

DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its November 2020 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMA HOUSE OF DELEGATES (November 2020 Meeting)

Report of Reference Committee B

Alethia Morgan, MD, Chair

1 Your Reference Committee recommends the following consent calendar for acceptance:

2
3 **RECOMMENDED FOR ADOPTION**

- 4
5 1. Board Report 5 – FDA Conflict of Interest (Resolution 216-A-18)
6 2. Board Report 6 – Covenants Not To Compete (Resolution 10 -A-19)
7 3. Board Report 13 – Merit-Based Incentive Payment System (MIPS) Update
8 4. Resolution 202 – Cares Act Equity and Loan Forgiveness in the Medicare
9 Accelerated Payment Program

10
11 **RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE**

- 12
13 5. Board Report 7 – Opposition to Involuntary Civil Commitment for Substance Use
14 Disorder (Resolution 22-A-19)
15 6. Board Report 14 – Advocating for the Standardization and Regulation of
16 Outpatient Addiction Rehabilitation Facilities (Resolution 201-I-19)

17
18 **RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED**

- 19
20 7. Board Report 16 – Enabling Methadone Treatment of Opioid Use Disorder in
21 Primary Care Settings, Bot Report 2-I-19
22 8. Resolution 203 – COVID-19 Emergency and Expanded Telemedicine
23 Resolution 205 – Telehealth Post SARS-COV-2
24 9. Resolution 206 – Strengthening Accountability Health Care Reviewers
25 10. Resolution 211 – Creating a Congressionally-Mandated Bipartisan Commission
26 to Examine the U.S. Preparations for and Response to the COVID-19 Pandemic
27 11. Resolution 218 – Crisis Payment Reform Advocacy

28
29 **RECOMMENDED FOR ADOPTION IN LIEU OF**

- 30
31 12. Resolution 212 – Copay Accumulator Policies
32

1 **RECOMMENDED FOR REFERRAL**

2

- 3 13. Resolution 213 – Pharmacies to Inform Physicians When Lower Cost Medication
4 Options are on Formulary

Click here to submit an amendment.

5

RECOMMENDED FOR ADOPTION

- 1
2
3 (1) BOARD OF TRUSTEES REPORT 5 – FDA CONFLICT OF
4 INTEREST

5
6 **RECOMMENDATION:**

7
8 **Recommendations in Board of Trustees Report 5 be adopted and the**
9 **remainder of the Report be filed.**

10
11
12 **HOD ACTION: Recommendations in Board of Trustees**
13 **Report 5 adopted and the remainder of the Report filed.**

14
15 In light of these considerations, your Board of Trustees recommends that the following
16 be adopted in lieu of Resolution 216-A-18 and the remainder of this report be filed:

- 17
18 1. That our American Medical Association (AMA) reaffirm Policy H-100.992,
19 “FDA,” which supports that FDA conflicts of interest should not overrule scientific
20 evidence in making policy decisions and the FDA should include clinical experts
21 on advisory committees. (Reaffirm HOD 14 Policy)

- 22
23 2. That our AMA adopt the following new policy:

24
25 It is the position of the AMA that decisions of the Food and Drug Administration
26 (FDA) must be trustworthy. Patients, the public, physicians, other health care
27 professionals and health administrators, and policymakers must have confidence
28 that FDA decisions and the recommendations of FDA advisory committees are
29 ethically and scientifically credible and derived through a process that is rigorous,
30 independent, transparent, and accountable. Rigorous policies and procedures
31 should be in place to minimize the potential for financial or other interests to
32 influence the process at all key steps. These should include, but not necessarily
33 be limited to: a) required disclosure of all relevant actual or potential conflicts of
34 interest, both financial and personal; b) a mechanism to independently audit
35 disclosures when warranted; c) clearly defined criteria for identifying and
36 assessing the magnitude and materiality of conflicts of interest; and d) clearly
37 defined processes for preventing or terminating the participation of a conflicted
38 member, and mitigating the influence of identified conflicts of interest (such as
39 prohibiting individuals from participating in deliberations, drafting, or voting on
40 recommendations on which they have conflicts) in those limited circumstances
41 when an individual’s participation cannot be terminated due to the individual’s
42 unique or rare skillset or background that is deemed highly valuable to the
43 process. Further, clear statements of COI policy and procedures, and disclosures
44 of FDA advisory committee members’ conflicts of interest relating to specific
45 recommendations, should be published or otherwise made public. Participation on
46 advisory committees should be facilitated through appropriate balancing of the
47 relative scarcity or uniqueness of an individual’s expertise and ability to contribute
48 to the process, as compared to the feasibility and effectiveness of mitigation
49 measures. Finally, our AMA urges the FDA to streamline the COI process to the

1 greatest extent possible, thereby eliminating any unnecessary documentation,
2 delays, or administrative barriers to qualified physicians' participation on FDA
3 advisory committees. (New HOD Policy)

4 -
5 3. That our AMA adopt the following new policy:
6

7 - It is the position of the AMA that the FDA should undertake an evaluation of pay-
8 later conflicts of interest (e.g., where a FDA advisory committee member develops
9 a financial conflict of interest only after his or her initial appointment on the
10 advisory committee has expired) to assess whether these undermine the
11 independence of advisory committee member recommendations and whether
12 policies should be adopted to address this issue. (New HOD Policy)

13
14 Your Reference Committee heard overwhelming supportive testimony on Board of
15 Trustees Report 5. The only reason that the HOD referred the previous version (Board of
16 Trustees Report 19-A-19) of Board of Trustees Report 5 was the desire to make a minor
17 revision, adding language that would call on our AMA to adopt policy that called on the
18 U.S. Food and Drug Administration to streamline its advisory committee conflict of
19 interest process. Given this minor revision, and the strong testimonial support for Board
20 of Trustees Report 5, your Reference Committee recommends that Board of Trustees
21 Report 5 be adopted, and the remainder of the Report be filed.

22
23 (2) BOARD OF TRUSTEES REPORT 6 – COVENANTS NOT
24 TO COMPETE

25
26 **RECOMMENDATION:**

27
28 **Recommendation in Board of Trustees Report 6 be adopted and the**
29 **remainder of the Report be filed.**

30
31
32 **HOD ACTION: Recommendation in Board of Trustees**
33 **Report 6 adopted and the remainder of the Report filed.**

34
35 In light of these considerations, the Board recommends that the following be adopted in
36 lieu of Resolution 10-A-19 and the remainder of this report be filed:

37
38 Our AMA create a state restrictive covenant legislative template to assist state medical
39 associations, national medical specialty societies and physician members as they
40 navigate the intricacies of restrictive covenant policy at the state level. (Directive to Take
41 Action)

42
43 Your Reference Committee heard overwhelmingly supportive testimony on Board Report
44 6. Testimony indicated a growing concern that post-employment non-competes can be
45 problematic for employed physicians and the patient-physician relationship, particularly
46 where physicians may be employed by non-physician-owned entities such as large
47 health systems. Testimony indicated that AMA members are on both sides of this issue,
48 but that our AMA's providing a thoughtful informational resource in the form of a
49 legislative template would be useful for physicians, regardless of their perspective on
50 non-competes and their use.

1
2 During the hearing, your Reference Committee received testimony from the American
3 College of Radiology (ACR) requesting that the recommendation in Board Report 6 be
4 amended to encompass anti-disparagement and non-disclosure clauses in addition to
5 non-competes. Your Reference Committee also heard testimony stating that the
6 proposed amendment is beyond the scope of Board of Trustees Report 6 and could
7 cloud the report's singular focus on covenants not to complete—an issue of great
8 concern to many physicians that has been repeatedly raised in the House of Delegates.
9 While your Reference Committee believes that the ACR amendment has merit, we
10 agree with those who opined that it is beyond the scope of BOT 6. Therefore, your
11 Reference Committee does not believe it should be adopted as part of BOT 6. Because
12 the proposed amendment is not an item of business before the HOD, it is procedurally
13 unable to be referred at this time. A representative from our AMA Board of Trustees
14 indicated the Board is already aware of the issue. Your Reference Committee therefore
15 recommends that Board of Trustees Report 6 be adopted and the remainder of the
16 report be filed.

17
18 (3) BOARD OF TRUSTEES REPORT 13 – MERIT-BASED
19 INCENTIVE PAYMENT SYSTEM (MIPS) UPDATE

20
21 **RECOMMENDATION:**

22
23 **Recommendations in Board of Trustees Report 13 be adopted and the**
24 **remainder of the Report be filed.**

25
26
27 **HOD ACTION: Recommendations in Board of Trustees**
28 **Report 13 adopted and the remainder of the Report filed.**

29
30 The Board of Trustees recommends that the following recommendations be adopted in
31 lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report
32 be filed:

- 33
34 1. That our American Medical Association (AMA) support legislation that ensures
35 Medicare physician payment is sufficient to safeguard beneficiary access to care,
36 replaces or supplements budget neutrality in MIPS with incentive payments, or
37 implements positive annual physician payment updates. (Directive to Take
38 Action)
- 39
40 2. That our AMA reaffirm Policy D-395.999, "Reducing MIPS Reporting Burden,"
41 Policy D27 395.998, "Opposed Replacement of the Merit-Based Incentive
42 Payment System with the Voluntary Value Program," Policy H-390.838, "MIPS
43 and MACRA Exemption," Policy D-390.950, "Preserving a Period of Stability in
44 Implementation of the Medicare Access and Children's Health Insurance
45 Program (CHIP) Reauthorization Act (MACRA)," Policy D-390.949, "Preserving
46 Patient Access to Small Practices Under MACRA," Policy H-385.913, "Physician-
47 Focused Alternative Payment Models," Policy H-385.913, "Physician-Focused
48 Alternative Payment Models," Policy H-450.931, "Moving to Alternative Payment
49 Models," and Policy H-385.908, "Physician-Focused Alternative Payment
50 Models: Reducing Barriers." (Reaffirm HOD Policy)

1
2 Your Reference Committee heard overwhelming supportive testimony on Board of
3 Trustees Report 13. Your Reference Committee heard that our AMA has worked closely
4 with Centers for Medicare & Medicare Services (CMS) and Congress on implementing
5 the MIPS program, and our AMA advocacy efforts resulted in policies that have
6 improved some, but not all, aspects of MIPS. Your Reference Committee heard that our
7 AMA has strong policy discussing the MIPS issues, and has long articulated and
8 advocated for policies to positively impact physician payment and reporting. Similarly,
9 our AMA continues to advocate against systems that increase administrative burden,
10 decrease reimbursement, and negatively impact patient care. Your Reference
11 Committee heard that our AMA should have the ability and the flexibility to support
12 legislation that would provide physicians with positive payment updates that could shift
13 the budget neutrality dynamic of the current MIPS program. Your Reference Committee
14 also heard testimony concerning our AMA's continued work with stakeholders to improve
15 MIPS, such as streamlining reporting requirements to decrease physician burden,
16 increasing the performance threshold, and refining the MIPS methodology to reduce the
17 total cost of care measures outside of physicians' control. Your Reference Committee
18 heard the concerns of small practices, their need for support, especially in light of
19 COVID-19 and planned cuts, and the importance of Medicare funding. Accordingly, your
20 Reference Committee recommends that Board of Trustees Report 13 be adopted and
21 the remainder of the Report be filed.

22
23 (4) RESOLUTION 202 – CARES ACT EQUITY AND LOAN
24 FORGIVENESS IN THE MEDICARE ACCELERATED
25 PAYMENT PROGRAM

26
27 **RECOMMENDATION:**

28
29 **Resolution 202 be adopted.**

30
31
32 **HOD ACTION: Resolution 202 adopted as amended.**

33
34 **RESOLVED, That our AMA and the federation of medicine**
35 **work to improve and expand various federal stimulus**
36 **programs (e.g., the CARES Act and MAPP) in order to**
37 **assist physicians in response to the Covid-19 pandemic,**
38 **including:**

39
40 **Restarting the suspended Medicare Advance payment**
41 **program, including significantly reducing the re-**
42 **payment interest rate and lengthening the repayment**
43 **period;**

44
45 **Expanding the CARES Act health care provider relief**
46 **pool and working to ensure that a significant share of**
47 **the funding from this pool is made available to**
48 **physicians in need regardless of the type of patients**
49 **treated by those physicians; and**
50

1 **Reforming the Paycheck Protection Program, to**
2 **ensure greater flexibility in how such funds are spent**
3 **and lengthening the repayment period (Directive to**
4 **Take Action); and be it further**
5

6 **RESOLVED, That, in the setting of the COVID-19 pandemic,**
7 **our AMA advocate for additional financial relief ~~for~~ to**
8 **physicians to reduce ~~via loan forgiveness~~ ~~for~~ medical**
9 **school educational debt. (Directive to Take Action)**

10
11 RESOLVED, That our AMA and the federation of medicine work to improve and expand
12 various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist
13 physicians in response to the Covid-19 pandemic, including:

- 14
15 - Restarting the suspended Medicare Advance payment program, including
16 significantly reducing the re-payment interest rate and lengthening the repayment
17 period;
- 18
19 - Expanding the CARES Act health care provider relief pool and working to ensure
20 that a significant share of the funding from this pool is made available to
21 physicians in need regardless of the type of patients treated by those physicians;
22 and
- 23
24 - Reforming the Paycheck Protection Program, to ensure greater flexibility in how
25 such funds are spent and lengthening the repayment period (Directive to Take
26 Action); and be it further

27
28 RESOLVED, That, in the setting of the COVID-19 pandemic, our AMA advocate for
29 additional relief to physicians via loan forgiveness for medical school educational debt.
30 (Directive to Take Action)

31
32 Your Reference Committee heard largely supportive testimony on Resolution 202. Your
33 Reference Committee heard that our AMA continues to work on the issues identified in
34 Resolution 202, and that many aspects in Resolution 202 are being implemented by our
35 AMA Advocacy Team. Your Reference Committee heard multiple examples
36 demonstrating AMA's continued advocacy on this important issue. Your Reference
37 Committee also heard testimony that there is considerable difficulty for physician
38 practices with large pediatric or Medicaid patient populations in obtaining CARES
39 funding or support similar to Medicare. Your Reference Committee heard testimony on
40 the need to expand funding to all physicians, not just those who serve patients covered
41 by Medicare.

42
43 Your Reference Committee heard a considerable amount of discussion on the second
44 Resolve, and considered an amendment that would change the terminology from "loan
45 forgiveness" to "temporary deferment of loan repayment, including suspension of interest
46 accumulation during the deferment period." However, your Reference Committee heard
47 opposition to the proposed change, and determined that keeping the term broader would
48 best meet the needs of our membership, therefore affording our AMA the flexibility to
49 advocate for physician educational debt relief. Your Reference Committee considered
50 our AMA's advocacy relating to medical school debt and recognizes that our Advocacy

- 1 Team is continuing to seek legislative solutions in COVID relief legislation. Accordingly,
- 2 your Reference Committee recommends that Resolution 202 be adopted.
- 3

RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE

- 1
2
3 (5) BOARD OF TRUSTEES REPORT 7 – OPPOSITION TO
4 INVOLUNTARY CIVIC COMMITMENT FOR SUBSTANCE
5 USE DISORDER
6

7 **RECOMMENDATION A:**
8

9 **Recommendations in Board of Trustees Report 7 be adopted and the**
10 **remainder of the Report be filed.**
11

12 **RECOMMENDATION B:**
13

14 **The title of Board of Trustees Report 7 be changed to read as follows:**
15

16 **INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER**
17

18
19 **HOD ACTION: Recommendations in Board of Trustees**
20 **Report 7 adopted with change in title and the remainder of**
21 **the Report filed.**
22

23 The Board recommends that Resolution 22-A-19 be amended by addition and deletion
24 and the remainder of the report be filed.
25

- 26 1. That our AMA oppose civil commitment proceedings for patients with a
27 substance use disorder unless: a) A physician or mental health professional
28 determines that civil commitment is in the patient's best interest consistent with
29 the AMA Code of Medical Ethics; b) Judicial oversight is present to ensure that
30 the patient can exercise his or her right to oppose the civil commitment; c) The
31 patient will be treated in a medical or other health care facility that is staffed with
32 medical professionals with training in mental illness and addiction, including
33 medications to help with withdrawal and other symptoms as prescribed by his or
34 her physician; and d) The facility is separate and distinct from a correctional
35 facility. (New HOD 47 Policy)
36
37 2. That our AMA continue its work to advance policy and programmatic efforts to
38 address gaps in voluntary substance use treatment services. (Directive to Take
39 Action)
40

41 Your Reference Committee heard largely supportive testimony on Board of Trustees
42 Report 7. Your Reference Committee heard discussions that highlighted concerns
43 associated with involuntary civil commitment, as well as many of the ethical and legal
44 issues that must be considered. Your Reference Committee is thankful that our AMA
45 Code of Medical Ethics can play a critical role to ensure that our policy
46 recommendations are well-informed by the ethical standards guiding our profession.
47 Your Reference Committee is also very pleased that our colleagues at the American
48 Psychiatric Association have excellent guidance in place that is publicly available to help
49 guide this discussion and our practice, and we acknowledge supportive testimony to this

1 effect. The issue of involuntary civil commitment has many gray areas, but your
2 Reference Committee is satisfied that the conditions laid out by our Board provide
3 excellent guidance moving forward. Your Reference Committee is also pleased by the
4 report's discussion of our AMA's ongoing advocacy to address gaps in access to care for
5 mental illness and substance use disorders. Given the scope of the nation's overdose
6 epidemic and massive treatment gap, it is unconscionable that health insurance
7 companies still display their continued intransigence to impose prior authorization for
8 medications to treat opioid use disorder and ongoing violations of mental health and
9 substance use disorder parity. Your Reference Committee is deeply appreciative of the
10 efforts of our Council on Legislation to help develop model legislation and our AMA to
11 partner with so many in our House of Medicine to remove barriers to evidence-based
12 care.

13
14 Your Reference Committee also heard testimony offering an amendment to change the
15 title of the Resolution to better reflect the report to read "Involuntary Civil Commitment
16 for Substance Use Disorder." For these reasons, your Reference Committee
17 recommends that Board of Trustees Report 7 be adopted, with a change in title as
18 indicated, and the remainder of the report filed.

19
20 (6) BOARD OF TRUSTEES REPORT 14 – ADVOCATING
21 FOR THE STANDARDIZATION AND REGULATION OF
22 OUTPATIENT ADDICTION REHABILITATION
23 FACILITIES

24
25 **RECOMMENDATION A:**

26
27 **Recommendations in Board of Trustees Report 14 be adopted and the**
28 **remainder of the Report be filed.**

29
30 **RECOMMENDATION B:**

31
32 **The title of Board of Trustees Report 14 be changed to read as follows:**

33
34 **ENHANCED FUNDING FOR AND ACCESS TO OUTPATIENT ADDICTION**
35 **REHABILITATION**

36
37
38 **HOD ACTION: Recommendations in Board of Trustees**
39 **Report 14 adopted with change in title and the remainder**
40 **of the Report filed.**

41
42 The Board of Trustees recommends that the following recommendations be adopted in
43 lieu of Resolution 201-I-19, and that the remainder of the report be filed.

- 44
45 1. That our AMA advocate for the expansion of federal grants in support of
46 treatment for a substance use disorder to states that are conditioned on that
47 state's adoption of law and/or regulation that prohibit drug courts, recovery
48 homes, sober houses, correctional settings, and other similar programs from
49 denying entry or ongoing care if a patient is receiving medication for an opioid
50 use disorder or other chronic medical condition. (Directive to Take Action)

2. That our AMA advocate for sustained funding to states in support of evidence-based treatment for patients with a substance use disorder and/or co-occurring mental disorder, such as that put forward by the American Society of Addiction Medicine, American Academy of Addiction Psychiatry, American Psychiatric Association, American Academy of Child and Adolescent Psychiatry and other professional medical organizations. (Directive to Take Action)
3. That our AMA reaffirm Policy D-95.981, “Improving Medical Practice and Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription Drug Use and Addiction.” (Reaffirm HOD Policy)
4. That our AMA reaffirm Policy H-95.922, “Substance Use and Substance Use Disorders.” (Reaffirm HOD Policy)
5. That our AMA reaffirm H-95.981, “Policy Federal Drug Policy in the United States.” (Reaffirm HOD Policy).

Your Reference Committee heard overwhelming supportive testimony on Board of Trustees Report 14. Testimony cited our AMA’s longstanding and extensive policy on addiction and substance use disorder treatment, and indicated that one of the primary challenges in ending the nation’s drug overdose epidemic remains the inability of most patients to obtain evidence-based care for a substance use disorder. Your Reference Committee heard that removing the barriers for patients to receive evidence-based treatment is critical to helping end the epidemic. Your Reference Committee also heard testimony that State and federal laws already govern outpatient treatment facilities and standardized evidence-based federal regulations are not the right approach. Your Reference Committee agrees with the testimony provided that the recommendations in the report acknowledge that medical specialties, such as the American Society of Addiction Medicine and the American Psychiatric Association, already have guidelines and standards to help ensure the provision of evidence-based care in treatment facilities for in-patient and out-patient care, and that the recommendations also acknowledge that sustained federal funding—rather than short-term grants—and a comprehensive framework to prevent and treat all substance use disorders are necessary to address the current epidemic.

Your Reference Committee also heard testimony offering an amendment to change the title of the Resolution to better reflect the content of the report to read “Enhanced Funding for and Access to Addiction Facilities.” Accordingly, your Reference Committee recommends that Board of Trustees Report 14 be adopted, with a change in title as indicated, and the remainder of the report filed.

**RECOMMENDED FOR ADOPTION AS AMENDED OR
SUBSTITUTED**

- (7) BOARD OF TRUSTEES REPORT 16 – ENABLING
METHADONE TREATMENT OF OPIOID USE DISORDER
IN PRIMARY CARE SETTINGS

RECOMMENDATION A:

Recommendation 2 in Board of Trustees Report 16 be amended by addition and deletion to read as follows:

That our AMA support further research to help define the population of patients who may be safely treated with methadone maintenance treatment via primary care office-based treatment, including primary care therapy.

RECOMMENDATION B:

Recommendations in Board of Trustees Report 16 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Board of Trustees Report 16 adopted as amended and the remainder of the Report filed.

The Board recommends that the following be adopted in lieu of the second recommendation of Board Report 2-I-19, and that the remainder of the report be filed:

1. That our AMA research current best practices and support pilot programs and other evidence-based efforts to expand and integrate primary care services for patients receiving methadone maintenance treatment. (New HOD Policy)
2. That our AMA support further research to help define the population of patients who may be safely treated with methadone maintenance treatment via primary care office-based therapy. (New HOD Policy)
3. That our AMA urge all payers, including health insurance companies, pharmacy benefit management companies, and state and federal agencies, to reduce prior authorization and other administrative burdens and to enhance the provision of primary care, counseling, and other medically necessary services for patients being treated with methadone maintenance treatment. (Directive to Take Action)

Your Reference Committee heard compelling testimony in support of adopting the recommendations in Board of Trustees Report 16. Methadone Maintenance Treatment (MMT) is both a highly stigmatized yet a highly successful form of treatment for opioid use disorder. Your Reference Committee commends the efforts of our AMA Opioid Task Force to work with its partners to remove stigma from evidence-based treatment and acknowledges that this work must continue. Your Reference Committee agrees with

1 testimony highlighting the challenges and benefits of patients receiving primary care
2 services alongside MMT. Your Reference Committee appreciates the Board's
3 explanations of the many requirements that would be imposed upon primary care
4 practices should they seek to provide MMT. Your Reference Committee agrees with the
5 Board that there should be continued research into best practices as well as further
6 advocacy to remove existing barriers to MMT.

7
8 Your Reference Committee also heard that primary care physicians are not the only
9 physicians who can effectively use MMT to treat patients, and that the report as written
10 may inadvertently restrict office-based treatment only to primary care physicians. Your
11 Reference Committee agrees with this testimony and consequently agrees with the
12 noted proffered amendment. Accordingly, your Reference Committee recommends that
13 Board of Trustees Report 16 be adopted as amended, and the remainder of the report
14 be filed.

- 15
16 (8) RESOLUTION 203 – COVID-19 EMERGENCY AND
17 EXPANDED TELEMEDICINE REGULATIONS
18 RESOLUTION 205 – TELEHEALTH POST SARS-COV-2

19
20 **RECOMMENDATION:**

21
22 **That Alternate Resolution 203 be adopted in lieu of Resolutions 203 and**
23 **205.**

24
25 **RESOLVED, That our AMA continue to advocate for the widespread**
26 **adoption of telehealth services in the practice of medicine for physicians**
27 **and physician-led teams post SARS-COV-2 (Directive to Take Action); and**
28 **be it further**

29
30 **RESOLVED, That our AMA advocate that the Federal government, including**
31 **the Centers for Medicare & Medicaid Services (CMS) and other agencies,**
32 **state governments and state agencies, and the health insurance industry,**
33 **adopt clear and uniform laws, rules, regulations, and policies relating to**
34 **telehealth services that ~~permanently~~:**

35
36 **1. provide equitable coverage that allows patients to access**
37 **telehealth services wherever they are located;**

38
39 ~~**2. promote continuity of care by preventing payors from using cost-**~~
40 ~~**sharing or other policies to prevent or disincentivize patients from**~~
41 ~~**receiving care via telehealth from their physician;**~~

42
43 ~~**3.**~~**2.** **provide for the use of accessible devices and technologies,**
44 **with appropriate privacy and security protections, for connecting**
45 **physicians and patients (New HOD Policy); and be it further;**

46
47 ~~**4. provide equitable payment for telehealth services that are**~~
48 ~~**comparable to in-person services;**~~

49

1 ~~5. ensure qualifications of physicians duly licensed in the state~~
2 ~~where the patient is located to provide such services in a secure~~
3 ~~environment; (New HOD Policy); and be it further~~
4

5 RESOLVED, That our AMA advocate for equitable access to telehealth
6 services, especially for at-risk and under-resourced patient populations
7 and communities, including but not limited to supporting increased funding
8 and planning for telehealth infrastructure such as broadband and internet-
9 connected devices for both physician practices and patients.

10
11 RESOLVED, that our AMA support the use of telehealth to reduce health
12 disparities and promote access to health care.
13

14
15 HOD ACTION: Alternate Resolution 203 adopted as
16 amended in lieu of Resolutions 203 and 205.
17

18 The Second Clause in the Second Resolved referred as
19 amended.
20

21 2. promote continuity of care by preventing payors from
22 using cost-sharing or other policies to prevent or
23 disincentivize patients from receiving care via telehealth
24 from ~~their physician~~ the physician of the patient's choice;
25

26 The Fourth Clause in the Second Resolved referred for
27 decision.
28

29 4. provide equitable payment for telehealth services that
30 are comparable to in-person services;
31

32 The Fifth Clause in the Second Resolved referred.
33

34 5. ensure qualifications of physicians duly licensed in the
35 state where the patient is located to provide such services
36 in a secure environment;
37

38 Amendment B4, to add a Sixth Clause to the Second
39 Resolved, referred for decision.
40

41 6. promote continuity of care by allowing physicians to
42 provide telehealth services, regardless of current location,
43 to established patients with whom the physician has had
44 previous face-to-face professional contact;
45

46 Resolution 203

47 RESOLVED, That, with the expanded use of telemedicine during the Covid-19
48 pandemic, our AMA continue to advocate for a continuation of coverage for the full
49 spectrum of technologies that were made available during the pandemic and that

1 physicians be reimbursed by government and private payers for time and complexity
2 (Directive to Take Action); and be it further

3
4 RESOLVED, That our AMA advocate that the current emergency regulations for
5 improved access to and payment for telemedicine services be made permanent with
6 respect to payment parity and use of commonly accessible devices for connecting
7 physicians and patients, without reference to the originating site, while ensuring
8 qualifications of duly licensed physicians to provide such services in a secure
9 environment (Directive to Take Action); and be it further

10
11 RESOLVED, That our AMA propose that all insurance carriers provide coverage for
12 telemedicine visits with any physician licensed and registered to practice in the United
13 States. (Directive to Take Action)

14
15 Resolution 205

16 RESOLVED, That our AMA advocate to facilitate the widespread adoption of telehealth
17 services in the practice of medicine for physicians or physician-led teams post SARS-
18 COV-2 (Directive to Take Action); and be it further

19
20 RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services,
21 health insurance industry, and Federal/State government agencies to adopt uniform,
22 clear regulations as well as equitable coverage and reimbursement mechanisms that
23 promote physician-led telehealth services (New HOD Policy); and be it further

24
25 RESOLVED, That our AMA advocate for equitable access to telehealth services
26 especially for the most at risk and under resourced patient populations and communities.
27 (Directive to Take Action)

28
29 Your Reference Committee heard largely positive testimony on Resolutions 203 and 205.
30 Your Reference Committee heard that our AMA currently has strong policy regarding the
31 expansion and coverage of telehealth. Your Reference Committee heard that our AMA
32 has robust advocacy efforts on telehealth expansion, including comments to Centers for
33 Medicare & Medicaid Services (CMS), outreach in Congress, and state-level activity. In
34 addition, your Reference Committee heard that Resolutions 203 and 205 have significant
35 overlap. Your Reference Committee heard testimony regarding the importance of
36 telehealth in maintaining the continuity of care within the medical home. Your Reference
37 Committee believes that current AMA policy sufficiently addresses those comments,
38 including H-480.946, Coverage of and Payment for Telemedicine, and H-160.919,
39 Principles of the Patient-Centered Medical Home; your Reference Committee also
40 believes that Alternate Resolution 203 sufficiently addresses those concerns. Your
41 Reference Committee heard testimony regarding appropriate terminology. Your
42 Reference Committee acknowledges that the term “telehealth,” defined as real-time,
43 audio-visual visits between a clinician and patient, is the appropriate terminology as it is
44 used by CMS, and in Current Procedural Terminology (CPT) codes. Your Reference
45 Committee heard some testimony that audio-only services should be covered. Our
46 AMA’s position on audio-only services is addressed in separate AMA policies D-70.993,
47 Reimbursement for Telephonic and Electronic Communications, and H-390.859,
48 Reimbursement for Telephonic and Electronic Communications. Your Reference
49 Committee believes that the substitute recommendations address inequities in access to
50 telehealth services, including the inability to access devices without internet capability.

1 Your Reference Committee also heard largely positive testimony in support of an
2 amendment that would direct our AMA to advocate for equity in broadband access,
3 including supporting increased funding for broadband infrastructure. In addition, your
4 Reference Committee heard testimony that highlighted the worsening of health
5 disparities and access to care during the SARS-COV-2 pandemic, especially for
6 underserved and rural populations, and the importance of ensuring that telehealth be
7 used to help provide care for patients. Accordingly, your Reference Committee
8 recommends adoption of Alternate Resolution 203 in lieu of Resolutions 203 and 205.

9
10 (9) RESOLUTION 206 – STRENGTHENING THE
11 ACCOUNTABILITY OF HEALTH CARE REVIEWERS

12
13 **RECOMMENDATION A:**

14
15 **The First Resolve of Resolution 206 be amended by insertion and deletion**
16 **to read as follows:**

17
18 **RESOLVED, That our AMA continue to advocate for the repeal of the**
19 **Employee Retirement Income Security Act (ERISA) as it pertains to prior**
20 **authorization decisions. that all health plans, including self-insured plans,**
21 **be subject to state prior authorization reforms that align with AMA policy.**

22
23 **RECOMMENDATION B:**

24
25 **The Second Resolve of Resolution 206 be deleted.**

26
27 **~~RESOLVED, That our AMA advocate for legislation to require physicians~~**
28 **~~contracted by health insurers or pharmacy benefit managers to possess an~~**
29 **~~active license in the states where they review prior authorizations and be~~**
30 **~~subject to the rules, statutes, medical board, and peer review of the state in~~**
31 **~~which the prior authorization request is made (Directive to Take Action);~~**
32 **~~and be it further~~**

33
34 **RECOMMENDATION C:**

35
36 **That AMA Policies H-320.968 and H-285.915 be reaffirmed.**

37
38 **RECOMMENDATION D:**

39
40 **That Resolution 206 be adopted as amended.**

41
42 **HOD ACTION: Resolution 206 adopted as amended.**

43
44
45 **RESOLVED, That our AMA advocate for legislation to require physicians contracted by**
46 **health insurers or pharmacy benefit managers to possess an active license in the states**
47 **where they review prior authorizations and be subject to the rules, statutes, medical**
48 **board, and peer review of the state in which the prior authorization request is made**
49 **(Directive to Take Action); and be it further**

1
2 RESOLVED, That our AMA advocate for the repeal of the Employee Retirement Income
3 Security Act (ERISA) as it pertains to prior authorization decisions. (Directive to Take
4 Action)
5

6 Your Reference Committee heard mixed discussion on Resolution 206. Your Reference
7 Committee heard testimony supporting the First Resolve, calling for greater
8 accountability for physicians contracted with health insurers making adverse
9 determinations for health plans and Pharmacy Benefit Managers, including requiring
10 licensure of the physician in the state in which the determination is being requested.
11 Your Reference Committee also heard testimony that our AMA has existing policy in
12 alignment with the First Resolve, as well as aligned legislative language in our AMA's
13 state prior authorization model bill, and that our AMA has been advocating on this issue
14 at the federal and state levels of government on behalf of AMA Members. Further, your
15 Reference Committee heard testimony concerning the Second Resolve because of the
16 ERISA preemption of state laws addressing prior authorization is frustrating to
17 physicians and stands as a barrier to broader and consistent reform. However, your
18 Reference Committee also heard testimony that the wording of the Second Resolve
19 would undo many protections in ERISA and its regulations that also serve as a floor for
20 prior authorization reform efforts, including in those states where their legislatures have
21 not enacted reform. Your Reference Committee also heard testimony requesting referral
22 on this item. However, your Reference Committee heard compelling testimony that there
23 is sufficient AMA policy on this topic. As such, your Reference Committee recommends
24 reaffirmation of H-320.968 and H-285.915 and that Resolution 206 be adopted as
25 amended.
26

27 **Approaches to Increase Payer Accountability H-320.968**

28

29 Our AMA supports the development of legislative initiatives to assure that payers
30 provide their insureds with information enabling them to make informed decisions
31 about choice of plan, and to assure that payers take responsibility when patients
32 are harmed due to the administrative requirements of the plan. Such initiatives
33 should provide for disclosure requirements, the conduct of review, and payer
34 accountability.
35

36 (1) Disclosure Requirements. Our AMA supports the development of model draft
37 state and federal legislation to require disclosure in a clear and concise standard
38 format by health benefit plans to prospective enrollees of information on (a)
39 coverage provisions, benefits, and exclusions; (b) prior authorization or other
40 review requirements, including claims review, which may affect the provision or
41 coverage of services; (c) plan financial arrangements or contractual provisions
42 that would limit the services offered, restrict referral or treatment options, or
43 negatively affect the physician's fiduciary responsibility to his or her patient; (d)
44 medical expense ratios; and (e) cost of health insurance policy premiums. (Ref.
45 Cmt. G, Rec. 2, A-96; Reaffirmation A-97)
46

47 (2) Conduct of Review. Our AMA supports the development of additional draft
48 state and federal legislation to: (a) require private review entities and payers to
49 disclose to physicians on request the screening criteria, weighting elements and
50 computer algorithms utilized in the review process, and how they were

1 developed; (b) require that any physician who recommends a denial as to the
2 medical necessity of services on behalf of a review entity be of the same
3 specialty as the practitioner who provided the services under review; (c) Require
4 every organization that reviews or contracts for review of the medical necessity of
5 services to establish a procedure whereby a physician claimant has an
6 opportunity to appeal a claim denied for lack of medical necessity to a medical
7 consultant or peer review group which is independent of the organization
8 conducting or contracting for the initial review; (d) require that any physician who
9 makes judgments or recommendations regarding the necessity or
10 appropriateness of services or site of service be licensed to practice medicine in
11 the same jurisdiction as the practitioner who is proposing the service or whose
12 services are being reviewed; (e) require that review entities respond within 48
13 hours to patient or physician requests for prior authorization, and that they have
14 personnel available by telephone the same business day who are qualified to
15 respond to other concerns or questions regarding medical necessity of services,
16 including determinations about the certification of continued length of stay; (f)
17 require that any payer instituting prior authorization requirements as a condition
18 for plan coverage provide enrollees subject to such requirements with consent
19 forms for release of medical information for utilization review purposes, to be
20 executed by the enrollee at the time services requiring such prior authorization
21 are recommended or proposed by the physician; and (g) require that payers
22 compensate physicians for those efforts involved in complying with utilization
23 review requirements that are more costly, complex and time consuming than the
24 completion of standard health insurance claim forms. Compensation should be
25 provided in situations such as obtaining preadmission certification, second
26 opinions on elective surgery, and certification for extended length of stay.

27
28 (3) Accountability. Our AMA believes that draft federal and state legislation
29 should also be developed to impose similar liability on health benefit plans for
30 any harm to enrollees resulting from failure to disclose prior to enrollment the
31 information on plan provisions and operation specified under Section 1 (a)-(d)
32 above.

33 34 **AMA Policy on ERISA H-285.915**

35
36 1. Our AMA will seek, through amendment of the ERISA statute, through
37 enactment of separate federal patient protection legislation, through enactment of
38 similar state patient protection legislation that is uniform across states, and
39 through targeted elimination of the ERISA preemption of self-insured health
40 benefits plans from state regulation, to require that such self-insured plans: (a)
41 Ensure that plan enrollees have access to all needed health care services; (b)
42 Clearly disclose to present and prospective enrollees any provisions restricting
43 patient access to or choice of physicians, or imposing financial incentives
44 concerning the provision of services on such physicians; (c) Be regulated in
45 regard to plan policies and practices regarding utilization management, claims
46 submission and review, and appeals and grievance procedures; (d) Conduct
47 scientifically based and physician-directed quality assurance programs; (e) Be
48 legally accountable for harm to patients resulting from negligent utilization
49 management policies or patient treatment decisions through all available means,
50 including proportionate or comparative liability, depending on state liability rules;

1 (f) Participate proportionately in state high-risk insurance pools that are financed
2 through participation by carriers in that jurisdiction; (g) Be prohibited from
3 indemnifying beneficiaries against actions brought by physicians or other
4 providers to recover charges in excess of the amounts allowed by the plan, in the
5 absence of any provider contractual agreement to accept those amounts as full
6 payment; (h) Inform beneficiaries of any discounted payment arrangements
7 secured by the plan, and base beneficiary coinsurance and deductibles on these
8 discounted amounts when providers have agreed to accept these discounted
9 amounts as full payment; (i) Be subject to breach of contract actions by providers
10 against their administrators; and (j) Adopt coordination of benefits provisions
11 applying to enrollees covered under two or more plans.
12

13 2. Our AMA will continue to advocate for the elimination of ERISA preemption of
14 self insured health plans from state insurance laws consistent with current AMA
15 policy.
16

17 (10) RESOLUTION 211 – CREATING A
18 CONGRESSIONALLY-MANDATED BIPARTISAN
19 COMMISSION TO EXAMINE THE U.S. PREPARATIONS
20 FOR AND RESPONSE TO THE COVID-19 PANDEMIC
21 TO INFORM FUTURE EFFORTS
22

23 **RECOMMENDATION A:**
24

25 **Resolution 211 be amended by addition to read as follows:**
26

27 **RESOLVED, That our AMA advocate for passage of federal legislation to**
28 **create a congressionally-mandated bipartisan commission composed of**
29 **scientists, physicians with expertise in pandemic preparedness and**
30 **response, public health experts, legislators and other stakeholders, which**
31 **is to examine the U.S. preparations for and response to the COVID-19**
32 **pandemic, in order to inform and support future public policy and health**
33 **systems preparedness (Directive to Take Action); and be it further**
34

35 **RECOMMENDATION B:**
36

37 **Resolution 211 be adopted as amended.**
38
39

40 **HOD ACTION: Resolution 211 adopted as amended.**
41

42 RESOLVED, That our AMA advocate for passage of federal legislation to create a
43 congressionally-mandated bipartisan commission composed of scientists, physicians
44 with expertise in pandemic preparedness and response, public health experts,
45 legislators and other stakeholders, which is to examine the U.S. preparations for and
46 response to the COVID-19 pandemic, in order to inform future public policy and health
47 systems preparedness (Directive to Take Action); and be it further
48

49 RESOLVED, That, in advocating for legislation to create a congressionally-mandated
50 bipartisan commission, our AMA seek to ensure key provisions are included, namely that

1 the delivery of a specific end product (i.e., a report) is required by the commission by a
2 certain period of time, and that adequate funding be provided in order for the
3 commission to complete its deliverables. (Directive to Take Action)

4
5 Your Reference Committee heard overwhelming supportive testimony on Resolution
6 211. Testimony was provided about the challenges that patients, physicians, hospitals,
7 other health care facilities, the entire health care system, communities, and schools have
8 experienced and continue to experience due to the COVID-19 pandemic. Your
9 Reference Committee heard testimony strongly in support of commissioning a bipartisan
10 task force under the direction of the United States Congress to complete a
11 comprehensive review and report on the United States' preparedness and immediate
12 response to the COVID-19 pandemic to inform preparation and response to future
13 pandemics. Further testimony stated that we need to prevent the problems experienced
14 during COVID-19 regarding effective testing strategies, timely directives on appropriate
15 utilization of social distancing, evidence-supported efforts to maintain strategic stockpiles
16 of Personal Protective Equipment (PPE), ventilators, and other supplies, and to inform
17 future health system preparedness. Further testimony was provided in support but with
18 an amendment in the First Resolve to add "support" after "inform." Your Reference
19 Committee agrees, and accordingly recommends adoption of Resolution 211 as
20 amended.

21
22 (11) RESOLUTION 218 – CRISIS PAYMENT REFORM
23 ADVOCACY

24
25 **RECOMMENDATION A:**

26
27 **The First Resolve of Resolution 218 be amended by addition and deletion**
28 **to read as follows:**

29
30 **RESOLVED, That our AMA continue to promote national awareness of the**
31 **loss of physician medical practices and patient access to care due to**
32 **COVID-19, and continue to advocate for reforms that support and sustain**
33 **physician medical practices that will disrupt healthcare availability to many**
34 **patients (Directive to Take Action);² and be it further**

35
36 **RECOMMENDATION B:**

37
38 **That the Second Resolve of Resolution 218 be deleted.**

39
40 **~~RESOLVED, That our AMA: (1) promote reform in our health care payment~~**
41 **~~system that supports and sustains physician medical practices not only~~**
42 **~~under routine circumstances but also in an extended crisis situation such~~**
43 **~~as COVID-19; (2) advocate for, as a priority directive, a blueprint for action~~**
44 **~~along those lines to the newly installed Presidential administration and~~**
45 **~~Congress in early 2021 and beyond; and (3) monitor and aim to improve,~~**
46 **~~along with other stakeholders, any new health care initiative(s) in a~~**
47 **~~contemporaneously effective manner. (Directive to Take Action)~~**

48
49 **RECOMMENDATION C:**
50

1 **Resolution 218 be adopted as amended.**

2
3
4 **HOD ACTION: Resolution 218 adopted as amended.**

5
6 RESOLVED, That our AMA promote national awareness of the loss of physician medical
7 practices due to COVID-19 that will disrupt healthcare availability to many patients
8 (Directive to Take Action); and be it further

9
10 RESOLVED, That our AMA: (1) promote reform in our health care payment system that
11 supports and sustains physician medical practices not only under routine circumstances
12 but also in an extended crisis situation such as COVID-19; (2) advocate for, as a priority
13 directive, a blueprint for action along those lines to the newly installed Presidential
14 administration and Congress in early 2021 and beyond; and (3) monitor and aim to
15 improve, along with other stakeholders, any new health care initiative(s) in a
16 contemporaneously effective manner. (Directive to Take Action)

17
18 Your Reference Committee heard mixed testimony on Resolution 218. Your Reference
19 Committee heard examples of how our AMA has worked aggressively on the issues
20 raised in this Resolution regarding physician payment during the COVID-19 public health
21 emergency. Our AMA's advocacy efforts include letters to Anthem, UnitedHealth Group,
22 Blue Cross Blue Shield Association (BCBSA), Centers for Medicare & Medicaid Services
23 (CMS), and other health plans (for use of Current Procedural Terminology (CPT) code
24 99072 which will help address the significant fiscal pressures placed on physicians by
25 the COVID-19 pandemic and to compensate practices for the additional supplies and
26 new staff activities required to provide safe patient care during the public health
27 emergency), an extensive library of AMA Advocacy efforts posted to the [website](#) (noting
28 more than \$175 billion from Congress for COVID-19 health-related funding to hospitals
29 and providers), and written comments on the Medicare Physician Fee Schedule and the
30 Medicare Accelerated and Advance Payment Program (both addressing financial issues
31 listed in the Resolution). Your Reference Committee heard testimony that our AMA is in
32 frequent communication with Congress, the Department of Health and Human Services,
33 CMS, the Centers for Disease Control and Prevention, the Food and Drug
34 Administration, and other government agencies to drive the messages encompassed in
35 the resolution and to advance towards solutions that positively impact physicians and
36 our patients.

37
38 Your Reference Committee heard testimony that the resolution does not take into
39 consideration our AMA's advocacy efforts included in our AMA's COVID-19 Advocacy
40 Progress Report, which lays out over 70 COVID-related advocacy efforts in which our
41 AMA has been engaged since the beginning of the pandemic. Furthermore, your
42 Reference Committee heard testimony that our AMA is already engaging in
43 conversations with the incoming Administration. Your Reference Committee therefore
44 agrees with an amendment offered by the Council on Legislation that would be
45 consistent with our AMA's continued effort to promote national awareness of the loss of
46 physician medical practices and patient access to care and to continue to advocate for
47 reforms that support and sustain physician medical practices. Your Reference
48 Committee heard proffered amendments to the Second Resolve; however, given the
49 active advocacy that our AMA is doing around this topic, built on extensive and
50 multifaceted AMA Policy, your Reference Committee does not believe the current

1 Second Resolve or amendments would add substantively to current AMA Policy. Thus,
2 your Reference Committee believes that the resolution as amended encompasses the
3 spirit of the original resolution. Accordingly, your Reference Committee recommends
4 Resolution 218 be adopted as amended.
5

RECOMMENDED FOR ADOPTION IN LIEU OF

(12) RESOLUTION 212 – COPAY ACCUMULATOR POLICIES

RECOMMENDATION A:

That AMA Policy D-110.986 be amended by addition.

Our AMA will develop model state legislation regarding Co-Pay Accumulators for all pharmaceuticals, biologics, medical devices, and medical equipment, and support federal and state legislation or regulation that would ban co-pay accumulator policies, including in federally regulated ERISA plans.

RECOMMENDATION B:

That amended Policy D-110.986 be adopted in lieu of Resolution 212.

HOD ACTION: Amended Policy D-110.986 adopted in lieu of Resolution 212.

RESOLVED, That our AMA with all haste directly engage and advocate for the adoption of proposed state legislation or regulation that would ban copay accumulator policies in state regulated health care plans, including Medicaid (Directive to Take Action); and be it further

RESOLVED, That our AMA with all haste directly engage and advocate for the adoption of proposed federal legislation or regulation that would ban copay accumulator policies in federally regulated ERISA plans. (Directive to Take Action)

Your Reference Committee heard testimony that our AMA has strong policy surrounding the increase in prescription medication prices that have continued to grow inexorably year-over year. Your Reference Committee acknowledges that physicians experience and see first-hand the difficulty and burden high pharmaceutical costs have imposed on our patients, on physician practices, and the broader health care system. Your Reference Committee also heard that our AMA has advocated with the Administration to eliminate copay accumulators since payers' growing use of copay accumulator benefit designs limits the success of other copay mechanisms, like copay coupons, in improving overall medication affordability for patients. Under copay accumulator programs, payers' do not apply the manufacturer's copay coupon to the patient's deductible or out-of-pocket maximum. When the copay coupon expires or runs out, or the patient exhausts all other forms of co-pay assistance, the patient is faced with a sudden—and often massive—increase in financial responsibility for the drug, as the coupons have not counted toward his/her deductible. Your Reference Committee heard testimony that our AMA has existing policy and is engaged in advocacy efforts to ban co-pay accumulators. Your Reference Committee heard testimony in support of amending Policy D-110.986 to better reflect and support our AMA's ongoing advocacy efforts at the state and federal

1 levels. Accordingly, your Reference Committee recommends that amended AMA Policy
2 D-110.986, Co-Pay Accumulators, be adopted in lieu of Resolution 212.
3
4

RECOMMENDED FOR REFERRAL

- 1
2
3 (13) RESOLUTION 213 – PHARMACIES TO INFORM
4 PHYSICIANS WHEN LOWER COST MEDICATION
5 OPTIONS ARE ON FORMULARY
6

7 **RECOMMENDATION:**
8

9 **Resolution 213 be referred.**
10

11
12 **HOD ACTION: Resolution 213 referred.**
13

14 RESOLVED, That our AMA support legislation or regulatory action to require that in the
15 event a patient cannot afford the medication prescribed, either because it is not on the
16 formulary or it is priced higher than other medications on the formulary, the pharmacist
17 must communicate to the prescriber a medication option in the same class prescribed
18 with the lowest out-of-pocket cost to the patient. (New HOD Policy)
19

20 Your Reference Committee heard mixed testimony on Resolution 213. Your Reference
21 Committee heard testimony in support of the intent of Resolution 213. However, your
22 Reference Committee also heard that the potential consequences of the policy proposed
23 by this resolution are unclear, including the potential for unintended consequences of
24 introducing unnecessary administrative burdens on physicians, creating confusion for
25 patients trying to fill prescriptions, and possibly opening the door for pharmacy scope of
26 practice issues. Therefore, your Reference Committee recommends that Resolution 213
27 be referred.
28

1 Madam Speaker, this concludes the report of Reference Committee B. I would like to
2 thank Elie Azrak, MD, MHA, Gary Delaney, MD, Christopher Gribbin, MD, Thomas Vidic,
3 MD, Mack Worthington, MD, Anna Yap, MD, and all those who testified before the
4 Committee.
5
6

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