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REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Covering the Uninsured under the AMA Proposal for Reform
(Resolution 108-A-18)
(Reference Committee A)

EXECUTIVE SUMMARY

Expanding health insurance coverage and choice have been long-standing goals of the American Medical Association (AMA). The AMA proposal for health system reform is grounded in AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage and choice to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and the Children's Health Insurance Program provide; and the preservation of employer-sponsored coverage to the extent the market demands it. The AMA proposal for reform recognizes that many individuals are generally satisfied with their coverage, but provides affordable coverage options to those who are uninsured or are having difficulties affording coverage options, including employer-sponsored, for which they are eligible.

The Council believes that our AMA proposal for reform, based on AMA policy, is still the right direction to pursue for covering the uninsured. In this environment, the Affordable Care Act (ACA) is the vehicle through which the AMA proposal for reform can be realized. That being said, the ACA is not broken, but it is imperfect. Instead of abandoning the ACA and threatening the stability of coverage for those individuals who are generally satisfied with their coverage, the Council believes that now is the time to invest not only in fixing the law, but improving it.

Improving the ACA targets providing coverage to the uninsured population, rather than upending the health insurance coverage of most Americans. In addition, focusing the efforts of our AMA on improving the ACA helps promote physician practice viability by maintaining variety in the potential payer mix for physician practices. As such, by putting forward the following new proposals to build upon and fix the ACA, as well as reaffirming existing policies adopted by the House of Delegates, the AMA proposal for reform has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Eliminate the subsidy "cliff," thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level;
- Increase the generosity of premium tax credits to improve premium affordability on ACA marketplaces and incentivize people to get covered; and
- Expand eligibility for and increase the size of cost-sharing reductions to help people with the cost-sharing obligations of the plan in which they enroll.

Importantly, the AMA proposal for reform provides a strong policy foundation to use in evaluating health reform proposals as they are introduced in the coming years, regardless of whether they are tied to the ACA. While the Council continues to believe that the AMA should not support single-payer proposals, the Council underscores that the AMA will continue to thoughtfully engage in discussions of health reform proposals, which will vary greatly in their structure and scope. Opposing single-payer proposals does not preclude that engagement, nor mean that the AMA should not evaluate health reform proposals that are introduced. Ultimately, our AMA, guided by policy, will continue forward in its efforts to advocate for coverage of the uninsured.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-A-19

Subject:	Covering the Uninsured under the AMA Proposal for Reform (Resolution 108-A-18)
Presented by:	James G. Hinsdale, MD, Chair
Referred to:	Reference Committee A (John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 108, "Expanding AMA's Position on Healthcare Reform Options," which was sponsored by the Medical Student Section. Resolution 108-A-18 asked that our American Medical Association (AMA) remove references in AMA policy to opposing single-payer health care by rescinding Policies H-165.844 and H-165.985; amending Policy H-165.888 by deletion to remove "1(b) Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed;" and amending Policy H-165.838 by deletion to remove "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." The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting.

This report provides background on health care coverage and costs in the US; summarizes potential approaches to cover the uninsured and achieve universal coverage; outlines factors to evaluate in proposals to expand coverage; and presents policy recommendations.

BACKGROUND

The health insurance coverage environment in the US for the nonelderly population heavily relies on the provision of employer-sponsored insurance, with nongroup coverage, Medicaid and other public programs covering smaller shares of the population. In 2017, 57 percent of the nonelderly population was covered by employer-sponsored health insurance coverage, with Medicaid and the Children's Health Insurance Program (CHIP) covering 22 percent, non-group plans covering eight percent, and other public plans covering three percent. Of concern, 27.4 million nonelderly individuals (10 percent) remained uninsured, an increase of 700,000 from 2016.[1]

The income demographic of the uninsured population is concentrated below 400 percent of the federal poverty level (FPL), with 82 percent of the uninsured with income below that threshold in 2017. Almost one-fifth of the uninsured population had incomes below the poverty line in 2017,[2] which in 2019 is $12,490 for an individual and $25,750 for a family of four.[3] Significantly, more than three-quarters of the nonelderly uninsured had at least one full-time worker in their family.[4]

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At the same time, $3.5 trillion was spent on health care in the US in 2017, an increase of 3.9 percent from 2016 – amounting to $10,739 per person. Hospital care made up 33 percent of total health care spending, with spending on physician and clinical services amounting to 20 percent, and retail prescription drugs 10 percent. Overall, health care spending made up 17.9 percent of the gross domestic product (GDP) in 2017.[5]

Health care is financed by a variety of entities in the US, via dedicated taxes and/or general revenues, or by contributions made to health insurance premiums and out-of-pocket costs. In 2017, the federal government and households each accounted for 28 percent of health care spending. Health care spending by private businesses amounted to 20 percent of spending, with state and local spending following at 17 percent.[6]

MOVING FORWARD: APPROACHES TO COVER THE UNINSURED

The uptick in the uninsured rate, coupled with increasing pressures relating to health care costs, has caused momentum to build in support of action to cover the remaining uninsured. There have been two main approaches outlined in legislation and organizational policy proposals to date to improve the coverage climate in the US. First, legislation and organizational proposals have been put forward to build upon and fix the Affordable Care Act (ACA) to cover more people. As an alternative, other proposals have been introduced to use Medicare as the foundation to cover all US residents, or allow Medicare or Medicaid buy-ins.

The AMA Proposal for Reform

Expanding health insurance coverage and choice have been long-standing goals of the AMA. The approach to coverage as outlined under the AMA proposal for reform supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. Notably, the AMA health system reform proposal has been extensively deliberated by the House of Delegates over the past 20 years. Based principally on recommendations developed by the Council on Medical Service, beginning in 1998, the AMA proposal for covering the uninsured and expanding choice advocates for the promotion of individually selected and owned health insurance using refundable and advanceable tax credits that are inversely related to income so that patients with the lowest incomes will receive the largest credits (Policies H-165.920 and H-165.865). Policy H-165.920 also 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. AMA policy also underscores that in the absence of private sector reforms that would enable persons with low-incomes to purchase health insurance, our AMA supports eligibility expansions of public sector programs, such as Medicaid and CHIP, with the goal of improving access to health care coverage to otherwise uninsured groups (Policy H-290.974). AMA policy has long supported the creation of basic national standards of uniform eligibility for Medicaid (Policy H-290.997), and at the invitation of state medical societies, the AMA will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent FPL as authorized by the ACA (Policy D-290.979). Addressing a public option, Policy H-165.838 states 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.

Since the enactment of the ACA, the House of Delegates has been very proactive in and responsive to the evolving coverage environment to ensure that AMA policy is able to address how to best

cover the remaining uninsured. Under the ACA, eligible individuals and families with incomes between 100 and 400 percent FPL (between 133 and 400 percent FPL in Medicaid expansion states) are being provided with refundable and advanceable premium credits that are inversely related to income to purchase coverage on health insurance exchanges. In addition, individuals and families with incomes between 100 and 250 percent FPL (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing subsidies if they select a silver plan, which leads them to face lower deductibles, out-of-pocket maximums, copayments and other cost-sharing amounts. At the time that this report was written, 36 states and the District of Columbia have adopted the Medicaid expansion provided for in the ACA, which extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.[7]

Significantly, the House of Delegates has adopted a multitude of policies that address coverage for the remaining uninsured in the ACA environment:

- *8.2 million individuals who are eligible for premium tax credits but remain uninsured:*[8] Policy H-165.824 supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits, and providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income.

- *1.9 million individuals who are ineligible for premium tax credits due to income higher than 400 percent FPL:*[9] AMA policy supports expanding eligibility for premium tax credits up to 500 percent FPL, encouraging state innovation with reinsurance (H-165.824), and establishing a permanent federal reinsurance program (H-165.842).

- *3.8 million individuals who are ineligible for premium tax credits to purchase coverage on health insurance exchanges because they have an offer of "affordable" employer coverage:*[10] Policy H-165.828 supports legislation or regulation, whichever is relevant, to fix the ACA's "family glitch," and supports lowering the threshold that determines whether an employee's premium contribution is "affordable," measured by comparing the employee's share of the premium to their income.

- *6.8 million individuals who are eligible for Medicaid or CHIP but remain uninsured:*[11] AMA policy supports efforts to expand coverage to uninsured children who are eligible for CHIP and Medicaid through improved and streamlined enrollment mechanisms and educational and outreach activities aimed at Medicaid-eligible and CHIP-eligible children. In addition, Policy H-290.961 opposes work requirements as a criterion for Medicaid eligibility.

- *2.5 million individuals with incomes below 100 percent FPL who fall into the "coverage gap" due to their state's decision not to expand Medicaid:*[12] Policy D-290.979 states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent (138 percent FPL including the income disregard) of FPL as authorized by the ACA.

- *Individuals who may choose not to get covered resulting from the elimination of the federal individual mandate penalty*: Policy H-165.824 encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. This policy builds upon Policy

H-165.848, which supports a requirement that individuals and families who can afford health insurance be required to obtain it, using the tax structure to achieve compliance. The policy advocates a requirement that those earning greater than 500 percent FPL obtain a minimum level of catastrophic and preventive coverage. Only upon implementation of tax credits or other coverage subsidies would those earning less than 500 percent FPL be subject to the coverage requirement.

Building Upon and Improving the Affordable Care Act

Legislative and organizational proposals to build upon and fix the ACA, on both the federal and state levels, generally include one or more of the following provisions:

- Increasing the amount of and expanding eligibility for premium tax credits, including removing the "subsidy cliff;"
- Providing "enhanced" tax credits to young adults;
- Increasing amounts of cost-sharing reductions received by individuals who qualify for them;
- Extending eligibility for cost-sharing reductions beyond 250 percent FPL;
- Establishing a reinsurance program;
- Fixing the "family glitch;"
- Establishing a state individual mandate and/or auto-enrollment program; and
- Restricting the availability of short-term limited duration insurance (STLDI) plans and association health plans.

These proposals are generally targeted at the populations that remain uninsured under the law, as well as to address the reasons individuals are uninsured or underinsured in the current environment. For example, in 2017, 45 percent of uninsured nonelderly adults reported that they were uninsured because the cost was too high.[13] Increasing the amount of and expanding eligibility for premium tax credits and cost-sharing reductions addresses concerns with both high premiums and cost-sharing requirements.

Expanding Medicare or Medicaid to Cover the Uninsured

Legislation has also been introduced to use Medicare or Medicaid as vehicles to expand coverage. "Medicare-for-All" legislation has been introduced in the US House of Representatives and the Senate: S 1129, the Medicare for All Act of 2019 (Senator Bernie Sanders, I-VT), and HR 1384, the Medicare for All Act of 2019 (Representative Pramila Jayapal, D-WA). These bills call for the replacement of employer-sponsored insurance, individual market coverage, and most public programs, including Medicaid, Medicare and CHIP, with Medicare-for-All. The new Medicare-for-All program would have no premiums, and in general no cost-sharing, with the exception of S 1129 giving the Secretary of Health and Human Services (HHS) the authority to allow for cost-sharing for prescription drugs, up to $200 per year. The new Medicare-for-All program would cover all medically necessary services in outlined benefit categories, dental and vision services, with coverage of long-term services and supports varying based on the legislation. These proposals would establish a global budget for all health spending. A fee schedule would be established for physicians, guided by Medicare rates.[14,15,16]

As an alternative to the traditional Medicare-for-All proposals, "Medicare for America" legislation was expected to be reintroduced this session of Congress at the time that this report was written. Of note, there may be differences between the legislation introduced this Congress and that introduced last Congress. Unlike Medicare-for-All, Medicare for America as introduced during the 115th

Congress would allow large employers to continue providing health insurance to their employees, if they provide gold-level coverage (80 percent of benefits costs covered). Alternatively, they can direct their contributions toward paying for premiums for Medicare for America. If employers continue to offer health insurance to their employees, employees would have the ability to choose Medicare for America coverage instead of their employer coverage. There would also be premiums and cost-sharing under Medicare for America. Premiums would be on a sliding scale based on income, with individuals with incomes below 200 percent FPL having no premium, deductible or out-of-pocket costs. Premiums overall would be capped at no more than 9.69 percent of monthly income. Individuals and families with incomes between 200 and 600 percent FPL would be eligible to receive subsidies to lower their premium contributions, with current Medicare beneficiaries either paying the premium for which they are responsible under Medicare, or that of Medicare for America, whichever is less expensive. Out-of-pocket maximums would also be applied on a sliding scale based on income, with the caps being $3,500 for an individual and $5,000 for families. Provider payment under Medicare for America would be based largely on Medicare rates, with increases in payment for primary care, mental and behavioral health, and cognitive services, and the Secretary being given the authority to establish a rate schedule for services currently not paid for under Medicare. Participating providers under Medicare or Medicaid would be considered to be participating providers under Medicare for America. Notably, as a condition of participation in the program, providers would accept Medicare for America rates paid by employer-sponsored insurance plans and Medicare Advantage plans.[17,18]

Smaller scale proposals have also been introduced to allow older individuals to buy in to Medicare starting at age 50; establish a public option that would be offered through the exchanges based on Medicare; and allow individuals to buy in to Medicaid. Senator Debbie Stabenow (D-MI) has introduced S 470, the Medicare at 50 Act, and Representative Brian Higgins (D-NY) has introduced HR 1346, the Medicare Buy-In and Health Care Stabilization Act of 2019, which would enable individuals to buy in to Medicare at age 50. Premiums would be based on estimating the average, annual per capita amount for benefits and administrative expenses that would be payable under Parts A, B, and D for the buy-in population. Notably, individuals enrolled in the buy-in would receive financial assistance similar to that which they would have received had they purchased a qualified health plan through the marketplace.[19,20]

Senator Brian Schatz (D-HI) and Representative Ben Ray Luján (D-NM) introduced S 489/HR 1277, the State Public Option Act. If enacted into law, the legislation which would give states the option to establish a Medicaid buy-in plan for residents regardless of income. Interestingly, for individuals ineligible for premium tax credits, their premiums cannot exceed 9.5 percent of household income. If these individuals were to enroll in other plans on state ACA marketplaces, their premiums would not be capped as a percentage of their income. In terms of physician payment rates, the State Public Option Act would make permanent a payment increase to Medicare levels for a range of primary care providers.[21,22] In addition, several states are considering a Medicaid buy-in or public option, including New Mexico, Colorado, Minnesota, New Jersey, Connecticut, Washington and Maine.[23] Some state proposals would use Medicaid provider rates as the basis for payment levels, whereas others would use Medicare or other approaches.

Legislative proposals have also been put forward in Congress to establish a public option on the exchanges that rely on components of the Medicare program in program structure and to keep plan costs down. The public option, available to individuals and/or small employers eligible to purchase such coverage, would require Medicare participating providers to participate in the public option. Proposals differ in their approaches to provider opt-out provisions, and whether providers in Medicaid would also be required to participate in the public option. Such public option proposals would also base provider payment rates on Medicare, either extending Medicare payment rates or

using Medicare rates as a guide to establish payment levels. Individuals who qualify for premium tax credits and cost-sharing subsidies could use such subsidies to purchase the public option. All public option proposals would at a minimum cover essential health benefits as required under the ACA, with some proposals covering more benefits.

International Approaches to Universal Coverage

Countries that have achieved universal coverage show that there is no "one-size-fits-all" approach to covering the uninsured and health system financing. Health system financing varies from country to country. While some countries can fall into one overarching financing model, others may incorporate multiple financing models in their health systems. Such models include a single-payer system financed through taxes, and employer-sponsored insurance and coverage provided by nonprofit, private insurers.

Many countries finance their health systems generally through taxes, with the government serving as single-payer. For example, in Denmark, health care is financed predominantly through a national health tax, equal to eight percent of taxable income. In the United Kingdom, the majority of financing for the National Health Service comes from general taxation and a payroll tax. Partly as a result of the level of health care benefits provided by the government, countries with single-payer systems tend to have higher tax rates and social insurance contributions. Overall, taxes that fund social insurance programs are often higher in other developed countries than in the United States.

Other countries have employer-sponsored insurance and coverage provided through nonprofit, private insurers. For example, health insurance in Germany is mandatory for all citizens and permanent residents, and is primarily provided by competing "sickness funds," not-for-profit, nongovernmental health insurance funds. Sickness funds are financed by mandatory contributions imposed as a percentage of employees' gross wages up to a ceiling. High-income individuals can choose to opt out and instead purchase substitutive private coverage. Switzerland requires residents to purchase mandatory statutory health insurance, which is offered by competing nonprofit insurers. Direct financing for health care providers, predominantly for hospitals providing inpatient acute care, comes from tax-financed government budgets. Residents pay premiums for statutory health insurance coverage; premiums are redistributed among insurers by a central fund, adjusted for risk. In the Netherlands, all residents are required to purchase statutory health insurance from private insurers. Its statutory health insurance is financed through a combination of a nationally defined, income-related contribution; a government grant for insured individuals under the age of 18; and community-rated premiums set by each insurer. Such contributions are collected centrally and allocated to insurers according to a risk-based capitation formula.[24]

In its analysis of international health systems, the Council noted that private insurance can play a supplementary and/or substitutive role to public health insurance options. Based on the country, premiums for private coverage can be paid by individuals and/or employers, unions or other organizations. Supplementary insurance, available in several countries, covers services that are excluded or not fully covered in the statutory plan, which could include prescription drug, dental and/or vision coverage. It can also build off the statutory coverage provided to improve coverage and can provide increased choice of or faster access to providers. For example, private health insurance in Australia and Norway offers more choice of providers, as well as expedited access to nonemergency care. Substitutive insurance is duplicative of coverage offered in the statutory plan, and could be available to populations not covered by or those who opt out of the statutory plan. In Germany, many young adults with higher incomes take advantage of substitutive private health insurance, because health insurers offer them coverage for a more extensive range of services, as well as lower premiums.[25]

The role of patient out-of-pocket payments in contributing to health care financing varies from country to country. In Canada, there is no patient cost-sharing for publicly insured physician, diagnostic and hospital services. In the United Kingdom, there is limited cost-sharing for publicly covered services. In countries where for many services patients have no cost-sharing, patients may have out-of-pocket responsibilities for outpatient prescription drugs, dental care and vision care. In many cases, vulnerable groups in these countries are either exempt from or face lower prescription drug copayments.[26]

Residents of Switzerland have similar types of cost-sharing exposures as privately insured individuals in the US. Insured adults are responsible for deductibles for statutory health insurance coverage, which can be lower, closer to $235, or higher, more than $1,900, depending on patient choice. After the deductible is met, individuals pay 10 percent coinsurance for all services, up to an annual maximum of approximately $550 for adults, with the cap for children being roughly half of that for adults. Low-income individuals are eligible for premium subsidies, and regional governments or municipalities cover the health insurance expenses of individuals receiving social assistance benefits or supplementary old age and disability benefits.[27]

Overall, several other countries, while requiring deductibles and/or copayments, also impose caps on cost-sharing, which limit patient out-of-pocket responsibilities. There are also exemptions from cost-sharing for vulnerable populations. For example, in Germany, there is an annual cap on cost sharing for adults equal to two percent of household income; the cap is equal to one percent of household income for chronically ill individuals. In Sweden, annual out-of-pocket payments for health care visits are capped below $200.[28]

Finally, approaches to paying providers vary, and are not wholly dependent on a country's health care financing model. Physicians can be salaried, or be paid via fee-for-service and capitation. Payments to physicians can also depend on whether patients have registered with and/or received a referral from their primary care physician. Physician fee schedules can be regulated or set by national, regional or local health authorities, negotiated between national medical societies/physician trade unions and the government, or negotiated/set by sickness funds or health plans. Physicians in some countries can also receive performance-based payments. Patient out-of-pocket payments contribute varying levels to physician payment, depending on cost-sharing responsibilities.

CONSIDERATIONS IN EVALUATING PROPOSALS TO EXPAND COVERAGE

Coverage Impacts

None of the legislative proposals to expand coverage highlighted in this report have been formally scored by the Congressional Budget Office to assess their impacts on coverage. That being said, proposals that would establish a single-payer system that would enroll all US residents into a single plan would be expected to lead to universal coverage. The coverage impacts of other proposals to expand coverage via a public plan available to all lawfully present individuals in the US would depend on whether individuals are able to opt out of the coverage, and what other provisions are included to maximize coverage rates. Some proposals would achieve universal coverage for legal residents, but not for undocumented individuals. Others, including public option proposals, would be expected to increase coverage, but at much lower rates.

The coverage impacts of proposals that aim to build upon and fix the ACA will depend on whether provisions to improve upon and/or expand premium tax credits and cost-sharing reductions; improve access to premium tax credits and cost-sharing reductions for those who find their

employer-sponsored coverage unaffordable; and/or establish a federal reinsurance program are coupled with mechanisms to maximize coverage rates, such as meaningful individual mandate penalties or an auto-enrollment mechanism. Also, additional states expanding their Medicaid programs would positively impact coverage rates, as 2.5 million of the nonelderly uninsured have incomes below 100 percent FPL and fall into the "coverage gap" due to their state's decision not to expand Medicaid.[29] Of note, certain policy options to improve the ACA have been evaluated to assess their potential impacts on overall coverage rates. For example, researchers from RAND Corporation modeled the impact of increasing the generosity of premium tax credits and extending eligibility for premium tax credits beyond 400 percent FPL, and concluded that implementing those policy options would increase the number of total insured by 2.4 million people in 2020. In addition, RAND modeled the impact of a generous reinsurance program, estimated to lead to an additional 2 million individuals having health insurance coverage in 2020.[30]

The Urban Institute also estimated the coverage impacts of reform proposals to build upon and fix the ACA, including:

- Reinstating the ACA's individual mandate penalties and cost-sharing reduction payments and prohibiting the expanded availability of STLDI plans;
- Expanding Medicaid eligibility in all remaining states, with full federal financing of the Medicaid expansion for all states; and
- Improving marketplace assistance, including the enhancement of the ACA's premium tax credit and cost-sharing subsidy schedules; tying ACA financial assistance to gold instead of silver level coverage; and establishing a permanent federal reinsurance program.

The Urban Institute assumed that 32.2 million nonelderly people would be uninsured in 2020. If these proposals to build upon and fix the ACA were enacted into law, the Urban Institute projected that number would drop to 21.1 million people in 2020 – a decrease of 11.1 million.[31]

Patient Choice of Health Plan

The ability of and degree to which patients would be able to choose their health plan would vary greatly under proposals put forth to cover the uninsured. Some Medicare-for-All proposals would not allow individuals with employer-sponsored coverage to keep their coverage; other proposals, including Medicare for America and proposals that build upon the ACA, would, to varying degrees. Depending on the proposal that builds upon Medicare to cover all US residents, patient choice of health plan would depend on whether the structure of the public plan is indeed a singular public plan in which everyone enrolls, or if it would follow a structure similar to Medicare Advantage. Under Medicare buy-in proposals, individuals starting at age 50 would have a choice between their existing mode of coverage and buying in to Medicare. Medicaid buy-in and other public option proposals are generally adding another plan to pick from on the marketplaces. The Council notes that if Medicaid buy-in and other public options are able to offer coverage at much lower premiums than existing marketplace plans, that could impact the size of premium tax credits available to individuals, which are pegged to the second lowest cost silver plan on the marketplace. If premium tax credit amounts are lower, individuals may have a choice of health plan, but may be able to afford fewer coverage options on the marketplaces.

Scope of Benefits

The scope of benefits under proposals introduced to cover the uninsured vary in terms of comprehensiveness of benefits and cost-sharing. Medicare-for-All proposals that have been introduced at the time that this report was written would cover medically necessary services in

outlined benefit categories, dental and vision services, and long-term services and supports. Generally, there would be no cost-sharing for these services, with the exception of S 1129**,** the Medicare for All Act of 2019, introduced by Senator Sanders, which would give the Secretary of HHS the authority to allow for cost-sharing for prescription drugs, up to $200 per year. Medicare for America would cover benefits determined to be medically necessary, including long-term services and supports for the elderly and individuals with disabilities, with cost-sharing responsibilities varying by income. Under the Medicare buy-in proposal for older individuals starting at age 50, such individuals would be entitled to the same benefits under Medicare Parts A, B and D as current Medicare beneficiaries. Public option proposals, including Medicaid buy-ins, generally follow the ACA's essential health benefits requirements, with cost-sharing dependent on income.

*Impacts on Patient Acces*s

Proposals to expand health insurance coverage can be expected to vary also in their impacts on patient access to care. Overall, increased demand for services would depend on how many individuals would become insured under the proposal. In addition, patient demand for services would vary based on the level of cost-sharing required under the proposal in question. For example, under traditional Medicare-for-All proposals, cost-sharing would generally be eliminated, which would be expected to lead to an increased utilization of medical services, as well as those services not typically covered under traditional health insurance (e.g. dental, vision, hearing). On the other hand, individuals use less care if cost-sharing is higher. As such, if patients were still responsible for a certain level of cost-sharing, the effect on demand for services would be expected to be more modest.

Provider supply and participation in any new public health insurance option can be expected to be impacted by the level at which providers are paid (e.g., Medicare or some variation thereof, Medicaid, new negotiated rates). For Medicare and Medicaid buy-in proposals as well as others that would create a public option, requiring provider participation could also impact whether providers continue to participate in traditional Medicare and/or Medicaid, potentially impacting current beneficiary access to care. In assessing the Medicare for All Act of 2017 as introduced by Senator Bernie Sanders, a working paper released by the Mercatus Center at George Mason University stated that "it is not precisely predictable how hospitals, physicians, and other health care providers would respond to a dramatic reduction in their reimbursements under M4A, well below their costs of care for all categories of patients combined."[32] In addition, RAND Corporation recently analyzed a single-payer plan for the state of New York, and an assumption incorporated into its modeling was that "providers reduce supply of services when payment levels decrease or financial risk increases."[33] Another RAND report assessing national health spending estimates under Medicare-for-All stated that "providers' willingness and ability to provide health care services including the additional care required by the newly insured and those benefiting from lower cost sharing would likely be limited."[34]

Of concern to the Council are those proposals that would greatly increase demand for services, while containing provisions expected to negatively impact provider supply. In detailing its methods for assessing the presidential campaign proposal of Senator Sanders in 2016, Urban Institute stated that "the Sanders plan would increase demand for health services by eliminating individuals' direct contributions to care (i.e., by eliminating deductibles, copayments, and coinsurance), but not all increased demand could be met because provider capacity would be insufficient."[35] The Mercatus Center study of the Medicare for All Act of 2017 stated that while some practices and facilities would be able to continue to operate, others would not, "thereby reducing the supply of health care services at the same time M4A sharply increases health care demand. It is impossible to say

precisely how much the confluence of these factors would reduce individuals' timely access to health care services, but some such access problems almost certainly must arise."[36] RAND's report on national health spending estimates under Medicare-for-All stated "[t]he extent and distribution of unmet care would depend on providers' payer mix under current law and their responses to Medicare-for-All payment levels. For example, some providers may elect to not participate in a Medicare-for-All plan (and instead enter in private contracts with individuals, an arrangement permitted in some single-payer bills), providers may alter when they retire, and potential medical students and trainees could change their career choices. As a result, some patients might experience longer wait times for care or face unmet needs."[37]

Concerns regarding wait times also echo data comparing health systems of different countries. For example, while 51 percent of patients in the United States were able to get an appointment the same or next day, that number falls to 49 percent in Sweden and 43 percent in Canada, and is 57 percent in the United Kingdom. Only six percent of patients in the US had a wait time of two months or longer to access a specialist, whereas wait times to see a specialist were significantly longer in countries with systems classified in the study as national health service and single-payer. Thirty-nine percent of patients in Canada had wait times of two-months or longer to see a specialist, with 19 percent of patients in the United Kingdom and Sweden facing such specialist wait times. Health systems in countries classified to be "insurance-based" (e.g. Germany, Switzerland, Netherlands, France) have more comparable wait times to the US.[38]

Other Impacts on Physician Practices

Health reform proposals that have been introduced have the potential to impact physicians and their practices in a multitude of ways, based on factors that include practice size and specialty; physician employment status; geography; and the payer mix of patients. As previously noted, transitioning the entire US population to a plan that pays Medicare rates, or has rates closely tied to that of Medicare, is expected to negatively impact practices that cannot cover their costs of care based on Medicare rates. Importantly, the Council notes innovation and practice enhancements can be undermined if practices were solely to rely on Medicare payment rates, therefore stifling delivery reform that promises to lower costs and improve care while maintaining access. Some Medicaid buy-in proposals raise similar concerns, especially those that use Medicaid payment rates in the buy-in program. On the other hand, proposals to build upon and fix the ACA would maintain the variety in the potential payer mix for physician practices.

The choices physicians currently have in their practice of medicine would be more limited under proposals that would enroll all US residents in a single public health insurance plan. That being said, it will be important to monitor if supplemental or substitutive private insurance would be allowed in such proposals, which would either replace the statutory coverage, or build off of the statutory coverage provided to improve coverage and provide increased choice of or faster access to providers. The Council notes that there may be an additional opportunity for physicians to participate in a parallel private market if it is allowed under such proposals.

Requirements for provider participation must be assessed in any proposal that would establish a public option or allow individuals to buy into Medicare or Medicaid. Such proposals assume physician participation in these plans if they participate in traditional Medicare and/or Medicaid. Under such proposals, if there is no provider opt-out provision, physicians would be expected to differ in their willingness to continue their participation in the existing traditional Medicare and Medicaid programs, as well as in their decisions on whether to accept new patients. Any proposal that ties physician participation in Medicare and/or Medicaid to a new public insurance option would also have the potential to significantly impact the payer mix of physician practices. The

Council notes that Policies H-285.989 and D-383.984 oppose "all products" clauses or linking a physician's participation in one insurance product to that physician's participation in any other insurance product.

Health reform proposals that drastically impact physician practice payer mix could also impact practice efficiency. While proposals that build upon the ACA would continue the practice of physicians interacting with a variety of health plans, transitioning all US residents into one public health insurance plan could mean that physicians only interact with one plan, with the same benefits package and payment rates, as well with one set of rules governing the use of utilization management practices.

Cost and Financing

The Council notes that none of the outlined legislative proposals to expand coverage have been formally scored by the Congressional Budget Office to assess their costs. That being said, think tanks and other entities have provided estimates of certain proposals. Medicare-for-All proposals that cover a comprehensive set of benefits with no cost-sharing are expected to incur the largest increases in federal spending. Recent analyses of Medicare-for-All proposals have been based on the Medicare for All Act of 2017 as introduced by Senator Sanders, his 2016 Medicare-for-All presidential campaign proposal, or a general Medicare-for-All proposal that would provide comprehensive health coverage, including long-term care benefits, with no-cost sharing. Of note, none of these analyses specifically measure the effects of S 1129, the Medicare for All Act of 2019, introduced by Senator Sanders in April of 2019. These analyses, published by the Urban Institute, the Mercatus Center at George Mason University, Kenneth Thorpe of Emory University and RAND Corporation, projected that Medicare-for-All proposals would require a large increase in federal spending. However, there are important differences among the analyses; as a result, they are not directly comparable. First, while Mercatus estimated the effects of the Medicare for All Act of 2017 as introduced, Urban Institute and Kenneth Thorpe evaluated Senator Sanders' 2016 presidential campaign proposal. As a result, the Mercatus Center assumed a four-year phase in of Medicare-for-All, but did not include an expansion in long-term services and supports – both differences between the 2017 version of the legislation and the campaign proposal. RAND, on the other hand, provided estimates of a more generic Medicare-for-All proposal. Of note, all of these studies made their cost projections over different time periods. The studies also did not have the same assumptions of the level at which providers would be paid under Medicare-for-All.[39,40]

The Mercatus Center estimated that the Medicare for All Act of 2017 would increase federal spending by approximately $32.6 trillion from 2022 to 2031, assuming a four-year phase-in period beginning in 2018.[41] The Urban Institute projected that federal spending under the 2016 presidential campaign proposal would increase by $32 trillion between 2017 and 2026.[42] The estimate of the campaign proposal put forth by Kenneth Thorpe was lower – closer to $25 trillion over the period from 2017 to 2026.[43] After the release of the Mercatus Center estimate, the Urban Institute noted that its estimates would differ if it were to standardize the assumptions between the two estimates. For example, Urban stated that if its estimate were over the same period as the Mercatus Center, and still included expansion of long-term services and supports, its estimate would be closer to $40 trillion.[44] RAND Corporation estimated that Medicare-for-All would increase federal health spending in 2019, rather than projecting a 10-year estimate, by 221 percent, from $1.09 trillion to approximately $3.5 trillion.[45]

All analyses estimating the cost of Medicare-for-All note that it would necessitate a complete change in how health care is financed in the US. Nearly all current national spending on health care by households, private businesses, and state and local governments would shift to the federal

government. How these entities fare after a transition to Medicare-for-All would ultimately depend on the pay-fors of the proposal. For example, in introducing the Medicare for All Act of 2019, Senator Sanders also released a white paper that laid out potential funding options, which included:

- Creating a 4 percent income-based premium paid by employees, exempting the first $29,000 in income for a family of four;
- Imposing a 7.5 percent income-based premium paid by employers, exempting the first $2 million in payroll to protect small businesses;
- Eliminating health tax expenditures;
- Making the federal income tax more progressive, including a marginal tax rate of up to 70 percent on those making above $10 million, taxing earned and unearned income at the same rates, and limiting tax deductions for filers in the top tax bracket;
- Making the estate tax more progressive, including a 77 percent top rate on an inheritance above $1 billion;
- Establishing a tax on extreme wealth;
- Closing the "Gingrich-Edwards Loophole;"
- Imposing a fee on large financial institutions; and
- Repealing corporate accounting gimmicks.[46]

Transitioning to the Medicare for America proposal, the Council notes that while the exact cost of the legislation is not yet known, it is expected to be significant, but cost less than the aforementioned Medicare-for-All proposals due to differences in plan premiums and cost-sharing requirements, and the role of employers. Of note, the sponsors of the bill put forward the following options to pay for the proposal as introduced during the 115th Congress:

- Sunsetting the Republican tax bill;
- Imposing a 5 percent surtax on adjusted gross income (including on capital gains) above $500,000;
- Increasing the Medicare payroll tax and the net investment income tax;
- Increasing the excise taxes on all tobacco products, beer, wine, liquor, and sugar-sweetened drinks; and
- Incentivizing states to make maintenance of effort payments equal to the amounts they currently spend on Medicaid and CHIP.[47]

The cost of proposals to build upon the ACA depends on the comprehensiveness of the proposal, and whether provisions are coupled with a mechanism to maximize coverage rates, such as an individual mandate or auto-enrollment system, as well as restrictions on short-term limited duration plans and association health plans. RAND Corporation estimated the impact on the federal deficit in 2020 of some potential proposals to improve coverage in the individual market under the ACA:

- Providing young adults with enhanced premium tax credits: $1.1 billion;
- Increasing the generosity of premium tax credits: $6.4 billion;
- Extending eligibility for premium tax credits beyond 400 percent FPL: $9.9 billion;
- Increasing and extending eligibility for premium tax credits: $18.8 billion; and
- Establishing a reinsurance program: Savings of $2.3 billion to $8.8 billion depending on generosity.[48]

The Urban Institute also estimated the impact of proposals to build upon and fix the ACA on federal spending on acute health care for the nonelderly in 2020:

- Reinstating the ACA's individual mandate penalties and cost-sharing reduction payments and prohibiting the expanded availability of STLDI plans: Savings of $11.4 billion;
- Expanding Medicaid eligibility in all remaining states, with full federal financing of the Medicaid expansion for all states (when added to the previous bullet): $68.1 billion; and
- Improving marketplace assistance, including enhancing the ACA's premium tax credit and cost-sharing subsidy schedules; tying ACA financial assistance to gold instead of silver level coverage; and establishing a permanent federal reinsurance program (added to the two previous bullets): $131 billion.[49]

The cost of public option proposals, as well as Medicare and Medicaid buy-ins, depends on several factors. First, the rate upon which provider payments are based will impact the cost, whether provider rates are tied to Medicare or a variation thereof, Medicaid, or another payment mechanism entirely. The cost of such proposals will also depend on whether they would be required to be financially self-sufficient and not depend on the traditional Medicare or Medicaid programs for parts of their financing. It will be paramount to assess the impact of any proposal that builds upon the Medicare program, or relies on Medicare program financing in part, on the solvency of the Medicare Trust Fund.

DISCUSSION

The AMA has long supported health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients. To expand coverage to all Americans, the AMA has advocated for the promotion of individually selected and owned health insurance; the maintenance of the safety net that Medicaid and CHIP provide; and the preservation of employer-sponsored coverage to the extent the market demands it. On the whole, the AMA proposal for reform recognizes that many individuals are generally satisfied with their coverage, but provides affordable coverage options to those who are uninsured or are having difficulties affording coverage options, including employer-sponsored, for which they are eligible.

While the ACA has made great strides in covering the uninsured, the Council is concerned with the recent uptick in the uninsured rate, as well as future coverage impacts of zeroing out the federal individual mandate penalty, the expanded provision of STLDI, and other proposals put forward that could likely undermine the progress made to date. That being said, the ACA is not broken, but it is imperfect. Instead of abandoning the ACA and threatening the stability of coverage for those individuals who are generally satisfied with their coverage, the Council believes that now is the time to invest not only in fixing the law, but improving it. Improving the ACA appropriately targets providing coverage to the uninsured population, rather than upending the health insurance coverage of most Americans. Modifications to the law could also improve the coverage options for many who are underinsured and/or cite costs as a barrier to accessing the care they need. In addition, focusing the efforts of our AMA on improving the ACA helps promote physician practice viability by maintaining the variety in the potential payer mix for physician practices. Importantly, the Council is concerned about the cost of proposed Medicare-for-All proposals, and how the proposals' pay-fors would impact patients and physicians.

The AMA proposal for reform, based on AMA policy, is still the right direction to pursue in order to cover the uninsured, and is cognizant that, in this environment, the ACA is the vehicle through which the AMA proposal for reform can be realized. As such, by putting forward new proposals to build upon and fix the ACA, as well as reaffirming existing policies adopted by the House of Delegates, the AMA proposal for reform as follows has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Premium tax credits would be available to all individuals without an offer of "affordable" employer coverage.
- Individuals currently caught in the "family glitch" and unable to afford coverage offered through their employers for their families would become eligible for ACA financial assistance based on the premium for family coverage of their employer plan.
- To help people currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income.
- The generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan.
- Young adults facing high premiums would be eligible for "enhanced" tax credits based on income.
- Eligibility for cost-sharing reductions would be increased to help more people with the cost-sharing obligations of the plan in which they enroll.
- The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impacts their ability to access and afford the care they need.
- A permanent federal reinsurance program would be established, to address the impact of high-cost patients on premiums.
- State initiatives to expand their Medicaid programs will continue to be supported. To incentivize expansion decisions, states that newly expand Medicaid would still be eligible for three years of full federal funding.
- To maximize coverage rates, the AMA would continue to support reinstating a federal individual mandate penalty, as well as state efforts to maximize coverage, including individual mandate penalties and auto-enrollment mechanisms.
- To improve coverage rates of individuals eligible for either ACA financial assistance or Medicaid/CHIP but who remain uninsured, the AMA would support investments in outreach and enrollment assistance activities.
- States would continue to have the ability to test different innovations to cover the uninsured, provided such experimentations a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.

Importantly, the Council stresses that our AMA proposal for reform provides a strong policy foundation to use in evaluating health reform proposals as they get introduced in the coming years, regardless of whether they are tied to the ACA. As such, the Council does not support the policy rescissions proposed in referred Resolution 108-A-18. While the Council continues to believe that AMA should not support single-payer proposals, there is the potential for other health reform proposals to be put forward in the future that could be consistent with AMA policy. The Council underscores that the AMA will continue to thoughtfully engage in discussions of health reform proposals, which will vary greatly in their structure and scope. Opposing single-payer proposals does not preclude that engagement, nor mean that the AMA will not evaluate health reform proposals that are introduced. Ultimately, our AMA, guided by policy, will continue forward in its efforts to advocate for coverage of the uninsured.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 108-A-18, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) support eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level (FPL). (New HOD Policy)

2. That our AMA support increasing the generosity of premium tax credits. (New HOD Policy)

3. That our AMA support expanding eligibility for cost-sharing reductions. (New HOD Policy)

4. That our AMA support increasing the size of cost-sharing reductions. (New HOD Policy)

5. That our AMA reaffirm Policy H-165.828, which supports legislation or regulation, whichever is relevant, to fix the Affordable Care Act (ACA's) "family glitch"; and capping the tax exclusion for employment-based health insurance as a funding stream to improve health insurance affordability. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-165.842, which supports the establishment of a permanent federal reinsurance program. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy H-165.824, which supports providing young adults with enhanced premium tax credits while maintaining the current premium tax credit structure which is inversely related to income; encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections; and supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL) including the income disregard)] FPL as authorized by the ACA. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policies H-290.976, H-290.971, H-290.982 and D-290.982, which support educational and outreach efforts targeted at those eligible for Medicaid and Children's Health Insurance Program, as well as improved and streamlined enrollment mechanisms for those programs. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy D-165.942, which advocates that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health

plan, and c) include reforms that eliminate denials for pre-existing conditions. (Reaffirm HOD Policy)

Fiscal Note: Less than $500

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REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-19

Subject: Medicare Coverage for Dental Services (Resolution 111-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A (John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 111, "Medicare Coverage for Dental Services," which was sponsored by the American College of Cardiology. Resolution 111 asked the American Medical Association (AMA) to (1) reaffirm appreciation and gratitude for the valuable contributions dental health professionals make to Americans' health and well-being as members of our health care team, and (2) promote and support legislative and administrative action to include preventive and therapeutic dental services as a standard benefit for all Medicare recipients. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting.

This report examines the unmet dental care needs of many Medicare beneficiaries, seniors' current options for obtaining dental health insurance and/or discounted care, the various challenges that would need to be overcome to create a Medicare benefit for dental services, and initiatives that are already underway to work towards better meeting the dental care needs of American seniors.

BACKGROUND

Medicare was created in 1965 as the federal health insurance program for people ages 65 and over, regardless of income or health status.[1] Medicare was later expanded to cover individuals under age 65 who are eligible for Social Security due to blindness or disability, or who have End Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). Medicare covers approximately 59 million people who meet one of the criteria for eligibility.[2] Notably, however, traditional Medicare does not include coverage for routine oral health care like checkups, cleanings, and x-rays, or restorative procedures (fillings, crowns, bridges, and root canals), tooth extractions, and dentures.[3] While some Medicare beneficiaries may be able to obtain dental coverage through other sources, the scope of dental benefits varies widely by geography and across plans. As a result, it is estimated that 70 percent of seniors lack or have limited dental insurance and fewer than half access dental care each year.[4]

Accordingly, Medicare beneficiaries have high out-of-pocket expenses when they do access dental care. For example, a 2016 analysis found that nearly one-fifth of the Medicare beneficiaries who received dental care paid more than $1,000 out-of-pocket.[5] For context, it has been reported that half of all Medicare beneficiaries live on annual incomes below $26,200, and one-quarter have incomes below $15,250.[6] The lack of dental coverage and high out-of-pocket costs can lead to patients delaying or forgoing dental care due to cost, as well as higher expenditures for medical and emergency care associated with untreated dental problems. However, while cost is often cited as a top reason for patients not going to the dentist, it is only one of many challenges senior citizens

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face as they seek dental care. Additional significant factors include: fear of the dentist, inconvenient appointment times or locations, dental health professional shortages, transportation challenges, and health literacy issues.[7]

At the same time, Medicare beneficiaries may have medical conditions and medications that worsen their oral health, or oral health issues that exacerbate or complicate treatment of their other medical conditions. Tooth decay and other oral diseases, when untreated, can cause pain, chronic and acute infection, tooth fractures and loss, compromised oral function, and impaired quality of life. Dental problems can make it difficult to eat, leading to poor nutrition, weight loss or gain, and exacerbation of chronic conditions like hypertension, diabetes, and hyperlipidemia – conditions which are common later in life. In addition, oral infections can be especially dangerous for older adults with weakened immune systems.[8] Recognizing that dental care is integral to overall well-being, many within the medical, dental, and patient advocacy communities have suggested that Medicare begin including dental care as a standard benefit. However, there is considerable agreement that adding the benefit would be very expensive and politically challenging.

CURRENT OPTIONS FOR DENTAL COVERAGE FOR SENIORS

It is important to recognize that the scope of dental coverage and affordability of dental care is an issue for people of all ages. The scope of covered benefits, cost-sharing rules, and annual dollar limitations that apply to private dental insurance plans can lead patients of all ages to face high out-of-pocket costs for dental treatment, and this issue extends to Medicare beneficiaries.[9] Medicare coverage policy for dental care is not completely clear, and the Medicare program is reviewing its authority to provide additional services. Currently, dental-related Medicare coverage includes:

- Dental services that are an integral part of a covered procedure;
- Extractions performed in preparation for radiation treatment for cancers involving the jaw;
- Oral examinations (but not treatment) preceding kidney transplants or heart valve replacements; and
- Hospital care resulting from complications of a dental procedure (but excluding the cost of the dental care).[10]

While traditional Medicare does not cover routine oral health care or restorative procedures, seniors have some options for obtaining some level of dental insurance coverage and/or discounted dental care. Medicare Advantage (MA) plans have been an option for seniors, as an alternative to enrolling in traditional Medicare, since the 1970s.[11] Virtually all Medicare beneficiaries have access to at least one MA plan in their area, and in 2018, the average Medicare beneficiary could choose among 21 MA plans offered by six insurers. MA plans provide all Medicare-covered services (except hospice), and they typically provide additional benefits, including dental care. For example, in 2018, approximately two-thirds of MA beneficiaries were enrolled in plans that offer some dental coverage. Beginning in 2019, MA plans will be able to provide targeted services for beneficiaries with chronic conditions. MA continues to be an increasingly popular option among Medicare beneficiaries: enrollment in MA plans has more than tripled, with 6 million beneficiaries in 2005 and 20 million reported in a 2018 study. Its popularity is expected to continue to grow – in 2018, 34 percent of the Medicare population was enrolled in MA, and that figure is projected to rise to 42 percent by 2028. However, as with insurance for other populations, some MA plans charge an additional premium for dental benefits, cost-sharing requirements vary by plan and geography, and dollar limitations on coverage commonly apply.[12]

In addition to MA plans being available, some Medicare beneficiaries receive dental coverage via Medicaid, employer-sponsored retiree health plans, or individually purchased dental plans.[13]

Again, however, the scope of dental benefits varies widely. Seniors must meet qualification criteria for Medicaid benefits, and not all states' Medicaid programs offer dental benefits.[14] Seniors (like other individuals) with employer-provided dental coverage must purchase their dental health plan separately from their medical insurance. Additionally, seniors can choose to purchase individual dental insurance plans through a variety of commercial insurance companies, or they can buy into a program that provides access to discounted dental care. However, given that these plans and programs carry sometimes significant monthly costs and can impose restrictive annual maximums on coverage (for example, a $1,000 annual maximum in some dental PPOs[15]), seniors must carefully consider whether such options are cost effective for them. Finally, some dental offices offer their own in-office dental plan (also known as a "dental membership savings plan" or "direct primary care agreement").[16] Patients participating in such plans pay their dentist/dental office a fixed amount per month or per year, and then they generally receive preventive services at no charge and discounts on other procedures.

CHALLENGES TO CREATING A NEW MEDICARE DENTAL BENEFIT

While it is clear that seniors need better access to affordable dental care, it is not clear how to provide that needed service via a new Medicare standard dental benefit. First, as a general matter, the Medicare program is already struggling under profoundly challenging finances. The 2018 Medicare Trustees Report (the 2018 Report) explains that Medicare Part B and Part D, which together comprise the Supplementary Medical Insurance Trust Fund (SMI), will continue to place a significant burden on the finances of taxpayers and Medicare beneficiaries. SMI costs are projected to demand an increasing proportion of beneficiaries' incomes, and SMI costs are projected to increase significantly as a share of GDP over the next 75 years, from 2.1 percent to 4.0 percent.[17] Yet, adding a comprehensive benefit for dental coverage to Medicare Part B has been estimated to cost approximately $32.3 billion.[18] Policymakers considering a new dental benefit would have to weigh significant competing demands to reduce growth in Medicare spending for currently covered benefits while also addressing the need for a very expensive additional benefit. It is also important to avoid jeopardizing funding for current Medicare benefits. This complicated policy decision must be made in the context of the broader solvency issues facing the Medicare program. The 2018 Report indicated that the Hospital Insurance Trust Fund (HI) component of Medicare has an estimated depletion date of 2026, which is three years earlier than in last year's report.[19] As in past years, the Trustees determined that the fund is not adequately financed over the next 10 years. In fact, the Trustees project deficits in all future years until the trust fund becomes depleted in 2026.

Second, creating a new Medicare benefit for dental care would require legislative and regulatory action. A statutory exclusion in Section 1862(a)(12) of the Social Security Act prevents inclusion of dental benefits in Medicare.[20] Congress would need to act to remove that exclusion, and additional statutory changes, such as establishing a scope of services and structuring provider payment, would be required to ensure a smooth integration of dental benefits into Medicare. Additionally, the Centers for Medicare & Medicaid Services (CMS) would need authority to promulgate new regulations to implement and administer Medicare dental health benefits.

Even if a new Medicare dental benefit were enacted, it is not clear that dentists would be sufficiently interested in participating to provide good access to dental care for Medicare patients. With 40 percent of national health expenditures for dental care being paid by patients out-of-pocket, dentists have been less reliant on third-party payer financial support for their practices than have physicians.[21] Additionally, dental fee-for-service models typically include unique costs such as dental laboratory material and supplies within the fee for a given procedure, and comprehensive dental practices often house significant equipment that contributes to large overhead costs. The

extent to which a newly created Medicare dental benefit covers these costs is likely to influence dental practices' decisions about whether to participate in a Medicare dental benefit.

PROPOSALS FOR IMPROVING ACCESS TO DENTAL CARE FOR SENIORS

A variety of policy options could be considered to expand access to dental care for Medicare beneficiaries. As "America's leading oral health advocate," the American Dental Association (ADA) is deeply committed to advocating for public policies "affecting the practice of dentistry and the oral health of the American public."[22] The ADA recognizes senior citizens' compelling need for dental care and continues to study methods for improving seniors' access to dental care, to explore the possibility of a Medicare dental benefit, and to advocate on behalf of the dental community and its patients. The ADA recently contributed to a multi-disciplinary collaboration that included representatives from the Center for Medicare Advocacy, Oral Health America, Families USA, Justice in Aging, and the Santa Fe Group and resulted in a white paper analyzing a potential oral health benefit in Medicare Part B. While the resulting white paper advocates for inclusion of an oral health benefit in Medicare Part B, the ADA has not reached that conclusion. Instead, the ADA's position has been one of thoughtful engagement, without endorsing a new Medicare dental care benefit. The ADA contributed data to the white paper, explaining that, "The ADA Board of Trustees determined that it was critical for the ADA to educate this coalition to ensure that the dentist perspective on this national health policy issue is represented and understood."[23] Critically, however, the ADA stated that "the Association's input does not constitute endorsement of inclusion of a dental benefit under Medicare at this time."[24] Instead, the ADA explained, "Ultimately, success depends on establishing a sustainable program that will actually increase oral health for seniors."[25] As of July 2018, the ADA's Council on Dental Benefit Programs has been "studying this issue [of a Medicare dental benefit] in order to make an informed recommendation for the profession."[26] More recently, when the ADA House of Delegates met in October 2018, it adopted policy that "calls for the ADA president to appoint an ad hoc committee to review and update existing policy. . . and to identify an implementation plan and timeline to address elder care including Medicare."[27] AMA staff communications with ADA staff indicate that the ADA is carefully studying the issue of senior oral health and Medicare coverage for dental services, and it plans to issue further guidance in the near future, potentially as soon as late 2019.

In addition to the proposal to add a dental benefit to Medicare Part B, others have proposed an optional supplementary Medicare benefit to provide coverage for dental, vision, and hearing services, similar to the Medicare Part D benefit. The optional benefit package would be mostly funded through premiums (with income-based subsidies that follow the design of the Part D subsidy potentially available). At the same time, the study authors acknowledge that calculating the cost of such a benefit package is challenging and dependent upon many assumptions, and they describe their policy option as a starting point for discussion and more extensive modeling.[28] Other policy options include the contention by some advocates that CMS has the authority to cover oral health care when it is medically necessary for the treatment of Medicare-covered diseases, illnesses, and injuries, and CMS is reviewing this question.[29]

Each of these policy options raises questions about budget, scope of coverage, cost-sharing, provider payment, and administration. To inform the policy debate, further studies of possible Medicare benefit plan design, impacts on clinical outcomes, and cost effectiveness are needed. For example, researchers could study outcomes and impacts reported from MA plans offering varying degrees of dental coverage to inform optimal benefit design. Additionally, clinical and comparative effectiveness research from the National Institute of Dental and Craniofacial Research (NIDCR) could inform future analyses.

As the specific debate surrounding a Medicare dental benefit continues to unfold, the ADA is also engaged in broader efforts to examine barriers to dental care and expand access. As part of a series on Access to Oral Health, the ADA issued a report on the role of finance in breaking down barriers to oral health for all Americans. The ADA emphasized that "adequate funding should be made available through both public and private financing mechanisms. Financial barriers to care must be removed or lessened to increase the utilization of dental services."[30] However, the ADA explained that "increased funding alone cannot 'fix' a dental financing system that is rife with inefficiencies and shifting policies. . . Funding alone will not guarantee other needed improvements in the system."[31] Since 2014, the ADA has led a community-based, grassroots movement called Action for Dental Health. Action for Dental Health aims to provide care for people who suffer from untreated dental disease, to strengthen and expand the public/private safety net, and to bring disease prevention and education into communities. This movement advocates for increased dental health protections under Medicaid, providing dental care for seniors in nursing homes with funding through Medicaid, training other health professionals to provide basic dental health education and recognize conditions that need to be referred to a dentist, and providing free dental care to underserved populations.[32] The Action for Dental Health movement recently won a significant victory with the enactment of the Action for Dental Health Act (the Act) which aims to improve access to oral health care for underserved Americans.[33] Specifically relevant to the issue of senior dental care, the Act supports the development of models for the provision of dental services (such as dental homes) for children and adults including the elderly, blind, individuals with disabilities, and individuals living in long-term care facilities. The Act will also support initiatives to reduce the use of emergency departments by individuals seeking dental services that would be more appropriately provided in a dental primary care setting.[34]

AMA POLICY

AMA policy emphasizes the important role of oral health in overall patient care. Policy D-160.925 recognizes the importance of managing oral health and access to dental care as a part of optimal patient care. The policy also states that the AMA will explore opportunities for collaboration with the ADA on a comprehensive strategy for improving oral health care and education for clinicians. Additional policy supports providing coverage for dental care for medical residents and fellows in training (Policies H-295.873 and H-310.912) and for individuals with developmental disabilities (Policy H-90.968).

Policy regarding insurance coverage for hearing aids is also instructive, as hearing aids constitute another category of care that is not covered by traditional Medicare, but that is critical to patient well-being. Policy H-185.929 encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams, and related services. The policy also supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's benefit.

However, Policy H-185.964 opposes new health benefit mandates unrelated to patient protections that jeopardize coverage to currently insured populations. Additionally, under Policy H-165.856, the AMA supports the principle that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options.

Extensive AMA policy emphasizes the importance of collaboration with health care community stakeholders and national medical specialty societies. Several policies support continued collaboration with national medical specialty societies, interest groups, and other stakeholders to develop clinical guidelines for preventive services; encourage coverage for evidence-based recommendations regarding preventive services, especially for populations at high risk for a given

condition; and promote to the public and the profession the value of Medicare-covered preventive services (Policies D-330.935, D-330.967, H-425.987, and H-425.988). Similarly, Policy D-185.979 encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

DISCUSSION

The Council commends the sponsors of referred Resolution 111-A-18 for highlighting the inextricable link between oral health and overall health and well-being and the dental care needs of Medicare beneficiaries. In light of the AMA's policy commitment to collaborating with the ADA, the critical importance of the dental profession's perspective on the issue of creating a Medicare benefit for dental care, and the currently evolving research on this issue, the Council believes that the AMA should continue to explore opportunities to work with the ADA to improve access to dental care for Medicare beneficiaries. As part of this collaboration, the AMA should continue to monitor and evaluate the ADA's research and policy recommendations regarding a Medicare benefit for dental care and the broader challenge of meeting the oral health care needs of America's senior citizens. In addition, the Council believes that the AMA should support initiatives to expand health services research regarding expanding affordable access to dental care for Medicare beneficiaries. This research could include studies of the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs for improving health and preventing disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. Finally, to underscore the importance of the goals articulated through Resolution 111-A-18 and the AMA's commitment to working with the ADA to achieve these goals, the Council recommends reaffirming Policy D-160.925, which recognizes the importance of managing oral health, access to dental care as a part of optimal patient care, and collaboration with the ADA.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 111-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) reaffirm Policy D-160.925, which recognizes the importance of managing oral health, access to dental care as a part of optimal patient care, and collaboration with the American Dental Association (ADA). (Reaffirm HOD Policy)

2. That our AMA support continued opportunities to work with the ADA and other interested national organizations to improve access to dental care for Medicare beneficiaries. (New HOD Policy)

3. That our AMA support initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization. (New HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policy Recommended for Reaffirmation

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

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-19

Subject: Reclassification of Complex Rehabilitation Technology (Resolution 117-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A (John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 117-A-18, "Supporting Reclassification of Complex Rehabilitation Technology (CRT)," which was introduced by the Texas Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2019 Annual Meeting. Resolution 117-A-18 asked that our American Medical Association (AMA) "advocate for the Centers for Medicare & Medicaid Services (CMS) to reclassify CRT as a separate and distinct payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs."

In this report, the Council explains complex rehabilitation technology, discusses legislation that has impacted funding for CRT, summarizes competitive bidding in this context, and highlights relevant AMA policy. The Council concurs with the intent of Resolution 117-A-18, and recommends minimal modifications to avoid potential unintended consequences of the reclassification.

BACKGROUND

Resolution 117-A-18 identifies challenges with the current classification of CRT within the broader category of durable medical equipment (DME) under Medicare's payment rules. The resolution explains that the DME category used by CMS does not distinguish technological differences between CRT and other DME. CRT is often required for optimal ongoing mobility at home as well as in daily living activities for individuals with debilitating chronic illnesses. The resolution also notes that long-term care facilities may not provide medically necessary CRT due to the cost or lack of experience with CRT configuration.

CRT can include specialized devices and services that meet the needs of beneficiaries with complex, long-term or permanent, mobility and other impairments. CRT consists of individually configured manual and power wheelchairs, seating and positioning systems, and other adaptive equipment such as standing devices and gait trainers. The specialization inherent in CRT contrasts with the far less complex mobility devices under the DME benefit, which typically serve a short-term, post-hospitalization beneficiary population in need of DME while recovering in the home. In 2014, CRT power wheelchairs and accessories accounted for two percent (about 13,000) of all Medicare wheelchair utilization and 22 percent (about $69 million) of wheelchair expenditures.[1]

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COMPETITIVE BIDDING

The Medicare Durable Medical Equipment, Prosthetics, Orthotics, & Supplies (DMEPOS) Competitive Bidding Program was enacted with the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which required Medicare to implement a competitive bidding process for selected DMEPOS items to reduce beneficiary out-of-pocket expenses and save the Medicare program money.[2]

Under competitive bidding, suppliers compete in established competitive bidding areas by submitting bids for selected products. Not all products or items are subject to competitive bidding. Bids are evaluated based on the supplier's eligibility, its financial stability and the bid price. Contracts are awarded to the Medicare suppliers who offer the best price and meet applicable quality and financial standards. Contract suppliers must agree to accept assignment on all claims for bid items and will be paid the single payment amount.

Notably, CRT power wheelchairs, but not other CRT products, were excluded from competitive bidding with the passage of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008. An exceptionally costly unanticipated expense, such as for CRT, can consume a large portion of the budgets of CRT device and service vendors, creating price pressures and/or potentially hindering beneficiary access. A July 2018 GAO report[3] found that competitive bidding of DME reduced payment levels substantially, with average reduction of 46 percent across the top 53 items. Rural areas are largely excluded from coverage in the bidding areas. DME vendors can compete in those non-bid areas and also refuse to provide services and products to those areas.

MIPPA acknowledged that complex rehabilitative power wheelchairs were unique and different from standard DME. However, the law did not establish a separate benefit/payment category for these wheelchairs and is limited in scope to apply only to certain complex rehabilitative power wheelchairs. Legislation would be needed to require that CMS create a separate and distinct classification for all products and services that are classified as CRT.

RELEVANT AMA POLICY AND ADVOCACY

Policy D-330.907 strongly encourages CMS to refrain from implementing policies that would curtail access to CRT wheelchairs and accessories by applying competitively bid prices to these specialized devices. If CMS does not refrain from implementing policies limiting access to CRT wheelchairs, the policy states that the AMA will encourage Congress to support legislation (e.g., HR 3229) that would provide a technical correction to federal law to clarify that CMS cannot apply Medicare competitive bidding pricing to CRT wheelchairs.

Policy H-185.963 (1) urges public and private third party payers to increase access to health insurance products for adults with congenital and/or childhood diseases that are designed for the unique needs of this population; and (2) emphasizes that any health insurance product designed for adults with congenital and/or childhood diseases include the availability of specialized treatment options, medical services, medical equipment and pharmaceuticals, as well as the accessibility of an adequate number of physicians specializing in the care of this unique population.

Policy H-330.955 states that the AMA (1) continues to voice its objection to CMS and other insurers regarding onerous requirements for the prescription of durable medical equipment; (2) advocates that additional members of a physician-led health care team be permitted to complete the certification of medical necessity form for durable medical equipment, according to their education, training and licensure and at the discretion of the physician team leader, but require that

the final signature authorizing the prescription for the durable medical equipment be the responsibility of the physician; (3) calls for CMS to revise its interpretation of the law, and advocates for other insurers, to permit that the physician's prescription be the only certification of medical necessity needed to initiate an order for and to secure Medicare or other insurer payment for durable medical equipment; and (4) calls on physicians to be aware of the abuses caused by product-specific advertising by manufacturers and suppliers of durable medical equipment, the impact on the consumers of inappropriate promotion, and the contribution such promotion makes to unnecessary health care expenditures.

Policy H-390.835 supports: (1) 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; (2) that no additional cost-sharing for the additional reimbursement will be passed on to patients with mobility disabilities, consistent with Federal Law; (3) that primary and specialty medical providers be educated regarding the care of patients with severely impaired mobility to improve access to care; and (4) 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.

In accordance with Policy D-330.907, the AMA submitted a letter to the Secretary of Health and Human Services on June 9, 2016, urging CMS to revoke the application of competitive bidding to complex rehabilitation wheelchairs.

DISCUSSION

Referred Resolution 117-A-18 is consistent with AMA policy and past advocacy urging the CMS to rescind the decision to apply the competitive bidding pricing program to CRT wheelchairs and wheelchair accessories and instead develop alternative approaches that consider beneficiary access.

Accordingly, the Council recommends the essence of Resolution 117-A-18, while noting that accomplishing the request of the resolution will require legislation and regulation. Because CMS cannot enact legislation, the Council recommends supporting reclassification without referring to CMS as the necessary change agent. Once legislation is enacted, the Council's recommended policy statement of support for reclassification would direct the AMA to advocate for CMS implementation. The Council also recommends supporting the efforts of Federation partners to accomplish adequately funded CRT reclassification.

If CRT is categorized as a distinct category it should be adequately funded. In addition, to address concerns that prices for CRT products and services could increase significantly within a distinct category, the Council believes that it would be appropriate for CMS to develop additional requirements and/or regulations beyond those that currently exist for the fitting and prescribing of CRT under DME regulations. Such possible requirements/regulations could include, but not be limited to competitive bidding of CRT, coverage policies, and quality standards.

Finally, the Council encourages the ongoing involvement of appropriate stakeholders to accomplish the adequately funded reclassification of CRT, such as pain physicians, physical therapists, occupational therapists.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 117-A-18, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the reclassification of complex rehabilitation technology (CRT) as a separate, distinct, and adequately funded payment category to improve access to the most appropriate and necessary equipment to allow individuals with significant disabilities and chronic medical conditions to increase their independence, reduce their overall health care expenses and appropriately manage their medical needs. (New HOD Policy).

2. That our AMA support state medical association and national medical specialty society efforts to accomplish adequately funded reclassification of CRT. (New HOD Policy)

3. That our AMA support, upon reclassification of CRT as a distinct category, the development by the Centers for Medicare & Medicaid Services of additional requirements and/or regulations specific to CRT, beyond those that exist under the broad category of durable medical equipment. (New HOD Policy)

Fiscal Note: Less than $500.

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REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
The Impact of Pharmacy Benefit Managers on Patients and Physicians
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-120.933, "Pharmacy Benefit Managers Impact on Patients." The Board of Trustees assigned the following provisions of the policy to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting:

> Our American Medical Association (AMA) will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; and (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts.

PBMs no longer simply negotiate drug prices on behalf of their clients, but rather fully administer the drug benefit creating formularies, making coverage decisions, and determining medical necessity with utilization management tools. The Council believes that PBMs' role managing drug benefits now resembles the typical role of insurers, and they should be treated as such by regulators. Overall, regulators must better understand and control the costs to patients and the systems that are resulting from PBM practices. As such, the Council recommends that PBMs be actively regulated under state departments of insurance. To implement this new policy, the Council believes that our AMA should develop model state legislation addressing state regulation of PBMs. On the federal level, the Council believes that PBMs, like health plans, should be subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.

The Council recognizes that the negative fluidity of the drug benefit is largely a result of the rebate system and the constant negotiations that take place to advance the interests of many drug benefit stakeholders – but not patients. The Council is concerned that the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor manufacturers currently have an incentive to lower list prices. As such, the Council questions whether rebates that are being negotiated by PBMs are resulting in any true savings. The disclosure of rebate and discount information, financial incentive information, and pharmacy and therapeutics (P&T) committee information would constitute critical steps toward improved transparency. The Council also believes that manufacturer rebates and pharmacy price concessions should be applied to drug prices at the point-of-sale. This policy, which also applies directly to DIR fees, would add much needed transparency and ensure that beneficiaries benefit from discounts, and dispensing physicians and practice-based pharmacies have more clarity regarding their true reimbursement rates.

In order to maintain cost transparency for patients and keep patients stable on their medications, the Council also recommends the reaffirmation of policies addressing mid-year formulary changes and utilization management requirements. These practices employed by PBMs can undermine the ability of patients to have timely access to the medically necessary treatment that they need.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5-A-19

Subject: The Impact of Pharmacy Benefit Managers on Patients and Physicians

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A
(John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates adopted Policy D-120.933, "Pharmacy Benefit Managers Impact on Patients." The Board of Trustees assigned the following provisions of the policy to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting:

> Our American Medical Association (AMA) will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy benefit manager (PBM) tactics may have on patient's timely access to medications, patient outcomes, and the physician-patient relationship; and (2) examine issues with PBM-related clawbacks and direct and indirect remuneration (DIR) fees to better inform existing advocacy efforts.

This report provides background on PBM operations and market conditions, outlines issues of concern for patients and physicians with respect to PBM operations; and presents policy recommendations.

BACKGROUND: PHARMACY BENEFIT MANAGER OPERATIONS AND MARKET CONDITIONS

PBMs represent payers, including health insurers and self-insured employers, to negotiate discounts on the prices of prescription drugs and rebates based on volume of sales with pharmaceutical companies. In turn, payers determine which drugs to cover and how much patients pay. The role of PBMs as "middlemen" among payers, pharmaceutical companies and pharmacies goes beyond the negotiation of drug prices on behalf of their clients. PBMs are more frequently fully administering the drug benefit of their clients, creating formularies, making coverage decisions, and determining medical necessity using utilization management tools. They also create networks of pharmacies and negotiate reductions in dispensing fees.

In general, PBMs have three primary revenue sources:

1. Fees from payers for claims administration and drug dispensing;

2. A percentage of the savings secured from rebates and discounts negotiated from pharmaceutical companies; and

3. Fees and savings associated with maintaining pharmacy networks.

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The PBM market is highly concentrated: three PBMs – Express Scripts, CVS Caremark and OptumRx – control more than 70 percent of the market.[1] These three PBMs, by representing so many covered lives, have substantial bargaining power in their negotiations with drug manufacturers. Complicating the market concentration is the trend toward PBMs merging with health insurers, and how that could impact pharmacy networks available to patients. CVS-Aetna announced their proposed merger in December of 2017. The US Department of Justice (DOJ) has approved the CVS-Aetna merger, contingent on a federal court approving a settlement in which Aetna has agreed to divest its Medicare Part D prescription drug plan business. At the time this report was written, a federal court is reviewing that settlement. Cigna-Express Scripts announced their intention to combine in March of 2018. The Cigna-Express Scripts merger has been approved and is being consummated. Pertaining to PBM operations, the health insurers in these instances are trying to merge with the entity that is providing them with PBM and pharmacy services. Concerns have been raised by the AMA and others that the CVS-Aetna merger could substantially lessen competition in PBM services, health insurance, retail pharmacy, Medicare Part D, and specialty pharmacy.[2]

OPERATIONS OF PHARMACY BENEFIT MANAGERS: ISSUES OF CONCERN FOR PATIENTS AND PHYSICIANS

Insufficient Regulation

While most states have laws that regulate various aspects of PBM operations, such laws are rather limited in nature, and do not necessarily reflect the roles that PBMs have assumed in fully administering the drug benefit of their clients. State laws that regulate aspects of PBM operations generally fall into the following categories:

- Requiring a PBM to register with or be licensed by the state, in order to conduct business in the state;
- Specifying pharmacy audit procedures by PBMs, including outlining audit appeals mechanisms, audit notification requirements, how frequently audits can occur and what can be audited;
- Outlining conflict of interest provisions with respect to pharmacy and therapeutics (P&T) committees and other areas;
- Requiring transparency in the development and utilization of maximum allowable cost (MAC) lists, which list the maximum amount a PBM will pay for drugs;
- Prohibiting “gag clauses” in PBM-pharmacy contracts;
- Enacting “anti co-pay clawback” provisions that aim to prevent patient co-payments from exceeding the full cost of the drug;
- Imposing a fiduciary duty on a PBM to the entity with which it contracts; and
- Imposing a performance duty on a PBM, which requires a PBM to operate in good faith with the entity with which it contracts.

On the federal level, the function PBMs have assumed in administering the drug benefit of their clients raise the issue of if, and to what extent, PBMs are currently subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. Concerns have been raised that clarity is needed in this regard, as while they are not a health plan, they are operating very much like one pertaining to drug benefits.

AMA Policy and Advocacy Regarding Regulation

Policy D-185.995 puts PBMs on the same footing as public and private sector payers, by stating that our AMA will (1) advocate our policies related to health plan coverage of prescription drugs to PBMs, as well as to public and private sector payers; and (2) advocate for the enactment of legislation consistent with AMA policies related to health plan coverage of prescription drugs. Accordingly, the multitude of AMA policies addressing formulary requirements and transparency, utilization management, mental health parity and other issues are applicable to PBMs in addition to health plans.

Policy H-125.986 provides significant guidance with respect to federal regulation of PBM operations. The policy: 1) encourages the Federal Trade Commission (FTC) and the Food and Drug Administration (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; 2) states that certain actions/activities by PBMs and others constitute the practice of medicine without a license and interfere with appropriate medical care to our patients; 3) supports efforts to ensure that reimbursement policies established by PBMs are based on medical need; these policies include, but are not limited to, prior authorization, formularies, and tiers for compounded medications; and 4) encourages the FTC and FDA to monitor PBMs' policies for potential conflicts of interest and anti-trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies in which the PBM holds an economic interest.

In its comments in response to the *American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint)* in July of 2018, the AMA outlined its support for regulating PBMs, stating that the benefit management of PBMs now resembles the typical role of insurers, and they should be treated as such by regulators. Also in July, the AMA submitted a letter in support of the efforts of the National Council of Insurance Legislators (NCOIL) in developing a draft state model act to require licensure of PBMs in the state and allow for oversight by the department of insurance or other equivalent regulatory agency. Additionally, the AMA has advocated for the National Association of Insurance Commissioners (NAIC) to include in its pharmacy benefit model legislation the regulation of PBM activities.

Lack of Transparency

The Council recognizes that the ability of patients and physicians to have the information they need to make key decisions regarding medication, and of policymakers to craft viable solutions to high and escalating pharmaceutical costs, has been hampered by the often byzantine and confidential arrangements that are driving increased medication prices without a clear and justifiable reason. The opaque nature of PBM negotiations of drug prices has raised questions whether the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor drug manufacturers currently have an incentive to lower list prices. In addition, there is a lack of transparency regarding what percent of the savings associated with rebates are passed through to patients or payers. The degree to which savings are passed on to payers and patients impacts health plan premiums as well as cost-sharing requirements.

Concerns have also been raised by physicians and their patients pertaining to transparency in formularies, prescription drug cost-sharing requirements, and utilization management requirements. This lack of transparency makes it exceedingly difficult for physicians to determine what treatments are preferred by a particular payer at the point-of-care, what level of cost-sharing their patients will face, and whether medications are subject to any step therapy or other utilization

management requirements. For patients, lack of transparency in their drug coverage may lead to delays in necessary medication treatment, as well as being unaware of their formulary and cost-sharing responsibilities, which can lead to an inability to afford the medications they need. Such lack of transparency is exacerbated when formularies are changed mid-year, which can have negative effects on patients and can have a major impact on health care costs. Actions of PBMs to remove a medication from a patient's formulary during the middle of the plan year and replace it with another medication that is not effective for the patient – or which the patient has previously tried and not done well on – could result in potential trips to the emergency room and/or hospitalizations, increased out-of-pocket costs if the patient is responsible for paying for the drug, and potential physician and patient resources spent on appeals and alternative solutions.

AMA Policy and Advocacy regarding Transparency

The AMA has been highly engaged in efforts to promote the transparency of PBM practices and operations, resulting from the adoption of Policy H-110.987, which encourages prescription drug price and cost transparency among pharmaceutical companies, PBMs and health insurance companies. Addressing mid-year formulary changes specifically, Policy H-125.979 states that drugs may not be removed from the formulary nor moved to a higher cost tier within a patient's health plan policy term. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, TruthinRx.org, in 2016. At the time this report was written, more than 338,000 individuals have signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency.

PBM transparency has also been a key theme highlighted in federal advocacy efforts related to drug pricing. In its comments in response to the proposed rule *Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees* in April 2019, the AMA supported applying manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale, and requiring PBMs to disclose a wide range of information, including additional information about their fee arrangements. In its statement for the record to the US House of Representatives Committee on Oversight and Reform on examining the actions of drug companies in raising prescription drug prices in January 2019, the AMA supported requiring PBMs to apply manufacturer rebates and pharmacy price concessions to drug prices at the point-of-sale to ensure that patients benefit from discounts as well as eliminate some incentives for higher drug list prices; requiring increased transparency in formularies, prescription drug cost-sharing, and utilization management requirements for patients and physicians at the point-of-prescribing as well as when beneficiaries make annual enrollment elections; and prohibiting removal of drugs from a formulary or moving to a higher cost tier during the duration of the patient's plan year unless a change is made for safety reasons. These concerns were echoed in the comments of the AMA submitted in response to *American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs (Blueprint)* in July 2018.

In addition, in August 2018, the AMA submitted a letter in support of S 2554, the "Patient Right to Know Drug Prices Act," which has since become law. The law prohibits health insurers and PBMs from using "gag clauses" that prevent pharmacists from sharing with patients the lower cost options when patients are purchasing medically necessary medication. In addition, the law will ensure that the FTC will have the necessary authorities to combat anti-competitive pay-for-delay

settlement agreements between manufacturers of biological reference products and follow-on biologicals.

In March 2019, the AMA submitted a letter that supported HR 1781, the Payment Commission Data Act of 2019. If enacted into law, the bill would provide access to essential data that the Medicare Payment Advisory Commission (MedPAC) and the Medicaid and CHIP Payment and Access Commission (MACPAC) need to evaluate the practices of various entities within the pharmaceutical supply chain that are either not readily available or not available at all for independent analysis, including drug pricing and rebate data. In its letter, the AMA noted that the lack of independent, data driven, third-party analysis of drug pricing and rebate data continues to hamstring additional efforts needed to combat anti-competitive business practices that undermine affordability and harm patients.

Concerning state-level advocacy, the AMA developed model state legislation entitled, "An Act to Increase Drug Cost Transparency and Protect Patients from Surprise Drug Cost Increases during the Plan Year" (AMA Model Act), which addresses the issues of stabilized formularies and cost transparency. In particular, the AMA Model Act requires PBMs operating in the state to disclose any discounts or other financial consideration they received that affect the price and cost-sharing of covered medicines placed on a formulary. In addition, the AMA has model state legislation that prohibits clawbacks and standard gag clauses in pharmacy-PBM contracts.

PBM Clawbacks and Direct and Indirect Remuneration Fees

DIR is a term used by the Centers for Medicare & Medicaid Services (CMS) to refer to compensation Medicare Part D plan sponsors or their PBMs receive after the point-of-sale, including rebates provided by drug manufacturers and concessions paid by pharmacies. Concessions paid by pharmacies – which can include dispensing physicians and practice-based pharmacies – can comprise of network participation fees and reimbursement reconciliations. Such additional compensation after the point-of-sale, therefore, changes the final cost of drugs for payers, or the prices paid to pharmacies for drugs. In Part D, DIR impacts Medicare payments to Part D plans. However, DIR fees or similar fee mechanisms are being used in the commercial marketplace as well.

The concern raised in Policy D-120.933, was directed not toward the role of DIR in capturing rebates from pharmaceutical companies, but the impact of DIR fees on pharmacies. The Council recognizes that such fees have negatively impacted some physicians who conduct in-office dispensing and/or have practice-based pharmacies. If DIR fees are not collected from pharmacies on a real-time basis, but rather after transactions take place, pharmacies and affected physician specialties have raised concerns that there exists a lack of clarity regarding their true reimbursement rates. In addition, such entities have cited a need for additional transparency regarding how DIRs are determined and calculated.

In November 2018, the Centers for Medicare & Medicaid Services issued a proposed rule, "Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses," that contains potential policy recommendations that would respond to the concerns raised in Resolution 225-A-18 concerning the impact of DIR fees on pharmacies. The proposed rule considers having DIR fees be accounted for and applied at the point-of-sale, which impacts the predictability of pharmacy reimbursement rates as well as patient cost-sharing.[3]

AMA Policy and Advocacy regarding Clawbacks and DIR Fees

Policy H-110.991 states that our AMA will disseminate model state legislation to promote increased drug price and cost transparency and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and PBMs that bar pharmacists from telling consumers about less-expensive options for purchasing their medication. Accordingly, in January 2019, the AMA submitted comments in response to the *Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses* proposed rule. In its comments, the AMA supported the proposed changes to the definition of "negotiated price" and other related changes that were outlined to ensure reduction in cost burden by beneficiaries at the point-of-sale for Part D prescription drugs, increased transparency, and enhanced competition among Part D plan sponsors. Further, the AMA noted that "when all pharmacy price concessions are not reflected in the price of a drug at the point-of-sale, beneficiaries do not benefit through a reduction in the amount that they must pay in cost-sharing and pay a larger share of the actual cost of a drug."

Utilization Management Requirements

When PBMs administer the drug benefits of payers, they have the ability to make coverage decisions and implement utilization management requirements that interfere with patients receiving the optimal treatment selected in consultation with their physicians. At the very least, utilization management requirements can delay access to needed care; in some cases, the barriers to care imposed by prior authorization and step therapy may lead to the patient receiving less effective therapy, no treatment at all, or even potentially harmful therapies. For physician practices, utilization management requirements often involve very manual, time-consuming processes that can divert valuable and scarce physician resources away from direct patient care.

The 2018 AMA Prior Authorization Physician Survey provides insight into the impact that PBM utilization management requirements can have on patients and physician practices. In response to the survey, more than nine in 10 physicians (91 percent) responded that the prior authorization process delays patient access to necessary care, and three-quarters of physicians (75 percent) report that prior authorization can at least sometimes lead to patients abandoning a recommended course of treatment. In addition, more than nine in 10 physicians (91 percent) reported that prior authorization programs have a negative impact on patient clinical outcomes. Of significant concern, 28 percent of physicians reported that prior authorization led to a serious adverse event for a patient in their care. The survey findings also showed that every week, a medical practice completes an average of 31 prior authorization requirements per physician, which take the equivalent of nearly two business days (14.9 hours) of physician and staff time to complete. To keep up with the administrative burden, more than a third of physicians (36 percent) employ staff members who work exclusively on tasks associated with prior authorization.[4]

In addition, a US Department of Health and Human Services (HHS) Office of Inspector General (OIG) review of Medicare Advantage service denials in 2014-2016 reinforces the point that utilization management requirements can prevent patients from receiving medically necessary care. The OIG found that more than 116,800 prior authorization requests that were initially denied were eventually overturned on appeal. These overturned denials represent specific drugs/services that were medically necessary and the patient needed the treatment. The Council notes that this figure is particularly concerning because beneficiaries and providers appealed only one percent of denials.[5]

AMA Policy and Advocacy regarding Utilization Management Requirements

Policy H-320.939 supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. Policy H-285.965 outlines AMA policy objectives addressing managed care cost containment involving prescription drugs. Policy D-330.910 states that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the CMS and other appropriate organizations to resolve them. Policy H-320.958 states that our AMA will advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession.

To educate the general public about the problems associated with prior authorization and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a grassroots website, FixPriorAuth.org, in July 2018. At the time that this report was written, there have been 10 million social media impressions, more than 500 patient and physician stories have been captured, and approximately 90,000 petitions have been signed.

In addition, the AMA has been very active in advocating for a reduction in both the number of physicians subjected to prior authorization and the overall volume of prior authorizations. In January 2017, the AMA and a coalition of state and specialty medical societies, national provider associations, and patient organizations developed and released a set of 21 Prior Authorization and Utilization Management Reform Principles intended to ensure that patients receive timely and medically necessary care and medications and reduce the administrative burdens. More than 100 other health care organizations have supported those principles. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and Medical Group Management Association in a Consensus Statement outlining a shared commitment to industry-wide improvements to prior authorization processes and patient-centered care. Additionally, the AMA has model legislation addressing prior authorization and utilization management programs that are often employed by PBMs, and works closely with many state and specialty medical societies to enact legislation each year.

Concerning federal advocacy, the AMA submitted comments in response to the *Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses* proposed rule, and raised significant concerns with the proposal to allow Part D plans to apply more prior authorization and step therapy requirements to protected class drugs. In its comments submitted in November 2018 in response to the proposed rule to modify Medicare regulations to promote program efficiency, transparency, and burden, the AMA urged CMS to reinstate its 2012 policy prohibiting Medicare Advantage plans from using step-therapy protocols for Part B physician-administered medications; and to carefully consider the care delays associated with prior authorization and the resulting impact on beneficiaries and their health and well-being when evaluating any additional prior authorization requirements for the Medicare program.

DISCUSSION

The Council recognizes that PBMs no longer simply negotiate drug prices on behalf of their clients, but rather fully administer the drug benefit creating formularies, making coverage decisions, and determining medical necessity with utilization management tools. The Council believes that PBMs' role managing drug benefits now resembles the typical role of insurers, and

they should be treated as such by regulators. Overall, regulators must better understand and control the costs to patients and the systems that are resulting from PBM practices. As such, the Council recommends that PBMs be actively regulated under state departments of insurance. To implement this new policy, the Council believes that our AMA should develop model state legislation addressing state regulation of PBMs. On the federal level, the Council believes that PBMs, like health plans, should be subject to federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.

The Council recognizes that the negative fluidity of the drug benefit is largely a result of the rebate system and the constant negotiations that take place to advance the interests of many drug benefit stakeholders – but not patients. The Council is concerned that the rebate process results in list prices above what they would be absent rebates, as neither PBMs nor manufacturers currently have an incentive to lower list prices. As such, the Council questions whether rebates that are being negotiated by PBMs are resulting in any true savings. Moreover, the Council notes there is insufficient evidence regarding what percent of the savings associated with rebates are being passed through to patients or to payers.

To improve transparency in this space, the disclosure of rebate and discount information, financial incentive information, and P&T committee information would constitute critical steps forward. The Council also believes that manufacturer rebates and pharmacy price concessions should be applied to drug prices at the point-of-sale. This policy, which also applies directly to DIR fees, would add much needed transparency and ensure that beneficiaries benefit from discounts, and dispensing physicians and practice-based pharmacies have more clarity regarding their true reimbursement rates. As these policy changes are implemented, the Council believes that it will be essential to monitor their impact on premiums, medication list prices, and the discount/rebate structure.

In order to maintain cost transparency for patients and keep patients stable on their medications, the Council urges improved transparency in formularies, prescription drug cost-sharing, and utilization management requirements. Requirements and restrictions should be easily accessible by patients and prescribers and unless a change is made for safety reasons, PBMs and health plans should be prohibited from making changes during the duration of the patient's plan year. As such, the Council recommends the reaffirmation of Policy H-125.979.

Utilization management practices employed by PBMs can undermine the ability of patients to have timely access to the medically necessary treatment that they need. The Council notes that reaffirming existing AMA policies helps to highlight the need for new and additional efforts to track and quantify the impact of PBMs' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. Existing AMA policies also aim to protect patients in managed care cost containment practices involving prescription drugs, and state that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the CMS and other appropriate organizations to resolve them.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) support the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance. (New HOD Policy)

2. That our AMA develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight. (Directive to Take Action)

3. That our AMA support requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale. (New HOD Policy)

4. That our AMA support efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity. (New HOD Policy)

5. That our AMA support improved transparency of PBM operations, including disclosing:

    - Utilization information;
    - Rebate and discount information;
    - Financial incentive information;
    - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
    - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
    - Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
    - Percentage of sole source contracts awarded annually. (New HOD Policy)

6. That our AMA encourage increased transparency in how DIR fees are determined and calculated. (New HOD Policy)

7. That our AMA reaffirm Policy H-125.979, which aims to prohibit drugs from being removed from the formulary or moved to a higher cost tier during the duration of the patient's plan year. (Reaffirm HOD Policy)

8. That our AMA reaffirm Policy H-320.939, which supports efforts to track and quantify the impact of health plans' prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm. (Reaffirm HOD Policy)

9. That our AMA reaffirm Policy H-285.965, which outlines AMA policy objectives addressing managed care cost containment involving prescription drugs. (Reaffirm HOD Policy)

10. That our AMA reaffirm Policy D-330.910, which states that our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare & Medicaid Services and other appropriate organizations to resolve them. (Reaffirm HOD Policy)

11. That our AMA reaffirm Policy H-320.958, which states that our AMA will advocate strongly for utilization management and quality assessment programs that are non-intrusive, have reduced administrative burdens, and allow for adequate input by the medical profession. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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REPORT 6 OF THE COUNCIL ON MEDICAL SERVICE (A-19)
Preventive Prostate Cancer Screening
(Resolution 226-A-18)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2018 Annual Meeting, the House of Delegates referred Resolution 226, "Model State Legislation for Routine Preventive Prostate Cancer Screening," which was sponsored by the American Urological Association (AUA), the American Association of Clinical Urologists, and the Virginia Delegation. Resolution 226 asked that the American Medical Association (AMA) develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after informed discussion between patients and their physicians without annual deductible or co-pay. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2019 Annual Meeting.

Prostate cancer is one of the most common types of cancer that affects men. In the United States, men's lifetime risk of being diagnosed with prostate cancer is approximately 11 percent and their lifetime risk of dying of prostate cancer is 2.5 percent. African-American men and men with a family history of prostate cancer have an increased risk of prostate cancer compared with other men. In fact, older age, African-American race, and family history of prostate cancer are the most important risk factors for the development of prostate cancer. This report examines prostate cancer screening in the context of general costs of care concerns, the legal basis for coverage of preventive services without patient cost-sharing, whether prostate cancer screening has been shown to meet the criteria for benefits provided without patient cost-sharing, key clinical practice guidelines for prostate cancer screening, and the AMA's approach to cancer prevention and expanding affordable access to care.

The Council recommends that our AMA encourage payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. Additionally, the Council recommends that our AMA encourage national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. The Council also recommends updating and expanding AMA policy regarding prostate cancer screening to encourage scientific research to address critical evidence gaps. In addition, the report describes extensive AMA policy that speaks to the resolves of referred Resolution 226-A-18. Accordingly, the Council recommends reaffirmation of policies which support: aligning clinical and financial incentives for high-value care, the role national medical specialty societies can play in helping to shape value-based insurance design (VBID) plans that decrease cost-sharing to encourage utilization of high-value services, VBID plans that explicitly consider the clinical benefit of a given service when determining cost-sharing structures or other benefit design elements, physician-patient shared decision-making and physician value-based decision-making, and coverage for evidence-based preventive services and genetic/genomic precision medicine.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6-A-19

Subject: Preventive Prostate Cancer Screening
(Resolution 226-A-18)

Presented by: James G. Hinsdale, MD, Chair

Referred to: Reference Committee A
(John Montgomery, MD, MPH, Chair)

At the 2018 Annual Meeting, the House of Delegates referred Resolution 226, "Model State Legislation for Routine Preventive Prostate Cancer Screening," which was sponsored by the American Urological Association (AUA), the American Association of Clinical Urologists, and the Virginia Delegation. Resolution 226 asked that the American Medical Association (AMA) develop model state legislation for screening of asymptomatic men ages 55-69 for prostate cancer after informed discussion between patients and their physicians without annual deductible or co-pay. The Board of Trustees assigned this item to the Council on Medical Service (CMS) for a report back to the House of Delegates at the 2019 Annual Meeting.

This report examines prostate cancer screening in the context of general costs of care concerns, the legal basis for coverage of preventive services without patient cost-sharing, whether prostate cancer screening has been shown to meet the criteria for benefits provided without patient cost-sharing, key clinical practice guidelines for prostate cancer screening, and the AMA's approach to cancer prevention and expanding affordable access to care.

BACKGROUND

Prostate cancer is one of the most common types of cancer that affects men.[1] In the United States, men's lifetime risk of being diagnosed with prostate cancer is approximately 11 percent and their lifetime risk of dying of prostate cancer is 2.5 percent.[2] African-American men and men with a family history of prostate cancer have an increased risk of prostate cancer compared with other men. In fact, older age, African-American race, and family history of prostate cancer are the most important risk factors for the development of prostate cancer.[3] As highlighted in the I-18 Joint Report of CMS and the Council on Science and Public Health (CSAPH), "Aligning Clinical and Financial Incentives for High-Value Care," more must be done to align incentives to support early prevention, detection, and treatment of disease, including cancer.

To ensure that patients get the medical care they need, they must be able to afford the full spectrum of care that they could require, from risk factor identification, to screening, to preventive interventions, to treatment of diagnosed disease. Even when a service is covered by a health plan, patients may incur significant costs in the form of co-payments, coinsurance, and/or large medical bills that they must pay before meeting their deductible. Such costs have been shown to cause people, especially those in low-income and vulnerable populations, to forgo not only unnecessary but also necessary care.[4] Cost-related non-adherence (CRN) refers to a state in which patients are unable to pursue recommended medical care due to financial barriers.[5] Sub-optimal use of evidence-based medical services can lead to negative clinical outcomes, increased disparities, and

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in some cases, higher aggregate costs.[6] CRN has been identified across the entire continuum of clinical care – physician visits, preventive screenings, prescription drugs, etc. – and it is especially problematic for vulnerable populations, such as those with multiple chronic conditions, and for socioeconomically and racially disparate populations.[7]

ACA REQUIREMENTS & PREVENTIVE SERVICES BENEFIT MANDATES

A factor mitigating patient concerns about the cost of preventive care is the Affordable Care Act's (ACA) requirement that health plans cover select preventive services without any patient cost-sharing (zero-dollar). CMS and CSAPH recently examined the ACA's zero-dollar preventive services requirement in three joint reports:

- A-17, "Value of Preventive Services" (A-17 Joint Report);
- A-18, "Coverage for Colorectal Cancer Screening" (A-18 Joint Report); and
- I-18, "Aligning Clinical and Financial Incentives for High-Value Care" (I-18 Joint Report).

As detailed in the A-17 Joint Report, the ACA required all private, non-grandfathered health insurance plans to provide zero-dollar coverage for the preventive services recommended by four expert organizations: the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), the Women's Preventive Services Initiative, and Bright Futures (collectively, the Expert Organizations). The report also described the varied methods used by the Expert Organizations for developing preventive service guidelines. The A-17 report established Policy H-460.894, which encouraged the Expert Organizations to develop their recommendations with transparency, clarity and specificity.

The A-18 Joint Report on colorectal cancer screening is highly relevant in the current context as another close examination of a cancer screening that has been recently evaluated by the USPSTF and other medical guideline issuing organizations. Notably, the USPSTF had already recommended colorectal cancer screening with an "A" grade, making the screening eligible for zero-dollar coverage for some patients with ACA-compliant health plans. A critical challenge addressed in the A-18 Joint Report was inconsistency in ACA-compliant and Medicare coverage. Accordingly, the A-18 Joint Report established Policy H-330.877, which supports Medicare coverage for colorectal cancer screenings consistent with ACA-compliant plan coverage requirements.

The I-18 Joint Report explored various challenges that the health care industry has faced in implementing the zero-dollar coverage requirement, and it established Policy D-185.979 to help address those challenges. Specifically, Policy D-185.979 supports clinical nuance in value-based insurance design (VBID) to respect individual patient needs, aligning financial incentives across physician payment initiatives and benefit design initiatives, and encouraging national medical specialty societies to identify high-value services and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

The ACA's mandated zero-dollar coverage for select preventive services enjoys strong bipartisan support. A recent poll found that the ACA provision eliminating out-of-pocket costs for certain preventive services was favored by 83 percent of Americans.[8] However, before a service is mandated as a zero-dollar benefit in accordance with the ACA, it must be recommended by one of the Expert Organizations based on their review of the scientific evidence.

Meaning of USPSTF Recommendation Grading

Critically, to qualify for mandated zero-dollar coverage based on a USPSTF recommendation, a health care service must receive an "A" or "B" recommendation. Services that receive a "C" recommendation are supported by the USPSTF for certain patients, but they do not qualify for the ACA's zero-dollar coverage. The evidence supporting a given service determines the recommendation grade it receives. "A," "B," and "C" recommendations from the USPSTF all encourage provision of the service at issue, to some extent, with the recommendations varying based on the strength of the evidence in support of the service:

- "A" recommendations mean: "The USPSTF recommends the service. There is high certainty that the net benefit is substantial." Accordingly, the USPSTF recommends that practitioners, "offer or provide this service."
- "B" recommendations mean: "The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial." As with an A recommendation, the USPSTF recommends that practitioners, "offer or provide this service."
- "C" recommendations are a bit more nuanced, and notably, the USPSTF's approach to "C" recommendations has evolved over the past two decades. Currently, a "C" recommendation means: "The USPSTF recommends selectively offering or providing this service to individual patients based on professional judgment and patient preferences. There is at least moderate certainty that the net benefit is small." Accordingly, the USPSTF recommends that practitioners, "Offer or provide this service for selected patients depending on individual circumstances." In describing the evolution of the "C" recommendation, the USPSTF explains, "Grade C recommendations are particularly sensitive to patient values and circumstances. Determining whether or not the service should be offered or provided to an individual patient will typically require an informed conversation between the clinician and patient."[9]

The USPSTF can also issue a negative recommendation, a "D" recommendation, meaning: "The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits." Accordingly, the USPSTF recommends that practitioners, "Discourage the use of this service."[10]

Finally, the USPSTF can issue an "I" statement which means, "The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined." For these services, the USPSTF recommends that providers, "Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms."[11]

Few Cancer Screenings are Eligible for Zero-Dollar Coverage

Resolution 226-A-18 asserts that, "screening for breast cancer and colonoscopies are covered preventive services for patients without an annual deductible or co-pay." While that is true for some patients screened for breast and colorectal cancer, it is not true for many patients. Some cancer screenings (such as breast and colorectal cancer) for some patient populations have received an "A" or "B" recommendation from the USPSTF and are therefore provided for some patients without patient cost-sharing. This zero-dollar coverage, however, only results from the fact that the USPSTF has found evidence supporting an "A" or "B" level recommendation, indicating the net benefit of those services, for those populations. Accordingly, the cancer screenings that are

provided without patient cost-sharing are limited to those for which the existing evidence meets the USPSTF's standards.

As a result, many services that may be valuable to patients are not provided without cost-sharing when the existing evidence does not demonstrate that the net benefit is substantial or moderate leading to an "A" or "B" recommendation from the USPSTF. Prostate cancer screening is an excellent example. In assigning prostate cancer screening in men aged 55 to 69 years a "C" recommendation, the USPSTF explained that prostate cancer screening is recognized as valuable for some patients, but the evidence of benefits may not outweigh the potential harms for other patients.[12] Other critical services falling into the USPSTF's C recommendation category include screening mammography in women prior to age 50 years[13] and screening for colorectal cancer in adults aged 76 to 85 years.[14] Moreover, when the evidence for cancer screenings is lacking, the screenings receive an "I" recommendation from the USPSTF. Currently, these services include adult skin cancer,[15] bladder cancer,[16] and oral cancer.[17]

Currently, the only cancer prevention services with an "A" or "B" recommendations for any patient population are:

- Aspirin Use to Prevent Cardiovascular Disease and Colorectal Cancer,[18]
- BRCA-Related Cancer: Risk Assessment, Genetic Counseling, and Genetic Testing,[19]
- Breast Cancer: Medications for Risk Reduction,[20]
- Breast Cancer: Screening,[21]
- Cervical Cancer: Screening,[22]
- Colorectal Cancer: Screening,[23]
- Lung Cancer: Screening,[24] and
- Skin Cancer Prevention: Behavioral Counseling (only applies to young adults, adolescents, children, and parents of young children).[25]

Moreover, among the cancer prevention services with "A" or "B" recommendations which are provided without cost-sharing, the recommendations are limited to specific patient populations. Accordingly, some patients for whom physicians would recommend these services fall outside the scope of the USPSTF recommendations, and therefore, the zero-dollar benefits do not apply to them. Relevant examples that the Council has examined in the A-18 and I-18 Joint Reports are:

- Breast cancer screening – "B" rating only applies to average risk women at certain ages. Screening for younger women is assigned a "C" recommendation, much like prostate cancer screening.[26] Moreover, women at heightened risk do not fall within the scope of the "B" recommendation. Accordingly, while some women will qualify for zero-dollar mammograms, others will not.
- Colorectal cancer screening – "B" rating only applies to average risk adults at certain ages.[27] Screening for older adults is assigned a "C" recommendation, and adults at heightened risk are outside the scope of the "B" recommendation. Once again, some adults will be able to receive a zero-dollar colorectal cancer screening, but others will not.
- Skin cancer prevention – the recommended scope of this cancer prevention service is even more limited. The USPSTF's "B" recommendation only applies to counseling, not screening, and for individuals aged 6 months to 24 years (or their parents). The USPSTF issued a "C" recommendation regarding counseling for adults with fair skin older than 24 years.[28] As a result, some patients can receive zero-dollar counseling regarding skin cancer prevention, but all skin cancer screenings would incur cost-sharing.

These examples illustrate that cost-sharing remains a concern not only for prostate cancer screening, but for other cancer screenings, too. At the same time, while cost-sharing is required, health insurance coverage for cancer screenings can help to defray the cost for insured patients.

RECOMMENDATIONS REGARDING PROSTATE CANCER SCREENING

The USPSTF's recommendations regarding prostate cancer screening are well-aligned with those of key medical specialty societies and other health care organizations. Prostate cancer screening has been reviewed repeatedly by the USPSTF,[29] and their most recent assessment is consistent with that of the AUA – both organizations recommend discussions of this service between a patient and his physician, and both recommend informed decision-making regarding whether to proceed with testing. Neither organization categorically recommends prostate cancer screening. For the AUA, this recommendation equates to a B on the AUA's scale,[30] while for the USPSTF, this recommendation equates to a C on the USPSTF's scale. These recommendations are also consistent with that of the American Cancer Society (ACS).[31] In addition to providing clinical guidelines, the ACS also takes an advocacy position supporting "insurance coverage" for prostate cancer screening, though it does not specifically call for zero-dollar coverage. [32] Notably, none of these three expert guidelines recommend universally screening any men of any age or risk category, and none of these evidence-based specialty guidelines justify a benefit mandate of zero-dollar coverage for prostate cancer screening in asymptomatic men ages 55-69.

EVIDENCE FOR CLINICAL GUIDELINES THAT INFORM COVERAGE DECISIONS

While the current evidence-based guidelines do not categorically recommend prostate cancer screening, the USPSTF has repeatedly highlighted evidence gaps, and with additional evidence, new, more precise recommendations, could be issued. When the USPSTF issued its 2018 recommendations on prostate cancer screening,[33] it explained that to update its 2012 recommendation, it commissioned two new reviews: a systematic review of the evidence regarding the benefits and harms of prostate-specific antigen (PSA)-based screening for prostate cancer and subsequent treatment of screen-detected prostate cancer, and a review of multiple contextual questions, including a review of existing decision analysis models and what they suggest about the potential for mitigating the harms of screening and treatment and the overdiagnosis rate of PSA-based screening. These studies also examined the effectiveness and harms of PSA-based screening in patient subpopulations at higher risk of prostate cancer, including older men, African American men, and men with a family history of prostate cancer. In addition, the USPSTF reviewed evidence from three randomized controlled trials (RCTs) studying PSA-based screening for prostate cancer: the US-based Prostate, Lung, Colorectal, and Ovarian (PLCO) Cancer Screening Trial, the European Randomized Study of Screening for Prostate Cancer (ERSPC), and the Cluster Randomized Trial of PSA Testing for Prostate Cancer (CAP). These trials used varying screening intervals (from 1-time screening to every 1 to 4 years) and PSA thresholds (2.5 to 10.0 ng/mL) for diagnostic biopsy. These RCTs each had at least a decade of median follow-up.

Even with this additional research, the USPSTF emphasized that there are many areas in need of research to improve the evidence-base for screening and treatment of prostate cancer, including:

1. Comparing different screening strategies;
2. Developing, validating, and providing longer-term follow-up of screening and diagnostic techniques;
3. Screening for and treatment of prostate cancer in African American men, and specifying that given the large disparities in prostate cancer mortality in African American men, this research should be a national priority;

4. How to better inform men with a family history of prostate cancer about the benefits and harms of PSA-based screening for prostate cancer;
5. How to refine active prostate cancer treatments to minimize harms; and
6. How to improve informed decision-making.[34]

The USPSTF highlighted these critical research gaps in its November 2018 Report to Congress on *High-Priority Evidence Gaps for Clinical Preventive Services.*[35] Notably, screening for prostate cancer, especially among African-American men and men with a family history, is one of only three high-priority cancer-related evidence gaps that the USPSTF highlighted in 2018. This USPSTF report also explains that the National Institutes of Health (NIH) reviews the research gaps identified by the USPSTF and utilizes the information in developing future funding opportunities.

In addition, growing from a desire to find prostate cancer screening tools that better identify clinically significant prostate cancer, research into improved screening modalities is rapidly evolving. A variety of companies are developing urine or blood-based risk assays using precision medicine to identify aggressive cases of prostate cancer, with some products already available to physicians and patients.[36] For example, ExoDx Prostate (IntelliScore) (EPI) is a non-invasive urine-based liquid biopsy for prostate cancer which can accurately identify high-grade prostate cancer at the time of biopsy and at surgery.[37] As a "rule out" test, EPI is designed to more accurately predict whether a patient presenting for an initial biopsy does not have a high-grade prostate cancer, and therefore could be monitored while avoiding a biopsy at that time.[38] Similarly, MDx Health offers physicians and patients SelectMDx, an epigenetic urine test for prostate cancer risk stratification.[39] Additionally, prostate magnetic resonance imaging (MRI) prior to prostate biopsy can be used to help reduce overdiagnosis of insignificant cancer and improve detection of clinically significant cancer. Recent clinical studies[40] and a consensus statement of the AUA and the Society of Abdominal Radiology (SAR)[41] support the use of high-quality prostate MRI in detecting prostate cancer. However, some experts have raised concerns about both the appropriateness and practicality of advocating for widespread use of MRI to detect prostate cancer, emphasizing that more research is needed to evaluate the relative aggressiveness of high-grade tumors missed by prostate MRI, and that both the costs and the subspecialist expertise required to successfully perform MRI for prostate cancer detection may make widespread implementation of this tool impractical.[42] Currently, insurance coverage for precision medicine[43] and prostate MRI[44] can pose challenges for patients and their physicians. Accordingly, continued research into the efficacy of new and evolving screening and detection methods will be essential to inform clinical guidelines and standards of care, which can in turn influence insurance coverage determinations.

INSURANCE COVERAGE FOR PROSTATE CANCER SCREENING

The ACS explains that while some states have slightly different prostate cancer screening coverage requirements, "most state laws assure annual coverage for men ages 50 and over and for high-risk men [African-American men and/or men with a family history of prostate cancer], ages 40 and over."[45] Additionally, Medicare covers the PSA blood test and a digital rectal exam (DRE) once a year for all male beneficiaries age 50 and over. There is no co-insurance and no Part B deductible for the PSA test. Unlike some cancers where the costs associated with merely screening for the cancer can be prohibitively expensive (e.g., the myriad fees associated with colonoscopies or the potential for multiple different imaging fees associated with breast cancer screenings), the cost associated with a PSA test is relatively minimal. A 2013 study found, "During 2007–2009, the average annual prostate cancer screening cost per beneficiary was $36."[46] Similarly, the Medicare 2019 Clinical Lab Fee Schedule Payment for PSA is approximately $20. While $20-36 is certainly a barrier for some patients, it pales in comparison to the costs patients could later face if their PSA test is positive, and it pales in comparison to the cost of a colonoscopy.

As explored in the A-18 and I-18 Joint Reports, the current health care system does not successfully identify all high-value preventive services that are worthy of reduced patient cost-sharing, and VBID presents an opportunity for physicians to help shape the identification of additional high-value preventive services. The I-18 Joint Report established Policy D-185.979 which encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. Prostate cancer screening could be an excellent example. Given the research gaps that will take time to fill and the powerful first-hand experience that physicians can share, physicians and payers could collaboratively evaluate prostate cancer screening to determine whether it should qualify as a high-value service, at least for certain patients, and be covered with reduced patient cost-sharing to encourage its utilization.

AMA POLICY

Many AMA policies support cancer prevention education, awareness, access and/or general insurance coverage, but they do not seek mandated zero-dollar coverage for specific cancer screening services. Key examples include:

- Breast and Cervical Cancers: Policies D-55.997, H-525.994, H-440.872, H-525.993, H-55.971, and H-525.977;
- Colorectal and Anal Cancers: Policies H-55.981, D-55.998, and H-460.913;
- Lung Cancer: Policy H-185.936;
- Skin Cancer: Policy H-55.972; and
- Prostate Cancer: Policies H-425.980 and D-450.957.

AMA policies that call for coverage with no cost-sharing broadly address categories of benefits, rather than individual disease states, including Policy H-185.969 regarding immunizations, Policy D-330.935 regarding Medicare preventive service benefits, and Policy H-290.972 regarding preventive coverage for health savings account holders in the Medicaid program. One exception, where AMA policy does seek zero-dollar coverage for a cancer screening, is for colorectal cancer screening (Policies H-185.960 and H-330.877). Critically, however, Policies H-185.960 and H-330.877 do not seek to establish a new zero-dollar benefit mandate; rather, they build on an ACA benefit mandate, seeking Medicare coverage on par with ACA-recognized evidence-based guidelines.

Longstanding AMA policy supports well-informed physician-patient shared decision-making regarding whether to pursue prostate cancer screening (Policy H-425.980), which is consistent with USPSTF, AUA, and ACS prostate cancer screening recommendations, as well as with AMA policy regarding many other cancer prevention efforts. Additionally, Policy H-373.997 sets forth core elements of physician-patient shared decision-making, and Policy H-450.938 sets forth the principles to guide physician value-based decision-making, including providing physicians with easy access to costs of care at the point of decision-making.

Extensive AMA policy supports insurance coverage for evidence-based preventive services (including Policies H-165.840, H-425.997, H-165.848, H-390.849, and H-185.954). Additionally, strong policy supports coverage and payment policies for evidence-based genetic/genomic precision medicine and encouraging national medical specialty societies develop clinical practice guidelines incorporating evidence-based precision medicine (Policy D-185.980).

Extensive AMA policy emphasizes the importance of collaboration with national medical specialty societies. Policies D-330.967 and H-425.987 support continued collaboration with national medical

specialty societies and interest groups to encourage coverage for evidence-based recommendations regarding preventive services, especially for populations at high risk for a given condition. Similarly, Policy D-185.979 encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. Policy H-425.988 supports continuing collaboration with the federal government, specialty societies, and others, to develop guidelines for, and effective means of delivery of, clinical preventive services.

Long-standing AMA policy opposes benefit mandates. Policy H-165.856 sets forth principles to guide health insurance market regulation and states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements, and that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. At the same time, AMA policy strongly supports the provision of evidence-based preventive services without patient cost-sharing. AMA policy does recognize the limitations of the USPSTF and emphasizes the importance of relevant specialty physician input in guideline development. Policy D-425.992 expresses concern regarding the effect that USPSTF recommendations can have on limiting access to preventive care for Americans (e.g., regarding access to screening mammography and prostate specific antigen screening) and encourages the USPSTF to implement procedures that allow for meaningful input on recommendation development from specialists and stakeholders in the topic area under study. Similarly, Policy D-450.957 specifically focuses on prostate cancer and the importance of including relevant specialty societies in guideline development.

Finally, AMA policy strongly supports VBID and innovative insurance design. Policy H-450.938 provides principles to guide physician value-based decision-making. Policy H-155.960 supports value-based decision-making and encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is determined based on the clinical value of a health care service or treatment, with consideration given to tailoring cost-sharing to patient income and other factors known to impact compliance. Policy H-185.939 supports flexibility in the design and implementation of VBID programs and outlines guiding principles, including that VBID consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Finally, Policy D-185.979 supports clinical nuance in VBID to respect individual patient needs.

DISCUSSION

The Council lauds the sponsors of referred Resolution 226-A-18 for highlighting the importance of prostate cancer screening and shares the goal of increasing access to this preventive service for appropriate patient populations. The Council is committed to developing AMA policy regarding prostate cancer screening that is consistent with the existing evidence-base, current clinical guidelines, and AMA policy. To accomplish this goal, the Council believes that the AMA should encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. Such policy would be consistent with the ACS recommendations for prostate cancer screening and AMA policy regarding various common cancers (Policies H-185.936, H-525.993, and H-55.981), as well as AMA policy regarding shared and value-based decision-making (Policies H-373.997 and H-450.938). Moreover, the resolution sponsors, the ACS, and the USPSTF all emphasize the importance of informed physician-patient shared decision-making in the context of prostate cancer screening, and the Council believes that the AMA should similarly emphasize this service. National medical specialty societies can play a critical role in promoting public education around the importance of informed physician-patient shared decision-making regarding prostate cancer

screening, and the Council encourages them to do so. In addition, the Council believes that, coupled with the new policies recommended in this report, reaffirming Policies H-373.997 and H-450.938 will help to emphasize the importance of well-informed shared physician-patient decision-making. Recognizing that the evidence-base for prostate cancer screening is rapidly evolving, and that more research is needed to better understand which patients should be screened, at which intervals, and with which tools, the Council recommends that Policy D-450.957 (see Appendix) be amended to change the title to read, "Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services," and to add a new subsection (3) encouraging scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services.

In addition, as improved, evidence-based methods for detecting clinically significant prostate cancer evolve, it will be essential that insurance coverage for medically necessary tests keep pace. Accordingly, the Council recommends reaffirming Policies D-185.980 and H-425.997 which support coverage for evidence-based genetic/genomic precision medicine and evidence-based, cost-effective preventive services. Moreover, prostate cancer screening, a service that is highly valuable to some patients and less necessary for others, is an outstanding example of how clinical nuance can be deployed through VBID to align clinical and financial incentives around care that is high-value for individual patients, consistent with Policy D-185.979. As also noted in Policy D-185.979, national medical specialty societies should play a key role in helping to shape VBID plans that decrease cost-sharing to encourage utilization of high-value services, and the Council recommends reaffirming that policy. Similarly, the Council believes that reaffirming Policy H-185.939 will emphasize the importance of VBID plans explicitly considering the clinical benefit of a given service when determining cost-sharing or other benefit design elements.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 226-A-18 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage public and private payers to ensure coverage for prostate cancer screening when the service is deemed appropriate following informed physician-patient shared decision-making. (New HOD Policy)

2. That our AMA encourage national medical specialty societies to promote public education around the importance of informed physician-patient shared decision-making regarding medical services that are particularly sensitive to patient values and circumstances, such as prostate cancer screening. (New HOD Policy)

3. That our AMA amend Policy D-450.957 to change the title to read, "Clinical Guidelines and Evidence Regarding Benefits of Prostate Cancer Screening and Other Preventive Services," and to add a new subsection, "(3) encouraging scientific research to address the evidence gaps highlighted by organizations making evidence-based recommendations about clinical preventive services." (Modify Current HOD Policy)

4. That our AMA reaffirm Policy D-185.979 regarding aligning clinical and financial incentives for high-value care and highlighting the role national medical specialty societies can play in helping to shape value-based insurance design (VBID) plans that decrease cost-sharing to encourage utilization of high-value services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-185.939 which supports VBID plans that explicitly consider the clinical benefit of a given service when determining cost-sharing structures or other benefit design elements. (Reaffirm HOD Policy)

6. That our AMA reaffirm Policy H-373.997, which sets forth core elements of physician-patient shared decision-making and Policy H-450.938, which sets forth the principles to guide physician value-based decision-making, including providing physicians with easy access to costs of care at the point of decision-making. (Reaffirm HOD Policy)

7. That our AMA reaffirm Policy D-185.980, which supports coverage for evidence-based genetic/genomic precision medicine and Policy H-425.997, which supports insurance coverage for evidence-based, cost-effective preventive services. (Reaffirm HOD Policy)

Fiscal Note: Less than $500.

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APPENDIX

Policies Recommended for Amendment or Reaffirmation

Policy, D-185.979 Aligning Clinical and Financial Incentives for High-Value Care

1. Our AMA supports Value-Based Insurance Design (VBID) plans designed in accordance with the tenets of "clinical nuance," recognizing that (a) medical services may differ in the amount of health produced, and (b) the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.
2. Our AMA supports initiatives that align provider-facing financial incentives created through payment reform and patient-facing financial incentives created through benefit design reform, to ensure that patient, provider, and payer incentives all promote the same quality care. Such initiatives may include reducing patient cost-sharing for the items and services that are tied to provider quality metrics.
3. Our AMA will develop coding guidance tools to help providers appropriately bill for zero-dollar preventive interventions and promote common understanding among health care providers, payers, patients, and health care information technology vendors regarding what will be covered at given cost-sharing levels.
4. Our AMA will develop physician educational tools that prepare physicians for conversations with their patients about the scope of preventive services provided without cost-sharing and instances where and when preventive services may result in financial obligations for the patient.
5. Our AMA will continue to support requiring private health plans to provide coverage for evidence-based preventive services without imposing cost-sharing (such as co-payments, deductibles, or coinsurance) on patients.
6. Our AMA will continue to support implementing innovative VBID programs in Medicare Advantage plans.
7. Our AMA supports legislative and regulatory flexibility to accommodate VBID that (a) preserves health plan coverage without patient cost-sharing for evidence-based preventive services; and (b) allows innovations that expand access to affordable care, including changes needed to allow High Deductible Health Plans paired with Health Savings Accounts to provide pre-deductible coverage for preventive and chronic care management services.
8. Our AMA encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. (Joint CMS CSAPH Rep. 01, I-18).

Policy, D-185.980 Payment and Coverage for Genetic/Genomic Precision Medicine

1. Our AMA encourages 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.
2. Our AMA encourages 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.
3. Our AMA will 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.
4. Our AMA encourages national medical specialty societies to develop clinical practice guidelines incorporating precision medicine approaches that support adoption of appropriate, evidence-based services.
5. Our AMA supports continued research and evidence generation demonstrating the validity, meaningfulness, short-term and long-term cost-effectiveness and value of precision medicine.

(Joint CMS / CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 06, A-18)

Policy, D-450.957 Draft Clinical Quality Measures Non-Recommended PSA-Based Screening
Our AMA will: (1) continue to advocate for inclusion of relevant specialty societies and their members in guideline and performance measure development, including in technical expert panels charged with developing performance measures; and (2) work with the federal government, specialty societies, and other relevant stakeholders to develop guidelines and clinical quality measures for the prevention or early detection of disease, such as prostate cancer, based on rigorous review of the evidence which includes expertise from any medical specialty for which the recommendation may be relevant to ultimately inform shared decision making. (Res. 225, I-15).

Policy, 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: Joint CMS/CSAPH Rep. 01, I-17 Reaffirmed: CMS Rep. 07, A-18 Reaffirmed: Joint CMS CSAPH Rep. 01, I-18)

Policy, H-373.997 Shared Decision-Making
Our AMA:
1. recognizes the formal shared decision-making process as having three core elements to help patients become active partners in their health care: (a) clinical information about health conditions, treatment options, and potential outcomes; (b) tools to help patients identify and articulate their values and priorities when choosing medical treatment options; and (c) structured guidance to help patients integrate clinical and values information to make an informed treatment choice;
2. supports the concept of voluntary use of shared decision-making processes and patient decision aids as a way to strengthen the patient-physician relationship and facilitate informed patient engagement in health care decisions;
3. opposes any efforts to require the use of patient decision aids or shared decision-making processes as a condition of health insurance coverage or provider participation;

4. supports the development of demonstration and pilot projects to help increase knowledge about integrating shared decision-making tools and processes into clinical practice;
5. supports efforts to establish and promote quality standards for the development and use of patient decision aids, including standards for physician involvement in development and evaluation processes, clinical accuracy, and conflict of interest disclosures; and
6. will continue to study the concept of shared decision-making and report back to the House of Delegates regarding developments in this area. (CMS Rep. 7, A-10 Reaffirmed in lieu of Res. 5, A-12 Reaffirmation I-14)

Policy, H-425.997 Preventive Services
1. Our AMA encourages the development of policies and mechanisms to assure the continuity, coordination and continuous availability of patient care, including professional preventive care and early-detection screening services, provided the services are cost effective.
2. It is the policy of the AMA that any preventive service that is being considered for inclusion in public or private sector insurance products have evidence-based data to demonstrate improved outcomes or quality of life and the cost effectiveness of the service.
3. Our AMA believes that preventive care should ideally be coordinated by a patient's physician.
(BOT Rep. A, NCCMC Rec. 31, A-78 Reaffirmed: CLRPD Rep. C, A-89 Reaffirmed: Sunset Report and Reaffirmed and Appended: CMS Rep. 7, A-00 Reaffirmed in lieu of Res. 104, A-06 Reaffirmation A-07 Modified and Reaffirmed: Sub. Res. 101, A-08 Reaffirmed: CMS Rep. 03, I-16 Reaffirmed:
CMS Rep. 03, I-17)

Policy, 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 Reaffirmation: I-17)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-19)

Introduced by: Indiana

Subject: Health Hazards of High Deductible Insurance

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Under the Affordable Care Act, high-deductible health insurance was allowed; and

Whereas, Patients were attracted to this option because of the lower premium costs; and

Whereas, Some patients under this plan tend to delay or defer treatment because their out-of-pocket cost is 100 percent until they spend $1,000 up to $5,000, dependent upon their plan. Studies of this population show that preventable diabetic complications are increased in patients insured under the high-deductible option, along with an increase in ER visits; therefore be it

RESOLVED, That our American Medical Association support health insurance deductibles of not more than $1,000 for an individual per year, especially to patients with significant chronic disease. (New HOD Policy)

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

Received: 03/06/18

RELEVANT AMA POLICY

Health Savings Accounts H-165.852
It is the policy of the AMA that:
(1) high-deductible health insurance plans issued to families in conjunction with Health Savings Accounts (HSAs) be allowed to apply lower, per-person deductibles to individual family members with the permitted levels for per-person deductibles being the same as permitted levels for individual deductibles, and with the annual HSA account contribution limit being determined by the full family deductible or the dollar-limit for family policies;
(2) contributions to HSAs should be allowed to continue to be tax deductible until legislation is enacted to replace the present exclusion from employees' taxable income of employer-provided health expense coverage with tax credits for individuals and families;
(3) advocacy of HSAs continues to be incorporated prominently in its campaign for health insurance market reform;
(4) activities to educate patients about the advantages and opportunities of HSAs be enhanced;
(5) efforts by companies to develop, package, and market innovative products built around HSAs continue to be monitored and encouraged;
(6) HSAs continue to be promoted and offered to AMA physicians through its own medical insurance programs; and
(7) legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses, including health and long-term care insurance premiums and other costs of long-term care, be strongly supported as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance.
Citation: CMS Rep. 11 - I-94; Reaffirmed by Sub. Res. 125 and Sub. Res. 109, A-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-97; Reaffirmed: CMS Rep. 5, I-97; Reaffirmation I-98; Reaffirmed: CMS Rep. 5 and 7, I-99; CMS Rep. 10, I-99; Appended by Res. 220, A-00; Reaffirmation I-00; Reaffirmed Res. 109 & Reaffirmation A-01; Reaffirmed: CMS Rep. 2, I-01; Reaffirmation A-02; CMS Rep. 3, I-02; Reaffirmed: CMS Rep. 3, A-03; Reaffirmation I-03; CMS Rep. 6, A-04; Reaffirmation A-04; Consolidated: CMS Rep. 7, I-05; Reaffirmation A-07; Reaffirmation A-10; Reaffirmed: CMS Rep. 2, A-11; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 5, I-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmed: CMS Rep. 05, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-19)

Introduced by: Illinois

Subject: Use of HSAs for Direct Primary Care

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, The healthcare system is constantly changing, and expanding access to quality medical care is a top priority of organized medicine; and

Whereas, There is predicted to be a shortage of primary care physicians over the next decade, and some primary care physicians are choosing Direct Primary Care (DPC) as a means to stay independent rather than be acquired or employed by a hospital or health system; and

Whereas, Direct Primary Care is an alternative payment model intended to improve access to highly functioning healthcare with a simple, flat affordable membership fee; and

Whereas, The defining element of DPC is an enduring and trusting relationship between a patient and his or her primary care provider; and

Whereas, The goal of DPC is better health outcomes, lower costs, and an enhanced patient experience, where there is no third-party billing; and

Whereas, Direct Primary Care is often referred to as “concierge” or “retainer” medicine; and

Whereas, Current IRS rules impede individuals with Health Savings Accounts (HSAs) from using these funds to pay for Direct Primary Care or even entering into periodic-fee DPC agreements because the current Internal Revenue Code (IRC) clearly states that HSAs must be paired with a high deductible health plan (HDHP), and Section 223(c) of the IRC also prohibits individuals with HSAs from having a second health plan to cover services not covered by the HDHP; and

Whereas, Current Treasury Department interpretation of the IRC treats Direct Primary Care monthly fee arrangements like a second health plan, rather than a payment for a medical service. Under current policy, individuals with HSAs are effectively barred from having a relationship with a DPC provider, because the DPC agreement makes the individual ineligible to fund the HSA; and

Whereas, 23 states have passed laws defining DPC as a medical service outside of health plan or insurance regulation, which would address some of the necessary concerns; and

Whereas, The Internal Revenue Code (IRC) is unclear about whether monthly payments to physicians practicing under the DPC model are considered a “qualified medical expense,” and when the regulations for HSAs were developed, DPC was not contemplated; and

Whereas, Two parts of the IRC need clarification; first, that DPC medical homes do not constitute a health plan under IRS Section 223(c), and second, that periodic payments to DPC practices for primary care services are to be treated as qualified medical expenses under IRC 213(d); therefore be it

RESOLVED, That our American Medical Association adopt policy that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense (New HOD Policy); and be it further

RESOLVED, That our AMA seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health “plans” and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use Health Savings Accounts (HSAs) to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-19)

Introduced by: New York

Subject: Health System Improvement Standards

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Single Payer legislation in some states and in the US Congress has a real opportunity to become law; and

Whereas, Millions of patients with health insurance go without needed health care, or suffer financial hardship to get it, because of onerous deductibles, co-pays, restricted provider networks, out-of-network charges and unjustified denials of coverage; and

Whereas, Millions of people remain uninsured; and

Whereas, Sponsors and proponents of a state wide single-payer system believe that it will provide better coverage, at less cost, saving money for patients and government alike; and

Whereas, Regardless of where individual physicians stand on the issue of single payer health insurance, there are certain needed health system reforms for which most physicians would agree; and

Whereas, From an advocacy/strategy perspective, it would be helpful to identify health care principles that physicians and the public can seek and that could in turn provide the basis for alternatives to the current single payer proposals (and thus form the basis of a more cogent and unified physician message); therefore be it

RESOLVED, That our American Medical Association advocate for health care reform proposals that would achieve the following:

- Reduce the number of uninsured; and
- Reduce barriers to insured patients receiving needed health care, including ensuring full transparency of patient-cost sharing requirements, preventing unjustified denials of coverage, ensuring comprehensive physician networks, including through fair reimbursement methodologies, and providing meaningful coverage for out-of-network care; and
- Reduce administrative burden on physicians; and
- Prevent imposition of new costs or unfunded mandates on physicians; and
- Provide needed tort reform; and
- Provide meaningful collective negotiation rights for physicians. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-19)

Introduced by: New York

Subject: Adverse Impacts of Single Specialty Independent Practice Associations

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Independent practice associations (IPAs) have been a health care fixture for some time; and

Whereas, Unlike an integrated medical group, IPA participating physicians maintain their separate medical practices, and use the IPA vehicle to pursue managed care contracts (based upon the societal benefits of practice transformation, integration of care, promotion of efficient care, elimination of redundancies and futile care, tied to proper reimbursement for this enhanced/high value care – as opposed to improperly utilizing market share and gatekeeper functions) that they could not obtain on their own; and

Whereas, Single specialty IPA's have become somewhat more common of late; and

Whereas, Single specialty IPA's have led to a greater interest in adverse payer policies such as capitation of physician services; and

Whereas, Compared to a multispecialty IPA, a specialty IPA is less likely to promote integration of care; and

Whereas, Some managed care plans have sought to drop participating physicians from its provider panel and to retain a physician only if the physician joins the company's contracted specialty IPA; and

Whereas, The typical IPA is a professional corporation with a panel of participating primary care physicians and a broad range of specialists, and a board that governs in a manner that promotes the interests of its member physicians; and

Whereas, The contracted specialty IPA selected by the managed care company may not at all represent the physician (and the community's) interests, but instead represents its own interests and those of the managed care company; therefore be it

RESOLVED, That our American Medical Association conduct a study relating to the impact of managed care plans replacing their participating physicians with those of a non-primary care physician single specialty independent practice association. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-19)

Introduced by: New York

Subject: Payment for Brand Medications When the Generic Medication is Recalled

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There have been many generic medication recalls recently in the United States because of poor manufacturing processes and oversight by the US Food and Drug Administration; and

Whereas, These recalls have resulted in medication shortages and have placed patients at risk; and

Whereas, Insurance companies and government programs will not pay for the brand medication that has not been recalled at the generic tier; and

Whereas, The Pharmacy Benefit Plans will not cover these medications, leaving a treatment and financial gap for patients; therefore be it

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services as well as third party payers to allow reimbursement for brand medications at the lowest copayment tier so that patients can be effectively treated until the medication manufacturing crisis is resolved. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-19)

Introduced by: New York

Subject: Raising Medicare Rates for Physicians

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Most physician payments are tied to the Medicare Fee Schedule; and

Whereas, The Medicare Fee Schedule is woefully inadequate for many physician codes and, in many regions, frequently well below the cost of providing the service; and

Whereas, The unsustainable Medicare Fee Schedule is probably the main reason physicians are going out of business in record numbers; therefore be it

RESOLVED, That our American Medical Association advocate strongly for raising the Medicare Fee Schedules for physicians. (Directive to Take Action)

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

Received: 04/25/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-19)

Introduced by: Ohio

Subject: Investigate Medicare Part D – Insurance Company Upcharge

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Each year, all insurers providing Medicare Part D coverage send the Government a detailed forecast of their projected cost for providing prescription drug coverage for the following year; and

Whereas, Under arcane rules, while insurers are directed to return to Centers for Medicare and Medicaid Services (CMS) any funds received exceeding 5% of their original estimate, but are permitted to keep any excess up to 5% for themselves; and

Whereas, According to a WSJ analysis of CMS data obtained via a public records request and published online, during the 2006-2015 period of review across all insurers, such direct subsidy estimates were over-estimated by $17.6 Billion, with plans actually keeping $9.1 Billion of those over-estimated funds; and

Whereas, All insurers were paid another $27.8 Billion to cover their reinsurance underestimates; and

Whereas, This process allows insurers to be protected from underestimating and paid extra for overestimating; therefore be it

RESOLVED, That our American Medical Association investigate Medicare Part D rules which allow providers to keep up to 5 % more than their actual cost of providing pharmacy prescription services while at the same time they are eligible to get paid by Centers for Medicare and Medicaid Services reinsurance rules for certain losses. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-19)

Introduced by: Ohio

Subject: Congressional Healthcare Proposals

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, U.S. Congressmen and Senators are promoting “Medicare for all” proposals; and

Whereas, The concept is a single, government-controlled health insurance program that would cover every person in the United States; and

Whereas, The legislative language in one bill prohibits any private health insurer from offering any of the 10 statutorily designated categories of health benefits or specialized services authorized by Congress; and

Whereas, One House bill states “It is unlawful for a private health insurer to sell health coverage that duplicates the benefits provided under this Act”; and

Whereas, One House bill would prohibit Americans from purchasing any alternative health coverage, except for items such as “cosmetic surgery” and services the government deems “not medically necessary”; and

Whereas, A Senate bill prohibits any private health plan that “duplicates” the benefit coverage of the government’s national health insurance program; and

Whereas, The Senate bill also outlaws employer sponsored health insurance and the House and Senate bills abolish Medicare; and

Whereas, The House and Senate bills abolish Medicaid, CHIP (Children’s Health Insurance Program), and Obamacare health plans; therefore be it

RESOLVED, That our American Medical Association support provisions in Federal legislation that:

1. Do not limit the choices available for Americans for health care coverage
2. Support improving existing health plans
3. Make any new plan voluntary
4. Do not eliminate the private insurance market. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-19)

Introduced by: Ohio

Subject: Part A Medicare Payment to Physicians

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Physicians save millions of dollars in healthcare expenses by seeing patients in our offices, which are the least costly sites of service, paying careful attention to physical findings, diagnoses, and treatment plans for our patients; and

Whereas, Physicians reap little monetary benefit when our patients do well and do not require expensive hospitalizations and procedures, thus saving the patient and our health care system much expense; and

Whereas, Our AMA is currently conducting a study on *The Leading Role That Physicians Play in Reducing Medicare Spending*; and

Whereas, In this day of Value-based Healthcare, we believe this AMA study will show that we physicians indeed add value to our healthcare system, and that physicians should be adequately compensated for that value; therefore be it

RESOLVED, That our American Medical Association work for enactment of legislation to direct cash payments from Part A Medicare to physicians in direct proportion to demonstrated savings that are made in Part A Medicare through the efforts of physicians. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-19)

Introduced by: Ohio

Subject: Establishing Fair Medicare Payer Rates

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Medicare physician compensation is already unreasonably low; and

Whereas, Recent trends are that Medicare eligible patients are shifting to commercial Medicare PPO's and HMO's; and

Whereas, Commercial Medicare PPO's and HMO's discriminate against small physician practices by paying LESS than Medicare rates; therefore be it

RESOLVED, That our American Medical Association pursue Centers for Medicare and Medicaid Services (CMS) intervention and direction to prevent commercial Medicare payers from compensating physicians at rates below Medicare's established rates. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-19)

Introduced by: Ohio

Subject: Practice Overhead Expense and the Site-of-Service Differential

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, In the 17-year period from 2001-2017, Medicare Part B payments to physicians increased only 6% while Medicare's index of inflation measuring the cost of running a medical practice increased 30%, (AMA Council on Medical Service (CMS) Report 4, I-18); and

Whereas, After adjustment for inflation in practice costs, physician pay has declined 19%, thus failing to match increases in office overhead costs (CMS Report 4, I-18); and

Whereas, In the 17-year period from 2001-2017, Medicare hospital payments increased roughly 50%, including average annual increases of 2.6% for inpatient services and 2.5% per year for outpatient services (CMS Report 4, I-18); and

Whereas, Hospitals have thus received payment increases more than 8-fold greater than payment adjustments to physicians in the period from 2001-2017; and

Whereas, Much of this disparate payment to hospitals is due to annual year- over-year increases in payments for services rendered in hospital outpatient facilities, where Medicare pays a so-called site-of-service differential amounting to, on average, approximately 360% of Medicare's payment for the same mix of services when they are performed in a physician's office; therefore be it

RESOLVED, That our American Medical Association appeal to the US Congress for legislation to direct the Centers for Medicare and Medicaid Services (CMS) to eliminate any site-of-service differential payments to hospitals for the same service that can safely be performed in a doctor's office (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS in regards to any savings to Part B Medicare, through elimination of the site-of-service differential payments to hospitals, (for the same service that can safely be performed in a doctor's office), be distributed to all physicians who participate in Part B Medicare, by means of improved payments for office-based Evaluation and Management Codes, so as to immediately redress underpayment to physicians in regards to overhead expense (Directive to Take Action); and be it further

RESOLVED, That our AMA appeal to the US Congress for legislation to direct CMS to make Medicare payments for the same service routinely and safely provided in multiple outpatient settings (e.g., physician offices, HOPDs and ASCs) that are based on sufficient and accurate data regarding the actual costs of providing the service in each setting. (Directive to Take Action)

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

Received: 04/30/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-19)

Introduced by: Oklahoma

Subject: Health Care Fee Transparency

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Healthcare transparency is an important issue in Congress and in many states with innovative bills cropping up from coast to coast; and

Whereas, A 2018 Gallup Poll found that a greater percentage of Americans (55%) stated that they worry "a great deal" more about the availability and affordability of health care than about 14 other major social issues such as crime, the economy, unemployment, terrorist attacks, and the availability of guns[1]; and

Whereas, A 2018 study found that the median price of a magnetic resonance imaging (MRI) scan of the spine ranges from $500 to $1,670 in Massachusetts, which is also more than a 200-percent difference[1]; and

Whereas, American Medical Association CEO James L. Madera, MD wrote a letter to US Senators on 3/23/2018 stating "The lack of complete, accurate, and timely information about the cost of health care services prevents health care markets from operating efficiently"[2]; and

Whereas, Hospitals across the U.S. were required to post online their pricing for medical services on Jan. 1 2019 under a new federal law (CMS-1694-F)[3]; and

Whereas, While publishing prices is an effort to increase transparency, the data may do little to affect consumers and their healthcare costs--the information isn't easy to decipher and many other factors go into the bill patients eventually pay; and

Whereas, The proposed Department of Health and Human Services (HHS) rule, titled "21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program," wants to take this a step further and require hospitals to disclose the prices they negotiate with health insurance companies to increase pricing transparency and reduce "surprise" medical bills[4]; and

Whereas, Under the price information section (pages 90-92) in the 187-page document, the HHS outlines a variety of changes the rule would put in place. This includes provisions such as requiring hospitals to share the entire pricing process, from list price to cost negotiated with a patient's health plan, including out-of-pocket expenses. It also mandates a tool so you could compare prices ahead of time and information on the cost of emergency services, such as ambulance rides[4]; and

Whereas, The proposed rule also states: Pricing information continues to grow in importance with the increase of high deductible health plans and surprise billing, which have resulted in an increase in out-of-pocket health care spending. Transparency in the price and cost of health

care would help address the concerns outlined above by empowering patients to make informed health care decisions[4]; and

Whereas, The American Hospital Association supports state-based efforts but may oppose the proposed pricing changes, saying patients only care about their out-of-pocket costs, not the whole pricing system[5,6]; and

Whereas, We believe it is in the best interest of our patients to know the cost of their health care prior to receiving the care and that a patient-based fee transparency model would be beneficial to our patients; therefore be it

RESOLVED, That our American Medical Association advocate for federal legislation and/or regulation to require disclosure of hospital prices negotiated with insurance companies in effort to achieve third-party contract transparency (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate for federal legislation and/or regulation to require pharmaceutical companies to disclose drug prices in their television (TV) ads in order to provide consumers more choice and control over their healthcare. (Directive to Take Action)

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

Received: 04/15/19

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.
6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18

References:

[1] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6281149/
[2] https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/about-ama/councils/Council%20Reports/council-on-medical-service/issue-brief-strategies-increase-health-care-price-transparency.pdf
[3] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2019-IPPS-Final-Rule-Home-Page-Items/FY2019-IPPS-Final-Rule-Regulations.html
[4] https://www.regulations.gov/document?D=CMS-2019-0039-0001
[5] https://www.aha.org/issue-brief/2018-05-04-hospital-price-transparency
[6] https://themighty.com/2018/12/nicole-vlaming-mental-health-hospital-bill-banner-health/

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-19)

Introduced by: Washington, Connecticut

Subject: Ensuring Access to Statewide Commercial Health Plans

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Approximately 26 percent of marketplace enrollees, living in 52 percent of counties, have only one insurer on the marketplace from which to select plans; and

Whereas, Provider market power vastly exceeds exchange plans' market power in virtually every exchange market; and

Whereas, Current exchange options are extremely expensive in terms of premiums, deductibles, and out-of-pocket maximums; and

Whereas, Very few exchange participants have access to plans with statewide networks; and

Whereas, Limited network plans greatly increase an enrollee's financial risk to being subjected to excessive out-of-network providers' charges; and

Whereas, State employee benefit programs provide health insurance coverage to millions of state employees, retirees, and their dependents statewide in virtually every state; and

Whereas, State employee health plans' massive size enables them to negotiate very affordable premiums, deductibles, out-of-pocket maximums, and statewide coverage; and

Whereas, State employee health plans are not required to follow fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, retrospective audits and reviews, and medical necessity; and

Whereas, Requiring state employee benefit programs' insurers, as a condition of continued participation, to offer everyone coverage would greatly increase access, affordability, and choice nationwide; therefore be it

RESOLVED, That our American Medical Association study the concept of offering state employee health plans to every state resident, including exchange participants qualifying for federal subsidies, and report back to the House of Delegates this year (Directive to Take Action); and be it further

RESOLVED, That our AMA advocate that State Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity. (New HOD Policy)

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

Received: 04/26/19

RELEVANT AMA POLICY

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
Citation: CMS Rep. 03, A-18

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-19)

Introduced by: Washington, Connecticut

Subject: Ensuring Access to Nationwide Commercial Health Plans

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Approximately 26 percent of marketplace enrollees, living in 52 percent of counties, have only one insurer on the marketplace from which to select plans (CMS Report 3, A-18); and

Whereas, Provider market power vastly exceeds exchange plans' market power in virtually every exchange market; and

Whereas, Current exchange options are extremely expensive in terms of premiums, deductibles, and out-of-pocket maximums; and

Whereas, Very few exchange participants have access to plans with nationwide networks; and

Whereas, Limited network plans greatly increase an enrollee's financial risk to being subjected to excessive out-of-network providers' charges; and

Whereas, The Federal Employees Health Benefits Program (FEHBP) provides health insurance coverage to approximately 8.2 million federal employees, retirees, and their dependents with an average of 24 plan offerings, most of which are nationwide fee for service plans available in all counties (CMS Report 3, A-18); and

Whereas, Federal employee health plans' massive size enables them to negotiate very affordable premiums, deductibles, out-of-pocket maximums, and nationwide coverage; and

Whereas, Federal employee health plans are not required to follow fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, retrospective audits and reviews, and medical necessity; and

Whereas, Requiring FEHBP insurers, as a condition of continued participation, to offer everyone coverage would greatly increase access, affordability, and choice nationwide; therefore be it

RESOLVED, That our American Medical Association advocate that Federal Employees Health Benefits Program health insurance plans should become available to everyone to purchase at actuarially appropriate premiums as well as be eligible for federal premium tax credits (New HOD Policy); and be it further

RESOLVED, That our AMA advocate that Federal Employees Health Benefits Program health insurance plans be subject to all fully insured state law requirements on prompt payment, fairness in contracting, network adequacy, limitations or restrictions against high deductible health plans, retrospective audits and reviews, and medical necessity. (New HOD Policy)

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

Received: 04/26/19

RELEVANT AMA POLICY

Ensuring Marketplace Competition and Health Plan Choice H-165.825
Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.
Citation: CMS Rep. 03, A-18

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-19)

Introduced by: Wisconsin

Subject: Safety of Drugs Approved by Other Countries

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, All drugs sold in the United States have to be approved by the US Food and Drug Administration; and

Whereas, The thalidomide tragedy that occurred in early 1960s in Europe with approximately 10,000 infants being born with limb abnormalities was largely avoided in the United States because FDA inspector Francis Kelsey prevented the approval of the drug for use in the United States. Since that time the FDA has been hypervigilant about approving new medications which has improved patient safety but unfortunately has also been used by pharmaceutical companies to their benefit by making it more difficult to allow the market to work effectively in pharmaceuticals because of decreased competition; and

Whereas, The vigilance of the FDA and required testing of new drugs has increased the cost of development and testing of new medications to approximately $1 billion for each new medicine approved and this cost has led to new medicines not being tested and approved for use in the United States; and

Whereas, In Europe the EMA (European Medicines Agency) does a similar but not identical job in approving new medications in Europe for a smaller expense and therefore more drugs are available in Europe than are available in the United States and often at a significantly lower price; and

Whereas, The cost of pharmaceuticals in the United States is increasing rapidly and is recognized as a major medical problem with many people having difficulty affording their medications and wondering why they cannot obtain drugs approved in Europe which are often considerably less expensive; therefore be it

RESOLVED, That our American Medical Association compare the results of our US Food and Drug Administration (FDA) and the European Medicines Agency (EMA) approval processes in terms of determining the safety and efficacy of pharmaceuticals using whatever data is available in order to determine whether the health of the citizens of the United States would be at risk if drugs approved by the EMA were imported and used as compared to the FDA (Directive to Take Action); and be it further

RESOLVED, That our AMA estimate what the reduction in the cost of medications would be for our patients if they were allowed to import EMA certified medications for use in the United States and thereby increasing competition for some of our current expensive pharmaceuticals. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/01/19

RELEVANT AMA POLICY

Prescription Drug Importation and Patient Safety D-100.983
Our AMA will:
(1) support the legalized importation of prescription drug products by wholesalers and pharmacies only if: (a) all drug products are Food and Drug Administration (FDA)-approved and meet all other FDA regulatory requirements, pursuant to United States laws and regulations; (b) the drug distribution chain is "closed," and all drug products are subject to reliable, "electronic" track and trace technology; and (c) the Congress grants necessary additional authority and resources to the FDA to ensure the authenticity and integrity of prescription drugs that are imported;
(2) oppose personal importation of prescription drugs via the Internet until patient safety can be assured;
(3) review the recommendations of the forthcoming report of the Department of Health and Human Services (HHS) Task Force on Drug Importation and, as appropriate, revise its position on whether or how patient safety can be assured under legalized drug importation;
(4) educate its members regarding the risks and benefits associated with drug importation and reimportation efforts;
(5) support the in-person purchase and importation of Health Canada-approved prescription drugs obtained directly from a licensed Canadian pharmacy when product integrity can be assured, provided such drugs are for personal use and of a limited quantity; and
(6) advocate for an increase in funding for the US Food and Drug Administration to administer and enforce a program that allows the in-person purchase and importation of prescription drugs from Canada, if the integrity of prescription drug products imported for personal use can be assured.
Citation: BOT Rep. 3, I-04; Reaffirmation A-09; Reaffirmed in lieu of: Res. 817, I-16; Appended: CMS Rep. 01, I-18

Pharmaceutical Quality Control for Foreign Medications D-100.977
Our AMA will call upon Congress to provide the US Food and Drug Administration with the necessary authority and resources to ensure that imported drugs are safe for American consumers and patients.
Citation: Res. 508, A-08;A-16;A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-19)

Introduced by: Wisconsin

Subject: Medicare for All

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There is a lot of interest on the political scene in the term “Medicare for all” and yet no one seems to have a good definition of what this would really mean; and

Whereas, Medicare is a popular provider of health insurance for the elderly population of America along with some disabled Americans; and

Whereas, Most people do not understand the financial workings of Medicare but only see the benefits they derive from the system; and

Whereas, Physicians, medical clinics, hospitals, healthcare systems all have different experience with the Medicare system in terms of reimbursement as there are different rules for the different providers of care with each of these providers of care receiving different amounts of money for similar services which are different percentages of their cost for providing the care; and

Whereas, Many of the above providers of medical care receive less than the cost of providing that care under the current Medicare reimbursement formula while other providers may get significantly more reimbursement for the same service provided depending on whether the service is provided in a physician’s office, hospital, or hospital owned outpatient facility; and

Whereas, There is a feeling that “Medicare for all” would result in a diminution of the benefits in Medicare that the current elderly and disabled enjoy, but this is never really discussed: and

Whereas, Our AMA will be expected to provide information on how “Medicare for all” will affect the current Medicare program, the current medical practices of private practice physicians, medical clinics, hospitals and healthcare systems in order that we can inform our patients to enable them to make an informed choice when they vote for various candidates for office; therefore be it

RESOLVED, That our American Medical Association gather current, accurate data on the reimbursement from Medicare for private practice physicians, medical clinics, hospital outpatient services, hospitals including rural hospitals and critical access hospitals, and healthcare systems along with accurate data as to how the reimbursement compares to the cost for providing the medical care for these services (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate what would happen to the healthcare economics of the United States and the ability to continue outpatient medical practice if the current Medicare reimbursement, compared to the cost of providing that care, became the major financing resource for medical care and predict what effect this would have on the access to medical care in the U.S. (Directive to Take Action); and be it further

RESOLVED, That our AMA evaluate how the current differential payments in Medicare to various entities for the same service would change in a " Medicare for all" scenario (Directive to Take Action); and be it further

RESOLVED, That our AMA, after analysis of the data, provide to the patients and physicians of our country the relevant questions that we can ask of political candidates advocating "Medicare for all" and (Directive to Take Action); and be it further

RESOLVED, That our AMA provide a better understanding of the impact of "Medicare for all" in terms of healthcare financing, workforce, ability to continue private practice medical care, incentives for physicians to join hospital systems, availability of care, and help understand how this might change the provision of healthcare in the United States. (Directive to Take Action)

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

Received: 05/01/19

RELEVANT AMA POLICY

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Policy Timeline: Res. 717, I-07 Reaffirmation A-09)

Health System Reform Legislation H-165.838
1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
a. Health insurance coverage for all Americans
b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
d. Investments and incentives for quality improvement and prevention and wellness initiatives
e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens
2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.
3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.
5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.
6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.
7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.
8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:
a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services
b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system
c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted
d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate
e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another
f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest
9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA's position based on AMA policy.
10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.
11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with the Federation to advance this goal.
12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.
13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform. (Policy Timeline: 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; Reaffirmation 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; Reaffirmed in lieu of: Res. 805, I-17; Reaffirmed: CMS Rep. 03, A-18)

Evaluating Health System Reform Proposals H-165.888
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the following principles:
A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient freedom of choice or physician ability to select mode of practice is limited or denied. Single-payer systems clearly fall within such a definition and, consequently, should continue to be opposed by the AMA. Reform proposals should balance fairly the market power between payers and physicians or be opposed.
C. All health system reform proposals should include a valid estimate of implementation cost, based on all health care expenditures to be included in the reform; and supports the concept that all health system reform proposals should identify specifically what means of funding (including employer-mandated funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and what the impact will be.
D. All physicians participating in managed care plans and medical delivery systems must be able without threat of punitive action to comment on and present their positions on the plan's policies and procedures for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and administrative matters, including physician representation on the governing board and key committees of the plan.
E. Any national legislation for health system reform should include sufficient and continuing financial support for inner-city and rural hospitals, community health centers, clinics, special programs for special populations and other essential public health facilities that serve underserved populations that otherwise lack the financial means to pay for their health care.
F. Health system reform proposals and ultimate legislation should result in adequate resources to enable medical schools and residency programs to produce an adequate supply and appropriate generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
G. All civilian federal government employees, including Congress and the Administration, should be covered by any health care delivery system passed by Congress and signed by the President.
H. True health reform is impossible without true tort reform.
2. Our AMA supports health care reform that meets the needs of all Americans including people with injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.
4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients. (Policy Timeline: Res. 118, I-91 Res. 102, I-92 BOT Rep. NN, I-92 BOT Rep. S, A-93 Reaffirmed: Res. 135, A-93 Reaffirmed: BOT Reps. 25 and 40, I-93 Reaffirmed in lieu of Res. 714, I-93 Res. 130, I-93 Res. 316, I-93 Sub. Res. 718, I-93 Reaffirmed: CMS Rep. 5, I-93 Res. 124, A-94 Reaffirmed by BOT Rep.1- I-94 CEJA Rep. 3, A-95 Reaffirmed: BOT Rep. 34, I-95 Reaffirmation A-00 Reaffirmation A-01 Reaffirmed: CMS Rep. 10, A-03 Reaffirmed: CME Rep. 2, A-03 Reaffirmed and Modified: CMS Rep. 5, A-04 Reaffirmed with change in title: CEJA Rep. 2, A-05 Consolidated: CMS Rep. 7, I-05 Reaffirmation I-07 Reaffirmed in lieu of Res. 113, A-08 Reaffirmation A-09 Res. 101, A-09 Sub. Res. 110, A-09 Res. 123, A-09 Reaffirmed in lieu of Res. 120, A-12 Reaffirmation: A-17)

Opposition to Nationalized Health Care H-165.985
Our AMA reaffirms the following statement of principles as a positive articulation of the Association's opposition to socialized or nationalized health care:
(1) Free market competition among all modes of health care delivery and financing, with the growth of any one system determined by the number of people who prefer that mode of delivery, and not determined by preferential federal subsidy, regulations or promotion.
(2) Freedom of patients to select and to change their physician or medical care plan, including those patients whose care is financed through Medicaid or other tax-supported programs, recognizing that in the choice of some plans the patient is accepting limitations in the free choice of medical services.
(3) Full and clear information to consumers on the provisions and benefits offered by alternative medical care and health benefit plans, so that the choice of a source of medical care delivery is an informed one.
(4) Freedom of physicians to choose whom they will serve, to establish their fees at a level which they believe fairly reflect the value of their services, to participate or not participate in a particular insurance plan or method of payment, and to accept or decline a third party allowance as payment in full for a service.
(5) Inclusion in all methods of medical care payment of mechanisms to foster increased cost awareness by both providers and recipients of service, which could include patient cost sharing in an amount which does not preclude access to needed care, deferral by physicians of a specified portion of fee income, and voluntary professionally directed peer review.
(6) The use of tax incentives to encourage provision of specified adequate benefits, including catastrophic expense protection, in health benefit plans.
(7) The expansion of adequate health insurance coverage to the presently uninsured, through formation of insurance risk pools in each state, sliding-scale vouchers to help those with marginal incomes purchase pool coverage, development of state funds for reimbursing providers of uncompensated care, and reform of the Medicaid program to provide uniform adequate benefits to all persons with incomes below the poverty level.
(8) Development of improved methods of financing long-term care expense through a combination of private and public resources, including encouragement of privately prefunded long-term care financing to the extent that personal income permits, assurance of access to needed services when personal resources are inadequate to finance needed care, and promotion of family caregiving.
(Policy Timeline: BOT Rep. U, I-88; Reaffirmed: BOT Rep. 40, I-93; Reaffirmed: Sub. Res. 110, A-94; Reaffirmed: CMS Rep. 7, I-97; Reaffirmed by CMS Rep. 9, A-98; Reaffirmed: CMS Rep. 4, A-99; Reaffirmation I-07; Modified: CMS Rep. 8, A-08; Reaffirmed in lieu of Res. 813, I-08; Reaffirmation A-09; Reaffirmed in lieu of Res. 112, A-09; Reaffirmation A-11; Reaffirmed: Res. 239, A-12; Modified: Speakers Rep., A-14)

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-19)

Introduced by: Resident and Fellow Section

Subject: Support for Medicare Disability Coverage of Contraception for Non-Contraceptive Use

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There are several non-contraceptive uses of hormonal contraception including treatment of abnormal uterine bleeding and endometrial hyperplasia; and

Whereas, Patients on Medicare disability insurance who present with abnormal uterine bleeding and/or endometrial hyperplasia may be poor surgical candidates thus limiting options to medical treatment with hormonal methods that may include contraceptive pills or long-term reversible contraception including the levonorgestrel intrauterine device; and

Whereas, Patients who are on Medicare disability insurance do not have coverage for contraception, including the levonorgestrel intrauterine device; therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other stakeholders to include coverage for all US Food and Drug Administration -approved contraception for non-contraceptive use for patients covered by Medicare. (Directive to Take Action)

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

Received: 05/01/19

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2. AAFP News (2017). “AAFP Addresses Contraceptive Access and Coverage With FDA, CMS”. American Family Physician. Retrieved June 23 from www.aafp.org/news/health-of-the-public/20170821contraceptivesletter.html.
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5. Pharr, J. R., & Bungum, T. (2012). “Health Disparities Experienced by People with Disabilities in the United States: A Behavioral Risk Factor Surveillance System Study”. Global Journal of Health Science 4(6):99-108. doi:10.5539/gjhs.v4n6p99

RELEVANT AMA POLICY

Coverage of Contraceptives by Insurance H-180.958
1. Our AMA supports federal and state efforts to require that every prescription drug benefit plan include coverage of prescription contraceptives.
2. Our AMA supports full coverage, without patient cost-sharing, of all contraception without regard to prescription or over-the-counter utilization because all contraception is essential preventive health care.
Citation: Res. 221, A-98; Reaffirmation A-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmation: I-17; Modified: BOT Rep. 10, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-19)

Introduced by: Oklahoma

Subject: Pharmaceutical Pricing Transparency

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Oklahoma patients continue to experience increases in pharmaceutical prices, and Pharmacy Benefit Managers (PBMs) create opacity in drug pricing; and

Whereas, PBMs act as middle men between insurers and drug manufacturers to determine which drugs will be covered by a health plan as part of a formulary; and

Whereas, Manufacturers wanting their drugs covered by health plans pay “rebates” to the PBMs, and manufacturers increase drug prices to offer the types of rebates necessary to keep their drugs in the formularies; and

Whereas, PBMs reimburse pharmacies for dispensing a medication, and the amount charged to the plan sponsor is often much higher than the reimbursement provided to the pharmacist for the drug, which is called “spread pricing”; and

Whereas, The PBM market has become a highly consolidated industry whose focus is not on serving consumers but on increasing company profits; therefore be it

RESOLVED, That our American Medical Association lobby for legislation that requires Pharmacy Benefit Managers to enhance drug-pricing transparency for the benefit of patients. (Directive to Take Action)

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

Received: 04/15/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-19)

Introduced by: American Thoracic Society

Subject: Returning Liquid Oxygen to Fee Schedule Payment

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Medical oxygen is a prescription drug accessible only by physician prescription; and

Whereas, Clinical trials have demonstrated the effectiveness of supplemental oxygen to address hypoxemia, improve exercise tolerance, and reduce mortality for patients with respiratory or cardiac conditions; and

Whereas, Liquid oxygen is the optimal modality of delivering supplemental oxygen for patient with high flow rates (>4 liters/minute), patients who do not tolerate oxygen conservation devices or patients with high levels of ambulation; and

Whereas, Liquid oxygen systems were included into the CMS DME competitive bidding program; and

Whereas, Medicare beneficiary utilization of liquid oxygen has dropped significantly since its inclusion in the CMS DME competitive bidding program, dropping from 32,220 Medicare beneficiaries on stationary liquid system in 2010 to 5948 in 2016 and dropping from 40938 liquid portable Medicare beneficiaries in 2010 to 8141 in 2016; and

Whereas, Anecdotal reports from Medicare beneficiaries say DME companies who were awarded competitive bidding contracts refused to supply liquid oxygen even though they were contractually obligated to follow the physician prescription to provide liquid oxygen; and

Whereas, CMS in its proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2019 (CMS- 1691-P) recognized the problems in the liquid oxygen market but failed to propose or finalize policy that would meaningfully address problems with Medicare beneficiary access to liquid; therefore be it

RESOLVED, That our American Medical Association support policy to remove liquid oxygen from the competitive bidding system and return payments for liquid oxygen to a Medicare fee schedule basis (New HOD Policy); and be it further

RESOLVED, That our AMA convey its patient quality and access concerns for Medicare beneficiaries obtaining insurance coverage for liquid oxygen in comments to the Centers for Medicare and Medicaid Services, including the forthcoming proposed rule, Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) Competitive Bidding Program (CBP) for Calendar Year 2020. (Directive to Take Action)

Fiscal Note: Modest - between $1,000 - $5,000.
Received: 05/08/19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-19)

Introduced by: Georgia

Subject: Medicare Coverage of Hearing Aids

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Nearly 30 million Americans have hearing loss; and

Whereas, The average price for economy, mid-level, and premium technology receiver-in-the-canal/ear hearing aids (RICs) is $1388, $2113, and $2789 each; and

Whereas, Medicare does not allow any reimbursement for RIC's and the 65+ year old patient who is in need of hearing amplification must pay for these devices out of pocket; and

Whereas, Untreated hearing loss has serious consequences and can result in depression, social isolation, anxiety about participating in social settings, and even paranoia, according to a study done by the National Council on the Aging; and

Whereas, The individual components of hearing aids cost anywhere from $50 to $150 per device, and there is no transparency into the wide disparity between the components and the ultimate price of a unit (one ear only) which can cost $2500; and

Whereas, Ninety percent of the RICs sold in the United States are manufactured by only six different companies; and

Whereas, If the cost of producing these devices could be brought down, and a patient had a supplement from Medicare to allow the purchase, that more seniors would be able to afford hearing amplification and enjoy the medical benefits that come with it; therefore be it

RESOLVED, That our American Medical Association urge Medicare to cover some or all of the costs of a "reasonable" device for both ears if a patient has had an audiological exam that identifies the need, and for Medicare to identify a vendor, or vendors, of hearing devices that produce a quality product without an exorbitant retail price. (Directive to Take Action)

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

Received: 05/09/19

RELEVANT AMA POLICY

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.
Citation: (CMS Rep. 6, I-15

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(A-19)

Introduced by: Michigan

Subject: Maintenance Hemodialysis for Undocumented Persons

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, There are 11.3 million undocumented persons living in the United States and about 6,480 of these persons have end-stage renal disease (ESRD) for which undergoing routine hemodialysis or transplant are life-sustaining treatments; and

Whereas, In 2016, there were an estimated 100,000 undocumented immigrants living in Michigan that paid approximately $87.6M in state and local taxes and $15 billion in Social Security payroll taxes annually, and have added $300 billion to the $2.7 trillion Social Security Trust Fund; and

Whereas, Despite this substantial financial contribution to the American economy, undocumented immigrants are considered “not qualified” by the United States Department of Health and Human Services for 31 programs, resulting in denial of Medicaid, Medicare and CHIP; and

Whereas, Undocumented individuals are unable to access federal subsidization for renal transplant, therefore hemodialysis is the only treatment option for these patients; and

Whereas, Due to ineligibility for federal programs, most undocumented persons must pay out-of-pocket for hemodialysis, which is cost prohibitive. This renders hospital emergency services as the only option for care; and

Whereas, While emergency departments are mandated to provide coverage through the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA) for emergent dialysis, they can only provide one to two sessions per week (rather than the recommended three sessions per week) and even then, high demand compromises the availability of dialysis chairs; and

Whereas, With a lack of consistent access to dialysis, many patients have experienced multiple cardiac arrests and resuscitations and severe psychosocial distress leading to significant, debilitating, and long-term health consequences that add further cost and burden to the health care system; and

Whereas, Emergency-only hemodialysis patients experienced a five-year mortality rate greater than 14-fold higher than patients undergoing scheduled maintenance dialysis, more ICU admissions, and an almost 10-fold greater use of acute-care days; and

Whereas, Emergency-only dialysis annually costs approximately $285,000 per patient versus $77,000 per patient for scheduled maintenance dialysis; and

Whereas, H.R.2644, the Chronic Kidney Disease Improvement in Research and Treatment Act of 2017, was proposed “to understand the progression of kidney disease and the treatment of kidney failure in minority populations and improve access to kidney disease treatment for those in underserved rural and urban areas;” and

Whereas, Eleven states and the District of Columbia are currently using state funding to provide undocumented persons with some maintenance dialysis coverage, including California which has changed its Medicaid policy to include “acute, ongoing, and maintenance renal hemodialysis” in its coverage of emergency services; and

Whereas, The Renal Physicians Association’s position on dialysis of undocumented individuals is as follows: “The federal government has a responsibility to provide care for all patients within the borders of the United States, and the financial burden of care provided to citizens and noncitizens is both a federal and state responsibility…difficult access to or denial of dialysis services will invariably hasten the patient’s demise and ultimate death;” therefore be it

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and other relevant stakeholders to identify and advocate for equitable health care options to provide scheduled maintenance hemodialysis to undocumented persons. (Directive to Take Action)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Increasing Access to Healthcare Insurance for Refugee Populations H-350.956
Our AMA supports state, local, and community programs that remove language barriers and promote education about low-cost health-care plans, to minimize gaps in health-care for refugees.
Citation: Res. 006, A-17

Addressing Immigrant Health Disparities H-350.957
1. Our American Medical Association recognizes the unique health needs of refugees, and encourages the exploration of issues related to refugee health and support legislation and policies that address the unique health needs of refugees.
2. Our AMA: (A) urges federal and state government agencies to ensure standard public health screening and indicated prevention and treatment for immigrant children, regardless of legal status, based on medical evidence and disease epidemiology; (B) advocates for and publicizes medically accurate information to reduce anxiety, fear, and marginalization of specific populations; and (C) advocates for policies to make available and effectively deploy resources needed to eliminate health disparities affecting immigrants, refugees or asylees.
Citation: (Res. 804, I-09; Appended: Res. 409, A-15

Health Care Payment for Undocumented Persons D-440.985
Our AMA shall assist states on the issue of the lack of reimbursement for care given to undocumented immigrants in an attempt to solve this problem on a national level.
Citation: Res. 148, A-02; Reaffirmation A-07; Reaffirmed: CMS Rep. 01, A-17

Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
Our AMA will lobby Congress to adequately appropriate and dispense funds for the current programs that provide reimbursement for the health care of undocumented aliens.
Citation: Sub. Res. 207, A-93; Reaffirmed BOT Rep. 17 - I-94; Reaffirmed by Ref. Cmt. B, A-96; Reaffirmation A-02; Reaffirmation A-07; Reaffirmed: BOT Rep. 22, A-17

Federation Payment for Emergency Services for Undocumented Immigrants H-160.917
Our American Medical Association supports federal legislation to extend Section 1011 of the Medicare Modernization Act (MMA, P.L. 108-173), which provides for federal funding to the states for emergency services provided to undocumented immigrants.
Citation: (Res. 212, I-09

Advancing Quality Coordinated Care for Patients with End Stage Renal Disease H-370.957
Our AMA will work with Members of Congress and their staffs to ensure that any legislation which promotes integrated and patient-centered care for End Stage Renal Disease (ESRD) patients does not inappropriately impinge on the patient-physician relationship and is in the best interest of ESRD patients.
BOT Action in response to referred for decision: Res. 219, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-19)

Introduced by: Michigan

Subject: Reimbursement for Telemedicine Visits

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Telemedicine can encompass a range of services from health monitoring and patient consultation to the transmission of medical records, but may be more broadly defined as any electronic exchange of health information (per the American Telemedicine Association), including the use of remote monitoring devices; and

Whereas, Telemedicine visits are increasing in frequency and have been shown to increase access, reduce 30-day hospital readmission rates, and reduce total cost of care; and

Whereas, Telemedicine services are also helping to fill gaps in health care faced by patients who struggle with mobility challenges, especially in rural communities; and

Whereas, Telemedicine services are also providing easy access for patients who appreciate receiving care in a more convenient manner, often with a lower cost to the patient than an in-office visit; and

Whereas, Primary care physicians are providing both synchronous (electronic exchange of health information with a real-time video component) and asynchronous (electronic exchange of health information without a real-time video component) telemedicine services for the benefit of patients with a concurrent liability risk for these services; and

Whereas, Reimbursement for telemedicine services is currently allowed only for synchronous telemedicine services (rural and non-rural settings) even though the expertise shared, and the liability risk incurred have similar value and associated risk with a synchronous or an asynchronous telemedicine visit; therefore be it

RESOLVED, That our American Medical Association work with third-party payers and the Centers for Medicare and Medicaid Services at the national level to provide reimbursement for both synchronous and asynchronous telemedicine services to encourage increased access and use of these services by patients and physicians. (Directive to Take Action)

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

Received: 05/09/19

RELEVANT AMA POLICY

Coverage of and Payment for Telemedicine H-480.946
1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:
a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:
- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.
Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.
b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.
c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.
d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.
e) The delivery of telemedicine services must be consistent with state scope of practice laws.
f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.
g) The standards and scope of telemedicine services should be consistent with related in-person services.
h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.
i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.
j) The patient's medical history must be collected as part of the provision of any telemedicine service.
k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.
l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.
m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.
2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.
3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines.
Citation: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18

Evolving Impact of Telemedicine H-480.974

Our AMA:
(1) will evaluate relevant federal legislation related to telemedicine;
(2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
(3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
(4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
(5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
(6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
(7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician's Recognition Award, for educational consultations using telemedicine;
(8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
(9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association (www.americantelemed.org) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted.
Citation: CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18

Insurance Coverage Parity for Telemedicine Service D-480.969
1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
Citation: Res. 233, A-16

Access and Equity in Telemedicine Payments D-480.970
Our AMA will advocate that the Centers for Medicare & Medicaid Services pay for telemedicine services for patients who have problems accessing physician specialties that are in short supply in areas that are not federally determined “shortage” areas, if that area can show a shortage of those physician specialists.
Citation: Res. 818, I-14; Reaffirmed: CME Rep. 06, A-16

Teleconsultations and Medicare Reimbursement H-480.961
Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various "fee splitting" or "fee sharing" reimbursement schemes.
Citation: (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(A-19)

Introduced by: Medical Student Section

Subject: Standardizing Coverage of Applied Behavioral Analysis Therapy for Persons with Autism Spectrum Disorder

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, The prevalence of children living with Autism Spectrum Disorder (ASD) is 1 in 59, according to the Center for Disease Control (CDC) as of April 2018, and 3.5 million Americans live with Autism Spectrum Disorder[1,2]; and

Whereas, Applied Behavioral Analysis (ABA) is a treatment program for patients with Autism Spectrum Disorder that seeks to promote useful social and educational behaviors through a comprehensive and highly individualized plan, while reducing behaviors that would interfere with learning[3,4]; and

Whereas, The effectiveness of ABA-based treatment programs has been well-documented through numerous studies across five decades of research, with strong empirical support for ABA as the most effective intervention for patients with Autism Spectrum Disorder[5-7]; and

Whereas, The American Academy of Child and Adolescent Psychiatry and the American Academy of Pediatrics assert that ABA therapy can produce improvements in social relationships, self-care, school, employment, communication, and play in all age groups[8-10]; and

Whereas, Children who receive early, intensive ABA therapy make larger improvements in social and life skills than those who are in a less intensive program, and research has shown significant improvements in Intellectual Quotient for children in ABA therapy[11]; and

Whereas, The Centers for Medicare and Medicaid Services (CMS) require states to cover all medically necessary services for children, including ABA for Autism Spectrum Disorders, but allows individual state Medicaid agencies to determine what services are medically necessary for eligible individuals who are not children[12]; and

Whereas, There exists significant variability among state mandated maximum ages of eligibility for ABA and among insurance coverage variability, including caps in some states to no annual or lifetime cap[13]; and

Whereas, Studies indicate that significant cost avoidance or cost savings up to $208,500 per child may be possible with early and consistent implementation of the ABA model[14]; and

Whereas, The majority of the costs for Autism Spectrum Disorder treatment are in the form of adult-care ($175 billion compared to $61 billion for children), and the cost of lifelong care can be reduced by up to 66 percent with early diagnosis and intervention such as ABA therapy[2,15]; and

Whereas, The AMA already "urge[s] physicians to assist parents in obtaining access to appropriate individualized early intervention services" (H-90.969), and asserts that "all people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives" (H-90.968); therefore be it

RESOLVED, That our American Medical Association support the coverage and reimbursement for Applied Behavioral Analysis for the purpose of treating Autism Spectrum Disorder. (Directive to Take Action)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Early Intervention for Individuals with Developmental Delay H-90.969

(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.
Citation: CCB/CLRPD Rep. 3, A-14; Reaffirmed: Res. 315, A-17

Medical Care of Persons with Developmental Disabilities H-90.968

1. Our AMA encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability (e.g. ableism) can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.
2. Our AMA seeks: (a) legislation to increase the funds available for training physicians in the care of individuals with intellectual disabilities/developmentally disabled individuals, and to increase the reimbursement for the health care of these individuals; and (b) insurance industry and government reimbursement that reflects the true cost of health care of individuals with intellectual disabilities/developmentally disabled individuals.
3. Our AMA entreats health care professionals, parents and others participating in decision-making to be guided by the following principles: (a) All people with developmental disabilities, regardless of the degree of their disability, should have access to appropriate and affordable medical and dental care throughout their lives; and (b) An individual's medical condition and welfare must be the basis of any medical decision. Our AMA advocates for the highest quality medical care for persons with profound developmental disabilities; encourages support for health care facilities whose primary mission is to meet the health care needs of persons with profound developmental disabilities; and informs physicians that when they are presented with an opportunity to care for patients with profound developmental disabilities, that there are resources available to them.
4. Our AMA will continue to work with medical schools and their accrediting/licensing bodies to encourage disability related competencies/objectives in medical school curricula so that medical professionals are able to effectively communicate with patients and colleagues with disabilities, and are able to provide the most clinically competent and compassionate care for patients with disabilities.
5. Our AMA recognizes the importance of managing the health of children and adults with developmental disabilities as a part of overall patient care for the entire community.
6. Our AMA supports efforts to educate physicians on health management of children and adults with developmental disabilities, as well as the consequences of poor health management on mental and physical health for people with developmental disabilities.
7. Our AMA encourages the Liaison Committee on Medical Education, Commission on Osteopathic College Accreditation, and allopathic and osteopathic medical schools to develop and implement curriculum on the care and treatment of people with developmental disabilities.
8. Our AMA encourages the Accreditation Council for Graduate Medical Education and graduate medical education programs to develop and implement curriculum on providing appropriate and comprehensive health care to people with developmental disabilities.

9. Our AMA encourages the Accreditation Council for Continuing Medical Education, specialty boards, and other continuing medical education providers to develop and implement continuing education programs that focus on the care and treatment of people with developmental disabilities.
10.Our AMA will advocate that the Health Resources and Services Administration include persons with intellectual and developmental disabilities (IDD) as a medically underserved population.
Citation: CCB/CLRPD Rep. 3, A-14; Appended: Res. 306, A-14; Appended: Res. 315, A-17; Appended: Res. 304, A-18; Reaffirmed in lieu of the 1st Resolved: Res. 304, A-18

Support for Persons with Intellectual Disabilities H-90.967
Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.
Citation: Res. 01, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 124
(A-19)

Introduced by: Medical Student Section

Subject: Increased Affordability and Access to Hearing Aids and Related Care

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, Age related hearing loss (ARHL) is the most common sensory deficit, affecting more than two-thirds of adults over the age of 70, and evidence suggests that hearing impairments increase the risk of costly health outcomes including disability, depression, cognitive impairment, and dementia[1]; and

Whereas, By impeding the ability to care for oneself and manage other chronic health conditions, ARHL contributes to the loss of independence, a decrease in self-reported health, and an increase in hospitalizations[2]; and

Whereas, The primary treatment for hearing loss is a properly-fitted hearing aid and hearing aid use is associated with better hearing-specific as well as general health-related quality of life[3]; and

Whereas, While the cost of hearing aids varies, the average patients spends $2360 for one hearing aid and, as in most cases of ARHL, $4720 if they need two[4]; and

Whereas, Section 1862(a)(7) of the Social Security Act explicitly excludes hearing aids and related exams from traditional Medicare coverage; a Section that has repeatedly been targeted by bills in Congress and noted to be a significant reason that fewer than 1 in 5 adults who could benefit from hearing aids use them[1,5-7]; and

Whereas, All Medicaid programs are required to cover hearing aids, exams, and related services for children under 21 as part of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program[8]; and

Whereas, Only about half of the states have Medicaid programs that cover some aspects of hearing aids, exams, and related services, for adults[9]; and

Whereas, The Veterans Administration (VA) provides coverage for hearing aids and additional hearing-related services and is able to bulk-purchase hearing aids at an average of $400 per device, making it the country's largest and most efficient purchaser of hearing aids[10,11]; and

Whereas, Bundled pricing for hearing aids is a marketing strategy where patients have to pay for additional services in order to receive hearing aids, even if they do not require those services, further lessening access to hearing aids[19]; and

Whereas, There have been proposals to improve the access to hearing aid technology through unbundling pricing strategies, development of personal sound amplification devices, and approval of the OTC sale of hearing aids[12-20]; and

Whereas, There has been recent interest in over-the-counter (OTC) hearing aids as a way to regain regulatory control over the direct-to-consumer hearing device market while still providing a low-cost and accessible solution[8]; and

Whereas, The FDA Reauthorization Act of 2017 established a new category of OTC hearing aids and tasked the FDA with proposing regulations for these devices by August 18, 2020[21]; therefore be it

RESOLVED, That our American Medical Association support policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly (New HOD Policy); and be it further

RESOLVED, That our AMA encourage increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids (New HOD Policy); and be it further

RESOLVED, That our AMA support the availability of over-the-counter hearing aids for the treatment of age-related mild-to-moderate hearing loss. (New HOD Policy)

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

Received: 05/09/19

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RELEVANT AMA POLICY

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation:
(1) There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan.
(2) State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection.
(3) Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges.
(4) Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual's genetic information should not be used to determine his or her premium.
(5) Insured individuals should be protected by guaranteed renewability.
(6) Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices.
(7) Guaranteed issue regulations should be rescinded.
(8) Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
(9) Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and pre-existing conditions limitations than individuals who are newly seeking coverage.
(10) The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically: (a) legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.
Citation: CMS Rep. 7, A-03; Reaffirmed: CMS Rep. 6, A-05; Reaffirmation A-07; Reaffirmed: CMS Rep. 2, I-07; Reaffirmed: BOT Rep. 7, A-09; Appended: Res. 129, A-09; Reaffirmed: CMS Rep. 9, A-11; Reaffirmed in lieu of Res. 811, I-11; Reaffirmed in lieu of Res. 109, A-12; Reaffirmed in lieu of Res. 125, A-12; Reaffirmed: Res. 239, A-12; Reaffirmed: CMS Rep. 9, A-14; Reaffirmation: A-17; Reaffirmed: Res. 518, A-17; Reaffirmed: Res. 105, A-18; Reaffirmed: Joint CMS CSAPH Rep. 01, I-18

Hearing Aid Coverage H-185.929
1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.
2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.
3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.
4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.

Citation: (CMS Rep. 6, I-15

Early Hearing Detection and Intervention H-245.970
Our AMA: 1) supports early hearing detection and intervention to ensure that every infant receives proper hearing screening, diagnostic evaluation, intervention, and follow-up in a timely manner; and 2) supports federal legislation that provides for the development and monitoring of statewide programs and systems for hearing screening of newborns and infants, prompt evaluation and diagnosis of children referred from screening programs, and appropriate medical, educational, and audiological interventions and follow-up for children identified with hearing loss.
Citation: (Res. 514, A-11; Reaffirmed: CMS Rep. 6, I-15

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 125
(A-19)

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

Subject: Mitigating the Negative Effects of High-Deductible Health Plans

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, High-deductible health plans disincentivize patients from seeking appropriate heath care; and

Whereas, The 2009 Affordable Care Act (ACA) requires that preventive services recommended by the US Preventive Services Task Force (USPSTF) be covered by insurers without a deductible; and

Whereas, Outpatient visits for the care of common conditions, such as hypertension, diabetes, coronary artery disease, hypothyroidism, etc., are not considered preventive, and therefore require that the patient pay in full for these visits, until the deductible is met; and

Whereas, As a result, many patients decide not to get appropriate care for their health conditions; and

Whereas, Several studies have found that improved access to a doctor's office to control chronic disease and provide early treatment of medical problems will reduce total health care costs through decreased use of emergency room and in-patient care[1]; and

Whereas, In addition to their adverse effect on patients' access to care, high-deductible health plans burden the economic viability of physician practices. While physicians are able to collect copayments at the time of the visit, we are not able to charge for a deductible until a claim for the visit has been submitted to the insurer, and the insurer has responded to the claim; and

Whereas, In the experience of many, physicians are usually not able to ascertain, at the time of service, how much of the patient's deductible has been met; even if a patient will eventually be found to be responsible for payment for the visit, the physician is unable to ask for payment at the time of the visit; and

Whereas, This delay in submitting the claim to the patient inexorably leads to a decrease in the collection rate for this portion of the fee. It is well known among private practice physicians that there is a steady decrease in collection rate as time goes on after the visit; and

Whereas, In summary, high-deductible plans have a negative impact on patient health, may increase total health care costs, and pose a threat to the economic viability of physician practices; and

Whereas, One change that would provide significant relief to both patients and physicians would be to exempt outpatient physician evaluation and management codes (99201–05 and 99211–15) from the deductible, for primary care and specialty practices; and

Whereas, There is precedent for this policy, in that the ACA requires that insurance plans exempt preventive services recommended by the USPSTF from deductible payments; and

Whereas, Exempting these codes from payment of the deductible would improve patient access to needed care, would likely reduce utilization of emergency room and in-patient services, and would help to stabilize the economic viability of physician practices; therefore be it

RESOLVED, That our American Medical Association advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. (Directive to Take Action)

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

Received: 05/09/19

[1]Nielsen M, Buett L, Patel K, Nichols L (2016). Patient Centered Medical Home's impact on cost and quality, review of the evidence 2014–15. http://www.pcpcc.org/resources.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 126
(A-19)

Introduced by:	Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont
Subject:	Ensuring Prescription Drug Price Transparency from Retail Pharmacies
Referred to:	Reference Committee A (John Montgomery, MD, Chair)

Whereas, The AMA has policy supporting both prescription drug price transparency as well as improved access to information about prescriptions drug prices and out-of-pocket costs for patients; and

Whereas, The AMA does not have an updated policy addressing the fact that less expensive purchasing options, such as alternative medications or generic formulations, may be available to physicians at time of prescribing and patients at the time of purchase at a retail pharmacy; and

Whereas, The Administration has recently removed pharmacy 'gag clauses', banning retail pharmacy restrictions on informing patients about differences in drug price with insurance coverage, copayment, and out-of-pockets price of the medication, highlighting the importance of price transparency on a federal level;[1,2] and

Whereas, Most physicians and patients have limited access to the out-of-pocket cost of medications due to the complexity of copays and formularies on different insurance plans, prices and costs at different pharmacies; and

Whereas, Health and Human Services is in the early stages of determining how to utilize "Real-Time Benefit check" to implement across all systems; and

Whereas, Barriers against prescription drug price transparency continue to limit the efficiency and effectiveness with which health care providers can support informed clinical and financial decision making for their patients;[3] therefore be it

RESOLVED, That our American Medical Association amend policy H-110.991, "Price of Medicine," by addition and deletion as follows:

Our AMA:
(1) work with relevant organizations to advocate for increased transparency through access to meaningful and relevant information about medication price and out-of-pocket costs for prescription medications sold at both retail and mail order/online pharmacies, including but not limited to Medicare's drug-pricing dashboard; ~~(1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications;~~
(2) will pursue legislation requiring pharmacies, pharmacy benefit managers and health plans to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication;
(3) opposes 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;
(4) will disseminate model state legislation to promote drug price and cost transparency ~~and to prohibit "clawbacks" and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication~~; and
(5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale. (Modify Current HOD Policy)

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

Received: 05/09/19

1. Patient Right to Know Drug Prices Act. https://www.congress.gov/bill/115th-congress/senate-bill/2554/text
2. Know the Lowest Price Act.
3. The Risky Game One Doctor Plays To Help Patients Find Affordable Insulin. https://www.wbur.org/commonhealth/2018/04/19/insulin-drug-pricing-pharmacy

RELEVANT AMA POLICY

Price Transparency D-155.987
1. Our AMA encourages physicians to communicate information about the cost of their professional services to individual patients, taking into consideration the insurance status (e.g., self-pay, in-network insured, out-of-network insured) of the patient or other relevant information where possible.
2. Our AMA advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information associated with both in-network and out-of-network provider services or other plan designs that may affect patient out-of-pocket costs.
3. Our AMA will actively engage with health plans, public and private entities, and other stakeholder groups in their efforts to facilitate price and quality transparency for patients and physicians, and help ensure that entities promoting price transparency tools have processes in place to ensure the accuracy and relevance of the information they provide.
4. Our AMA will work with states to support and strengthen the development of all-payer claims databases.
5. Our AMA encourages electronic health records vendors to include features that assist in facilitating price transparency for physicians and patients.

6. Our AMA encourages efforts to educate patients in health economics literacy, including the development of resources that help patients understand the complexities of health care pricing and encourage them to seek information regarding the cost of health care services they receive or anticipate receiving.
7. Our AMA will request that the Centers for Medicare and Medicaid Services expand its Medicare Physician Fee Schedule Look-up Tool to include hospital outpatient payments.
Citation: CMS Rep. 4, A-15; Reaffirmed in lieu of: Res. 121, A-16; Reaffirmed in lieu of: Res. 213, I-17; Reaffirmed: BOT Rep. 14, A-18

Price of Medicine H-110.991
Our AMA: (1) advocates that pharmacies be required to list the full retail price of the prescription on the receipt along with the co-pay that is required in order to better inform our patients of the price of their medications; (2) will pursue legislation requiring pharmacies to inform patients of the actual cash price as well as the formulary price of any medication prior to the purchase of the medication; (3) opposes provisions in pharmacies contracts with pharmacy benefit managers that prohibit pharmacists from disclosing that a patients co-pay is higher than the drugs cash price;(4) will disseminate model state legislation to promote increased drug price and cost transparency and to prohibit clawbacks and standard gag clauses in contracts between pharmacies and pharmacy benefit managers (PBMs) that bar pharmacists from telling consumers about less-expensive options for purchasing their medication; and (5) supports physician education regarding drug price and cost transparency and challenges patients may encounter at the pharmacy point-of-sale.
Citation: CMS Rep. 6, A-03; Appended: Res. 107, A-07; Reaffirmed in lieu of: Res. 207, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987
1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10.Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade

Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11.Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18;

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

Drug Price and Cost Transparency D-110.988
1. Our AMA will continue implementation of its TruthinRx grassroots campaign to expand drug pricing transparency among pharmaceutical manufacturers, pharmacy benefit managers and health plans, and to communicate the impact of each of these segments on drug prices and access to affordable treatment.
2. Our AMA will report back to the House of Delegates at the 2018 Interim Meeting on the progress and impact of the TruthinRx grassroots campaign.
Citation: Alt. Res. 806, I-17

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs.
Citation: Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Reaffirmed in lieu of: Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127
(A-19)

Introduced by: New Jersey

Subject: Eliminating the CMS Observation Status

Referred to: Reference Committee A
(John Montgomery, MD, Chair)

Whereas, “Observation Status” for a hospitalization does not count to meet Medicare’s “three day inpatient rule” for “skilled nursing facility care” financial coverage; and

Whereas, “Observation Status” to a hospital means our patients are financially responsible for a 20 percent co-pay for hospital costs, the full cost of medications and diagnostic testing; and

Whereas, Our patients should present for emergency care assessment as soon as symptoms and/or signs dictate, but the financial risks of “Observation Status” may dissuade patients from seeking hospital based care through the emergency department; and

Whereas, Medicare Part A patients do not get a thorough explanation, including situational examples, of Medicare coverage rules for “Observation Status” when pre-admitted or admitted to a hospital; and

Whereas, There is no insurance available for Part A “Observation Status” financial risk; therefore be it

RESOLVED, That our American Medical Association request, for the benefit of our patients’ financial, physical and mental health, that the Centers for Medicare and Medicaid Services terminate the “48 hour observation period” and observation status in total. (Directive to Take Action)

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

Received: 05/09/19