DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its 2017 Interim Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (I-17)

Report of Reference Committee J

Dolleen Mary Licciardi, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 1 - Affordable Care Act Section 1332 Waivers
2. Council on Medical Service Report 3 - Non-Physician Screening Tests
3. Council on Medical Service Report 4 - Health Insurance Affordability: Essential Health Benefits and Subsidizing the Coverage of High-Risk Patients
5. Resolution 802 - Opposition to Medicaid Work Requirements
6. Resolution 803 - Air Ambulance Regulations and Reimbursements
7. Resolution 811 - Update OBRA Nursing Facility Preadmission Screening Requirements
8. Resolution 818 - On-Call and Emergency Services Pay
9. Resolution 819 - Consultation Codes and Private Payers
10. Resolution 820 - Elimination of the Laboratory 14-Day Rule under Medicare
11. Resolution 825 - Support for VA Health Services for Women Veterans
12. Resolution 827 - Hospital Accreditation Programs and Medical Staffs
13. Council on Medical Service Report 2 - Hospital Surveys and Health Care Disparities
15. Resolution 801 - Chronic Care Management Payment for Patients Also on Home Health
16. Resolution 806 - Mandate Transparency by Pharmacy Benefit Managers
17. Resolution 810 - Pharmacy Benefit Managers and Prescription Drug Affordability
18. Resolution 823 - Unconscionable Generic Drug Pricing
19. Resolution 808 - Opposition to Reduced Payment for the 25 Modifier
20. Resolution 814 - Appropriate Reimbursement for Evaluation and Management Services for Patients with Severe Mobility-Related Impairments
21. Resolution 824 - Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED
RECOMMENDED FOR REFERRAL

20. Resolution 813 - Sustain Patient-Centered Medical Home Practices
21. Resolution 816 - Social Determinants of Health in Payment Models
22. Resolution 817 - Addressing the Site of Service Differential

RECOMMENDED FOR NOT ADOPTION

23. Resolution 812 - Medicare Coverage of Services Provided by Proctored Medical Students

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

24. Resolution 805 - A Dual System for Universal Health Care in the United States
25. Resolution 809 - Expansion of Network Adequacy Policy
26. Resolution 822 - Elimination of All Cost-Sharing for Screening Colonoscopies
27. Resolution 826 - Improving Affordability of Insulin

Existing policy was reaffirmed in lieu of the following resolutions via the Reaffirmation Consent Calendar:

- Resolution 804 - Prior Authorization
- Resolution 807 - Structural Barriers to Achieving Better Health Care Efficiency and Outcomes: ACOs and Physician Employment by Hospitals
- Resolution 815 - Pediatric Representation for E/M Documentation Guideline Revision
- Resolution 821 - Hormonal Contraception as a Preventive Service
RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 1 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendations of Council on Medical Service Report 1 adopted and the remainder of the report filed.

Council on Medical Service Report 1 recommends that our AMA support the criteria outlined in Section 1332 of the Affordable Care Act for the approval of State Innovation Waivers: a. The waiver proposal will provide coverage to at least a comparable number of the state’s residents as would be provided absent the waiver; b. The waiver proposal will provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state’s residents as would be provided absent the waiver; c. The waiver proposal will provide coverage that is at least as comprehensive for the state’s residents as would be provided absent the waiver; and d. The waiver proposal will not increase the federal deficit. The report also recommends that our AMA support the deficit neutrality requirement of Section 1332 waivers being enforced over the period of the waiver and in total over the ten-year budget plan submitted by a state, not in each individual year of the waiver; and support legislation to allow other federal savings projected to be achieved as a result of a Section 1332 waiver, including any reductions in the cost of the tax exclusion for employer-sponsored coverage, to be included in the amount of federal pass-through funding provided to a state to subsidize state innovations.

Your Reference Committee heard supportive testimony on Council on Medical Service Report 1. A member of the Council on Medical Service introduced the report, noting that states submitting applications for Section 1332 waivers need flexibility in two arenas – first, with respect to meeting deficit neutrality requirements in the longer term versus annually, and second, regarding the federal funding that is passed through to them to implement their waivers. Your Reference Committee believes that the recommendations of the report constitute important steps to improve the ability of states to fund Section 1332 waivers that allow for state innovation in providing health insurance coverage, and recommends that the recommendations of Council on Medical Service Report 1 be adopted and the remainder of the report be filed.
COUNCIL ON MEDICAL SERVICE REPORT 3 - NON-PHYSICIAN SCREENING TESTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted and the remainder of the report be filed.

HOD ACTION: The recommendations of Council on Medical Service Report 3 adopted as amended and the remainder of the report filed.

3. That it be the policy of our AMA that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles:
   a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines;
   b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed;
   c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test;
   d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure;
   e. Should send results of any screening only to the individual patient and to the primary care physician or usual source of medical care, upon patient request; and
   f. Should require a consultation with the patient’s primary care physician or usual source of care if a screening test shows a positive or otherwise abnormal test result; and
   g. If the test results are of a critical level or value, the patient should be contacted immediately and notified of the need for urgent or emergent medical evaluation. (New HOD Policy)

Council on Medical Service Report 3 recommends that our AMA reaffirm Policies H-425.994 and H-425.997; and that it be the policy of our AMA that any wellness program vendor providing non-physician ordered screenings should adhere to the following principles: a. Must disclose for whom a screening test is indicated on the basis of accepted evidence-based guidelines; b. Must inform patients of the potential benefits and risks of performing a test and of the implications of positive or negative screening test results before a test is performed; c. Must disclose the qualifications of any persons in contact with the patient and of any persons interpreting the results of any screening test; d. Should use local physicians as medical directors or supervisors in the appropriate specialty with the requisite state licensure; e. Should send results of any
screening only to the individual patient; and f. Should require a consultation with the
patient’s primary care physician or usual source of care if a screening test shows a
positive or otherwise abnormal test result. The report also recommends that our AMA
support that physicians not be held liable for delayed or missed diagnoses indicated on
wellness program vendor non-physician ordered screenings and to rescind Policy H-
425.996.

There was unanimous supportive testimony on Council on Medical Service Report 3. A
member of the Council on Medical Service introduced the report. Testimony thanked the
Council on Medical Service for its comprehensive report recognizing the importance of
ensuring continuity of care in the arena of non-physician screenings. Accordingly, your
Reference Committee recommends that the recommendations in Council on Medical
Service Report 3 be adopted and the remainder of the report be filed.

(3) COUNCIL ON MEDICAL SERVICE REPORT 4 - HEALTH INSURANCE AFFORDABILITY: ESSENTIAL HEALTH BENEFITS AND SUBSIDIZING THE COVERAGE OF HIGH-RISK PATIENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that the recommendations in Council on Medical Service
Report 4 be adopted and the remainder of the report be
filed.

HOD ACTION: The recommendations of Council on
Medical Service Report 4 adopted and the remainder of the
report filed.

Council on Medical Service Report 4 recommends that our AMA 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; prefer reinsurance as a cost-effective and equitable mechanism to subsidize the costs of
high-cost and high-risk patients; and rescind Policy H-165.995.

Your Reference Committee heard mixed but predominantly supportive testimony on
Council on Medical Service Report 4. In introducing the report, a member of the Council
on Medical Service stressed that protecting current EHB categories is critical not only to
ensure that patients have meaningful health insurance coverage, but that patients also
are protected against annual and lifetime limits, and out-of-pocket expenses. In
response to testimony highlighting the need for state variation in EHBs, a member of the
Council on Medical Service stressed that the current approach to EHBs is not a one-
size-fits all-approach. Currently, states can choose one of four benchmark plan options
for EHBs: 1) The largest plan by enrollment in any of the three largest small group
insurance products in the state’s small group market; 2) Any of the largest three state
employee health benefit plans by enrollment; 3) Any of the largest three national Federal
Employees Health Benefits Program (FEHBP) plan options by enrollment; and 4) The
largest insured commercial non-Medicaid health maintenance organization operating in
the state.

A member of the Council on Medical Service also outlined that data has shown that
reinsurance programs, including the ACA’s temporary reinsurance program as well as
state reinsurance programs, have been effective in reducing premiums while ensuring
that patients with pre-existing conditions enjoy the same protections as healthy patients.
Concerns were raised with the third and fourth recommendations of the report. However,
and importantly, a member of the Council on Medical Service underscored that the AMA
will still be able to support high-risk pools, as Policy H-165.842 remains in place. Policy
H-165.842 supports the principle that health insurance coverage of high-risk patients be
subsidized through direct risk-based subsidies such as high-risk pools, risk adjustment,
and reinsurance, rather than through indirect methods that rely heavily on market
regulation; and supports state-based demonstration projects to subsidize coverage of
high-risk patients through mechanisms such as high-risk pools, risk adjustment,
reinsurance, and other risk-based subsidies.

A member of the Council on Legislation noted that this report is incredibly timely, as
some legislative proposals introduced and/or considered this year included provisions to
allow for EHB changes, or for people with pre-existing conditions to be placed in high-
risk pools – approaches that could have caused a significant number of Americans to
lose access to affordable health insurance coverage. In addition, testimony underscored
that the recommendations of the report are very much consistent with AMA’s advocacy
efforts this year to ensure individuals have access to quality, affordable health insurance
coverage and to the medical care they need, and maintain protections for people with
pre-existing conditions. Your Reference Committee notes that the report is also
consistent with the AMA vision for health system reform released at the 2016 Interim
Meeting. As such, your Reference Committee recommends that the recommendations of
Council on Medical Service Report 4 be adopted and the remainder of the report be
filed.

COUNCIL ON MEDICAL SERVICE REPORT 5 -
REAFFIRMATION OF AMA POLICY OPPOSING CAPS
ON FEDERAL MEDICAID FUNDING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that the recommendation in Council on Medical Service
Report 5 be adopted and the remainder of the report be
filed.

HOD ACTION: The recommendations of Council on
Medical Service Report 5 adopted and the remainder of the
report filed.

Council on Medical Service Report 5 recommends that our AMA reaffirm Policy H-
290.963.
Your Reference Committee heard generally supportive testimony on Council on Medical Service Report 5. Your Reference Committee believes that this report sends a concise and consistent message in opposition to capping federal Medicaid funds. As such, your Reference Committee recommends that the recommendation of Council on Medical Service Report 5 be adopted and that the remainder of the report be filed.

(5) RESOLUTION 802 - OPPOSITION TO MEDICAID WORK REQUIREMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 802 be adopted.

HOD ACTION: Resolution 802 adopted.

Resolution 802 asks that our AMA oppose work requirements as a criterion for Medicaid eligibility.

Your Reference Committee heard generally supportive testimony on Resolution 802. Many speakers testified that Medicaid work requirements do not reflect the employment status of the adult Medicaid population. Data shared by many speakers, including a member of the Council on Medical Service, indicate that nearly 8 in 10 Medicaid adults are in working families, with nearly 60 percent working themselves. Of those nonelderly adults who are not working, 35 percent cite an illness or disability that prevents them from work, 28 percent cite they are taking care of their home or family, 18 percent are in school, 8 percent are looking for work and 8 percent are retired.

Considering that most Medicaid beneficiaries who can work already do – only three percent of adult enrollees outside of the categories listed above are not working or actively looking for work – testimony stressed that Medicaid work requirements would yield little or no improvement in employment among the population. At the same time, speakers noted that Medicaid work requirements would increase administrative burdens and costs for states, while imposing additional documentation burdens on a vulnerable population. Speakers stressed that imposing Medicaid work requirements could cause some individuals currently covered by Medicaid to become uninsured, counter to AMA policy and advocacy efforts this year protecting Medicaid and preserving the program as a safety net. Testimony also highlighted that this resolution is incredibly timely, as seven states have submitted waivers to allow for Medicaid work requirements. Your Reference Committee agrees with testimony provided, and recommends that Resolution 802 be adopted.

(6) RESOLUTION 803 - AIR AMBULANCE REGULATIONS AND REIMBURSEMENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 803 be adopted.
Resolution 803 asks that our AMA and appropriate stakeholders study the role, clinical
efficacy, and cost-effectiveness of air ambulance services, including barriers to adequate
competition, reimbursement, and quality improvement.

Testimony on Resolution 803 was supportive. An amendment was offered to request
that the AMA advocate for repeal of the Airline Deregulation Act, however your
Reference Committee finds this amendment highly prescriptive and premature without
further study. Accordingly, your Reference Committee recommends that Resolution 803
be adopted.

Resolution 811 asks that our AMA work with the US Department of Health and Human
Services and Congress to amend applicable statutes and regulations to revise the
Preadmission Screening and Resident Review requirement for nursing facility placement
to provide more consistent enactment among states and to allow more reasonable and
cost-effective approaches to this mandatory screening process.

There was supportive testimony on Resolution 811. Testimony noted that this resolution
is consistent with AMA policy on the three-day stay rule. Your Reference Committee
agrees and recommends that Resolution 811 be adopted.

Resolution 818 asks that our AMA amend Policy H-130.948 to include the statement that
"physicians should be provided adequate compensation for being available and
providing on-call and emergency services;" and develop and make available policy
guidance for physicians to negotiate with hospital medical staffs to support physician
compensation for on call and emergency services.

Your Reference Committee heard generally supportive of testimony on Resolution 818.
Speakers stressed the need for physicians to be adequately compensated for being
available and providing on-call and emergency services. There was an amendment offered to specify that adequate compensation be based on fair market value, which your Reference Committee believes may be too prescriptive. Also, the use of “adequate compensation” is consistent with the terminology used in Policy H-130.948. Your Reference Committee believes that Resolution 818 should be adopted.

(9) RESOLUTION 819 - CONSULTATION CODES AND PRIVATE PAYERS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 819 be adopted.

HOD ACTION: Resolution 819 adopted.

Resolution 819 asks that our AMA proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change; and a reason given by an insurance company for the policy change to discontinue payment of consultation codes includes purported coding errors or abuses, request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

There was supportive testimony on Resolution 819. Testimony stated that discontinuing payment of consultation codes only serves to create a barrier to care and prevents patients from receiving specialty care. Additionally, testimony stated that such policies fail to recognize the expertise and additional collaboration that is reflected in the use of consultation codes. Testimony noted that physicians must be allowed enough time to be educated on how to comply with new coding guidelines in order to avoid payment disruptions. An amendment was offered to include mention of the Centers for Medicare and Medicaid Services (CMS) in addition to private payers; however, your Reference Committee believes Resolution 819 is intended to address commercial insurers who have recently discontinued payment for consultation codes or insurers who are presently proposing the elimination of consultation codes, of which CMS is neither after eliminating consultation codes in 2010. Additionally, your Reference Committee notes that the AMA already supports legislation to overturn CMS action to eliminate reimbursement for consultation codes (Policy D-70.953) and does not see the need to include CMS in Resolution 819. Accordingly, your Reference Committee recommends that Resolution 819 be adopted.
(10) RESOLUTION 820 - ELIMINATION OF THE LABORATORY 14-DAY RULE UNDER MEDICARE

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 820 be adopted.

**HOD ACTION:** Resolution 820 adopted.

Resolution 820 asks that our AMA actively lobby the federal government to change laboratory Date of Service rules under Medicare such that complex diagnostic laboratory services performed on pathologic specimens collected from a hospital procedure be paid separately from inpatient and outpatient bundled payments.

Your Reference Committee heard generally supportive testimony on Resolution 820. Your Reference Committee believes that Resolution 820, without suggested changes, is focused and consistent with AMA advocacy on this issue, and recommends its adoption.

(11) RESOLUTION 825 - SUPPORT FOR VA HEALTH SERVICES FOR WOMEN VETERANS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 825 be adopted.

**HOD ACTION:** Resolution 825 adopted.

Resolution 825 asks that our AMA recognize the disparity in access to care for women veterans; and encourage research to address this population’s specific needs to improve patient outcomes.

Your Reference Committee heard highly supportive testimony on Resolution 825. Your Reference Committee believes that Resolution 825 is consistent with AMA policy in support of providing quality care to veterans, as well as ensuring that veterans have timely access to the medical care they need within close proximity to their residence. As such, your Reference Committee recommends that Resolution 825 be adopted.

(12) RESOLUTION 827 - HOSPITAL ACCREDITATION PROGRAMS AND MEDICAL STAFFS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 827 be adopted.

**HOD ACTION:** Resolution 827 adopted.
Resolution 827 asks that our AMA engage accrediting organizations to ensure that their hospital accreditation standards acknowledge the medical staff’s essential role in the provision of high quality care, and otherwise appropriately position the medical staff to fulfill its responsibility to provide leadership and work collaboratively with the health care organization’s administration and governing body to continuously improve patient care and outcomes.

Your Reference Committee heard limited yet supportive testimony on Resolution 827. Your Reference Committee believes Resolution 827 is consistent with existing AMA policy addressing the role of the medical staff in providing quality care, and recommends its adoption.

(13) COUNCIL ON MEDICAL SERVICE REPORT 2 - HOSPITAL SURVEYS AND HEALTH CARE DISPARITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be amended by addition of a new Recommendation to read as follows:

That our American Medical Association oppose hospital quality program assessments that have the effect of financially penalizing physicians, including those practicing in safety net hospitals. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

HOD ACTION: The recommendations of Council on Medical Service Report 2 adopted as amended and the remainder of the report filed.

Council on Medical Service Report 2 recommends that our AMA reaffirm Policies H-450.966, D-385.958, H-450.982 and H-295.897; support that the goal of hospital quality program assessments should be to identify areas to improve patient outcomes and quality of patient care; recognize the importance of cultural competency to patient experience and treatment plan adherence and encourage the implementation of cultural competency practices across health care settings; support that hospital quality program assessments should account for social risk factors so that they do not have the unintended effect of financially penalizing safety net hospitals and exacerbating health care disparities; continue to advocate for better risk models that account for social risk factors in hospital quality program assessments; and continue to work with CMS and other stakeholders, including representatives of America’s Essential Hospitals, to address issues related to hospital quality program assessments.
Testimony on Council on Medical Service Report 2 was unanimously supportive. A member of the Council on Medical Service introduced the report. Testimony suggested that not only should hospital quality program assessments not financially penalize safety net hospitals, but they should not financially penalize physicians. The Council on Medical Service accepted this friendly amendment. Accordingly, your Reference Committee recommends that the recommendations in Council on Medical Service Report 2 be adopted as amended and the remainder of the report be filed.

(14) JOINT REPORT OF THE COUNCIL ON MEDICAL SERVICE AND THE COUNCIL ON SCIENCE AND PUBLIC HEALTH - PAYMENT AND COVERAGE FOR GENETIC/GENOMIC PRECISION MEDICINE

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by deletion of Recommendation 8 as follows:

8. That our AMA modify Policy D-460.971 by addition and deletion to read as follows:

Our AMA: (1) encourages payers, regulators and providers to make clinical variant data and their interpretation publicly available through a system that assures patient and provider privacy protection; and (2) encourages laboratories to place all clinical variants and the clinical data that was used to assess the clinical significance of these results into the public domain which would allow appropriate interpretation and surveillance for these variations that can impact the public’s health; and (3) encourages laboratories to establish a process by which patients and their physicians could be notified when interpretation and clinical significance changes for previously reported variants. (Modify Current HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Recommendation 11 of Joint Report of the Council on Medical Service and the Council on Science and Public Health be amended by addition to read as follows:

11. That our AMA work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics that have clinical impact. (New HOD Policy)
RECOMMENDATION C:

Madam Speaker, your Reference Committee recommends that the recommendations in the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed.


The Joint Report of the Council on Medical Service and the Council on Science and Public Health recommends that our reaffirm Policies H-460.968, H-460.908, D-480.987, H-185.939, H-329.949, H-65.969 and H-460.902; modify Policy D-460.971 by addition and deletion to encourage laboratories to establish a process by which patients and their physicians could be notified when interpretation and clinical significance changes for previously reported variants; encourage public and private payers to adopt processes and methodologies for determining coverage and payment for genetic/genomic precision medicine that: a. Promote transparency and clarity, b. Involve multidisciplinary stakeholders, including genetic/genomic medicine experts and relevant national medical specialty societies, c. Describe the evidence being considered and methods for updating the evidence, d. Provide opportunities for comment and review as well as meaningful reconsiderations and e. Incorporate value assessments that consider the value of genetic/genomic tests and therapeutics to patients, families and society as a whole, including the impact on quality of life and survival; encourage coverage and payment policies for genetic/genomic precision medicine that are evidence-based and take into account the unique challenges of traditional evidence development through randomized controlled trials, and work with test developers and appropriate clinical experts to establish clear thresholds for acceptable evidence for coverage; work with interested national medical specialty societies and other stakeholders to encourage the development of a comprehensive payment strategy that facilitates more consistent coverage of genetic/genomic tests and therapeutics; encourage national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services; and support continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine.

Testimony on the Joint Report of the Council on Medical Service and the Council on Science and Public Health was supportive. An amendment was offered to add a phrase to Recommendation 11 to encourage the development of payment strategies for genetic/genomic tests and therapeutics that have clinical impact. The Council on Medical Service testified that it found the amendment friendly, and your Reference Committee accepts the amendment. Additional testimony raised concerns that the proposed modification of policy in Recommendation 8 may open up physicians to liability and lead to a slippery slope. Further, testimony noted that the proposed modification posed a daunting task to physicians, particularly with constantly changing data and the lack of
registries to revisit the necessary information at this time. Therefore, your Reference Committee suggests striking Recommendation 8 and highlighting that, in future reports on precision medicine, the issue in Recommendation 8 should be addressed. Accordingly, your Reference Committee recommends that the recommendations in the Joint Report of the Council on Medical Service and the Council on Science and Public Health be adopted as amended and the remainder of the report be filed.

(15) RESOLUTION 801 - CHRONIC CARE MANAGEMENT
PAYMENT FOR PATIENTS ALSO ON HOME HEALTH

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 801 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association advocate for the authorization of Chronic Care Management (CCM) reimbursement for all physicians, including those practicing in Rural Health Clinics, and Federally Qualified Health Centers, and all other physician clinics providing CCM for patients enrolled in a home health episode, to the Centers for Medicare and Medicaid Services and to Congress if federal law must be amended.

(RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 801 be adopted as amended.

HOD ACTION: Resolution 801 adopted as amended.

Resolution 801 asks that our AMA advocate for the authorization of Chronic Care Management (CCM) reimbursement for Rural Health Clinics, Federally Qualified Health Centers, and all other physician clinics providing CCM for patients enrolled in a home health episode, to the Centers for Medicare and Medicaid Services and to Congress if federal law must be amended.

Testimony on Resolution 801 was supportive. An amendment was offered to be inclusive of all physicians, and your Reference Committee accepts this amendment. Testimony further suggested deletion of the reference to specific advocacy efforts, and your Reference Committee accepts this amendment noting that it allows the AMA to advocate through any avenues as appropriate. Accordingly, your Reference Committee recommends that Resolution 801 be adopted as amended.
REF: RESOLUTION 806 - MANDATE TRANSPARENCY BY PHARMACY BENEFIT MANAGERS

RESOLUTION 810 - PHARMACY BENEFIT MANAGERS AND PRESCRIPTION DRUG AFFORDABILITY

RESOLUTION 823 - UNCONSCIONABLE GENERIC DRUG PRICING

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that the following resolution be adopted in lieu of Resolutions 806, 810 and 823.

HOD ACTION: The following resolution adopted in lieu of Resolutions 806, 810 and 823.

RESOLUTION 806 - MANDATE TRANSPARENCY

RESOLVED, That our AMA reaffirm Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers (PBMs) and health insurance companies; and supports drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug by 10% 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 Federal Trade Commission (FTC) to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA reaffirm Policy H-125.986, which encourages the FTC and the Food and Drug Administration to continue monitoring the relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers' influences on PBM drug formularies and drug product switching programs, and to take enforcement actions as appropriate; and states that certain actions/activities by pharmacy benefit managers and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients (Reaffirm HOD Policy); and be it further
RESOLVED, That our AMA reaffirm Policy H-125.979 containing provisions to improve private health insurance formulary transparency (Reaffirm HOD Policy); and be it further

RESOLVED, That our AMA oppose provisions in pharmacies’ contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patient’s co-pay is higher than the drug’s cash price (New HOD Policy); and be it further

RESOLVED, That our AMA continue its efforts with the National Association of Insurance Commissioners addressing the development and management of pharmacy benefits (Directive to Take Action); and be it further

RESOLVED, That our AMA develop model state legislation on the development and management of pharmacy benefits (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase (New HOD Policy); and be it further

RESOLVED, That our AMA continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmaceutical benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment (Directive to Take Action); and be it further

RESOLVED, That our AMA report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign (Directive to Take Action).

Resolution 806 asks that our AMA ask Congress and other appropriate entities to require that there be transparency of drug pricing by pharmacy benefit managers (PBM) to help prevent PBM price manipulation of patient prescription costs; and advocate for policy that retail pharmacies and health plans be required to disclose to patients the lowest possible cost of any prescription medication—specifically, any price differential between the price of a drug when using an insurance benefit vs the price of the drug without using that benefit.

Resolution 810 asks that our AMA expand the Truth in Rx advocacy campaign to include and explicitly address through educational outreach the effects of pharmacy benefit manager (PBM) practices on drug prices and access to affordable treatment; engage in
efforts to educate federal lawmakers about the role of PBM practices in drug pricing and urge Congressional action to increase transparency of PBM practices; work at the federal and state level to increase transparency for PBMs by: eliminating increases in patient cost-sharing obligations for prescription drugs if such drugs are chosen for profit to the PBM, restricting PBM use of non-medical switching and other utilization management techniques related to PBM formulary development that disrupt the patient treatment plan, and further regulating PBM practices in order to ensure patients have access to effective and affordable medication therapies; and develop model guidelines for effective and meaningful transparency in the rebate system, to include PBM and health plan disclosure to physicians of the contracted cost of medications including discounts and rebates from manufacturers paid back to health plans and PBMs, and urge PBMs to take active steps to implement those guidelines.

Resolution 823 asks that our advocate for national legislation that will prohibit price gouging on off-patent medications where there are fewer than three manufacturers and where there have been no external factors to justify the price increase; and report back at the 2018 Annual Meeting on the results of the AMA Truth in Rx Campaign designed to bring attention to the rising prices of prescription drugs and the status of any proposed legislation on drug pricing transparency, price gouging, and expedited review of generic drug applications as called for in AMA Policy H-110.987.

There was highly supportive testimony on Resolutions 806, 810 and 823. Members of the Council on Medical Service and Council on Legislation supported crafting a substitute resolution in lieu of Resolutions 806, 810 and 823, to develop a new, concise message on prescription drug price transparency, while rectifying any overlap between the resolutions. A member of the Council on Legislation noted that the AMA has model bills addressing this issue, and is actively engaged on this issue through its efforts with the National Association of Insurance Commissioners.

Considering the overlap between the recommendations and intent of Resolutions 806, 810 and 823, your Reference Committee has crafted a substitute that comprehensively addresses the issue of prescription drug price and cost transparency incorporating the recommendations of the resolutions, including those that are already AMA policy. Resolutions 810 and 823 included recommendations addressing AMA’s TruthinRx grassroots campaign, which aims to expand drug pricing transparency among pharmaceutical manufacturers, pharmaceutical benefit managers and health plans. In addition, the TruthinRx website explicitly includes content addressing practices of PBMs highlighted in testimony. Resolution 823 called for a report back on the results of the TruthinRx campaign, which your Reference Committee believes is appropriate. With the content of the TruthinRx website very recently being updated, your Reference Committee believes a report back to the House of Delegates at the 2018 Interim Meeting would be appropriate to allow for sufficient time to gather metrics and data to truly measure the campaign’s progress and impact.

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. (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)

H-125.986 Pharmaceutical Benefits Management Companies
Our AMA: (1) encourages physicians to report to the Food and Drug
Administration's (FDA) MedWatch reporting program any instances of adverse
consequences (including therapeutic failures and adverse drug reactions) that
have resulted from the switching of therapeutic alternates; (2) encourages the
Federal Trade Commission (FTC) and the FDA to continue monitoring the
relationships between pharmaceutical manufacturers and PBMs, especially with
regard to manufacturers' influences on PBM drug formularies and drug product
switching programs, and to take enforcement actions as appropriate; (3) pursues
Congressional action to end the inappropriate and unethical use of confidential
patient information by pharmacy benefits management companies; (4) states that
certain actions/activities by pharmacy benefit managers and others constitute the
practice of medicine without a license and interfere with appropriate medical care
to our patients; and (5) encourages physicians to routinely review their patient's
treatment regimens for appropriateness to ensure that they are based on sound
science and represent safe and cost-effective medical care. (BOT Rep. 9, I-97;
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. (Sub. Res. 724, A-14; Appended: Res. 701, A-16)

(17) RESOLUTION 808 - OPPosition TO REDUCed
PAYOUT FOR THE 25 MODIFIER

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends
that the following resolution be adopted in lieu of
Resolution 808:

HOD ACTION: The following resolution adopted as
amended in lieu of Resolution 808:

RESOLVED, That our American Medical Association
aggressively and immediately advocate through any legal
means possible, including direct payer negotiations,
regulations, legislation, or litigation, to ensure when an
evaluation and management (E&M) code is appropriately
reported with a modifier 25, that both the procedure and
E&M codes are paid at the non-reduced, allowable
payment rate. (Directive to Take Action)
Resolution 808 asks that our AMA amend Policy D-70.971 by addition and deletion, including to state that our AMA will include in its model managed care contract, provisions that will require managed care plans to adhere to CPT rules concerning modifiers and, in the case where a procedure is appropriately modified by a modifier – 25, require that both the procedure and evaluation and management are paid at 100% of the non-reduced, allowable payment rate.

There was supportive testimony on Resolution 808. A delegate serving on the AMA/Specialty Society Resource-Based Relative Value Scale (RVS) Update Committee (RUC) offered alternative language. The delegate testified that the RUC Research Subcommittee is looking into E&M services to determine if they are reimbursed appropriately. A member of the Council on Medical Service offered support for the alternate language and testified that the proposed change to the Model Managed Care Contract in the resolution was to a degree of specificity that is unprecedented. The member testified that the Council on Medical Service believes the proposed alternate language proactively addresses this issue of the modifier 25. Your Reference Committee agrees and accepts the alternative language with a note that the AMA should aggressively advocate on this issue. An amendment was offered to target advocacy efforts specifically to Anthem; however, your Reference Committee found this mention overly prescriptive and notes that, as written, the alternative language encompasses all payers, including Anthem. Further testimony offered an amendment dictating how the AMA should go about rectifying this issue with insurers, and your Reference Committee rejects this amendment and believes the alternate language allows flexibility in the requested advocacy efforts. An additional amendment called for the AMA to develop educational materials disclosing the negative consequences of the insurer policies at issue for patients and insurance purchasers to corporate health benefit managers. Your Reference Committee does not find the need to launch an educational campaign to insurers who are not currently implementing such policies. Further testimony also called for immediate action. Your Reference Committee recognizes the immediate need to advocate on the insurer policies at issue.

Your Reference Committee highlights that the AMA is actively involved in ongoing discussions with insurers over potentially inappropriate insurer policy changes and is involved in legislative campaigns on such issues. Therefore, the AMA can incorporate this issue into such discussions and campaigns. For the reasons stated above, your Reference Committee recommends that the following resolution be adopted in lieu of Resolution 808.

(18) RESOLUTION 814 - APPROPRIATE REIMBURSEMENT FOR EVALUATION AND MANAGEMENT SERVICES FOR PATIENTS WITH SEVERE MOBILITY-RELATED IMPAIRMENTS

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 814 be amended by addition of a fourth
Resolve to read as follows:
RESOLVED, That our AMA support additional funding for payment for services provided to patients with mobility related impairments that is not through a budget neutral adjustment to the physician fee schedule. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 814 be adopted as amended.

HOD ACTION: Resolution 814 adopted as amended.

Resolution 814 asks that our AMA support additional reimbursement for evaluation and management services for patients who require additional time and specialized equipment during medical visits due to severe mobility-related impairments; support that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; and support that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care.

There was supportive testimony on Resolution 814. Your Reference Committee notes that the AMA’s comments on the 2017 Physician Fee Schedule Proposed Rule opposed CMS’ plan to eliminate the 2017 physician payment increase Congress provided in MACRA in order to fund an add-on payment for services provided to patients with mobility-related disabilities. The comment letter stated that there is no justification for funding these services with an overall cut in physician payment rates. An amendment was offered to request that additional payment for providing care to patients with mobility-related disabilities not be done through a budget neutral adjustment to the fee schedule. Your Reference Committee accepts this amendment and recommends that Resolution 814 be adopted as amended.
(19) RESOLUTION 824 - PAYMENT FOR DEMENTIA TREATMENT IN HOSPITALS AND OTHER PSYCHIATRIC FACILITIES

RECOMMENDATION A:

Madam Speaker, your Reference Committee recommends that Resolution 824 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with relevant specialty societies urgently convene a task force with all interested stakeholders to promote appropriate payment by the Centers for Medicare and Medicaid Services and other third-party payers for treatment for all types of dementias when patients are treated in a Joint Commission accredited facility, whether a free-standing or part of a general medical facility, even when dementia is the primary diagnosis for admission. (New HOD Policy)

RECOMMENDATION B:

Madam Speaker, your Reference Committee recommends that Resolution 824 be adopted as amended.

HOD ACTION: Resolution 824 adopted as amended.

Resolution 824 asks that our AMA urgently convene a task force with all interested stakeholders to promote appropriate payment by the Centers for Medicare and Medicaid Services and other third-party payers for treatment for all types of dementias when patients are treated in a Joint Commission accredited facility, whether a free-standing or part of a general medical facility, even when dementia is the primary diagnosis for admission.

Your Reference Committee received supportive testimony on Resolution 824. One speaker suggested that this resolution may be overly prescriptive with mention of a task force and limiting this to Joint Commission accredited facilities. Your Reference Committee agrees with these amendments and specifically believes that the formation of a task force, which carries a significant fiscal note, is not a prudent use of limited AMA resources. Accordingly, your Reference Committee recommends that Resolution 824 be adopted as amended.
RESOLUTION 813 - SUSTAIN PATIENT-CENTERED MEDICAL HOME PRACTICES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 813 be referred.

HOD ACTION: Resolution 813 referred.

Resolution 813 asks that our AMA make an amendment to Policy H-160.918; and encourage the Centers for Medicare and Medicaid Services to subsidize the cost of sustaining Patient-Centered Medical Home designated practices for practicing physicians.

Testimony on Resolution 813 was supportive. An amendment was offered to include recognized Patient-Centered Specialty Practices in the second resolve and to increase payment rates for physician operating Patient-Centered Medical Homes (PCMHs). A member of the Council on Medical Service thanked the sponsor of Resolution 813. The member noted that the PCMH has evolved greatly within the last decade yet current policy on the PCMH predates both the Medicare Access and CHIP Reauthorization Act and the Affordable Care Act. Therefore, the member of the Council on Medical Service welcomed referral to revise current policy on PCMHs keeping in mind the issues raised by the sponsors of Resolution 813 and those offering amendments. The member further testified that, if referred, the Council on Medical Service believes it can come back to the House of Delegates with a more up-to-date and comprehensive policy on PCMHs. Your Reference Committee agrees, and recommends that Resolution 813 be referred.

RESOLUTION 816 - SOCIAL DETERMINANTS OF HEALTH IN PAYMENT MODELS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 816 be referred.

HOD ACTION: Resolution 816 referred.

Resolution 816 asks that our AMA support payment reform policy proposals that incentivize screening for social determinants of health, as defined by Healthy People 2020, and referral to community support systems.

There was supportive testimony on Resolution 816. Numerous speakers testified for referral of Resolution 816 stating that the policy proposal was vague and that it is unclear who is doing this screening and how much time the screening would take. Additional testimony noted that Resolution 711 from the 2017 Annual Meeting on screening tools for social determinants of health was referred for study and notes that referral of Resolution 816 may be incorporated into the current study. Your Reference Committee agrees and therefore recommends referral of Resolution 816.
RESOLUTION 817 - ADDRESSING THE SITE OF SERVICE DIFFERENTIAL

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 817 be referred.

HOD ACTION: Resolution 817 referred with report back at the 2018 Annual Meeting.

Resolution 817 asks that our AMA study the Site of Service Differential with a report back no later than the 2018 Interim Meeting, including: a) The rising gap between independent practice expenses and Medicare reimbursement, taking into account the costs of the regulatory requirements; b) The increased cost of medical personnel and equipment, including electronic health record (EHR/EMR) purchase, software requirements, and ongoing support and maintenance; c) The expense of maintaining hospital based facilities not common to independent practices, such as burn units and emergency departments, and determine what payment should be provided to cover those explicit costs; and d) The methodology by which hospitals report their uncompensated care, and the extent to which this is based on actual costs, not charges. The resolution also asks that our AMA advocate for a combined Health Care Payment System for patients who receive care that is paid for by the Centers for Medicare and Medicaid Services (CMS), that: a) Follows the recommendation of MedPAC to pay "Site-Neutral" reimbursement that sufficiently covers practice expenses without regard to whether services are performed under the Hospital Outpatient Prospective Payment System (HOPPS) or the Physician Fee Schedule (PFS); b) Pays appropriate facility fees for both hospital owned facilities and independently owned non-hospital facilities, computed using the real costs of a facility based on its fair market value; and c) Provides independent practices with the same opportunity to receive reimbursement for uncompensated care as is provided to hospital owned practices.

There was generally supportive testimony on Resolution 817. A number of speakers stated that adoption of the second resolve is premature at this time without further study.

A member of the Council on Legislation (COL) called for referral. The COL member testified that adopting a payment policy to address differentials in payment between hospital-owned facilities and independently owned physician practices is highly complex. Further, the member of COL stated that, due to the focus on cost reduction in the current environment, it is unrealistic to imagine that physician payments would be raised to match any higher facility payments. Therefore, the member noted that COL has concerns that if the AMA advocated for a single payment system, the Centers for Medicare and Medicaid Services would pick the lower of the Ambulatory Surgical Center (ASC), Hospital Outpatient Department (HOPD), or Physician Fee Schedule (PFS) amount and pay all providers at that rate or it might simply reduce payments on the physician side as it did in 2014 when it proposed to cut physician pay to the same level as HOPD or ASC payments where physician payments were higher. The member testified that this action would not provide any relief for physicians in independent
practices, while potentially reducing resources available for items such as equipment and salaries at hospital-owned facilities.

Furthermore, the member testified that there is a possibility that the Centers for Medicare and Medicaid Services, in order to reduce workload, may impose the payment system in use for HOPDs and ASCs on physician payments, which would result in a number of services being grouped together and paid at the same rate based on data from hospital cost reports, not physician costs, and that imposing a combined, group payment methodology on physicians might harm efforts by physician and specialty societies to develop alternative payment models. Taken together, the member testified that COL believes it would be premature to adopt this resolution without further analysis.

A member of the Council on Medical Service echoed the call for referral stating that this is a highly complex, multi-faceted resolution touching on not only site of service but also EHRs and uncompensated care. Therefore, the member stated that it is premature to adopt the second resolve without appropriate study and believes the entirety of Resolution 817 should be referred. Your Reference Committee agrees, and recommends that Resolution 817 be referred.

(23) RESOLUTION 812 - MEDICARE COVERAGE OF SERVICES PROVIDED BY PROCTORED MEDICAL STUDENTS

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Resolution 812 not be adopted.

HOD ACTION: Resolution 812 referred with report back at the 2018 Annual Meeting.

Resolution 812 asks that our AMA amend Policy H-390.999 to state that when a physician assumes responsibility for the services rendered to a patient by a medical student, the physician may ethically bill the patient for services which were performed under the physician’s personal observation, direction, and supervision; and work with the Centers for Medicare and Medicaid Services to require coverage of medical services performed by medical students while under the physician’s personal observation, direction, and supervision.

There was testimony calling for referral of Resolution 812. However, your Reference Committee does not find the need to refer this issue due to the Centers for Medicare and Medicaid Services’ (CMS) policy on payment for services rendered by students and has concerns that physicians are already paid for their services and believes allowing for such a policy may amount to getting paid twice. Additionally, your Reference Committee has liability concerns about allowing physicians to bill for services performed by medical students and believes that such a policy would undermine the student’s role as learner. Moreover, there was testimony from the Council on Medical Education calling for Resolution 812 to not be adopted. The testimony noted that the teaching physician billing guidelines from CMS state that any contribution and participation of a student to the performance of a billable service must be performed in the presence of a teaching
physician or resident for a service that meets teaching physician’s billing requirements. In addition, testimony stated that CMS only reimburses for services provided by licensed physicians, which medical students are not. Therefore, your Reference Committee recommends that Resolution 812 not be adopted.

(24) RESOLUTION 805 - A DUAL SYSTEM FOR UNIVERSAL HEALTH CARE IN THE UNITED STATES

RECOMMENDATION:

Madam Speaker, your Reference Committee recommends that Policies H-165.838 and H-165.920 be reaffirmed in lieu of Resolution 805.

HOD ACTION: Policies H-165.838 and H-165.920 reaffirmed in lieu of Resolution 805.

Resolution 805 asks that our AMA vigorously advocate for compromise health care reform legislation which restructures all existing government health care programs into a single universal government system which provides health care to all United States citizens and legal residents at a level which is sustainable and affordable; simultaneously, with equal vigor, advocate for a far reaching deregulation of privately purchased health care, while maintaining the emphasis on improving quality and safety; resist all legislation which attempts to coerce or infringe upon the freedom of the people of the United States to choose the terms of their health care; and advocate for both public and private health care reforms as an inseparable package.

Your Reference Committee heard mixed testimony on Resolution 805. Many speakers raised concerns with establishing policy in support of a single payer system, as well as complete deregulation of private insurance. There were calls to reaffirm policy in lieu of the resolution. A member of the Council on Medical Service noted that the Council is presenting two additional reports at the upcoming Annual Meeting targeted at improving health insurance affordability and competition, which will also include studying the feasibility of a public option. Your Reference Committee believes that the policy of our AMA related to health reform needs to continue to emphasize pluralism, freedom of choice, freedom of practice and universal access to patients. As such, your Reference Committee believes that Policies H-165.838 and H-165.920 be reaffirmed in lieu of Resolution 805.

H-165.838 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. (Sub. Res. 203, I-09;
Reaffirmation A-10; Reaffirmed in lieu of Res. 102, A-10; Reaffirmed in lieu of
Res. 228, A-10; Reaffirmed: CMS Rep. 2, I-10; Reaffirmed: Sub. Res. 222, I-10;
Reaffirmed: CMS Rep. 9, A-11; Reaffirmation A-11; Reaffirmed: CMS Rep. 6, I-
11; Reaffirmed in lieu of Res. 817, I-11; Reaffirmation I-11; Reaffirmed A-12;
Reaffirmed in lieu of Res. 108, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed:
Sub. Res. 813, I-13; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation A-15;
Reaffirmed in lieu of Res. 215, A-15; Reaffirmation: A-17; Reaffirmed in lieu of:
Res. 712, A-17)

H-165.920 Individual Health Insurance
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. (BOT Rep. 41, I-93; CMS Rep. 11,
I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Amended by CMS
Rep. 2, I-96; Amended and Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-
97; Reaffirmed: CMS Rep. 5, I-97; Res. 212, I-97; Appended and Amended by
CMS Rep. 9, A-98; Reaffirmation I-98; Reaffirmation I-98; Res. 105 & 108, A-99;
Reaffirmation A-99; Reaffirmed: CMS Rep. 5 and 7, I-99; Modified: CMS Rep. 4,
CMS Rep. 5, and Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed:
CMS Rep. 2, I-01; Reaffirmed CMS Rep. 5, A-02; Reaffirmation A-03;
Reaffirmed: CMS Rep. 1 and 3, A-02; Reaffirmed: CMS Rep. 3, I-02; Reaffirmed:
CMS Rep. 3, A-03; Reaffirmation I-03; Reaffirmation A-04; Consolidated: CMS
Reaffirmation A-07; Appended and Modified: CMS Rep. 5, A-08; Modified: CMS
Rep. 8, A-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 9, A-11; Reaffirmation
A-11; Reaffirmed: Res. 239, A-12; Appended: Res. 239, A-12; Reaffirmed: CMS
Rep. 6, A-12; Reaffirmed: CMS Rep. 9, A-14)
(25) RESOLUTION 809 - EXPANSION OF NETWORK ADEQUACY POLICY

RECOMMENDATION:


HOD ACTION: Resolution 809 adopted as amended.

RESOLVED, That our American Medical Association amend Policy H-285.908 by addition to read as follows: Network Adequacy H-285.908

12. Our AMA supports requiring that health insurers that terminate in-network providers:

a) Notify providers of pending termination at least 30 days prior to removal from network.

b) Give to providers, at least 14 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status.

c) Allow the provider 30 days to respond to and contest if necessary the letter prior to its distribution.

(Modify Current HOD Policy)

Resolution 809 asks that our AMA amend Policy H-285.908 by addition to state that our AMA supports requiring that health insurers that terminate in-network providers notify providers of pending termination at least 30 days prior to removal from network; and give to providers, at least 14 days prior to distribution, a copy of the health insurer’s letter notifying patients of the provider’s change in network status.

Your Reference Committee heard mixed testimony on Resolution 809. Speakers supported different notice periods before provider terminations without cause. A member of the Council on Medical Service noted that a recent Council report established Policy H-285.908 which is proposed to be amended by Resolution 809, but noted that two other policies – Policies H-285.952 and H-285.991 – address the intent of the resolution. The Council member underscored that existing policy that supports a 60-day threshold for notice to physicians is more stringent than the 30-day recommendation included in Resolution 809. Your Reference Committee notes that AMA’s model state legislation on network adequacy already includes a 60-day policy specifically on network terminations.

Your Reference Committee agrees that Policies H-285.952 and H-285.991 address the intent of Resolution 809, believes a 60-day policy on network terminations remains appropriate, and as such recommends that the policies be reaffirmed in lieu of Resolution 809.

H-285.952 Amendments to Managed Care Contracts

1. It is policy of the AMA that: (A) participating physicians be allowed a minimum of 60 days to review amendments to managed care contracts; (B) patients should have the opportunity for continued transitional care from physicians and hospitals whose contracts with health plans have terminated for reasons other than loss
of restrictions on their license/certification or fraud. Patients eligible for transitional care should specifically include, but not be limited to those who are: undergoing a course of treatment for a serious or complex condition, undergoing a course of institutional or inpatient care, undergoing non-elective surgery, pregnant, or are terminally ill at the time that they receive notice of the termination. Transitional care should be provided at the physicians' and hospitals' discretion, and should continue for an appropriate length of time. Physicians and hospitals also should continue to receive payment for the services provided during this transitional period; (C) when a participating physician leaves a managed care plan, patients of the physician be informed, in a timely manner, of the departure by the physician and/or the managed care plan, and, if applicable, of their right to elect continued transitional care from that physician; (D) when a participating physician voluntarily leaves a managed care plan, patients of the physician be informed of the departure by the physician and/or the managed care plan; (E) the AMA opposes managed care plan mandating that physician to notify all his/her patients; (F) the AMA opposes the preapproval of physician-developed notification letters by managed care plans required if a participating physician who is voluntarily leaving the plan chooses to inform his/her patient of the departure; and (G) managed care contracts not hold participating physicians financially liable for medical services delivered to a patient who electively chooses or mistakenly receives medical services from a "non-plan" physician. 2. Our AMA supports patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals at in-network cost-sharing levels. Transitional care should be provided at the physicians' and hospitals' discretion. 3. Our AMA will continue to provide assistance upon request to state medical associations in support of state legislative and regulatory efforts, and disseminate relevant models state legislation, to ensure continuity of care protections for patients in an active course of treatment. (Sub. Res. 708, I-96; Appended and Modified: CMS Rep. 8, A-02; Reaffirmed: CMS Rep. 4, A-12; Appended: CMS Rep. 03, A-17)  

H-285.991 Qualifications and Credentialing of Physicians Involved in Managed Care  
1. AMA policy on selective contracting is as follows: (a) Health plans or networks should provide public notice within their geographic service areas when applications for participation are being accepted. (b) Physicians should have the right to apply to any health care plan or network in which they desire to participate and to have that application approved if it meets physician-developed objective criteria that are available to both applicants and enrollees and are based on professional qualifications, competence and quality of care. (c) Selective contracting decisions made by any health delivery or financing system should be based on an evaluation of multiple criteria related to professional competency, quality of care, and the appropriateness by which medical services are provided. In general, no single criterion should provide the sole basis for selecting, retaining, or excluding a physician from a health delivery or financing system. (d) Prior to initiation of actions leading to termination or nonrenewal of a physician's participation contract for any reason the physician shall be given notice specifying the grounds for termination or nonrenewal, a defined process for appeal, and an opportunity to initiate and complete remedial activities except
in cases where harm to patients is imminent or an action by a state medical board or other government agency effectively limits the physician's ability to practice medicine. Participation in a physician health program in and of itself shall not count as a limit on the ability to practice medicine. Our AMA supports the following appeals process for physicians whose health insurance contract is terminated or not renewed: (i) the specific reasons for the termination or nonrenewal should be provided in sufficient detail to permit the physician to respond; (ii) a name and address of the Director of Provider Appeals, or an individual with equivalent authority, should be provided for the physician to direct communications; (iii) the evidence or documentation underlying the proposed termination or nonrenewal should be provided and the physician should be permitted to review it upon request; (iv) the physician should have the right to request a hearing to challenge the proposed termination or nonrenewal; (v) the physician or his/her representative should be able to appear in person at the hearing and present the physician's case; (vi) the physician should be able to submit supporting information both before and at the fair hearing; (vii) the physician should have a right to ask questions of any representative of the health insurance company who attends the hearing; (viii) the physician should have at least thirty days from the date the termination or nonrenewal notice was received to request a hearing; and (ix) the hearing must be held not less than thirty days after the date the health insurer receives the physician's request for the review or hearing. 2. The qualifications, responsibilities, and duties of physicians employed as medical directors of managed care plans should be developed on an individual basis by the plan concerned. Physicians who participate in the plan, or the plan's medical staff, if one is so designated, should participate in developing such qualifications, responsibilities, and duties. (CMS Rep. B, A-93; BOT Rep. I-93-25; Reaffirmed: Sub. Res. 704, I-94; Reaffirmed: Sub. Res. 701, I-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 3, I-97; Reaffirmed by Res. 108, A-98; Reaffirmation A-01; Appended: CMS Rep. 8, A-10; Reaffirmed: Res 119, A-14; Modified: Res. 708, A-14; Reaffirmation A-14; Reaffirmed: CMS Rep. 4, I-14)

(26) RESOLUTION 822 - ELIMINATION OF ALL COST-SHARING FOR SCREENING COLONOSCOPIES

RECOMMENDATION:


HOD ACTION: Resolution 822 referred with report back at the 2018 Annual Meeting.

Resolution 822 asks that our AMA develop model national policy that supports the voluntarily removal of all cost-sharing associated with screening colonoscopies in all commercial and Medicare Advantage product lines and advocates for the adoption of these policies nationwide.
Your Reference Committee heard mixed testimony on Resolution 822. A member of the Council on Medical Service called for reaffirmation of existing policies on coverage of preventive services, including colonoscopies, in lieu of Resolution 822, noting that these policies address the intent of the resolution. A member of the Council on Legislation also supported reaffirmation of policy in lieu of Resolution 822, noting that AMA advocacy efforts have called for requiring Medicare to waive the coinsurance for colorectal screening tests, regardless of whether therapeutic intervention is required during the procedure, and last month submitted letters to the sponsors of the relevant House and Senate bills in support of their legislation. Your Reference Committee agrees that existing policy enables the AMA to advocate on the issues raised in Resolution 822, while noting that under the ACA, screening colonoscopies that are provided in-network are required to have no cost-sharing. As such, your Reference Committee recommends that Policies H-165.840, H-185.954, H-185.960, H-425.987 and H-425.992 be reaffirmed in lieu of Resolution 822.

H-165.840 Preventive Medical Care Coverage for All
Our AMA advocates for (1) health care reform that includes evidence-based prevention insurance coverage for all; (2) evidence-based prevention in all appropriate venues, such as primary care practices, specialty practices, workplaces and the community. (Res. 827, I-08; Reaffirmed in lieu of Res. 107, A-12; Reaffirmed: Res. 123, A-17)

H-185.954 Coverage for Certain Types of Well Care Examinations by Health Insurers
Our AMA: (1) will continue to facilitate the education of the American public and physicians as to the benefits of clinical preventive services, such as mammography screening and periodic physical examinations; (2) will continue to evaluate on a regular basis the benefits and cost-effectiveness of clinical preventive services guidelines; and (3) urges all health insurers to make available for purchase a wide variety of group and individual health insurance policies that provide coverage for a range of clinical preventive services. (Sub. Res. 108, A-97; Modified: CMS Rep. 7, A-00; Reaffirmed: CMS Rep. 3, A-02; Renumbered: CMS Rep. 7, I-05; Reaffirmed in lieu of Res. 107, A-12)

H-185.960 Support for the Inclusion of the Benefit for Screening for Colorectal Cancer in All Health Plans
Our AMA supports health plan coverage for the full range of colorectal cancer screening tests. (Res. 726, I-04; Reaffirmation I-07; Reaffirmed: CMS Rep. 01, A-17; Reaffirmed: Res. 123, A-17)

H-425.987 Preventive Medicine Services
1. Our AMA supports (A) continuing to work with the appropriate national medical specialty societies in evaluating and coordinating the development of practice parameters, including those for preventive services; (B) continuing to actively encourage the insurance industry to offer products that include coverage for general preventive services; and (C) appropriate reimbursement and coding for established preventive services. 2. Our AMA will seek legislation or regulation so that evidence-based screenings are paid for separately when provided as part of a comprehensive well-patient examination/review. (CMS Rep. B, I-90;
Reaffirmed: Sunset Report, I-00; Reaffirmation A-07; Reaffirmed and Appended: Res. 804, I-11; Reaffirmed in lieu of Res. 107, A-12; Reaffirmed: Res. 123, A-17)

H-425.992 Coverage of Preventive Medical Services by Medicare
The AMA advocates revision of current Medicare guidelines to include coverage of appropriate preventive medical services. (Res. 85, A-85; Reaffirmed CLRPD Rep. 2, I-95; Reaffirmation A-99; Reaffirmed in lieu of Res. 104, A-06; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 123, A-17)

(27) RESOLUTION 826 - IMPROVING AFFORDABILITY OF INSULIN

RECOMMENDATION:
Madam Speaker, your Reference Committee recommends that Policies H-110.987, H-125.977, H-125.979, H-185.939 and H-450.938 be reaffirmed in lieu of Resolution 826.

HOD ACTION: Resolution 826 referred with report back at the 2018 Annual Meeting.

Resolution 826 asks that our AMA work with relevant medical specialty societies to convene a summit with participation by patients, clinicians, manufacturers, PBMs, insurers and the appropriate federal representatives to highlight the dramatic increase in insulin costs and identify potential solutions; pursue solutions to reduce patient cost-sharing for insulin and ensure patients benefit from rebates at the point of sale; 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; encourage insulin price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies; and 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.

Your Reference Committee heard mixed testimony on Resolution 826. Testimony raised concerns with the price of insulin increasing 240 percent over the past decade. However, other speakers noted that insulin is not the only drug to experience noteworthy price increases; numerous other generic, brand and specialty drugs impacting a wide swath of patients also have had significant price increases. For example, your Reference Committee notes that between 2010 and 2015, Metformin HCl 850 mg tablet had a 574.7 percent retail price increase. The retail price of a 1-year supply of Truvada 200 mg-300 mg tablets increased from $8,977 in 2006 to $16,811 in 2015. Between 2010 and 2015, Sun Pharmaceutical’s doxycycline hyclate 100 mg tablets increased by 1,788.9 percent and Actavis’ doxycycline hyclate 100 mg capsules increased by 1,244.2 percent. In addition, between 2010 and 2015, Divalproex sodium ER 500 mg tablet had a 450.6 percent price increase. Wellbutrin XL 300 mg tablets had a retail price increase of 1,185 percent over the 10-year period ending in 2015.
Members from the Council on Medical Service and the Council on Legislation underscored that the AMA needs to continue to take a comprehensive approach to drug pricing, versus singling out individual drugs, and that AMA advocacy can be more effective with a comprehensive approach. As such, speakers rose in support of reaffirmation, noting that existing policies address the intent and spirit of Resolution 826. Your Reference Committee agrees, and recommends that Policies H-110.987, H-125.977, H-125.979, H-185.939 and H-450.938 be reaffirmed in lieu of Resolution 826.

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. (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)

H-125.977 Non-Formulary Medications and the Medicare Part D Coverage Gap
Our AMA will advocate for: (1) the inclusion of out of pocket, non-formulary, prescription medication expenses in calculating a patient's contributions toward...
the Medicare Part D coverage gap, after which coverage resumes; and (2) 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. (Res. 826, I-14; Reaffirmation I-15)

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. (Sub. Res. 724, A-14; Appended: Res. 701, A-16)

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 H-450.947), and AMA policy on physician economic profiling and tiered, narrow or restricted networks (Policies H-450.941 and D-285.972). (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: CMS-CSAPH Rep. 01, A-17)

H-450.938 Value-Based Decision-Making in the Health Care System

PRINCIPLES TO GUIDE PHYSICIAN VALUE-BASED DECISION-MAKING

1. Physicians should encourage their patients to participate in making value-based health care decisions. 2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality. 3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated. 4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients. 5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making. 6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life. (CMS Rep. 7, A-08; Reaffirmed in lieu of Res. 5, A-12; Reaffirmation I-14)
Madam Speaker, this concludes the report of Reference Committee J. I would like to thank Abhi Amarnani, Pratistha Koirala, Ramin Manshadi, MD, Arthur E. Palamara, MD, Sion Roy, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, and Andrea Preisler, JD.

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