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

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

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, however, recognizes 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. Other necessary activities include increasing health workforce diversity, advocating for equity in health care access, promoting equity in care, ensuring equitable practices and processes in research and data collection, and addressing structural root determinants of health, including structural racism.

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

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

BACKGROUND

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

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

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

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

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

ADDRESSING SOCIAL DETERMINANTS OF HEALTH: WITHIN AND OUTSIDE OF THE HEALTH CARE SYSTEM

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

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

Healthcare Anchor Network

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

Health in All Policies and the National Prevention Strategy

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

Capturing Data on Patients Impacted by Social Determinants of Health

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

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

Incorporating Social Determinants of Health in USPSTF Recommendations

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

Neighborhood and Community Initiatives

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

Accountable Health Communities

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

Medicaid Accountable Care Organization Initiatives Addressing Social Determinants

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

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

SOCIAL DETERMINANTS OF HEALTH IN HEALTH INSURANCE BENEFIT DESIGN

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

Medicaid State Plan and Waiver Opportunities

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

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

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

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

Medicare Advantage

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

Tailoring Benefits for Dual Eligibles Targeting Social Determinants of Health

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

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

RELEVANT AMA POLICY

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

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

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

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

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

DISCUSSION

The Council welcomes the growing number of initiatives within and outside of the health care system to address social determinants of health by prioritizing health within non-health sectors and developing and implementing initiatives to address health-related social needs. At the outset, 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.

RECOMMENDATIONS

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

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

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

3. That our AMA encourage public and private 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. (New HOD Policy)

4. That our AMA reaffirm Policies D-478.972 and D-478.996 supporting proactive and practical approaches to promote interoperability at the point of care. (Reaffirm HOD Policy)

5. That our AMA support mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians. (New HOD Policy)

6. That our AMA support research 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. (New HOD Policy)

7. That our AMA encourage coverage pilots 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. (New HOD Policy)

Fiscal Note: Less than $500.

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