value of CRCS.

As described above in the context of AMA advocacy with respect to HR 1017, the AMA is already actively engaged in efforts to address some of the challenges in Medicare coverage for CRCS, and thus already working toward the third opportunity above. Similarly, as described above, the AMA has several policies that firmly support the goals of this report. Accordingly, it is recommended that policies D-330.935, D-330.967, H-185.960, H-390.849, and H-425.992 be reaffirmed. In addition, in Recommendation 6, the Councils support a new policy to codify on-going support of efforts to align coverage under Medicare and ACA-compliant health plans for CRCS.

In Recommendation 8, the Councils propose amending existing policy regarding appropriate screening programs to delete reference to specific types of screening. Since the evidence-base for screening evolves over time, the Councils do not feel it is prudent to outline specific types of screening within AMA policy.

RECOMMENDATIONS

The Council on Medical Service and the Council on Science and Public Health recommend that the following be adopted in lieu of Resolution 822-I-17, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-330.935, which supports AMA collaboration with relevant stakeholders, including medical specialty societies, to actively promote to the public and the profession the value of Medicare-covered preventive

services, and supports first-dollar coverage under Medicare for preventive visits and required tests. (Reaffirm HOD Policy)

2. That our AMA reaffirm Policy D-330.967, which supports continued collaboration with national medical specialty societies and interest groups in the context of evidence-based recommendations regarding preventive services and especially the provision of preventive services to populations at high risk for a given condition. (Reaffirm HOD Policy)

3. That our AMA reaffirm Policy H-185.960, which advocates for health plan coverage of the full range of colorectal cancer screening tests. (Reaffirm HOD Policy)

4. That our AMA reaffirm Policy H-390.849, which advocates for physician payment reform consistent with promoting improved patient access to high-quality, cost-effective care, promoting designs that incorporate input from the physician community, and providing patients with information and incentives to encourage appropriate utilization of preventive services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-425.992, which advocates for revision of current Medicare guidelines to include coverage of appropriate preventive services. (Reaffirm HOD Policy)

6. That our AMA continue to support Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements. (New HOD Policy)

7. That our AMA encourage the development of a coding guide to help providers appropriately bill for various colorectal cancer screening services and promote common understanding among health care providers, payers, and patients so that all know what will be covered at given cost-sharing levels. (Directive to Take Action)

8. That Policy, H-55.981, "Carcinoma of the Colon and Rectum," be amended by addition and deletion to read as follows:

   Our AMA supports: (1) Appropriate screening programs to detect colorectal cancer in individuals who are older than 50 years of age or have risk factors. ~~(2) The general recommendations of major health care organizations for colorectal cancer (CRC), which are as follows: annual fecal occult blood testing, beginning at age 50, and flexible sigmoidoscopy every 3 to 5 years from age 50, for persons at average risk. Colonoscopy and/or double-contrast barium enema procedures, which screen the entire colon, should be considered as appropriate alternatives. (3)~~ (2) Persons at increased risk for CRC (family history of CRC, previous adenomatous polyps, inflammatory bowel disease, previous resection of CRC, genetic syndromes) receiving more intensive screening efforts. ~~(4)~~ (3) Physicians becoming aware of genetic alterations that influence the development of CRC, and of diagnostic and screening tests that ~~may become~~ are available in this area. (Modify Current HOD Policy)

Fiscal Note: Less than $2,000.

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[16] *Supra* note 11.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-18)

Introduced by: Louisiana

Subject: Medicaid Reform

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

Whereas, The concepts of pluralism and patient choice in the healthcare payment system are long standing AMA policy (D-330.924, H-165.844, H-390.854), and

Whereas, The Medicaid healthcare payment model in the United States violates these concepts of pluralism and patient choice [1,2,3,4,5,6,7,8,9,10] by only allowing its recipients to use government funds for the payment [1,5,8,10,11,12,13,14] and by limiting recipients to a single defined benefit and pharmacy package [2,3,4,7,10,11,12,14]; and

Whereas, These flaws in the Medicaid health care delivery system are contributing to the need for Medicaid Payment System reform [1,4,8,13,15,16,17]; therefore be it

RESOLVED, That our American Medical Association support reform of the Medicaid health care delivery model using the principles of expanded individual choice, individual opportunity, individual and governmental responsibility (New HOD Policy); and be it further

RESOLVED, That our AMA support reform of the Medicaid healthcare delivery model which provides the individual patient the opportunity and responsibility to make wise choices in their own health care delivery model, and to share in the financial savings when using the Medicaid healthcare delivery system wisely (New HOD Policy); and be it further

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RESOLVED, That our AMA encourage pluralism and patient choice in the Medicaid healthcare delivery model by requesting the Centers for Medicare and Medicaid Services develop multiple patient choice healthcare payment options at the Federal level, or by approving waivers at the state level, that include but are not limited to the following:

Option 1: Maintenance of the traditional legacy Medicaid program whereby the recipient is allotted a defined contribution per member per month and is provided a government issued identification card, which upon presentation entitles that recipient to receive healthcare services from any willing provider according to a defined benefit package and prescription formulary. Recipients desiring expanded healthcare services or pharmacy benefits may obtain this by paying the additional cost out-of-pocket.

Option 2: Creation of a Medicaid Advantage program similar to a Medicare Advantage program where the defined Medicaid contribution for the recipient is assigned to a third party which in turn must provide the health care services to the recipient. This third party then utilizes the principles of managed care to generate savings which can then be applied to the recipient in the form of expanded services and pharmacy benefits.

Option 3: Creation of a Medicaid voucher system whereby the recipient could then apply that Medicaid defined contribution toward the purchase of private healthcare coverage of their choice. The recipient could choose a coverage plan similar to the defined benefit package of traditional Medicaid, and if they could find such coverage for a lower premium the recipient could apply the savings toward the purchase of expanded service or pharmacy benefit. The premium for that basic benefit packaged could be required by insurance rule never to be more than the defined contribution amount provided by Medicaid. This protects the recipient from excess personal expense. The recipient could also choose to contribute employer sponsored health care plan premium funds, personal funds, or other funds such as a those provided by a philanthropic organization to expand the premium and thus choose to enhance the healthcare or pharmacy benefit.

Option 4: Creation of a Medicaid Medical Savings Account program in which the Medicaid defined contribution allotted for each recipient is then assigned to an account created for the recipient. The recipient can then choose the health care delivery model best for them, with the cost then assigned to that model. Healthcare coverage is maintained for wellness care, illness care and accident care by participation in in a health system payment model, but the recipient is incentivized to maintain healthy lifestyle and judiciously use the healthcare delivery system by sharing in any savings they help to create. These savings can then be used contemporaneously to acquire expanded healthcare or pharmacy services, or be retained in that recipient account until such time as they reach the age of eligibility for Medicare. Those lifetime accumulated savings could then be used to purchase Medicare supplemental insurance coverage, or the savings could be transferred to the recipient's Social Security or other retirement plan for any use in their retirement years. (New HOD Policy)

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

Received: 04/11/18

RELEVANT AMA POLICY

Preservation of Physician-Patient Relationships and Promotion of Continuity of Patient Care H-160.901 - Our AMA supports: (1) policies that encourage the freedom of patients to choose the health care delivery system that best suits their needs and provides them with a choice of physicians; (2) the freedom of choice of physicians to refer their patients to the physician practice or hospital that they think is most able to provide the best medical care when

appropriate care is not available within a limited network of providers; and (3) policies that encourage patients to return to their established primary care provider after emergency department visits, hospitalization or specialty consultation. Citation: Res. 815, I-16

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. Citation: CMS Rep 3, I-09, Reaffirmation A-10, Reaffirmation 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, Reaffirmed: Res. 108, A-17.

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. Citation: Res. 717, I-07, Reaffirmation A-09

State Efforts to Expand Coverage to the Uninsured H-165.845 - Our AMA supports the following principles to guide in the evaluation of state health system reform proposals: 1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level. 2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. 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 references when considering if a given plan would provide meaningful coverage. 3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable. 4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care. 5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. Citation: CMS Rep. 3, I-07, Reaffirmed: Res. 239, A-12

Flexible Spending Accounts (FSAs) H-165.863 - 1. Along with other efforts to liberalize the Health Savings Account rules, our AMA places a top priority on allowing employees to roll-over any unexpended funds in a Flexible Spending Account into a Health Savings Account. 2. Our AMA will advocate for a reasonable increase in Section 125 Flex Spending accounts. Citation: Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95, Reaffirmation A-97, Reaffirmed: CMS Rep. 5, I-97, Reaffirmation I-98, Reaffirmed: CMS Rep. 5 and 7, I-99, Appended by Res. 220, A-00, Reaffirmation I-00, Res 120, A-01, Reaffirmed: CMS Rep. 2, I-01, Reaffirmation A-02, Reaffirmed: CMS Rep. 3, I-02, Reaffirmed: CMS Rep. 3, A-03, Reaffirmation I-03, Reaffirmation A-04, Consolidated: CMS Rep. 7, I-05, Appended: Res. 121, A-15, Modified: CMS Rep.1, A-15

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

Individual Health Insurance H-165.920 - Our AMA: (1) affirms its support for pluralism of health care delivery systems and financing mechanisms in obtaining universal coverage and access to health care services; (2) recognizes incremental levels of coverage for different groups of the uninsured, consistent with finite resources, as a necessary interim step toward universal access; (3) actively supports the principle of the individual's right to select his/her health insurance plan and actively support ways in which the concept of individually selected and individually owned health insurance can be appropriately integrated, in a complementary position, into the Association's position on achieving universal coverage and access to health care services. To do this, our AMA will: (a) Continue to support equal tax treatment for payment of health insurance coverage whether the employer provides the coverage for the employee or whether the employer provides a financial contribution to the employee to purchase individually selected and individually owned health insurance coverage, including the exemption of both employer and employee contributions toward the individually owned insurance from FICA (Social Security and Medicare) and federal and state unemployment taxes; (b) Support the concept that the tax treatment would be the same as long as the employer's contribution toward the cost of the employee's health insurance is at least equivalent to the same dollar amount that the employer would pay when purchasing the employee's insurance directly; (c) Study the viability of provisions that would allow individual employees to opt out of group plans without jeopardizing the ability of the group to continue their employer sponsored group coverage; and (d) Work toward establishment of safeguards, such as a health care voucher system, to ensure that to the extent that employer direct contributions made to the employee for the purchase of individually selected and individually owned health insurance coverage continue, such contributions are used only for that purpose when the employer direct contributions are less than the cost of the specified minimum level of coverage. Any excess of the direct contribution over the cost of such coverage could be used by the individual for other purposes; (4) will identify any further means through which universal coverage and access can be achieved; (5) supports individually selected and individually-owned health insurance as the preferred method for people to obtain health insurance coverage; and supports and advocates a system where individually-purchased and owned health insurance coverage is the preferred option, but employer-provided coverage is still available to the extent the market demands it; (6) supports the individual's right to select his/her health insurance plan and to receive the same tax treatment for individually purchased coverage, for contributions toward employer-provided coverage, and for completely employer provided coverage; (7) supports immediate tax equity for health insurance costs of self-employed and unemployed persons; (8) supports legislation to remove paragraph (4) of Section 162(l) of the US tax code, which discriminates against the self-employed by requiring them to pay federal payroll (FICA) tax on health insurance premium expenditures; (9) supports legislation requiring a "maintenance of effort" period, such as one or two years, during which employers would be required to add to the employee's salary the cash value of any health insurance coverage they directly provide if they discontinue that coverage or if the employee opts out of the employer-provided plan; (10) encourages through all appropriate channels the development of educational programs to assist consumers in making informed choices as to sources of individual health insurance coverage; (11) encourages employers, unions, and other employee groups to consider the merits of risk-adjusting the amount of the employer direct contributions toward individually purchased coverage. Under such an approach, useful risk adjustment measures such as age, sex, and family status would be used to provide higher-risk employees with a larger contribution and lower-risk employees with a lesser one; (12) supports a replacement of the present federal income tax exclusion from employees' taxable income of employer-provided health insurance coverage with tax credits for individuals and families, while allowing all health insurance expenditures to be exempt from federal and state payroll taxes, including FICA (Social Security and Medicare) payroll tax, FUTA (federal unemployment tax act) payroll tax, and SUTA (state unemployment tax act) payroll tax (13) advocates that, upon replacement, with tax credits, of the exclusion of employer-sponsored health insurance from employees' federal income tax, any states and municipalities conforming to this federal tax change be required to use the resulting increase in state and local tax revenues to finance health insurance tax credits, vouchers or other coverage subsidies; and (14) believes that refundable, advanceable tax credits inversely related to income are preferred over public sector expansions as a means of providing coverage to the uninsured. (15) Our AMA reaffirms our policies committed to our patients and their individual responsibility and freedoms consistent with our United States Constitution. Citation: BOT Rep. 41, I-93CMS Rep. 11, I-94Reaffirmed by Sub. Res. 125 and Sub. Res. 10 A-95 Amended by CMS Rep. 2, I-96 Amended and Reaffirmed by CMS Rep. 7, A-97 Reaffirmation A-97 Reaffirmed: CMS Rep. 5, I-97 Res. 212, I-97 Appended and Amended by CMS Rep. 9, A-98 Reaffirmation I-98 Reaffirmation I-98 Res. 105 & 108, A-99 Reaffirmation A-99 Reaffirmed: CMS Rep. 5 and 7, I-99 Modified: CMS Rep. 4, CMS Rep. 5, and Appended by Res. 220, A-00 Reaffirmation I-00 Reaffirmed: CMS Rep. 2, I-01 Reaffirmed CMS Rep. 5, A-02 Reaffirmation A-03 Reaffirmed: CMS Rep. 1 and 3, A-02 Reaffirmed: CMS Rep. 3, I-02 Reaffirmed: CMS Rep. 3, A-03 Reaffirmation I-03 Reaffirmation A-04 Consolidated: CMS Rep. 7, I-05 Modified: CMS Rep. 3, A-06 Reaffirmed in lieu of Res. 105, A-06 Reaffirmation A-07Appended and Modified: CMS Rep. 5, A-08 Modified: CMS Rep. 8, A-08 Reaffirmation A-10 Reaffirmed: CMS Rep. 9, A-11 Reaffirmation A-11Reaffirmed: Res. 239, A-12 Appended: Res. 239, A-12 Reaffirmed: CMS Rep. 6, A-12 Reaffirmed: CMS Rep. 9, A-14 Reaffirmed in lieu of: Res. 805, I-17

See also: Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982; Affordable Care Act Medicaid Expansion H-290.965; Medicaid Expansion Options and Alternatives H-290.966; Health Savings Accounts in the Medicaid Program H-290.972; Access to Care by Medicaid Patients H-290.989; Reform the Medicare System D-330.924; Patient Information and Choice H-373.998; Health Care Reform Physician Payment Models D-385.963; Freedom of Choice H-390.854; Informed Choice for Patients H-415.988; Moving to Alternative Payment Models H-450.931

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-18)

Introduced by: American Academy of Pediatrics

Subject: Effectiveness of Risk Assessment Models in Representing Healthcare Resources Expended for Infants and Children

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

Whereas, Risk adjustment models represent the foundation by which health insurance organizations and alternative payment models assess probability of resource utilization among patients; and

Whereas, Risk adjustment methodologies typically utilize a standard population representing a combination of adults and children whereby conditions of childhood may be under-represented and whereby calculated risk adjustment factors may not be reflective of resource utilization across all age groups; and

Whereas, Although the Hierarchal Condition Category models published as CMS-HCC (for Medicare Advantage) and as HHS-HCC (for non-Medicare use) provide structural detail including stratification of infant and child, healthcare organizations may modify HCC models in proprietary ways that are not transparently disclosed to providers; and

Whereas, Childhood-relevant, resource-intensive conditions often represent complex associations of chronic abnormalities (especially behavioral) exacerbated by unfavorable social health determinants all of which may be under-represented in proprietary risk adjustment models; therefore be it

RESOLVED, That our American Medical Association support risk modeling that appropriately represents care that is specific to all age groups including infants, children, and adolescents as unique risk strata (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that health insurance organizations transparently publish their risk adjustment models so that clinicians can more effectively document care that reflects patient risk and so that clinicians can assess whether the risk adjustment model appropriately defines the risk of their patients. (New HOD Policy)

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

Received: 04/19/18

References:
Landon, Bruce and Mechanic, Robert. The Paradox of Coding — Policy Concerns Raised by Risk-Based Provider Contracts. New England Journal of Medicine 2017; 377 (13): 1211-1213.

Kahn et al. Risk Adjustment for Pediatric Populations—Milliman Healthcare Reform Briefing Paper. November 2013 (http://www.milliman.com/uploadedFiles/insight/2013/risk-adjustment-for-pediatric-populations-healthcare-reform-bulletin.pdf)

Centers for Medicare & Medicaid Services. March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper. March 24, 2016 (https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf)

RELEVANT AMA POLICY

Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts H-285.957 - The AMA will work with interested medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. Res. 128, A-96. Reaffirmed: CMS Rep. 8, A-06

Hierarchical Condition Category Coding D-160.928 - Our AMA will continue to work with the Centers for Medicare and Medicaid Services to refine risk adjustment in all alternative payment models and Medicare Advantage plans, particularly to revise risk-adjustment processes, to allow hierarchical condition category (HCC) codes to automatically follow the beneficiary from year-to-year to reflect chronic conditions that will never change. Res. 112, A-16

Risk Adjustment Refinement in ACO Settings and Medicare Shared Savings Programs D-160.927 - Our AMA will continue seeking the even application of risk-adjustment in ACO settings to allow Hierarchical Condition Category risk scores to increase year-over-year within an agreement period for the continuously assigned Medicare Shared Savings Program beneficiaries and report progress back to this House at the 2017 Annual Meeting. Res. 114, A-16.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-18)

Introduced by: New York

Subject: Oppose Medicaid Eligibility Lockout

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

Whereas, Many national health leaders such as the HHS Secretary and the Surgeon General hail from Indiana, it may be instructive to observe Indiana health initiatives; and

Whereas, Indiana's new Medicaid waiver includes a lock-out provision whereby eligibles who fail to promptly complete the state's periodic eligibility redetermination can no longer simply reapply for benefits and instead remain 'locked out' for three months; and

Whereas, Indiana officials estimate half of people who fail to satisfy the redetermination process remain eligible; and

Whereas, This rule forces people to do without coverage for missing a paperwork deadline; and

Whereas, This rule will result in discontinuation of health care delivery for thousands of our most vulnerable citizens including children and the elderly; therefore be it

RESOLVED, That our American Medical Association oppose 'lock-out' provisions that exclude Medicaid eligible persons for lengthy periods merely for failing to meet paperwork burdens or deadlines, and support provisions that permit them to reapply immediately for redetermination. (New HOD Policy)

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

Received: 04/25/18

RELEVANT AMA POLICY

Medicaid - Towards Reforming the Program H-290.997
Our AMA believes that greater equity should be provided in the Medicaid program, through adoption of the following principles:
(1) the creation of basic national standards of uniform eligibility for all persons below poverty level income (adjusted by state per capita income factors);
(2) the creation of basic national standards of uniform minimum adequate benefits;
(3) the elimination of the existing categorical requirements;
(4) the creation of adequate payment levels to assure broad access to care; and
(5) establishment of national standards that result in uniform eligibility, benefits and adequate payment mechanisms for services across jurisdictions.
BOT Rep. UU, A-88 Reaffirmed: CMS Rep. G, A-93 Reaffirmation I-96 Reaffirmation A-00 Reaffirmed: BOT Action in response to referred for decision Res. 215, I-00 Reaffirmation A-05 Reaffirmed: Res. 804, I-09

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-18)

Introduced by: New York

Subject: Emergency Out of Network Services

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

Whereas, The Affordable Care Act provided that if a patient had an emergency hospital admission and was treated by an out of network physician, that the insurer could hold the patient responsible for no more than they would have for an in-network doctor, which seemed to suggest that the insurer would be paying the physician's bill; and

Whereas, The subsequent Health and Human Service regulation on this provision said that in this case, the insurer need pay only the greater of three sums (1) Medicare; (2) the insurer's in-network rate; or (3) the insurer's out-of-network rate; and

Whereas, National medical organizations strongly objected at the time that this would leave the determination of the out of network payment entirely up to the insurer; and

Whereas, Most insurers have subsequently changed their out of network rate to a percentage of Medicare, and are therefore not required to pay more than a very small portion of emergency out of network physician bills, leaving patients to pay the majority of the bills; and

Whereas, The HHS regulation further stipulated that the health insurer's requirement not to hold the patient responsible for more than a small fixed out of pocket yearly maximum did not apply in this case, again freeing the insurer from paying for the physician's services; and

Whereas, One of the basic provisions of a health insurance plan should be that major emergency bills are covered; and

Whereas, For many physicians, the ability to get paid for emergency work is an important component of their ability to maintain a viable practice; and

Whereas, A new HHS administration might well be willing to reverse a flawed regulation of a prior administration; therefore be it

RESOLVED, That our American Medical Association pursue legislation or regulation to require health plans not regulated by their states (such as ERISA plans) to pay physicians for emergency out of network care at least at the 80th percentile of charges for that particular geo-zip, as reported by the Fair Health database. (Directive to Take Action)

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

Received: 04/25/18

RELEVANT AMA POLICY

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.
Res. 108, A-17

Out-of-Network Care H-285.904
Our AMA adopts the following principles related to unanticipated out-of-network care:
1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.
Res. 108, A-17

See also: Network Adequacy H-285.908

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-18)

Introduced by: New York

Subject: Use of High Molecular Weight Hyaluronic Acid

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

Whereas, Negative payment decisions have and are being made related to the use of high molecular weight hyaluronic acid (HMWHA) based partially upon the American Academy of Orthopedic Surgeon's (AAOS) Clinical Practice Guidelines (CPG) and Appropriate Use Criteria (AUC) on knee osteoarthritis published in 2013[1]; and

Whereas, The AAOS Clinical Practice Guidelines recommended that payment decisions should not be based upon its opinion for the usage of hyaluronic acid; and

Whereas, Conclusions drawn from recent reviews of studies indicate one of the most efficacious treatment modalities for knee osteoarthritis is hyaluronic acid[2]; therefore be it

RESOLVED, That our American Medical Association advocate for reimbursement and national coverage for high molecular weight hyaluronic acid intraarticular injections as appropriate care and treatment for patients with mild to moderate osteoarthritis of the knee. (New HOD Policy)

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

Received: 04/25/18

[1] 2013 AAOS Clinical Practice Guidelines: TREATMENT OF OSTEOARTHRITIS OF THE KNEE
[2] AANA Nov. 13, 2017 letter to Anthem Re: Evidence supporting the value of high molecular weight hyaluronic acid for the care and treatment for patients with mild to moderate osteoarthritis of the knee.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-18)

Introduced by: New York

Subject: Prohibit Retrospective ER Coverage Denial

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

Whereas, Health care cost has continued to rise and payers are devising plans to decrease healthcare expenditure; and

Whereas, Government and commercial payers are shifting inpatient care to outpatient settings; and

Whereas, Government and commercial payers discourage patient utilization of hospital emergency rooms; and

Whereas, Patients cannot determine, before appropriate medical evaluation, the need to be under emergency care; and

Whereas, Many states including Georgia, Kentucky, Indiana, and Missouri have implemented requirements on publicly sponsored health plan policies to increase insured/enrollee cost sharing for “non-urgent” care provided in the emergency room; and

Whereas, Anthem has included policy language in some insurance markets which deny coverage for “non-urgent” care provided in the emergency room; and

Whereas, Patients cannot self-diagnose prior to appropriate emergency room evaluation; and

Whereas, Patients are left with increasing cost sharing and in some instances the entire emergency room bill when the condition is retrospectively determined to be “non-urgent”; therefore be it

RESOLVED, That our American Medical Association actively work toward ensuring strong enforcement of federal and state laws which require health insurance companies to cover emergency room care when a patient reasonably believes they are in need of immediate medical attention, including the imposition of meaningful financial penalties on insurers who do not comply with the law. (Directive to Take Action)

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

Received: 04/25/18

RELEVANT AMA POLICY

Billing Procedures for Emergency Care H-130.978
(1) Our AMA urges physicians rendering emergency care to ensure that the services they provide are accurately and completely described and coded on the appropriate claim forms. (2) In the interest of high quality care, patients who seek medical attention on an emergency basis should have the benefit of an immediate evaluation of any indicated diagnostic studies. The physician who provides such evaluation is entitled to adequate compensation for his or her services. When such evaluations are provided as an integral part of and in conjunction with other routine services rendered by the emergency physician, ideally an inclusive charge, commensurate with the services provided, should be made. Where the carrier collapses or eliminates CPT-4 coding for payment purposes, the physician may be left with no realistic alternative other than to itemize. Such an itemized bill should not be higher than the amount which would be paid if the appropriate inclusive charge were recognized. The interpretation of diagnostic procedures by a consulting specialist, as a separate and independent service provided the emergency patient, is equally important to good patient care. Physicians who provide such interpretations are also entitled to adequate compensation for their services. (3) Our AMA encourages state and local organizations representing the specialty of emergency medicine to work with both private and public payers in their area to implement payment practices and coding procedures which assure that payment to physicians rendering emergency care adequately reflects the extent of services provided.
CMS Rep. J, I-86 Reaffirmed by Res. 118, I-95 Reaffirmation A-00 Reaffirmed: BOT Rep. 6, I-01 Reaffirmed: CMS Rep. 7, A-11 Reaffirmed in lieu of Res. 808, I-15

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)
(C) All health plans should be prohibited from requiring prior authorization for emergency services.
(D) Health plans may require patients, when able, to notify the plan or primary physician at the time of presentation for emergency services, as long as such notification does not delay the initiation of appropriate assessment and medical treatment.
(E) All health payers should be required to cover emergency services provided by physicians and hospitals to plan enrollees, as required under Section 1867 of the Social Security Act (i.e., medical screening examination and further examination and treatment needed to stabilize an "emergency medical condition" as defined in the Act) without regard to prior authorization or the emergency care physician's contractual relationship with the payer.
(F) Failure to obtain prior authorization for emergency services should never constitute a basis for denial of payment by any health plan or third party payer whether it is retrospectively determined that an emergency existed or not.
(G) States should be encouraged to enact legislation holding health plans and third party payers liable for patient harm resulting from unreasonable application of prior authorization requirements or any restrictions on the provision of emergency services.
(H) Health plans should educate enrollees regarding the appropriate use of emergency facilities and the availability of community-wide 911 and other emergency access systems that can be utilized when for any reason plan resources are not readily available.
(I) In instances in which no private or public third party coverage is applicable, the individual who seeks emergency services is responsible for payment for such services.
2. Our AMA will work with state insurance regulators, insurance companies and other stakeholders to immediately take action to halt the implementation of policies that violate the prudent layperson standard of determining when to seek emergency care.
CMS Rep. A, A-89 Modified by CMS Rep. 6, I-95 Reaffirmation A-97 Reaffirmed by Sub. Res. 707, A-98 Reaffirmed: Res. 705, A-99 Reaffirmed: CMS Rep. 3, I-99 Reaffirmation A-00 Reaffirmed: Sub. Res. 706, I-00 Amended: Res. 229, A-01 Reaffirmation and Reaffirmed: Res. 708, A-02 Reaffirmed: CMS Rep. 4, A-12 Reaffirmed: CMS Rep. 07, A-16 Appended: Res. 128, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-18)

Introduced by: New York

Subject: Opposition to Medicaid Work Requirement

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

Whereas, In recent years many states, have expanded Medicaid eligibility; and

Whereas, Medicaid expansion has helped lower the uninsured rate; and

Whereas, The federal government has recently given states permission to obtain a waiver in order to impose work requirements on Medicaid beneficiaries; and

Whereas, Most non-elderly Medicaid adults already are working or face significant barriers to work; and

Whereas, It is unclear if tying eligibility to work promotes health or is instead an indicator of health; and

Whereas, Working at minimum wage may paradoxically render some people ineligible for Medicaid; and

Whereas, Tens of thousands of eligible people may lose coverage simply for failing to adequately document their eligibility; and

Whereas, Work requirements may support the goals of cash programs (such as welfare), it may be antithetical to the goals of health coverage programs; therefore be it

RESOLVED, That our American Medical Association reaffirm policy H-290.961 which opposes work requirements as a criterion for Medicaid eligibility. (Reaffirm HOD Policy)

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

Received: 04/25/18

RELEVANT AMA POLICY

Opposition to Medicaid Work Requirements H-290.961
Our AMA opposes work requirements as a criterion for Medicaid eligibility.
Res. 802, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-18)

Introduced by: Medical Student Section

Subject: Expanding AMA's Position on Healthcare Reform Options

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

Whereas, Current AMA Policy H-165.847 establishes that comprehensive health system reform achieving quality healthcare for all Americans is of the highest priority to our AMA; and

Whereas, Our AMA is limited in its ability to engage in open and honest debate about all health care reform options via its blanket opposition to single payer financing mechanisms (AMA Policy H-165.838); and

Whereas, Evidence suggests that our AMA's stance on single payer does not currently represent the majority of physicians, with two recent surveys by the Merritt Hawkins and the Chicago Medical Society each reporting a majority of physicians either strongly or somewhat supporting the concept of a broadly labeled single payer health care system;[1,2] and

Whereas, Several US senators have recently supported legislation to move forward with a national single-payer health care financing reform, and as such our AMA must be equipped to have open, productive discussions on the matter in the coming years;[3] and

Whereas, H.R. 676 - Expanded & Improved Medicare For All Act - has 122 cosponsors, and as such will likely come to the AMA for debate in the near future;[4] therefore be it

RESOLVED, That our AMA rescind HOD Policy H-165.844; and be it further

RESOLVED, That our AMA rescind HOD Policy H-165.985; and be it further

RESOLVED, That our AMA amend HOD Policy H-165.888 by deletion as follows:

Evaluating Health System Reform Proposals
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physician's maintain primary ethical responsibility to advocate for their patients' interests and needs.

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[1] Candidate Corner. (2017). Survey: 42% of Physicians Strongly Support a Single Payer Healthcare System, 35% are Strongly Opposed. Available at https://www.merritthawkins.com/candidates/BlogPostDetail.aspx?PostId=40982.
[2] Chicago Medical Society. (2017). Survey: Physician Attitudes Shift To Single Payer - Chicago Medical Society. http://www.cmsdocs.org/news/survey-physician-attitudes-shift-to-single-payer.
[3] Kiley J. (2017). Public support for 'single payer' health coverage grows, driven by Democrats. Pew Research Center. http://www.pewresearch.org/fact-tank/2017/06/23/public-support-for-single-payer-health-coverage-grows-driven-by-democrats/. Accessed September 6th 2017.
[4] Conyers J. (2017) H.R.676 - 115th Congress (2017-2018): Expanded & Improved Medicare For All Act. https://www.congress.gov/bill/115th-congress/house-bill/676.

~~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. (Modify Current HOD Policy); and be it further

RESOLVED, That our AMA amend HOD policy H-165.838 by deletion as follows:

Health System Reform Legislation

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. (Modify Current HOD Policy)

Fiscal note: Minimal - less than $1,000.

Received: 04/26/18

Relevant AMA Policy:

Achieving Health Care Coverage for All D-165.974
Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.
Citation: (Res. 733, I-02; Modified: CCB/CLRPD Rep. 4, 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.
Citation: (Res. 717, I-07; Reaffirmation A-09)

Universal Health Coverage H-165.904
Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans
Citation: (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12)

See also: **Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care D-165.935; Individual Health Insurance H-165.920; Preferred Provider Organizations H-415.999; Reform the Medicare System D-330.924; Increasing Detection of Mental Illness and Encouraging Education D-345.994; Health System Reform Legislation H-165.838; Opposition to Nationalized Health Care H-165.985; Evaluating Health System Reform Proposals H-165.888**

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-18)

Introduced by: Medical Student Section

Subject: Medicaid Coverage of Fitness Facility Memberships

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

Whereas, Low-income adults who qualify for Medicaid bear the greatest burden of chronic diseases, including diabetes mellitus, cardiovascular disease, and obesity;[1] and

Whereas, Forty-two percent of Americans today live with multiple chronic conditions, constituting over 70 percent of all healthcare spending in the United States;[2,3,4,5,6] and

Whereas, For every dollar spent on Medicaid, 83 cents go towards the treatment of chronic diseases;[5,7] and

Whereas, The frequency of fitness center visits has been shown to be directly correlated with monthly healthcare savings;[6,8] and

Whereas, In contrast to private fitness facilities, community-based recreational exercise spaces are often pedestrian-unfriendly, unsafe, or inaccessible, leading to their underutilization;[7,9] and

Whereas, Cost is a major barrier to attaining fitness facility memberships, particularly for families eligible for Medicaid; [8,9,10,11] and

Whereas, In a survey of low-income adults at risk for chronic disease, fitness facility memberships were rated as the most helpful among insurance-provided wellness benefits;[10] and

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[1] Gallup I. With Poverty Comes Depression, More Than Other Illnesses. Gallup.com. http://www.gallup.com/poll/158417/poverty-comes-depression-illness.aspx?utm_. Published October 30, 2012. Accessed September 4, 2017.
[2] Buttorff C, Ruder T, Bauman M. Multiple Chronic Conditions in the United States. Published 2017 by the Partnership to Fight Chronic Disease. Accessed September 18, 2017. http://www.fightchronicdisease.org/sites/default/files/TL221_final.pdf
[3] US Department of Health and Human Services. (2010). Multiple chronic conditions—a strategic framework: optimum health and quality of life for individuals with multiple chronic conditions. Washington, DC: US Department of Health and Human Services.
[4] Erdem, E., Prada, S. I., & Haffer, S. C. (2013). Medicare payments: How much do chronic conditions matter?. Medicare & medicaid research review, 3(2).
[5] Almanac of Chronic Disease 2009. Partnership to Fight Chronic Disease. Fightchronicdisease.org. http://www.fightchronicdisease.org/sites/default/files/docs/2009AlmanacofChronicDisease_updated81009.pdf. Published 2009. Accessed September 6, 2017.
[6] Navratil-Strawn, J, Hartley S, Ozminkowski, R. Frequency of Participation in an Employee Fitness Program and Health Care Expenditures. Population Health Manage. 2016; 19(5):315-323. doi: 10.1089/pop.2015.0102.
[7] Jilcott SB, Laraia BA, Evenson KR, Lowenstein LM, Ammerman AS. A Guide for Developing Intervention Tools Addressing Environmental Factors to Improve Diet and Physical Activity. Health Promotion Practice. 2007;8(2):192-204. doi:10.1177/1524839906293189.
[8] What we need to get by: A basic standard of living costs $48,778, and nearly a third of families fall short. Economic Policy Institute. http://www.epi.org/publication/bp224/. Accessed September 4, 2017.
[9] Medicaid and CHIP Eligibility Levels. Medicaid.gov. https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-eligibility-levels/index.html. Accessed September 4, 2017.
[10] Jarlenski MP, Gudzune KA, Bennett WL, Cooper LA, Bleich SN. Insurance Coverage for Weight Loss. American Journal of Preventive Medicine. 2013;44(5):453-458. doi:10.1016/j.amepre.2013.01.021.

Whereas, Fitness facility memberships alone yielded similarly effective improvements in chronic illness-related risk factors, in comparison to more costly comprehensive wellness programs that added nutritional education and personal fitness trainers;[11] and

Whereas, Existing AMA policies urge the development of exercise programs targeted to individuals over 65 and under 18, but non-elderly adults living in poverty have limited access to basic fitness facilities (AMA Policies H-25.995, H-470.961, H-470.975, H-470.989, H-470.998, H-470.999); and

Whereas, Existing AMA policies call upon physicians to promote physical fitness to the general public and encourage funding of community exercise venues in order to reduce incidence of chronic illness (H-470.990, H-470.991, H-470.997, D-470.993); therefore be it

RESOLVED, That our American Medical Association support Medicaid coverage of fitness facility memberships as a standard preventive health insurance benefit for patients. (New HOD Policy)

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

Received: 04/26/18

RELEVANT AMA POLICY:

Promotion of Exercise H-470.991
1. Our AMA: (A) supports the promotion of exercise, particularly exercise of significant cardiovascular benefit; and (B) encourages physicians to prescribe exercise to their patients and to shape programs to meet each patient's capabilities and level of interest.
2. Our AMA supports National Bike to Work Day and encourages active transportation whenever possible.
Citation: (Res. 83, parts 1 and 2, I-77; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed: CSAPH Rep. 1, A-10; Appended: Res. 604, A-11)

Government to Support Community Exercise Venues D-470.993
Our AMA will encourage: (1) towns, cities and counties across the country to make recreational exercise more available by utilizing existing or building walking paths, bicycle trails, swimming pools, beaches and community recreational fitness facilities; and (2) governmental incentives such as tax breaks and grants for the development of community recreational fitness facilities.
Citation: (Res. 423, A-04; Reaffirmed in lieu of Res. 434, A-12)

Requirement for Daily Free Play in Schools H-470.961
Our AMA recommends that elementary schools maintain at least thirty minutes of daily free play or physical education that is consistent with CDC guidelines.
Citation: Res. 409, A-04; Reaffirmation A-07; Reaffirmed: CSAPH Rep. 01, A-17;
Cardiovascular Preparticipation Screening of Student Athletes H-470.962
Our AMA supports increasing awareness among physicians, state and local medical societies, parent-teacher organizations, state legislatures, athletic associations, school administrators, and school boards of the availability of consensus medical guidelines and recommendations for sports preparticipation evaluations
Citation: (CSA Rep. 5, I-99; Modified and Reaffirmed: CSAPH Rep. 1, A-09)

See also: Mandatory Physical Education H-470.975; Physical Fitness and Physical Education H-470.989; Youth Physical Fitness H-470.998; Youth Fitness H-470.999; Promotion of Exercise Within Medicine and Society H-470.990; Exercise Programs for the Elderly H-25.995; Exercise and Physical Fitness H-470.997

[11] Naslund JA, Aschbrenner KA, Pratt SI, et al. Association Between Cardiovascular Risk and Depressive Symptoms Among People With Serious Mental Illness. Journal of Nervous and Mental Disease. 2017; 205(8):634-640.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-18)

Introduced by: Missouri

Subject: Return to Prudent Layperson Standard for Emergency Services

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

Whereas, Symptomatic patients cannot accurately determine the need for emergency medical care prospectively; and

Whereas, The Emergency Medicine Treatment and Active Labor Act of 1986 (EMTALA) established a mandate for the provision of emergency medical care, the violation of which jeopardizes the very existence and continuance of hospital operations; and

Whereas, The federal program of Medicare and the federally sponsored program of Medicaid adopted a prudent layperson standard for seeking emergency medical care as incorporated in the Balanced Budget Act of 1997; and

Whereas, Many states have adopted a prudent layperson standard for seeking emergency medical care; and

Whereas, Anthem Blue Cross and Blue Shield has adopted a list of diagnoses that the insurer will not pay for, an ex post facto action that does not consider the prudent layperson standard or the necessary work of emergency department physicians to make the diagnosis; therefore be it

RESOLVED, That our American Medical Association oppose the arbitrary denial of payment for emergency services based on diagnostic coding alone and support the use of the prudent layperson standard. (New HOD Policy)

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

Received: 04/30/18

RELEVANT AMA POLICY

Access to Emergency Services H-130.970
1. Our AMA supports the following principles regarding access to emergency services; and these principles will form the basis for continued AMA legislative and private sector advocacy efforts to assure appropriate patient access to emergency services:
(A) Emergency services should be defined as those health care services that are provided in a hospital emergency facility after the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily function; or (3) serious dysfunction of any bodily organ or part.
(B) All physicians and health care facilities have an ethical obligation and moral responsibility to provide needed emergency services to all patients, regardless of their ability to pay. (Reaffirmed by CMS Rep. 1, I-96)

Coverage of Emergency Services D-130.989
Our AMA: (1) will promote legislation, regulation, or both to require all health payers to utilize the AMA's definition of "emergency medical condition"; (2) will promote legislation, regulation, or both to require all health payers, including ERISA plans and Medicaid fee-for-service, to cover emergency services according to AMA policy; and (3) in conjunction with interested national medical specialty societies, continue to work expeditiously toward a comprehensive legislative solution to the continued expansion of EMTALA and problems under its current rules.
Citation: (Res. 229, A-01; Reaffirmed: BOT Rep. 22, A-11)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-18)

Introduced by: American College of Cardiology

Subject: Medicare Coverage for Dental Services

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

Whereas, Periodontal disease is closely linked to coronary heart disease, endocarditis, and hypertension; and

Whereas, Cardiovascular disease is the leading cause of death and disability in Medicare recipients; and

Whereas, Oral health is integral to an individual's overall health and well-being; and

Whereas, Prevention and treatment is effective in reducing adverse consequences of dental disease; and

Whereas, Current AMA policy recognizes the importance of access to comprehensive dental services as part of optimal patient (D-160.925), and supports provision of dental care insurance for medical students, residents and fellows in training (H-295.873 and H-310.912), and persons with developmental disabilities (H-90.968); and

Whereas, The Medicare program established by Congress in 1965 to provide Americans age 65 and over with insurance for hospital and physician services "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member," explicitly omitting coverage for prevention and screening of disease and most dental services, and chronic care of patients of all ages with end-stage renal disease; and

Whereas, Congress has amended original Medicare to include several preventive services, including screening for breast cancer, colorectal cancer and abdominal aortic aneurysm; and

Whereas, Value-based healthcare is evolving to prevent acute illness and treat chronic diseases outside the hospital; and

Whereas, Dental offices and clinics are an important component in effective healthcare delivery; therefore be it

RESOLVED, That our American Medical Association reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our healthcare team (New HOD Policy); and be it further

RESOLVED, That our AMA promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients. (Directive to Take Action)

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

Received: 05/01/18

RELEVANT AMA POLICY

Importance of Oral Health in Patient Care D-160.925
Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.
Citation: Res. 911, I-16

Eliminating Benefits Waiting Periods for Residents and Fellows H-295.873
Our AMA:
(1) supports the elimination of benefits waiting periods imposed by employers of resident and fellow physicians-in-training;
(2) will strongly encourage the Accreditation Council for Graduate Medical Education (ACGME) to require programs to make insurance for health care, dental care, vision care, life, and disability available to their resident and fellow physicians on the trainees' first date of employment and to aggressively enforce this requirement; and
(3) will work with the ACGME and with the Liaison Committee on Medical Education (LCME) to develop policies that provide continuous hospital, health, and disability insurance coverage during a traditional transition from medical school into graduate medical education.
(4) encourages the Accreditation Council for Graduate Medical Education to request that sponsoring institutions offer to residents and fellows a range of comparable medical insurance plans no less favorable than those offered to other institution employees.
Citation: (BOT Action in response to referred for decision Res. 318, A-06; Appended: CME Rep. 5, A-10)

See also: Residents and Fellows' Bill of Rights H-310.912
Medical Care of Persons with Developmental Disabilities H-90.968

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-18)

Introduced by: AMDA - The Society for Post-Acute and Long-Term Care Medicine

Subject: Enabling Attending Physicians to Waive the Three-Midnight Rule for Patients Receiving Care within Downside Risk Sharing Accountable Care Organizations and Advance Bundled Payments Care Improvement Programs

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

Whereas, Medicare beneficiaries who need skilled nursing care in a nursing facility are required to have an inpatient stay in a hospital lasting for three midnights at a minimum before they are eligible for such care; and

Whereas, Even as skilled nursing care is expensive, such care is essential to maintain wellness and wellbeing of our aging population, especially after bouts of acute illness; and

Whereas, Programs that participate in a downside risk sharing arrangement with Medicare-such as a Track 1+ or higher Accountable Care Organizations (ACO) or the Advanced Bundled Payments for Care Improvement Programs - have an inherent incentive to be good stewards of the Medicare program and generate savings for the Government; and

Whereas, Some Medicare ACOs (Track 1+ and above) are allowed to waive three midnight stay requirements, the process is not uniform, nor is it Physician centric; therefore be it

RESOLVED, That our American Medical Association support provisions that allow attending physicians caring for Medicare recipients in any setting be allowed to waive the three midnight inpatient stay requirement for initiation of skilled nursing care in a facility when the attending physician and the skilled nursing facility are both part of a downside risk sharing arrangement with Medicare--such as a Track 1+ or higher Medicare Accountable Care Organization or an Advanced Bundled Payments for Care Improvement Program. (New HOD Policy)

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

Received: 05/01/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-18)

Introduced by: American Society of Clinical Oncology

Subject: Survivorship Care Plans

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

Whereas, According to the Office of Cancer Survivorship at the National Cancer Institute, in 2016 there were an estimated 15.5 million cancer survivors in the United States, projected to increase to 20.3 million by 2026 and 26.1 million by 2040[1]; and

Whereas, In 2006 the Institute of Medicine (IOM) issued a report recommending every cancer patient receive an individualized survivorship care plan (SCP) that includes guidelines for monitoring and maintaining their health[2], yet a recent Commission on Cancer (CoC) survey of accredited programs found that just 21% indicated that a survivorship care plan process had been developed[3]; and

Whereas, Major barriers to SCP implementation include (1) lack of diagnostic codes [i.e. the ICD-10 code for 'cancer survivorship' is Z85, an aftercare code indicating 'personal history of malignant neoplasm' that is not directly billable]; (2) no care protocols compatible with electronic health record (EHR) templates; and (3) absence of specific evaluation and management (E&M) codes despite the high complexity of care and medical-decision making [MDM] associated with SCPs; and

Whereas, Codifying survivorship as a distinct clinical category that belongs on problem lists with payment-linked (fee, value based, or capitated) care services benefits healthcare delivery across specialties, and moreover meets the needs of a growing cadre of patients; therefore be it

RESOLVED, That our American Medical Association study challenges in billing and coding for cancer survivorship care and invite collaboration from internal medicine and specialty societies for guideline development and implementation (Directive to Take Action); and be it further

RESOLVED, That our AMA prioritize assignation of distinct ICD-10 and E&M codes associated with cancer survivorship care, and collaborate with the Centers for Medicare and Medicaid Services implementation in order to provide standards of care and reimbursement for survivorship care plans. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 05/02/18

[1] Bluethmann SM, Mariotto AB, Rowland, JH. Anticipating the "Silver Tsunami": Prevalence Trajectories and Comorbidity Burden among Older Cancer Survivors in the United States. Cancer Epidemiol Biomarkers Prev. 2016;25:1029-1036.
[2] From Cancer Patient to Cancer Survivor: Lost in Transition. Institute of Medicine Report. Released November 3, 2005.
[3] Rowland, Julia H. Cancer Survivorship: New Challenge in Cancer Medicine. John Wiley & Sons, Inc., 2017.
[4] Tonorezos, Emily S., and Joseph Conigliaro. "Integration of cancer survivorship care and primary care practice." JAMA internal medicine 177.12 (2017): 1732-1734.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-18)

Introduced by: AMDA - The Society for Post-Acute and Long-Term Care Medicine

Subject: Inclusion of Bundled Payments Care Improvement (BPCI) Post-Acute Only Model 3 in Advanced BPCI

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

Whereas, The Centers for Medicare and Medicaid Services (CMS) had allowed bundled payments for certain diagnoses under the Bundled Payment for Care Initiative (BCPI) program to be initiated by the start of Skilled Nursing Facility (SNF) stay and 90 days beyond (Model 3 Post-Acute only - BPCI); and

Whereas, CMS and numerous participating SNFs have generated savings and created efficiencies and better outcomes in post-acute care of Medicare recipients by way of BPCI Model 3; and

Whereas, In the 'BPCI- Advanced' version, initiation of bundles in SNFs has been left out, thereby excluding SNFs and physicians working in SNF setting from initiating bundles; therefore be it

RESOLVED, That our American Medical Association advocate for inclusion of the existing Bundled Payments Care Improvement (BPCI) Model 3 Post-Acute care bundle in the Advanced BPCI program so that physicians working in Skilled Nursing Facilities (SNFs) and SNFs are allowed to initiate episodes of care bundles. (New HOD Policy)

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

Received: 05/01/18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-18)

Introduced by: Maryland

Subject: Expanding On-Site Physician Home Health Care to Low-Income Families and the Chronically Ill

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

Whereas, In 2011, 2 million Medicare patients age 65 or older were homebound, many with severe chronic conditions and functional impairments making it difficult to visit a doctor[1]; and

Whereas, Lack of transportation is the third-greatest barrier to care for disabled adults, with 12.2% percent of patients stating that they could not get a ride to their doctor's office as shown in a 2014 survey of Medicaid users[2]; and

Whereas, Home health technology advancements have improved physicians' delivery of care outside the office, particularly for patients with multiple conditions and limited mobility[3-5]; and

Whereas, House call programs that target high-risk patients have significantly reduced healthcare costs and improved medical outcomes[6]; and

Whereas, The Patient Protection and Affordable Care Act established the Maternal and Infant Early Childhood Home Visiting program (MIECHV) in 2010, targeting high risk families and leading to reduced child health care costs and need for remedial education[7]; and

Whereas, Policymakers have increased support of home visits since 2012 when introducing the Independence at Home (IAH) Demonstration aimed at delivering comprehensive primary care for Medicare beneficiaries with multiple chronic conditions; and

Whereas, Based on findings from Centers for Medicare & Medicaid Services' (CMS) IAH demonstration, introducing medically necessary home visits saved $25 million in the program's inaugural year[8]; and

[1] Ornstein, K. A., Leff, B., Covinsky, K. E., Ritchie, C. S., Federman, A. D., Roberts, L., & Szanton, S. L. (2015). Epidemiology of the homebound population in the United States. JAMA internal medicine, 175(7), 1180-1186.
[2] Health Care Experiences of Adults with Disabilities Enrolled in Medicaid Only: Findings from a 2014-2015 Nationwide Survey of Medicaid Beneficiaries. Nationwide Adult Medicaid CAHPS Analytical Brief. 2017.
[3]Hayashi J, Leff B. Medically oriented HCBS: house calls make a comeback. Generations. 2012. http://www.asaging.org/blog/medically-oriented-hcbs-house-calls-make-comeback. Accessed March 23, 2018.
[4]Landers SH. Why health care is going home. N Engl J Med. 2010;363:1690-1691.
[5]Kao H, Conant R, Soriano T, McCormick W. The past, present, and future of house calls. Clin Geriatr Med. 2009;25:19-34, v.
[6]De Jonge KE, Jamshed N, Gilden D, Kubisiak J, Bruce SR, Taler G. Effects of home-based primary care on Medicare costs in high-risk elders. J Am Geriatr Soc. 2014;62:1825-1831.
[7]Sarah Avellar et al., Home Visiting Evidence of Effectiveness Review: Executive Summary, Washington, D.C. U.S. Department of Health and Human Services, Office of Policy, Research and Evaluation, September 2013

Whereas, The Medicaid program allows states to develop 1915(c) home and community-based services (HCBS) waivers targeting specific high-risk populations who prefer to receive long-term care in their homes or communities rather than at medical institutions. Annual HCBS waiver expenditure of $25 billion in 2006 resulted in estimated savings of over $57 billion, or $57,338 per participant.[9] While health outcomes of HCBS programs are difficult to evaluate, as they are highly variable, it has been found that states that invest more in HCBS as a percentage of total long-term care spending produce lower rates of adverse health outcomes[10]; and

Whereas, Veterans Health Administration (VHA) created the Home-based Primary Care (HBPC) program in 1970 to provide comprehensive primary care in homes of veterans with conditions precluding them from clinic-based care. Targeting patients among the 5% highest cost, the model has been associated with 24% reduction in total cost of VHA care, 9% fewer hospitalizations, 10% fewer emergency department visits, and 23% fewer specialist visits[9]; and

Whereas, Although these house call programs have shown great promise in cutting healthcare costs while improving medical outcomes, their utility is limited by the small number of high-risk or low income patients they serve; and

Whereas, The MIECHV program represents the largest federal investment in home visits, the program reached only 145,500 parents and children in 2015, leaving many high-risk, low-income families without home visit resources[11]; and

Whereas, Patients must live near one of only 14 participating health care providers nationwide in order to be eligible for the IAH demonstration. Expanding project to all eligible beneficiaries could save Medicare up to $4.8 billion a year[12]; and

Whereas, Despite being the nation's largest house call program, HCBS provides home-and community-based services to only 4% of total Medicaid population, representing 2.2 million beneficiaries[13]; and

Whereas, As of 2010, HBPC only provided home-based care to merely 25,000 of the 8.1 million veterans VHA served annually, significantly restricting the program's cost-savings and impact[14]; and

Whereas, Ensuring that at-risk families have access to home visiting services even if they are not covered by Medicaid is critical; therefore be it

[8] Centers for Medicare and Medicaid Services. (2016). Affordable Care Act payment model saves more than $25 million in first performance year. press release, June, 18, 2-15.
[9] Harrington, C., Ng, T., & Kitchener, M. (2011). Do Medicaid home and community based service waivers save money?. Home health care services quarterly, 30(4), 198-213.
[10] Burwell B, Sredl K, Eiken S. Medicaid long-term care expenditures in FY 2005. Cambridge, MA: Chronic Care and Disability Group, Truven Health Analytics; July 7, 2006.
[11] Herzfeldt-Kamprath, R.. Calsyn, M., & Huelskoetter T. Medicaid and Home Visiting Best Practices from States. www.americanprogress.org/issues/early-childhood/reports/2017/01/25/297160/ medicaid-and-home-visiting/ Updated January 25, 2017. Accessed March 23, 2018.
[12] Edes, T., Kinosian, B., Vuckovic, N. H., Olivia Nichols, L., Mary Becker, M., & Hossain, M. (2014). Better access, quality, and cost for clinically complex veterans with home-based primary care. Journal of the American Geriatrics Society, 62(10), 1954-1961.
[13] Konetzka, R. T., Karon, S. L., & Potter, D. E. B. (2012). Users of Medicaid home and community-based services are especially vulnerable to costly avoidable hospital admissions. Health Affairs, 31(6), 1167-1175.
[14] Kubat, B. (2016). For Veterans, Good Health Care Begins at Home. Caring for the Ages, 17(1), 18.

RESOLVED, That our American Medical Association amend Policy H-210.981, "On-site Physician Home Health Care," by addition and deletion to read as follows:

The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill, disabled or low-income patient is a goal that can ~~only~~ be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or ~~excessively tiring and painful for~~ detrimental to the patient's health.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, video telemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls, including the development of programs for low-income families and older adults.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status, ~~and~~ severity of illness, and socioeconomic status.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians. (Modify Current HOD Policy)

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

Received: 05/08/18

RELEVANT AMA POLICY

On-Site Physician Home Health Care H-210.981
The AMA: (1) recognizes that timely access to physician care for the frail, chronically ill or disabled patient is a goal that can only be met by an increase in physician house calls to this vulnerable, underserved population.
(2) strongly supports the role of interdisciplinary teams in providing direct care in the patient's own home, but recognizes that physician oversight of that care from a distance must sometimes be supplemented by on-site physician care through house calls.
(3) advocates that the physician who collaborates in a patient's plan of care for home health services should see that patient on a periodic basis.
(4) recognizes the value of the house call in establishing and enhancing the physician-patient and physician-family relationship and rapport, in assessing the effects of the social, functional and physical environment on the patient's illness, and in incorporating the knowledge gained into subsequent health care decisions.
(5) believes that physician on-site care through house calls is important when there is a change in condition that cannot be diagnosed over the telephone with the assistance of allied health personnel in the home and assisted transportation to the physician's office is costly, difficult to arrange, or excessively tiring and painful for the patient.
(6) recognizes the importance of improving communication systems to integrate the activities of the disparate health professionals delivering home care to the same patient. Frequent and comprehensive communication between all team members is crucial to quality care, must be part of every care plan, and can occur via telephone, FAX, e-mail, videotelemedicine and in person.
(7) recognizes the importance of removing economic, institutional and regulatory barriers to physician house calls.
(8) supports the requirement for a medical director for all home health agencies, comparable to the statutory requirements for medical directors for nursing homes and hospice.
(9) recommends that all specialty societies address the effect of dehospitalization on the patients that they care for and examine how their specialty is preparing its residents in-training to provide quality care in the home.
(10) encourages appropriate specialty societies to continue to develop educational programs for practicing physicians interested in expanding their involvement in home care.
(11) urges CMS to clarify and make more accessible to physicians information on standards for utilization of home health services, such as functional status and severity of illness.
(12) urges CMS, in its efforts to redefine homebound, to consider the adoption of criteria and methods that will strengthen the physician's role in authorizing home health services, as well as how such criteria and methods can be implemented to reduce the paperwork burden on physicians.
Citation: (CSA Rep. 9, I-96; Reaffirmed and Appended:CMS Rep. 4, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 4, A-08)

Providing Cost Estimate with Home Health Care Order Authorization H-210.996
The AMA urges physicians to request home health care providers to provide a cost estimate with the physician authorization form, when the form is sent to the physician for his/her signature.
Citation: Res. 63, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Res. 122, A-97; Reaffirmed: CMS Rep. 9, A-07; Reaffirmed: CMS Rep. 01, A-17

Medicaid Patient-Centered Medical Home Models H-160.913
Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the unique needs of the physicians and patients in their states.
Citation: (CMS Rep. 3, A-12)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-18)

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

Subject: Ban on Medicare Advantage “No Cause” Network Terminations

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

Whereas, In recent years Medicare Advantage plans have been issuing “no cause” terminations to physicians in their network; and

Whereas, UnitedHealthcare Medicare Advantage in 2013 and Anthem Blue Cross Medicare Advantage in 2018 are but two examples of major insurers that have issued such “no cause” network terminations; and

Whereas, Physicians have been given limited time to appeal such “no cause” network terminations; and

Whereas, Appealing a “no cause” network termination presents an extreme challenge for physicians as there is no reason given for the termination; and

Whereas, Such “no cause” network termination notices often come in a non-descript generic mailing and are often missed as junk mail by physician office staff; and

Whereas, As a result, many physicians miss the limited appeal window given; and

Whereas, Patients are often misinformed and not informed in a timely matter of such physician termination; therefore be it

RESOLVED, That our American Medical Association advocate for legislation that would ban Medicare Advantage plans from issuing “no cause” network terminations, require a Medicare Advantage plan that terminates a physician from a network to provide substantive reasons for such termination, require such termination to be sent by certified mail, require that the Medicare Advantage plan provide at least sixty (60) days for physicians to appeal such termination; and require that the Medicare Advantage plan provide the physician with a listing of the impacted patient names and a copy of the correspondence sent to impacted patients. (Directive to Take Action)

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

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