

## AMA HOUSE OF DELEGATES (November 2020 Meeting)

### Report of Reference Committee B

Alethia Morgan, MD, Chair

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

#### 33 **RECOMMENDED FOR REFERRAL**

- 34  
35 13. Resolution 213 – Pharmacies to Inform Physicians When Lower Cost Medication  
36 Options are on Formulary

Click here to submit an amendment.

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

- 13  
14 1. That our American Medical Association (AMA) reaffirm Policy H-100.992,  
15 “FDA,” which supports that FDA conflicts of interest should not overrule scientific  
16 evidence in making policy decisions and the FDA should include clinical experts  
17 on advisory committees. (Reaffirm HOD 14 Policy)  
18  
19 2. That our AMA adopt the following new policy:

20  
21 It is the position of the AMA that decisions of the Food and Drug Administration  
22 (FDA) must be trustworthy. Patients, the public, physicians, other health care  
23 professionals and health administrators, and policymakers must have confidence  
24 that FDA decisions and the recommendations of FDA advisory committees are  
25 ethically and scientifically credible and derived through a process that is rigorous,  
26 independent, transparent, and accountable. Rigorous policies and procedures  
27 should be in place to minimize the potential for financial or other interests to  
28 influence the process at all key steps. These should include, but not necessarily  
29 be limited to: a) required disclosure of all relevant actual or potential conflicts of  
30 interest, both financial and personal; b) a mechanism to independently audit  
31 disclosures when warranted; c) clearly defined criteria for identifying and  
32 assessing the magnitude and materiality of conflicts of interest; and d) clearly  
33 defined processes for preventing or terminating the participation of a conflicted  
34 member, and mitigating the influence of identified conflicts of interest (such as  
35 prohibiting individuals from participating in deliberations, drafting, or voting on  
36 recommendations on which they have conflicts) in those limited circumstances  
37 when an individual’s participation cannot be terminated due to the individual’s  
38 unique or rare skillset or background that is deemed highly valuable to the  
39 process. Further, clear statements of COI policy and procedures, and disclosures  
40 of FDA advisory committee members’ conflicts of interest relating to specific  
41 recommendations, should be published or otherwise made public. Participation on  
42 advisory committees should be facilitated through appropriate balancing of the  
43 relative scarcity or uniqueness of an individual’s expertise and ability to contribute  
44 to the process, as compared to the feasibility and effectiveness of mitigation  
45 measures. Finally, our AMA urges the FDA to streamline the COI process to the  
46 greatest extent possible, thereby eliminating any unnecessary documentation,  
47 delays, or administrative barriers to qualified physicians’ participation on FDA  
48 advisory committees. (New HOD Policy)

1 3. That our AMA adopt the following new policy:  
2

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

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

19 (2) BOARD OF TRUSTEES REPORT 6 – COVENANTS NOT  
20 TO COMPETE  
21

22 **RECOMMENDATION:**  
23

24 **Recommendation in Board of Trustees Report 6 be adopted and the**  
25 **remainder of the Report be filed.**  
26

27 In light of these considerations, the Board recommends that the following be adopted in  
28 lieu of Resolution 10-A-19 and the remainder of this report be filed:  
29

30 Our AMA create a state restrictive covenant legislative template to assist state medical  
31 associations, national medical specialty societies and physician members as they  
32 navigate the intricacies of restrictive covenant policy at the state level. (Directive to Take  
33 Action)  
34

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

44 During the hearing, your Reference Committee received testimony from the American  
45 College of Radiology (ACR) requesting that the recommendation in Board Report 6 be  
46 amended to encompass anti-disparagement and non-disclosure clauses in addition to  
47 non-competes. Your Reference Committee also heard testimony stating that the  
48 proposed amendment is beyond the scope of Board of Trustees Report 6 and could  
49 cloud the report's singular focus on covenants not to complete—an issue of great  
50 concern to many physicians that has been repeatedly raised in the House of Delegates.

1 While your Reference Committee believes that the ACR amendment has merit, we  
2 agree with those who opined that it is beyond the scope of BOT 6. Therefore, your  
3 Reference Committee does not believe it should be adopted as part of BOT 6. Because  
4 the proposed amendment is not an item of business before the HOD, it is procedurally  
5 unable to be referred at this time. A representative from our AMA Board of Trustees  
6 indicated the Board is already aware of the issue. Your Reference Committee therefore  
7 recommends that Board of Trustees Report 6 be adopted and the remainder of the  
8 report be filed.

9  
10 (3) BOARD OF TRUSTEES REPORT 13 – MERIT-BASED  
11 INCENTIVE PAYMENT SYSTEM (MIPS) UPDATE  
12

13 **RECOMMENDATION:**  
14

15 **Recommendations in Board of Trustees Report 13 be adopted and the**  
16 **remainder of the Report be filed.**  
17

18 The Board of Trustees recommends that the following recommendations be adopted in  
19 lieu of Resolutions 206-I-18, 231-I-18, and 243-A-19 and that the remainder of the report  
20 be filed:  
21

- 22 1. That our American Medical Association (AMA) support legislation that ensures  
23 Medicare physician payment is sufficient to safeguard beneficiary access to care,  
24 replaces or supplements budget neutrality in MIPS with incentive payments, or  
25 implements positive annual physician payment updates. (Directive to Take  
26 Action)  
27
- 28 2. That our AMA reaffirm Policy D-395.999, “Reducing MIPS Reporting Burden,”  
29 Policy D27 395.998, “Opposed Replacement of the Merit-Based Incentive  
30 Payment System with the Voluntary Value Program,” Policy H-390.838, “MIPS  
31 and MACRA Exemption,” Policy D-390.950, “Preserving a Period of Stability in  
32 Implementation of the Medicare Access and Children’s Health Insurance  
33 Program (CHIP) Reauthorization Act (MACRA),” Policy D-390.949, “Preserving  
34 Patient Access to Small Practices Under MACRA,” Policy H-385.913, “Physician-  
35 Focused Alternative Payment Models,” Policy H-385.913, “Physician-Focused  
36 Alternative Payment Models,” Policy H-450.931, “Moving to Alternative Payment  
37 Models,” and Policy H-385.908, “Physician-Focused Alternative Payment  
38 Models: Reducing Barriers.” (Reaffirm HOD Policy)  
39

40 Your Reference Committee heard overwhelming supportive testimony on Board of  
41 Trustees Report 13. Your Reference Committee heard that our AMA has worked closely  
42 with Centers for Medicare & Medicare Services (CMS) and Congress on implementing  
43 the MIPS program, and our AMA advocacy efforts resulted in policies that have  
44 improved some, but not all, aspects of MIPS. Your Reference Committee heard that our  
45 AMA has strong policy discussing the MIPS issues, and has long articulated and  
46 advocated for policies to positively impact physician payment and reporting. Similarly,  
47 our AMA continues to advocate against systems that increase administrative burden,  
48 decrease reimbursement, and negatively impact patient care. Your Reference  
49 Committee heard that our AMA should have the ability and the flexibility to support  
50 legislation that would provide physicians with positive payment updates that could shift

1 the budget neutrality dynamic of the current MIPS program. Your Reference Committee  
2 also heard testimony concerning our AMA's continued work with stakeholders to improve  
3 MIPS, such as streamlining reporting requirements to decrease physician burden,  
4 increasing the performance threshold, and refining the MIPS methodology to reduce the  
5 total cost of care measures outside of physicians' control. Your Reference Committee  
6 heard the concerns of small practices, their need for support, especially in light of  
7 COVID-19 and planned cuts, and the importance of Medicare funding. Accordingly, your  
8 Reference Committee recommends that Board of Trustees Report 13 be adopted and  
9 the remainder of the Report be filed.

10  
11 (4) RESOLUTION 202 – CARES ACT EQUITY AND LOAN  
12 FORGIVENESS IN THE MEDICARE ACCELERATED  
13 PAYMENT PROGRAM

14  
15 **RECOMMENDATION:**

16  
17 **Resolution 202 be adopted.**

18  
19 RESOLVED, That our AMA and the federation of medicine work to improve and expand  
20 various federal stimulus programs (e.g., the CARES Act and MAPP) in order to assist  
21 physicians in response to the Covid-19 pandemic, including:

- 22  
23 - Restarting the suspended Medicare Advance payment program, including  
24 significantly reducing the re-payment interest rate and lengthening the repayment  
25 period;  
26  
27 - Expanding the CARES Act health care provider relief pool and working to ensure  
28 that a significant share of the funding from this pool is made available to  
29 physicians in need regardless of the type of patients treated by those physicians;  
30 and  
31  
32 - Reforming the Paycheck Protection Program, to ensure greater flexibility in how  
33 such funds are spent and lengthening the repayment period (Directive to Take  
34 Action); and be it further  
35

36 RESOLVED, That, in the setting of the COVID-19 pandemic, our AMA advocate for  
37 additional relief to physicians via loan forgiveness for medical school educational debt.  
38 (Directive to Take Action)  
39

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

1 Your Reference Committee heard a considerable amount of discussion on the second  
2 Resolve, and considered an amendment that would change the terminology from “loan  
3 forgiveness” to “temporary deferment of loan repayment, including suspension of interest  
4 accumulation during the deferment period.” However, your Reference Committee heard  
5 opposition to the proposed change, and determined that keeping the term broader would  
6 best meet the needs of our membership, therefore affording our AMA the flexibility to  
7 advocate for physician educational debt relief. Your Reference Committee considered  
8 our AMA’s advocacy relating to medical school debt and recognizes that our Advocacy  
9 Team is continuing to seek legislative solutions in COVID relief legislation. Accordingly,  
10 your Reference Committee recommends that Resolution 202 be adopted.

**RECOMMENDED FOR ADOPTION WITH CHANGE IN TITLE**

- (5) BOARD OF TRUSTEES REPORT 7 – OPPOSITION TO INVOLUNTARY CIVIC COMMITMENT FOR SUBSTANCE USE DISORDER

**RECOMMENDATION A:**

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

**RECOMMENDATION B:**

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

**INVOLUNTARY CIVIL COMMITMENT FOR SUBSTANCE USE DISORDER**

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

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

Your Reference Committee heard largely supportive testimony on Board of Trustees Report 7. Your Reference Committee heard discussions that highlighted concerns associated with involuntary civil commitment, as well as many of the ethical and legal issues that must be considered. Your Reference Committee is thankful that our AMA Code of Medical Ethics can play a critical role to ensure that our policy recommendations are well-informed by the ethical standards guiding our profession. Your Reference Committee is also very pleased that our colleagues at the American Psychiatric Association have excellent guidance in place that is publicly available to help guide this discussion and our practice, and we acknowledge supportive testimony to this effect. The issue of involuntary civil commitment has many gray areas, but your Reference Committee is satisfied that the conditions laid out by our Board provide excellent guidance moving forward. Your Reference Committee is also pleased by the report's discussion of our AMA's ongoing advocacy to address gaps in access to care for mental illness and substance use disorders. Given the scope of the nation's overdose

1 epidemic and massive treatment gap, it is unconscionable that health insurance  
2 companies still display their continued intransigence to impose prior authorization for  
3 medications to treat opioid use disorder and ongoing violations of mental health and  
4 substance use disorder parity. Your Reference Committee is deeply appreciative of the  
5 efforts of our Council on Legislation to help develop model legislation and our AMA to  
6 partner with so many in our House of Medicine to remove barriers to evidence-based  
7 care.

8  
9 Your Reference Committee also heard testimony offering an amendment to change the  
10 title of the Resolution to better reflect the report to read “Involuntary Civil Commitment  
11 for Substance Use Disorder.” For these reasons, your Reference Committee  
12 recommends that Board of Trustees Report 7 be adopted, with a change in title as  
13 indicated, and the remainder of the report filed.

14  
15 (6) BOARD OF TRUSTEES REPORT 14 – ADVOCATING  
16 FOR THE STANDARDIZATION AND REGULATION OF  
17 OUTPATIENT ADDICTION REHABILITATION  
18 FACILITIES

19  
20 **RECOMMENDATION A:**

21  
22 **Recommendations in Board of Trustees Report 14 be adopted and the**  
23 **remainder of the Report be filed.**

24  
25 **RECOMMENDATION B:**

26  
27 **The title of Board of Trustees Report 14 be changed to read as follows:**

28  
29 **ENHANCED FUNDING FOR AND ACCESS TO OUTPATIENT ADDICTION**  
30 **REHABILITATION**

31  
32 The Board of Trustees recommends that the following recommendations be adopted in  
33 lieu of Resolution 201-I-19, and that the remainder of the report be filed.

- 34  
35 1. That our AMA advocate for the expansion of federal grants in support of  
36 treatment for a substance use disorder to states that are conditioned on that  
37 state’s adoption of law and/or regulation that prohibit drug courts, recovery  
38 homes, sober houses, correctional settings, and other similar programs from  
39 denying entry or ongoing care if a patient is receiving medication for an opioid  
40 use disorder or other chronic medical condition. (Directive to Take Action)  
41  
42 2. That our AMA advocate for sustained funding to states in support of evidence-  
43 based treatment for patients with a substance use disorder and/or co-occurring  
44 mental disorder, such as that put forward by the American Society of Addiction  
45 Medicine, American Academy of Addiction Psychiatry, American Psychiatric  
46 Association, American Academy of Child and Adolescent Psychiatry and other  
47 professional medical organizations. (Directive to Take Action)



- 1 3. That our AMA reaffirm Policy D-95.981, “Improving Medical Practice and  
2 Patient/Family Education to Reverse the Epidemic of Nonmedical Prescription  
3 Drug Use and Addiction.” (Reaffirm HOD Policy)  
4
- 5 4. That our AMA reaffirm Policy H-95.922, “Substance Use and Substance Use  
6 Disorders.” (Reaffirm HOD Policy)  
7
- 8 5. That our AMA reaffirm H-95.981, “Policy Federal Drug Policy in the United  
9 States.” (Reaffirm HOD Policy).

10  
11 Your Reference Committee heard overwhelming supportive testimony on Board of  
12 Trustees Report 14. Testimony cited our AMA’s longstanding and extensive policy on  
13 addiction and substance use disorder treatment, and indicated that one of the primary  
14 challenges in ending the nation’s drug overdose epidemic remains the inability of most  
15 patients to obtain evidence-based care for a substance use disorder. Your Reference  
16 Committee heard that removing the barriers for patients to receive evidence-based  
17 treatment is critical to helping end the epidemic. Your Reference Committee also heard  
18 testimony that State and federal laws already govern outpatient treatment facilities and  
19 standardized evidence-based federal regulations are not the right approach. Your  
20 Reference Committee agrees with the testimony provided that the recommendations in  
21 the report acknowledge that medical specialties, such as the American Society of  
22 Addiction Medicine and the American Psychiatric Association, already have guidelines  
23 and standards to help ensure the provision of evidence-based care in treatment facilities  
24 for in-patient and out-patient care, and that the recommendations also acknowledge that  
25 sustained federal funding—rather than short-term grants—and a comprehensive  
26 framework to prevent and treat all substance use disorders are necessary to address the  
27 current epidemic.

28  
29 Your Reference Committee also heard testimony offering an amendment to change the  
30 title of the Resolution to better reflect the content of the report to read “Enhanced  
31 Funding for and Access to Addiction Facilities.” Accordingly, your Reference Committee  
32 recommends that Board of Trustees Report 14 be adopted, with a change in title as  
33 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.**

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 testimony highlighting the challenges and benefits of patients receiving primary care services alongside MMT. Your Reference Committee appreciates the Board's explanations of the many requirements that would be imposed upon primary care practices should they seek to provide MMT. Your Reference Committee agrees with the

1 Board that there should be continued research into best practices as well as further  
2 advocacy to remove existing barriers to MMT.

3  
4 Your Reference Committee also heard that primary care physicians are not the only  
5 physicians who can effectively use MMT to treat patients, and that the report as written  
6 may inadvertently restrict office-based treatment only to primary care physicians. Your  
7 Reference Committee agrees with this testimony and consequently agrees with the  
8 noted proffered amendment. Accordingly, your Reference Committee recommends that  
9 Board of Trustees Report 16 be adopted as amended, and the remainder of the report  
10 be filed.

- 11  
12 (8) RESOLUTION 203 – COVID-19 EMERGENCY AND  
13 EXPANDED TELEMEDICINE REGULATIONS  
14 RESOLUTION 205 – TELEHEALTH POST SARS-COV-2

15  
16 **RECOMMENDATION:**

17  
18 **That Alternate Resolution 203 be adopted in lieu of Resolutions 203 and**  
19 **205.**

20  
21 **RESOLVED, That our AMA continue to advocate for the widespread**  
22 **adoption of telehealth services in the practice of medicine for physicians**  
23 **and physician-led teams post SARS-COV-2 (Directive to Take Action); and**  
24 **be it further**

25  
26 **RESOLVED, That our AMA advocate that the Federal government, including**  
27 **the Centers for Medicare & Medicaid Services (CMS) and other agencies,**  
28 **state governments and state agencies, and the health insurance industry,**  
29 **adopt clear and uniform laws, rules, regulations, and policies relating to**  
30 **telehealth services that permanently:**

- 31  
32 **1. provide equitable coverage that allows patients to access**  
33 **telehealth services wherever they are located;**  
34  
35 **2. promote continuity of care by preventing payors from using cost-**  
36 **sharing or other policies to prevent or disincentivize patients from**  
37 **receiving care via telehealth from their physician;**  
38  
39 **3. provide for the use of accessible devices and technologies, with**  
40 **appropriate privacy and security protections, for connecting**  
41 **physicians and patients;**  
42  
43 **4. provide equitable payment for telehealth services that are**  
44 **comparable to in-person services;**  
45  
46 **5. ensure qualifications of physicians duly licensed in the state**  
47 **where the patient is located to provide such services in a secure**  
48 **environment; (New HOD Policy); and be it further**

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

6  
7           **RESOLVED, that our AMA support the use of telehealth to reduce health**  
8           **disparities and promote access to health care.**

9  
10          Resolution 203

11          RESOLVED, That, with the expanded use of telemedicine during the Covid-19  
12          pandemic, our AMA continue to advocate for a continuation of coverage for the full  
13          spectrum of technologies that were made available during the pandemic and that  
14          physicians be reimbursed by government and private payers for time and complexity  
15          (Directive to Take Action); and be it further

16  
17          RESOLVED, That our AMA advocate that the current emergency regulations for  
18          improved access to and payment for telemedicine services be made permanent with  
19          respect to payment parity and use of commonly accessible devices for connecting  
20          physicians and patients, without reference to the originating site, while ensuring  
21          qualifications of duly licensed physicians to provide such services in a secure  
22          environment (Directive to Take Action); and be it further

23  
24          RESOLVED, That our AMA propose that all insurance carriers provide coverage for  
25          telemedicine visits with any physician licensed and registered to practice in the United  
26          States. (Directive to Take Action)

27  
28          Resolution 205

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

32  
33          RESOLVED, That our AMA encourage the Centers for Medicare and Medicaid Services,  
34          health insurance industry, and Federal/State government agencies to adopt uniform,  
35          clear regulations as well as equitable coverage and reimbursement mechanisms that  
36          promote physician-led telehealth services (New HOD Policy); and be it further

37  
38          RESOLVED, That our AMA advocate for equitable access to telehealth services  
39          especially for the most at risk and under resourced patient populations and communities.  
40          (Directive to Take Action)

41  
42          Your Reference Committee heard largely positive testimony on Resolutions 203 and 205.  
43          Your Reference Committee heard that our AMA currently has strong policy regarding the  
44          expansion and coverage of telehealth. Your Reference Committee heard that our AMA  
45          has robust advocacy efforts on telehealth expansion, including comments to Centers for  
46          Medicare & Medicaid Services (CMS), outreach in Congress, and state-level activity. In  
47          addition, your Reference Committee heard that Resolutions 203 and 205 have significant  
48          overlap. Your Reference Committee heard testimony regarding the importance of  
49          telehealth in maintaining the continuity of care within the medical home. Your Reference  
50          Committee believes that current AMA policy sufficiently addresses those comments,

1 including H-480.946, Coverage of and Payment for Telemedicine, and H-160.919,  
2 Principles of the Patient-Centered Medical Home; your Reference Committee also  
3 believes that Alternate Resolution 203 sufficiently addresses those concerns. Your  
4 Reference Committee heard testimony regarding appropriate terminology. Your  
5 Reference Committee acknowledges that the term “telehealth,” defined as real-time,  
6 audio-visual visits between a clinician and patient, is the appropriate terminology as it is  
7 used by CMS, and in Current Procedural Terminology (CPT) codes. Your Reference  
8 Committee heard some testimony that audio-only services should be covered. Our  
9 AMA’s position on audio-only services is addressed in separate AMA policies D-70.993,  
10 Reimbursement for Telephonic and Electronic Communications, and H-390.859,  
11 Reimbursement for Telephonic and Electronic Communications. Your Reference  
12 Committee believes that the substitute recommendations address inequities in access to  
13 telehealth services, including the inability to access devices without internet capability.  
14 Your Reference Committee also heard largely positive testimony in support of an  
15 amendment that would direct our AMA to advocate for equity in broadband access,  
16 including supporting increased funding for broadband infrastructure. In addition, your  
17 Reference Committee heard testimony that highlighted the worsening of health  
18 disparities and access to care during the SARS-COV-2 pandemic, especially for  
19 underserved and rural populations, and the importance of ensuring that telehealth be  
20 used to help provide care for patients. Accordingly, your Reference Committee  
21 recommends adoption of Alternate Resolution 203 in lieu of Resolutions 203 and 205.

22  
23 (9) RESOLUTION 206 – STRENGTHENING THE  
24 ACCOUNTABILITY OF HEALTH CARE REVIEWERS

25  
26 **RECOMMENDATION A:**

27  
28 **The First Resolve of Resolution 206 be amended by insertion and deletion**  
29 **to read as follows:**

30  
31 **RESOLVED, That our AMA continue to advocate for the repeal of the**  
32 **Employee Retirement Income Security Act (ERISA) as it pertains to prior**  
33 **authorization decisions. that all health plans, including self-insured plans,**  
34 **be subject to state prior authorization reforms that align with AMA policy.**

35  
36 **RECOMMENDATION B:**

37  
38 **The Second Resolve of Resolution 206 be deleted.**

39  
40 **~~RESOLVED, That our AMA advocate for legislation to require physicians~~**  
41 **~~contracted by health insurers or pharmacy benefit managers to possess an~~**  
42 **~~active license in the states where they review prior authorizations and be~~**  
43 **~~subject to the rules, statutes, medical board, and peer review of the state in~~**  
44 **~~which the prior authorization request is made (Directive to Take Action);~~**  
45 **~~and be it further~~**

46  
47 **RECOMMENDATION C:**

48  
49 **That AMA Policies H-320.968 and H-285.915 be reaffirmed.**

1           **RECOMMENDATION D:**

2  
3           **That Resolution 206 be adopted as amended.**

4  
5           RESOLVED, That our AMA advocate for legislation to require physicians contracted by  
6 health insurers or pharmacy benefit managers to possess an active license in the states  
7 where they review prior authorizations and be subject to the rules, statutes, medical  
8 board, and peer review of the state in which the prior authorization request is made  
9 (Directive to Take Action); and be it further

10  
11          RESOLVED, That our AMA advocate for the repeal of the Employee Retirement Income  
12 Security Act (ERISA) as it pertains to prior authorization decisions. (Directive to Take  
13 Action)

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

35  
36           **Approaches to Increase Payer Accountability H-320.968**

37  
38           Our AMA supports the development of legislative initiatives to assure that payers  
39 provide their insureds with information enabling them to make informed decisions  
40 about choice of plan, and to assure that payers take responsibility when patients  
41 are harmed due to the administrative requirements of the plan. Such initiatives  
42 should provide for disclosure requirements, the conduct of review, and payer  
43 accountability.

44  
45           (1) Disclosure Requirements. Our AMA supports the development of model draft  
46 state and federal legislation to require disclosure in a clear and concise standard  
47 format by health benefit plans to prospective enrollees of information on (a)  
48 coverage provisions, benefits, and exclusions; (b) prior authorization or other  
49 review requirements, including claims review, which may affect the provision or  
50 coverage of services; (c) plan financial arrangements or contractual provisions

1 that would limit the services offered, restrict referral or treatment options, or  
2 negatively affect the physician's fiduciary responsibility to his or her patient; (d)  
3 medical expense ratios; and (e) cost of health insurance policy premiums. (Ref.  
4 Cmt. G, Rec. 2, A-96; Reaffirmation A-97)  
5

6 (2) Conduct of Review. Our AMA supports the development of additional draft  
7 state and federal legislation to: (a) require private review entities and payers to  
8 disclose to physicians on request the screening criteria, weighting elements and  
9 computer algorithms utilized in the review process, and how they were  
10 developed; (b) require that any physician who recommends a denial as to the  
11 medical necessity of services on behalf of a review entity be of the same  
12 specialty as the practitioner who provided the services under review; (c) Require  
13 every organization that reviews or contracts for review of the medical necessity of  
14 services to establish a procedure whereby a physician claimant has an  
15 opportunity to appeal a claim denied for lack of medical necessity to a medical  
16 consultant or peer review group which is independent of the organization  
17 conducting or contracting for the initial review; (d) require that any physician who  
18 makes judgments or recommendations regarding the necessity or  
19 appropriateness of services or site of service be licensed to practice medicine in  
20 the same jurisdiction as the practitioner who is proposing the service or whose  
21 services are being reviewed; (e) require that review entities respond within 48  
22 hours to patient or physician requests for prior authorization, and that they have  
23 personnel available by telephone the same business day who are qualified to  
24 respond to other concerns or questions regarding medical necessity of services,  
25 including determinations about the certification of continued length of stay; (f)  
26 require that any payer instituting prior authorization requirements as a condition  
27 for plan coverage provide enrollees subject to such requirements with consent  
28 forms for release of medical information for utilization review purposes, to be  
29 executed by the enrollee at the time services requiring such prior authorization  
30 are recommended or proposed by the physician; and (g) require that payers  
31 compensate physicians for those efforts involved in complying with utilization  
32 review requirements that are more costly, complex and time consuming than the  
33 completion of standard health insurance claim forms. Compensation should be  
34 provided in situations such as obtaining preadmission certification, second  
35 opinions on elective surgery, and certification for extended length of stay.  
36

37 (3) Accountability. Our AMA believes that draft federal and state legislation  
38 should also be developed to impose similar liability on health benefit plans for  
39 any harm to enrollees resulting from failure to disclose prior to enrollment the  
40 information on plan provisions and operation specified under Section 1 (a)-(d)  
41 above.  
42

### 43 **AMA Policy on ERISA H-285.915**

44

45 1. Our AMA will seek, through amendment of the ERISA statute, through  
46 enactment of separate federal patient protection legislation, through enactment of  
47 similar state patient protection legislation that is uniform across states, and  
48 through targeted elimination of the ERISA preemption of self-insured health  
49 benefits plans from state regulation, to require that such self-insured plans: (a)  
50 Ensure that plan enrollees have access to all needed health care services; (b)

1 Clearly disclose to present and prospective enrollees any provisions restricting  
2 patient access to or choice of physicians, or imposing financial incentives  
3 concerning the provision of services on such physicians; (c) Be regulated in  
4 regard to plan policies and practices regarding utilization management, claims  
5 submission and review, and appeals and grievance procedures; (d) Conduct  
6 scientifically based and physician-directed quality assurance programs; (e) Be  
7 legally accountable for harm to patients resulting from negligent utilization  
8 management policies or patient treatment decisions through all available means,  
9 including proportionate or comparative liability, depending on state liability rules;  
10 (f) Participate proportionately in state high-risk insurance pools that are financed  
11 through participation by carriers in that jurisdiction; (g) Be prohibited from  
12 indemnifying beneficiaries against actions brought by physicians or other  
13 providers to recover charges in excess of the amounts allowed by the plan, in the  
14 absence of any provider contractual agreement to accept those amounts as full  
15 payment; (h) Inform beneficiaries of any discounted payment arrangements  
16 secured by the plan, and base beneficiary coinsurance and deductibles on these  
17 discounted amounts when providers have agreed to accept these discounted  
18 amounts as full payment; (i) Be subject to breach of contract actions by providers  
19 against their administrators; and (j) Adopt coordination of benefits provisions  
20 applying to enrollees covered under two or more plans.

21  
22 2. Our AMA will continue to advocate for the elimination of ERISA preemption of  
23 self insured health plans from state insurance laws consistent with current AMA  
24 policy.

25  
26 (10) RESOLUTION 211 – CREATING A  
27 CONGRESSIONALLY-MANDATED BIPARTISAN  
28 COMMISSION TO EXAMINE THE U.S. PREPARATIONS  
29 FOR AND RESPONSE TO THE COVID-19 PANDEMIC  
30 TO INFORM FUTURE EFFORTS

31  
32 **RECOMMENDATION A:**

33  
34 **Resolution 211 be amended by addition to read as follows:**

35  
36 **RESOLVED, That our AMA advocate for passage of federal legislation to**  
37 **create a congressionally-mandated bipartisan commission composed of**  
38 **scientists, physicians with expertise in pandemic preparedness and**  
39 **response, public health experts, legislators and other stakeholders, which**  
40 **is to examine the U.S. preparations for and response to the COVID-19**  
41 **pandemic, in order to inform and support future public policy and health**  
42 **systems preparedness (Directive to Take Action); and be it further**



1           **RECOMMENDATION B:**

2  
3           **Resolution 211 be adopted as amended.**

4  
5           RESOLVED, That our AMA advocate for passage of federal legislation to create a  
6           congressionally-mandated bipartisan commission composed of scientists, physicians  
7           with expertise in pandemic preparedness and response, public health experts,  
8           legislators and other stakeholders, which is to examine the U.S. preparations for and  
9           response to the COVID-19 pandemic, in order to inform future public policy and health  
10          systems preparedness (Directive to Take Action); and be it further

11  
12          RESOLVED, That, in advocating for legislation to create a congressionally-mandated  
13          bipartisan commission, our AMA seek to ensure key provisions are included, namely that  
14          the delivery of a specific end product (i.e., a report) is required by the commission by a  
15          certain period of time, and that adequate funding be provided in order for the  
16          commission to complete its deliverables. (Directive to Take Action)

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

34  
35          (11)    **RESOLUTION 218 – CRISIS PAYMENT REFORM**  
36                  **ADVOCACY**

37  
38           **RECOMMENDATION A:**

39  
40           **The First Resolve of Resolution 218 be amended by addition and deletion**  
41           **to read as follows:**

42  
43           **RESOLVED, That our AMA continue to promote national awareness of the**  
44           **loss of physician medical practices and patient access to care due to**  
45           **COVID-19, and continue to advocate for reforms that support and sustain**  
46           **physician medical practices that will disrupt healthcare availability to many**  
47           **patients (Directive to Take Action); ~~and be it further~~**

1 **RECOMMENDATION B:**

2  
3 **That the Second Resolve of Resolution 218 be deleted.**

4  
5 ~~**RESOLVED, That our AMA: (1) promote reform in our health care payment**~~  
6 ~~**system that supports and sustains physician medical practices not only**~~  
7 ~~**under routine circumstances but also in an extended crisis situation such**~~  
8 ~~**as COVID-19; (2) advocate for, as a priority directive, a blueprint for action**~~  
9 ~~**along those lines to the newly installed Presidential administration and**~~  
10 ~~**Congress in early 2021 and beyond; and (3) monitor and aim to improve,**~~  
11 ~~**along with other stakeholders, any new health care initiative(s) in a**~~  
12 ~~**contemporaneously effective manner. (Directive to Take Action)**~~

13  
14 **RECOMMENDATION C:**

15  
16 **Resolution 218 be adopted as amended.**

17  
18 **RESOLVED, That our AMA promote national awareness of the loss of physician medical**  
19 **practices due to COVID-19 that will disrupt healthcare availability to many patients**  
20 **(Directive to Take Action); and be it further**

21  
22 **RESOLVED, That our AMA: (1) promote reform in our health care payment system that**  
23 **supports and sustains physician medical practices not only under routine circumstances**  
24 **but also in an extended crisis situation such as COVID-19; (2) advocate for, as a priority**  
25 **directive, a blueprint for action along those lines to the newly installed Presidential**  
26 **administration and Congress in early 2021 and beyond; and (3) monitor and aim to**  
27 **improve, along with other stakeholders, any new health care initiative(s) in a**  
28 **contemporaneously effective manner. (Directive to Take Action)**

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

1 Your Reference Committee heard testimony that the resolution does not take into  
2 consideration our AMA's advocacy efforts included in our AMA's COVID-19 Advocacy  
3 Progress Report, which lays out over 70 COVID-related advocacy efforts in which our  
4 AMA has been engaged since the beginning of the pandemic. Furthermore, your  
5 Reference Committee heard testimony that our AMA is already engaging in  
6 conversations with the incoming Administration. Your Reference Committee therefore  
7 agrees with an amendment offered by the Council on Legislation that would be  
8 consistent with our AMA's continued effort to promote national awareness of the loss of  
9 physician medical practices and patient access to care and to continue to advocate for  
10 reforms that support and sustain physician medical practices. Your Reference  
11 Committee heard proffered amendments to the Second Resolve; however, given the  
12 active advocacy that our AMA is doing around this topic, built on extensive and  
13 multifaceted AMA Policy, your Reference Committee does not believe the current  
14 Second Resolve or amendments would add substantively to current AMA Policy. Thus,  
15 your Reference Committee believes that the resolution as amended encompasses the  
16 spirit of the original resolution. Accordingly, your Reference Committee recommends  
17 Resolution 218 be adopted as amended.

**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.**

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

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

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

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.

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