

REPORT 7 OF THE BOARD OF TRUSTEES  
2019 AMA Advocacy Efforts

EXECUTIVE SUMMARY

Policy G-640.005, “AMA Advocacy Analysis,” calls on the Board of Trustees (BOT) to provide a report to the House of Delegates (HOD) at each Interim Meeting highlighting the year’s advocacy activities and should include efforts, successes, challenges, and recommendations/actions to further optimize advocacy efforts. The BOT has prepared the following report to provide an update on American Medical Association (AMA) advocacy activities for the year. (Note: It was prepared in early August based on approval deadlines and may be updated if warranted based on legislative, regulatory, or judicial developments.)

The AMA continues to be a powerful ally for physicians as it shapes the health of the nation by working to reduce dysfunction in the health care system, achieve health equity, train the next generation of physicians, and improve public health. The AMA produced strong results again in 2019 by advancing key policy objectives on physician payment, drug pricing, ill-conceived health insurer policies, the opioid epidemic, and consolidation in the health sector. The AMA’s stellar advocacy work is recognized by industry watchers including APCO Worldwide which ranked the AMA as a “top-rated association” in four of 15 categories in its TradeMarks report (coalition building, industry reputation steward, local impact, and bipartisanship) when compared to 50 other associations representing various industries. The AMA was the top-rated association in 11 of 15 categories when compared only to other health care stakeholders.

Key AMA advocacy wins in 2019 include:

- The Centers for Medicare & Medicaid Services (CMS) is recommending adoption of recommendations from the RUC and CPT regarding coding changes and relative work values for office-based E/M services (further work is needed on the E/M component for global surgical services).
- CMS also approved several new Alternative Payment Models (APMs) and is moving towards a new approach for the Merit-based Incentive Payment System (MIPS) based on recommendations from an AMA-led Federation work group.
- AMA research and advocacy led a federal judge to conduct a rigorous review of the proposed CVS-Aetna merger—decision pending.
- CMS limited step therapy in Medicare Advantage plans and nine states, such as Colorado and Kentucky, enacted state legislation to limit prior authorization across the board.
- Eleven states and Washington, DC enacted laws or implemented policies to limit prior authorization for medication-assisted treatment (MAT) for substance use disorder (SUD).
- Congress is considering drug pricing legislation and the AMA is actively engaged on this issue with over 1 million physician/patient messages sent to Congress through AMA grassroots efforts since the campaign’s inception.
- The House of Representatives has passed a universal firearm background check bill, and the AMA is advocating for similar legislation in the Senate.

## REPORT OF THE BOARD OF TRUSTEES

B of T Report 7-I-19

Subject: 2019 AMA Advocacy Efforts

Presented by: Jesse M. Ehrenfeld, MD, MPH, Chair

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### BACKGROUND

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The AMA continues to be a powerful ally for physicians as it shapes the health of the nation by working to reduce dysfunction in the health care system, achieve health equity, train the next generation of physicians, and improve public health. The AMA produced strong results again in 2019 by advancing key policy objectives on physician payment, drug pricing, health insurer abuses, the opioid epidemic, and industry consolidation. The AMA’s stellar advocacy work is recognized by industry watchers including APCO Worldwide which ranked the AMA as a “top-rated association” in four of 15 categories in its TradeMarks report (coalition building, industry reputation steward, local impact, and bipartisanship) when compared to 50 other associations representing various industries. The AMA was the top-rated association in 11 of 15 categories when compared only to other health care stakeholders.

The AMA collaborates closely with the Federation of Medicine in its advocacy work and greatly appreciates the invaluable contributions made by the national medical specialty societies, state medical associations, and county medical associations to advance our collective goals.

While advocacy efforts continue in 2019, the AMA is already preparing for 2020 when the presidential election will bring even greater attention to many health care issues. Health care was the top issue for voters in 2018, and it is at the top of the list for voters heading into the 2020 elections.

### DISCUSSION OF 2019 ADVOCACY EFFORTS

#### *QPP implementation*

Physicians need support as they continue the transition to the Medicare Quality Payment Program (QPP). The AMA is working to improve the QPP at both the regulatory and legislative levels. AMA Immediate Past President Barbara L. McAneny, MD, testified on May 8 before the Senate Committee on Finance on the Medicare Access and Chip Reauthorization Act (MACRA) and offered ways for Congress to continue improving the QPP.

Initial results from CMS show that AMA efforts have had an impact. Merit-based Incentive Payment System (MIPS) participation rates increased from 95 percent in 2017 to 98 percent in 2018, with 98 percent of clinicians earning an incentive payment that will apply to Medicare physician fee schedule payments in 2020. The AMA's strong push for additional flexibilities for small practices resulted in nearly 85 percent receiving a positive payment adjustment, up from 74 percent in 2017. Additionally, the number of eligible clinicians who qualified for a 5 percent APM incentive payment nearly doubled from 2017 to 2018, increasing from 99,076 to 183,306 clinicians. The AMA is encouraged by these results and will continue to work with CMS and the Federation to identify further solutions that will reduce the burden and cost to participate in MIPS and increase opportunities for physicians to move to alternative payment models (APMs).

Further on the APM front, the AMA was pleased to host the Secretary of Health and Human Services Alex Azar, along with Centers for Medicare & Medicaid Services (CMS) Administrator Seema Verma, and Director Center for Medicare and Medicaid Innovation (CMMI) Adam Boehler, as they announced two new primary care models. Under the programs, Medicare would reward practices for providing more convenient access to care, and start paying for services such as enhanced chronic disease care management, acute care in-home services and palliative care. CMMI is also implementing an APM covering emergency services and another on treatment for kidney disease. The AMA is supportive of the roll out of more APM options for physicians as they seek to be innovative in providing care to their patients.

Finally, CMS issued its 1700-page proposed 2020 Medicare physician payment rule in late July, with comments due at the end of September. Two notable policy provisions were included:

- The agency agreed to coding changes and revised relative work values for office-based evaluation and management (E/M) services that were initially developed by a Federation workgroup and ultimately approved by CPT and the RUC. These changes would be made in lieu of plans the agency announced last year to collapse office E/M codes and payments. The new proposal reflects the increasing complexity of these services and the resources required to provide them and streamlines reporting requirements. Unfortunately, the agency did not propose making the same adjustments to the E/M component of global surgical services, as recommended by the RUC, which would distort the relativity of the fee schedule. The AMA will continue pressing CMS to make these adjustments.
- Another provision of the proposed rule is the framework for a more cohesive Merit-based Incentive Payment System (MIPS) that would give physicians the choice to focus on episodes of care rather than following the current, more fragmented approach. Making MIPS more clinically relevant and less burdensome is a top priority for the AMA, and CMS is taking an important step toward this goal.

#### *Prior authorization*

Prior authorization (PA) is one of the most vexing issues for patients and physicians in the health care system today, and the AMA is addressing it in multiple venues. Key findings from the AMA's December 2018 PA physician survey include:

- 28 percent of physicians reported that the PA process required by health insurers for certain drugs, tests and treatments had led to a serious adverse event (e.g., death, hospitalization, disability, or another life-threatening event);
- On average, practices complete 31 PAs per physician, per week; and
- 91 percent of physicians surveyed said that PA processes delay access to necessary care.

The AMA has attempted to work directly with health insurers and other stakeholders by identifying joint principles to reform PA, but demonstrable progress by insurers in reducing PA burdens has been negligible. The AMA is also pressing for legislation at the federal and state levels on PA reform. Federal legislation, H.R. 3107, the “Improving Seniors’ Timely Access to Care Act,” was recently introduced, and the bill aims to streamline PA processes by Medicare Advantage plans. The AMA is supportive of the bill and assisted with a Federation sign-on letter to highlight the broad support for the bill in the physician community. Also at the federal level, CMS moderated its earlier proposed approach to use step therapy and other utilization management tools within the six protected classes of drugs used to treat complex conditions in final regulations on Medicare Advantage and Part D drug plans. While its earlier proposal would have allowed step therapy and other tools to be applied broadly across all six protected classes, the agency’s final policy allows step therapy within five of the six protected classes and limits its use to new starts.

Much of the legislative activity on PA in 2019 occurred at the state level. To date, Colorado, Kentucky, Maine, Maryland, Missouri, New Mexico, Texas, Virginia, and West Virginia have enacted PA laws this year despite the state medical associations in those states facing strong opposition from insurers and their local trade associations. Kentucky S.B 54 is a strong PA reform law based on AMA model legislation that was enacted this year, and it will require insurers to respond to PA requests for urgent care within 24 hours and for non-urgent care within 5 days. Another benefit of the Kentucky law for patients is that their prescriptions for maintenance drugs will be valid for one year or until the last day of coverage, and if there is a change in dosage, PA will not be required during this time period.

In 2019, the AMA enhanced its grassroots advocacy campaign—FixPriorAuth.org—directed at both physicians and patients to spur further activity on PA reform. Campaign components include a successful online hub, an active social media campaign, and videos featuring both patient and physician stories that illustrate the negative impact of utilization management restrictions on timely patient care. To date, the social media campaign has generated more than 610 patient and physician stories and 90,000 signatures on a petition to Congress.

### *CVS-Aetna*

The AMA has taken a leading role in challenging the massive CVS-Aetna proposed merger, the largest in the history of U.S. health care. If approved, the merger would hurt competition in five key health care markets: Medicare Part D prescription drug plan (PDP); health insurance; pharmacy benefit management; retail pharmacy; and specialty pharmacy. The AMA opposition is evidence-based, the result of months of analysis by nationally-recognized health economists and legal experts. The AMA’s advocacy led to an almost unheard-of development: a federal judge holding hearings to evaluate the settlement between the U.S. Department of Justice (DOJ) and CVS-Aetna that led to the DOJ approving the merger.

The AMA’s main concerns about the proposed merger and subsequent agreement were contained in a March 2019 filing before Judge Richard Leon. The AMA contends that the DOJ settlement with Aetna, which requires Aetna to sell its PDP assets for the DOJ to approve the CVS-Aetna merger, would not adequately address the merger’s anticompetitive effects. The AMA has three main concerns:

- The divestiture would decrease the number of firms in already concentrated and rapidly consolidating PDP markets;
- New entry will not solve the problem because there are high barriers to entry into PDP markets; and

- The merger and divestiture would eliminate the unique and important role of competition between Aetna and CVS in the PDP market.

The AMA participated in closing arguments before Judge Leon on July 19. Many expected this merger to sail through the approval process, but that is clearly not the case. Judge Leon is giving the proposed merger a very rigorous review, and his ruling is expected later this summer/early fall.

#### *Access to care*

The AMA remains committed to protecting coverage for the 20 million Americans who acquired it through the Affordable Care Act (ACA) and expanding coverage for those who did not. The AMA also supports policies that would improve coverage options for many who are underinsured and/or cite costs as a barrier to accessing the care they need. The status quo is unacceptable, and federal policymakers need to build upon the ACA instead of attempting to weaken it.

The AMA filed an *amicus* brief with several Federation groups to defend the ACA in 2018 in *Texas v. United States*—a case challenging the validity of the ACA after the individual mandate tax penalty was repealed by Congress. The district court judge sided with those challenging the ACA, so the AMA has filed another *amicus* in 2019 at the appellate level to overturn the lower court ruling. A ruling on the appeal is expected shortly.

The AMA has also advocated for building on and fixing the ACA rather than scrapping it and adopting a single payer model. The AMA advocated in 2019 to build on the foundation of the current system to reach universal coverage through a pluralistic approach involving a strong competitive private market, employer sponsored coverage, a publicly financed safety net, and consumer protections such as the current prohibition against pre-existing condition coverage exclusions. This will be a major issue as the nation heads into a presidential election year where health care will again be front and center, although no legislative action is anticipated before 2021.

At the state level, the AMA has continued to advocate for Medicaid expansion. To date, 36 states and DC have expanded Medicaid eligibility under the ACA. In 2019, three states (Idaho, Nebraska, and Utah) moved forward with expansion plans that were approved by voters via ballot initiative in 2018. Arkansas and Montana reauthorized existing Medicaid expansion programs, and Georgia enacted a law authorizing a waiver for expanded coverage. Many states, however, are coupling burdensome work requirements with coverage expansions and the AMA continues to work with state medical associations to counter restrictions that will cause coverage losses. With AMA support, New Hampshire enacted a law to halt the state's work requirements if a substantial number of beneficiaries are negatively affected, and Montana passed a "trigger" provision requiring the state to reevaluate the work program if a substantial number of enrollees lose coverage. The AMA has also joined *amicus* briefs in legal challenges to Medicaid work requirements in Arkansas, Kentucky, and New Hampshire.

#### *Regulatory relief*

The Administration has made regulatory relief for physicians a priority. The AMA successfully called for a reduction in documentation requirements that were in the final Physician Fee Schedule rule last November. CMS is expected to undertake more regulatory reduction efforts for physicians as they issue various upcoming rules. The AMA has had a number of discussions with CMS on prior authorization and is optimistic that CMS will find ways to reduce this burden for physicians. The AMA is also working on responding to a CMS proposed rule regarding electronic prior

1 authorization (ePA). CMS is seeking comment about how to mitigate burden to support successful  
2 adoption of ePA.

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4 CMS also issued a Request for Information (RFI) seeking feedback on regulatory relief more  
5 broadly. The AMA solicited input from the specialty societies, the Council on Medical Service, and  
6 the Council on Legislation to help identify additional ideas regarding burden reduction to include  
7 in the AMA response to the RFI. A lengthy comment letter with detailed recommendations for  
8 easing physician regulatory burdens was submitted on August 9.

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10 Lastly, the AMA has met with HHS about necessary changes to Stark and Anti-Kickback policies.  
11 The AMA is providing extensive comments to the HHS RFI on the topic. At the time of this report,  
12 there are two separate proposed rules looking to modernize the Stark and Anti-Kickback  
13 regulations that are pending Office of Management and Budget (OMB) review. The AMA  
14 anticipates clarification as to the definition of key terms and potential new exceptions/safe harbors  
15 around value-based care and cybersecurity. The AMA also recommended in recent comments that  
16 the federal ban on physician-owned hospitals be lifted.

### 17 *Surprise billing*

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20 Patients, physicians, and policymakers are deeply concerned about the impact that unanticipated  
21 medical bills are having on patient out-of-pocket costs and the patient-physician relationship. The  
22 AMA and more than 100 state and specialty organizations submitted a letter to Congress laying out  
23 seven principles that the AMA believes must guide any federal legislation on surprise billing to  
24 ensure that patients are not burdened by unanticipated out-of-network medical bills: (1) insurer  
25 accountability; (2) limits on patient responsibility; (3) transparency; (4) universality; (5) setting  
26 benchmark payments; (6) alternative dispute resolution; and (7) keep patients out of the middle. On  
27 May 21, AMA Trustee Bobby Mukkamala, MD, testified before the House Ways and Means  
28 Committee on surprise billing offering the AMA's proposed solutions in his remarks and written  
29 testimony.

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31 On July 17, the House Committee on Energy and Commerce reported out several health care bills  
32 including the "REACH Act" which would extend funding for Community Health Centers, the  
33 Teaching Health Centers GME program and the National Health Service Corps and also included  
34 the "No Surprises Act" to address surprise medical billing. As originally introduced, the "No  
35 Surprises Act" would have plans pay out-of-network physicians the median in-network contract  
36 amount for the service provided in that particular geographic area. Not only would that bind out-of-  
37 network physicians to contracted amounts they did not agree to accept, but it would eliminate much  
38 of the incentive for plans to contract with an adequate number of physicians in the first place.  
39 Furthermore, as the Congressional Budget Office (CBO) has noted on similar proposals, plans  
40 would have an incentive to cancel or cut contracted amounts for any physicians currently above the  
41 median rate, reducing payment for both in- and out-of-network physicians. Such a solution would  
42 tilt the advantage in negotiating fair contracts even further in the direction of plans. On June 24, the  
43 Senate Health, Education, Labor, and Pensions Committee approved similar legislation.

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45 At the urging of Energy and Commerce Committee members Rep. Raul Ruiz, MD (D-CA), Rep.  
46 Larry Buschon, MD (R-IN) and others, the committee adopted an amendment to provide for an  
47 independent dispute resolution process. Under the proposal, if either party was dissatisfied with the  
48 initial payment offer, an appeals process could be triggered that would allow an independent entity  
49 to decide between the payment offer of the plan and the physician's billed amount while  
50 considering a number of other factors related to the circumstances of the case and the training and  
51 experience of the physician. While the proposal still needs improvement, it represents an important

step forward, and an improvement over the Senate bill, by recognizing that the resolution of these disputes requires a solution that is fair and encourages both sides to make reasonable offers to resolve the payment dispute. At the time of this report, the AMA is seeking to make further improvements to these provisions and has activated the AMA's grassroots networks. Two other House committees—Education & Labor and Ways & Means, also plan to produce surprise billing legislation.

At the state level, medical societies continue to push for fair solutions and push back on insurer-supported proposals that undercut fair contracting. So far in 2019, more than 40 bills in 20 states related to surprise billing were introduced and many remain in play. In Washington, Texas, Colorado, New Mexico, and Nevada, comprehensive bills were enacted this year (i.e., bills that established both patient protections and payment processes). While none of these new laws is squarely aligned with Federation principles, the new laws are fairer because of strong physician advocacy. Much of the work in these states now turns toward engagement in the regulatory process and implementation.

### *Opioid epidemic*

The opioid epidemic continues to have a devastating effect on our nation; however, there is continuing progress in physicians' actions to help end it. Last fall, the AMA joined the Pennsylvania Medical Society to help secure a landmark agreement in Pennsylvania between the governor and the Commonwealth's seven largest health plans to remove prior authorization requirements for medication-assisted treatment (MAT) to treat a substance use disorder. Since then, AMA advocacy with state and specialty societies has helped enact/implement similar laws and policies in Arkansas, Colorado, Delaware, the District of Columbia, Iowa, Maine, Missouri, New Jersey, New York, Vermont, Virginia, and Washington. The AMA has also worked closely with Manatt Health on reports in Pennsylvania, Colorado, North Carolina and Mississippi to spotlight their efforts to combat the opioid epidemic and areas for future collaboration to strengthen these efforts. The AMA and Manatt will also roll out a national roadmap on this issue building on this state work in the fall.

The AMA Opioid Task Force issued a report in June 2019 updating some of the progress that is being made:

- From 2013-2018 annual opioid prescriptions dropped by one-third, from 251 million to 168 million. Every state has experienced a decrease in opioid prescriptions over the last five years.
- Use of prescription drug monitoring programs (PDMP) is growing—435 million queries were made in 2018—more than triple the total from 2016.
- Naloxone prescriptions increased from 136,000 in 2016 to nearly 600,000 in 2018.
- More than, 700,000 physicians and other health care professionals completed continuing medical education trainings and accessed other Federation resources in 2018; in addition, more than one million physicians and other readers of the JAMA Network viewed opioid-related research and related material.
- The number of physicians trained/certified to provide buprenorphine in-office continues to rise—more than 66,000 physicians are now certified—an increase of more than 28,000 physicians and other providers since 2016.

The AMA was also pleased that the U.S. Centers for Disease Control and Prevention (CDC) recently clarified its opioid prescribing guidelines as recommended by the AMA, and the Food and Drug Administration also issued revised guidance to help protect patients.

*Pharmaceutical cost transparency*

In 2019, the AMA continued advocacy to increase drug pricing transparency. This includes successfully advocating for Medicare Advantage and Part D to require plans to provide real-time access to drug price data through at least one electronic health record (EHR) or drug e-prescribing system by 2021.

Immediate Past Chair of the Board Jack Resneck, Jr., MD, testified before the House Energy and Commerce Subcommittee on Health on May 9 to press Congress to take action on this issue. The House of Representatives is expected to consider drug pricing legislation this fall. On the Senate side, the Finance Committee recently marked up drug pricing legislation that attempts to reduce the cost of prescription drugs by among other provisions capping Medicare beneficiaries out-of-pocket costs at \$3100 on prescription drugs and placing a limit on prescription drug price increases in Medicare Part D. At the time this report was drafted, the AMA was reviewing the Senate legislation and will review any upcoming House legislation before activating further the AMA's grassroots networks. The AMA's TruthinRx.org grassroots campaign has created a strong network of over 338,000 advocates who have sent over 1 million messages to Congress already, so the AMA is poised to have further impact as the drug pricing debate continues.

The AMA is working on drug pricing at the state level and has developed model bills that focus on pharmacy benefit manager (PBM) practices. The AMA is also engaging the National Association of Insurance Commissioners, the National Conference of Insurance Legislators, and state attorneys general to reform PBM practices. Maine and New York made progress on this issue in 2019 with Maine enacting legislation that prohibits PBMs from retaining rebates from manufacturers and New York's new law increases transparency and requires PBMs to work "for the best interests primarily of the covered individual."

*Vaccines*

With the number of measles cases reaching the highest levels in more than 25 years, vaccine exemptions were a hot topic in states across the country, and the AMA was active on the advocacy front helping states address these bills. Several sought to eliminate all nonmedical exemptions to the childhood immunizations required for parents to enroll children in school—including enactments in Maine and New York. These two states join California, Mississippi and West Virginia to bring the total count of states that prohibit all nonmedical exemptions to five. Washington also strengthened its vaccine laws, barring personal and philosophical objection to the measles, mumps, and rubella vaccine. In addition, no new laws were enacted that would discourage immunization. In particular, the AMA worked closely with the Arizona Medical Association to defeat three high-profile bills that would have loosened vaccination laws. The AMA also wrote to major social media companies calling on them to eliminate false and misleading vaccine information from their platforms.

*Gun violence*

Gun violence in America has reached epidemic proportions. In 2019, the AMA continued its advocacy to find workable, comprehensive solutions to reduce gun violence. At the federal level, the House of Representatives passed a universal background check bill supported by the AMA. The sponsor of H.R. 8, Rep. Mike Thompson (D-CA), spoke at the AMA's National Advocacy Conference and expressed his thanks for AMA's support. The bill awaits consideration in the Senate.



At the state-level, several states made progress on the issue in 2019. Four states (Colorado, Hawaii, New York and Nevada) passed laws authorizing extreme risk protection orders (sometimes called “Red Flag laws”). Connecticut expanded safe storage requirements in the home. California approved a first-in-the-nation requirement that anyone purchasing ammunition must undergo a background check. Washington, New Mexico and Nevada strengthened background check requirements, and several states closed loopholes that enable domestic abusers’ access to firearms, including North Dakota, New Mexico and Washington. Lastly, while no state currently prohibits physicians from counseling patients about firearm safety and risks, the AMA continues to watch for such legislation.

Following the mass shootings in Gilroy, CA, El Paso, TX, and Dayton, OH, the AMA joined with other physician groups in a joint call to action that was published online by the *Annals of Internal Medicine* on August 7. The joint document calls for commonsense reforms such as expanded background checks, more federal support for firearms injury research, and other proposals.

#### *Detention of children at the southern border*

The AMA is very concerned about the treatment of children at the southern border and has expressed these concerns several times to federal officials. In June, the AMA signed on to a letter of support for H.R. 3239, the “Humanitarian Standards for Individuals in Customs and Border Protection Custody Act,” along with 13 other health care organizations. H.R. 3239 takes important steps toward ensuring that appropriate medical and mental health screening and care are provided to all individuals, including immigrant children and pregnant women, in U.S. Customs and Border Protection (CBP) custody. In July, the AMA called on the U.S. Department of Homeland Security (DHS) and CBP to address the condition of their facilities at the southern border, which are inconsistent with evidence-based recommendations for appropriate care and treatment of children and pregnant women. The AMA also issued a letter to the House Committee on Oversight and Reform in advance of the upcoming congressional hearings entitled, “Kids in Cages: Inhumane Treatment at the Border,” and “The Trump Administration’s Child Separation Policy: Substantiated Allegations of Mistreatment.” In the AMA letter, CEO and EVP James L. Madara, MD, stated: “Conditions in CBP facilities, including open toilets, constant light exposure, insufficient food and water, extreme temperatures, and forcing pregnant women and children to sleep on cement floors, are traumatizing. These facilities are simply not appropriate places for children or for pregnant women. We strongly urge the Administration and Congress to work with the medical community to develop policies that ensure the health of children and families is protected throughout the immigration process.”

#### *Protecting the patient-physician relationship*

The AMA filed two major lawsuits in 2019 that challenged governmental intrusion into the patient-physician relationship. Both cases are working their way through the litigation process. The first was filed in conjunction with the Oregon Medical Association and other plaintiffs in federal court in Oregon and argues that proposed Administration regulatory changes would decimate the successful Title X program. The AMA’s main concerns are that:

- The regulation imposes a “gag rule” on physicians that restricts them from providing complete information to patients about all of their health care options and providing appropriate referrals for care.
- It re-directs funds away from evidence-based contraception methods and to non-medical family planning services such as abstinence and “fertility awareness.”

- It withholds funds from qualified Title X providers that offer the full range of family planning services to vulnerable populations.

The AMA also filed a lawsuit to challenge the constitutionality of two North Dakota laws that compel physicians and other members of the care team to provide patients with false, misleading, non-medical information about reproductive health. Filed in federal court in North Dakota, the lawsuit asks the court to block enforcement of North Dakota's compelled speech laws, which the AMA argues would inflict irreparable harm on patients and force physicians to violate their obligation to give honest and informed advice.

#### *Nondiscrimination in health care*

The AMA is assessing the full impact of the regulatory proposal issued in 2019 to remove anti-discrimination protections related to sexual orientation, gender identity, and termination of pregnancy across a wide range of health care programs and insurance plans. We strongly believe that discrimination on the basis of sex includes discrimination on the basis of gender identity and sexual orientation. Similarly, the AMA does not condone discrimination based on whether a woman has had an abortion. Respect for the diversity of patients is a fundamental value of the medical profession and reflected in long-standing AMA ethical policy opposing discrimination based on race, gender, sexual orientation, gender identity, pregnancy, or termination thereof. The AMA submitted comments that highlight these concerns on August 13.

#### *Conversion therapy*

The AMA opposes the practice of "conversion therapy" on minors and works with states to ban this practice. Four states (Colorado, Massachusetts, Maine and New York) enacted laws prohibiting the practice in 2019. This practice refers to interventions that attempt to change an individual's sexual orientation, sexual behaviors, gender identity, or gender expression. Eighteen states and Washington, DC now prohibit the harmful practice and one state, North Carolina, bars use of state funding for conversion therapy. The AMA produced an issue brief on this topic to assist states that seek to address it in coming legislative sessions.

#### *Tobacco*

Tobacco use particularly among youth remains a public health concern for the AMA. There are state and federal efforts to move to an age 21 threshold for tobacco purchase. This year 10 states (Arkansas, Connecticut, Delaware, Illinois, Maryland, Texas, Utah, Virginia, Vermont, and Washington) raised the minimum age to purchase tobacco products to 21 from 18, bringing the total number of Tobacco 21 states to 17 plus Washington, DC. The AMA is also reviewing federal legislation that would create a federal requirement as well. The AMA also has strong policy on e-cigarettes and is monitoring federal and state legislative and regulatory efforts closely. The AMA will continue to seek opportunities to advocate for AMA policy on this public health concern.

#### *Scope of practice*

State legislatures considered over 1000 bills seeking to eliminate team-based care models of health care delivery and/or expand the scope of practice of non-physician health care professionals in 2019. For example, nurse practitioners continued to seek independent practice authority and to chip around the edges of state law. Physician assistants were more emboldened this year to seek independent practice with the adoption of the optimal team practice act by the American Academy of PAs (AAPA) last year, and pharmacists sought prescriptive authority in at least a dozen states.

1 While these three groups of non-physician health care professionals accounted for the vast majority  
2 of scope bills this year, hard fought battles also occurred in a number of states on other scope  
3 issues. With tough fights in all cases, most bills that threatened passage were defeated, often with  
4 AMA support and a coordinated approach from state medical associations and national medical  
5 specialty societies through the AMA-led Scope of Practice Partnership (SOPP). The SOPP has  
6 provided close to \$2 million in grants to states and specialties since its inception to help on the  
7 scope front.

8  
9 **CONCLUSION**

10  
11 The AMA continues to be a powerful advocate for physicians as it attacks the major problems that  
12 promote dysfunction in health care including payment issues, egregious health insurance practices,  
13 industry consolidation, and drug pricing. At the same time, the AMA is seeking to improve public  
14 health by working to solve the gun violence crisis, continue progress being made on the opioid  
15 epidemic, and promote health equity across the board. AMA advocacy work will continue through  
16 the rest of 2019, and the AMA will be prepared as health care policy will go under the microscope  
17 again in the presidential primaries and general election in 2020.