REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Lynda M. Young, MD, Chair:

1. OPTIONS TO MAXIMIZE COVERAGE UNDER THE AMA PROPOSAL FOR REFORM

Reference committee hearing: see report of Reference Committee A.

**HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTIONS 113-A-19 AND 114-A-19
REMAINDER OF REPORT FILED**
See Policies H-165.823, H-165.825 and H-165.828

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

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

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

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

The amendment offered during the House of Delegates' consideration of this item at the 2019 Annual Meeting asked that our AMA support various approaches that offer a public option in addition to current sources of coverage, private or public, including but not limited to: (a)(i) a Medicare buy-in; (ii) a public option offered on health insurance exchanges; and (iii) buying into either the FEHBP or a state employee health plan; and (b) study the options to effectively implement such approaches.

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

THE AMA PROPOSAL FOR REFORM

Covering the uninsured and improving health insurance affordability have been long-standing goals of the AMA. Since the enactment of the Affordable Care Act (ACA), the AMA proposal for reform has continued to evolve to ensure that AMA policy is able to address how to best cover the remaining uninsured in the current coverage

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environment. In 2018, nearly 60 percent of nonelderly Americans (153.8 million) had employer-sponsored health insurance coverage, 22 percent (57.9 million) had Medicaid coverage, and 7 percent (19.4 million) had non-group coverage, while 10.4 percent (27.9 million) remained uninsured.[1]

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

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

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

By appropriately targeting the provision of coverage to the uninsured population, the AMA proposal for reform as follows has the potential to make significant strides in covering the remaining uninsured and providing health insurance to millions more Americans:

- Premium tax credits would be available to individuals without an offer of "affordable" employer coverage, with no upper income limit (Policy H-165.824).
- Individuals currently caught in the "family glitch" and unable to afford coverage offered through their employers for their families would become eligible for ACA financial assistance based on the premium for family coverage of their employer plan (Policy H-165.828). Currently, in determining eligibility for premium tax credits, coverage for family members of an employee is considered to be affordable as long as employee-only coverage is affordable. The employee-only definition of affordable coverage pertaining to employer-sponsored coverage, commonly referred to as ACA's "family glitch," does not take into consideration the cost of family-based coverage, which commonly is much more expensive than employee-only coverage. As a result, the "family glitch" leaves many workers and their families ineligible to receive premium and cost-sharing subsidies to purchase coverage on health insurance exchanges, even though in reality they would likely have to pay well over 9.78 percent of their income for family coverage.
- To help employees currently having difficulties affording coverage, the threshold used to determine the affordability of employer coverage would be lowered, which would make more people eligible for ACA financial assistance based on income (Policy H-165.828).
- The generosity of premium tax credits would be increased to improve premium affordability, by tying premium tax credit size to gold-level instead of silver-level plan premiums, and/or lowering the cap on the percentage of income individuals are required to pay for premiums of the benchmark plan (Policy H-165.824).
- Young adults facing high premiums would be eligible for "enhanced" tax credits based on income (Policy H-165.824).
- Eligibility for cost-sharing reductions would be expanded to help more people with the cost-sharing obligations of the plan in which they enroll (Policy H-165.824).
- The size of cost-sharing reductions would be increased to lessen the cost-sharing burdens many individuals with low incomes face, which impact their ability to access and afford the care they need (Policy H-165.824).
- A permanent federal reinsurance program would be established, to address the impact of high-cost patients on premiums (H-165.842).
- State initiatives to expand their Medicaid programs will continue to be supported. To incentivize expansion decisions, states that newly expand Medicaid would still be eligible for three years of full federal funding (Policies D-290.979 and H-290.965).

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- To maximize coverage rates, the AMA would continue to support reinstating a federal individual mandate penalty, as well as state efforts to maximize coverage, including individual mandate penalties and auto-enrollment mechanisms (Policies H-165.848 and H-165.824).
- To improve coverage rates of individuals eligible for either ACA financial assistance or Medicaid/CHIP but who remain uninsured, the AMA would support investments in outreach and enrollment assistance activities (Policies H-165.824, H-290.976, H-290.971, H-290.982 and D-290.982).
- States would continue to have the ability to test different innovations to cover the uninsured, provided such experimentations: a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care; b) ensure and maximize patient choice of physician and private health plan; and c) include reforms that eliminate denials for pre-existing conditions (Policy D-165.942).

APPROACHES TO A PUBLIC OPTION

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

Public Option on Exchanges

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

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

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

Importantly, the Council notes that adding a public option to health insurance exchanges may not necessarily achieve significant additional coverage gains, compared to proposals to build upon the ACA. Many of the proposals that aim to cover more people under the ACA are included in the AMA proposal for reform. For example, the Urban Institute in October 2019 modeled the coverage and cost impacts of various health reform options. It found that, after implementing a range of proposals to build upon and improve the ACA – including enhancing and extending subsidies for marketplace coverage, establishing a permanent reinsurance program, restoring the ACA's individual mandate, addressing the Medicaid eligibility gap in non-expansion states, and allowing for limited Medicaid autoenrollment – 21.4 million individuals would be uninsured in 2020. When a public option is added to these ACA improvement provisions, 21.3 million individuals would still be uninsured in 2020. Under this scenario, adding a public option

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would not achieve meaningful additional coverage gains, as the public option would only lower health insurance premiums for individuals not eligible for subsidies in the nongroup market, which would be a smaller population after the implementation of the aforementioned ACA improvements. That being said, adding a public option was shown to meaningfully lower federal spending on subsidies for marketplace coverage, as lower premiums, premised on lower provider payment rates, would lead to lower premium tax credit amounts.[6]

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

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

Broader Availability of a Public Option

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

For example, as an alternative to the traditional Medicare-for-All proposals, Representative Rosa DeLauro (D-CT) introduced H.R. 2452, the Medicare for America Act of 2019. Unlike Medicare-for-All, Medicare for America would allow large employers to continue providing health insurance to their employees, if they provide gold-level coverage (i.e., 80 percent of benefits costs covered). Alternatively, employers can direct their contributions for employee coverage toward paying for premiums for Medicare for America. If employers continue to offer health insurance to their employees, employees would have the ability to choose Medicare for America coverage instead of their employer coverage. There would also be premiums and cost-sharing under Medicare for America, but notably, there would be no deductibles. Premiums would be on a sliding scale based on income, with individuals with incomes below 200 percent FPL having no premium, deductible or out-of-pocket costs. Premiums overall would be capped at no more than eight percent of monthly income. Individuals and families with incomes between 200 and 600 percent FPL would be eligible to receive subsidies to lower their premium contributions, with current Medicare beneficiaries either paying the premium for which they are responsible under Medicare, or that of Medicare for America, whichever is less expensive. Out-of-pocket maximums would also be applied on a sliding scale based on income, with the caps being $3,500 for an individual and $5,000 for families. Provider payment under Medicare for America would be based largely on Medicare and Medicaid rates, with increases in payment for primary care, mental and behavioral health, and cognitive services, and the Secretary being given the authority to establish a rate schedule for services currently

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not paid for under Medicare. Participating providers under Medicare or Medicaid would be considered to be participating providers under Medicare for America.[10,11]

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

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

Medicare Buy-In

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

RAND Corporation has modeled various approaches to a Medicare buy-in to assess the impacts of allowing individuals ages 50 to 64 to buy in to the Medicare program, including on total health insurance enrollment. Across all approaches to a Medicare buy-in analyzed by RAND, 2.8 to 7 million older adults would enroll, with 6 million individuals enrolling under RAND's base buy-in scenario. This rate of take-up of a Medicare buy-in is due to the premiums for the buy-in being less expensive than plans offered on the individual market – the result of factors including the buy-in paying providers at Medicare rates. However, when these older adults exit the individual market, premiums for plans offered on the individual market increase, as the remaining risk pool is smaller, and comprised of less healthy and more expensive individuals considering their ages. Accordingly, the RAND analysis showed that a Medicare buy-in has little to no effect on total health insurance enrollment, as more older adults enrolling in health insurance pursuant to the establishment of the buy-in is countered by more younger adults becoming uninsured.[16]

Medicaid Buy-In

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

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

Leveraging the Federal Employees Health Benefits Program (FEHBP) and State Employee Benefit Plans

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

Leveraging health plan FEHBP participation has been included in a leading proposed solution to prevent bare counties in the marketplaces. A 2017 bipartisan proposal to fix the ACA supported, in the short-term, requiring the two largest FEHBP insurers in any county to offer at least one silver-level plan though the federal exchange in all counties that would otherwise be without coverage as a condition of participation in FEHBP. These plans would be eligible for premium tax credits and could otherwise charge actuarially appropriate premiums.[20] In addition, last Congress, Representative Darrell Issa (R-CA) introduced legislation to allow individuals who are not federal employees to enroll in FEHBP unless the individual is enrolled, or eligible to enroll, in a different public health insurance program; or is a member of the uniformed services.[21]

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

Relevant AMA Policy

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

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

ACHIEVING HIGHER COVERAGE RATES THROUGH AUTO-ENROLLMENT

In 2018, 27.9 million nonelderly individuals (10.4 percent) were uninsured, an increase from the 27.4 million (10.2 percent) who were uninsured in 2017.[23] Nearly seven million of the nonelderly uninsured were eligible for Medicaid or CHIP. More than nine million nonelderly individuals were eligible for premium tax credits provided for under the

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ACA.[24] In December 2019, the Kaiser Family Foundation estimated that, of the uninsured who could purchase coverage on health insurance exchanges, 4.7 million are eligible to purchase a zero-premium bronze plan (i.e., 60 percent of benefits costs covered) after subsidies in 2020.[25]

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

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

1. How to obtain eligibility information so uninsured individuals can be identified and matched to coverage for which they are eligible, including Medicaid/CHIP and marketplace coverage, as well as premium tax credits.
2. How to collect premiums, if applicable.
3. How to assign individuals to an insurance plan.
4. How to manage situations where individuals are auto-enrolled into coverage for which they are not eligible, or remain uninsured despite believing they were enrolled in health insurance coverage.[26]

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

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

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

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

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Relevant AMA Policy

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

DISCUSSION

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

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

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

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

After providing consent to applicable state and/or federal entities to share their health insurance status and tax data, the Council believes that individuals should only be auto-enrolled in health insurance coverage if coverage options are available at no cost to them after any applicable subsidies. As such, candidates for auto-enrollment would be individuals eligible for Medicaid/CHIP or zero-premium marketplace coverage, unless they choose to opt out. Individuals who are auto-enrolled should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.

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Individuals eligible for zero-premium marketplace coverage should be randomly assigned among plans with the highest actuarial value with a zero-dollar premium option, and plans should be incentivized to offer pre-deductible coverage including physician services to maximize the value of zero-premium plans to patients. Individuals enrolled in a zero-premium bronze plan who would otherwise qualify for significant cost-sharing reductions if they enrolled in a silver plan (70 percent of benefits costs covered) should be notified of their eligibility for cost-sharing reductions, and what enrolling in a silver plan would mean in terms of differences in out-of-pocket responsibilities, so they could be appropriately informed in advance of the subsequent open enrollment period. In this scenario, to assist with out-of-pocket responsibilities of the bronze plan into which they are enrolled in the meantime, the Council recommends reaffirmation of Policy H-165.824, which supports these individuals having access to a health savings account (HSA) partially funded by an amount determined to be equivalent to the cost-sharing subsidy.

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

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

RECOMMENDATIONS

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

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

    a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
    b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
    c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
    d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
    e. The public option is financially self-sustaining and has uniform solvency requirements.
    f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
    g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid–having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits–at no or nominal cost.

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

   a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
   b. Individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would, therefore, include individuals eligible for Medicaid/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
   c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
   d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
   e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
   f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
   g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
   h. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and establishing a special enrollment period.

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

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

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2. MITIGATING THE NEGATIVE EFFECTS OF HIGH-DEDUCTIBLE HEALTH PLANS

Reference committee hearing: see report of Reference Committee G

HOD ACTION: **RECOMMENDATIONS ADOPTED**
IN LIEU OF RESOLUTION 125-A-19
REMAINDER OF REPORT FILED
See Policies H-165.828, H-185.918 and D-185.979

At the 2019 Annual Meeting, the House of Delegates referred the enclosed Resolution 125, which was sponsored by Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont. Resolution 125-A-19 directed the AMA to advocate for legislation or regulation specifying that codes for outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments. The Board of Trustees assigned this item to the Council on Medical Service (CMS) for a report back to the House of Delegates at the 2020 Annual Meeting. This report examines clinical and financial challenges associated with high-deductible health plans (HDHPs), explores several potential strategies for improvement, and makes recommendations to mitigate the negative effects of HDHPs.

BACKGROUND

HDHPs are insurance plans associated with lower premiums, higher deductibles, and greater cost-sharing requirements as compared with traditional health plans.[1] Both enrollment in HDHPs and the size of deductibles has increased dramatically in recent years. In 2019, approximately 30 percent of enrollees in employer-sponsored health plans were covered by HDHPs, compared to 4 percent in 2006.[2] The imposition of greater consumer cost-sharing is frequently described as a means of ensuring that those receiving health care services "have skin in the game," and used as a lever to minimize the growth of health insurance premiums.

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However, while an HDHP's lower premium may be enticing, higher patient cost-sharing can lead to significant challenges. Reductions in health care spending achieved through HDHPs have been found to be due to patients simply receiving less medical care.[3] Moreover, HDHPs appear to reduce health care spending by decreasing the use of both appropriate care (such as recommended cancer screenings) and less appropriate care (such as low-severity emergency department visits).[4] Studies have found that families who have members with chronic disease and who are enrolled in HDHPs are more likely to go without care due to cost and/or face substantial financial burdens, such as trouble paying bills, than families enrolled in traditional plans.[5] Another study found that enrollment in an HDHP combined with a savings account led to significant increases in out-of-pocket (OOP) spending, with more than half of the enrollees with lower-incomes and more than one-third of the enrollees with chronic conditions facing "excessive financial burden."[6]

The challenges of underinsurance and cost-related nonadherence (CRN) which can negatively affect patient care in general can be exacerbated in the context of HDHPs. Rates of underinsurance (e.g. OOP costs that are high relative to income) have risen. Even when a service is covered by a health plan, patients may incur significant costs in the form of copayments, coinsurance, and/or large medical bills that they must pay before meeting their deductibles. Such costs have been shown to cause people, especially those with low incomes and/or chronic conditions, to forgo necessary care.[7] Similarly, CRN refers to a state in which patients are unable to pursue recommended medical care due to financial barriers.[8] CRN and sub-optimal patient use of evidence-based medical services can lead to negative clinical outcomes, increased disparities, and in some cases, higher aggregate costs.[9] CRN has been identified across the entire continuum of clinical care, including physician visits, preventive screenings, and prescription drugs,[10] and the challenges of CRN may be magnified by the COVID-19 pandemic as payers experience financial pressure and strive to lower medical spending.[11] CRN is especially problematic for vulnerable populations, such as those with multiple chronic conditions, lower socioeconomic status, and/or belonging to diverse racial or ethnic groups.[12] For example, a recent study found that HDHPs were associated with cost-related barriers to care for cancer survivors, and these barriers were significantly greater for Black patients.[13] Additionally, greater OOP costs for medication to treat certain chronic conditions has been found to reduce initiation and adherence, lower the likelihood of achieving desired health outcomes, and sometimes, increase utilization of acute care services.[14] At the same time, studies have demonstrated that reducing or eliminating cost-sharing leads to improvements in medication adherence[15] and reductions in health disparities based on socioeconomic status and race.[16]

In addition to increases in deductible spending, total patient OOP spending has also risen significantly in recent years. Total OOP spending, which includes pre-deductible spending, copayments, and coinsurance, increased by 54 percent between 2006 and 2016.[17] Intensifying this challenge is the fact that over the past decade, growth in OOP costs has outpaced increases in workers' wages.[18] The COVID-19 pandemic highlighted critical shortcomings, with many health plans not providing affordable coverage for services to treat many chronic conditions and COVID-19-related illness.[19] In fact, 68 percent of adults said that OOP costs would be very or somewhat important in their decision to get care if they had COVID-19 symptoms.[20]

To help offset the burdens of higher deductibles and greater cost-sharing that patients face when enrolled in HDHPs, plans and employers can make available one or more of several tax-advantaged savings accounts including: Health Savings Accounts (HSAs), Health Reimbursement Arrangements (HRAs), Flexible Spending Arrangements (FSAs), and for certain small employers or self-employed individuals, Medical Savings Accounts (MSAs).[21] Each of these savings accounts has unique benefits and drawbacks, and the "best option" is very case specific. However, many patients do not, or cannot, optimally utilize savings accounts to help them offset OOP costs associated with HDHPs.[22] In light of these significant financial concerns, more needs to be done to ensure access to necessary, high-value care.

POTENTIAL STRATEGIES FOR IMPROVEMENT

Resolution 125-A-19 recommended that outpatient evaluation and management services, including initial and established patient office visits, be exempt from deductible payments in an effort to improve patient health and decrease total health care costs. The AMA supports innovative benefit designs that could allow certain physician services and prescription drugs to be provided pre-deductible. Moreover, in CMS Report 1-I-20, the Council is recommending that health plans be incentivized to offer pre-deductible coverage including physician services in their bronze plans, to maximize the value of zero-premium plans to plan enrollees. This is similar to the requirement that catastrophic plans sold on health insurance exchanges must cover at least three primary care visits per year pre-deductible.[23] Pre-deductible coverage for certain physician visits in these specific contexts, however, is a significant departure from pre-deductible coverage for all physician visits in all contexts.

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When health plans become more generous in exempting additional items and services from a deductible, other elements of benefit design become less generous (ie, more costly to the enrollee) to counterbalance the additional cost. In theory, over a long time horizon with a consistent enrollee base, a health plan might find long-term cost savings, such as through decreases in hospital admissions or emergency department visits, to offset short-term cost increases associated with increased generosity in services exempt from deductibles. However, when short-term costs are critical, such as in health insurance exchanges and among plans sponsored by employers in industries that experience high levels of employee turnover, short-term costs heavily influence benefit design. In the health insurance exchanges, increases in plan generosity cause an increase in actuarial value (AV) of a health plan, and the plan must become less generous in other domains to maintain its AV. For example, in a study designed to test how plans could provide more generous coverage for high-value services, the more generous coverage for some services had to be offset by less generous coverage of other services in order to maintain required AV.[24] Similarly, in the private market, health plans might increase premiums or impose greater cost-sharing on some items or services to compensate for decreased cost-sharing for other items and services.

While high deductibles and OOP costs pose a significant challenge to many, this challenge is not universal, so it is important to recognize that blunt instruments that simply cause health care costs to shift among deductibles, cost-sharing, and premiums will be reallocating the burden of health care costs among a general population with very disparate health care utilization. US health care spending is dramatically concentrated, with very few individuals incurring very large shares of spending, while other large portions of the population incur very little spending. In fact, in 2016, half of the population had health spending under $971, accounted for only 2.8 percent of total health spending in the US, and incurred average OOP health care spending of only $73.[25] In contrast, 10 percent of the population had health spending of at least $12,024, accounted for 66 percent of total US spending, and incurred average OOP spending of $2,380.[26]

Benefit Design Initiatives

Rather than applying a blunt instrument that categorically shifts health care costs, health plans could be designed with "clinical nuance," a principle of value-based insurance design (VBID). "Clinical nuance" recognizes that medical services may differ in the amount of health produced, and that the clinical benefit derived from a specific service depends on the person receiving it, as well as when, where, and by whom the service is provided.[27] The same service could be high-value to one patient and low-value to another, and the ability of patients and their physicians to make this determination on a case-by-case basis is critical and well-supported by AMA policy. Achieving truly nuanced plan design is a laudable goal and one that VBID researchers have been pursuing for over a decade[28] with some progress. For example, the US Department of Treasury recently released Notice 2019-45, allowing HSA-HDHP plans the flexibility to cover specified medications and services used to treat chronic diseases prior to meeting the plan deductible.[29] While the list of specified medications and services is limited, it is a decisive step in the direction of expanding health plan flexibility to improve affordable access to high-value care.

More recently, legislative and regulatory changes have further expanded HSA-HDHPs' capacity for clinical nuance in the context of COVID-19. Explicitly recognizing the potential administrative and financial barriers to care present for individuals enrolled in HSA-HDHPs, the Internal Revenue Service (IRS) issued Notice 2020-15 to remove those barriers in the context of the unprecedented public health emergency.[30] Specifically, Notice 2020-15 makes another limited exception to the general rules governing qualification for HSA-HDHPs to allow health plans the flexibility to cover testing and treatment of COVID-19 pre-deductible and without imposition of patient cost sharing. Many of the nation's leading insurance companies pursued this opportunity and waived patient cost-sharing for COVID-19-related testing, but the scope and duration of these waivers varies across insurers.[31] IRS Notice 2020-29 further clarified that the testing and treatment of COVID-19 that can be provided pre-deductible includes the panel of diagnostic testing for influenza A & B, norovirus and other coronaviruses, and respiratory syncytial virus (RSV).[32] Additionally, the Coronavirus Aid, Relief and Economic Security (CARES) Act created a temporary safe harbor allowing HDHPs to cover telehealth services and other remote care without cost to participants before their deductibles are met.[33] The safe harbor is currently in effect until the end of 2021.[34] It is up to payers, though, to implement plan changes to take advantage of this legal flexibility, and it remains to be seen how much relief patients will experience. As understanding of the clinical impacts of COVID-19 continues to evolve and patients begin experiencing long-term impacts from the infection, patients have reported receiving medical bills totaling tens of thousands of dollars for treatment for COVID-19 and complications.[35]

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A second key consideration is that to effectively enhance patients' access to high-value care, health plans must make high-value care across the clinical continuum affordable. Making physician visits more affordable is therefore a necessary, but insufficient, step toward achieving the improved access goal of Resolution 125-A-19. If only physician office visits are targeted for deductible exemption, some patients and physicians may be frustrated to realize that they can identify a problem but lack the resources to resolve it. For example, consider the scenario where patients can visit their physician and learn that they are at risk for diabetes without incurring costs under their health plan, but to pursue necessary testing, pharmaceuticals, and medical devices, they must pay OOP until reaching their deductibles. In fact, a recent study found that patients enrolled in an HDHP who received a prescription for a brand name antihyperglycemic medication were less likely to refill that prescription than were patients enrolled in non-HDHP plans who were prescribed the same medicine.[36] This study suggests that HDHP enrollment can impact the quality and delivery of care for patients with type 2 diabetes when branded antihyperglycemic medications offer optimal disease management.[37] Similarly, another study found that patients with diabetes experienced minimal changes in outpatient visits and disease monitoring after switching to an HDHP, but low-income, high-morbidity, and HSA-HDHP subgroups experienced major increases in emergency department visits or expenditures for preventable acute diabetes complications.[38]

However, VBID can be applied to reduce some of the negative impacts of HSA-HDHPs and reduce health care disparities. A recent study found that when HSA-HDHPs incorporate a preventive drug list (PDL) which exempts specific high-value classes of medications from deductibles, patients experienced substantial decreases in annual OOP costs, increased medication utilization, and lower barriers to initiating treatment.[39] The study authors emphasized the importance of these findings for patients with lower incomes and encouraged employers to consider tailoring their benefit designs to concentrate PDL coverage in lower-income employees who may benefit most from the subsidized coverage. Additionally, a recent study demonstrated that an "HDHP+," a hypothetical HSA-HDHP that would reduce cost-sharing for certain high-value items and services intended to treat chronic conditions, would likely save the federal government money, and at a minimum, be cost neutral.[40] Moreover, plans that apply VBID principles to HDHPs could improve health equity by ensuring that all enrollees can afford high-value services, even during the deductible phase of their coverage.[41] At the same time, especially with such complex benefit designs, active counseling to help enrollees understand the value of their benefits may be critical to the success of these programs.[42] Collectively, these studies reinforce the principle that mitigating the deleterious effects of HDHPs will require efforts from stakeholders from across the health care continuum.

Payer-Driven Initiatives

In addition to considering alternative benefit design strategies that incentivize use of high-value care, payers can adopt strategies to minimize the deleterious effects of high deductibles. Given the trend of increasing patient OOP spending, payers could nevertheless soften the burden of these increasing OOP costs on patients and their physicians. Two key variables add to the stress of increasing OOP patient spending – first, the extent to which health care expenditures may need to be paid in large lump sums, and second, the extent to which patients and their physicians are unable to anticipate how much a given item or service will cost a patient OOP. When deductibles reset every year on January 1, many patients, including the 60 percent of Americans living with at least one chronic condition, may face significant OOP costs.[43] Patients may delay or forgo necessary care early in the year when they are facing the full OOP burden of their deductibles and have not accumulated funds in health savings accounts. In fact, it has been shown that nearly all incremental reductions in high-deductible health care spending occur while patients are subject to their deductibles.[44] Moreover, for patients enrolled in plans with coinsurance, the cost of health care items and services often cannot be known in advance, even after they have met their deductibles. In contrast, plans designed with copayments allow patients and their physicians to anticipate patient OOP costs.

Copayments are the most common form of patient cost-sharing associated with physician visits,[45] but with the increasing use of HDHPs, increasing numbers of patients and physicians are facing high deductibles and unpredictable bills for coinsurance. From 2007 to 2017, among patients with large employer coverage, coinsurance, deductible, and patient OOP spending increased, and copayment spending decreased.[46] In 2019, approximately 15 percent of patients enrolled in an HDHP paired with a savings account were subject to copayments for a physician office visit, with 68 percent subject to coinsurance.[47] The opposite pattern is present for patients enrolled in non-HDHP plans – between 86 and 95 percent of patients in non-HDHP plans paid copayments for physician office visits, with only 4 to 11 percent paying coinsurance.[48] With patients bearing increasing OOP health care costs, health plans that allow patients to predict their OOP costs in advance and also spread their OOP expenses over time may present a more patient-friendly and physician practice-friendly benefit design.

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Employers, in specific, play a unique role as designers of employee health care benefits, and employers can choose to deploy a variety of strategies to encourage patients to pursue the care they need. Benefit packages are increasingly important to employees, with employees seeking choice and personalization, and looking to their employers to provide the tools they need to make good decisions.[49] Employers can take a variety of actions to make the health insurance benefits they offer valuable and accessible to their employees. For example, in 2019, JPMorgan Chase provided employees with health plans that applied lower deductible and coinsurance maximum amounts to lower-income employees.[50] For 2020, some JPMorgan Chase and Amazon employees have even more innovative plan options via the Haven Healthcare program, the venture among JPMorgan Chase, Amazon, and Berkshire Hathaway. Few details are available, but reporting indicates that the JPMorgan Chase plans remove patient deductibles, and copayments for most services range from $15 to $110.[51] Employers have a variety of more incremental options for tailoring the health plans they offer to their employees' needs. Some potential options for employers to consider include:

- Seed and/or match employee contributions to one or more types of savings accounts that can be used for health care expenses to encourage savings and use of these savings accounts. Employers contributing to employees' HSAs can improve employee awareness, consideration, and ultimately adoption and self-funding of HSAs.[52] Research indicates that on average, employees contribute 10 percent more to their HSAs each year when their employer seeds money to their HSAs, and 59 percent of employees would contribute more to their HSAs if their employer provides a matching contribution.[53] However, a recent study found that 55 percent of employers offering HSA-HDHPs do not make contributions toward their employees' HSAs.[54]
- When possible, grant employees access to the full annual employer and/or employee contribution to a savings account at the beginning of a plan year so that patients can pursue care as they need it, rather than delaying care until savings have accumulated.
- Provide, and perhaps incentivize employees to participate in, robust health insurance and financial literacy campaigns that give them tools to choose the plan that best meets their needs and identify affordable care options throughout the plan year. When making decisions about health care savings, patients must navigate a complex set of choices, and even those with high financial literacy have trouble deciding where to save and how to spend.[55] For example, a 2018 study found that 69 percent of employees who did not enroll in an HSA say they chose not to enroll because they did not see any benefits to an HSA, did not understand what HSAs do, or simply did not take the time to understand the HSA. Moreover, only 15 percent of employees with high financial literacy choose to save their HSA money for the future.[56] Educational campaigns could include practical information regarding which items and services are available without patient cost-sharing pre-deductible and information about how funds placed in an HSA, HRA, FSA, MSA, or other savings account can be used to pay for health expenses. Via online and in-person education, employers can provide decision support and care navigation tools to help their employees at the time of health insurance enrollment and throughout the year.[57]
- Consider how predictable copayments vs. variable coinsurance can influence patient tendencies to pursue necessary health care and provide patients with a variety of health plan design options whenever possible.
- Collaborate with organized medicine to ensure that their innovations in plan design are likely to achieve intended clinical goals, as well as enhanced access to affordable care.

Physician Practice Initiatives

Physician practice initiatives focused on helping patients with high deductibles can serve physicians and the patients in their care. High deductibles burden patients and their physicians when patient fears about cost of care impair joint patient-physician decision-making and care planning. High deductibles also pose billing and collection challenges for physician practices. Fortunately, there are tools available that can help physicians and their practices. The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) related to standard electronic transactions and associated operating rules empower health care providers to obtain real-time information regarding patients' health plan coverage and financial obligations. Specifically, the operating rules for the electronic eligibility standard transaction require health plans to respond in real-time (within 20 seconds)[58] to health care providers' electronic requests for information about patients' health plan benefits.[59] Implementation of this legal requirement has been imperfect[60] – challenges persist – but the eligibility operating rules provide physicians with an avenue to obtain necessary data to inform their practice and their physician-patient joint decision-making. Specifically, physician practices can ascertain the patient's portion of the financial responsibility, including copayment, coinsurance and patient-specific remaining deductible. This information can help practices estimate patient costs before treatment decisions are made, and in some cases, collect patient deductibles and/or coinsurance before patients leave the office.[61] To empower physicians to implement and exercise their rights under the HIPAA administrative simplification provisions and to streamline their practices' billing processes, the AMA has published several toolkits and educational

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resources, including those entitled, "What you need to know about electronic eligibility verification," "Managing patient payments," and "Electronic transaction toolkits for administrative simplification, which includes a resource on Compliance in standard electronic transactions: Responsibilities of health plans and physicians."[62]

RELEVANT AMA POLICY

AMA policy strongly supports value-based care, VBID, and innovative insurance design. Policy H-185.939 broadly supports flexibility in the design and implementation of VBID programs and outlines a series of guiding principles including that VBID explicitly consider the clinical benefit of a given service or treatment when determining cost-sharing or other benefit design elements. Policy D-185.979 also supports clinical nuance in VBID to respect individual patient needs and supports legislative and regulatory flexibility to accommodate VBID, including innovations that expand access to affordable care, such as changes needed to allow HSA-HDHPs to provide pre-deductible coverage for preventive and chronic care management services. Policy D-185.979 also encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services. Consistent with calls to remove legislative and regulatory barriers to innovative plan design, Policy H-165.856 states that the regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements and further states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. Policy H-450.938 provides principles to guide physician value-based decision-making, and Policy H-155.960 supports value-based decision-making among other broad strategies for addressing rising health care costs. Moreover, this policy recognizes the role of physician leadership and collaboration among physicians, patients, insurers, employers, unions, and government in successful cost-containment and quality-improvement initiatives. The policy encourages third-party payers to use targeted benefit design, whereby patient cost-sharing is determined based on the clinical value of a health care service or treatment, with consideration given to further tailoring cost-sharing to patient income and other factors known to impact compliance. AMA policy also supports value-based pricing for pharmaceuticals (Policy H-110.986) and providing patients with information and incentives to encourage appropriate utilization of preventive services (Policy H-390.849).

Policy H-165.846 states that provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations. Policy H-165.828 encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy. That policy also supports education regarding deductibles, cost-sharing, and HSAs. Policy H-165.852 supports, as an integral component of AMA efforts to achieve universal access and coverage and freedom of choice in health insurance, legislation promoting the establishment and use of HSAs and allowing the tax-free use of such accounts for health care expenses. That policy also supports the enhancement of activities to educate patients about the advantages and opportunities of HSAs. In addition, Policy H-165.854 supports HRAs as a mechanism for empowering patients to have greater control over their health care decision-making.

DISCUSSION

The Council lauds the sponsors of Resolution 125-A-19 for highlighting key challenges that HDHPs present to both patients and physicians, and it shares the goal of reducing barriers to necessary health care. The Council is committed to developing AMA policy to mitigate the negative impacts of HDHPs that is consistent with the broader context of AMA policy on health reform and value-based decision-making. To accomplish this goal, the Council believes that the AMA should encourage further research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients. Such policy would be consistent with AMA policy regarding "clinical nuance" in VBID (Policy D-185.979) and policy encouraging private market innovation in product development and purchasing arrangements (Policy H-165.856). Recognizing that more than half of Americans under age 65 get their health insurance through an employer,[63] employers have a powerful role to play in designing health plans to meet their employees' needs and educating their employees about the benefits provided by the health plans. Accordingly, the Council recommends that employers should be encouraged to collaborate with their employees in ways that help them to better understand their employees' health insurance preferences and needs, tailor the benefits they offer to meet the preferences and needs of employees and their dependents, and provide robust education to help patients make good use of their benefits to obtain the care they need. Moreover, to ease the financial burden of large

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lump sum expenditures, the Council recommends that employers pursue strategies to help enrollees spread the costs associated with high OOP costs across the plan year. Additionally, consistent with Policy H-155.960, which highlights the importance of collaboration among physicians and employers in successful cost-containment and quality-improvement initiatives, the Council encourages state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care. In addition, to emphasize the importance of health plans designed with "clinical nuance," the need for legislative and regulatory flexibility to accommodate innovations in health plan design that expand access to affordable care, and the critical role of collaboration among national medical specialty societies and payers in designing innovative health plans, the Council recommends reaffirming Policy D-185.979. Similarly, to highlight the importance of robust education regarding deductibles, cost-sharing, and health care savings accounts, and to amplify the AMA's support for funding health savings accounts, the Council recommends reaffirming Policy H-165.828. Moreover, the Council notes that in CMS Report 1-I-20, it recommends incentivizing health plans to offer pre-deductible coverage, including physician services in bronze plans, to maximize the value of zero-premium plans to plan enrollees.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 125-A-19 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) encourage ongoing research and advocacy to develop and promote innovative health plan designs, including designs that can recognize that medical services may differ in the amount of health produced and that the clinical benefit derived from a specific service can vary among patients.

2. That our AMA encourage employers to: (a) provide robust education to help patients make good use of their benefits to obtain the care they need, (b) take steps to collaborate with their employees to understand employees' health insurance preferences and needs, (c) tailor their benefit designs to the health insurance preferences and needs of their employees and their dependents, and (d) pursue strategies to help enrollees spread the costs associated with high out-of-pocket costs across the plan year.

3. That our AMA encourage state medical associations and state and national medical specialty societies to actively collaborate with payers as they develop innovative plan designs to ensure that the health plans are likely to achieve their goals of enhanced access to affordable care.

4. That our AMA reaffirm Policy D-185.979, which supports health plans designed to respect individual patient needs and legislative and regulatory flexibility to accommodate innovations in health plan design that expand access to affordable care, and which encourages national medical specialty societies to identify services that they consider to be high-value and collaborate with payers to experiment with benefit plan designs that align patient financial incentives with utilization of high-value services.

5. That our AMA reaffirm Policy H-165.828, which supports education regarding deductibles, cost-sharing, and health savings accounts (HSAs), and encourages the development of demonstration projects to allow individuals eligible for cost-sharing subsidies, who forego these subsidies by enrolling in a bronze plan, to have access to an HSA partially funded by an amount determined to be equivalent to the cost-sharing subsidy.

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3. MEDICARE PRESCRIPTION DRUG AND VACCINE COVERAGE AND PAYMENT

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 203-A-19 REMAINDER OF REPORT FILED
See Policies H-110.980, H-440.860, H-440.875, D-330.954, D-330.898 and D-440.981

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

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

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

MEDICARE COVERAGE OF AND PAYMENT FOR VACCINES

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

In terms of physician payment for vaccines under Medicare Part B, physicians submit claims to their Medicare Administrative Contractor for the vaccine and its administration. When physicians agree to accept assignment for both the vaccine and its administration, which is common, patients do not have to pay copayments or any contribution towards their Part B deductible for the seasonal influenza virus, pneumococcal, and Hepatitis B vaccines. Physicians who are in-network providers of their patient's Medicare Advantage plan submit claims to the plan for payment.

Under Medicare Part D, there are multiple pathways for vaccine payment and administration. Physicians may not be able to directly bill Part D plans for vaccines and their administration. In some cases, patients may need to pay their physicians up front for Part D vaccines, and then submit a claim to their Part D plan for reimbursement. If the

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physician's charge for the vaccine is greater than the plan's allowable charge, the patient would then be responsible for paying the difference. To limit patient out-of-pocket responsibilities, the physician can receive authorization, via a vaccine-specific notice requested by the physician or Part D plan enrollee. The vaccine-specific notice would provide the physician with instructions on how to receive a coverage authorization for a vaccine and how to submit an out-of-network claim, the plan's vaccine reimbursement rates, and any applicable cost-sharing responsibilities of the patient. In this situation, the physician would agree to accept payment received by the patient's Part D plan as payment in full, and the patient would pay the physician any cost-sharing amount required by their plan.

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

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

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

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

In addition, vaccine utilization rates among adults enrolled in Medicare have historically been, and continue to remain, low.[2] While the Affordable Care Act (ACA) drastically changed the cost-sharing requirements for vaccines under private health plan coverage and Medicaid, the law did not change cost-sharing requirements for vaccines covered under Medicare Part D. As a result, approximately four percent or less of enrollees of either stand-alone or Medicare Advantage prescription drug plans had access to ten vaccines without cost-sharing that are recommended by Advisory Committee on Immunization Practices either generally for adults ages 65 and older, or for adults with certain risk factors.[3] This level of access to these vaccines with no cost-sharing under Medicare Part D remained generally the same from 2015. Of note, no stand-alone Part D plan covered these vaccines with zero cost-sharing between 2015 and 2017.[4]

Relevant AMA Policy

Policy D-440.981 states that our AMA will: (1) continue to work with CMS and provide comment on the Medicare Program payment policy for vaccine services; (2) continue to pursue adequate reimbursement for vaccines and their administration from all public and private payers; (3) encourage health plans to recognize that physicians incur costs associated with the procurement, storage and administration of vaccines that may be beyond the average wholesale price of any one particular vaccine; and (4) advocate that a physician's office can bill Medicare for all vaccines

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administered to Medicare beneficiaries and that the patient shall only pay the applicable copay to prevent fragmentation of care.

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

MEDICARE PART D DRUG PRICE NEGOTIATION

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

In an effort to lower drug prices and patient out-of-pocket costs in Medicare Part D, multiple bills have been introduced in Congress to enable and/or require the Secretary of HHS to negotiate covered Part D drug prices on behalf of Medicare beneficiaries. However, historically, the Congressional Budget Office (CBO), as well as CMS actuaries, have estimated that providing the Secretary of HHS broad negotiating authority by itself would not have any effect on negotiations taking place between Part D plans and drug manufacturers or the prices that are ultimately paid by Part D.[5,6]

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

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

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Relevant AMA Policy

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

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

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

MEDICARE PART B DRUG PRICES AND PHYSICIAN PAYMENT

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

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

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

In October of 2018, the Trump Administration released an Advance Notice of Proposed Rulemaking (ANPRM) entitled "International Pricing Index Model for Part B Drugs." The ANPRM did not represent a formal proposal, but rather outlined the Administration's current thinking and sought stakeholder input on a variety of topics and questions related to this new drug pricing model prior to entering formal rulemaking. Under the ANPRM, providers would select vendors from which to receive included drugs but would not be responsible for buying and billing Medicare for the drug product. Instead, providers would continue to be entitled to bill a drug administration fee and would also be entitled to receive a drug add-on fee. While the ANPRM was somewhat short on detail on exactly how this add-on fee

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would be calculated, it appears the add-on fee would be a flat fee that is based on six percent of the historical average sales price for the drug in question.[13]

In September 2020, an executive order "Lowering Drug Prices by Putting America First" was issued which called for testing of payment models to apply international price benchmarking to Part B and Part D prescription drugs and biological products. For Part B, the executive order instructed the Secretary of HHS to implement rulemaking to test a payment model under which "Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price." The executive order defined the "most-favored-nation price" as "the lowest price, after adjusting for volume and differences in national gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a member country of the Organization for Economic Co-operation and Development (OECD) that has a comparable per-capita gross domestic product." For Part D, the executive order instructed the Secretary of HHS to develop and implement rulemaking to test a payment model for high-cost Part D drugs, limiting payment to these drugs to the most-favored-nation price, to the extent feasible.[14] At the time that this report was written, no proposed and/or interim final rule had been issued to begin the implementation of the provisions of the executive order, which could also propose changes to Medicare Part B drug reimbursement.

Relevant AMA Advocacy and Policy

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

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

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

DISCUSSION

The prices and coverage of, and payment for, prescription drugs and vaccines under Medicare Parts B and D not only impact patients' ability to access the drugs and vaccines they need, but also impact the ability of physician practices to cover their costs associated with acquiring, storing and administering Part B drugs, and Part B and Part D vaccines. Over the years, proposals aimed at lowering drug prices in Medicare Part B have also included provisions that would transition reimbursement for the cost of Part B drugs away from the current approach that is tied to ASP plus six percent (which has been reduced to 4.3 percent under the budget sequester). The Council recognizes that there has not yet been consensus among national medical specialty societies, and the house of medicine as a whole, concerning the preferred alternative(s) to using a rate tied to ASP to reimburse physicians and hospitals for the cost of Part B drugs. The Council believes, however, that the time is now for organized medicine to move forward with building consensus on which alternative methods would be preferred to reimburse physicians for the cost of Part B drugs. As a first step, our AMA should build upon past efforts and solicit input from national medical specialty societies and state medical

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associations for their recommendations to ensure adequate Part B drug reimbursement. The Council is hopeful that there will be a high level of participation among members of the Federation, in an effort to work collectively and collaboratively on this issue within the house of medicine. Subsequently, the AMA should work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs.

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

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

RECOMMENDATIONS

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

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

2. That our AMA work with interested national medical specialty societies on alternative methods to reimburse physicians and hospitals for the cost of Part B drugs.

3. That our AMA continue working with interested stakeholders to improve the utilization rates of adult vaccines by individuals enrolled in Medicare.

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

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

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

7. That our AMA reaffirm Policy D-330.954, which supports the use of Medicare drug price negotiation.

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

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4. ECONOMIC DISCRIMINATION IN THE HOSPITAL PRACTICE SETTING

Reference committee hearing: see report of Reference Committee G

HOD ACTION: RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 718-A-19 REMAINDER OF REPORT FILED
See Policies H-230.951, H-230.953, H-230.975, H-230.976 and H-230.982

At the 2019 Annual Meeting, the House of Delegates referred Resolution 718, "Economic Discrimination in the Hospital Practice Setting," which was introduced by the Organized Medical Staff Section. The Board of Trustees assigned this item to the Council on Medical Service for a report back at the 2020 Annual Meeting. Resolution 718 asked that our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation.

This report addresses concerns regarding the use of case and volume metrics to limit access to hospital services by private practice physicians on hospital staff, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Relationships between hospitals and physicians have changed over the years as health care payment and delivery systems have evolved, more care has moved to outpatient settings, and physician practice ownership has shifted away from physician-owned practice and toward working for a hospital or hospital-owned practice. The shift toward hospital employment is evidenced by AMA's Physician Practice Benchmark Surveys, which show that 35 percent of physicians worked either directly for a hospital or in a practice at least partially owned by a hospital in 2018, up from 29 percent in 2012.[1]

Hospital care has similarly evolved over time, such that inpatients are now sicker, hospital stays are shorter, and the hospitalist model—which was introduced in the 1990s—is in place in a majority of hospitals. Although primary care physicians and other generalist physicians still serve as inpatient attendings, far fewer specialists do so,[2] and most inpatient care is managed by hospitalists.[3] Prior to these shifts and the advent of hospital medicine, physicians largely practiced independently and managed patient care across outpatient and inpatient settings. Although many private practice physicians remain members of hospital medical staffs and have clinical privileges, most hospitals (approximately 75 percent in 2016) utilize hospitalists.[4]

Recently, concerns have been raised in the House of Delegates regarding hospital-physician relationships and hospitals giving preference to their employed physicians to the detriment of private practice physicians and patient-physician relationships. Referred Resolution 718-A-19 focuses specifically on concerns regarding hospitals using case and volume metrics to limit access to hospital services by private practice physicians who are on staff. The *AMA Physician's Guide to Medical Staff Organization Bylaws* speaks to similar concerns:

> In exclusive contracting situations, some hospitals argue that exclusive rights to use hospital resources, such as radiology equipment or operating rooms, can be awarded by contract to some holders of privileges, while others with the same privileges are barred from their use.[5]

Such actions by hospitals violate the intent of Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges. To address these concerns, the *AMA Physician's Guide to Medical Staff Organization Bylaws* includes the following sample bylaw regarding clinical privileges:

> Clinical privileges or privileges means the permission granted to medical staff members to provide patient care and includes unrestricted access to hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.[6]

The Guide consists of sample bylaw language on self-governance and other issues relevant to hospital-medical staff relationships. A seventh iteration of the Guide was being developed at the time this report was written.

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Physicians need full access to hospital services in order to provide high quality care to their patients. Additionally, physicians must have access to hospital services to maintain medical staff memberships and privileges. Case in point is The Joint Commission's Ongoing Professional Practice Evaluation (OPPE) requirements, which are factored into decisions to maintain existing privileges. Data used for the OPPE process must include physician activities performed at the hospital where privileges have been requested.

RELEVANT AMA POLICY

In addition to defining clinical privileges and addressing access to hospital resources, Policy H-230.982 states that privileges can be abridged only upon recommendation of the medical staff for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff.

An extensive collection of AMA medical staff policy aims to protect the rights of physicians who are members of hospital medical staffs. Policy H-225.942 delineates medical staff member rights and responsibilities, including fundamental rights that apply to individual medical staff members regardless of employment, contractual, or independent status. Policy H-225.950 includes principles for physician employment; Policy H-225.957 outlines principles for strengthening the physician-hospital relationship; and Policy H-225.997 addresses physician-hospital relationships. Policy H-220.951 requests The Joint Commission to require that conditions for hospital medical staff membership be based only on the physician's professional training, experience, qualifications, and adherence to medical staff bylaws. Policy H-230.953 encourages The Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges. Policy H-225.984 encourages hospital medical executive committees to regularly examine hospital/corporate bylaws, rules and regulations for any conflicts with the medical staff bylaws, rules and regulations or practices. Policy H-230.987 supports the concept that individual medical staff members who have been granted clinical privileges are entitled to full due process in any attempt to abridge those privileges by granting exclusive contracts by the hospital governing body.

The AMA also has extensive policy on economic credentialing and volume discrimination. Policies H-230.975 and H-230.976 strongly oppose economic credentialing, defined in policy as the use of economic criteria unrelated to quality of care or professional competency in determining an individual's qualifications for hospital medical staff membership or privileges. Policy H-230.971 asks the AMA to work with The Joint Commission to assure that criteria used in the credentialing process are directly related to the quality of patient care. Under Policy H-225.949, medical staffs are encouraged to develop medical staff membership categories for physicians who provide a low volume or no volume of clinical services in the hospital, and also encourages medical staffs and hospitals to engage community physicians, as appropriate, in medical staff and hospital activities.

Policy H-285.964 states that hospitalist programs should be developed consistent with AMA policy on medical staff bylaws and implemented with the formal approval of the organized medical staff, and that hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to hospitalists. This policy also opposes any hospitalist model that disrupts patient/physician relationships or continuity of care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

As a benefit of membership, the AMA provides assistance, such as information and advice (but not legal opinions or representation) to employed physicians, physicians in independent practice, and independent physician contractors in matters pertaining to their relationships with hospitals, health systems, and other similar entities (Policy D-215.990).

DISCUSSION

Although the Council was unable to find more than anecdotal information regarding physicians being subjected to the discrimination discussed in referred Resolution 718-A-19, it agrees that new policy is needed. The Council also believes that economic discrimination may be based on the type, as well as number of referrals made. Accordingly, the Council recommends actively opposing policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation. Having heard broader concerns about fairness and the need to protect physicians serving on medical staffs, the Council also recommends new policy recognizing that physician onboarding, credentialing, and peer review should not be tied in a discriminatory manner to hospital employment status.

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The Council acknowledges the strength of existing AMA medical staff policy and recommends reaffirmation of Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff. To address the OPPE issue, the Council recommends reaffirmation of Policy H-230.953, which encourages The Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges. Finally, the Council recommends reaffirmation of Policies H-230.975 and H-230.976, which strongly oppose economic credentialing.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 718-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) actively oppose policies that limit a physician's access to hospital services based on the number and type of referrals made, the number of procedures performed, the use of any and all hospital services or employment affiliation.

2. That our AMA recognize that physician onboarding, credentialing and peer review should not be tied in a discriminatory manner to hospital employment status.

3. That our AMA reaffirm Policy H-230.982, which states that clinical privileges shall include access to those hospital resources essential to the full exercise of such privileges, and that privileges can be abridged only upon recommendation of the medical staff, for reasons related to professional competence, adherence to appropriate standards of medical care, health status, or other parameters agreed upon by the medical staff.

4. That our AMA reaffirm Policy H-230.953, which encourages the Joint Commission to support alternative processes to evaluate competence, for the purpose of credentialing, of physicians who do not meet the traditional minimum volume requirements needed to maintain credentials and privileges.

5. That our AMA reaffirm Policy H-230.975, which strongly opposes economic credentialing and believes that physicians should attempt to assure provisions in hospital medical staff bylaws of an appropriate role of the medical staff in decisions to grant or maintain exclusive contracts.

6. That our AMA reaffirm Policy H-230.976, which opposes use of economic criteria not related to quality to determine a physician's qualification for the granting or renewal of medical staff membership or privileges.

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5. MEDICAID REFORM

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: **RECOMMENDATIONS ADOPTED IN LIEU OF RESOLUTION 809-I-19 REMAINDER OF REPORT FILED**
See Policies H-290.958, H-290.963, H-290.965, H-290.966, H-290.976, H-290.986 and D-290.979

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

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

BACKGROUND

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

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

In March 2020, Medicaid and Children's Health Insurance Program (CHIP) covered nearly 71 million people (just over 64 million people were enrolled in Medicaid while an additional 6.7 million were enrolled in CHIP) and over half (51 percent) of total enrollees were children.[2] Notably, prior to the pandemic Medicaid provided coverage to more than 20 percent of low-wage workers.[3] As initial unemployment claims surged nationwide, early forecasts predicted that the economic crisis would trigger large-scale Medicaid enrollment increases. A model by Health Management Associates, for example, estimated that enrollment could increase by 11 to 23 million people,[4] while the Kaiser Family Foundation projected that over half (12.7 million) of the nearly 27 million individuals who could lose employer-sponsored insurance would become eligible for Medicaid.[5] Three months into the pandemic, the Georgetown University Center for Children and Families found enrollment increases of five percent on average in the 22 states being tracked as well as significant variability across states.[6] National enrollment figures for May 2020, the most recent available at the time this report was written, indicate that 73.5 million individuals were enrolled in Medicaid and CHIP, an increase of approximately 2.5 million from March.[7] The modest increase was at least partially attributed to the ability of furloughed workers to keep employer-sponsored coverage and the fact that, early in the pandemic, fewer people were seeking medical care. The situation is evolving and while enrollment growth over time is uncertain, many states are anticipating and/or already experiencing significant increases in Medicaid applications.

Although Medicaid enrollment and spending increased during the 2002 and 2009 recessions and following Affordable Care Act (ACA) implementation, growth in Medicaid spending per enrollee has generally been less than that of private insurance spending,[8] in part because payment rates are significantly lower than rates paid by Medicare and private

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insurance for comparable services. Inadequate Medicaid payment rates often do not cover the full cost of patient care and have been associated with lower physician participation in Medicaid, which in turn negatively impacts patient access to care.[9] Delayed payments and administrative burdens also steer some providers away from participating in the program.

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

MEDICAID EXPANSION

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

Since 2013, more than 14 million people have enrolled in Medicaid under the ACA expansion.[12] Council on Medical Service Report 5-I-14, Medicaid Expansion Options and Alternatives, expressed concern for individuals left in what is known as the coverage gap of earning too much to qualify for Medicaid in their states but too little (less than 100 percent of the FPL) to qualify for premium subsidies to purchase health insurance through ACA marketplaces. Expansion states have eliminated the coverage gap but, nationally, prior to the pandemic, an estimated 2.3 million uninsured adults fell into the gap in non-expansion states, a number that is sure to grow. Nine out of 10 of these individuals live in southern states, with one third residing in Texas and another 17 percent in Florida.[13]

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

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

Studies of economic measures have also shown that Medicaid expansion may offset costs in other areas (such as uncompensated care) and that it spurs economic activity and may even generate savings for states.[20] Nevertheless, the main arguments against expansion focus on costs and fiscal accountability. Prior to the pandemic, total Medicaid spending had grown to nearly $600 billion[21] with the federal share reaching over $400 billion.[22] Medicaid is the third largest domestic federal program and one of the largest budget items in most states, and has been projected to be a trillion-dollar program by 2026.[23] In 2018, Medicaid accounted for 16.4 percent of national health care spending.[24]

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WAIVERS

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

Section 1115 waivers have been around for decades and are frequently used by Administrations to implement domestic priorities. In early 2020, CMS announced the Healthy Adults Opportunity (HAO) initiative, inviting states to apply for Section 1115 waivers under which states would agree to limited federal financing without being bound to many existing programmatic and oversight requirements.[27] Under the HAO initiative, states agreeing to an aggregate or per-capita cap financing model for adult Medicaid expansion populations would be granted a menu of flexibilities that could be attractive to some states, although state interest in HAO waivers has been limited.

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

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

COVID-19 Waivers and Other Temporary Changes

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

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

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FEDERAL MEDICAL ASSISTANCE PERCENTAGES (FMAP) INCREASE

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

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

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

NARROWING DISPARITIES IN HEALTH COVERAGE AND ACCESS TO CARE

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

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

Disparities in access to care, as measured by two indicators—foregoing care due to cost and not having a usual source of care—also decreased in all states since 2013, and more so in expansion states.[40] Although Medicaid expansion under the ACA has played a key role in reducing disparities in health insurance coverage and access to care, almost half of Black adults live in states that have not expanded the program. Black adults in these states who would be eligible for Medicaid if the state had expanded the program are likely to instead fall into the coverage gap. Expansion of Medicaid across the 12 states that have not yet opted to do so may narrow the gaps in coverage and access to care in those states, although disparities will likely remain.

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RELEVANT AMA POLICY

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

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

Policy H-160.913 recognizes the potential value of Medicaid patient-centered medical home models. Streamlined application and enrollment processes are supported by Policy H-290.982, while Policy D-290.985 encourages sufficient federal and state funding for Medicaid/CHIP to support enrollment and the provision of necessary services. Policy H-290.984 opposes mandatory enrollment in managed care plans. The AMA advocates for the same policies for Medicaid managed care that are advocated for private managed care plans, as well as criteria for federal and state oversight of Medicaid managed care plans that are delineated in Policy H-290.985. Network adequacy elements are outlined in Policy H-285.908, and Policy H-320.908 addresses prior authorization.

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

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

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

AMA ADVOCACY

Because Medicaid patients too often face barriers to care, the AMA works diligently at the state and federal levels to improve Medicaid programs, expand coverage options, and make it easier for physicians to see Medicaid patients. Since the ACA was enacted, AMA advocacy on Medicaid reform has been guided by AMA policy, highlighted in the AMA's Plan to Cover the Uninsured, which seeks to extend the reach of coverage to the remaining uninsured, including individuals eligible for Medicaid/CHIP and adults who fall into the coverage gap. Consistent with AMA policy, the AMA continues to advocate for Medicaid expansion and three years of 100 percent federal funding for states that newly expand. The AMA also supports investments in Medicaid/CHIP outreach and enrollment activities and opposes work requirements. Council on Medical Service Report 1, November 2020, Options to Maximize Coverage under the AMA Proposal for Reform, recommends establishing new AMA policy on auto-enrollment in health insurance as a means of maximizing coverage of the uninsured who are eligible for Medicaid/CHIP or zero-premium marketplace coverage. Importantly, the AMA—along with other physician organizations—has argued against striking down the ACA (and Medicaid expansion) in an amicus brief filed in the case of *Texas v. California* that is before the US Supreme Court.

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

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

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

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

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DISCUSSION

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

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

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

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

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

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

As it has during past deliberations, the Council discussed the potential for bifurcating the Medicaid program which would remove the long-term care function that accounts for two-thirds of the program's spending. Due to concerns

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regarding the complexity, feasibility, and potential unintended consequences of bifurcation, the Council does not recommend utilizing AMA resources to engage in advocacy on bifurcation. The Council also notes that financing for long-term services and supports was addressed in a 2018 Council report.

RECOMMENDATIONS

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

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

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

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

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

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

6. That our AMA reaffirm Policy H-290.963, which opposes caps on federal Medicaid funding.

7. That our AMA reaffirm Policy H-290.976, which affirms the AMA's commitment to advocating that Medicaid should pay physicians at minimum 100 percent of Medicare rates.

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APPENDIX - Crosswalk of Resolution 809-I-19 with AMA Policy

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

Resolution 809-I-19 Proposed Principle	Relevant AMA Policy and Council Analysis
1. Provide appropriate access to care that is the most cost effective and efficient to our citizens.	Access to care is addressed in numerous policies, including Policies H-290.965 and H-290.997. Policy H-290.989 urges that Medicaid reform be undertaken in conjunction with broader health insurance reform to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients.
2. Encourage individuals to be enrolled in private insurance supported by Medicaid funding, if possible.	A preference for enrollment in private insurance is embedded throughout policy, including Policies H-165.920, H-165.855 and H-290.982.
3. Create the best coverage at the lowest possible cost.	Policy H-165.846 supports principles for guiding the evaluation and adequacy of health insurance coverage.
4. Incentivize Medicaid patient behavior to improve lifestyle, health, and compliance with appropriate avenues of care and utilization of services.	Policy H-170.963 advocates that Medicaid and other publicly funded health insurance programs incentivize voluntary healthy behaviors among their participants which may decrease the cost of their medical care to the tax-paying public.
5. Establish a set of specialty specific high-quality metrics with appropriate remuneration and incentives for clinicians to provide high quality care.	Policy H-290.982 calls for CMS to develop better measurement, monitoring and accountability systems and indices within Medicaid to assess program effectiveness. Policy D-350.974 encourages the development of measures that identify socioeconomic and racial/ethnic disparities in quality.
6. Seek to establish improved access for Medicaid patients to primary care providers and referrals to specialists for appropriate care.	Policy D-290.977 advocated that the ACA's Medicaid primary care payment increases continue past 2014 in a manner that does not negatively impact payment for any other physicians. Policy H-290.965 advocates for robust access to specialty care.
7. Assure appropriate payment and positive incentives to encourage but not require clinician participation in Medicaid for both face-to-face and non-face-to-face encounters, under appropriate establishment of clinician-patient relationship.	Fair and adequate physician payment by Medicaid that should be a minimum of 100 percent of Medicare rates is supported by Policies H-290.965, H-290.989, H-290.997, H-330.932, and H-385.921. Policy H-480.946 supports coverage of and payment for telemedicine services while Policy D-480.969 supports coverage parity for telemedicine services.
8. Include payment incentives to clinicians for after-hours primary care to assist patients with an inability to access care during normal business hours.	Policy H-290.985 advocates that the availability of off-hours, walk-in primary care and other criteria be used in the oversight and evaluation of Medicaid managed care plans. Policy H-385.940 advocates for fair and equitable payment of services described by CPT codes, including those CPT codes which already exist for off-hour services. Examples of CPT codes for after-hours care include 99050 and 99051.
9. Avoid tactics and processes that inhibit access to care, delay interventions and prevent ongoing maintenance of health.	Parameters related to prior authorization relief in Medicaid plans are outlined in Policy H-320.938. Policy D-320.981 outlines protections related to step therapy.
10. Eliminate current disincentives (e.g., Medicaid spend-down in order to qualify) to patients improving their lives while on Medicaid, to increase successful transition into the private insurance market.	Policy H-280.991 suggests policy directions for the financing of long-term care and encourages private sector coverage. As stated above (under #2), the preference for enrollment in private insurance is embedded throughout policy.
11. Cease any tax, or attempt to tax, any health care profession for the purpose of supporting the cost of Medicaid.	The AMA strongly opposes the use of provider taxes or fees to fund health care programs such as Medicaid (Policy H-385.925).
12. Develop a physician directed clinician oversight board at the state level to insure the proper access, quality and cost of care under the Medicaid program throughout all geographically diverse areas of the states.	Policy H-290.975 supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients.
13. Allow clinicians to see patients for more than one procedure in a visit so that patients do not have to return for another service at an extra cost to the Medicaid program and extra time and effort to the Medicaid patient (e.g., if patient comes because they are sick,	Policy H-385.944 supports payment for E&M services and procedures performed on the same day, where consistent with CPT guidelines.

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allow them to have a diabetes check-up at the same time).	
14. Strategically plan to reduce administrative costs and burdens to clinicians, and of the Medicaid program itself, by reducing at least, but not limited to, burdensome documentation requirements, administrative obstacles, and regulatory impediments.	Policy H-320.938 supports prior authorization relief for Medicaid and Medicaid managed care plans and outlines parameters for such relief. The AMA supports improvements in Medicaid that will reduce administrative burdens under Policy D-290.979.

6. VALUE-BASED MANAGEMENT OF DRUG FORMULARIES

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLUTION 814-I-19
REMAINDER OF REPORT FILED
See Policies H-110.979, H-110.986, H-120.988, H-285.965 and D-110.987

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

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

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

BACKGROUND

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

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

An underlying concern of referred Resolution 814-I-19 pertains to the tiering of specialty drugs in formularies. Specialty drugs, which have the highest prices, continue to enter the market, raising questions of how these drugs will be covered by health plans. Spending on specialty drugs is approaching one-half of drug spending.[1] Responding to this financial reality, some private and public payers have taken steps to subdivide the specialty tier of formularies into separate preferred and non-preferred categories, which can further exacerbate the financial burden posed by specialty drugs on patients as well as complicate physician prescribing decisions. For example, a proposed rule released in February 2020 included a proposal to allow Medicare Part D sponsors to establish a second, "preferred" specialty tier that would have lower cost-sharing than the current specialty tier. The proposed rule, if finalized without

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changes, would also establish a cost-sharing maximum that would be applicable to the higher-cost specialty tier. The proposed rule stipulates that if there are two specialty tiers, one must be a "preferred" tier that has lower cost sharing than the proposed maximum allowable specialty tier cost-sharing, defined as between 25 and 33 percent, which is dependent upon whether a Part D plan includes a deductible.[2] The AMA submitted comments in response to the proposed rule, noting that the creation of a second specialty tier may lead to increased patient copays/cost shares for a chronic medication on which the patient is stabilized. In addition, AMA's comments stressed that in the case of biologic medications, switching to a biosimilar on a lower specialty tier may have negative clinical implications for a patient stabilized on a reference product. As such, the AMA urged the Centers for Medicare & Medicaid Services to consider any Medicare patients currently stabilized on a specialty drug to be exempt from unfavorable coverage changes (e.g., increased patient copays/cost shares) resulting from a secondary specialty tier.[3]

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

VALUE-BASED MANAGEMENT OF PRESCRIPTION DRUG FORMULARIES

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

Indication-Based Formularies

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

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Outcomes-Based Contracts

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

Leveraging Value-Based Frameworks in Guiding Formulary Placement

Payers are also increasingly using analyses of entities such as the Institute for Clinical and Economic Review (ICER), not only in their drug price negotiations with pharmaceutical companies, but also in their decisions pertaining to formulary inclusions of newly launched drugs. For example, in 2018, CVS Caremark launched a program that would allow its clients to exclude any drug launched at a price of greater than $100,000 per quality adjusted life year (QALY) from their plan. The QALY ratio used by CVS Caremark in this program originated from ICER analyses. CVS Caremark stipulated that breakthrough therapies would be excluded from this program, instead focusing on drugs for which similar effective drug therapies already exist–"me too" drugs.[5] As of the end of 2019, this plan offering had gained little traction with CVS Caremark clients, with patient advocacy groups raising significant concerns.[6]

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

American Society of Clinical Oncology

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

RELEVANT AMA POLICY

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

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

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

DISCUSSION

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

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

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

The Council has significant concerns with the increasing use of indication-based formularies. On the patient side of the equation, indication-based formularies can make patient selection of a health plan (in Medicare Part D, for example) much more difficult, as patients would not only have to search for a particular drug, but also confirm that the drug is covered for their particular indication. And, for newly diagnosed patients already enrolled in a health plan, the drug that may be best to treat their condition may not be covered for their specific indication.

For physicians, indication-based formularies introduce new complications along the chain from a patient's office visit, to a pharmaceutical being dispensed at a pharmacy. Patients' drug coverage is already dependent on and varies

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according to each individual health plan. Indication-based formularies have the potential to build upon the existing complexity and exacerbate the existing transparency issues surrounding PBM formulary design, as physicians cannot access indication-based formulary data in their EHRs at the point of prescribing. Ultimately, there will be even more variations within and between health plans regarding whether a drug is covered. In addition, drugs could potentially be removed from formularies for indications where they are not deemed as effective. Indication-based formularies could also introduce new administrative burdens for physicians. For example, coverage restrictions will likely not be discovered until after the prescription claim is submitted by the pharmacy and denied by the PBM, which will request the applicable diagnosis code. The pharmacy will need to contact the physician practice for this additional information, and under the best-case scenario, the claim will be resubmitted and paid by the PBM. However, if the PBM does not cover the drug for the reported indication, the pharmacy will contact the physician again and request that an alternate therapy be prescribed. This "prescription rework" and multiple workflow disruptions will further increase physicians' already significant challenges in navigating patients' prescription drug benefits. As such, the Council recommends that indication-based formularies be opposed, in order to protect the ability of patients to access and afford the prescription drugs they need, and physicians to make the best prescribing decisions for their patients.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) reaffirm Policy H-120.988, upholding the ability of patients to access treatments prescribed by their physicians.

2. That our AMA reaffirm Policy H-285.965, which states that pharmacy and therapeutics (P&T) committee members should include independent physician representatives, and that mechanisms should be established for ongoing peer review of formulary policy as well as for appealing formulary exclusions.

3. That our AMA advocate that pharmacy benefit managers (PBMs) and health plans use a transparent process in formulary development and administration, and include practicing network physicians from the appropriate medical specialty when making determinations regarding formulary inclusion or placement for a particular drug class.

4. That our AMA reaffirm Policy D-110.987, which supports improved transparency of PBM operations, including disclosing rebate and discount information as well as P&T committee information, including records describing why a medication is chosen for or removed in the P&T committee's formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy; and formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities.

5. That our AMA reaffirm Policy H-110.986, which outlines principles guiding AMA's support for value-based pricing programs, initiatives and mechanisms for pharmaceuticals.

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

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

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7. HEALTH PLAN INITIATIVES ADDRESSING SOCIAL DETERMINANTS OF HEALTH

Reference committee hearing: see report of Reference Committee A.

HOD ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
REMAINDER OF REPORT FILED
See Policies H-165.922, D-478.972 and D-478.996

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

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

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

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As such, this report provides background on social determinants of health as well as their contributions in the 2019 novel coronavirus (COVID-19) pandemic; highlights examples of how the health and non-health sectors are addressing social determinants of health; outlines emerging health plan initiatives to address social determinants of health in health insurance benefit design; summarizes relevant AMA policy; and presents policy recommendations.

BACKGROUND

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

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

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

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

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

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

The Council notes that initiatives to address social determinants of health within and outside of the health care system are diverse in nature, both in structure and programmatic aims and goals. Outside of the health care system, the focus of initiatives has been on how to build partnerships and bring non-health sectors into discussions centered on the improvement of health and health equity. Within the health care system, payers on the state and federal levels have implemented payment and delivery reform initiatives to address social needs, including under the auspices of the Center for Medicare and Medicaid Innovation (CMMI), and state Medicaid programs.

Healthcare Anchor Network

Hospitals, health systems and other health care entities are functioning as anchor institutions, rooted in the communities they serve through invested capital, relationships with employees and community members, and other endeavors. Approximately 50 hospitals and health systems make up the Healthcare Anchor Network, a collaboration aimed at advancing an Anchor Mission within participating institutions, to ensure that health care anchor institutions

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

Health in All Policies and the National Prevention Strategy

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

Capturing Data on Patients Impacted by Social Determinants of Health

Stakeholders across the health care spectrum – including physicians, hospitals, health systems and health plans – have taken steps to capture individual patient data to show the impacts of social determinants of health on health status and outcomes. For example, within the ICD-10-CM code set, Z codes can be utilized to capture data pertaining to and quantify the number of patients impacted by social determinants of health. Z codes capture the "factors that influence health status and contact with health services,"[12] with codes Z55-65 specifically being used to identify individuals with potentially hazardous socioeconomic and psychosocial circumstances.[13] However, although such codes are available the Council notes that they are underutilized. For example, within the Medicare fee-for-service, Z codes were used for 467,136 beneficiaries in 2017, amounting to 1.4 percent of total beneficiaries. Among the beneficiaries with Z code claims in 2017, the top chronic conditions included hypertension, depression and hyperlipidemia, with many beneficiaries having more than one chronic condition.[14]

Incorporating Social Determinants of Health in USPSTF Recommendations

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

Neighborhood and Community Initiatives

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

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youth participating in the Healthy Harlem fitness and nutrition program. The same year, 1.2 million healthy, nutritious student meals were prepared by the program.[16]

Accountable Health Communities

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

Medicaid Accountable Care Organization Initiatives Addressing Social Determinants

As of January 2020, 12 states have adopted Medicaid Accountable Care Organizations (ACOs), nine of which have implemented initiatives addressing social determinants of health. Some of the drivers of Medicaid ACO incorporation of social determinants of health include the potential to contain costs, and the pursuit of health equity. Common strategies to address social determinants of health within Medicaid ACOs include requiring providers to screen for social needs; requiring or incentivizing providers to partner with social service organizations; and including requirements or incentives for quality metrics associated with social determinants of health. For example, in Oregon, coordinated care organizations are expected to focus their investments on services that address social determinants of health and health equity. From 2020 to 2022, housing services will be prioritized. Significantly, coordinated care organizations within Oregon are required to spend part of any end-of-year surplus on combatting health disparities. The Oregon Health Authority is planning to begin offering bonus payments to coordinated care organizations that meet performance measures on social determinants of health and health equity.[18]

SOCIAL DETERMINANTS OF HEALTH IN HEALTH INSURANCE BENEFIT DESIGN

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

Medicaid State Plan and Waiver Opportunities

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

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Significantly, North Carolina's Medicaid program has taken advantage of Section 1115 waiver authority to cover non-medical services in its Medicaid program. North Carolina's Section 1115 Medicaid demonstration waiver includes a Healthy Opportunities Pilot program that allows the state to use up to $650 million in Medicaid funds over a five-year period for enhanced case management and other services to address beneficiary needs in the arenas of housing, food, transportation, and interpersonal safety. Such pilot services would only be available to certain high-risk enrollees residing in select regions of the state (due to funding limitations) that meet physical or behavioral health and social risk factor criteria. Pilot services that may be covered include housing modifications (e.g., carpet replacement, air conditioner repair) to improve a child's asthma control and reduce emergency department visits and hospitalizations, travel vouchers to a community-based food pantry or a medically-targeted healthy food box for an adult with diabetes living in a rural food desert, or assistance in securing safe housing and establishing a new phone number for a pregnant woman experiencing interpersonal violence. At the time this report was written, due to the COVID-19 pandemic, North Carolina had suspended the evaluation of the Healthy Opportunities Lead Pilot Entity proposals, and a new award date had not yet been announced.[20,21]

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

Medicare Advantage

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

Tailoring Benefits for Dual Eligibles Targeting Social Determinants of Health

Health Alliance Plan (HAP), an operating unit of the Henry Ford Health System (HFHS), is a Michigan-based, nonprofit health plan providing health coverage to nearly 500,000 commercial and government program (Medicare, Medicaid, Medicare/Medicaid duals) members. Since 2015, HAP has participated in the Medicare/Medicaid Dual Eligible Demonstration Program, which fully integrates funding from federal Medicare and State of Michigan Medicaid to support the needs of nearly 5,000 vulnerable Medicare/Medicaid beneficiaries in southeast Michigan. Established by Congress in 1981, 1915(c) waivers permit states to seek waivers to provide Home and Community Based Services (HCBS) as Medicaid benefits. The State of Michigan specifically expanded its HCBS program for the Medicare/Medicaid Dual Demonstration in 2014 as part of the MI Health Link Program to facilitate services to keep vulnerable people safe at home. Since 2015, HAP's MI Health Link HCBS program has focused on identifying dual eligible plan members with significant social determinant risks that exacerbate their underlying clinical conditions and provide non-traditional social supports to reduce unnecessary/preventable emergency room visits, hospitalizations,

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readmissions, and nursing home stays, while giving them a higher quality of life in their own homes. Through the HCBS program, HAP has provided services in the home including personal emergency response systems to promote home safety, medical and non-medical transportation to facilitate clinical care as well as support social needs (shopping, religious services), home delivered meals to promote effective clinical condition aligned nutrition, personal care/chore services to support daily needs for disabled members, and direct environmental home modifications (chair lifts, wheelchair ramps, bathroom modifications) to keep members safe in the home and avoid injury. These services are provided at no additional cost to the member and are paid directly or through an intermediary by the health plan leveraging integrated Medicare/Medicaid premium dollars.[28]

RELEVANT AMA POLICY

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

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

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

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

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

DISCUSSION

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

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

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for health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training.

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

RECOMMENDATIONS

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

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

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

3. That our AMA encourage public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training.

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

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

6. That our AMA support research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs.

7. That our AMA encourage coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

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