

Reference Committee A

CMS Report(s)

- 01 Options to Maximize Coverage under the AMA Proposal for Reform
- 03 Medicare Prescription Drug and Vaccine Coverage and Payment
- 05 Medicaid Reform
- 06 Value-Based Management of Drug Formularies
- 07 Health Plan Initiatives Addressing Social Determinants of Health

Resolution(s)

- 101 End of Life Care Payment
- 102 Hospice Recertification for Non-Cancer Diagnosis
- 103 Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance
- 104 Reinstatement of Consultation Codes
- 105 Access to Medication
- 106 Bundling Physician Fees with Hospital Fees
- 107 COBRA for College Students
- 108 Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing
- 109 Health Insurance that Fairly Compensates Physicians
- 110 Medicaid Tax Benefits
- 111 Payment for Regadenoson (Lexiscan)
- 112 Private Payor Payment Integrity
- 113 Most Favored Nation Executive Order

REPORT 1 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Options to Maximize Coverage under the AMA Proposal for Reform
(Resolution 113-A-19 and Resolution 114-A-19)
(Reference Committee A)

EXECUTIVE SUMMARY

The American Medical Association (AMA) proposal for reform has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans. However, the Council sees an opportunity to further maximize coverage rates and improve coverage affordability under the AMA proposal for reform by establishing new policy on a public option, as well as auto-enrollment in health insurance coverage. Of note, both approaches cannot be implemented without safeguards in place to protect patients, as well as physicians and their practices.

The Council is aware of the growing interest within the House of Delegates for our AMA to support a public option. However, the term “public option” has several different meanings, and blanket support for a public option without safeguards in place could have negative consequences for physicians and their practices. If all criteria established by the policy proposed by the Council in this report are met, there is the potential for our AMA to support a public option, as it would provide patients with another choice of health plan. As such, a primary goal of establishing a public option should be to maximize patient choice of health plan and maximize health plan marketplace competition. Importantly, eligibility for premium tax credit and cost-sharing assistance to purchase the public option needs to be restricted to individuals without access to affordable employer-sponsored coverage. Otherwise, physician practice payer mix and revenues could be significantly impacted, especially if payment rates under the public option are tied to or guided by Medicare and/or Medicaid payment rates. Regardless of the public option design, payment rates need to be established through meaningful negotiations and contracts and must not be tied to or guided by Medicare and/or Medicaid rates. Physician freedom of practice needs to also be at the forefront of assessing any public option proposal and, as such, public option proposals should not require provider participation, and/or tie a provider’s participation in Medicare, Medicaid and/or any commercial product to participation in the public option.

The Council sees tremendous potential in the use of auto-enrollment to improve the coverage reach of the AMA proposal for reform, especially amid the COVID-19 pandemic. In 2018, 57 percent of the nonelderly uninsured population was eligible for financial assistance – either through Medicaid or the Children’s Health Insurance Program, or via premium tax credits to purchase marketplace coverage as provided for under the Affordable Care Act (ACA). Additionally, a substantial percentage of the newly unemployed are eligible for Medicaid or premium tax credits to purchase ACA marketplace coverage. As such, a significant number of uninsured Americans are currently eligible for no- or low-cost coverage but are not enrolled. The Council believes that states and the federal government should seriously consider the use of auto-enrollment to maximize coverage rates, alongside key improvements to the ACA as outlined in the AMA proposal for reform. As such, the Council proposes standards for states and/or the federal government to follow as they pursue auto-enrollment in health insurance coverage. The Council believes that, especially considering the coverage impacts of the COVID-19 pandemic, there needs to be a mechanism in AMA policy to ensure that the AMA proposal for reform can maximize its coverage potential and reach. Physicians have the responsibility to advocate for improving health insurance coverage and health care access so that patients receive timely, high quality care, preventive services, medications and other necessary treatments.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 1, November 2020

Subject: Options to Maximize Coverage under the AMA Proposal for Reform
(Resolution 113-A-19 and Resolution 114-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

1 At the 2019 Annual Meeting, the House of Delegates referred two resolutions jointly sponsored by
2 the Washington and Connecticut Delegations, Resolutions 113 and 114; an alternate resolution
3 offered by Reference Committee A; and an amendment offered by the American College of
4 Physicians during House of Delegates floor consideration of the reference committee report item
5 addressing Resolutions 113 and 114. The Board of Trustees assigned these items to the Council on
6 Medical Service for a report back to the House of Delegates.
7

8 Resolution 113-A-19, Ensuring Access to Statewide Commercial Health Plans, asked that our
9 American Medical Association (AMA) study the concept of offering state employee health plans to
10 every state resident, including exchange participants qualifying for federal subsidies, and report
11 back to the House of Delegates this year; and advocate that State Employees Health Benefits
12 Program health insurance plans be subject to all fully insured state law requirements on prompt
13 payment, fairness in contracting, network adequacy, limitations or restrictions against high
14 deductible health plans, retrospective audits and reviews, and medical necessity.
15

16 Resolution 114-A-19, Ensuring Access to Nationwide Commercial Health Plans, asked that our
17 AMA advocate that Federal Employees Health Benefits Program (FEHBP) health insurance plans
18 should become available to everyone to purchase at actuarially appropriate premiums as well as be
19 eligible for federal premium tax credits; and advocate that FEHBP health insurance plans be
20 subject to all fully insured state law requirements on prompt payment, fairness in contracting,
21 network adequacy, limitations or restrictions against high deductible health plans, retrospective
22 audits and reviews, and medical necessity.
23

24 The alternate resolution proposed by Reference Committee A asked that our AMA study the
25 impacts of various approaches that offer a public option in addition to current sources of coverage,
26 private or public, including but not limited to a Medicare buy-in; a public option offered on health
27 insurance exchanges; and buying into either the FEHBP or a state employee health plan; and
28 reaffirm Policy H-165.838, which states that insurance coverage options offered in a health
29 insurance exchange be self-supporting; have uniform solvency requirements; not receive special
30 advantages from government subsidies; include payment rates established through meaningful
31 negotiations and contracts; not require provider participation; and not restrict enrollees' access to
32 out-of-network physicians.
33

34 The amendment offered during the House of Delegates' consideration of this item at the 2019
35 Annual Meeting asked that our AMA support various approaches that offer a public option in
36 addition to current sources of coverage, private or public, including but not limited to: (a)(i) a
37 Medicare buy-in; (ii) a public option offered on health insurance exchanges; and (iii) buying into

1 either the FEHBP or a state employee health plan; and (b) study the options to effectively
2 implement such approaches.

3
4 This report provides background on the AMA proposal for reform; summarizes potential
5 approaches to a public option; outlines how the use of auto-enrollment has the potential to
6 maximize coverage rates; and presents policy recommendations.

7
8 **THE AMA PROPOSAL FOR REFORM**

9
10 Covering the uninsured and improving health insurance affordability have been long-standing goals
11 of the AMA. Since the enactment of the Affordable Care Act (ACA), the AMA proposal for reform
12 has continued to evolve to ensure that AMA policy is able to address how to best cover the
13 remaining uninsured in the current coverage environment. In 2018, nearly 60 percent of nonelderly
14 Americans (153.8 million) had employer-sponsored health insurance coverage, 22 percent (57.9
15 million) had Medicaid coverage, and 7 percent (19.4 million) had non-group coverage, while 10.4
16 percent (27.9 million) remained uninsured.¹

17
18 Under the ACA, eligible individuals and families with incomes between 100 and 400 percent of the
19 federal poverty level (FPL) (between 133 and 400 percent FPL in Medicaid expansion states) are
20 being provided with refundable and advanceable premium credits that are inversely related to
21 income to purchase coverage on health insurance exchanges. Individuals eligible for premium
22 credits include individuals who are offered an employer plan that does not have an actuarial value
23 of at least 60 percent or if the employee share of the premium exceeds 9.78 percent of income in
24 2020. In addition, individuals and families with incomes between 100 and 250 percent FPL
25 (between 133 and 250 percent FPL in Medicaid expansion states) also qualify for cost-sharing
26 subsidies if they select a silver plan, which reduces their deductibles, out-of-pocket maximums,
27 copayments and other cost-sharing amounts. At the time that this report was written, 38 states and
28 the District of Columbia had adopted the Medicaid expansion provided for in the ACA, which
29 extended Medicaid eligibility to individuals with incomes up to 133 percent FPL.²

30
31 The AMA proposal for reform focuses on expanding health insurance coverage to four main
32 population targets:

33
34 1. Individuals eligible for ACA's premium tax credits who remain uninsured (9.2 million in
35 2018);
36 2. Individuals eligible for Medicaid or the Children's Health Insurance Program (CHIP) who
37 remain uninsured (6.7 million in 2018);
38 3. People that remain uninsured who are ineligible for ACA's premium tax credits due to
39 income or an offer of "affordable" employer-sponsored coverage (5.7 million in 2018); and
40 4. People with low incomes that remain uninsured and are ineligible for Medicaid (2.3
41 million in 2018).³

42
43 By appropriately targeting the provision of coverage to the uninsured population, [the AMA](#)
44 [proposal for reform](#) as follows has the potential to make significant strides in covering the
45 remaining uninsured and providing health insurance to millions more Americans:

46
47 • Premium tax credits would be available to individuals without an offer of "affordable"
48 employer coverage, with no upper income limit (Policy H-165.824).
49 • Individuals currently caught in the "family glitch" and unable to afford coverage offered
50 through their employers for their families would become eligible for ACA financial
51 assistance based on the premium for family coverage of their employer plan (Policy

1 H-165.828). Currently, in determining eligibility for premium tax credits, coverage for
2 family members of an employee is considered to be affordable as long as employee-only
3 coverage is affordable. The employee-only definition of affordable coverage pertaining to
4 employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not
5 take into consideration the cost of family-based coverage, which commonly is much more
6 expensive than employee-only coverage. As a result, the "family glitch" leaves many
7 workers and their families ineligible to receive premium and cost-sharing subsidies to
8 purchase coverage on health insurance exchanges, even though in reality they would likely
9 have to pay well over 9.78 percent of their income for family coverage.

10 • To help employees currently having difficulties affording coverage, the threshold used to
11 determine the affordability of employer coverage would be lowered, which would make
12 more people eligible for ACA financial assistance based on income (Policy H-165.828).
13 • The generosity of premium tax credits would be increased to improve premium
14 affordability, by tying premium tax credit size to gold-level instead of silver-level plan
15 premiums, and/or lowering the cap on the percentage of income individuals are required to
16 pay for premiums of the benchmark plan (Policy H-165.824).
17 • Young adults facing high premiums would be eligible for "enhanced" tax credits based on
18 income (Policy H-165.824).
19 • Eligibility for cost-sharing reductions would be expanded to help more people with the
20 cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
21 • The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens
22 many individuals with low incomes face, which impact their ability to access and afford
23 the care they need (Policy H-165.824).
24 • A permanent federal reinsurance program would be established, to address the impact of
25 high-cost patients on premiums (H-165.842).
26 • State initiatives to expand their Medicaid programs will continue to be supported. To
27 incentivize expansion decisions, states that newly expand Medicaid would still be eligible
28 for three years of full federal funding (Policies D-290.979 and H-290.965).
29 • To maximize coverage rates, the AMA would continue to support reinstating a federal
30 individual mandate penalty, as well as state efforts to maximize coverage, including
31 individual mandate penalties and auto-enrollment mechanisms (Policies H-165.848 and
32 H-165.824).
33 • To improve coverage rates of individuals eligible for either ACA financial assistance or
34 Medicaid/CHIP but who remain uninsured, the AMA would support investments in
35 outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971,
36 H-290.982 and D-290.982).
37 • States would continue to have the ability to test different innovations to cover the
38 uninsured, provided such experimentations: a) meet or exceed the projected percentage of
39 individuals covered under an individual responsibility requirement while maintaining or
40 improving upon established levels of quality of care; b) ensure and maximize patient
41 choice of physician and private health plan; and c) include reforms that eliminate denials
42 for pre-existing conditions (Policy D-165.942).
43

44 APPROACHES TO A PUBLIC OPTION

45 As evidenced by the House of Delegates' discussion of this item at the 2019 Annual Meeting, the
46 term "public option" can be interpreted to include different proposals to expand public coverage. In
47 general, proposals to expand public coverage can range from creating a public option on health
48 insurance exchanges, to allowing people to buy into Medicare or Medicaid. In addition, proposals
49 have explored leveraging the FEHBP and state employee benefit plans to increase the plan
50 offerings available to individuals seeking exchange coverage.
51

1 *Public Option on Exchanges*

2
3 In general, proposals put forward in Congress to establish a public option on the exchanges rely on
4 components of the Medicare program both for structure and to keep plan costs down. The public
5 option would be available to individuals and/or employers eligible to purchase such coverage.
6 Under these proposals, Medicare participating providers could potentially be required to participate
7 in the public option. Proposals differ in their approaches to provider opt-out provisions, and
8 whether providers in Medicaid would also be required to participate in the public option. Most
9 public option proposals would also base provider payment rates on Medicare, either extending
10 Medicare payment rates or using Medicare rates as a guide to establish payment levels. Individuals
11 who qualify for premium tax credits and cost-sharing subsidies could use such subsidies to
12 purchase the public option. All public option proposals would cover essential health benefits as
13 required under the ACA, with some proposals covering more benefits.

14
15 State public option proposals vary in their structure and scope, and how they leverage
16 Medicare/Medicaid payment rates, as well as state employee plans. For example, Washington's
17 public option, Cascade Care, which was enacted in 2019, aims to increase coverage options on
18 *Washington Healthplanfinder* by requiring the state health care authority to contract with one or
19 more health insurance carriers to offer a public option plan at the bronze, silver and gold levels by
20 January 1, 2021. At the time that this report was written, five insurance carriers had applied to offer
21 public option plans in a majority of counties across the state.⁴ Washington's public option is not a
22 fully public option governed exclusively by the state; rather, it is a blended public-private
23 approach. The state will contract with private insurers to administer the state-sponsored plan but
24 maintain control of the terms to manage cost.

25
26 Cascade Care carriers must cap payment of providers and facilities at a maximum of 160 percent of
27 Medicare rates but excluding pharmacy benefits. Payment for critical access hospitals and sole
28 community hospitals may not be less than 101 percent of Medicare's allowable cost. Of note,
29 payment for primary care services provided by physicians in family medicine, general internal
30 medicine, or pediatric medicine may not be less than 135 percent of the amount that Medicare pays
31 for the same or similar services.⁵ There is not a defined floor for payment for services provided by
32 specialists outlined in the law.

33
34 Importantly, the Council notes that adding a public option to health insurance exchanges may not
35 necessarily achieve significant additional coverage gains, compared to proposals to build upon the
36 ACA. Many of the proposals that aim to cover more people under the ACA are included in the
37 AMA proposal for reform. For example, the Urban Institute in October 2019 [modeled the coverage](#)
38 [and cost impacts of various health reform options](#). It found that, after implementing a range of
39 proposals to build upon and improve the ACA – including enhancing and extending subsidies for
40 marketplace coverage, establishing a permanent reinsurance program, restoring the ACA's
41 individual mandate, addressing the Medicaid eligibility gap in non-expansion states, and allowing
42 for limited Medicaid autoenrollment – 21.4 million individuals would be uninsured in 2020. When
43 a public option is added to these ACA improvement provisions, 21.3 million individuals would still
44 be uninsured in 2020. Under this scenario, adding a public option would not achieve meaningful
45 additional coverage gains, as the public option would only lower health insurance premiums for
46 individuals not eligible for subsidies in the nongroup market, which would be a smaller population
47 after the implementation of the aforementioned ACA improvements. That being said, adding a
48 public option was shown to meaningfully lower federal spending on subsidies for marketplace
49 coverage, as lower premiums, premised on lower provider payment rates, would lead to lower
50 premium tax credit amounts.⁶

1 Similarly, in [a March 2020 brief that assessed the impacts of various public option designs](#), the
2 Urban Institute found that “[a] public option’s largest effects are on government and private
3 spending—not on insurance coverage, unless paired with other reforms, such as enhanced premium
4 tax credits and strategies to provide subsidized coverage for more low-income adults in states that
5 have not expanded Medicaid eligibility.” As evidence of its finding, Urban Institute estimated that
6 introducing a public option into the nongroup market would cause a small decrease in the number
7 of uninsured Americans – ranging from approximately 155,000 to 230,000 in 2020.⁷

8
9 In May 2020, RAND Corporation released a report that assessed the impact of four public option
10 alternatives: 1) coverage offered off of the ACA marketplaces, with provider payment set at 79
11 percent of commercial rates; 2) coverage offered on the ACA marketplaces, with provider payment
12 set at 79 percent of commercial rates; 3) coverage offered on the ACA marketplaces, with provider
13 payment set at 93 percent of commercial rates; and 4) coverage offered on the ACA marketplaces,
14 with provider payment set at 93 percent of commercial rates, and eligibility for ACA’s premium
15 tax credits extended to 500 percent FPL. Overall, the RAND analysis found that changes to the
16 number of the uninsured resulting from the introduction of a public option in scenarios 2, 3 and 4
17 would be small, with the first alternative having the largest impact on the uninsured. Notably, there
18 was also a shift in enrollment from private individual market plans to public plans, due in large part
19 to the lower premium of the public option, driven by lower provider payment rates. The analysis
20 also showed that the introduction of a public option could reduce premium tax credit amounts and
21 increase premiums for private ACA marketplace plans. As such, while some individuals would be
22 better off with a public option, those who would be worse off would likely be those with lower
23 incomes who would be eligible for smaller premium tax credits as a result.⁸

24
25 *Broader Availability of a Public Option*

26
27 Proposals introduced in Congress would also leverage a public option that relies heavily on
28 Medicare and Medicaid payment rates to achieve near-universal coverage. Unlike federal and state
29 legislation that proposes offering a public option on ACA marketplaces, which would be available
30 only to marketplace participants and keep the ACA’s eligibility criteria for premium tax credits and
31 cost-sharing subsidies the same, more expansive public option proposals would also open up the
32 public option and eligibility for premium and cost-sharing assistance to individuals who are offered
33 affordable employer-sponsored coverage. As a result, these proposals to establish a public option
34 would be expected to cause crowd-out from employer-sponsored coverage, as well as higher
35 enrollment in the public option, which would impact the payer mix of physician practices. In
36 addition, as employer-sponsored health plans tend to have higher provider payment rates than
37 nongroup health plans, opening up a public option to individuals with employer-sponsored
38 coverage has the potential to significantly reduce provider revenues and cause disruptions in the
39 health care delivery system.⁹

40
41 For example, as an alternative to the traditional Medicare-for-All proposals, Representative Rosa
42 DeLauro (D-CT) introduced H.R. 2452, the Medicare for America Act of 2019. Unlike Medicare-
43 for-All, Medicare for America would allow large employers to continue providing health insurance
44 to their employees, if they provide gold-level coverage (i.e., 80 percent of benefits costs covered).
45 Alternatively, employers can direct their contributions for employee coverage toward paying for
46 premiums for Medicare for America. If employers continue to offer health insurance to their
47 employees, employees would have the ability to choose Medicare for America coverage instead of
48 their employer coverage. There would also be premiums and cost-sharing under Medicare for
49 America, but notably, there would be no deductibles. Premiums would be on a sliding scale based
50 on income, with individuals with incomes below 200 percent FPL having no premium, deductible
51 or out-of-pocket costs. Premiums overall would be capped at no more than eight percent of

1 monthly income. Individuals and families with incomes between 200 and 600 percent FPL would
2 be eligible to receive subsidies to lower their premium contributions, with current Medicare
3 beneficiaries either paying the premium for which they are responsible under Medicare, or that of
4 Medicare for America, whichever is less expensive. Out-of-pocket maximums would also be
5 applied on a sliding scale based on income, with the caps being \$3,500 for an individual and
6 \$5,000 for families. Provider payment under Medicare for America would be based largely on
7 Medicare and Medicaid rates, with increases in payment for primary care, mental and behavioral
8 health, and cognitive services, and the Secretary being given the authority to establish a rate
9 schedule for services currently not paid for under Medicare. Participating providers under Medicare
10 or Medicaid would be considered to be participating providers under Medicare for America.^{10,11}

11

12 In addition, former Vice President Joe Biden, the Democratic presidential nominee, in conjunction
13 with Senator Bernie Sanders (I-VT), put forward the Biden-Sanders Unity Task Force
14 recommendations, which included provisions related to a public option. The recommendations
15 called for the establishment of a public option administered by the Centers for Medicare &
16 Medicaid Services that would be available to individuals covered by employer-sponsored coverage
17 (regardless of whether such coverage is affordable), those with individually purchased coverage,
18 and the uninsured. Significantly, uninsured individuals who fall in the coverage gap – not eligible
19 for Medicaid, and not eligible for tax credits because they reside in states that did not expand
20 Medicaid – would be automatically enrolled in a premium-free public option, with the ability to opt
21 out should they choose. The public option would also be a health plan choice for older members of
22 the workforce, along with their employer-sponsored plan, and the ability to enroll in Medicare at
23 the age of 60. The public option would be required to provide at least one plan choice without
24 deductibles, would cover all primary care without any cost-sharing, and would negotiate prices
25 with physicians and hospitals to control costs for other treatments and services, “just like Medicare
26 does on behalf of older people.”¹²

27

28 The Biden-Sanders Unity Task Force recommendations also called for leveraging a public option
29 in the context of a health emergency, which would include the COVID-19 pandemic. First, when
30 an individual’s eligibility for Consolidated Omnibus Budget Reconciliation Act (COBRA)
31 coverage expires, the recommendations call for workers whose incomes would qualify them for a
32 zero-premium public option to be automatically enrolled in the public option, with the ability to opt
33 out. In addition, the recommendations support automatically enrolling in the public option
34 individuals eligible for a zero-premium public option, and individuals enrolled in any social safety
35 net program for low-income Americans, such as the Supplemental Nutrition Assistance Program
36 (SNAP) and Temporary Assistance for Needy Families (TANF).¹³

37

38 *Medicare Buy-In*

39

40 Senator Debbie Stabenow (D-MI) introduced S. 470, the Medicare at 50 Act, and Congressman
41 Brian Higgins (D-NY) introduced H.R. 1346, the Medicare Buy-In and Health Care Stabilization
42 Act of 2019, both of which would enable individuals to buy in to Medicare at age 50. Premiums
43 would be based on estimating the average, annual per capita amount for benefits and administrative
44 expenses that would be payable under Parts A, B, and D for the buy-in populations. Notably,
45 individuals enrolled in the buy-in would receive financial assistance similar to that which they
46 would have received had they purchased a qualified health plan through the marketplace.^{14,15}

47

48 RAND Corporation has modeled various approaches to a Medicare buy-in to assess the impacts of
49 allowing individuals ages 50 to 64 to buy in to the Medicare program, including on total health
50 insurance enrollment. Across all approaches to a Medicare buy-in analyzed by RAND, 2.8 to 7
51 million older adults would enroll, with 6 million individuals enrolling under RAND’s base buy-in

1 scenario. This rate of take-up of a Medicare buy-in is due to the premiums for the buy-in being less
2 expensive than plans offered on the individual market – the result of factors including the buy-in
3 paying providers at Medicare rates. However, when these older adults exit the individual market,
4 premiums for plans offered on the individual market increase, as the remaining risk pool is smaller,
5 and comprised of less healthy and more expensive individuals considering their ages. Accordingly,
6 the RAND analysis showed that a Medicare buy-in has little to no effect on total health insurance
7 enrollment, as more older adults enrolling in health insurance pursuant to the establishment of the
8 buy-in is countered by more younger adults becoming uninsured.¹⁶
9

10 *Medicaid Buy-In*

11 Senator Brian Schatz (D-HI) and Congressman Ben Ray Luján (D-NM) introduced S. 489/H.R.
12 1277, the State Public Option Act. The legislation would give states the option to establish a
13 Medicaid buy-in plan for residents regardless of income. For individuals ineligible for premium tax
14 credits, their premiums cannot exceed 9.5 percent of household income. However, if these
15 individuals were to enroll in other plans on state ACA marketplaces, their premiums would not be
16 capped as a percentage of their income. In terms of physician payment rates, the State Public
17 Option Act would make permanent a payment increase to Medicare levels for a range of primary
18 care providers.^{17,18} Understandably, this approach to a Medicaid buy-in is more likely to be taken
19 up by states that have expanded Medicaid versus states that have not. Urban Institute, in analyzing
20 this approach to a Medicaid buy-in, found that, while it may not have a meaningful impact in states
21 with competitive markets, it could make a difference in states with limited insurer competition and
22 high premiums.¹⁹
23

24 As state Medicaid programs are different, Medicaid buy-in proposals can be expected to vary from
25 state to state. For example, a Medicaid buy-in can be offered on the exchanges (potentially a
26 Medicaid managed care plan), or a Medicaid-like program could be offered off of the exchanges.
27 Such design differences could impact the ability of individuals to use ACA subsidies to purchase
28 Medicaid buy-in coverage. Importantly, Medicaid buy-in proposals strive to not change the
29 existing Medicaid program for those currently eligible and enrolled. Approaches to physician
30 payment can vary as well, from using Medicaid or Medicare rates as a guide, to opening the door to
31 negotiated rates. Several states are considering a Medicaid buy-in approach, including New
32 Mexico, Delaware, Massachusetts and Oregon.
33

34
35 *Leveraging the Federal Employees Health Benefits Program (FEHBP) and State Employee Benefit
36 Plans*

37 The FEHBP provides health insurance coverage to federal employees, retirees, and their
38 dependents. By entering into contracts with qualified health insurance carriers, the US Office of
39 Personnel Management (OPM) offers through FEHBP two primary types of plans – fee-for-service
40 (FFS) plans (most of which have a preferred provider organization component) and health
41 management organization (HMO) plans. While FFS plans are offered nationwide to all enrollees,
42 HMO plans offer coverage in certain geographic areas. In reviewing health plans to be offered
43 under FEHBP, OPM considers the ability of plans to provide reasonable access to and choice of
44 primary and specialty medical care throughout the service area.
45

46 Leveraging health plan FEHBP participation has been included in a leading proposed solution to
47 prevent bare counties in the marketplaces. A 2017 bipartisan proposal to fix the ACA supported, in
48 the short-term, requiring the two largest FEHBP insurers in any county to offer at least one silver-
49 level plan through the federal exchange in all counties that would otherwise be without coverage as
50 a condition of participation in FEHBP. These plans would be eligible for premium tax credits and

1 could otherwise charge actuarially appropriate premiums.²⁰ In addition, last Congress,
2 Representative Darrell Issa (R-CA) introduced legislation to allow individuals who are not federal
3 employees to enroll in FEHBP unless the individual is enrolled, or eligible to enroll, in a different
4 public health insurance program; or is a member of the uniformed services.²¹

5
6 Some states are exploring leveraging state employee benefit plans to bolster proposed public
7 options, or to increase exchange plan offerings available. For example, the public option legislation
8 passed in the state of Washington requires the state authority to submit a report to the legislature by
9 December 1, 2022, that addresses the impact on exchange market choices, affordability, and
10 stability of linking a carrier's ability to offer a state-contracted public option with their
11 participation in programs administered by the public employees' benefits board, the school
12 employees' benefits board, or the health care authority; and the impact on the exchange market of
13 requiring providers who participate in the aforementioned programs to participate in public option
14 plan networks.²² In addition, an option available to potentially increase exchange plan offerings is
15 to require plans that participate in state employee benefit plans to offer plans on the exchange.

16
17 *Relevant AMA Policy*
18

19 Policy H-165.838 states that insurance coverage options offered in a health insurance exchange
20 should be self-supporting; have uniform solvency requirements; not receive special advantages
21 from government subsidies; include payment rates established through meaningful negotiations and
22 contracts; not require provider participation; and not restrict enrollees' access to out-of-network
23 physicians. Policy H-165.825 states that the largest two FEHBP insurers in counties that lack a
24 marketplace plan should be required to offer at least one silver-level marketplace plan as a
25 condition of FEHBP participation.

26
27 Addressing a Medicare buy-in, Policy H-330.896 states that Medicare's age-eligibility
28 requirements and incentives should be restructured to match the Social Security schedule of
29 benefits. Concerning Medicaid expansion, Policy D-290.979 advocates working with interested
30 states to expand Medicaid eligibility in their states to 133 percent of the federal poverty level.

31
32 ACHIEVING HIGHER COVERAGE RATES THROUGH AUTO-ENROLLMENT
33

34 In 2018, 27.9 million nonelderly individuals (10.4 percent) were uninsured, an increase from the
35 27.4 million (10.2 percent) who were uninsured in 2017.²³ Nearly seven million of the nonelderly
36 uninsured were eligible for Medicaid or CHIP. More than nine million nonelderly individuals were
37 eligible for premium tax credits provided for under the ACA.²⁴ In December 2019, the Kaiser
38 Family Foundation estimated that, of the uninsured who could purchase coverage on health
39 insurance exchanges, 4.7 million are eligible to purchase a zero-premium bronze plan (i.e., 60
40 percent of benefits costs covered) after subsidies in 2020.²⁵

41
42 The elimination of the federal individual mandate penalty as a part of tax reform legislation enacted
43 in December 2017, as well as job losses amid the COVID-19 pandemic, raise the need to examine
44 alternative approaches to maximize coverage rates. Resulting from the reality that a significant
45 proportion of the uninsured and newly unemployed are eligible for no- or low-cost coverage
46 provided for under the ACA, auto-enrollment has emerged as a prominent policy option. Federal
47 and/or state auto-enrollment approaches could address auto-enrollment in marketplace coverage,
48 Medicaid/CHIP and employer coverage.

1 Any auto-enrollment program needs to address four policy challenges:

2

3 1. How to obtain eligibility information so uninsured individuals can be identified and
4 matched to coverage for which they are eligible, including Medicaid/CHIP and
5 marketplace coverage, as well as premium tax credits.

6 2. How to collect premiums, if applicable.

7 3. How to assign individuals to an insurance plan.

8 4. How to manage situations where individuals are auto-enrolled into coverage for which
9 they are not eligible, or remain uninsured despite believing they were enrolled in health
10 insurance coverage.²⁶

11

12 There are multiple approaches to auto-enrollment. First, states and/or the federal government can
13 pursue tax-based auto-enrollment, under which individuals at the time of tax filing would either
14 indicate whether or not they had health insurance coverage, and/or authorize the state or federal
15 entity to determine eligibility for Medicaid/CHIP, or free or low-cost health insurance offered on
16 the marketplaces. Once coverage determinations take place, auto-enrollment can occur that results
17 in coverage for the upcoming year or coverage could be applied retroactively. Under traditional
18 auto-enrollment programs, individuals could either be auto-enrolled in Medicaid/CHIP, as well as
19 no-premium bronze plans if they are eligible; a special enrollment period could be established for
20 individuals who qualify for premium tax credits for marketplace coverage; and/or targeted outreach
21 activities could be implemented to facilitate the health insurance enrollment of those eligible for
22 premium tax credits and Medicaid/CHIP.

23

24 For example, the Maryland Easy Enrollment Health Insurance Program, enacted in 2019, is taking
25 steps to use a tax-based approach to auto-enrollment. Under the first phase of the program,
26 individuals check a box on their tax return to indicate any uninsured household members, and then
27 have a choice of providing authorization to the state to share information from their tax return with
28 the state exchange to determine their eligibility for no- or low-cost insurance. If individuals grant
29 the state authorization, the state exchange makes a preliminary eligibility determination and sends
30 out a written notice to the household. While individuals must use traditional channels to sign up for
31 marketplace coverage, they are granted a special enrollment period so they can sign up for
32 coverage after tax filing, versus waiting for the next open enrollment period. In the second phase of
33 implementation, which commences January 2021, the state is striving for real-time eligibility
34 determinations; automatic Medicaid enrollment; and streamlined marketplace plan enrollment,
35 again coupled with the use of a special enrollment period.²⁷

36

37 Auto-enrollment in health insurance coverage could also be implemented retroactively. For
38 example, individuals uninsured at the time of tax filing could be considered covered by a “backstop
39 plan” for each month of the previous year they were uninsured. As a result, these individuals would
40 pay premiums retroactively for the backstop coverage, which would be income-adjusted. If they
41 accessed health care services during their time of being uninsured and retroactively covered by the
42 backstop plan, the backstop plan would pay their claims.

43

44 If disconnected from tax filing, auto-enrollment programs could also leverage existing state
45 systems, such as automobile registration and drivers’ license renewal, or could be implemented in
46 partnership with health care providers, clinics and hospitals. Relevant to the tens of millions of
47 Americans who are projected to lose their employer-sponsored health insurance coverage resulting
48 from the COVID-19 pandemic, state unemployment insurance systems could be leveraged to
49 facilitate enrollment in no- or low-cost health insurance for which the newly unemployed are
50 eligible.

1 *Relevant AMA Policy*

2
3 Policy H-165.824 encourages state innovation, including considering state-level individual
4 mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and
5 stabilize health insurance premiums without undercutting any existing patient protections. Policy
6 H-165.855 states that, should tax credits be given to Medicaid beneficiaries, that they be given a
7 choice of coverage, and that a mechanism be developed to administer a process by which those
8 who do not choose a health plan will be assigned a plan in their geographic area through auto-
9 enrollment until the next enrollment opportunity. The policy also stipulates that patients who have
10 been auto-enrolled should be permitted to change plans any time within 90 days of their original
11 enrollment.

12
13 DISCUSSION
14

15 The AMA proposal for reform has the potential to make significant strides in covering the
16 remaining uninsured and providing health insurance to millions more Americans. However, the
17 Council sees an opportunity to further maximize coverage rates and improve coverage affordability
18 under the AMA proposal for reform by establishing new policy on a public option, as well as auto-
19 enrollment in health insurance coverage. The Council stresses that both approaches cannot be
20 implemented without safeguards in place to protect patients, as well as physicians and their
21 practices.

22
23 The Council is aware of the growing interest within the House of Delegates for our AMA to
24 support a public option. However, the term “public option” has several different meanings, and
25 blanket support for a public option without safeguards in place could have negative consequences
26 for physicians and their practices. For example, public option proposals that allow individuals with
27 affordable employer coverage to qualify for premium and cost-sharing subsidies and enroll in a
28 public option could significantly change the payer mix of physician practices, especially if payment
29 rates under the public option are tied to or guided by Medicare and/or Medicaid payment rates.
30 Regardless of the public option design, payment rates need to be established through meaningful
31 negotiations and contracts and must not be tied to or guided by Medicare and/or Medicaid rates.
32 Physician freedom of practice needs to also be at the forefront of assessing any public option
33 proposal and, as such, public option proposals should not require provider participation, and/or tie a
34 provider’s participation in Medicare, Medicaid and/or any commercial product to participation in
35 the public option. Public options need to be financially self-sustaining and not receive
36 advantageous government subsidies, so they do not place stressors on other funding streams of
37 government health programs, such as the Medicare Trust Fund.

38
39 If all criteria established by the policy proposed by the Council in this report are met, there is the
40 potential for the AMA to support a public option, as it would provide patients with another choice
41 of health plan. As such, a primary goal of establishing a public option should be to maximize
42 patient choice of health plan and maximize health plan marketplace competition. The Council
43 recognizes public options could be designed in many ways, and as a result could have various
44 coverage and affordability impacts. Overall, with guardrails in place to protect patients and
45 physicians, the Council underscores that a public option should not be seen as a panacea to cover
46 the uninsured. The Council reiterates that, in the meantime, in the event of bare counties in the
47 ACA marketplaces, Policy H-165.825 supports that the largest two FEHBP insurers in counties that
48 lack a marketplace plan should be required to offer at least one silver-level marketplace plan as a
49 condition of FEHBP participation.

1 On the other hand, the Council sees tremendous potential in the use of auto-enrollment to improve
2 the coverage reach of the AMA proposal for reform, especially amid the COVID-19 pandemic. In
3 2018, 57 percent of the nonelderly uninsured was eligible for financial assistance – either through
4 Medicaid/CHIP, or via premium tax credits to purchase marketplace coverage as provided for
5 under the ACA. In addition, a substantial percentage of the newly unemployed are eligible for
6 Medicaid or premium tax credits to purchase ACA marketplace coverage. As such, a significant
7 number of uninsured Americans are currently eligible for no- or low-cost coverage but are not
8 enrolled. The Council believes that states and the federal government should seriously consider the
9 use of auto-enrollment to maximize coverage rates, alongside key improvements to the ACA as
10 outlined in the [AMA proposal for reform](#).

11
12 After providing consent to applicable state and/or federal entities to share their health insurance
13 status and tax data, the Council believes that individuals should only be auto-enrolled in health
14 insurance coverage if coverage options are available at no cost to them after any applicable
15 subsidies. As such, candidates for auto-enrollment would be individuals eligible for
16 Medicaid/CHIP or zero-premium marketplace coverage, unless they choose to opt out. Individuals
17 who are auto-enrolled should not be penalized if they are auto-enrolled into coverage for which
18 they are not eligible or remain uninsured despite believing they were enrolled in health insurance
19 coverage via auto-enrollment. Individuals eligible for zero-premium marketplace coverage should
20 be randomly assigned among plans with the highest actuarial value with a zero-dollar premium
21 option, and plans should be incentivized to offer pre-deductible coverage including physician
22 services to maximize the value of zero-premium plans to patients. Individuals enrolled in a zero-
23 premium bronze plan who would otherwise qualify for significant cost-sharing reductions if they
24 enrolled in a silver plan (70 percent of benefits costs covered) should be notified of their eligibility
25 for cost-sharing reductions, and what enrolling in a silver plan would mean in terms of differences
26 in out-of-pocket responsibilities, so they could be appropriately informed in advance of the
27 subsequent open enrollment period. In this scenario, to assist with out-of-pocket responsibilities of
28 the bronze plan into which they are enrolled in the meantime, the Council recommends
29 reaffirmation of Policy H-165.824, which supports these individuals having access to a health
30 savings account (HSA) partially funded by an amount determined to be equivalent to the cost-
31 sharing subsidy.

32
33 To facilitate health insurance enrollment of other individuals (eligible for coverage, but with a
34 premium after application of any subsidies), the Council also believes that there should be targeted
35 outreach promoting enrollment. In addition, states and/or the federal government should consider
36 establishing a special enrollment period for these individuals to enroll in the coverage of their
37 choosing so they do not have to wait until the next open enrollment period to get covered.

38
39 The Council believes that, in the absence of a federal individual mandate penalty and as millions of
40 Americans have lost their employer-sponsored health insurance coverage resulting from the
41 COVID-19 pandemic, there needs to be a mechanism in AMA policy to ensure that the AMA
42 proposal for reform can maximize its coverage potential and reach. Physicians have the
43 responsibility to advocate for improving health insurance coverage and health care access so that
44 patients receive timely, high quality care, preventive services, medications and other necessary
45 treatments. The Council believes its recommendations address gaps in AMA policy with respect to
46 covering the uninsured and improving affordability, which are necessary to ensure that our patients
47 are able to secure affordable and meaningful coverage, and access the care that they need.

1 RECOMMENDATIONS

2

3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 113-A-19, Resolution 114-A-19, the alternate resolution proposed by Reference Committee A, and
5 the amendment offered during the House of Delegates' consideration of item 9 of the report of
6 Reference Committee A, and that the remainder of the report be filed.

7

8 1. That our American Medical Association (AMA) support that a public option to expand health
9 insurance coverage must meet the following standards:

10

11 a. The primary goals of establishing a public option are to maximize patient choice of
12 health plan and maximize health plan marketplace competition.

13 b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public
14 option is restricted to individuals without access to affordable employer-sponsored
15 coverage.

16 c. Physician payments under the public option are established through meaningful
17 negotiations and contracts. Physician payments under the public option must not be
18 tied to Medicare and/or Medicaid rates.

19 d. Physicians have the freedom to choose whether to participate in the public option.
20 Public option proposals should not require provider participation and/or tie physician
21 participation in Medicare, Medicaid and/or any commercial product to participation in
22 the public option.

23 e. The public option is financially self-sustaining and has uniform solvency requirements.

24 f. The public option does not receive advantageous government subsidies in comparison
25 to those provided to other health plans. (New HOD Policy)

26

27 2. That our AMA support states and/or the federal government pursuing auto-enrollment in health
28 insurance coverage that meets the following standards:

29

30 a. Individuals must provide consent to the applicable state and/or federal entities to share
31 their health insurance status and tax data with the entity with the authority to make
32 coverage determinations.

33 b. Individuals should only be auto-enrolled in health insurance coverage if they are
34 eligible for coverage options that would be of no cost to them after the application of
35 any subsidies. Candidates for auto-enrollment would, therefore, include individuals
36 eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium
37 marketplace coverage.

38 c. Individuals should have the opportunity to opt out from enrolling in health insurance
39 coverage.

40 d. Individuals should not be penalized if they are auto-enrolled into coverage for which
41 they are not eligible or remain uninsured despite believing they were enrolled in health
42 insurance coverage via auto-enrollment.

43 e. Individuals eligible for zero-premium marketplace coverage should be randomly
44 assigned among the zero-premium bronze plans with the highest actuarial values.

45 f. Health plans should be incentivized to offer pre-deductible coverage including
46 physician services in their bronze plans, to maximize the value of zero-premium plans
47 to plan enrollees.

48 g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing
49 reductions should be notified of the cost-sharing advantages of enrolling in silver
50 plans.

1 h. There should be targeted outreach and streamlined enrollment mechanisms promoting
2 health insurance enrollment, which could include raising awareness of the availability
3 of premium tax credits and cost-sharing reductions, and establishing a special
4 enrollment period. (New HOD Policy)

5

6 3. That our AMA reaffirm Policy H-165.825, which states that the largest two Federal Employees
7 Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan should be
8 required to offer at least one silver-level marketplace plan as a condition of FEHBP
9 participation. (Reaffirm HOD Policy)

10

11 4. That our AMA reaffirm Policy H-165.828, which encourages the development of
12 demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego
13 these subsidies by enrolling in a bronze plan, to have access to a health savings account
14 partially funded by an amount determined to be equivalent to the cost-sharing subsidy.
15 (Reaffirm HOD Policy)

Fiscal Note: Less than \$500

REFERENCES

¹ Kaiser Family Foundation. State Health Facts. Health Insurance Coverage of Nonelderly 0-64. Available at: <https://www.kff.org/other/state-indicator/nonelderly-0-64/?dataView=1¤tTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

² Kaiser Family Foundation. Status of State Action on the Medicaid Expansion Decision. August 17, 2020. Available at: <https://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

³ Tolbert, J et al. Key Facts about the Uninsured Population. Kaiser Family Foundation. December 13, 2019. Available at: <https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/>.

⁴ Washington Governor Jay Inslee. Inslee Announces Five Carriers Intend to Participate in Public Option. July 7, 2020. Available at: <https://www.governor.wa.gov/news-media/inslee-announces-five-carriers-intend-participate-public-option>.

⁵ Initial draft of the quality, value, and affordability standards for Cascade Care public option plans offered for 2021, as directed by Senate Bill 5526, WASH. ST. HEALTH CARE AUTHORITY. Available at: <https://www.hca.wa.gov/assets/program/cascade-care-quality-value-and-affordability-standards.pdf>.

⁶ Blumberg, L et al. From Incremental to Comprehensive Health Insurance Reform: How Various Reform Options Compare on Coverage and Costs. Urban Institute. October 2019. Available at: https://www.urban.org/sites/default/files/2019/10/15/from_incremental_to_comprehensive_health_insurance_reform-how_various_reform_options_compare_on_coverage_and_costs.pdf.

⁷ Blumberg, L et al. Introducing a Public Option or Capped Provider Payment Rates into Private Insurance Markets. Urban Institute. March 2020. Available at: <https://www.urban.org/sites/default/files/introducing-a-public-option-or-capped-provider-payment-rates-into-private-insurance-markets.pdf>.

⁸ Liu J, Wilks A, Nowak S, Rao P, and Eibner C. Public Options for Individual Health Insurance: Assessing the Effects of Four Public Option Alternatives. RAND Corporation. May 2020. Available at: https://www.rand.org/pubs/research_reports/RR3153.html.

⁹ Blumberg, *supra* note 7.

¹⁰ Summary: The Medicare for America Act of 2019. Available at: <https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf>.

¹¹ HR 2452, the Medicare for America Act of 2019. Available at: <https://www.congress.gov/116/bills/hr2452/BILLS-116hr2452ih.pdf>.

¹² Biden-Sanders Unity Task Force Recommendations. July 2020. Available at: <https://joebiden.com/wp-content/uploads/2020/08/UNITY-TASK-FORCE-RECOMMENDATIONS.pdf>.

¹³ *Ibid.*

¹⁴ S 470, the Medicare at 50 Act. Available at: <https://www.congress.gov/116/bills/s470/BILLS-116s470is.pdf>.

¹⁵ HR1346, the Medicare Buy-In and Health Care Stabilization Act of 2019. Available at: <https://www.congress.gov/116/bills/hr1346/BILLS-116hr1346ih.pdf>.

¹⁶ Eibner, C et al. Medicare for 50-to-64-Year-Olds: Assessing the Effects of Allowing Older Adults to Buy Into the Medicare Program. RAND Corporation. November 2019. Available at: https://www.rand.org/pubs/research_reports/RR4246.html.

¹⁷ S 489, the State Public Option Act. Available at: <https://www.congress.gov/116/bills/s489/BILLS-116s489is.pdf>.

¹⁸ HR 1277, the State Public Option Act. Available at: <https://www.congress.gov/116/bills/hr1277/BILLS-116hr1277ih.pdf>.

¹⁹ Holahan, J and Blumberg, L. The Implications of a Medicaid Buy-In Proposal. Urban Institute. January 2018. Available at: https://www.urban.org/sites/default/files/publication/95961/2001672_medicaid_buy_in_2018.pdf.

²⁰ Health Reform Roundtable. A Bipartisan Answer to “What Now?” for Health Reform. August 8, 2017. Available at: <http://www.convergencepolicy.org/wp-content/uploads/2017/06/FINAL-Roundtable-statement-8.7.17.pdf>.

²¹ HR 2400, to amend title 5, United States Code, to allow individuals who are not Federal employees to enroll in the Federal Employees Health Benefits Program, and for other purposes. Available at: <https://www.congress.gov/115/bills/hr2400/BILLS-115hr2400ih.pdf>.

²² Washington State Legislature. Engrossed Substitute Senate Bill 526. July 28, 2019. Available at: <http://lawfilesext.leg.wa.gov/biennium/2019-20/Pdf/Bills/Session%20Laws/Senate/5526-S.SL.pdf#page=1>

²³ KFF, *supra* note 1.

²⁴ Tolbert, *supra* note 3.

²⁵ Fehr, R et al. How Many of the Uninsured Can Purchase a Marketplace Plan for Free in 2020? Kaiser Family Foundation. December 10, 2019. Available at: <https://www.kff.org/private-insurance/issue-brief/how-many-of-the-uninsured-can-purchase-a-marketplace-plan-for-free-in-2020/>.

²⁶ Linke Young, C. Three Ways to Make Health Insurance Auto-Enrollment Work. USC-Brookings Schaeffer Initiative for Health Policy. June 2019. Available at: https://www.brookings.edu/wp-content/uploads/2019/06/Yonu_Autoenrollment_6.19.19.pdf.

²⁷ Dorn, S. Automatic Enrollment. Presentation on January 27, 2020.

REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Medicare Prescription Drug and Vaccine Coverage and Payment
(Resolution 203-A-19)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2019 Annual Meeting, the House of Delegates referred Resolution 203, “Medicare Part B and Part D Drug Price Negotiation,” which was sponsored by the California Delegation. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates at the 2020 Annual Meeting. Resolution 203-A-19 asked:

That our American Medical Association (AMA): (1) advocate for Medicare to cover all physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B programs; (2) make it a priority to advocate for a mandate on pharmaceutical manufacturers to negotiate drug prices with the Centers for Medicare & Medicaid Services (CMS) for Medicare Part D and Part B covered drugs; and (3) explore all options with the state and national specialty societies to ensure that physicians have access to reasonable drug prices for the acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling, and administration of the medications, to ensure access to high-quality, cost-effective care in a physician’s office.

Over the years, proposals aimed at lowering drug prices in Medicare Part B have also included provisions that would transition reimbursement for the cost of Part B drugs away from the current approach that is tied to average sales price (ASP) plus six percent (which has been reduced to 4.3 percent under the budget sequester). The Council recognizes that there has not yet been consensus among national medical specialty societies, and the house of medicine as a whole, concerning the preferred alternative(s) to using a rate tied to ASP to reimburse physicians and hospitals for the cost of Part B drugs. The Council believes, however, that the time is now for organized medicine to move forward with building consensus on which alternative methods would be preferred to reimburse physicians for the cost of Part B drugs. As a first step, our AMA should build upon past efforts and solicit input from national medical specialty societies and state medical associations for their recommendations to ensure adequate Part B drug reimbursement. Subsequently, the AMA should work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs.

The Council recognizes that coverage and payment policies concerning vaccines under Medicare Parts B and D may be impacting the utilization rates of adult vaccines by Medicare patients, and raises financial risk for patients and physicians. While our AMA has ample, strong policy in this space, which are being recommended for reaffirmation, the Council believes that it is imperative for our AMA to continue to work with interested stakeholders to improve utilization rates of adult vaccines by Medicare beneficiaries. Underscoring the importance of lowering drug prices in Medicare Part D, the Council recommends the reaffirmation of policies that support the elimination of Medicare’s prohibition on drug price negotiation; support CMS negotiating pharmaceutical pricing for all applicable medications covered by CMS, and outline safeguards to ensure that international drug price averages are used as a part of drug price negotiations in a way that upholds market-based principles and preserve patient access to necessary medications.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3, November 2020

Subject: Medicare Prescription Drug and Vaccine Coverage and Payment
(Resolution 203-A-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

1 At the 2019 Annual Meeting, the House of Delegates referred Resolution 203, “Medicare Part B
2 and Part D Drug Price Negotiation,” which was sponsored by the California Delegation. The Board
3 of Trustees assigned this item to the Council on Medical Service for a report back to the House of
4 Delegates at the 2020 Annual Meeting. Resolution 203-A-19 asked:

5
6 That our American Medical Association (AMA): (1) advocate for Medicare to cover all
7 physician-recommended adult vaccines in both the Medicare Part D and the Medicare Part B
8 programs; (2) make it a priority to advocate for a mandate on pharmaceutical manufacturers to
9 negotiate drug prices with the Centers for Medicare & Medicaid Services (CMS) for Medicare
10 Part D and Part B covered drugs; and (3) explore all options with the state and national
11 specialty societies to ensure that physicians have access to reasonable drug prices for the
12 acquisition of Medicare Part B physician-administered drugs and that Medicare reimburse
13 physicians for their actual drug acquisition costs, plus appropriate fees for storage, handling,
14 and administration of the medications, to ensure access to high-quality, cost-effective care in a
15 physician’s office.

16
17 This report provides background on how vaccines are covered and paid for under Medicare Parts B
18 and D; outlines proposals that would allow for drug price negotiation under Medicare Part D;
19 highlights approaches addressing drug prices and associated physician payment under Medicare
20 Part B; and presents policy recommendations.

21 MEDICARE COVERAGE OF AND PAYMENT FOR VACCINES

22
23 Vaccines are covered in Medicare under Parts B and D. Medicare Part B covers the Hepatitis B
24 vaccine for patients at high or intermediate risk; the influenza vaccine; the pneumococcal
25 pneumonia vaccine; and vaccines directly related to treatment of an injury or direct exposure to a
26 disease or condition (e.g., rabies, tetanus). In addition, should a vaccine become available for
27 coronavirus (COVID-19), it will be covered under Medicare Part B, with no cost-sharing for
28 Medicare beneficiaries for the vaccine itself or its administration.¹ At the time this report was
29 written, no COVID-19 vaccine had been approved by the US Food & Drug Administration (FDA).
30 Part D plans generally cover commercially available vaccines that Part B does not cover when they
31 are reasonable and necessary to prevent illness, with required co-insurance rates and copayment
32 amounts varying by plan. Vaccines covered under Part D could range from the shingles vaccine to
33 vaccines for Hepatitis A.

34
35 In terms of physician payment for vaccines under Medicare Part B, physicians submit claims to
36 their Medicare Administrative Contractor for the vaccine and its administration. When physicians
37 agree to accept assignment for both the vaccine and its administration, which is common, patients

1 do not have to pay copayments or any contribution towards their Part B deductible for the seasonal
2 influenza virus, pneumococcal, and Hepatitis B vaccines. Physicians who are in-network providers
3 of their patient's Medicare Advantage plan submit claims to the plan for payment.
4

5 Under Medicare Part D, there are multiple pathways for vaccine payment and administration.
6 Physicians may not be able to directly bill Part D plans for vaccines and their administration. In
7 some cases, patients may need to pay their physicians up front for Part D vaccines, and then submit
8 a claim to their Part D plan for reimbursement. If the physician's charge for the vaccine is greater
9 than the plan's allowable charge, the patient would then be responsible for paying the difference.
10 To limit patient out-of-pocket responsibilities, the physician can receive authorization, via a
11 vaccine-specific notice requested by the physician or Part D plan enrollee. The vaccine-specific
12 notice would provide the physician with instructions on how to receive a coverage authorization for
13 a vaccine and how to submit an out-of-network claim, the plan's vaccine reimbursement rates, and
14 any applicable cost-sharing responsibilities of the patient. In this situation, the physician would
15 agree to accept payment received by the patient's Part D plan as payment in full, and the patient
16 would pay the physician any cost-sharing amount required by their plan.
17

18 Alternatively, physicians can administer Part D vaccines and bill a patient's Part D plan through a
19 web-assisted out-of-network billing system. To participate in such a system, the physician would
20 enroll with a company with a portal through which they can electronically submit out-of-network
21 claims for Part D vaccines they administer to their patient, the Part D plan enrollee. In this
22 situation, the physician would also agree to accept payment received by the patient's Part D plan as
23 payment in full, and the patient would pay the physician any cost-sharing amount required by the
24 plan.
25

26 In addition, in some instances, prescriptions for Part D vaccines are transmitted to an in-network
27 pharmacy of a patient's Part D plan. After the prescription is transmitted to an in-network
28 pharmacy, there are two potential pathways for vaccine administration: the pharmacist administers
29 the vaccine if permitted under state law; or the pharmacy fills the prescription and distributes it to
30 the prescribing physician's office. In the latter scenario, the pharmacy bills the patient's Part D plan
31 for the vaccine itself, with the pharmacy receiving any cost-sharing amount for the vaccine, and the
32 physician receiving the cost-sharing associated with vaccine administration. Following the
33 administration of the vaccine, the patient can submit the physician prescriber's charge for vaccine
34 administration to their Part D plan for reimbursement.
35

36 Under Part D, vaccine administration costs are included as part of the negotiated price for a Part D
37 vaccine. Part D plans can charge a single vaccine administration fee for all vaccines or multiple
38 administration fees based on such factors as vaccine type and complexity of administration.
39

40 The complexity of Medicare Part D vaccine physician payment presents challenges and can add
41 administrative burdens and costs to physician practices. Due to the variation in vaccine
42 reimbursement rates of Part D plans, as well as the uncertainty of whether patients will be able to
43 fulfill their out-of-pocket responsibilities, physicians assume risk as they determine how much Part
44 D vaccine to stock, especially considering the need to stock vaccine products for other non-
45 Medicare age groups served by their practices. The mechanisms of payment for vaccines under Part
46 D exacerbate the issues faced by physician practices in having reimbursement not cover the true
47 costs of providing immunizations, which extend beyond the price of the vaccine. These additional
48 issues include the cost of vaccine storage equipment as well as administrative costs including
49 monitoring temperature, ordering, maintaining supply and minimizing waste. The Council
50 recognizes that smaller physician practices often encounter more challenges offering a full array of
51 vaccine products to their patients, due to factors including vaccine acquisition costs and difficulties.

1 In addition, vaccine utilization rates among adults enrolled in Medicare have historically been, and
2 continue to remain, low.² While the Affordable Care Act (ACA) drastically changed the cost-
3 sharing requirements for vaccines under private health plan coverage and Medicaid, the law did not
4 change cost-sharing requirements for vaccines covered under Medicare Part D. As a result,
5 approximately four percent or less of enrollees of either stand-alone or Medicare Advantage
6 prescription drug plans had access to ten vaccines without cost-sharing that are recommended by
7 Advisory Committee on Immunization Practices either generally for adults ages 65 and older, or
8 for adults with certain risk factors.³ This level of access to these vaccines with no cost-sharing
9 under Medicare Part D remained generally the same from 2015. Of note, no stand-alone Part D
10 plan covered these vaccines with zero cost-sharing between 2015 and 2017.⁴

11
12 *Relevant AMA Policy*
13

14 Policy D-440.981 states that our AMA will: (1) continue to work with CMS and provide comment
15 on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate
16 reimbursement for vaccines and their administration from all public and private payers;
17 (3) encourage health plans to recognize that physicians incur costs associated with the
18 procurement, storage and administration of vaccines that may be beyond the average wholesale
19 price of any one particular vaccine; and (4) advocate that a physician's office can bill Medicare for
20 all vaccines administered to Medicare beneficiaries and that the patient shall only pay the
21 applicable copay to prevent fragmentation of care.
22

23 Policy H-440.875 states that our AMA will aggressively petition CMS to include coverage and
24 payment for any vaccinations administered to Medicare patients that are recommended by the
25 Advisory Committee on Immunization Practices, the US Preventive Services Task Force
26 (USPSTF), or based on prevailing preventive clinical health guidelines. Policy H-440.860 supports
27 easing federally imposed immunization burdens by, for example: (i) Providing coverage for
28 Medicare-eligible individuals for all vaccines, including new vaccines, under Medicare Part B;
29 (ii) Creating web-based billing mechanisms for physicians to assess coverage of the patient in real
30 time and handle the claim, eliminating out-of-pocket expenses for the patient; and (iii) Simplifying
31 the reimbursement process to eliminate payment-related barriers to immunization. The policy also
32 states that CMS should raise vaccine administration fees annually, synchronous with the increasing
33 cost of providing vaccinations.
34

35 MEDICARE PART D DRUG PRICE NEGOTIATION
36

37 The “noninterference clause” in the Medicare Modernization Act of 2003 (MMA) states that the
38 Secretary of Health and Human Services (HHS) “may not interfere with the negotiations between
39 drug manufacturers and pharmacies and [prescription drug plan] PDP sponsors, and may not
40 require a particular formulary or institute a price structure for the reimbursement of covered part D
41 drugs.” Instead, participating Part D plans compete with each other based on plan premiums, cost-
42 sharing and other features, which provides an incentive to contain prescription drug spending. To
43 contain spending, Part D plans not only establish formularies, implement utilization management
44 measures and encourage beneficiaries to use generic and less-expensive brand-name drugs, but are
45 required under the MMA to provide plan enrollees access to negotiated drug prices. These prices
46 are achieved through direct negotiation with pharmaceutical companies to obtain rebates and other
47 discounts, and with pharmacies to establish pharmacy reimbursement amounts.
48

49 In an effort to lower drug prices and patient out-of-pocket costs in Medicare Part D, multiple bills
50 have been introduced in Congress to enable and/or require the Secretary of HHS to negotiate

1 covered Part D drug prices on behalf of Medicare beneficiaries. However, historically, the
2 Congressional Budget Office (CBO), as well as CMS actuaries, have estimated that providing the
3 Secretary of HHS broad negotiating authority by itself would not have any effect on negotiations
4 taking place between Part D plans and drug manufacturers or the prices that are ultimately paid by
5 Part D.^{5,6}

6

7 In fact, CBO has previously acknowledged that, in order for the Secretary to have the ability to
8 obtain significant discounts in negotiations with drug manufacturers, the Secretary would also need
9 the “authority to establish a formulary, set prices administratively, or take other regulatory actions
10 against firms failing to offer price reductions. In the absence of such authority, the Secretary’s
11 ability to issue credible threats or take other actions in an effort to obtain significant discounts
12 would be limited.”⁷ CMS actuaries have concurred, stating “the inability to drive market share via
13 the establishment of a formulary or development of a preferred tier significantly undermines the
14 effectiveness of this negotiation. Manufacturers would have little to gain by offering rebates that
15 are not linked to a preferred position of their products, and we assume that they will be unwilling to
16 do so.”⁸

17

18 Showing the impact of negotiating leverage, the December 10, 2019 CBO cost estimate “Budgetary
19 Effects of HR 3, the Elijah E. Cummings Lower Drug Costs Now Act” stated that Title I of the
20 legislation would reduce federal direct spending for Medicare by \$448 billion over the 2020-2029
21 period.⁹ In its October 11, 2019 estimate, CBO estimated that the largest savings would be the
22 result of lower prices for existing drugs that are sold internationally, which would be impacted by
23 the application of the “average international market price” outlined in the bill.¹⁰ Title I of HR 3
24 would require the Secretary of HHS to directly negotiate with manufacturers to establish a
25 maximum fair price for drugs selected for negotiation, which would be applied to Medicare, with
26 flexibility for Medicare Advantage and Medicare Part D plans to use additional tools to negotiate
27 even lower prices. An “average international market price” would be established to serve as an
28 upper limit for the price reached in any negotiation, if practicable for the drug at hand, defined as
29 no more than 120 percent of the drug’s volume-weighted net average price in six countries –
30 Australia, Canada, France, Germany, Japan and the United Kingdom.

31

32 *Relevant AMA Policy*

33

34 Policy D-330.954 states that our AMA: (1) will support federal legislation which gives the
35 Secretary of HHS the authority to negotiate contracts with manufacturers of covered Part D drugs;
36 (2) will work toward eliminating Medicare prohibition on drug price negotiation; and (3) will
37 prioritize its support for CMS to negotiate pharmaceutical pricing for all applicable medications
38 covered by CMS.

39

40 Addressing the use of international price indices and averages as part of the Secretary of HHS
41 negotiating drug prices in Medicare Part D, Council on Medical Service Report 4-I-19 established
42 Policy H-110.980, which outlines the following policy principles:

43

- 44 a. Any international drug price index or average should exclude countries that have single-
45 payer health systems and use price controls;
- 46 b. Any international drug price index or average should not be used to determine or set a
47 drug’s price, or determine whether a drug’s price is excessive, in isolation;
- 48 c. The use of any international drug price index or average should preserve patient access to
49 necessary medications;
- 50 d. The use of any international drug price index or average should limit burdens on physician
51 practices; and

1 e. Any data used to determine an international price index or average to guide prescription
2 drug pricing should be updated regularly.

3

4 MEDICARE PART B DRUG PRICES AND PHYSICIAN PAYMENT

5

6 Medicare reimburses physicians and hospitals for the cost of Part B drugs at a rate tied to the
7 average sales price (ASP) for all purchasers—including those that receive large discounts for
8 prompt payment and high-volume purchases—plus a percentage of the ASP. Currently, the
9 percentage add-on is six percent, which is then reduced to 4.3 percent under the budget sequester
10 enacted in 2011. Over the years, there have been a number of calls for reductions in the ASP add-
11 on, modifications in the calculation of the ASP, and inflation-related limits on Medicare increases
12 in drug payments.

13

14 For example, in 2017, the Medicare Payment Advisory Commission (MedPAC) put forth proposals
15 addressing the ASP payment system. Such proposals included reducing payment rates for new
16 single-source Part B drugs that lack ASP data from 106 percent to 103 percent of wholesale
17 acquisition costs; establishing an ASP inflation rebate; and developing a voluntary alternative, the
18 Drug Value Program (DVP), to the ASP payment system for physicians and outpatient hospitals.
19 Under the proposed DVP, providers would purchase all DVP products at the price negotiated by
20 their selected DVP vendor; Medicare would pay providers the DVP-negotiated price and pay
21 vendors an administrative fee; and Medicare payments under the DVP could not exceed 100
22 percent of ASP.¹¹

23

24 Based on a June 2015 MedPAC report to Congress, in 2016, CMS, under the Obama
25 Administration, put forward a proposed rule, *Medicare Program: Part B Drug Payment Model*, to
26 implement a two-phase, multipronged nationwide model that would restructure the way Medicare
27 reimburses physicians for Part B drugs. Under phase 1 of the model, CMS proposed to retain the
28 current rates in some communities and set a reduced rate of ASP+2.5 percent in addition to a
29 \$16.80 flat fee in others. After the sequester is factored in, the add-on in the model areas would
30 have been 0.86 percent of ASP plus \$16.53. Under phase 2, five additional “value-based” drug
31 payment strategies (test arms) were outlined to be on tap for implementation in specified localities
32 in subsequent years. As a result, Medicare payment policy would have remained unchanged in
33 approximately 25 percent of the country while multiple changes could have been applied to 75
34 percent of the country.¹² Due to strong opposition from the AMA and other stakeholders, the
35 proposed rule was not implemented and eventually formally withdrawn.

36

37 In October of 2018, the Trump Administration released an Advance Notice of Proposed
38 Rulemaking (ANPRM) entitled “International Pricing Index Model for Part B Drugs.” The
39 ANPRM did not represent a formal proposal, but rather outlined the Administration’s current
40 thinking and sought stakeholder input on a variety of topics and questions related to this new drug
41 pricing model prior to entering formal rulemaking. Under the ANPRM, providers would select
42 vendors from which to receive included drugs but would not be responsible for buying and billing
43 Medicare for the drug product. Instead, providers would continue to be entitled to bill a drug
44 administration fee and would also be entitled to receive a drug add-on fee. While the ANPRM was
45 somewhat short on detail on exactly how this add-on fee would be calculated, it appears the add-on
46 fee would be a flat fee that is based on six percent of the historical average sales price for the drug
47 in question.¹³

48

49 In September 2020, an executive order “Lowering Drug Prices by Putting America First” was
50 issued which called for testing of payment models to apply international price benchmarking to
51 Part B and Part D prescription drugs and biological products. For Part B, the executive order

1 instructed the Secretary of HHS to implement rulemaking to test a payment model under which
2 “Medicare would pay, for certain high-cost prescription drugs and biological products covered by
3 Medicare Part B, no more than the most-favored-nation price.” The executive order defined the
4 “most-favored-nation price” as “the lowest price, after adjusting for volume and differences in
5 national gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a
6 member country of the Organization for Economic Co-operation and Development (OECD) that
7 has a comparable per-capita gross domestic product.” For Part D, the executive order instructed the
8 Secretary of HHS to develop and implement rulemaking to test a payment model for high-cost Part
9 D drugs, limiting payment to these drugs to the most-favored-nation price, to the extent feasible.¹⁴
10 At the time that this report was written, no proposed and/or interim final rule had been issued to
11 begin the implementation of the provisions of the executive order, which could also propose
12 changes to Medicare Part B drug reimbursement.

13

14 *Relevant AMA Advocacy and Policy*

15

16 In its comments submitted in response to the ANPRM, the AMA stated that “reimbursement
17 models based on an ‘add-on’ formula are intended to adequately reimburse physicians for the costs
18 of acquisition, proper storage and handling, and other administrative costs associated with
19 providing these treatment options for patients. Many drugs included in this model, such as
20 biological products, are complicated drug products that require special attention to handling and
21 storage to remain stable and viable for administration to patients. Drugs that require specific
22 conditions for shipping, storage, and handling result in significantly higher administrative costs to
23 physician practices than many small molecule-type drugs. Due to the special nature of these
24 products, these costs are fixed, and will not decrease as the price of the drug goes down. Given
25 these fixed administrative costs, the Council is very concerned that, should drug prices decrease as
26 this model predicts, any add-on payment based on an ASP would ultimately decrease with the price
27 of the drug and would no longer be sufficient to cover the administrative costs to the practice. If
28 add-on reimbursement decreases enough that it is no longer sufficient to cover the expenses
29 associated with providing these treatment options, it is likely that practices will no longer be able to
30 offer these options for patients. The Council strongly urges CMS to consider the impact on the add-
31 on as the IPI model over time could reduce this amount below actual clinician cost.”

32

33 Policy D-330.960 supports efforts to seek legislation to ensure that Medicare payments for drugs
34 fully cover the physician’s acquisition, inventory and carrying cost and that Medicare payments for
35 drug administration and related services are adequate to ensure continued patient access to
36 outpatient infusion services. The policy also states that our AMA will continue strong advocacy
37 efforts working with relevant national medical specialty societies to ensure adequate physician
38 payment for Part B drugs and patient access to biologic and pharmacologic agents.

39

40 Addressing a Medicare Part B Competitive Acquisition Program (CAP), Policy H-110.983 states
41 that it should provide supplemental payments to reimburse for costs associated with special
42 handling and storage for Part B drugs; and that it must not reduce reimbursement for services
43 related to provision/administration of Part B drugs, and reimbursement should be indexed to an
44 appropriate health care inflation rate.

45

46 **DISCUSSION**

47

48 The prices and coverage of, and payment for, prescription drugs and vaccines under Medicare Parts
49 B and D not only impact patients’ ability to access the drugs and vaccines they need, but also
50 impact the ability of physician practices to cover their costs associated with acquiring, storing and
51 administering Part B drugs, and Part B and Part D vaccines. Over the years, proposals aimed at

1 lowering drug prices in Medicare Part B have also included provisions that would transition
2 reimbursement for the cost of Part B drugs away from the current approach that is tied to ASP plus
3 six percent (which has been reduced to 4.3 percent under the budget sequester). The Council
4 recognizes that there has not yet been consensus among national medical specialty societies, and
5 the house of medicine as a whole, concerning the preferred alternative(s) to using a rate tied to ASP
6 to reimburse physicians and hospitals for the cost of Part B drugs. The Council believes, however,
7 that the time is now for organized medicine to move forward with building consensus on which
8 alternative methods would be preferred to reimburse physicians for the cost of Part B drugs. As a
9 first step, our AMA should build upon past efforts and solicit input from national medical specialty
10 societies and state medical associations for their recommendations to ensure adequate Part B drug
11 reimbursement. The Council is hopeful that there will be a high level of participation among
12 members of the Federation, in an effort to work collectively and collaboratively on this issue within
13 the house of medicine. Subsequently, the AMA should work with interested national medical
14 specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part
15 B drugs.

16
17 The Council recognizes that coverage and payment policies concerning vaccines under Medicare
18 Parts B and D may be impacting the utilization rates of adult vaccines by Medicare patients. There
19 is a complicated web guiding coverage and payment for vaccines under Medicare Parts B and D,
20 raising financial risk for patients and physicians. In addition, for some vaccines provided to
21 Medicare beneficiaries, reimbursement to physician practices does not cover the true costs of
22 providing immunizations, which extend beyond the price of the vaccine and also include the cost of
23 vaccine storage equipment as well as administrative costs including monitoring temperature,
24 ordering, maintaining supply and minimizing waste. While our AMA has ample, strong policy in
25 this space, the Council believes that it is imperative for our AMA to continue to work with
26 interested stakeholders to improve utilization rates of adult vaccines by Medicare beneficiaries. In
27 addition, the Council recommends the reaffirmation of Policies D-440.981, H-440.875 and
28 H-440.860, policies that contain strong and innovative approaches to improve the coverage and
29 payment environment for vaccines under Medicare Parts B and D.

30
31 Recognizing the importance of lowering drug prices in Medicare Part D, the Council recommends
32 reaffirmation of Policy D-330.954, which states that our AMA supports federal legislation which
33 gives the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Part
34 D drugs; will work toward eliminating Medicare prohibition on drug price negotiation; and will
35 prioritize its support for CMS to negotiate pharmaceutical pricing for all applicable medications
36 covered by CMS. Finally, with the introduction of proposals that would use the average of a drug's
37 price internationally to serve as an upper limit in drug price negotiations, the Council recommends
38 the reaffirmation of Policy H-110.980, which outlines safeguards to ensure that international drug
39 price averages are used as a part of drug price negotiations in a way that upholds market-based
40 principles and preserves patient access to necessary medications.

1 RECOMMENDATIONS
2

3 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
4 203-A-19, and that the remainder of the report be filed.

5

6 1. That our American Medical Association (AMA) continue to solicit input from national medical
7 specialty societies and state medical associations for their recommendations to ensure adequate
8 Medicare Part B drug reimbursement. (Directive to Take Action)

9

10 2. That our AMA work with interested national medical specialty societies on alternative methods
11 to reimburse physicians and hospitals for the cost of Part B drugs. (Directive to Take Action)

12

13 3. That our AMA continue working with interested stakeholders to improve the utilization rates
14 of adult vaccines by individuals enrolled in Medicare. (Directive to Take Action)

15

16 4. That our AMA reaffirm Policy H-440.860, which supports easing federally imposed
17 immunization burdens by, for example, covering all vaccines in Medicare under Part B and
18 simplifying the reimbursement process to eliminate payment-related barriers to immunization;
19 and urges the Centers for Medicare & Medicaid Services (CMS) to raise vaccine
20 administration fees annually, synchronous with the increasing cost of providing vaccinations.
21 (Reaffirm HOD Policy)

22

23 5. That our AMA reaffirm Policy D-440.981, which supports adequate reimbursement for
24 vaccines and their administration from all public and private payers; encourages health plans to
25 recognize that physicians incur costs associated with the procurement, storage and
26 administration of vaccines that may be beyond the average wholesale price of any one
27 particular vaccine; and advocates that a physician's office can bill Medicare for all vaccines
28 administered to Medicare beneficiaries and that the patient shall only pay the applicable copay
29 to prevent fragmentation of care. (Reaffirm HOD Policy)

30

31 6. That our AMA reaffirm Policy H-440.875, which states that our AMA will aggressively
32 petition CMS to include coverage and payment for any vaccinations administered to Medicare
33 patients that are recommended by the Advisory Committee on Immunization Practices, the US
34 Preventive Services Task Force, or based on prevailing preventive clinical health guidelines.
35 (Reaffirm HOD Policy)

36

37 7. That our AMA reaffirm Policy D-330.954, which supports the use of Medicare drug price
38 negotiation. (Reaffirm HOD Policy)

39

40 8. That our AMA reaffirm Policy H-110.980, which outlines safeguards to ensure that
41 international drug price averages are used as a part of drug price negotiations in a way that
42 upholds market-based principles and preserve patient access to necessary medications.
43 (Reaffirm HOD Policy)

Fiscal Note: Between \$15,000 and \$20,000.

REFERENCES

¹ Cubanski, J and Freed, M. FAQs on Medicare Coverage and Costs Related to COVID-19 Testing and Treatment. Kaiser Family Foundation. March 30, 2020. Available at: <https://www.kff.org/medicare/issue-brief/faqs-on-medicare-coverage-and-costs-related-to-covid-19-testing-and-treatment/>.

² US Government Accountability Office. Medicare: Many Factors, Including Administrative Challenges, Affect Access to Part D Vaccinations. December 2011. Available at: <https://www.gao.gov/assets/590/587009.pdf>.

³ Tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine, adsorbed (Boostrix®); zoster vaccine live (Zostavax®); varicella virus vaccine live (Varivax®); A/C/Y/W-135, meningococcal polysaccharide vaccine, groups A, C, Y and W-135 combined (Menomune®); hepatitis A vaccine (Havrix®); hepatitis A vaccine, inactivated (Vaqta®); hepatitis B vaccine recombinant (Engerix-B®); hepatitis B vaccine recombinant (Recombivax HB®); hepatitis A and hepatitis B recombinant (Twinrix®); and tetanus and diphtheria toxoids vaccine, adsorbed (Tenivac™).

⁴ Wouters, A et al. Trends in Medicare Part D Benefit Design and Cost Sharing for Adult Vaccines, 2015–2017. Manatt Health Strategies. January 2018. Available at: <https://www.manatt.com/Manatt/media/Documents/Articles/Medicare-Part-D-for-Adult-Vaccines-Issue-Brief.pdf>.

⁵ Congressional Budget Office. Letter to Senator Ron Wyden (D-OR) relating to options for allowing the Secretary of HHS to negotiate over the prices paid for drugs under that Medicare Part D. April 10, 2007. Available at: <https://www.cbo.gov/sites/default/files/110th-congress-2007-2008/reports/drugpricenegotiation.pdf>.

⁶ Centers for Medicare & Medicaid Services. CMS Actuaries Conclude That H.R. 4 Would Have No Effect on Lowering Drug Prices. January 11, 2007. Available at: <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2007-Press-releases-items/2007-01-11.html>.

⁷ CBO, *supra* note 5.

⁸ CMS, *supra* note 6.

⁹ Congressional Budget Office. Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act. December 10, 2019. Available at: https://www.cbo.gov/system/files/2019-12/hr3_complete.pdf.

¹⁰ Congressional Budget Office. Effects of Drug Price Negotiation Stemming From Title 1 of H.R. 3, the Lower Drug Costs Now Act of 2019, on Spending and Revenues Related to Part D of Medicare. October 11, 2019. Available at: <https://www.cbo.gov/system/files/2019-10/hr3ltr.pdf>.

¹¹ Medicare Payment Advisory Commission. Report to the Congress: Medicare and the Health Care Delivery System. June 2017. Available at: http://www.medpac.gov/docs/default-source/reports/jun17_reporttocongress_sec.pdf?sfvrsn=0.

¹² American Medical Association. Letter to Acting Administrator Slavitt in response to Medicare Program; Part B Drug Payment Model; CMS-1670-P. May 9, 2016. Available at: <https://searchlif.ama-assn.org/letter/documentDownload?uri=/unstructured/binary/letter/LETTERS/medicare-program-part-b-letter-09may2016.pdf>.

¹³ Centers for Medicare & Medicaid Services. Medicare Program; International Pricing Index Model for Medicare Part B Drugs: Advance notice of proposed rulemaking. October 2018. Available at: <https://www.govinfo.gov/content/pkg/FR-2018-10-30/pdf/2018-23688.pdf>.

¹⁴ The White House. Executive Order on Lowering Drug Prices by Putting America First. September 13, 2020. Available at: <https://www.whitehouse.gov/presidential-actions/executive-order-lowering-drug-prices-putting-america-first-2/>.

REPORT 5 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Medicaid Reform
(Resolution 809-I-19)
(Reference Committee A)

EXECUTIVE SUMMARY

At the 2019 Interim Meeting, the House of Delegates referred Resolution 809, “AMA Principles of Medicaid Reform,” which was sponsored by the Utah Delegation. Resolution 809-I-19 asked the American Medical Association (AMA) to support a series of principles and to pursue action to improve the federal requirements for Medicaid programs based on the AMA’s Medicaid reform principles. The Council agrees with the intent of the principles proposed in referred Resolution 809-I-19. As demonstrated in the appended crosswalk, the Council analyzed each of the 14 principles and found them to be largely addressed by AMA policy.

AMA Medicaid reform efforts are guided by some 70 AMA policies that have been deliberated over the years by the Council and in the House of Delegates. The Council believes these policies provide the right direction for continued federal and state advocacy efforts and recommends reaffirmation of the following principles:

- Medicaid’s role as a safety net must be supported and sustained (Policy H-290.986).
- Medicaid reform should be undertaken within the AMA’s broader health insurance reform efforts, which support individually purchased and owned health insurance coverage as the preferred option (Policy H-165.920).
- State efforts to expand Medicaid eligibility as authorized by the Affordable Care Act (ACA) should be supported (Policy D-290.979), and states that newly expand eligibility should receive three years of 100 percent federal funding (Policy H-290.965).
- State waivers should be supported, provided they promote improved access to quality medical care; are properly funded; have sufficient provider payment levels to secure adequate access; and do not coerce physicians into participating (Policy H-290.987).
- Caps on federal Medicaid funding should be opposed (Policies H-290.963 and D-165.966).
- Medicaid should pay physicians a minimum of 100 percent of Medicare rates (Policies H-385.921 and H-290.976).

The Council also considered the need for new policy in the context of the 2019 novel coronavirus (COVID-19) pandemic and the ensuing demands on patients, physicians, and state Medicaid programs. The dual health and economic crises triggered by the pandemic have resulted in unparalleled financial uncertainty for millions of Americans, including physicians serving Medicaid patients. To help safeguard Medicaid funding, the Council recommends new policy supporting increases in states’ Federal Medical Assistance Percentage (FMAP) during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 5, November 2020

Subject: Medicaid Reform
(Resolution 809-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

1 At the 2019 Interim Meeting, the House of Delegates referred Resolution 809, "AMA Principles of
2 Medicaid Reform," which was sponsored by the Utah Delegation. Resolution 809-I-19 asked the
3 American Medical Association (AMA) to support a series of principles and to pursue action to
4 improve the federal requirements for Medicaid programs based on the AMA's Medicaid reform
5 principles. The Board of Trustees assigned this item to the Council on Medical Service for a report
6 back to the House of Delegates at the 2020 Interim Meeting.

7
8 This report provides an overview of Medicaid expansion, waivers and financing; describes the
9 impact of the 2019 novel coronavirus (COVID-19) pandemic; highlights Medicaid's role in
10 addressing disparities in health coverage and access to care; summarizes relevant AMA policy; and
11 makes policy recommendations. A crosswalk comparing each of the 14 principles proposed in
12 Resolution 809-I-19 with current AMA policy is appended.

13 BACKGROUND

14 In response to referred Resolution 809-I-19, the Council reviewed approximately 70 AMA policies
15 that guide AMA's federal and state Medicaid advocacy and found that the principles proposed in
16 the resolution are largely addressed by existing policy. At the onset of COVID-19, the Council
17 broadened its analysis to consider the need for new AMA policy in the context of the pandemic and
18 the ensuing demands on physicians, state Medicaid programs, and the health care system.

19
20 Medicaid is the largest health insurance program in the US; the leading payer of births, mental
21 health services and long-term care;¹ and an indispensable safety net for low-income and vulnerable
22 populations. As a countercyclical program, Medicaid spending increases during economic
23 downturns as job losses mount, incomes fall, and more people enroll in the program. Enrollment
24 growth occurs just as states, bringing in less tax revenue, experience budget shortfalls that put
25 pressure on state spending, including Medicaid spending. In the current downturn, Medicaid
26 programs are central to state efforts to care for low-income COVID-19 patients and also provide
27 coverage to the newly unemployed and uninsured. Accordingly, the impact of the pandemic on
28 state Medicaid programs could be extraordinary.

29
30 In March 2020, Medicaid and Children's Health Insurance Program (CHIP) covered nearly 71
31 million people (just over 64 million people were enrolled in Medicaid while an additional 6.7
32 million were enrolled in CHIP) and over half (51 percent) of total enrollees were children.²
33 Notably, prior to the pandemic Medicaid provided coverage to more than 20 percent of low-wage
34 workers.³ As initial unemployment claims surged nationwide, early forecasts predicted that the
35 economic crisis would trigger large-scale Medicaid enrollment increases. A model by Health

1 Management Associates, for example, estimated that enrollment could increase by 11 to 23 million
2 people,⁴ while the Kaiser Family Foundation projected that over half (12.7 million) of the nearly 27
3 million individuals who could lose employer-sponsored insurance would become eligible for
4 Medicaid.⁵ Three months into the pandemic, the Georgetown University Center for Children and
5 Families found enrollment increases of five percent on average in the 22 states being tracked as
6 well as significant variability across states.⁶ National enrollment figures for May 2020, the most
7 recent available at the time this report was written, indicate that 73.5 million individuals were
8 enrolled in Medicaid and CHIP, an increase of approximately 2.5 million from March.⁷ The modest
9 increase was at least partially attributed to the ability of furloughed workers to keep employer-
10 sponsored coverage and the fact that, early in the pandemic, fewer people were seeking medical
11 care. The situation is evolving and while enrollment growth over time is uncertain, many states are
12 anticipating and/or already experiencing significant increases in Medicaid applications.
13

14 Although Medicaid enrollment and spending increased during the 2002 and 2009 recessions and
15 following Affordable Care Act (ACA) implementation, growth in Medicaid spending per enrollee
16 has generally been less than that of private insurance spending,⁸ in part because payment rates are
17 significantly lower than rates paid by Medicare and private insurance for comparable services.
18 Inadequate Medicaid payment rates often do not cover the full cost of patient care and have been
19 associated with lower physician participation in Medicaid, which in turn negatively impacts patient
20 access to care.⁹ Delayed payments and administrative burdens also steer some providers away from
21 participating in the program.
22

23 The greatest share (almost two-thirds) of all Medicaid spending goes toward the care of elderly and
24 disabled persons, while a far smaller percentage (approximately 14 percent in 2017) pays for the
25 Medicaid expansion population, which is financed primarily with federal dollars.¹⁰ Spending varies
26 by state as do eligibility, coverage and payment policies, so one state's Medicaid program can look
27 very different from another. Notably, disparities in eligibility and coverage are most pronounced
28 between states that have and have not expanded Medicaid under the ACA.
29

30 MEDICAID EXPANSION

31

32 The Supreme Court ruling—in *National Federation of Independent Business v. Sebelius*—that
33 Medicaid expansion was optional allowed states to decline the opportunity to expand coverage to
34 individuals with incomes up to 133 percent (138 percent including the ACA's five percentage point
35 income disregard) of the federal poverty level (FPL). At the time this report was written, all but 12
36 states (AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, WY) had chosen to expand Medicaid,¹¹
37 although Missouri, Nebraska and Oklahoma had not yet implemented their Medicaid expansions.
38 Wisconsin covers adults up to 100 percent of the FPL, thereby bridging the gap between Medicaid
39 and premium tax credit eligibility without receiving the enhanced federal match. Section 1115
40 waivers have been used by states to try to customize the scope and structure of expansion plans in
41 ways that would not otherwise be permitted under federal rules. Although a handful of states have
42 sought partial expansions that cover individuals at 100 instead of 133 percent (138 percent
43 including the income disregard) of the FPL and allow them to receive the enhanced federal match
44 associated with full expansion, the Centers for Medicare & Medicaid Services (CMS) has not
45 approved these requests.
46

47 Since 2013, more than 14 million people have enrolled in Medicaid under the ACA expansion.¹²
48 [Council on Medical Service Report 5-I-14, Medicaid Expansion Options and Alternatives](#),
49 expressed concern for individuals left in what is known as the coverage gap of earning too much to
50 qualify for Medicaid in their states but too little (less than 100 percent of the FPL) to qualify for
51 premium subsidies to purchase health insurance through ACA marketplaces. Expansion states have

1 eliminated the coverage gap but, nationally, prior to the pandemic, an estimated 2.3 million
2 uninsured adults fell into the gap in non-expansion states, a number that is sure to grow. Nine out
3 of 10 of these individuals live in southern states, with one third residing in Texas and another 17
4 percent in Florida.¹³

5
6 Policymakers in states that have not expanded Medicaid have voiced concerns about increasing the
7 government's role in health care and are wary of the fiscal impacts associated with expansion
8 (Medicaid expansion was 100 percent federally financed through 2016 and has phased down to 90
9 percent in 2020). In a [2016 report on Medicaid expansion](#), the Council expressed concerns about
10 the enormous federal investment in Medicaid expansion, as well as massive enrollment increases
11 which led some states like California to further reduce payment rates to providers. Additionally, the
12 Council noted in its report that initial reviews of the impact of Medicaid expansion on coverage,
13 quality and outcomes were somewhat mixed.

14
15 The effects of Medicaid expansion have been widely studied since the Council's last report on the
16 topic in 2016, when data on the impact of the expansion were not yet conclusive. Evidence from a
17 number of studies has since shown that Medicaid expansion is associated with increased access to
18 care, decreased mortality, increased financial well-being, and improved self-reported health.^{14,15,16}
19 Enrollees have been found to be more likely to obtain primary and preventive care, be diagnosed
20 and treated for chronic conditions, and have access to prescription medications.¹⁷ Expansion states
21 have experienced greater reductions in their uninsured populations,¹⁸ with coverage gains playing a
22 significant role in addressing the opioid epidemic. Evidence also points to a narrowing of
23 disparities in coverage among people of different races and ethnicities, most notably in expansion
24 states.¹⁹

25
26 Studies of economic measures have also shown that Medicaid expansion may offset costs in other
27 areas (such as uncompensated care) and that it spurs economic activity and may even generate
28 savings for states.²⁰ Nevertheless, the main arguments against expansion focus on costs and fiscal
29 accountability. Prior to the pandemic, total Medicaid spending had grown to nearly \$600 billion²¹
30 with the federal share reaching over \$400 billion.²² Medicaid is the third largest domestic federal
31 program and one of the largest budget items in most states, and has been projected to be a trillion-
32 dollar program by 2026.²³ In 2018, Medicaid accounted for 16.4 percent of national health care
33 spending.²⁴

34
35 **WAIERS**

36
37 In states reluctant to expand Medicaid eligibility as designed in the ACA, Section 1115 waivers
38 may provide a workable alternative. Waivers permit states to put aside certain Medicaid
39 requirements to test and evaluate a novel delivery model or provide services not typically covered.
40 Expanding Medicaid is one of the ways that the US Department of Health and Human Services
41 (HHS) has permitted states to employ demonstration waivers. States have also sought waivers that
42 would allow them to charge premiums, require contributions to health savings accounts, require
43 enrollment in private plans, incentivize healthy behaviors, impose work requirements as a
44 condition of eligibility, impose closed prescription formularies, implement lock-out periods, use
45 funds for inpatient substance use and/or mental health services, and use funds for social
46 determinants of health interventions.^{25,26} While supportive of state flexibility via Medicaid waivers,
47 AMA policy also underscores the need for safeguards to protect low-income patients and sustain
48 Medicaid's role as an indispensable safety net.

49
50 Section 1115 waivers have been around for decades and are frequently used by Administrations to
51 implement domestic priorities. In early 2020, CMS announced the Healthy Adults Opportunity

1 (HAO) initiative, inviting states to apply for Section 1115 waivers under which states would agree
2 to limited federal financing without being bound to many existing programmatic and oversight
3 requirements.²⁷ Under the HAO initiative, states agreeing to an aggregate or per-capita cap
4 financing model for adult Medicaid expansion populations would be granted a menu of flexibilities
5 that could be attractive to some states, although state interest in HAO waivers has been limited.
6

7 AMA policy opposing caps on federal Medicaid funding was reaffirmed in [Council on Medical](#)
8 [Service Report 5-I-17](#). Accordingly, the AMA urged CMS to reject Oklahoma's HAO Section
9 1115 demonstration application to implement a per capita cap model, the only state application to
10 be submitted under the HAO initiative that has since been withdrawn. The AMA believes that per
11 capita caps artificially limit the growth of Medicaid expenditures, and may hinder a state's ability
12 to address the health care needs of its vulnerable citizens and respond to public health emergencies.
13

14 Although waivers imposing work requirements have been encouraged by the current
15 Administration, they have been repeatedly struck down in court. The AMA opposes work
16 requirements as a condition of Medicaid eligibility (Policy H-290.961) because of the potential for
17 continuity of care interruptions when patients subject to the requirements churn in and out of the
18 program, experiencing periods of being uninsured. Work requirements can cause otherwise eligible
19 enrollees to lose coverage, as it did in Arkansas, the only state that has fully implemented such
20 eligibility restrictions. Research has demonstrated that work requirements in Arkansas did not
21 increase rates of employment and that nearly 17,000 people lost coverage in the initial months after
22 the requirements were implemented.²⁸
23

24 *COVID-19 Waivers and Other Temporary Changes*

25 Under guidance issued to state Medicaid directors in March 2020, CMS began considering new
26 COVID-19 Section 1115 waivers. Unlike traditional waivers, CMS is not requiring states to submit
27 budget neutrality calculations for the special waivers, which focus primarily on home and
28 community-based services for the long-term care population. At the time this report was written,
29 six states had CMS-approved Section 1115 waivers to address COVID-19. States can also apply for
30 special Section 1135 waivers that are only authorized during public health emergencies. CMS has
31 approved Section 1135 waivers—focusing on provider enrollment, prior authorizations, appeals,
32 long-term services and supports and state plan processes—for all states.²⁹
33

34 Temporary changes have also been approved by CMS for 49 states through Medicaid disaster relief
35 state plan amendments (SPAs). At the time this report was written, 31 states had increased state
36 plan payment rates using SPAs, 20 states had waived or extended prescription drug prior
37 authorization requirements, 18 states had expanded coverage for testing and testing-related services
38 to uninsured individuals, and 14 states had eliminated deductibles and other cost-sharing.³⁰ States
39 have also taken a range of administrative actions in response to COVID-19, including issuing
40 guidance to expand Medicaid telehealth coverage (49 states), instituting payment parity for some
41 telehealth services (43 states), and waiving or lowering telehealth cost-sharing (20 states).³¹ The
42 AMA is monitoring Medicaid waivers and state administrative actions and providing assistance to
43 state medical associations upon request.
44

45 **FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP) INCREASE**

46 Under Medicaid's joint financing model, CMS matches each state's Medicaid expenditures
47 according to the federal medical assistance percentage (FMAP), which varies by state and is
48 inversely related to a state's per capita income. Prior to the pandemic, the 2020 Medicaid FMAP
49 ranged from the minimum 50 percent in 12 states to 77 percent in Mississippi.³²
50

1 A temporary 6.2 percentage point increase in federal Medicaid matching funds was provided to
2 states by the Families First Coronavirus Response Act (PL 116-127) to help them shoulder the
3 costs of increased Medicaid enrollment and services, including COVID-19 testing and treatment.
4 As a condition for receiving these funds, states must provide continuous eligibility through the
5 emergency period and are not permitted to restrict eligibility or make it more difficult to apply for
6 Medicaid.
7

8 The temporary 6.2 percentage point increase in the FMAP was an important first step to help states
9 continue serving the tens of millions of Americans enrolled in Medicaid. However, it is unlikely to
10 make up for state budget shortfalls and, at the time this report was written, Medicaid cuts were
11 under consideration in several states. A six percent cut had been made to Nevada's Medicaid
12 program—to be largely taken out of provider payment rates and some optional benefits—and
13 Colorado's Medicaid program had been cut by one percent. Increasing the FMAP is widely
14 recognized as a quick and easy way to provide fiscal relief to states during economic downturns
15 and incentivize them to maintain current Medicaid levels and services. Further enhancements to the
16 6.2 percentage point increase in the FMAP enjoy broad support from a range of national medical
17 specialty societies and other stakeholders, including the AMA.
18

19 NARROWING DISPARITIES IN HEALTH COVERAGE AND ACCESS TO CARE 20

21 Although the impact of COVID-19 on our nation, its people and our health care system is
22 continuing to unfold, one feature is unmistakably clear. The pandemic is disproportionately
23 impacting minoritized and marginalized populations, particularly Black, Latino and Native
24 American communities that in many places are testing positive, being hospitalized, and dying from
25 COVID-19 at much higher rates.³³ One in four deaths from the virus have been among Black
26 Americans, who are also more likely than White Americans to have lost income because of the
27 pandemic.³⁴ COVID-19 has highlighted longstanding health inequities that disproportionately
28 affect many communities of color—including higher rates of chronic diseases, lower access to
29 health care, and lack of or inadequate health insurance. The current crisis underscores the
30 importance of addressing racial and ethnic disparities in health insurance coverage and access to
31 health care and the need to better understand the role of social determinants of health (SDOH),
32 which can negatively affect health outcomes among people of color. Medicaid initiatives
33 addressing SDOH are described in Council on Medical Service Report 11-I-20, Health Insurance
34 Benefits Addressing SDOH. Covering the uninsured and improving health insurance affordability
35 have been long-standing goals of the AMA (see the [AMA's Plan to Cover the Uninsured](#)). The
36 AMA recognizes that racism in its systemic, structural, institutional, and interpersonal forms is an
37 urgent threat to public health, the advancement of health equity, and a barrier to excellence in the
38 delivery of medical care.³⁵
39

40 Studies have shown that coverage expansions implemented under the ACA have reduced racial
41 disparities in both health insurance coverage and access to care but that significant disparities
42 remain.^{36,37} The percentage of uninsured Black adults decreased from 24.4 percent in 2013 to 14.4
43 percent in 2018 while the uninsured rates of Latino adults fell from 40.2 percent to 24.9 percent
44 and uninsured rates of White adults decreased from 14.5 percent to 8.6 percent during the same
45 time period.³⁸ Notably, coverage disparities narrowed most significantly in states that expanded
46 Medicaid.³⁹
47

48 Disparities in access to care, as measured by two indicators—foregoing care due to cost and not
49 having a usual source of care—also decreased in all states since 2013, and more so in expansion
50 states.⁴⁰ Although Medicaid expansion under the ACA has played a key role in reducing disparities
51 in health insurance coverage and access to care, almost half of Black adults live in states that have

1 not expanded the program. Black adults in these states who would be eligible for Medicaid if the
2 state had expanded the program are likely to instead fall into the coverage gap. Expansion of
3 Medicaid across the 12 states that have not yet opted to do so may narrow the gaps in coverage and
4 access to care in those states, although disparities will likely remain.

5

6 RELEVANT AMA POLICY

7

8 AMA policy maintains that Medicaid reform should be undertaken in conjunction with broader
9 health insurance reform (Policy H-290.982) and supports Medicaid's role as a safety net for the
10 nation's most vulnerable populations (Policy H-290.986). AMA policy on covering the uninsured
11 and expanding choice is largely based on recommendations developed by the Council over the
12 years. Although AMA policy supports and advocates that individually purchased and owned health
13 insurance coverage is the preferred option (Policy H-165.920), Policy H-290.974 states that in the
14 absence of private sector reforms that would enable persons with low-incomes to purchase health
15 insurance, the AMA supports eligibility expansions of public sector programs, such as
16 Medicaid/CHIP. Policy D-290.979 states that, at the invitation of state medical societies, the AMA
17 will work with state and specialty medical societies in advocating at the state level to expand
18 Medicaid eligibility as authorized by the ACA (138% FPL including the income disregard). Policy
19 H-290.965, established by [Council on Medical Service Report 2-A-16](#), supports extending to states
20 the three years of 100 percent federal funding for Medicaid expansions that are implemented
21 beyond 2016 and maintaining federal funding for Medicaid expansion populations at 90 percent
22 beyond 2020.

23

24 Policy H-165.855 supports states having the option to provide coverage to nonelderly and
25 nondisabled Medicaid populations within the current Medicaid program or using premium tax
26 credits that are refundable, advanceable, inversely related to income, and administratively simple
27 for patients. AMA policy further encourages the development of coverage options, notably through
28 state demonstration waivers, for low-income adults in the coverage gap (Policies H-290.966,
29 D-165.966, and H-290.987). Policy H-290.966 advocates for CMS to exercise broad authority in
30 approving state demonstration waivers, provided that the waivers are consistent with the goals and
31 spirit of expanding health insurance coverage and eliminating the coverage gap for low-income
32 adults. Policy H-290.987 asserts that Section 1115 waivers should meet certain criteria before
33 being approved by HHS, including that the waivers: assist in promoting the Medicaid Act's
34 objective of improving access to quality medical care; are properly funded; have sufficient provider
35 payment levels to secure adequate access; and do not coerce physicians into participating. AMA
36 policy opposes caps on federal Medicaid funding (Policies H-290.963 and D-165.966). AMA
37 policy also opposes lock-out provisions that block Medicaid patients from the program for lengthy
38 periods (Policy H-290.960) and tying work requirements to Medicaid eligibility (Policy
39 H-290.961). Policy H-290.982 supports modest cost-sharing for non-emergent, non-preventive
40 services as a means of expanding coverage to uninsured individuals while Policy H-170.963
41 advocates that Medicaid and other publicly funded programs incentivize voluntary healthy
42 behaviors.

43

44 Policy H-160.913 recognizes the potential value of Medicaid patient-centered medical home
45 models. Streamlined application and enrollment processes are supported by Policy H-290.982,
46 while Policy D-290.985 encourages sufficient federal and state funding for Medicaid/CHIP to
47 support enrollment and the provision of necessary services. Policy H-290.984 opposes mandatory
48 enrollment in managed care plans. The AMA advocates for the same policies for Medicaid
49 managed care that are advocated for private managed care plans, as well as criteria for federal and
50 state oversight of Medicaid managed care plans that are delineated in Policy H-290.985. Network

1 adequacy elements are outlined in Policy H-285.908, and Policy H-320.908 addresses prior
2 authorization.

3
4 Longstanding AMA policy advocates that Medicaid should pay physicians at minimum 100
5 percent of Medicare rates (Policies H-385.921 and H-290.976). Policy H-290.965 supports:
6 increasing physician payment rates in any redistribution of funds in Medicaid expansion states
7 experiencing budget savings; strict oversight by CMS to ensure that states are setting and
8 maintaining Medicaid rate structures at levels to ensure there is sufficient physician participation;
9 and a mechanism for physicians to challenge payment rates directly to CMS. The AMA opposes
10 cuts in Medicaid and Medicare budgets that may reduce patient access to care and undermine care
11 quality under Policy H-330.932, which also supports expansion of these budgets to adjust for cost
12 of living, population growth, and the cost of new technologies. Policy D-290.979 advocates for
13 increases in Medicaid payments to physicians as well as improvements and innovations in
14 Medicaid that will reduce administrative burdens and deliver health care more effectively. Provider
15 taxes are opposed under Policy H-385.925.

16
17 AMA policy supports the creation of basic national standards of uniform eligibility for Medicaid
18 (Policy H-290.997), continuous eligibility (Policy H-165.832), and presumptive assessment of
19 eligibility and retroactive coverage to the time at which an eligible person sought medical care
20 (Policy H-165.855). Principles regarding Basic Health Programs are outlined in Policy H-165.832.
21 AMA policy supports expanded Medicaid coverage for management and treatment of substance
22 abuse disorders (Policy H-290.962) and for twelve months postpartum (Policy D-290.974). Policies
23 H-290.983 and H-440.903 support Medicaid benefits for legal immigrants.

24
25 The AMA has several policies focusing on health inequities and reducing racial and ethnic
26 disparities in health care, including Policies D-350.995, D-350.996, H-185.943 and H-65.963.
27 Policy H-350.974 prioritizes the elimination of racial and ethnic disparities in health care through
28 various approaches, including ensuring greater access to health care; encourages the development
29 of measures that identify socioeconomic and racial/ethnic disparities in quality; and supports the
30 use of evidence-based guidelines to promote the consistency and equity of care for all persons.
31 Under Policy H-180.944, health equity is a goal toward which our AMA will work by: advocating
32 for health care access, research and data collection; promoting equity in care; increasing health
33 workforce diversity; influencing determinants of health; and voicing and modeling commitment to
34 health equity. Policies H-65.960, H-160.896 and D-385.952 address SDOH.

35
36 AMA ADVOCACY
37

38 Because Medicaid patients too often face barriers to care, the AMA works diligently at the state
39 and federal levels to improve Medicaid programs, expand coverage options, and make it easier for
40 physicians to see Medicaid patients. Since the ACA was enacted, AMA advocacy on Medicaid
41 reform has been guided by AMA policy, highlighted in the [AMA's Plan to Cover the Uninsured](#),
42 which seeks to extend the reach of coverage to the remaining uninsured, including individuals
43 eligible for Medicaid/CHIP and adults who fall into the coverage gap. Consistent with AMA
44 policy, the AMA continues to advocate for Medicaid expansion and three years of 100 percent
45 federal funding for states that newly expand. The AMA also supports investments in
46 Medicaid/CHIP outreach and enrollment activities and opposes work requirements. Council on
47 Medical Service Report 1, November 2020, Options to Maximize Coverage under the AMA
48 Proposal for Reform, recommends establishing new AMA policy on auto-enrollment in health
49 insurance as a means of maximizing coverage of the uninsured who are eligible for
50 Medicaid/CHIP or zero-premium marketplace coverage. Importantly, the AMA—along with other

1 physician organizations—has argued against striking down the ACA (and Medicaid expansion) in
2 an [amicus brief](#) filed in the case of *Texas v. California* that is before the US Supreme Court.
3

4 The AMA has long encouraged policymakers to work together to identify realistic coverage
5 options for low-income people and believes it is important for states to develop and test new
6 Medicaid models that best meet the needs of low-income and vulnerable populations. AMA
7 advocacy emphasizes that Medicaid reform efforts must ensure that the program remains viable
8 and effective, and that financing changes should not undermine coverage gains that have been
9 made under the ACA. To expand access to care, the AMA works with state-level stakeholders to
10 advocate in favor of fully funding the Medicaid program, increasing participation with policies to
11 streamline enrollment, ensuring fair audit procedures and improving managed care programs. The
12 AMA comments regularly on federal and state proposals regarding Medicaid financing, access to
13 care and managed care, and monitors state actions to expand Medicaid eligibility and seek waivers
14 to Medicaid requirements from CMS.
15

16 In response to the COVID-19 pandemic, the AMA has also:
17

- 18 • Successfully sought temporary expansion of Medicaid eligibility to uninsured individuals for
19 COVID-19 testing.
- 20 • Urged states to eliminate Medicaid cost-sharing for COVID-19-related care, simplify Medicaid
21 enrollment and renewal processes, and eliminate barriers to Medicaid coverage such as work
22 requirements.
- 23 • Called on the Administration to promote health equity by collecting and releasing demographic
24 data to help address any potential race, sex and age disparities during the pandemic.
- 25 • Submitted a written statement to Congress on the disproportionate impact of COVID-19 on
26 people of color.
- 27 • Urged Congress to enhance federal financing for the Medicaid program by at least 12
28 percentage points and to keep any increased FMAP in place until states' economic recovery is
29 secure and stable.

30
31 Because low Medicaid payment rates have been shown to impact patient access to care, the AMA
32 has for many years advocated at the federal and state levels that physicians be provided fair and
33 adequate Medicaid payment, defined in AMA policy as a minimum of 100 percent of Medicare
34 rates. The AMA has advocated that CMS ensure that states are maintaining Medicaid rate
35 structures at levels that ensure there is sufficient physician participation, so that Medicaid patients
36 can get care in a timely manner. In response to COVID-19, the AMA pressed HHS to distribute
37 funds to assist practices and facilities treating Medicaid patients, which were operating on thin
38 margins even before the pandemic. When initial payments from the Provider Relief Fund were not
39 reaching Medicaid practices, the AMA urged CMS to authorize such payments, warning that
40 without immediate financial assistance, the safety net that these Medicaid practices provide may
41 not survive, endangering a vital part of the health care infrastructure.
42

43 DISCUSSION 44

45 Because Medicaid is an important—and often the only—source of consistent coverage for low-
46 income children, adults, pregnant women, people with substance use disorders, and the elderly and
47 disabled, the Council recognizes that the roughly 70 policies that provide the foundation for AMA
48 Medicaid advocacy require periodic review. Accordingly, the Council appreciates the compilation
49 of principles proposed in referred Resolution 809-I-19 which were reviewed individually for
50 consistency with AMA policy. As demonstrated in the appended crosswalk, the proposed
51 principles are largely addressed in AMA policy.

1 The Council points out that the first principle proposed in referred Resolution 809-I-19, which calls
2 for the provision of access to care that is “the most cost-effective and efficient,” could be
3 problematic in the context of lower-cost retail clinics. In a [2017 report](#), the Council expressed
4 concerns that the retail clinic model may have the effect of fragmenting care delivery by potentially
5 undermining the medical home and the patient-physician relationship. Regarding Principle #5 of
6 the resolution, the Council acknowledges that AMA policy does not “establish specialty-specific
7 quality metrics with appropriate remuneration and incentives for clinicians to provide high quality
8 care.” After discussing this language, the Council concluded that new policy delineating specific
9 quality metrics is not warranted. On the contrary, the Council is concerned that additional metrics
10 on top of existing quality measures could be detrimental to physicians by exacerbating
11 administrative burdens.

12 The sponsor of the resolution could not have anticipated that the Council’s deliberations would
13 coincide with COVID-19-induced health and economic crises that have placed extraordinary
14 demands on state and federal budgets and state Medicaid programs. The pandemic has had an
15 unparalleled impact on our nation and its people, leading to massive job losses, financial
16 uncertainty, and reduced health care coverage and access. A recent report estimates that half of the
17 nearly 27 million people who could lose their employer-sponsored health insurance will be eligible
18 for Medicaid.⁴¹ Although the totality of Medicaid enrollment growth stemming from the pandemic
19 remains uncertain, many millions of the newly uninsured are likely to turn to Medicaid, especially
20 in expansion states where most low-income adults will be eligible. In non-expansion states, many
21 of the same adults will not be Medicaid eligible and will instead fall into the coverage gap.
22

23 Physician practices have also been hit hard by COVID-19 as they struggle to meet the needs of
24 their patients while incurring new costs related to personal protective equipment and supplies and
25 confronting ongoing revenue shortages from deferred patient visits. Practices and facilities serving
26 Medicaid patients operated on thin margins prior to the pandemic and will be particularly
27 vulnerable to state Medicaid cuts. While the FMAP increase provided in the Families First Act was
28 an important first step, it will not be sufficient to overcome projected state budget shortfalls and
29 stave off state Medicaid cuts. To help safeguard Medicaid funding, which will help physicians and
30 patients, the Council recommends new policy supporting increases in states’ FMAP or other
31 funding during significant economic downturns to allow state Medicaid programs to continue
32 serving Medicaid patients and cover rising enrollment.
33

34 The Council believes that foundational AMA policies supporting various aspects of Medicaid
35 reform remain sound and provide the right direction for continued AMA federal and state
36 advocacy. Accordingly, the Council recommends reaffirming that:
37

- 38 • Medicaid’s role as a safety net must be supported and sustained (Policy H-290.986).
- 39 • Medicaid reform should be undertaken within the AMA’s broader health insurance reform
40 efforts, which support individually purchased and owned health insurance coverage as the
41 preferred option (Policy H-165.920).
- 42 • State efforts to expand Medicaid eligibility as authorized by the Affordable Care Act (ACA)
43 should be supported (Policy D-290.979), and states that newly expand eligibility should receive
44 three years of 100 percent federal funding (Policy H-290.965).
- 45 • State waivers should be supported, provided they promote improved access to quality medical
46 care; are properly funded; have sufficient provider payment levels to secure adequate access;
47 and do not coerce physicians into participating (Policy H-290.987).
- 48 • Caps on federal Medicaid funding should be opposed (Policies H-290.963 and D-165.966).
- 49 • Medicaid should pay physicians a minimum of 100 percent of Medicare rates (Policies
50 H-385.921 and H-290.976).

1 As it has during past deliberations, the Council discussed the potential for bifurcating the Medicaid
2 program which would remove the long-term care function that accounts for two-thirds of the
3 program's spending. Due to concerns regarding the complexity, feasibility, and potential
4 unintended consequences of bifurcation, the Council does not recommend utilizing AMA resources
5 to engage in advocacy on bifurcation. The Council also notes that financing for long-term services
6 and supports was addressed in a [2018 Council report](#).
7

8 RECOMMENDATIONS
9

10 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
11 809-I-19, and that the remainder of the report be filed.

12 1. That our American Medical Association (AMA) support increases in states' Federal Medical
13 Assistance Percentages or other funding during significant economic downturns to allow state
14 Medicaid programs to continue serving Medicaid patients and cover rising enrollment. (New
15 HOD Policy)
16

17 2. That our AMA reaffirm Policy H-290.986, which supports the Medicaid program's role as a
18 safety net for the nation's most vulnerable populations. (Reaffirm HOD Policy)
19

20 3. That our AMA reaffirm Policy D-290.979, which states that our AMA, at the invitation of state
21 medical societies, will work with state and specialty medical societies in advocating at the state
22 level to expand Medicaid eligibility to 133 percent [(138 percent federal poverty level (FPL)
23 including the income disregard)] as authorized by the ACA. (Reaffirm HOD Policy)
24

25 4. That our AMA reaffirm Policy H-290.965, which supports extending to states the three years
26 of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016 and
27 maintaining federal funding for Medicaid expansion populations at 90 percent beyond 2020.
28 (Reaffirm HOD Policy)
29

30 5. That our AMA reaffirm Policy H-290.966, which supports state Medicaid waivers, provided
31 they promote improving access to quality medical care; are properly funded; have sufficient
32 provider payment levels; and do not coerce physicians into participating. (Reaffirm HOD
33 Policy)
34

35 6. That our AMA reaffirm Policy H-290.963, which opposes caps on federal Medicaid funding.
36 (Reaffirm HOD Policy)
37

38 7. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to
39 advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.
40 (Reaffirm HOD Policy)
41

Fiscal Note: Less than \$500.

REFERENCES

¹ National Association of Medicaid Directors. Medicaid Financing. Available at <https://medicaiddirectors.org/key-issues/medicaid-financing/>

² US Department of Health and Human Services, Center for Medicaid and CHIP Services. March 2020 Medicaid & CHIP Enrollment Data Highlights. Available at <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

³ Kaiser Family Foundation. Double Jeopardy: Low Wage Workers at Risk for Health and Financial Implications of COVID-19. April 29, 2020. Available at: <https://www.kff.org/medicaid/issue-brief/double-jeopardy-low-wage-workers-at-risk-for-health-and-financial-implications-of-covid-19/>

⁴ Health Management Associates. COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State. April 3, 2020. Available at: <https://www.healthmanagement.com/wp-content/uploads/HMA-Estimates-of-COVID-Impact-on-Coverage-public-version-for-April-3-830-CT.pdf>

⁵ Kaiser Family Foundation. Eligibility for ACA Health Coverage Following Job Loss. May 13, 2020. Available at: <https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/>

⁶ Georgetown University Health Policy Institute, Center for Children and Families. Medicaid Enrollment Increases Show Surprisingly Wide Variability Among State. July 2, 2020. Available at: <https://ccf.georgetown.edu/2020/07/02/medicaid-enrollment-increases-show-surprisingly-wide-variability-among-state/>

⁷ US Department of Health and Human Services, Center for Medicaid and CHIP Services. May 2020 Medicaid & CHIP Enrollment Data Highlights. Available at: <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>

⁸ Kaiser Family Foundation. Medicaid Financing: The Basics. March 21, 2019. Available at: <https://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/>

⁹ American Academy of Pediatrics. Medicaid Policy Statement. *Pediatrics* 131(5) May 2013. Available at: <https://pediatrics.aappublications.org/content/131/5/e1697>

¹⁰ KFF, *supra* note 8.

¹¹ Kaiser Family Foundation. An Overview of State Approaches to Adopting the Medicaid Expansion. February 27, 2019. Available at: <https://www.kff.org/medicaid/issue-brief/an-overview-of-state-approaches-to-adopting-the-medicaid-expansion/>

¹² Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid enrollment changes following the ACA. Available at: <https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/>

¹³ Kaiser Family Foundation. The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid. January 2020. Available at: <http://files.kff.org/attachment/Issue-Brief-The-Coverage-Gap-Uninsured-Poor-Adults-in-States-that-Do-Not-Expand-Medicaid>

¹⁴ Kaiser Family Foundation. The Effects of Medicaid Expansion under the ACA: Updated Findings from a Literature Review. March 2020. Available at: <http://files.kff.org/attachment/Report-The-Effects-of-Medicaid-Expansion-under-the-ACA-Updated-Findings-from-a-Literature-Review.pdf>

¹⁵ Medicaid and CHIP Payment and Access Commission (MACPAC). Medicaid and the ACA: Changes in Coverage and Access. Available at: <https://www.macpac.gov/subtopic/changes-in-coverage-and-access/>

¹⁶ Allen H and Summers BD. Medicaid Expansion and Health Assessing the Evidence After 5 Years. *JAMA* 322(13) Sept. 6, 2019, Available at: <https://jamanetwork.com/journals/jama/article-abstract/2749799?resultClick=24>

¹⁷ US Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation. Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care. June 20, 2016. Available at: <https://aspe.hhs.gov/system/files/pdf/205141/medicaidexpansion.pdf>

¹⁸ *Ibid.*

¹⁹ The Commonwealth Fund. How the Affordable Care Act Has Narrowed Racial and Ethnic Disparities in Access to Care. January 2020. Available at: https://www.commonwealthfund.org/sites/default/files/2020-01/Baumgartner_ACA_racial_ethnic_disparities_db.pdf

²⁰ KFF, *supra* note 14.

²¹ Hartman M, Martin AB, Benson J et al. National Health Care Spending in 2018: Growth Driven By Accelerations in Medicare and Private Insurance. *Health Affairs* 39, No. 1, January 2020.

²² Congressional Budget Office. Medicaid—CBO’s Baseline as of March 6, 2020. Available at: <https://www.cbo.gov/system/files/2020-03/51301-2020-03-medicaid.pdf>

²³ Wolf CJ et al. 2017 actuarial report on the financial outlook for Medicaid. CMS Office of the Actuary. September 20, 2018.

²⁴ Hartman, *supra* note 21.

²⁵ Kaiser Family Foundation. Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State. July 23, 2020. Available at: <https://www.kff.org/report-section/section-1115-waiver-tracker-definitions/>

²⁶ American Medical Association. Issue Brief: Medicaid expansion demonstration waivers. 2016. Available at: <https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/specialty%20group/arc/medicaid-expansion-waivers-issue-brief.pdf>

²⁷ Centers for Medicare & Medicaid Services. Letter to state Medicaid directors re Healthy Adult Opportunity. Jan. 30, 2020. Available at: <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf>

²⁸ Sommers B, Goldman A, Blendon R et al. Medicaid Work Requirements—Results from the First Year in Arkansas. *New England Journal of Medicine* 381(11) Sept. 12, 2019.

²⁹ Kaiser Family Foundation. Medicaid Emergency Authority Tracker: Approved State Actions to Address COVID-19. July 24, 2020. Available at: <https://www.kff.org/medicaid/issue-brief/medicaid-emergency-authority-tracker-approved-state-actions-to-address-covid-19/>

³⁰ *Ibid.*

³¹ *Ibid.*

³² Urban Institute. Increasing Federal Medicaid Matching Rates to Provide Fiscal Relief to States during the COVID-19 Pandemic. April 2020. Available at:

https://www.urban.org/sites/default/files/publication/102098/increasing-federal-medicaid-matching-rates-to-provide-fiscal-relief-to-states-during-the-covid-19-pandemic_1.pdf

³³ American Medical Association. Statement for the Record to the U.S. House of Representatives Committee on Ways and Means re: The Disproportionate Impact of COVID-19 on Communities of Color. June 8. 2020.

³⁴ Centers for Disease Control and Prevention. National Center for Health Statistics. Weekly Updates by Select Demographic and Geographic Characteristics: Provisional Death Counts for Coronavirus Disease 2019 (COVID-19). July 22, 2020. Available at: https://www.cdc.gov/nchs/nvss/vsrr/covid_weekly/index.htm

³⁵ American Medical Association. AMA Board of Trustees pledges action against racism, police brutality. June 7, 2020. Available at: <https://www.ama-assn.org/press-center/ama-statements/ama-board-trustees-pledges-action-against-racism-police-brutality>

³⁶ Buchmueller TC and Levy HG. The ACA’s Impact on Racial and Ethnic Disparities in Health Insurance Coverage and Access to Care. *Health Affairs* 39, No. 3 March 2020.

³⁷ Commonwealth, *supra* note 19.

³⁸ *Ibid.*

³⁹ *Ibid.*

⁴⁰ *Ibid.*

⁴¹ KFF, *supra* note 5.

Appendix: Crosswalk of Resolution 809-I-19 with AMA Policy

The following table outlines the fourteen principles proposed in Resolution 809-I-19 and relevant AMA policy:

Resolution 809-I-19 Proposed Principle	Relevant AMA Policy and Council Analysis
1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.	Access to care is addressed in numerous policies, including Policies H-290.965 and H-290.997. Policy H-290.989 urges that Medicaid reform be undertaken in conjunction with broader health insurance reform to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.	A preference for enrollment in private insurance is embedded throughout policy, including Policies H-165.920, H-165.855 and H-290.982.
3. Create the best coverage at the lowest possible cost.	Policy H-165.846 supports principles for guiding the evaluation and adequacy of health insurance coverage.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.	Policy H-170.963 advocates that Medicaid and other publicly funded health insurance programs incentivize voluntary healthy behaviors among their participants which may decrease the cost of their medical care to the tax-paying public.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.	Policy H-290.982 calls for CMS to develop better measurement, monitoring and accountability systems and indices within Medicaid to assess program effectiveness. Policy D-350.974 encourages the development of measures that identify socioeconomic and racial/ethnic disparities in quality.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.	Policy D-290.977 advocated that the ACA's Medicaid primary care payment increases continue past 2014 in a manner that does not negatively impact payment for any other physicians. Policy H-290.965 advocates for robust access to specialty care.
7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.	Fair and adequate physician payment by Medicaid that should be a minimum of 100 percent of Medicare rates is supported by Policies H-290.965, H-290.989, H-290.997, H-330.932, and H-385.921. Policy H-480.946 supports coverage of and payment for telemedicine services while Policy D-480.969 supports coverage parity for telemedicine services.

8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.	Policy H-290.985 advocates that the availability of off-hours, walk-in primary care and other criteria be used in the oversight and evaluation of Medicaid managed care plans. Policy H-385.940 advocates for fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services. Examples of CPT codes for after-hours care include 99050 and 99051.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.	Parameters related to prior authorization relief in Medicaid plans are outlined in Policy H-320.938. Policy D-320.981 outlines protections related to step therapy.
10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.	Policy H-280.991 suggests policy directions for the financing of long-term care and encourages private sector coverage. As stated above (under #2), the preference for enrollment in private insurance is embedded throughout policy.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.	The AMA strongly opposes the use of provider taxes or fees to fund health care programs such as Medicaid (Policy H-385.925).
12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.	Policy H-290.975 supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients.
13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick, allow them to have a diabetes check-up at the same time).	Policy H-385.944 supports payment for E&M services and procedures performed on the same day, where consistent with CPT guidelines.
14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments.	Policy H-320.938 supports prior authorization relief for Medicaid and Medicaid managed care plans and outlines parameters for such relief. The AMA supports improvements in Medicaid that will reduce administrative burdens under Policy D-290.979.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 6, November 2020

Subject: Value-Based Management of Drug Formularies
(Resolution 814-I-19)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

1 At the 2019 Interim Meeting, the House of Delegates referred Resolution 814, “PBM Value-Based
2 Framework for Formulary Design,” which was sponsored by the American Society of Clinical
3 Oncology (ASCO). The Board of Trustees assigned this item to the Council on Medical Service for
4 a report back to the House of Delegates at the 2020 Interim Meeting. Resolution 814-I-19 asked:

5
6 That our American Medical Association (1) emphasize the importance of physicians’ choice of
7 the most appropriate pharmaceutical treatment for their patients in its advocacy; and (2)
8 advocate for pharmacy benefit managers (PBMs) and health plans to use a value-based
9 decision-making framework that is transparent and includes applicable specialty clinical
10 oversight when determining which specialty drugs to give preference on their formularies.

11
12 This report provides background regarding the development, use and transparency of prescription
13 drug formularies; outlines mechanisms for the value-based management of formularies;
14 summarizes relevant AMA policy; and presents policy recommendations.

15 BACKGROUND

16 Formularies are lists of covered drugs used by health plans and PBMs to direct increased and
17 decreased usage of certain pharmaceuticals. Some formularies attempt to tie the level of coverage
18 of a pharmaceutical to its “value”—its cost as well as clinical effectiveness. At the most basic level,
19 formulary drug tiers signal which pharmaceuticals are preferred or discouraged by payers, with
20 “preferred” drugs requiring lower patient cost-sharing levels than their counterparts. That being
21 said, “preferred” status on a formulary is not solely influenced by a drug’s price and effectiveness.
22 For example, drug placement on formularies is also influenced by the number of rebates and
23 discounts PBMs can secure from pharmaceutical manufacturers.

24
25 Within formularies, generic drugs are often promoted over their brand counterparts, and therefore
26 typically require much lower patient cost-sharing amounts. However, the dynamic created by
27 rebates and discounts sometimes generates exceptions to this rule. Formulary design is not only
28 tied to patient cost-sharing levels; health plans and PBMs also leverage prior authorization, step
29 therapy and quantity limits in conjunction with their formulary tiers to influence drug selection. For
30 those drugs not covered by formularies, patients and their physicians must pursue a formulary
31 exception to get some level of a drug’s cost covered, or patients have to pay the full retail price for
32 a drug.

1 An underlying concern of referred Resolution 814-I-19 pertains to the tiering of specialty drugs in
2 formularies. Specialty drugs, which have the highest prices, continue to enter the market, raising
3 questions of how these drugs will be covered by health plans. Spending on specialty drugs is
4 approaching one-half of drug spending.¹ Responding to this financial reality, some private and
5 public payers have taken steps to subdivide the specialty tier of formularies into separate preferred
6 and non-preferred categories, which can further exacerbate the financial burden posed by specialty
7 drugs on patients as well as complicate physician prescribing decisions. For example, a proposed
8 rule released in February 2020 included a proposal to allow Medicare Part D sponsors to establish a
9 second, “preferred” specialty tier that would have lower cost-sharing than the current specialty tier.
10 The proposed rule, if finalized without changes, would also establish a cost-sharing maximum that
11 would be applicable to the higher-cost specialty tier. The proposed rule stipulates that if there are
12 two specialty tiers, one must be a “preferred” tier that has lower cost sharing than the proposed
13 maximum allowable specialty tier cost-sharing, defined as between 25 and 33 percent, which is
14 dependent upon whether a Part D plan includes a deductible.² The AMA submitted comments in
15 response to the proposed rule, noting that the creation of a second specialty tier may lead to
16 increased patient copays/cost shares for a chronic medication on which the patient is stabilized. In
17 addition, AMA’s comments stressed that in the case of biologic medications, switching to a
18 biosimilar on a lower specialty tier may have negative clinical implications for a patient stabilized
19 on a reference product. As such, the AMA urged the Centers for Medicare & Medicaid Services to
20 consider any Medicare patients currently stabilized on a specialty drug to be exempt from
21 unfavorable coverage changes (e.g., increased patient copays/cost shares) resulting from a
22 secondary specialty tier.³
23

24 In addition, physicians and patients continue to raise concerns pertaining to the complexity as well
25 as the transparency in the development and administration of formularies, prescription drug cost-
26 sharing requirements, and utilization management requirements. This lack of transparency makes it
27 exceedingly difficult for physicians to determine what treatments are preferred by a particular
28 payer at the point-of-care, what level of cost-sharing their patients will face, and whether
29 medications are subject to any prior authorization, step therapy or other utilization management
30 requirements. For patients, lack of formulary transparency can lead to confusion regarding their
31 plan’s utilization management requirements and/or their cost-sharing responsibilities, which could
32 result in delays in accessing necessary prescription medications, impact their ability to afford their
33 prescription medications, and ultimately result in treatment adherence issues. These transparency
34 issues are further exacerbated when formularies are changed mid-year, which can have negative
35 effects on patients and can have a major impact on health care costs. When PBMs choose to
36 remove a medication from a patient’s formulary, change its tier within the formulary, or add new
37 restrictions on continued prescription of that medication, sub-optimal outcomes may occur as
38 patients are encouraged to try new medications that may or not be as efficacious for them, or that
39 they have previously failed. These may result in expensive trips to the emergency room and/or
40 hospitalizations, increased out-of-pocket drug costs for the patient, and potentially wasted
41 physician and patient resources used on appeals and attempts to determine an alternative treatment
42 solution.
43

44 VALUE-BASED MANAGEMENT OF PRESCRIPTION DRUG FORMULARIES

45
46 Various public and private payers have moved forward in implementing initiatives to further
47 incorporate “value” in formulary development and management. However, the term “value” has
48 different meanings to different stakeholders. Policy H-460.909 defines value as “the best balance
49 between benefits and costs, and better value as improved clinical outcomes, quality, and/or patient
50 satisfaction per dollar spent. Improving value in the US health care system will require both
51 clinical and cost information.”

1 *Indication-Based Formularies*

2
3 Under indication-based formulary design, health plans and PBMs can tailor on-formulary drug
4 coverage based on specific indications. The use of indication-based formulary design constitutes a
5 significant transition away from what has been the status quo—a drug’s coverage being the same
6 on a formulary, regardless of the indication it is treating. While indication-based formulary design
7 has been promoted as a way to better target drug coverage to individual patient characteristics as
8 well as more closely tie a drug’s price to its value, indication-based formularies can make patient
9 selection of a health plan (in Medicare Part D, for example) much more difficult. In addition, it
10 presents new complications for physicians in making the best prescribing decisions for their
11 patients, as drugs could be removed from formularies for indications where they are not deemed as
12 effective. Moreover, the prescription drug formulary and benefit data currently available to
13 physicians in their electronic health records (EHRs) is not sufficiently granular to report differential
14 coverage based on indication, and EHRs typically do not provide sufficient information about the
15 coverage or cost-sharing of a particular drug for a patient, including whether the patient has met his
16 or her deductible. Physicians cannot access basic levels of information, let alone indication-based
17 formulary data in their EHRs at the point of prescribing, which further exacerbates the existing
18 transparency issues surrounding health plan and PBM formulary design. Of note, as of calendar
19 year 2020, indication-based formulary design is allowed in Medicare Part D. Significantly,
20 indication-based formulary design and utilization management are now allowed for new starts in
21 five of the six protected classes in Medicare Part D (excluding antiretroviral medications), which
22 permits Part D plans to exclude a protected class Part D drug for non-protected class indications.
23

24 *Outcomes-Based Contracts*

25
26 Payers have also moved forward with initiatives that tie how much they pay for drugs to the health
27 outcomes of patients. Under outcomes-based contracts, a PBM negotiates not only a drug’s price,
28 but also measurable outcomes, with a pharmaceutical manufacturer on behalf of a health plan. If
29 the drug delivers its intended outcomes for patients, the original negotiated price remains in place.
30 However, if the drug does not meet the agreed-to outcomes in patients, the drug manufacturer
31 would issue a rebate for part, or all, of the cost. Payers thus far have entered outcomes-based
32 contracts with pharmaceutical companies covering medications for conditions including high
33 cholesterol, diabetes, hepatitis C, multiple sclerosis and chronic heart failure. Outcomes-based
34 contracts have also emerged as a mechanism to address the high costs of new gene therapies. For
35 example, Harvard Pilgrim Health Care entered an outcome-based contract with Spark Therapeutics,
36 the manufacturer of Luxturna, a gene therapy to treat a form of retinal dystrophy. Under the
37 contract, the level of payment for Luxturna is tied to measured improvements in patients after a 30-
38 to 90-day period, and then again at 30 months. If the therapy does not meet the measured outcomes
39 agreed to, Harvard Pilgrim will receive a rebate from Spark Therapeutics.⁴
40

41 *Leveraging Value-Based Frameworks in Guiding Formulary Placement*

42
43 Payers are also increasingly using analyses of entities such as the Institute for Clinical and
44 Economic Review (ICER), not only in their drug price negotiations with pharmaceutical
45 companies, but also in their decisions pertaining to formulary inclusions of newly launched drugs.
46 For example, in 2018, CVS Caremark launched a program that would allow its clients to exclude
47 any drug launched at a price of greater than \$100,000 per quality adjusted life year (QALY) from
48 their plan. The QALY ratio used by CVS Caremark in this program originated from ICER
49 analyses. CVS Caremark stipulated that breakthrough therapies would be excluded from this
50 program, instead focusing on drugs for which similar effective drug therapies already exist—“me

1 too” drugs.⁵ As of the end of 2019, this plan offering had gained little traction with CVS Caremark
2 clients, with patient advocacy groups raising significant concerns.⁶

3
4 The Value Assessment Framework developed by ICER includes two components: a drug’s long-
5 term care value and the potential short-term budget impact following a drug’s introduction to the
6 marketplace. ICER determines a drug’s long-term value by evaluating a drug’s comparative
7 clinical effectiveness, incremental cost-effectiveness, other benefits or disadvantages (e.g., methods
8 of administration, public health benefit) and contextual considerations (e.g., future competition in
9 the marketplace). ICER also develops a “health-benefit price benchmark” as part of all of its
10 assessments, which puts forward a price range that is in line with the added benefits of a treatment
11 for patients over their lifetime. Such prices align with long-term cost-effectiveness thresholds,
12 ranging from \$100,000 to \$150,000 per QALY gained and from \$100,000 to \$150,000 per Equal
13 Value of a Life Year Gained (evLYG).⁷

14
15 *American Society of Clinical Oncology*
16

17 ASCO, the sponsor of referred Resolution 814-I-19, released a conceptual framework in June 2015
18 to assess the value of cancer treatment options to be used in shared decision-making. Two versions
19 of the framework were developed: one for advanced cancer and one for potentially curative
20 treatment. ASCO then opened up the conceptual value framework to a 60-day public comment
21 period; more than 400 comments were received. Based on the input and feedback received, ASCO
22 released revised versions of the framework for advanced disease and adjuvant settings in May
23 2016. In both frameworks, points are awarded based on clinical benefit and toxicity, and bonus
24 points can also be applied. Overall, both versions of the framework use points to determine the net
25 health benefit, and have the net health benefit and the cost of the regimen side by side in order to
26 assist physicians and patients to assess value at the point-of-care.⁸

27
28 RELEVANT AMA POLICY
29

30 Addressing the first resolve of Resolution 814-I-19, Policy H-120.988 strongly supports the
31 autonomous clinical decision-making authority of a physician and that a physician may lawfully
32 use an US Food and Drug Administration approved drug product or medical device for an off-label
33 indication when such use is based upon sound scientific evidence or sound medical opinion; and
34 affirms the position that, when the prescription of a drug or use of a device represents safe and
35 effective therapy, third-party payers, including Medicare, should consider the intervention as
36 clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their
37 beneficiaries by covering such therapy, and be required to cover appropriate “off-label” uses of
38 drugs on their formulary.

39
40 Policy H-125.991 outlines standards for drug formulary systems as well as pharmacy and
41 therapeutics (P&T) committees. Policy H-285.965 states that P&T committee members should
42 include independent physician representatives, and that mechanisms should be established for
43 ongoing peer review of formulary policy as well as for appealing formulary exclusions. Policy
44 D-110.987, established by [CMS Report 5-A-19](#), supports improved transparency of PBM
45 operations, including disclosing P&T committee information, including records describing why a
46 medication is chosen for or removed in the P&T committee’s formulary, whether P&T committee
47 members have a financial or other conflict of interest, and decisions related to tiering, prior
48 authorization and step therapy; and formulary information, specifically information as to whether
49 certain drugs are preferred over others and patient cost-sharing responsibilities.

1 [CMS Report 5-I-16](#) established Policy H-110.986, which supports value-based pricing programs,
2 initiatives and mechanisms for pharmaceuticals that are guided by the following principles:
3 (a) value-based prices of pharmaceuticals should be determined by objective, independent entities;
4 (b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and
5 reliable inputs and data that incorporate rigorous scientific methods, including clinical trials,
6 clinical data registries, comparative effectiveness research, and robust outcome measures that
7 capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of
8 pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide
9 practicing physicians and researchers a central and significant role; (d) processes to determine
10 value-based prices of pharmaceuticals should limit administrative burdens on physicians and
11 patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate
12 affordability criteria to help assure patient affordability as well as limit system-wide budgetary
13 impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and
14 physician discretion.

15
16 DISCUSSION
17

18 Long-standing AMA Policy H-120.988 strongly supports the autonomous clinical decision-making
19 authority of a physician to determine the most appropriate pharmaceutical treatment for their
20 patients. The policy outlines a key AMA position: When the prescription of a drug represents safe
21 and effective therapy, third-party payers, including Medicare, should consider the intervention as
22 clinically appropriate medical care, irrespective of labeling, and should fulfill their obligation to
23 their beneficiaries by covering such therapy. The Council believes that the AMA has historically
24 advocated strongly for its members and the nation's patients in this regard and calls for the
25 reaffirmation of Policy H-120.988 to highlight both the policy and ongoing advocacy of the AMA.
26

27 Overall, PBMs and health plans must use a transparent process in formulary development and
28 administration and include practicing network physicians from the appropriate medical specialty
29 when making determinations regarding formulary inclusion or placement for a particular drug
30 class. This builds upon the intent of Policy H-285.965, a policy that also stresses the importance of
31 there being a mechanism to appeal formulary exclusions, providing another avenue for patients to
32 receive the pharmaceutical treatments they need. Overall, physicians and patients need to have
33 access to information relating to how pharmaceuticals are included and/or tiered in formularies, as
34 called for in Policy D-110.987.
35

36 As payers continue to move forward in implementing initiatives to further incorporate "value" in
37 formulary development and management, the Council strongly believes there is a need to closely
38 examine these initiatives, to ensure they are in the best interests of patients. Existing Policy
39 H-110.986 took key steps in that direction, but more needs to be done. First, in the event that
40 payers/PBMs enter into an outcomes-based contract with a pharmaceutical manufacturer, and the
41 terms of the contract yield savings to the payer, such savings should be shared with impacted
42 patients. If payers benefit from outcomes-based contracts, so should the patients for whom the
43 pharmaceutical is meant to help. To facilitate the sharing of savings from such refunds and rebates,
44 it is essential that rebate and discount information be made transparent, as called for in Policy
45 D-110.987.
46

47 The Council has significant concerns with the increasing use of indication-based formularies. On
48 the patient side of the equation, indication-based formularies can make patient selection of a health
49 plan (in Medicare Part D, for example) much more difficult, as patients would not only have to
50 search for a particular drug, but also confirm that the drug is covered for their particular indication.

1 And, for newly diagnosed patients already enrolled in a health plan, the drug that may be best to
2 treat their condition may not be covered for their specific indication.
3
4 For physicians, indication-based formularies introduce new complications along the chain from a
5 patient's office visit, to a pharmaceutical being dispensed at a pharmacy. Patients' drug coverage is
6 already dependent on and varies according to each individual health plan. Indication-based
7 formularies have the potential to build upon the existing complexity and exacerbate the existing
8 transparency issues surrounding PBM formulary design, as physicians cannot access indication-
9 based formulary data in their EHRs at the point of prescribing. Ultimately, there will be even more
10 variations within and between health plans regarding whether a drug is covered. In addition, drugs
11 could potentially be removed from formularies for indications where they are not deemed as
12 effective. Indication-based formularies could also introduce new administrative burdens for
13 physicians. For example, coverage restrictions will likely not be discovered until after the
14 prescription claim is submitted by the pharmacy and denied by the PBM, which will request the
15 applicable diagnosis code. The pharmacy will need to contact the physician practice for this
16 additional information, and under the best-case scenario, the claim will be resubmitted and paid by
17 the PBM. However, if the PBM does not cover the drug for the reported indication, the pharmacy
18 will contact the physician again and request that an alternate therapy be prescribed. This
19 "prescription rework" and multiple workflow disruptions will further increase physicians' already
20 significant challenges in navigating patients' prescription drug benefits. As such, the Council
21 recommends that indication-based formularies be opposed, in order to protect the ability of patients
22 to access and afford the prescription drugs they need, and physicians to make the best prescribing
23 decisions for their patients.
24

25 RECOMMENDATIONS

26

27 The Council on Medical Service recommends that the following be adopted in lieu of Resolution
28 814-I-19, and that the remainder of the report be filed.
29

- 30 1. That our American Medical Association (AMA) reaffirm Policy H-120.988, upholding the
31 ability of patients to access treatments prescribed by their physicians. (Reaffirm HOD Policy)
32
- 33 2. That our AMA reaffirm Policy H-285.965, which states that pharmacy and therapeutics (P&T)
34 committee members should include independent physician representatives, and that
35 mechanisms should be established for ongoing peer review of formulary policy as well as for
36 appealing formulary exclusions. (Reaffirm HOD Policy)
37
- 38 3. That our AMA advocate that pharmacy benefit managers (PBMs) and health plans use a
39 transparent process in formulary development and administration, and include practicing
40 network physicians from the appropriate medical specialty when making determinations
41 regarding formulary inclusion or placement for a particular drug class. (New HOD Policy)
42
- 43 4. That our AMA reaffirm Policy D-110.987, which supports improved transparency of PBM
44 operations, including disclosing rebate and discount information as well as P&T committee
45 information, including records describing why a medication is chosen for or removed in the
46 P&T committee's formulary, whether P&T committee members have a financial or other
47 conflict of interest, and decisions related to tiering, prior authorization and step therapy; and
48 formulary information, specifically information as to whether certain drugs are preferred over
49 others and patient cost-sharing responsibilities. (Reaffirm HOD Policy)

1 5. That our AMA reaffirm Policy H-110.986, which outlines principles guiding AMA's support
2 for value-based pricing programs, initiatives and mechanisms for pharmaceuticals. (Reaffirm
3 HOD Policy)

4

5 6. That our AMA advocate that any refunds or rebates received by a health plan or PBM from a
6 pharmaceutical manufacturer under an outcomes-based contract be shared with impacted
7 patients. (New HOD Policy)

8

9 7. That our AMA oppose indication-based formularies in order to protect the ability of patients to
10 access and afford the prescription drugs they need, and physicians to make the best prescribing
11 decisions for their patients. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ IQVIA Institute for Human Data Science. Medicine Use and Spending in the U.S.: A Review of 2018 and Outlook to 2023. May 2019. Available at: <https://www.iqvia.com/insights/the-iqvia-institute/reports/medicine-use-and-spending-in-the-us-a-review-of-2018-and-outlook-to-2023>.

² Centers for Medicare & Medicaid Services. Proposed Rule: Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly (CMS-4190-P). February 18, 2020. Available at: <https://www.federalregister.gov/documents/2020/02/18/2020-02085/medicare-and-medicaid-programs-contract-year-2021-and-2022-policy-and-technical-changes-to-the>.

³ American Medical Association. Comments to the Centers for Medicare & Medicaid Services (CMS) on the Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule (Proposed Rule). April 6, 2020. Available at: <https://search1.ama-assn.org/undefined/documentDownload?url=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-6-Letter-to-Verma-re-MA-and-Part-D-NPRM.pdf>.

⁴ Harvard Pilgrim Health Care. Harvard Pilgrim Is First Plan to Directly Negotiate Outcomes-Based Agreement for Groundbreaking Gene Therapy. January 3, 2018. Available at: https://www.harvardpilgrim.org/public/news-detail?nt=HPH_News_C&nid=1471914707173.

⁵ CVS Health. Current and New Approaches to Making Drugs More Affordable. August 2018. Available at: <https://cvshealth.com/sites/default/files/cvs-health-current-and-new-approaches-to-making-drugs-more-affordable.pdf>.

⁶ Humer, C. CVS Drug Coverage Plan Based on Outside Pricing Review Is off to a Slow Start. Reuters. October 3, 2019. Available at: <https://www.reuters.com/article/us-cvs-health-drugpricing-focus/cvs-drug-coverage-plan-based-on-outside-pricing-review-is-off-to-a-slow-start-idUSKBN1WI2IO>.

⁷ Institute for Clinical and Economic Review. 2020-2023 Value Assessment Framework. January 31, 2020. Available at: https://icer-review.org/wp-content/uploads/2019/05/ICER_2020_2023_VAF_013120-4.pdf.

⁸ American Society of Clinical Oncology. Value in Cancer Care. Available at: <https://www.asco.org/practice-policy/cancer-care-initiatives/value-cancer-care>.

REPORT 7 OF THE COUNCIL ON MEDICAL SERVICE (November 2020)
Health Plan Initiatives Addressing Social Determinants of Health
(Reference Committee A)

EXECUTIVE SUMMARY

At recent meetings of the House of Delegates, delegates have adopted policies that have provided the foundation for our American Medical Association's (AMA's) pursuit of greater health equity by identifying and eliminating inequities through advocacy, community leadership and education. AMA Policy H-180.944 states that "health equity," defined as optimal health for all, is a goal toward which our AMA will work by advocating for health care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

In that light, in reviewing AMA policy as well as initiatives across and outside of the health care system addressing social determinants of health, the Council concluded that additional policy is needed to respond to innovative health plan initiatives that incorporate social determinants of health in health insurance benefit design and coverage. The Council recognizes, however, that this represents only a fraction of what needs to be done at the health system level to address health inequities and social determinants of health. The Council underscores that addressing social determinants of health requires an "all hands on deck" approach that is not limited to stakeholders within the health care system. New and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations are critical. While there are avenues to address social determinants of health within the health system, the opportunities outside of the health care system, in non-health sectors, cannot and should not be ignored.

The Council recognizes that health plans have begun to incorporate social determinants of health in their decisions related to benefit design. Some benefit design inclusions of non-medical, yet critical health services are often the result of evidence showing not only improvements in health outcomes, but reductions in hospital admissions and readmissions, emergency department utilization, skilled nursing facility stays and ultimately, health care costs. The Council believes that such efforts should continue, serving as a critical step in addressing social determinants of health among vulnerable populations as well as in promoting health equity. To guide their efforts in this space, it is essential for health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training.

However, gaps and inconsistencies in data pertaining to social determinants of health remain. These data limitations undercut the ability to use evidence to evaluate health plan interventions addressing social determinants of health and benefit design decisions that incorporate non-medical, yet critical health services. As such, the Council supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, and believes that Policies D-478.972 and D-478.996 should be reaffirmed. Critically, more research is needed to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs. Coupled with more research in this space, coverage pilots should be pursued to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7, November 2020

Subject: Health Plan Initiatives Addressing Social Determinants of Health

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

1 At recent meetings of the House of Delegates, delegates have adopted policies that have provided
2 the foundation for our American Medical Association's (AMA's) pursuit of greater health equity
3 by identifying and eliminating inequities through advocacy, community leadership and education.
4 AMA Policy H-180.944 states that "health equity," defined as optimal health for all, is a goal
5 toward which our AMA will work by advocating for health care access, research and data
6 collection; promoting equity in care; increasing health workforce diversity; influencing
7 determinants of health; and voicing and modeling commitment to health equity.
8

9 In addition, last year, the AMA launched the Center for Health Equity (CHE) with the goal of
10 embedding health equity across the AMA so that it becomes part of the organization's practice,
11 process, action, innovation, and organizational performance and outcomes. The CHE's goals are to:
12 1) identify and address inequities in how care is delivered; 2) advocate for equitable access to care
13 and research; 3) increase diversity and inclusion in the medical workforce; 4) influence
14 determinants of health; and 5) elevate the AMA as a recognized leader and a model for equity
15 across health care and in our society. The CHE's mission is to strengthen, amplify, and sustain the
16 AMA's work to eliminate health inequities—improving health outcomes and closing disparities
17 gaps—which are rooted in historical and contemporary injustices and discrimination. As part of this
18 work, earlier this year the AMA announced a \$2 million investment in a community collaborative
19 focused on improving economic conditions for residents on Chicago's West Side, neighborhoods
20 where life expectancy is far below the national average, and significantly lower than in
21 communities just a few miles away. Through this initiative, called West Side United, the AMA has
22 highlighted that investing in neighborhoods and ensuring improved and equitable distribution of
23 resources can help begin to address social determinants of health and structural root causes of
24 health, and improve the health prospects for individuals and entire communities.
25

26 In that light, in reviewing AMA policy as well as initiatives across and outside of the health care
27 system addressing social determinants of health, the Council concluded that additional policy is
28 needed to respond to innovative health plan initiatives that incorporate social determinants of
29 health in health insurance benefit design and coverage. The Council, however, recognizes that this
30 represents only a fraction of what needs to be done at the health system level to address health
31 inequities and social determinants of health. Other necessary activities include increasing health
32 workforce diversity, advocating for equity in health care access, promoting equity in care, ensuring
33 equitable practices and processes in research and data collection, and addressing structural root
34 determinants of health, including structural racism.
35

36 As such, this report provides background on social determinants of health as well as their
37 contributions in the 2019 novel coronavirus (COVID-19) pandemic; highlights examples of how
38 the health and non-health sectors are addressing social determinants of health; outlines emerging

1 health plan initiatives to address social determinants of health in health insurance benefit design;
2 summarizes relevant AMA policy; and presents policy recommendations.

3
4 **BACKGROUND**

5
6 According to Healthy People 2020, the “social determinants of health are conditions in the
7 environment in which people are born, live, learn, work, play, worship, and age that affect a wide
8 range of health, functioning, and quality of life outcomes and risk.”¹ Such social determinants of
9 health include economic stability, neighborhood, education and life opportunities, access to food,
10 quality and safety of housing, community/social support and access to health care.

11
12 Social determinants of health directly impact outcomes, including life expectancy.² Individual
13 behavior has been estimated to account for 40 percent of health outcomes, with genetics accounting
14 for 30 percent, and social and economic factors accounting for 20 percent.³ Another estimate shows
15 that various factors have differential impacts on keeping people healthy, with 50 percent being
16 attributed to healthy behaviors, 20 percent to genetics and 20 percent being attributed to the
17 environment.⁴ Conversely, social determinants can also negatively affect outcomes, including
18 hospital readmission rates,⁵ length of stay and early death. For example, estimates indicate that
19 social determinants of health contribute to early deaths in the United States, with behavioral
20 patterns accounting for 40 percent, genetics 30 percent, social circumstances 15 percent and
21 environmental exposures five percent.⁶

22
23 In comparison to the other ten highest-income countries, the United States is below the mean of the
24 group with respect to total social spending (defined as spending on old age, incapacity, labor
25 market, education, family, and housing). The US ranked below the mean of all 11 countries with
26 respect to public social spending, and fourth with respect to private social spending.⁷

27
28 Social determinants of health are not experienced equally by all residents of the United States and
29 are often inextricably linked to each other. For example, education and access to transportation can
30 impact employment opportunities, and one’s neighborhood can impact access to healthful food
31 options. Social determinants of health serve as an underlying contributor to multiple conditions
32 including obesity, heart disease and diabetes – as well as health care expenditures. These outlined
33 conditions, of note, make individuals significantly more vulnerable to complications and death
34 from COVID-19.

35
36 Additional considerations of social determinants of health have also contributed to the
37 disproportionate impact of COVID-19 on marginalized and minoritized communities.^{8,9} These
38 communities are more likely to be in poverty, lack access to health care, nutritious food, affordable
39 housing, and accessible transportation; and have a stronger likelihood of living in congregate living
40 with multi-generational family members. In addition, people of color have a greater probability of
41 working in essential jobs that increase their exposure to the virus, such as in meatpacking plants,
42 warehouses, supermarkets, hospitals, and nursing homes.

43
44 **ADDRESSING SOCIAL DETERMINANTS OF HEALTH: WITHIN AND OUTSIDE OF THE**
45 **HEALTH CARE SYSTEM**

46
47 The Council notes that initiatives to address social determinants of health within and outside of the
48 health care system are diverse in nature, both in structure and programmatic aims and goals.
49 Outside of the health care system, the focus of initiatives has been on how to build partnerships and
50 bring non-health sectors into discussions centered on the improvement of health and health equity.
51 Within the health care system, payers on the state and federal levels have implemented payment

1 and delivery reform initiatives to address social needs, including under the auspices of the Center
2 for Medicare and Medicaid Innovation (CMMI), and state Medicaid programs.

3
4 *Healthcare Anchor Network*

5
6 Hospitals, health systems and other health care entities are functioning as anchor institutions,
7 rooted in the communities they serve through invested capital, relationships with employees and
8 community members, and other endeavors. Approximately 50 hospitals and health systems make
9 up the Healthcare Anchor Network, a collaboration aimed at advancing an Anchor Mission within
10 participating institutions, to ensure that health care anchor institutions use their economic stature in
11 partnership with the communities they serve in a way that is mutually beneficial to the community
12 as well as the institution itself. For example, hospitals and health systems, as major employers and
13 purchasers in the community, can work to improve the social and economic opportunities of low-
14 income and underserved residents. As such, the long-term goal of the Healthcare Anchor Network
15 is to “reach a critical mass of health systems adopting as an institutional priority to improve
16 community health and well-being by leveraging all their assets, including hiring, purchasing, and
17 investment for equitable, local economic impact.” Advancing toward this goal, the Network
18 members have identified priority areas for their work, and have initiative groups in such areas as
19 effective collaboration with community stakeholders in implementing anchor strategies; developing
20 a shared policy and advocacy agenda around addressing upstream determinants of health;
21 implementing anchor strategies around inclusive, local hiring and internal workforce development,
22 place-based investing and inclusive, local purchasing; and leveraging internal and external
23 philanthropy to catalyze other anchor strategies.¹⁰

24
25 *Health in All Policies and the National Prevention Strategy*
26

27 Health in All Policies (HiAP) recognizes the reality that multiple sectors outside of the traditional
28 health care enterprise affect health. As such, HiAP stipulates that health considerations should be a
29 factor in decision-making across sectors and policy areas, including but not limited to education,
30 transportation, housing and employment. The Council believes that such public-private
31 partnerships envisioned in HiAP are critical to addressing social determinants of health moving
32 forward. At the state and local levels, the HiAP approach is being used to convene stakeholders
33 across agencies and the community to collaborate on and prioritize health and health equity. On the
34 federal level, the National Prevention Strategy, the result of the provision of the Affordable Care
35 Act (ACA) that established the National Prevention Council, highlights the need for and
36 encourages partnerships among all levels of government; business, industry, and other private
37 sector partners; philanthropic organizations; community and faith-based organizations; and the
38 general public to improve health through prevention.¹¹

39
40 *Capturing Data on Patients Impacted by Social Determinants of Health*
41

42 Stakeholders across the health care spectrum – including physicians, hospitals, health systems and
43 health plans – have taken steps to capture individual patient data to show the impacts of social
44 determinants of health on health status and outcomes. For example, within the ICD-10-CM code
45 set, Z codes can be utilized to capture data pertaining to and quantify the number of patients
46 impacted by social determinants of health. Z codes capture the “factors that influence health status
47 and contact with health services,”¹² with codes Z55-65 specifically being used to identify
48 individuals with potentially hazardous socioeconomic and psychosocial circumstances.¹³ However,
49 although such codes are available the Council notes that they are underutilized. For example,
50 within the Medicare fee-for-service, Z codes were used for 467,136 beneficiaries in 2017,
51 amounting to 1.4 percent of total beneficiaries. Among the beneficiaries with Z code claims in

1 2017, the top chronic conditions included hypertension, depression and hyperlipidemia, with many
2 beneficiaries having more than one chronic condition.¹⁴

3

4 *Incorporating Social Determinants of Health in USPSTF Recommendations*

5

6 The US Preventive Services Task Force (USPSTF) has also taken steps to incorporate social
7 determinants of health in its evidence-based recommendations about clinical preventive services
8 such as screenings, counseling services, and preventive medications. Already, the USPSTF has
9 issued multiple recommendations on social risks impacted by social determinants of health,
10 including interpersonal violence, alcohol use, tobacco use, obesity, adherence to healthy behaviors,
11 and depression. Often, social determinants of health are included as part of the risk assessment in
12 USPSTF recommendation statements, and/or provide the foundation for identifying higher-risk
13 individuals.¹⁵

14

15 *Neighborhood and Community Initiatives*

16

17 With zip code recognized as a strong predictor of quality of health, across the country, in
18 neighborhoods and communities, initiatives are being developed and implemented to coordinate
19 strategies across sectors to address the various and diverse barriers that lead to poor health
20 outcomes and health inequities. For example, Harlem Children's Zone (HCZ) project, which served
21 27,573 children and adults in 2017, focuses its efforts on a 100-block area in central Harlem that
22 has higher rates of poverty, unemployment, chronic disease and infant mortality than many other
23 sections of New York City. HCZ offers a wide range of health, social service and family-based
24 programs to improve the educational, economic and health outcomes of members of the
25 community. For example, in 2017, the HCZ had 9,000 youth participating in the Healthy Harlem
26 fitness and nutrition program. The same year, 1.2 million healthy, nutritious student meals were
27 prepared by the program.¹⁶

28

29 *Accountable Health Communities*

30

31 In 2016, CMMI announced a new “Accountable Health Communities” model to promote
32 clinical/community collaboration to address health-related social needs. The model aims to
33 promote such collaboration through: “screening of community-dwelling beneficiaries to identify
34 certain unmet health-related social needs; referral of community-dwelling beneficiaries to increase
35 awareness of community services; provision of navigation services to assist high-risk community-
36 dwelling beneficiaries with accessing community services; and encouragement of alignment
37 between clinical and community services to ensure that community services are available and
38 responsive to the needs of community-dwelling beneficiaries.” From 2017 to 2022, the model will
39 provide support to community bridge organizations to pilot new and innovative service delivery
40 approaches that have the goal of connecting beneficiaries with community services that address
41 health-related social needs ranging from housing to food to transportation. Currently, 29
42 organizations are participating in the Accountable Health Communities Model.¹⁷

43

44 *Medicaid Accountable Care Organization Initiatives Addressing Social Determinants*

45

46 As of January 2020, 12 states have adopted Medicaid Accountable Care Organizations (ACOs),
47 nine of which have implemented initiatives addressing social determinants of health. Some of the
48 drivers of Medicaid ACO incorporation of social determinants of health include the potential to
49 contain costs, and the pursuit of health equity. Common strategies to address social determinants of
50 health within Medicaid ACOs include requiring providers to screen for social needs; requiring or
51 incentivizing providers to partner with social service organizations; and including requirements or

1 incentives for quality metrics associated with social determinants of health. For example, in
2 Oregon, coordinated care organizations are expected to focus their investments on services that
3 address social determinants of health and health equity. From 2020 to 2022, housing services will
4 be prioritized. Significantly, coordinated care organizations within Oregon are required to spend
5 part of any end-of-year surplus on combatting health disparities. The Oregon Health Authority is
6 planning to begin offering bonus payments to coordinated care organizations that meet
7 performance measures on social determinants of health and health equity.¹⁸

8

9 SOCIAL DETERMINANTS OF HEALTH IN HEALTH INSURANCE BENEFIT DESIGN

10

11 Resulting from federal regulatory changes and initiatives on the state level, health plans have more
12 flexibility to address social determinants of health, especially in Medicaid and Medicare
13 Advantage. Health plan initiatives that address social determinants of health have the potential to
14 not only improve the health status and outcomes of plan enrollees but can also impact health care
15 costs. For non-medical services that have a strong evidentiary base, including demonstrated
16 impacts on hospital admissions and readmissions and emergency department utilization, health
17 plans generally have more incentive to include coverage of those services as part of their benefit
18 design. For non-medical services for which the evidence base is nascent, pilot coverage of such
19 services has offered an opportunity to grow the evidence base to show impacts on not only health
20 outcomes but also health care costs.

21

22 *Medicaid State Plan and Waiver Opportunities*

23

24 Addressing social determinants of health via Medicaid is important as Medicaid patients frequently
25 have unmet social needs, but doing so requires some creativity. Federal law generally requires
26 federal Medicaid dollars to be spent only on direct medical care. There are, however, certain
27 opportunities for states to cover certain non-clinical services under the Medicaid benefit package.
28 States may use the 1915(i) state plan option to cover case management services (such as providing
29 assistance signing up for other social services), the 1915(c) waiver authority to cover home and
30 community based services, and the 1115 demonstration waiver authority to make other changes to
31 Medicaid that would otherwise not be permitted under the state plan, including changes to the
32 benefit package. For example, in Louisiana, the state Department of Health partnered with the
33 Louisiana Housing Authority to establish a Permanent Supportive Housing (PSH) program under
34 the 1915(i) state plan option, aimed at preventing and reducing homelessness as well as
35 unnecessary institutionalization. Under the auspices of the state Medicaid program, tenancy support
36 services are covered, starting from the transition into a PSH unit, ultimately working to ensure that
37 participants can maintain their own housing. Louisiana has reported that the program currently has
38 a 95 percent tenancy rate. Importantly, the program has achieved a 25 percent reduction in
39 Medicaid costs for individuals participating in the PSH program.¹⁹

40

41 Significantly, North Carolina's Medicaid program has taken advantage of Section 1115 waiver
42 authority to cover non-medical services in its Medicaid program. North Carolina's Section 1115
43 Medicaid demonstration waiver includes a Healthy Opportunities Pilot program that allows the
44 state to use up to \$650 million in Medicaid funds over a five-year period for enhanced case
45 management and other services to address beneficiary needs in the arenas of housing, food,
46 transportation, and interpersonal safety. Such pilot services would only be available to certain high-
47 risk enrollees residing in select regions of the state (due to funding limitations) that meet physical
48 or behavioral health and social risk factor criteria. Pilot services that may be covered include
49 housing modifications (e.g., carpet replacement, air conditioner repair) to improve a child's asthma
50 control and reduce emergency department visits and hospitalizations, travel vouchers to a
51 community-based food pantry or a medically-targeted healthy food box for an adult with diabetes

1 living in a rural food desert, or assistance in securing safe housing and establishing a new phone
2 number for a pregnant woman experiencing interpersonal violence. At the time this report was
3 written, due to the COVID-19 pandemic, North Carolina had suspended the evaluation of the
4 Healthy Opportunities Lead Pilot Entity proposals, and a new award date had not yet been
5 announced.^{20,21}

6
7 Generally, the predominant way through which state Medicaid programs can implement strategies
8 to address social determinants of health is through managed care contracts. Medicaid managed care
9 plans are increasingly addressing social determinants of health, and some already have
10 relationships and contracts with entities including local social services agencies. Moving forward,
11 states can review and revise their managed care contracts to increasingly incorporate social
12 determinants of health, ranging from the inclusion of requirements to screen and connect
13 beneficiaries to social and economic supports, to the promotion of value-based payments to enable
14 providers to address social determinants of health. In addition, states can require Medicaid
15 managed care organizations to participate in initiatives at the state and local levels with the goal of
16 improving options for affordable housing.²²

17

18 *Medicare Advantage*

19

20 Resulting from the enactment of the Creating High-Quality Results and Outcomes Necessary to
21 Improve Chronic (CHRONIC) Care Act, Medicare Advantage plans now have greater flexibility to
22 offer plan enrollees non-medical benefits, including transportation, healthy food options and
23 housing improvements. The new benefits must have a “reasonable expectation of improving or
24 maintaining the health or overall function of the patient as it relates to their chronic condition or
25 illness.”²³ As of 2019, Medicare Advantage plans were able to offer a broader range of benefits to
26 any plan enrollee, including grab bars or wheelchair ramps, as well as in-home personal care
27 attendants and adult day care. Starting this year, plans have the ability to offer special supplemental
28 benefits to chronically ill members who: “1) have at least one complex chronic condition that is life
29 threatening or significantly limits overall health or function, 2) are at high risk of hospitalization or
30 other adverse health outcomes, and 3) require intensive care coordination.”²⁴ Such benefits can
31 include home-delivered meals, nonmedical transportation and minor home repairs. For example,
32 Humana has partnered with Mom’s Meals to deliver ten fully-prepared meals after an inpatient stay
33 at a hospital or skilled nursing facility as part of its Well Dine Post Discharge program, and 20
34 meals to enrollees with certain chronic conditions as part of its Well Dine Chronic Condition
35 Program.²⁵ Mom’s Meals has reported past achievements of up to an 80 percent reduction in
36 inpatient stays 30 days after discharge, and more than a 40 percent reduction in emergency
37 department visits 30 days after discharge.²⁶ Of note, the coverage of such supplemental benefits by
38 Medicare Advantage plans is still limited, with only 139 of 3052 plans offering Special
39 Supplemental Benefits for the Chronically Ill in 2020. For those plans that do offer such benefits,
40 the most common are pest control, and produce and meal delivery.²⁷

41

42 *Tailoring Benefits for Dual Eligibles Targeting Social Determinants of Health*

43

44 Health Alliance Plan (HAP), an operating unit of the Henry Ford Health System (HFHS), is a
45 Michigan-based, nonprofit health plan providing health coverage to nearly 500,000 commercial
46 and government program (Medicare, Medicaid, Medicare/Medicaid duals) members. Since 2015,
47 HAP has participated in the Medicare/Medicaid Dual Eligible Demonstration Program, which fully
48 integrates funding from federal Medicare and State of Michigan Medicaid to support the needs of
49 nearly 5,000 vulnerable Medicare/Medicaid beneficiaries in southeast Michigan. Established by
50 Congress in 1981, 1915(c) waivers permit states to seek waivers to provide Home and Community
51 Based Services (HCBS) as Medicaid benefits. The State of Michigan specifically expanded its

1 HCBS program for the Medicare/Medicaid Dual Demonstration in 2014 as part of the MI Health
2 Link Program to facilitate services to keep vulnerable people safe at home. Since 2015, HAP's MI
3 Health Link HCBS program has focused on identifying dual eligible plan members with significant
4 social determinant risks that exacerbate their underlying clinical conditions and provide non-
5 traditional social supports to reduce unnecessary/preventable emergency room visits,
6 hospitalizations, readmissions, and nursing home stays, while giving them a higher quality of life in
7 their own homes. Through the HCBS program, HAP has provided services in the home including
8 personal emergency response systems to promote home safety, medical and non-medical
9 transportation to facilitate clinical care as well as support social needs (shopping, religious
10 services), home delivered meals to promote effective clinical condition aligned nutrition, personal
11 care/chore services to support daily needs for disabled members, and direct environmental home
12 modifications (chair lifts, wheelchair ramps, bathroom modifications) to keep members safe in the
13 home and avoid injury. These services are provided at no additional cost to the member and are
14 paid directly or through an intermediary by the health plan leveraging integrated
15 Medicare/Medicaid premium dollars.²⁸

16
17 **RELEVANT AMA POLICY**
18

19 Policy H-65.960 acknowledges that the provision of health care services as well as optimizing the
20 social determinants of health is an ethical obligation of a civil society. Policy H-160.896 supports
21 payment reform policy proposals that incentivize screening for social determinants of health and
22 referral to community support systems.

23
24 Addressing housing benefits specifically, Policy H-160.890 supports improved access to housing
25 modification benefits for populations that require modifications in order to mitigate preventable
26 health conditions, including but not limited to the elderly, the disabled and other persons with
27 physical and/or mental disabilities. Policy H-160.903 supports improving the health outcomes and
28 decreasing the health care costs of treating the chronically homeless through clinically proven, high
29 quality, and cost effective approaches that recognize the positive impact of stable and affordable
30 housing coupled with social services; and encourages the collaborative efforts of communities,
31 physicians, hospitals, health systems, insurers, social service organizations, government, and other
32 stakeholders to develop comprehensive homelessness policies and plans that address the healthcare
33 and social needs of homeless patients.

34
35 Addressing patient transportation needs, Policy H-130.954 encourages the development of non-
36 emergency patient transportation systems that are affordable to the patient, thereby ensuring cost
37 effective and accessible health care for all patients. Policy H-290.985 states that Medicaid managed
38 care plans should be responsive to cultural, language and transportation barriers to access.

39
40 Concerning access to healthful foods, Policy H-150.937 supports efforts to decrease the price gap
41 between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health
42 in economically disadvantaged populations by encouraging the expansion, through increased funds
43 and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity.
44 Policy H-150.931 recognizes the value of nutrition support team services and their role in positive
45 patient outcomes and supports payment for the provision of their services.

46
47 Addressing interpersonal violence, Policy H-515.965 urges hospitals, community mental health
48 agencies, and other helping professions to develop appropriate interventions for all survivors of
49 intimate violence, including individual and group counseling efforts, support groups, and shelters;
50 and stresses that it is critically important that programs be available for survivors and perpetrators
51 of intimate violence.

1 DISCUSSION

2

3 The Council welcomes the growing number of initiatives within and outside of the health care
4 system to address social determinants of health by prioritizing health within non-health sectors and
5 developing and implementing initiatives to address health-related social needs. At the outset, the
6 Council underscores that addressing social determinants of health requires an “all hands on deck”
7 approach that is not limited to stakeholders within the health care system. New and continued
8 partnerships among all levels of government, the private sector, philanthropic organizations, and
9 community- and faith-based organizations are critical. While there are avenues to address social
10 determinants of health within the health system, the opportunities outside of the health care system,
11 in non-health sectors, cannot and should not be ignored.

12

13 The Council recognizes that health plans have begun to incorporate social determinants of health in
14 their decisions related to benefit design. Some benefit design inclusions of non-medical, yet critical
15 health services are often the result of evidence showing not only improvements in health outcomes,
16 but reductions in hospital admissions and readmissions, emergency department utilization, skilled
17 nursing facility stays and ultimately, health care costs. The Council believes that such efforts
18 should continue, serving as a critical step in addressing social determinants of health among
19 vulnerable populations as well as in promoting health equity. To guide their efforts in this space, it
20 is essential for health plans to examine implicit bias and the role of racism and social determinants
21 of health, including through such mechanisms as professional development and other training.

22

23 However, gaps and inconsistencies in data pertaining to social determinants of health remain.
24 These data limitations undercut the ability to use evidence to evaluate health plan interventions
25 addressing social determinants of health and benefit design decisions that incorporate non-medical,
26 yet critical health services. As such, the Council supports mechanisms, including the establishment
27 of incentives, to improve the acquisition of data related to social determinants of health, and
28 believes that Policies D-478.972 and D-478.996 should be reaffirmed. Critically, more research is
29 needed to determine how best to integrate and finance non-medical services as part of health
30 insurance benefit design, and the impact of covering non-medical benefits on health care and
31 societal costs. Coupled with more research in this space, coverage pilots should be pursued to test
32 the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data
33 and evidence are not available, on health outcomes and health care costs.

34

35 RECOMMENDATIONS

36

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

39

40 1. That our American Medical Association (AMA), recognizing that social determinants of health
41 encompass more than health care, encourage new and continued partnerships among all levels
42 of government, the private sector, philanthropic organizations, and community- and faith-based
43 organizations to address non-medical, yet critical health needs and the underlying social
44 determinants of health. (New HOD Policy)

45

46 2. That our AMA support continued efforts by public and private health plans to address social
47 determinants of health in health insurance benefit designs. (New HOD Policy)

48

49 3. That our AMA encourage public and private health plans to examine implicit bias and the role
50 of racism and social determinants of health, including through such mechanisms as
51 professional development and other training. (New HOD Policy)

- 1 4. That our AMA reaffirm Policies D-478.972 and D-478.996 supporting proactive and practical
- 2 approaches to promote interoperability at the point of care. (Reaffirm HOD Policy)
- 3
- 4 5. That our AMA support mechanisms, including the establishment of incentives, to improve the
- 5 acquisition of data related to social determinants of health. (New HOD Policy)
- 6
- 7 6. That our AMA support research to determine how best to integrate and finance non-medical
- 8 services as part of health insurance benefit design, and the impact of covering non-medical
- 9 benefits on health care and societal costs. (New HOD Policy)
- 10
- 11 7. That our AMA encourage coverage pilots to test the impacts of addressing certain non-medical,
- 12 yet critical health needs, for which sufficient data and evidence are not available, on health
- 13 outcomes and health care costs. (New HOD Policy)

Fiscal Note: Less than \$500.

REFERENCES

¹ Office of Disease Prevention and Health Promotion, US Department of Health and Human Services. Social Determinants of Health. Available at: <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>.

² Chetty R et al. The Association Between Income and Life Expectancy in the United States, 2001-2014. JAMA. 2016; 315(16): 1750-1766.

³ Aligning for Health. Social Determinants of Health. Available at: <http://aligningforhealth.org/social-determinants-of-health/>.

⁴ Bipartisan Policy Center. What Makes Us Healthy vs. What We Spend on Being Healthy. June 5, 2012. Available at: <https://bipartisanpolicy.org/report/what-makes-us-healthy-vs-what-we-spend-on-being-healthy/>.

⁵ Auerbach A et al. Preventability and Causes of Readmissions in a National Cohort of General Medicine Patients. JAMA Internal Medicine. 2016; 176(4): 484-493.

⁶ McGinnis JM, Williams-Russo P, and Knickman J. The Case For More Active Policy Attention To Health Promotion. Health Affairs, March/April 2002.

⁷ Papanicolas I, PhD; Woskie L, and Jha A. Health Care Spending in the United States and Other High-Income Countries. JAMA. 2018; 319(10): 1024-1039.

⁸ Metzl J, Maybank A, and De Maio F. Responding to the COVID-19 Pandemic: The Need for a Structurally Competent Health Care System. JAMA, June 2020.

⁹ Webb Hooper, M, Nápoles, AM, Pérez-Stable, EJ. COVID-19 and Racial/Ethnic Disparities. JAMA. 2020; Volume 323(24): 2466-2467.

¹⁰ Healthcare Anchor Network: Health Systems Collaborating to Build Inclusive, Local Economies. Available at: <https://healthcareanchor.network/wp-content/uploads/edd/2020/08/Healthcare-Anchor-Network-One-Pager.pdf>.

¹¹ US Department of Health and Human Services, Office of the Surgeon General, National Prevention Council. National Prevention Strategy. 2011. Available at: <https://www.hhs.gov/sites/default/files/disease-prevention-wellness-report.pdf>.

¹² ICD-10-CM Codes. Factors influencing health status and contact with health services. Available at: <https://www.icd10data.com/ICD10CM/Codes/Z00-Z99>.

¹³ Centers for Medicare & Medicaid Services. ICD-10-CM Official Guidelines for Coding and Reporting FY 2019. (October 1, 2018 – September 30, 2019). Available at: <https://www.cms.gov/Medicare/Coding/ICD10/Downloads/2019-ICD10-Coding-Guidelines-.pdf>.

¹⁴ Office of Minority Health, Centers for Medicare & Medicaid Services. Z Codes Utilization among Medicare Fee-for-Service (FFS) Beneficiaries in 2017. Data Highlight No. 18. January 2020.

¹⁵ Davidson K et al. Developing Primary Care-Based Recommendations for Social Determinants of Health: Methods of the U.S. Preventive Services Task Force. Annals of Internal Medicine. July 2020.

¹⁶ Harlem Children's Zone. Our Results. Available at: <https://hczone.org/results/>.

¹⁷ Centers for Medicare & Medicaid Services. Accountable Health Communities Model. Available at: <https://innovation.cms.gov/innovation-models/ahcm>.

¹⁸ Tobin-Tyler E and Ahmad B. Marrying Value-Based Payment and the Social Determinants of Health through Medicaid ACOs: Implications for Policy and Practice. Milbank Memorial Fund. May 2020. Available at: https://www.milbank.org/wp-content/uploads/2020/05/Medicaid-ACOs-and-SDOH.ver5_.pdf.

¹⁹ Louisiana Department of Health. Aging and Adult Services, Permanent Supportive Housing. Available at: <http://ldh.la.gov/index.cfm/page/1732#:~:text=Housing%20retention%20is%20essential%20to,people%20in%20the%20PSH%20program>.

²⁰ Hinton E, Artiga S and Musumeci M. A First Look at North Carolina's Section 1115 Medicaid Waiver's Healthy Opportunities Pilots. Kaiser Family Foundation. May 15, 2019. Available at: <https://www.kff.org/report-section/a-first-look-at-north-carolinas-section-1115-medicaid-waivers-healthy-opportunities-pilots-issue-brief/#:~:text=In%20October%202018%20CMS%20approved,new%20managed%20care%20delivery%20system..>

²¹ North Carolina Department of Health and Human Services. Healthy Opportunities Pilots. Available at: <https://www.ncdhhs.gov/about/department-initiatives/healthy-opportunities/healthy-opportunities-pilots>.

²² Manatt Health. Addressing Social Factors That Affect Health: Emerging Trends and Leading Edge Practices in Medicaid. April 2019. Available at: https://www.manatt.com/Manatt/media/Documents/Articles/Social-Factors-That-Affect-Health_Final.pdf.

²³ Centers for Medicare and Medicaid Services. 2020 Medicare Advantage and Part D Rate Announcement and Final Call Letter Fact Sheet. April 1, 2019. Available at: <https://www.cms.gov/newsroom/fact-sheets/2020-medicare-advantage-and-part-d-rate-announcement-and-final-call-letter-fact-sheet>.

²⁴ Hostetter M and Klein S. In Focus: CHRONIC Care Act Prompts Some Medicare Advantage Plans to Incorporate Social Services. The Commonwealth Fund. January 9, 2020. Available at: <https://www.commonwealthfund.org/publications/newsletter-article/2020/jan/focus-chronic-care-act-prompts-some-medicare-advantage#:~:text=The%20new%20benefits%20must%20have,other%20social%20determinants%20of%20health.&text=Starting%20in%202020%203A%20Plans%20may,benefits%20for%20the%20chronically%20ill..>

²⁵ Humana. Humana Well Dine. Available at: <https://www.humana.com/manage-your-health/home-and-community-support/well-dine>.

²⁶ Mom's Meals. Humana Offering Meal Benefit to Medicare Advantage Members through Mom's Meals for Plan Year 2020. February 24, 2020. Available at: <https://www.momsmeals.com/news/press-releases/humana-offering-meal-benefit-to-medicare-advantage-members-through-moms-meals/>.

²⁷ Meyers D, Gadbois E, Brazier J et al. Medicare Plans' Adoption of Special Supplemental Benefits for the Chronically Ill for Enrollees With Social Needs. JAMA Network Open. May 12, 2020.

²⁸ Watson, P. Health Alliance Plan. July 19, 2020.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(November 2020)

Introduced by: New York

Subject: End of Life Care Payment

Referred to: Reference Committee A

1 Whereas, Getting a patient into hospice two days before they expire is a failure but an all too
2 common experience; and
3
4 Whereas, At the end of life a nursing home or an assisted living facility may be a patient's home;
5 and
6
7 Whereas, Hospice benefits do not usually cover the cost of housing a patient in a nursing home
8 or assisted living facility ("room and board"); and
9
10 Whereas, Covering the cost of room and board in a nursing home or assisted living facility is
11 less expensive than hospitalized acute care; therefore be it
12
13 RESOLVED, That our American Medical Association petition the Centers for Medicare &
14 Medicaid Services to allow hospice patients to cover the cost of housing ("room and board") as
15 a patient in a nursing home or assisted living facility (Directive to Take Action); and be it further
16
17 RESOLVED, That our AMA advocate that patients be allowed to use their skilled nursing home
18 benefit while receiving hospice services. (Directive to Take Action)

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

Received: 06/18/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(November 2020)

Introduced by: New York

Subject: Hospice Recertification for Non-Cancer Diagnosis

Referred to: Reference Committee A

1 Whereas, The number of Americans ages 65 and older is projected to more than double from 46
2 million today to over 98 million by 2060; and

3
4 Whereas, The rate of dementia and failure to thrive at the end of life for older Americans is
5 increasing because of these demographic shifts; and

6
7 Whereas, The ability to predict the end of life is an art as opposed to a science; and

8
9 Whereas, These patients will need hospice care; therefore be it

10
11 RESOLVED, That our American Medical Association request that the Centers for Medicare &
12 Medicaid Services allow automatic reinstatement for hospice if a patient survives for more than
13 6 months with a non-cancer diagnosis and that prognosis remains terminal. (Directive to Take
14 Action)

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

Received: 06/18/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(November 2020)

Introduced by: Resident and Fellow Section

Subject: Recognizing the Need to Move Beyond Employer-Sponsored Health Insurance

Referred to: Reference Committee A

1 Whereas, Americans entering the workforce currently have from one quarter to one eighth of the
2 average job tenure as workers now aging into retirement¹; and
3
4 Whereas, Trends such as a higher average worker education level and an increasing share of
5 available jobs in industries with shorter-tenured careers are also contributing to increasing
6 worker mobility, likely more so than any generational differences¹; and
7
8 Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40
9 years, decreasing the collective bargaining power of today's workers to attain benefits such as
10 quality health insurance²; and
11
12 Whereas, The number of Americans that have employer-sponsored health insurance has
13 declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among
14 low- and middle-income families³; and
15
16 Whereas, Even among those workers with employer-sponsored health insurance, as many as
17 25% have out-of-pocket costs so high as to be effectively uninsured⁴; and
18
19 Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on
20 employer-sponsored health insurance results in undesirable effects on the American worker
21 such as "job-lock" (being unable to leave a job because of reliance on its health benefits),
22 medical bankruptcy when a patient changes or loses their job while they or a family member
23 require ongoing medical treatment, and downward pressure on wages⁵; and
24
25 Whereas, The predominance of employer-sponsored insurance arose by accident out of an
26 attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of
27 1942, and was never intended to become the principal form of health insurance in the United
28 States⁶; and
29
30 Whereas, As a result of these and other trends, reliance upon a health insurance system tied to
31 employment is becoming increasingly untenable for large portions of the United States
32 population; therefore be it
33
34 RESOLVED, That our American Medical Association recognize the importance of providing
35 avenues for affordable health insurance coverage and health care access to patients who do
36 not have employer-sponsored health insurance, or for whom employer-sponsored health
37 insurance does not meet their needs (New HOD Policy); and be it further

1 RESOLVED, That our AMA recognize that a significant and increasing proportion of patients are
2 unable to meet their health insurance or health care access needs through employer-sponsored
3 health insurance, and that these patients must be considered in the course of ongoing efforts to
4 reform the healthcare system in pursuit of universal health insurance coverage and health care
5 access. (New HOD Policy)

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

Received: 08/25/20

References:

1. Job Hopping Analysis: Trends by Generation and Education Level. LiveCareer/TIRO Communications Online Publication. 2018. <https://www.livecareer.com/wp-content/uploads/2018/05/2018-Job-Hopping-Report.pdf>
2. Union Members Summary. U.S. Bureau of Labor Statistics. Jan 18 2019. <https://www.bls.gov/news.release/union2.nr0.htm>
3. Long, Michelle; Rae, Matthew; Claxton, Gary; Damico, Anthony. Trends in Employer-Sponsored Insurance Offer and Coverage Rates, 1999-2014. Kaiser Family Foundation. Mar 21, 2016. <https://www.kff.org/private-insurance/issue-brief/trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014/>
4. Collins, Sara; Gunja, Munira; Doty, Michelle. How Well Does Insurance Coverage Protect Consumers from Health Care Costs?: Findings from the Commonwealth Fund Biennial Health Insurance Survey, 2016. The Commonwealth Fund. Oct 18 2017. <https://www.commonwealthfund.org/publications/issue-briefs/2017/oct/how-well-does-insurance-coverage-protect-consumers-health-care>
5. Currie, Janet; Madrian, Brigitte C. Health, Health Insurance and the Labor Market. Handbook of Labor Economics, Vol. 3C. Pub. 1999. O. Ashenfelter and D. Card eds. (Amsterdam: Elsevier)
6. Mihm, Stephen. Employer-Based Health Care was a Wartime Accident. The Chicago Tribune. Feb 24 2017. <https://www.chicagotribune.com/opinion/commentary/ct-obamacare-health-care-employers-20170224-story.html>

RELEVANT AMA POLICY:

The Future of Employer-Sponsored Insurance H-165.829

Our AMA: (1) supports requiring state and federally facilitated Small Business Health Options Program (SHOP) exchanges to maximize employee choice of health plan and allow employees to enroll in any plan offered through the SHOP; and (2) encourages the development of state waivers to develop and test different models for transforming employer-provided health insurance coverage, including giving employees a choice between employer-sponsored coverage and individual coverage offered through health insurance exchanges, and allowing employers to purchase or subsidize coverage for their employees on the individual exchanges

Citation: CMS Rep. 6, I-14

Trends in Employer-Sponsored Health Insurance H-165.843

Our AMA encourages employers to:

- a) promote greater individual choice and ownership of plans;
- b) enhance employee education regarding how to choose health plans that meet their needs;
- c) offer information and decision-making tools to assist employees in developing and managing their individual health care choices;
- d) support increased fairness and uniformity in the health insurance market; and
- e) promote mechanisms that encourage their employees to pre-fund future costs related to retiree health care and long-term care.

Citation: CMS Rep. 4, I-07; Reaffirmed CMS Rep. 1, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(November 2020)

Introduced by: Georgia

Subject: Reinstatement of Consultation Codes

Referred to: Reference Committee A

1 Whereas, In 2010, due to a perception of abuse or misuse of consult codes, Medicare
2 eliminated consult codes in what they calculated to be a revenue neutral manner, whereby they
3 increased the value of other evaluation and management (E&M) codes; and
4
5 Whereas, Medicare has proposed re-valuation of E&M codes, effective 2021 if finalized; and
6
7 Whereas, United Health Care (UHC) and Cigna are moving to eliminate consult codes; and
8
9 Whereas, The American Medical Association House of Delegates passed Resolution 819 in
10 2017, which passed without changes but has progressed negatively; and
11
12 Whereas, It appears cognitive care is undervalued; therefore be it
13
14 RESOLVED, That our American Medical Association proactively engage and advocate with any
15 commercial insurance company that discontinues payment for consultation codes or that is
16 proposing to or considering eliminating payment for such codes, requesting that the company
17 reconsider the policy change. (Directive to Take Action)

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

Received: 09/28/20

RELEVANT AMA POLICY

Medicare's Proposal to Eliminate Payments for Consultation Service Codes D-70.953

1. Our American Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes, and supports legislation to overturn recent Center for Medicare & Medicaid Services' (CMS) action to eliminate consultation codes. 2. Our AMA will work with CMS and interested physician groups through the CPT Editorial Panel to address all concerns with billing consultation services either through revision or replacement of the current code sets or by some other means. 3. Our AMA will, at the conclusion of the CPT Editorial Panel's work to address concerns with billing consultation services, work with CMS and interested physician groups to engage in an extensive education campaign regarding appropriate billing for consultation services. 4. Our AMA will: (a) work with the Centers for Medicare & Medicaid Services to consider a two-year moratorium on RAC audit claims based on three-year rule violations for E/M services previously paid for as consultations; and (b) pursue Congressional action through legislation to reinstate payment for consultation codes within the Medicare Program and all other governmental programs. 5. Our AMA will petition the CMS to limit RAC reviews to less than one year from payment of claims.

Citation: Res. 807, I-09; Appended: Sub. Res. 212, I-10; Reaffirmation A-12; Appended: Res. 216, A-12; Modified: CCB/CLRPD Rep. 2, A-14; Reaffirmation: A-17

Consultation Codes and Private Payers D-385.955

1. Our AMA will proactively engage and advocate with any commercial insurance company that discontinues payment for consultation codes or that is proposing to or considering eliminating payment for such codes, requesting that the company reconsider the policy change. 2. Where a reason given by an insurance company for policy change to discontinue payment of consultation codes includes purported coding errors or abuses, our AMA will request the company carry out coding education and outreach to physicians on consultation codes rather than discontinue payment for the codes, and call for release of de-identified data from the company related to purported coding issues in order to help facilitate potential education by physician societies.

Citation: Res. 819, I-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(November 2020)

Introduced by: New York

Subject: Access to Medication

Referred to: Reference Committee A

1 Whereas, Patients have a choice of receiving maintenance prescriptions from either a mail
2 order pharmacy or a brick-and-mortar pharmacy without any financial penalty; and
3
4 Whereas, Insurance plans should be required to fill prescriptions as written up to a 90 day
5 supply for all maintenance medications at a pharmacy or by mail order; and
6
7 Whereas, Pharmacists and their professional organizations should be ensuring the option for
8 patients to have prescriptions dispensed at a local pharmacy; and
9
10 Whereas, When a patient's prescription is initially placed by mail order, the medication cannot
11 also be dispensed by the local pharmacy resulting in a "re-order" delay causing many patients to
12 interrupt or experience an unnecessary delay in their prescribed treatment; therefore be it
13
14 RESOLVED, That our American Medical Association seek regulations on a national level that
15 would prohibit pharmacy benefit plans from limiting patient access to medications because an
16 initial prescription was placed and/or filled by mail-order. (Directive to Take Action)

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

Received: 10/08/20

RELEVANT AMA POLICY

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, 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"; (5) supports physician education regarding drug price and cost transparency, manufacturers' pricing practices, and challenges patients may encounter at the pharmacy point-of-sale; and (6) 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.

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; Reaffirmation: A-19; Appended: Res. 126, A-19

National Mail Order Pharmacy Practices H-120.962

1. The AMA insists that mail-order pharmacy companies respect the prescribing authority of physicians and dispense prescription medications only in the amounts prescribed; and recommends that mail order pharmacy companies charge only a reasonable and small shipping and handling fee per shipment in order not to encourage patients to request amounts of medications greater than those warranted by their physician's best judgment.
2. Our AMA opposes charging patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken.
3. Our AMA will make traditional pharmacies, including national chains, mail-order pharmacies, appropriate insurance carriers, and pharmaceutical benefit management companies aware of its policy opposing the charging of patients more than one co-pay for multiple prescriptions of the same or varying doses of a long-term medication within a 90-day period when evidence-based medicine dictates that less than 90-day prescriptions should be written during the initialization and dose stabilization of a newly prescribed long-term medication or during change in dosing of a long-term medication currently being taken.

Sub. Res. 506, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Appended: Res. 121, A-07; Reaffirmed: BOT Rep. 8, A-11; Reaffirmation A-14

Improve Safety of Mail-Ordered Medication H-120.936

Our AMA supports the establishment of national guidelines for mail-order pharmacies to ensure that medications reach patients in a safe and timely manner with full potency, and that when medication is damaged or loses potency during shipment, it should be replaced by the pharmacy at no cost to the patient.

Res. 917, I-14

Mail Service Pharmacy H-120.989

The AMA believes that: (1) MSP is an established alternative method of distributing drugs in the United States. (2) Controlled studies in the 1970s support the fact that MSPs are less vulnerable to drug diversion than retail pharmacies. Although numerous concerns about lack of safety and drug diversion have been expressed in trade publications and newsletters, documented controlled data regarding these concerns are minimal. There is no evidence of lack of safety in the peer-reviewed controlled-study literature. Presently, the practice of obtaining drugs from mail service pharmacies appears to be relatively safe. (3) Mail service pharmacy for prescription drugs is probably most appropriate for patients who have a well-established diagnosis, who have long-term chronic illnesses, whose disease is relatively stable and in whom the dose and dosage schedule is well regulated, who are isolated because of geographic or personal reasons, who have a drug history profile on record, who have been adequately informed about their medication, and who continue to see their physician regularly. Certainly, MSP is not best utilized for medications that are to be used acutely. Further, there must be assurance that generic substitution occur only by order of the prescribing physician. (4) Any purported price savings from the use of MSP is difficult to assess, since studies are generally limited to regional and limited patient populations. (5) Physicians have the responsibility to prescribe reasonable amounts of prescription medications based on the diagnosis and needs of their patients. Physicians must not be influenced by purely economic reasons, but they must take into account the patient's ability to pay and be aware of the guidelines recommended by particular health benefit programs for drugs.

BOT Rep. I, I-87; Reaffirmed: Sunset Report, I-97; Reaffirmed: CSAPH Rep. 3, A-07; Reaffirmed: BOT Rep. 8, A-11

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(November 2020)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

1 Whereas, There is some thought about bundling the fees of physicians with those of the hospital
2 in which the services are provided; and

3
4 Whereas, Such "bundled" payments will go to the hospital which will then control the
5 payments; and

6
7 Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also
8 much more dependent on the hospitals; and

9
10 Whereas, Hospitals would similarly never agree to bundled payments that went directly to
11 physicians; therefore be it

12
13 RESOLVED, That our American Medical Association oppose bundling of physician payments
14 with hospital payments, unless the physician has agreed to such an arrangement in advance.
15 (New HOD Policy)

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

Received: 10/09/20

RELEVANT AMA POLICY

Health Care Reform Physician Payment Models D-385.963

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.
5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.
6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.
7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.
8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.
9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.
10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

Citation: Sub. Res. 128, A-10; Appended: Res. 819, I-10; Appended: CMS Rep. 8, A-11; Appended: CMS Rep. 1, A-11; Reaffirmation A-11; Modified: BOT Rep. 18, A-12; Reaffirmation: I-12; Appended: Res. 702, A-13; Appended: Res. 827, I-14; Modified: Speakers Rep., I-15; Reaffirmed: CMS Rep. 09, A-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(November 2020)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

1 Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance
2 program that allows an eligible employee and his or her dependents the continued benefits of
3 health insurance coverage in the case that an employee loses his or her job or experiences a
4 reduction of work hours; and
5
6 Whereas, COBRA allows former employees to obtain continued health insurance coverage at
7 group rates that otherwise might be terminated and which are typically less expensive than
8 those associated with individual health insurance plans; and
9
10 Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could
11 occur when a person's employment is terminated; and
12
13 Whereas, College students enjoy similar group rate discounts with student health
14 insurance; and
15
16 Whereas, These students, upon graduation or other termination of an enrollment, potentially
17 face similar disruption in their healthcare coverage; therefore be it
18
19 RESOLVED, That our American Medical Association call for legislation similar to COBRA to
20 allow college students to continue their healthcare coverage, at their own expense, for up to
21 18 months after graduation or other termination of enrollment. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(November 2020)

Introduced by: New York

Subject: Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing

Referred to: Reference Committee A

1 Whereas, Consumer Operated and Oriented Plans (CO-OPs) were enacted as a part of the
2 Affordable Care Act (ACA) to improve competition in the health care marketplace; and
3
4 Whereas, CO-OPs may improve the cooperation of patients, physicians, and other providers to
5 improve health outcomes while controlling costs; and
6
7 Whereas, CO-OPs were anticipated to have at least a 33% failure rate but have exceeded that
8 rate substantially; and
9
10 Whereas, CO-OP failures have been due in large part to a combination of premiums that were
11 too low, benefits that were too generous, enrollees who were sicker than anticipated,
12 competition from bigger carriers with larger reserves, changing regulations for risk corridor
13 payments, and restrictions on enrollments from large group markets; and
14
15 Whereas, Four of the original 23 CO-OPs have continued to operate despite these
16 challenges; and
17
18 Whereas, The remaining CO-OPs have had some success in reducing the cost of premiums,
19 but have limited market share and restrictions on enrollment; and
20
21 Whereas, Changing regulations or legislation to allow CO-OPs to more effectively compete in
22 the larger health insurance marketplace, further improve governance, further improve
23 operations, and stabilize the regulatory environment in which they operate may allow CO-OPs
24 to enhance competition in the broader health insurance market; therefore be it
25
26 RESOLVED, That Our American Medical Association study options to improve the performance
27 of Consumer Operated and Oriented Plans as a potential public option to improve competition in
28 the health insurance marketplace and to improve the value of healthcare to patients (Directive to
29 Take Action); and be it further
30
31 RESOLVED, That our AMA work with the National Alliance of State Health Co-Ops
32 (NASCHCO) to request that Congress and the US Department of Health and Human Services
33 reestablish funding for new health insurance co-operatives. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(November 2020)

Introduced by: New York

Subject: Health Insurance that Fairly Compensates Physicians

Referred to: Reference Committee A

1 Whereas, There are increasing numbers of health insurance plans that do not adequately
2 compensate physicians for their services, including Medicaid, Medicare and many private
3 insurance plans; and

5 Whereas, Adequate insurance compensation is necessary for the continued independent
6 practice of medicine; and

8 Whereas, Hospitals and other groups providing medical goods and services would never accept
9 insurances that do not adequately compensate their services and products; therefore be it

10 RESOLVED. That our American Medical Association advocate for insurance plans to
11 adequately compensate physicians so that they are able to remain in practice independent of
12 hospital employment. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(November 2020)

Introduced by: New York

Subject: Medicaid Tax Benefits

Referred to: Reference Committee A

1 Whereas, There are many patients with Medicaid or no health insurance that physicians care for
2 routinely for little or no payment; and
3
4 Whereas, It may be politically complicated to rectify this fact directly with improved payments to
5 physicians; and
6
7 Whereas, One way to offset the problem would be to use tax deduction techniques; and
8
9 Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or
10 Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes
11 providing tax deductions or credits for the provision of care to the medically uninsured and
12 underinsured; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for legislation that would allow
15 physicians who take care of Medicaid or uninsured patients to receive some financial benefit
16 through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use
17 the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

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

Received: 10/09/20

RELEVANT AMA POLICY

Income Tax Credits or Deductions as Compensation for Treating Medically Uninsured or Underinsured H-180.965

The AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured.

Citation: BOT Rep. 49, I-93; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed in lieu of Res. 141, A-07; Reaffirmed: CMS Rep. 01, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(November 2020)

Introduced by: New York

Subject: Payment for Regadenoson (Lexiscan)

Referred to: Reference Committee A

1 Whereas, During exercise stress testing in cardiology, many patients are unable to walk on the
2 treadmill due to arthritis of knees and hips, PVD or deconditioning; and
3
4 Whereas, For such patients, a pharmacologic stress test is used to evaluate presence of
5 coronary artery disease using Regadenoson (Lexiscan) which is adenosine related
6 compound; and
7
8 Whereas, Cost of this agent from the supplier is around \$248.00 for a single dose; and
9
10 Whereas, No insurance company including Centers for Medicare and Medicaid Services pays
11 the complete amount of \$248.00; and
12
13 Whereas, Some HMOs like Fidelis and WellCare pay as little as \$135.00, thus expecting the
14 stress test lab to absorb the loss of \$110.00 each time such patient is tested; and
15
16 Whereas, This practice of underpaying by HMOs and insurance companies discourages stress
17 test labs to use Regadenoson for these patients due to significant financial loss; and
18
19 Whereas, The costs of other medical agents, such as vaccines and chemotherapy, are also not
20 adequately reimbursed; therefore be it
21
22 RESOLVED, That our American Medical Association petition the Centers for Medicare and
23 Medicaid Services to investigate the disparity between the cost of medical agents and the
24 reimbursement by insurance companies and develop a solution so physicians are not financially
25 harmed when providing medical agents. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(November 2020)

Introduced by: New York

Subject: Private Payor Payment Integrity

Referred to: Reference Committee A

1 Whereas, Private for-profit medical insurers often use self-developed payment guidelines to
2 their financial advantage in reducing or denying payment for necessary medical care; and
3
4 Whereas, For-profit private insurers have an unresolvable conflict of interest in denying payment
5 for diagnostic and treatment options approved by the FDA and adopted by CMS, Workers'
6 Compensation, auto liability insurance and other private payers and are considered medically
7 necessary by the patient and treating physician; therefore be it
8
9 RESOLVED, That our American Medical Association advocate for private insurers to require, at
10 a minimum, to pay for diagnosis and treatment options that are covered by government payers
11 such as Medicare (Directive to Take Action); and be it further
12
13 RESOLVED, That our AMA seek to ensure by legislative or regulatory means that private
14 insurers shall not be allowed to deny payment for treatment options as "experimental and/or
15 investigational" when they are covered under the government plans; such coverage shall
16 extend to managed Medicaid, Workers' Compensation plans, and auto liability insurance
17 companies. (Directive to Take Action)

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

Received: 10/09/20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(November 2020)

Introduced by: Association for Clinical Oncology, American Academy of Neurology

Subject: Most Favored Nation Executive Order

Referred to: Reference Committee A

1 Whereas, On September 13, 2020, President Trump signed a long-promised executive order
2 aimed at reducing the price of drugs. The order grants authority to the Secretary of HHS to
3 implement a demonstration project to test a “most favored nation” (MFN) policy for some drugs
4 or biologicals under Part B and Part D of Medicare;¹ and

5
6 Whereas, According to the Administration, it is planning to use the Organization for Economic
7 Co-operation and Development (OECD) to identify countries with a comparable per-capita gross
8 domestic product and, after adjusting for volume and differences in national gross domestic
9 product, to have Medicare pay the lowest price for drugs available in those countries. This policy
10 would enable Medicare to pay the same amount for drugs as other specified developed
11 countries; and

12
13 Whereas, It is expected that the Part B demonstration will be the first that the Centers for
14 Medicare and Medicaid Services (CMS) will propose; however, details of the demonstrations
15 have not been released; and

16
17 Whereas, CMS has not been transparent about the rulemaking process by which this Executive
18 Order would be implemented; and

19
20 Whereas, Our AMA approved H-110.980, “Additional Mechanisms to Address High and
21 Escalating Pharmaceutical Prices,” at the 2019 Interim meeting advocating that any use of any
22 international drug price index or average should limit burdens on physician practices; and

23
24 Whereas, Our AMA approved D-330.904, “Opposition to the CMS Medicare Part B Drug
25 Payment Model,” at the 2016 Annual meeting advocating against policies that are likely to
26 undermine access to the best course of treatment for individual patients and oppose
27 demonstration programs that could lead to lower quality of care and do not contain mechanisms
28 for safeguarding patients; and

29
30 Whereas, There are concerns that a hastily developed demonstration could have a negative
31 impact on patient access to critical therapies given that practices and patients are already
32 strained due to the current COVID-19 public health emergency; therefore be it

33
34 RESOLVED, That our American Medical Association advocate against the implementation of
35 mandatory demonstration projects testing “Most Favored Nation” policy during the ongoing
36 COVID-19 Public Health Emergency (PHE) to avoid potential further burden on practices
37 (Directive to Take Action); and be it further

¹ <https://www.whitehouse.gov/presidential-actions/executive-order-lowering-drug-prices-putting-america-first/>

1 RESOLVED, That our AMA, in the event that a mandatory demonstration project is proposed
2 pursuant to the Most Favored Nation Executive Order during the PHE, oppose the
3 demonstration project's implementation. (New HOD Policy)

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

Received: 10/14/20

RELEVANT AMA POLICY

Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:

- a. The arbitration process should be overseen by objective, independent entities;
- b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
- c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
- d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
- e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
- f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
- g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
- h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
- i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.

2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:

- a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
- b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
- c. The use of any international drug price index or average should preserve patient access to necessary medications;
- d. The use of any international drug price index or average should limit burdens on physician practices; and
- e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.

3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.

Citation: CMS Rep. 4, I-19

Most Favored Nation Clause within Insurance Contracts H-385.938

Our AMA opposes the inclusion of "Most Favored Nation Clauses" into insurance contracts that require a physician or other health care provider to give a third party payer his most discounted rate for medical services.

Citation: Res. 712, I-98; Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18

Opposition to the CMS Medicare Part B Drug Payment Model D-330.904

1. Our AMA will request that the Centers for Medicare & Medicaid Services (CMS) withdraw the proposed Part B Drug Payment Model.
2. Our AMA will support and actively work to advance Congressional action to block the proposed Part B Drug Payment Model if CMS proceeds with the proposal.
3. Our AMA will advocate against policies that are likely to undermine access to the best course of treatment for individual patients and oppose demonstration programs that could lead to lower quality of care and do not contain mechanisms for safeguarding patients.
4. Our AMA will advocate for ensuring that CMS solicits and takes into consideration feedback from patients, physicians, advocates, or other stakeholders in a way that allows for meaningful input on any Medicare coverage or reimbursement policy that impacts patient access to medical therapies, including policies on coverage and reimbursement.

Citation: Res. 241, A-16