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REPORT 2 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)  
Continuity of Care for Patients Discharged from Hospital Settings  
(Resolution 212-A-19, Second Resolve)  
(Reference Committee A)

EXECUTIVE SUMMARY

Medications are frequently prescribed or changed during hospital discharge, and although medication reconciliation is used by hospitals to boost adherence after discharge, barriers to filling or refilling hospital discharge medications remain. Some discharge prescriptions go unfilled due to mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record or other easily accessible tool. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to adverse tiering or prior authorization.

The Council researched numerous strategies employed by hospitals to ensure continuity of care after hospital discharge, as well as health information technology solutions such as real-time pharmacy benefit (RTPB) tools. The Council recognizes that, because inpatient and outpatient formularies differ, ensuring continuous coverage of medications and medical services is not always feasible, in part, because some hospital physicians lack access to patients' outpatient formulary information. Accordingly, the Council recommends that the American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. Additional report recommendations support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications and call for AMA advocacy with the Office of the National Coordinator for Health Information Technology and the Centers for Medicare & Medicaid Services on RTPB technology.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 2-JUN-21

Subject: Continuity of Care for Patients Discharged from Hospital Settings  
(Resolution 212-A-19, Second Resolve)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

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At the 2019 Annual Meeting, the House of Delegates (HOD) referred the second resolve clause of Resolution 212, which was introduced by the New York Delegation and directed our American Medical Association (AMA) to advocate to ensure that medications prescribed during hospitalization with ongoing indications for the outpatient and other non-hospital-based care settings continue to be covered by pharmacy benefit management (PBM) companies, health insurance companies, and other payers after hospital discharge. The referred second resolve clause was crafted by the reference committee and was assigned by the Board of Trustees to the Council on Medical Service for a report back.

This report discusses strategies to ensure continuity of care and safe transitions after hospital discharge; highlights real-time pharmacy benefit (RTPB) tools intended to generate cost and coverage data at the point of care; summarizes relevant AMA policy; and makes policy recommendations.

### BACKGROUND

The intent of the reference committee's second resolve clause of Resolution 212-A-19 is to ensure continuity of care for patients transitioning from a hospital to an outpatient setting by ensuring coverage of hospital prescribed medications that are to be continued after discharge. Adherence to medications has long been recognized to be a key component of effective medical treatment and is associated with decreases in morbidity, mortality, and hospitalizations. As discussed in [Council on Medical Service Report 7-I-16, Hospital Discharge Communications](#), patients often experience medication-related problems during the period following hospital discharge, and more than a third of post-discharge follow-up testing is never completed.

Medications are frequently prescribed or changed during care transitions, including hospital admissions and discharges, which can be confusing for patients and put them at risk of nonadherence. Medication reconciliation—the process of reviewing and resolving discrepancies between medications a patient is using and new medications that have been ordered for the patient—is employed by hospitals during the discharge process to boost adherence to prescribed regimens and prevent adverse health outcomes. Medication reconciliation is built into the National Patient Safety Goals developed by The Joint Commission,<sup>1</sup> which recognizes that organizations face challenges with medication reconciliation and that its effectiveness will increase as more advanced health information technology (IT) systems are adopted.<sup>2</sup>

Importantly, barriers to filling or refilling hospital discharge medications remain even when medications have been effectively reconciled. Some discharge prescriptions go unfilled due to

mobility or transportation issues, or because of the high cost of certain medications. Outpatient formulary restrictions and adverse formulary tiering may similarly thwart medication adherence, a problem that is amplified when hospital-based prescribers do not have access to a patient's outpatient formulary information through the inpatient electronic health record (EHR) or other easily accessible tool. Accordingly, access to outpatient drug formularies is vital to medication management and continuity of care during patient hospitalizations and the period after discharge.

Formulary systems can be complicated and confusing for both patients and physicians. First, hospital inpatient formulary systems have traditionally been distinct from health plan outpatient formularies, which differ among themselves and are frequently adjusted (even during the benefit year). Hospitals that have merged with or grown into larger health systems, including those that have integrated with payers, may have multiple formularies in place, each of which is continuously evaluated against lists of available medications and prescribing guidelines.<sup>3</sup> Hospital formulary systems are managed by a pharmacy and therapeutics committee (P&T committee), which oversees medication management and use at the hospital. A P&T committee usually reports to the medical staff, which should have final approval over the hospital's medication-use policy.<sup>4</sup> Because hospitals/health systems are unable to procure, stock and administer all available medications, most hospital formularies make one or two medications available for each therapeutic class. A hospital formulary may also restrict the prescribing of some medications to certain specialties, although medications not available on the formulary can generally be requested.<sup>5</sup>

Upon admission to a hospital, hospitals may substitute a patient's home (outpatient) medication through approved therapeutic interchange if that medication is not part of the hospital's formulary. Ideally, at the time of discharge, patients should be reconciled back to their home medications to ensure continued adherence. Hospital physicians may also prescribe new medications intended for use after discharge, and those prescriptions may be based on the hospital formulary. Without access to outpatient formulary information, hospital physicians may unwittingly prescribe discharge medications that are subject to restrictions such as adverse tiering or prior authorization (PA). Accordingly, patients may be discharged with prescriptions that will not be adequately covered or paid for by their pharmacy benefits plan.

### *Strategies to ensure continuity of care after hospital discharge*

Strategies to ensure continuity of care after hospital discharge are numerous and varied and include pharmacist interventions to address medication and/or insurance issues, as well as discharge checklists that require confirmation of coverage of prescribed discharge medications. Examples of care transition interventions centered on discharge include the SafeMed care transitions model and Project BOOST (Better Outcomes for Older Adults through Safe Transitions). SafeMed uses intensive medication reconciliation and home visits to manage high-risk/high needs patients as they transition from the hospital to outpatient setting. As part of its Steps Forward™ initiative, the AMA developed a [module](#) for implementing the SafeMed model within primary care practices. Project BOOST is the Society of Hospital Medicine's signature mentoring program for improving the care of patients as they transition home from the hospital or to other care facilities. Among other interventions, Project BOOST identifies patients at high risk of hospital readmission and follows up with them to monitor adherence after discharge.

Some hospitals have established bedside medication delivery services to help mitigate the number of hospital prescriptions that go unfilled after discharge. Also known as "meds-to-beds" or "meds-in-hand" interventions, these services are provided by hospitals in partnership with their outpatient pharmacies, which are able to access outpatient formulary information<sup>6</sup> and coordinate PA requirements. A study of one hospital's "meds-in-hand" process highlighted use of the hospital

1 outpatient pharmacy to reliably verify insurance coverage of prescribed outpatient medications, and  
2 further posited that patients may incur lower costs from receiving medications from the outpatient  
3 pharmacy rather than the inpatient pharmacy.<sup>7</sup> Another study found that a pediatric “meds-in-hand”  
4 project increased the proportion of patients discharged in possession of their medications and may  
5 have decreased unplanned visits to the emergency department in the 30 days after discharge.<sup>8</sup> In  
6 addition to bedside medication delivery services, some hospitals provide a transitional supply of  
7 medications to high-risk uninsured patients at the time of discharge and also help patients obtain  
8 medications through patient assistance programs.<sup>9</sup> Many hospitals routinely follow up with patients  
9 after discharge to check on medication access and adherence.

#### 10 11 *Real-time pharmacy benefit (RTPB) tools*

12  
13 Transparency of drug coverage and formulary information in EHRs could prove useful in  
14 preventing medication nonadherence and treatment abandonment during the post-discharge period.  
15 To ensure such transparency, accurate, real-time information needs to be available at the point of  
16 prescribing. Although the AMA has been advocating that insurers, PBMs, and EHR vendors move  
17 quickly to develop point-of-care software that provides patient coverage and cost-sharing  
18 information, problems remain. Specifically, there are concerns with the accuracy of Formulary and  
19 Benefit (F&B) files based on how often payers update their formularies and provide the F&B  
20 update files to intermediaries and EHR vendors. Notably, F&B files are static and may not  
21 represent the most current formulary data. Moreover, these files do not provide drug coverage  
22 information at a granular, patient-specific level of detail.

23  
24 In contrast, real-time pharmacy benefit (RTPB) technology holds promise for improving continuity  
25 of care for patients discharged from the hospital setting. Although RTPB tools are relatively new  
26 and have not yet been widely implemented, adoption continues to improve, and prescribers should  
27 have greater access to real-time benefit and coverage restriction information at the point of care  
28 through RTPB tools in the near future. To accelerate the use of electronic RTPB tools in the  
29 Medicare Part D program, the Centers for Medicare & Medicaid Services (CMS) requires every  
30 Part D plan to support one or more real-time benefit tools capable of integrating with at least one  
31 e-prescribing system or EHR, effective January 1, 2021. While this requirement falls short of  
32 ensuring that all prescribers have access to RTPB information for every patient they encounter, it is  
33 a positive step for increasing RTPB tool adoption and improving access to benefit information. In  
34 addition, CMS will require Part D plans to offer a consumer-facing RTPB tool starting  
35 January 1, 2023, which will allow patients to obtain information about medication costs and  
36 possible lower-cost alternatives under their prescription drug benefit plan.<sup>10</sup>

37  
38 Over the past few years, the National Council for Prescription Drug Programs (NCPDP) has been  
39 developing an electronic standard for the communication of real-time prescription drug coverage  
40 and pricing information, including therapeutic alternatives, between payers and prescribers. The  
41 AMA actively participates in the NCPDP effort to ensure that the standard will provide the  
42 prescription drug information that physicians need at the point of prescribing. Based on progress of  
43 the NCPDP work, it is expected that an RTPB standard will be recommended to CMS for an  
44 eventual federal mandate under the Part D program in late 2021. Because there are several  
45 proprietary RTPB systems on the market, the AMA supports a standardized RTPB process that  
46 allows providers to access information for all of their patients, regardless of what payer the patient  
47 is covered under or what EHR/e-prescribing system is used by the provider. The AMA also  
48 strongly advocates for alignment between the prescription drug data offered in physician-facing  
49 and consumer-facing RTPB tools, as any discrepancies in the pricing or coverage information  
50 presented to these different audiences will result in increased administrative burdens for physicians,  
51 patient dissatisfaction, and mutual confusion.

## AMA ACTIVITY

The AMA engages in robust federal and state advocacy on a range of policy issues relevant to improving continuity of care and preventing treatment delays after hospital discharge. The Council has previously discussed concerns related to transparency in drug formularies, which make it exceedingly difficult for physicians to determine which treatments are preferred by a particular health plan at the point-of-care (see [Council on Medical Service Report 5-A-19, The Impact of Pharmacy Benefit Managers on Patients and Physicians](#)). For patients, lack of transparency in drug coverage information may lead to treatment delays as well as being unaware of their cost-sharing responsibilities which can affect medication adherence. To expose the opaque process that pharmaceutical companies, PBMs, and health insurers engage in when pricing prescription drugs and to rally grassroots support to call on lawmakers to demand transparency, the AMA launched a grassroots campaign and website, [TruthInRx.org](#), in 2016. At the time this report was written, nearly 350,000 individuals had signed a petition to members of Congress in support of greater drug pricing transparency, with the campaign also generating more than one million messages sent to Congress demanding drug price transparency. The AMA has also developed model state legislation which addresses issues related to stabilized formularies and cost transparency.

To educate the public about problems associated with PA and to gather stories from physicians and patients about how they have been affected by it, the AMA launched a second grassroots website, [FixPriorAuth.org](#), in 2018. This site showcases an array of stories about PA requirements delaying care, including [one video](#) about a patient who had undergone heart stenting but was unable to fill a discharge prescription for a blood thinner because of a PA hurdle. The physician was unaware that the insurer would not approve the prescription, and the patient ended up back in the hospital after suffering another heart attack.

More broadly, the AMA is very active in advocating for a reduction in both the number of physicians subjected to PA and the overall volume of PA (see Council on Medical Service Report 4-JUN-21, Accountability in Prior Authorization). In January 2017, the AMA and a coalition of state and specialty medical societies, national provider organizations and patient organizations developed and released a set of 21 [Prior Authorization and Utilization Management Principles](#) intended to ensure that patients receive timely and medically necessary care and medications and reduce administrative burdens. Four of these principles speak directly to continuity of care, and Principle #8 addresses formulary data transparency in EHRs. In January 2018, the AMA joined the American Hospital Association, America's Health Insurance Plans, American Pharmacists Association, Blue Cross Blue Shield Association and the Medical Group Management Association in a [Consensus Statement](#) outlining a shared commitment to industry-wide improvements to PA processes and patient-centered care. The Consensus Statement underscores that continuity of care is vitally important for patients undergoing an active course of treatment when there is a formulary or treatment coverage change and/or a change of health plan, and also addresses making PA requirements and other formulary information electronically accessible in EHRs. Additionally, the AMA has model legislation addressing PA and works closely with many state medical associations to enact legislation.

The AMA continues to advocate with the Office of the National Coordinator for Health Information Technology (ONC) and CMS around opportunities to improve health IT and EHRs, including standards, certification and vendor requirements that will help improve interoperability, EHR performance and data usability. As stated previously, the AMA participates in the NCPDP effort to advocate for physicians' interests and supports a standardized RTPB process that ensures alignment between physician-facing and patient-facing RTPB tools.

## 1 RELEVANT AMA POLICY

2  
3 The AMA has extensive policy on hospital discharge and medication reconciliation. Policy  
4 D-160.945 advocates for timely and consistent communication between physicians in inpatient and  
5 outpatient settings to decrease gaps in care coordination and improve quality and patient safety.  
6 Evidence-based principles of discharge and discharge criteria are outlined in Policy H-160.942.  
7 Policy H-160.902, established with [Council Report 7-I-16](#), encourages the development of  
8 discharge summaries that are presented to physicians in a meaningful format that prominently  
9 highlight salient patient information, such as the discharging physician's narrative and  
10 recommendations for ongoing care. This policy also encourages hospital engagement of patients  
11 and families in the discharge process, supports implementation of medication reconciliation as part  
12 of the discharge process, and encourages patient follow-up in the early time period after discharge.  
13 Policy D-120.965 also supports medication reconciliation to improve patient safety.

14  
15 The AMA also has substantial policy on drug plans and formularies. Policy D-330.910 states that  
16 the AMA will explore problems with prescription drug plans, including issues related to continuity  
17 of care, PA, and formularies, and work with CMS and other organizations to resolve them. AMA  
18 policy objectives addressing managed care cost containment involving prescription drugs are  
19 outlined in Policy H-285.965, which speaks to mechanisms to appeal formulary exclusions and  
20 urges pharmacists to contact prescribing physicians if prescriptions violate the managed care  
21 formulary so that physicians can prescribe an alternative drug that may be on the formulary. Under  
22 Policy H-285.952, the AMA will continue providing assistance to state medical associations in  
23 support of state legislative and regulatory efforts to ensure continuity of care protections for  
24 patients in an active course of treatment.

25  
26 Policy H-125.979 directs the AMA to: work with PBMs, health insurers and pharmacists to enable  
27 physicians to receive accurate, real-time formulary data at the point of prescribing; promote that, in  
28 the event that a drug is no longer on the formulary when a prescription is presented, notice of  
29 covered formulary alternatives shall be provided to the prescriber so that appropriate medication  
30 can be provided; and promote the value of online access to up-to-date and accurate prescription  
31 drug formulary plans from all insurance providers. [Council on Medical Service Report 5-A-19](#)  
32 established Policy D-110.987, which supports regulation of PBMs and improved transparency of  
33 PBM operations, including disclosing formulary information such as whether certain drugs are  
34 preferred over others and patient cost-sharing responsibilities, which should be made available to  
35 patients and to prescribers at the point-of-care in EHRs. Policies D-125.997 and H-185.942 support  
36 protecting patient-physician relationships from interference by PBMs and payers. Policy  
37 H-125.979 aims to prohibit drugs from being removed from the formulary or moved to a higher  
38 cost tier during the duration of a patient's plan year.

39  
40 Drug formularies, P&T committees, and therapeutic interchange are addressed in Policy  
41 H-125.991, which outlines standards that must be satisfied in order for drug formulary systems to  
42 be acceptable. This policy also insists that health plans have well-defined processes for physicians  
43 to prescribe non-formulary drugs when medically indicated and discourages the switching to  
44 therapeutic alternates in chronic disease patients who are stabilized on drug therapy. Finally, the  
45 AMA has numerous policies on usability and interoperability of EHRs, including Policy D-478.995  
46 on health IT which, among other directives, supports AMA advocacy for standardization of key  
47 elements of the EHR.

1 DISCUSSION  
2

3 Although the referred second resolve clause of amended Resolution 212-A-19 focuses on  
4 continued coverage of prescribed discharge medications, the Council believes that continuity of  
5 care for medical services is also vital to improving the health outcomes of patients transitioning out  
6 of hospitals. The Council recognizes that, because inpatient and outpatient formularies differ,  
7 ensuring continuous coverage of medications and medical services is not always feasible, in part  
8 because some hospital physicians lack access to patients' outpatient formulary information.  
9 Accordingly, the Council recommends that our AMA advocate for protections of continuity of care  
10 for medical services and medications that are prescribed during patient hospitalizations, including  
11 when there are formulary or treatment coverage changes that have the potential to disrupt therapy  
12 following discharge.

13  
14 The Council recognizes that there are multiple ways for hospitals to carry out medication  
15 reconciliation and does not wish to prescribe how this process should be accomplished. Some  
16 hospitals assign staff (usually pharmacy staff) to work through coverage issues and facilitate  
17 patient access to discharge medications. Others utilize hospital outpatient pharmacies to review  
18 coverage and PA requirements during the reconciliation process. The Council recommends  
19 supporting—but not requiring—medication reconciliation that includes confirmation that  
20 prescribed discharge medications will be covered by a patient's health plan and completion of PA  
21 requirements.

22  
23 Aside from medication reconciliation, the Council identified other innovative strategies employed  
24 by hospitals to improve medication adherence after hospital discharge. "Meds-to-beds"/"meds-in-  
25 hand" services take a variety of forms and can be administered hospital-wide or for specific patient  
26 populations. However, these programs may not be achievable at all facilities, particularly those  
27 without an outpatient pharmacy on site. Safety-net hospitals are more likely to provide an initial  
28 30-day supply of medications to uninsured patients, and the Council supports these efforts—and  
29 broadening them—while acknowledging the cost implications for hospitals. Accordingly, the  
30 Council recommends a more general policy statement supportive of strategies to address coverage  
31 barriers and facilitate patient access to prescribed discharge medications, such as bedside  
32 medication delivery services and the provision of transitional supplies of discharge medications.

33  
34 The Council believes that RTPB systems hold promise for improving continuity of care during the  
35 discharge period and looks forward to the release of an RTPB standard, widespread implantation of  
36 this technology in physicians' and hospitals' EHR systems, and ongoing evaluations of and  
37 improvements to these tools to ensure that RTPB technology meets the needs of prescribers. At this  
38 time, the Council believes it is premature to require EHR vendors to incorporate RTPB for  
39 certification. Instead, the Council recommends that our AMA advocate that ONC and CMS work  
40 with physician and hospital organizations, and health IT developers, to identify RTPB  
41 implementations and published standards that provide real-time or near-time formulary information  
42 across all prescription drug plans, patient portals and other viewing applications, and EHR vendors.  
43 The Council further recommends that any policies requiring health IT developers to integrate  
44 RTPB systems within their products do so with minimal disruption to EHR usability and cost to  
45 physicians and hospitals. Finally, the Council believes that it is critically important for the data  
46 offered on emerging consumer-facing RTPB tools to match the drug pricing and coverage  
47 information displayed in physicians' and hospitals' EHRs, as discrepancies will lead to confusion  
48 and dissuade both physicians and patients from using these technologies. Accordingly, the Council  
49 recommends that our AMA support alignment and real-time accuracy between the prescription  
50 drug data offered in physician-facing and consumer-facing RTPB tools.



The Council acknowledges the strength of AMA policy on problems with prescription drug plans and formulary transparency and recommends reaffirmation of Policies H-125.979 and D-330.910. Previous Council reports on [hospital discharge communications](#) and [physician communication and care coordination during patient hospitalizations](#) underscored that consistent physician-to-physician communication across care settings is integral to achieving a safe and efficient discharge process. The Council recommends reaffirmation of Policy D-160.945, which supports timely and consistent communication between physicians in inpatient and outpatient care settings.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of amended Resolution 212-A-19, and the remainder of the report be filed.

1. That our American Medical Association (AMA) advocate for protections of continuity of care for medical services and medications that are prescribed during patient hospitalizations, including when there are formulary or treatment coverage changes that have the potential to disrupt therapy following discharge. (New HOD Policy)
2. That our AMA support medication reconciliation processes that include confirmation that prescribed discharge medications will be covered by a patient's health plan and resolution of potential coverage and/or prior authorization (PA) issues prior to hospital discharge. (New HOD Policy)
3. That our AMA support strategies that address coverage barriers and facilitate patient access to prescribed discharge medications, such as hospital bedside medication delivery services and the provision of transitional supplies of discharge medications to patients. (New HOD Policy)
4. That our AMA advocate to the Office of the National Coordinator for Health Information Technology (ONC) and the Centers for Medicare & Medicaid Services (CMS) to work with physician and hospital organizations, and health information technology developers, in identifying real-time pharmacy benefit implementations and published standards that provide real-time or near-time formulary information across all prescription drug plans, patient portals and other viewing applications, and electronic health record (EHR) vendors. (New HOD Policy)
5. That our AMA advocate to the ONC and the CMS that any policies requiring health information technology developers to integrate real-time pharmacy benefit systems (RTBP) within their products do so with minimal disruption to EHR usability and cost to physicians and hospitals. (New HOD Policy)
6. That our AMA support alignment and real-time accuracy between the prescription drug data offered in physician-facing and consumer-facing RTBP tools. (New HOD Policy)
7. That our AMA reaffirm Policy H-125.979, which directs the AMA to work with pharmacy benefit managers, health insurers, and pharmacists to enable physicians to receive accurate, real-time formulary data at the point of prescribing, and promotes the value of online access to up-to-date and accurate prescription drug formulary plans from all insurance providers. (Reaffirm HOD Policy)

- 1 8. That our AMA reaffirm Policy D-330.910, which directs the AMA to explore problems with  
2 prescription drug plans, including issues related to continuity of care, prior authorization, and  
3 formularies, and work to resolve them. (Reaffirm HOD Policy)  
4
- 5 9. That our AMA reaffirm Policy D-160.945, which directs the AMA to advocate for timely and  
6 consistent communication between physicians in inpatient and outpatient settings to decrease  
7 gaps in care coordination and improve quality and patient safety, and to explore new  
8 mechanisms to facilitate and incentivize this communication. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

## REFERENCES

<sup>1</sup> The Joint Commission. National Patient Safety Goals Effective January 2020. Home Care Accreditation Program. Available online at: [https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/npsg\\_chapter\\_ome\\_jan2020.pdf](https://www.jointcommission.org/-/media/tjc/documents/standards/national-patient-safety-goals/npsg_chapter_ome_jan2020.pdf).

<sup>2</sup> Ibid.

<sup>3</sup> Stefanacci, RG. Dealing with new formulary types: Health system outpatient formularies. *Journal of Clinical Pathways*. April 2018.

<sup>4</sup> American Society of Health-System Pharmacists. ASHP Guidelines on the Pharmacy and Therapeutics Committee and the Formulary System. 2008. Available online at: <https://www.ashp.org/-/media/assets/policy-guidelines/docs/guidelines/gdl-pharmacy-therapeutics-committee-formulary-system.ashx?la=en&hash=9EC241A67B0A5A6412E18B9D05876B2470B67DA7>.

<sup>5</sup> Barbee J, Lauderdale K, and Smith A. Hospital Formulary Management. *Pharmacy Times*. September 28, 2017. Available online at: <https://www.pharmacytimes.com/publications/health-system-edition/2017/september2017/hospital-formulary-management>.

<sup>6</sup> Hatoun JH, Bair-Merritt M, Cabral H and Moses J. Increasing Medication Possession at Discharge for Patients with Asthma: The Meds-in-Hand Project. *Pediatrics*. 2016;137(3):e20150461. Available online at: <https://pediatrics.aappublications.org/content/137/3/e20150461>.

<sup>7</sup> Hoefgen ER, Jones Y et al. Leveraging the outpatient pharmacy to reduce medication waste in pediatric asthma hospitalizations. *Journal of Hospital Medicine* Vol 14, No 1. January 2020. Available online at: <https://www.journalofhospitalmedicine.com/jhospmed/article/206278/hospital-medicine/leveraging-outpatient-pharmacy-reduce-medication-waste>.

<sup>8</sup> Hatoun J, Bair-Merritt M et al. Increasing medication possession at discharge for patients with asthma: The meds-in-hand project. *Pediatrics*. Vol. 137(3)Le20150461. 2016. Available online at: <https://pediatrics.aappublications.org/content/137/3/e20150461>.

<sup>9</sup> American Society of Health-System Pharmacists and American Pharmacists Association. Best practices from the ASHP-APhA medication management in care transitions initiative. February 2013. Available online at: <https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/quality-improvement/learn-about-quality-improvement-medication-management-care-transitions.ashx>.

<sup>10</sup> Centers for Medicare & Medicaid Services. Final Rule. Medicare and Medicaid Programs; Contract Year 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly. Available online at <https://www.federalregister.gov/documents/2021/01/19/2021-00538/medicare-and-medicare-programs-contract-year-2022-policy-and-technical-changes-to-the-medicare>.

REPORT 07 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)  
Addressing Equity in Telehealth  
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)  
(Reference Committee A)

## EXECUTIVE SUMMARY

In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council decided to initiate a report addressing equity in telehealth, believing that additional AMA policy is needed to advocate for solutions and infrastructure that facilitate equitable telehealth access. In addition, this report specifically responds to Items (a) and (c) of the second resolve of Alternate Resolution 203 that were referred and referred for decision, respectively, at the November 2020 Special Meeting of the House of Delegates.

Existing AMA policy addressing equity in telehealth recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

The Council welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the novel coronavirus pandemic. To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 7-JUN-21

Subject: Addressing Equity in Telehealth  
(Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

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In reviewing American Medical Association (AMA) policy as well as telehealth initiatives on the local, state and federal levels, the Council believes that additional AMA policy is needed that advocates for solutions and infrastructure that facilitate equitable telehealth access. Policy D-480.963, newly adopted at the November 2020 Special Meeting of the House of Delegates, states that our AMA will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and supports the use of telehealth to reduce health disparities and promote access to health care. This new policy provides an essential foundation upon which additional policy addressing equity in telehealth can be developed and is consistent with the AMA's recent adoption of a new, eighth enterprise value embracing equity, which states: "We center the voices of the most marginalized in shaping policies and practices toward improving the health of the nation." Furthermore, AMA's vision statement for health equity states: "The AMA's vision for health equity is a nation where all people live in thriving communities where resources work well, systems are equitable and create no harm, everyone has the power to achieve optimal health, and all physicians are equipped with the consciousness, tools, and resources to confront inequities as well as embed and advance equity within and across all aspects of the health care system."

In addition, at the November 2020 Special Meeting of the House of Delegates, four potential additions to the second resolve of Alternate Resolution 203 were referred or referred for decision. The second resolve of Alternate Resolution 203-Nov-20, which is now Policy D-480.963[2] asked:

That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that:

1. provide equitable coverage that allows patients to access telehealth services wherever they are located; and
2. provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second resolve. Items (a) and (b) were referred. Items (c) and (d) were referred for decision.

- a) promote continuity of care by preventing payers from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
- b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c) provide equitable payment for telehealth services that are comparable to in-person services.
- d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Items (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report specifically responds to Items (a) and (c); Council on Medical Service Report 8, also being considered at this meeting, addresses Items (b) and (d).

This report provides background on barriers to and inequities in accessing telehealth; highlights programs and pathways to augment the ability of physicians to provide telehealth to historically marginalized and minoritized communities; summarizes relevant AMA policy; and presents policy recommendations.

## BACKGROUND

The expansion of telehealth services as a result of the novel coronavirus (COVID-19) pandemic has positively impacted patients who now have the ability to utilize telecommunication technology to access their physicians without having to navigate public transportation in densely populated urban communities, take time off from work to commute to and from the appointment, or drive lengthy distances in rural areas to attend an outpatient office visit with a specialist. In addition, telehealth provides a mechanism to overcome other barriers affecting patients' ability to access in-person services, including functional impairments that make it difficult to get to a physician's office or require a family member, friend, or caregiver to accompany the patient, and the need to find care for children or grandchildren. Importantly, the increased use of telehealth provides another pathway for physicians to learn more about the social determinants of health that may influence a patient's health and access to health care, including one's living environment, economic stability and food security.

Overall, according to a recent survey, during the first six months of the COVID-19 pandemic, one-third of adults ages 18 to 64 reported having had a telehealth visit--defined in the survey as either audio-only or two-way audio-video. Adults with multiple chronic conditions as well as those in poorer health were much more likely to report using telehealth to access care than their counterparts. Black and Hispanic adults were more likely to use telehealth than White adults, and adults living in metropolitan areas were more likely to have used telehealth than adults living outside metropolitan areas. At the same time, patients reported going without a telehealth visit despite wanting one; adults in fair or poor health, those with chronic conditions, and Hispanic adults were more likely to report going without wanted telehealth care.<sup>1</sup> Of the Medicare fee-for-service population, more than 9 million beneficiaries received a telehealth service during the period ranging from mid-March through mid-June of 2020. More than 20 percent of Medicare beneficiaries residing in rural areas used telehealth services during that time, with 30 percent of beneficiaries in urban areas accessing telehealth services.<sup>2</sup>

Examining outpatient visits and telehealth use in a database of 16.7 million commercially insured and Medicare Advantage enrollees, a study showed that 30.1 percent of all visits from

March 18, 2020, to June 16, 2020, were provided via telehealth. During this period, the weekly number of telehealth visits among the population studied increased to 397,977 visits per week, up from 16,540 visits per week during the period from January 1, 2020, to March 17, 2020. However, not all of these services were distributed evenly across different population groups. Notably, the percentage of total visits provided via telehealth was smallest among those ages 65 and older. In addition, health plan enrollees residing in counties with the lowest percentages of residents with incomes below the federal poverty level, and percentages of White residents had a greater proportion of total visits delivered via telehealth from March to June 2020 when compared with counties with higher percentages of these residents. In addition, a lower percentage of care was provided by telehealth in rural counties than in urban counties.<sup>3</sup>

Other studies also have reported inequitable access to telehealth services during the COVID-19 pandemic, as well as potential reliance on or preference for audio-only visits over two-way audio-video visits. For example, a cohort study of patients with appointments for primary care and specialty ambulatory telehealth visits during March through May of 2020 at a large academic health system showed that older adults, patients with limited English proficiency, Medicaid beneficiaries, and Asian patients had lower rates of telemedicine utilization. The study also found that Black, Hispanic, lower-income, female and older patients had lower rates of two-way audio-video utilization.<sup>4</sup> In addition, a claims-based analysis of approximately 7 million commercially insured patients found that, in the early stages of the pandemic in March and April of 2020, zip codes with 80 percent or more residents of historically minoritized racial/ethnic communities had smaller reductions in the use of in-person office visits, and smaller increases in the use of telehealth, than zip codes with 80 percent or more White residents.<sup>5</sup> CMS has estimated that of the Medicare fee-for-service beneficiaries who accessed a telehealth service in the early months of the pandemic, 30 percent used audio-only telephone technology,<sup>6</sup> with other studies showing higher rates of utilization of audio-only visits among low-income patients.<sup>7</sup>

## BARRIERS TO TELEHEALTH ACCESS FOR PATIENTS

Telehealth has the potential to be an important tool for addressing long-standing health inequities among historically marginalized and minoritized communities that have been impacted disproportionately by the COVID-19 pandemic. However, far more emphasis needs to be placed on ensuring that telehealth solution functionality, content, user interface, and service access are designed in an equity-centric participatory fashion with and for historically minoritized and marginalized communities, including addressing culture, language, digital literacy ability, and broadband access. In addition to assessing how solutions are designed, it is also critical that an upstream lens is used to understand the root causes of barriers to optimal use of telehealth services within historically marginalized communities, namely systemic racism and inequitable resource allocation impacting infrastructure development and access to economic and education opportunities.

In 2019, 25 million individuals in the US did not have internet access at home, and 14 million did not have equipment capable of playing video--essential for two-way audio-video telehealth--such as a smartphone, tablet, computer or other connected device.<sup>8</sup> Not all home internet services are equal; speed and bandwidth issues may continue to serve as obstacles to accessing telehealth services even for patients who have internet access at home. In addition, patients who only have a smartphone and solely rely on their phone's data plan and capacity for internet access may confront data and bandwidth challenges in accessing two-way audio-video telehealth visits.

There are, notably, racial and ethnic inequities in access to the internet, with a larger percentage of Black and Hispanic individuals not having internet access at home. Individuals residing in rural

1 areas are less likely to have access to the internet at home than those in urban areas. Age-related  
 2 disparities also exist, with older individuals being less likely to have internet access at home.  
 3 Significantly, Medicare and Medicaid beneficiaries make up two-thirds of those who lack internet  
 4 access at home, and the uninsured make up 15 percent.<sup>9</sup>

5  
 6 In addition, the continued use and expansion of telehealth rely on equitable design to meet the need  
 7 for varying levels of patient digital literacy, and how the availability of telehealth services is  
 8 communicated to patients. Individuals without access to a computer or smartphone may be left out  
 9 of telehealth service offerings. Even among patients with equitable access to devices and to the  
 10 internet, there remain exclusionary and suboptimal design issues requiring patients to navigate  
 11 email, fill out a form online or find a website--significant barriers to participating in a two-way  
 12 audio-video telehealth visit. Requiring the use of a patient portal for accessing telehealth services  
 13 can serve as another barrier for patients. Furthermore, the lack of transparency and equity in the  
 14 design of privacy and security policies and practices in many telehealth solutions cause hesitancy  
 15 among some patients as to the safety and security of telehealth visits with their physicians.

## 16 17 AUGMENTING THE ABILITY OF PHYSICIANS TO PROVIDE TELEHEALTH TO 18 HISTORICALLY MARGINALIZED AND MINORITIZED POPULATIONS

19  
 20 To help close the digital divide in access to telehealth services, initiatives at the state and federal  
 21 levels can serve as examples of, and first steps towards, what needs to be done to address some of  
 22 the upstream barriers to equity in telehealth--including ensuring affordable access to needed  
 23 technology to engage in two-way audio-video telehealth and investing in broadband capacity in  
 24 underserved communities. Patient access to telehealth is inextricably linked to whether and how  
 25 such services are covered by their health plans, including whether they can use telehealth to access  
 26 care from their regular physician. Barriers to patients accessing telehealth can be overcome by  
 27 fairly and equitably financing services in formats most accessible to and appropriate for patients,  
 28 including two-way audio-video and audio-only.

### 29 30 *Federal and State Initiatives Addressing Equity in Telehealth Service Delivery and Access*

31  
 32 Increased investments in telehealth service delivery and access are essential to ensure patients can  
 33 maintain needed access to health care regardless of where they are and augment the ability of  
 34 physicians to provide telehealth to populations who cannot currently access telehealth services.  
 35 Federal initiatives have recently been launched to assist health care providers in purchasing  
 36 necessary services and equipment to provide telehealth services to underserved populations and in  
 37 areas that have been disproportionately impacted by the COVID-19 pandemic. In addition, many  
 38 states have leveraged available Medicaid authorities to provide technology and care coordination  
 39 support to augment the ability of Medicaid beneficiaries to access telehealth services during the  
 40 COVID-19 pandemic.

### 41 42 Connected Care Pilot

43  
 44 Under the auspices of the Federal Communications Commission (FCC), the Connected Care Pilot  
 45 Program is a temporary program that will provide up to \$100 million over a three-year period to  
 46 defray the costs faced by selected health care providers in providing connected care services,  
 47 prioritizing providing these services to low-income or veteran patients. The Connected Care Pilot  
 48 will cover 85 percent of the eligible costs incurred by selected pilot programs of patient broadband  
 49 internet access services, health care provider broadband data connections, other connected care  
 50 information services, and certain network equipment. Provider eligibility for the Connected Care  
 51 Pilot Program is limited to public and nonprofit providers, including community health and mental

health centers; local health departments; rural health clinics; skilled nursing facilities; not-for-profit hospitals; and other entities.<sup>10</sup>

#### COVID-19 Telehealth Program

The COVID-19 Telehealth Program was established by the FCC in response to the COVID-19 public health emergency to assist health care providers in providing connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic. The FCC adopted the Program in a report and order released in April 2020. Through this program, the FCC will distribute the \$200 million appropriated by Congress as part of the Coronavirus Aid, Relief, and Economic Security (CARES) Act, providing immediate support to eligible health care providers--limited to public and nonprofit providers like the Connected Care Pilot--responding to the COVID-19 pandemic. The FCC has outlined the following examples under the auspices of the three main categories of eligible services related to the delivery of connected care that could be funded under the Program:

- Telecommunications Services and Broadband Connectivity Services: Voice services for health care providers or their patients.
- Information Services: Internet connectivity services for health care providers or their patients; remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation.
- Connected Devices/Equipment: Tablets, smart phones, or connected devices to receive connected care services at home (e.g., broadband-enabled blood pressure monitors; pulse oximetry monitors) for patient or health care provider use; or telemedicine kiosks/carts for health care provider sites.<sup>11</sup>

#### Emergency Broadband Benefit Program

In February 2021, the FCC formally adopted a report and order to establish the Emergency Broadband Benefit Program, a program with \$3.2 billion in federal funding aimed at providing financial assistance to qualifying households to help cover the costs of broadband and device ownership. Broadband access and device ownership are critical building blocks to enable more equitable patient access to telehealth. Under the program, eligible households can receive discounts of up to \$50 per month for broadband service, up to \$75 if the household is on Tribal lands. Eligible households will also be eligible for a one-time discount of up to \$100 for the purchase of a computer or tablet. Households eligible for assistance under the Emergency Broadband Benefit Program include those that participate in an existing low-income or pandemic relief program offered by a broadband provider; Lifeline subscribers, including those who are Medicaid beneficiaries or receive Supplemental Nutrition Assistance Program (SNAP) benefits; households with children receiving free or reduced-price school meals; Pell grant recipients; and those who have lost jobs and experienced reductions in their income in the past year.<sup>12</sup>

#### Medicaid Appendix K Waivers

Medicaid Appendix K is a stand-alone appendix that states can use during emergencies, such as the COVID-19 pandemic, to request amendment to approved 1915(c) home and community-based waivers. During the COVID-19 pandemic, states have used Medicaid Appendix K authority to provide needed technology and care coordination support to targeted beneficiaries. For example, New Mexico was approved to provide up to \$500 to select Medicaid beneficiaries who do not



1 currently have access to a computer, tablet or other device to purchase such a device to support  
2 their access to telehealth, including two-way audio-video as well as needed training.<sup>13</sup> Kansas was  
3 approved under Medicaid Appendix K authority to provide remote monitoring technology and  
4 requisite training to beneficiaries with chronic diseases.<sup>14</sup>

5  
6 *Covering Telehealth Services by Patients' Physicians*

7  
8 Referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020  
9 Special Meeting was to "promote continuity of care by preventing payors from using cost-sharing  
10 or other policies to prevent or disincentivize patients from receiving care via telehealth from the  
11 physician of the patient's choice." Patient access to telehealth is inextricably linked to whether  
12 telehealth services provided by their physicians--the physicians with whom they have a  
13 relationship--are covered by their health plan. The AMA has been highly active on the state and  
14 federal levels to ensure that health plans allow all contracted physicians to provide care via  
15 telehealth, and that cost-sharing is not used to incent care from other providers. Prior to the  
16 COVID-19 pandemic, many health plans established a separate network for telehealth or select  
17 telehealth providers, which did not always include contracted physicians who provide in-person  
18 services. As a result of the pandemic, adoption of telehealth has increased dramatically and is more  
19 likely to be available from an individual's physician. AMA advocacy on the state and federal levels  
20 has underscored that the pre-pandemic separation of telehealth and in-person visits can no longer  
21 be justified based on low levels of adoption that no longer exist. In addition, the AMA has stressed  
22 that the perpetuation of separate networks is confusing for patients and threatens continuity of care  
23 and the patient-physician relationship.

24  
25 For example, AMA model state legislation addressing this issue, the Telemedicine Reimbursement  
26 Act, states that "each carrier offering a health plan in this state shall provide coverage for the cost  
27 of health care services provided through telemedicine on the same basis and to the same extent that  
28 the carrier is responsible for coverage for the provision of the same service through in-person  
29 treatment or consultation. Coverage must not be limited only to services provided by select  
30 corporate telemedicine providers." In addition, in an April 2020 comment letter in response to a  
31 proposed rule on the Medicare Advantage program, the AMA stated that "the rapid deployment of  
32 telehealth services by physicians in response to the COVID-19 pandemic is significantly changing  
33 the practice of medicine in ways that are likely to last long after the pandemic. Many patients are  
34 now having office visits with their regular physicians via telehealth. The AMA strongly encourages  
35 MA plans to cover telehealth visits and other services, at a minimum for those on the Medicare  
36 telehealth list, with their physicians. The AMA is aware that some plans contract with telehealth  
37 providers and encourage their enrollees to use these other services instead of covering telehealth  
38 services provided by the patients' regular physicians. Patient advocates have made it very clear that  
39 what is most important to patients is for all members of the patient's health care team to be  
40 involved in, and adhere to, the patient's treatment plan. This continuity of care will not be possible  
41 if patients are directed to separately contracted telehealth providers even when the patients' regular  
42 physicians are able to provide the services via telehealth themselves."<sup>15</sup>

43  
44 In addition, AMA advocacy has underscored that the cost-sharing for services provided via  
45 telehealth should not vary based on the telehealth provider. Reducing cost sharing for select  
46 telehealth providers who do not also provide in-person care inappropriately steers patients away  
47 from their current physicians, fragmenting the health care system and threatening patients'  
48 continuity of care. Importantly, the AMA has stressed that health insurers should ensure  
49 transparency in coverage and patient cost-sharing of services provided via telehealth, and health  
50 care professionals should effectively communicate information about the scope of telehealth visits  
51 to patients.

# *Ensuring Fair and Equitable Payment for Two-Way Audio-Video and Audio-Only Visits*

Relevant to Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, several states enacted Executive Orders early in 2020 requiring payers to provide equivalent payment for two-way audio-video visits, and sometimes audio-only visits, as compared to in-person visits. Through the end of the COVID-19 public health emergency, CMS will continue to pay for telehealth visits equivalent to in-person office visits. In the Final Rule for the 2021 Medicare Physician Payment Schedule, CMS stated that audio-only visits, described by CPT codes 99441-99443, will not be payable after the conclusion of the COVID-19 public health emergency. CMS will allow payment, however, for brief communication technology-based services (e.g., virtual check-in), described by codes G2251 and G2252, at 2021 payment rates of \$15 and \$27 respectively.

During the COVID-19 public health emergency, two-way audio-video visits are reported with existing Current Procedural Terminology (CPT) codes for office visits. Prior to the COVID-19 public health emergency, payment for two-way audio-video telehealth visits was typically equivalent to an office visit provided in a facility setting (e.g., outpatient hospital clinic), where the physician is presumed to incur no direct costs (clinical staff, medical supplies and equipment). During the COVID-19 public health emergency, payment for two-way audio-video visits was paid equivalent to an office visit provided in a non-facility setting (e.g., physician's office). It is likely that the CPT Editorial Panel will receive an application to modernize the CPT codes describing audio-only services to address the CMS concerns and to align with the temporary G codes. After such an action, the AMA/Specialty Society RVS Update Committee would review the resources typically required to perform these services.

## RELEVANT AMA POLICY

Newly adopted at the November 2020 Special Meeting of the House of Delegates, Policy D-480.963 states that our AMA: (1) will continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post SARS-CoV-2; (2) will advocate that the federal government, including CMS and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that: (a) provide equitable coverage that allows patients to access telehealth services wherever they are located, and (b) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients; (3) will advocate for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients; and (4) supports the use of telehealth to reduce health disparities and promote access to health care. Policy H-478.980 advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Policy H-478.996 states that it is the policy of the AMA to support efforts to address the economic, literacy, and cultural barriers to patients utilizing information technology.

Relevant to referred-for-decision Item (c) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy D-480.965 states our AMA will work with third-party payers, CMS, Congress and interested state medical associations to provide coverage and reimbursement for telehealth to ensure increased access and use of these services by patients and physicians. Established by Council Report 7-A-14, Policy H-480.946 outlines principles to guide

the coverage and payment of telemedicine services. Regarding payment for audio-only visits, Policy H-390.889 states that our AMA supports and advocates with all payers the right of physicians to obtain payment for telephone calls not covered by payments for other services; and continues to work with CMS and the appropriate medical specialty societies to assure that the relative value units assigned to certain services adequately reflect the actual telephone work now performed incident to those services.

Relevant to referred Item (a) proposed to be added to Alternate Resolution 203 from the November 2020 Special Meeting, Policy H-480.946 states that patients seeking care delivered via telemedicine must have a choice of provider; and that telemedicine services must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities. Policy D-480.969 advocates for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers. Policy H-450.941 strongly opposes the use of tiered and narrow physician networks that deny patient access to, or attempt to steer patients towards, certain physicians primarily based on cost of care factors. Policy D-155.987 advocates that health plans provide plan enrollees or their designees with complete information regarding plan benefits and real time cost-sharing information or other plan designs that may affect patient out-of-pocket costs.

## DISCUSSION

While the AMA has foundational policy pertaining to the coverage and payment for telehealth, Policy D-490.963, adopted at the November 2020 Special Meeting, serves as an essential step forward in developing policy specific to addressing equity in telehealth. The new policy, as well as Policy H-478.980, recognizes that historically marginalized and minoritized populations cannot optimally access telehealth services without the basics: a connected device that has video capabilities, and access to the internet. The Council notes that ownership of devices and access to the internet are beneficial for telehealth only if patients know how to use the devices and if those solutions are designed for patients with varying digital literacy levels to participate in two-way audio-video telehealth. In addition, telehealth technologies need to be designed upfront to meet the needs of older adults, individuals with vision impairment, and individuals with disabilities. Furthermore, telehealth solutions must be designed with and for patients with limited English proficiency, ensuring all cultures and languages represented in a patient population are centered in the creation of communications promoting telehealth services and supporting engagement in a telehealth visit. As such, the Council recommends reaffirmation of Policy D-385.957, which advocates for legislative and/or regulatory changes to require that payers including Medicaid programs and Medicaid managed care plans cover interpreter services and directly pay interpreters for such services.

Ultimately, for patients to access and engage in telehealth, they must be aware of the telehealth services available to them and be comfortable with accessing care via telehealth. Hospitals, health systems and health plans need to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and provider diversity, offering training and technology support for equity-centered participatory design, and launching new and innovative outreach campaigns to inform and educate communities about telehealth.

In addition, it is essential for physicians to serve as leading partners in efforts to improve the access of historically marginalized and minoritized communities to telehealth services. The Council

welcomes initiatives to assist health care providers in purchasing necessary services and equipment to provide telehealth services to underserved populations and in areas that have been disproportionately impacted by the COVID-19 pandemic. However, eligibility of physician practices for these programs remains quite limited, and the Council sees tremendous potential in expanding eligibility for these programs so that physicians are able to help their patients engage with and access telehealth services.

To ensure that physicians are able to provide care to their patients via telehealth, health plans need to allow all contracted physicians to provide care via telehealth. Policy D-480.969 provided a policy foundation in this regard, advocating for telemedicine parity laws that do not limit coverage only to services provided by select corporate telemedicine providers, relevant to the emergence of companies including Amazon expanding in the telehealth space. The Council is concerned that physicians are being prevented from, or facing barriers to, providing covered services via telehealth to their patients. In addition, cost-sharing should not be used to require or incentivize the use of telehealth or in-person care, or to incentivize care from a separate or preferred telehealth network. Such incentives could also include creating separate cost-sharing requirements or structures for in-person care and care provided via telehealth.

The Council believes that barriers to patients accessing telehealth can be overcome by fairly and equitably financing services in formats most accessible to and appropriate for patients, including two-way audio-video and audio-only. The expanded use of audio-video telehealth services during the COVID-19 pandemic has made it clear that requiring the use of video limits the number of patients who can benefit from telecommunications-supported services, particularly lower-income patients and those in rural and other areas with limited internet access. In addition, some patients, even those who own the technology needed for two-way real-time audio-video communication, do not know how to employ it or for other reasons are not comfortable communicating with their physician in this manner. Ultimately, physician payments should consider the resource costs required to provide all physician visits and should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. Fair and equitable payments will help ensure that patients are able to receive the right care, via the most appropriate and accessible modality, at the right time.

## RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2, Items (a) and (c) of Alternate Resolution 203-Nov-2020, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-480.963, which advocates for equitable access to telehealth services, especially for at-risk and under-resourced patient populations and communities, including but not limited to supporting increased funding and planning for telehealth infrastructure such as broadband and internet-connected devices for both physician practices and patients. (Reaffirm HOD Policy)
2. That our AMA reaffirm Policy H-478.980, which advocates for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States. (Reaffirm HOD Policy)
3. That our AMA encourage initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically marginalized and minoritized populations. (New HOD Policy)

- 1 4. That our AMA encourage telehealth solution and service providers to implement design  
2 functionality, content, user interface, and service access best practices with and for historically  
3 minoritized and marginalized communities, including addressing culture, language, technology  
4 accessibility, and digital literacy within these populations. (New HOD Policy)  
5
- 6 5. That our AMA support efforts to design telehealth technology, including voice-activated  
7 technology, with and for those with difficulty accessing technology, such as older adults,  
8 individuals with vision impairment and individuals with disabilities. (New HOD Policy)  
9
- 10 6. That our AMA reaffirm Policy D-385.957, which advocates for legislative and/or regulatory  
11 changes to require that payers including Medicaid programs and Medicaid managed care plans  
12 cover interpreter services and directly pay interpreters for such services. (Reaffirm HOD  
13 Policy)  
14
- 15 7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives  
16 aimed at designing access to care via telehealth with and for historically marginalized and  
17 minoritized communities, including improving physician and provider diversity, offering  
18 training and technology support for equity-centered participatory design, and launching new  
19 and innovative outreach campaigns to inform and educate communities about telehealth. (New  
20 HOD Policy)  
21
- 22 8. That our AMA support expanding physician practice eligibility for programs that assist  
23 providers in purchasing necessary services and equipment in order to provide telehealth  
24 services to augment the broadband infrastructure for, and increase connected device use among  
25 historically marginalized, minoritized and underserved populations. (New HOD Policy)  
26
- 27 9. That our AMA reaffirm Policy D-480.969, which advocates for telemedicine parity laws that  
28 require private insurers to cover telemedicine-provided services comparable to that of in-person  
29 services, and not limit coverage only to services provided by select corporate telemedicine  
30 providers. (Reaffirm HOD Policy)  
31
- 32 10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care  
33 via telehealth. (New HOD Policy)  
34
- 35 11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or  
36 require the use of telehealth or in-person care or incentivize care from a separate or preferred  
37 telehealth network over the patient's current physicians. (New HOD Policy)  
38
- 39 12. That our AMA advocate that payments should consider the resource costs required to provide  
40 all physician visits and payments should be fair and equitable, regardless of whether the service  
41 is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

Fiscal Note: Less than \$500.

## REFERENCES

- <sup>1</sup> Smith L and Blavin F. One in Three Adults Used Telehealth during the First Six Months of the Pandemic, but Unmet Needs for Care Persisted. Robert Wood Johnson Foundation/Urban Institute. January 2021. Available at: [https://www.urban.org/sites/default/files/publication/103457/one-in-three-adults-used-telehealth-during-the-first-six-months-of-the-pandemic-but-unmet-needs-for-care-persisted\\_1.pdf](https://www.urban.org/sites/default/files/publication/103457/one-in-three-adults-used-telehealth-during-the-first-six-months-of-the-pandemic-but-unmet-needs-for-care-persisted_1.pdf).
- <sup>2</sup> Verma, S. Early Impact Of CMS Expansion Of Medicare Telehealth During COVID-19. Health Affairs Blog. July 15 2020. Available at: <https://www.healthaffairs.org/doi/10.1377/hblog20200715.454789/full/>.
- <sup>3</sup> Patel S, Mehrotra A, Huskamp H, Uscher-Pines L, Ganguli G, and Barnett M. Variation In Telemedicine Use And Outpatient Care During The COVID-19 Pandemic In The United States. Health Affairs. 40(2): 349-358. February 2021. Available at: <https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2020.01786>.
- <sup>4</sup> Eberly LA et al. Patient Characteristics Associated With Telemedicine Access for Primary and Specialty Ambulatory Care During the COVID-19 Pandemic. JAMA Network Open. 2020; 3(12). December 29, 2020. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2774488?resultClick=3>.
- <sup>5</sup> Whaley C, Pera M, Cantor J, et al. Changes in Health Services Use Among Commercially Insured US Populations During the COVID-19 Pandemic. JAMA Netw Open. 2020;3(11):e2024984. Available at: <https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2772537>.
- <sup>6</sup> Verma, *supra* note 2.
- <sup>7</sup> Uscher-Pines L, Sousa J, Jones M, et al. Telehealth Use Among Safety-Net Organizations in California During the COVID-19 Pandemic. JAMA. Published online February 02, 2021. Available at: <https://jamanetwork.com/journals/jama/fullarticle/2776166>.
- <sup>8</sup> Amin K, Rae M, Ramirez G, and Cox C. How Might Internet Connectivity Affect Health Care Access? Peterson-KFF Health System Tracker. December 14, 2020. Available at: <https://www.healthsystemtracker.org/chart-collection/how-might-internet-connectivity-affect-health-care-access/>.
- <sup>9</sup> *Ibid*.
- <sup>10</sup> Federal Communications Commission. Connected Care Pilot Program Frequently Asked Questions (FAQs). Available at: <https://www.fcc.gov/connected-care-pilot-program-frequently-asked-questions-faqs>.
- <sup>11</sup> Federal Communications Commission. COVID-19 Telehealth Program - Frequently Asked Questions (FAQs). Available at: <https://www.fcc.gov/covid-19-telehealth-program-frequently-asked-questions-faqs>.
- <sup>12</sup> Federal Communications Commission. FCC Adopts Report and Order to Implement Emergency Broadband Benefit Program. February 25, 2021. Available at: <https://www.fcc.gov/document/fcc-adopts-report-and-order-emergency-broadband-benefit-program>.
- <sup>13</sup> New Mexico Appendix: Emergency Preparedness and Response and COVID-19 Addendum. Developmental Disabilities Waiver, Mi Via ICF/IDD Waiver, Medically Fragile Waiver. January 27, 2020. Available at: <https://www.medicaid.gov/state-resource-center/downloads/nm-combined-appendix-k-appvl.pdf>.
- <sup>14</sup> Kansas Appendix: Emergency Preparedness and Response and COVID-19 Addendum. Autism; Brain Injury, Frail Elderly, Intellectual & Developmental Disability; Physical Disability; Serious Emotional Disturbance; Technology Assisted. January 27, 2020. Available at: <https://www.medicaid.gov/state-resource-center/downloads/ks-combined-appendix-k-appvl.pdf>.
- <sup>15</sup> Comment Letter to CMS Administrator Seema Verma in response to the Medicare and Medicaid Programs; Contract Year 2021 and 2022 Policy and Technical Changes to the Medicare Advantage Program, Medicare Prescription Drug Benefit Program, Medicaid Program, Medicare Cost Plan Program, and Programs of All-Inclusive Care for the Elderly Proposed Rule (Proposed Rule). April 6, 2020. Available at: <https://search.hf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-4-6-Letter-to-Verma-re-MA-and-Part-D-NPRM.pdf>.

REPORT 8 OF THE COUNCIL ON MEDICAL SERVICE (June 2021)  
Licensure and Telehealth  
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)  
Reference Committee A

EXECUTIVE SUMMARY

This report is the Council's second on licensure and telehealth in as many years and responds to elements (b) and (d) of the second Resolve of Alternate Resolution 203 that the House of Delegates referred during its November 2020 Special Meeting. Since the Council's previous report (Council Report 1-I-19, Established Patient Relationships and Telemedicine) was presented, the coverage and payment landscape for telehealth has changed considerably in response to the novel coronavirus (COVID-19) pandemic, enabling physicians to provide uninterrupted care to patients while adhering to social distancing. The surge in virtual visits across most practices and settings has been so significant that more than three-quarters of physicians reported using telehealth in 2020, up from one quarter in 2018. The Council anticipates that most physicians who increased their use of telehealth during the public health emergency will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care.

The Council acknowledges the breadth of existing American Medical Association (AMA) licensure and telehealth policy and the organization's long history of supporting solutions that make it easier for physicians to obtain licenses to practice medicine across state lines while protecting patients and preserving state oversight of the practice of medicine. The Council continues to support the Interstate Medical Licensure Compact as an important licensure solution and recommends reaffirmation of AMA policy supportive of the Compact and reduced application and licensure fees.

This report addresses a common frustration among physicians—that, outside of the temporary licensure flexibilities put in place during the public health emergency, they are prohibited by most states from using telehealth to provide longitudinal care to existing patients who may live across a state border, attend college in another state, or travel for work or seasonally. The Council believes that multiple pathways are available to states to facilitate interstate telehealth for continuity of care purposes, including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not yet proffered. Accordingly, the Council recommends that the AMA work with the Federation of State Medical Boards and other stakeholders to encourage states to allow an out-of-state physician to use telehealth to provide continuity of care to an existing patient if certain conditions are met.

The Council believes the recommendations in this report will increase physician and patient satisfaction with health care, reduce physician administrative burdens, help sustain physician practices as they continue to recover from the economic impacts of COVID-19, and address the needs of individuals with complex health conditions who lack access to specialty care locally and would benefit from virtual visits with out-of-state specialist physicians.

## REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 8-JUN-21

Subject: Licensure and Telehealth  
(Resolve 2, Items (b) and (d) of Alternate Resolution 203-Nov-2020)

Presented by: Lynda M. Young, MD, Chair

Referred to: Reference Committee A

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At the November 2020 Special Meeting of the House of Delegates, four potential additions to the second Resolve of Alternate Resolution 203 were referred or referred for decision. The second Resolve of Alternate Resolution 203-I-20, which is now Policy D-480.963[2] asked:

That our American Medical Association (AMA) advocate that the federal government, including the Centers for Medicare & Medicaid Services (CMS) and other agencies, state governments and state agencies, and the health insurance industry, adopt clear and uniform laws, rules, regulations, and policies relating to telehealth services that (1) provide equitable coverage that allows patients to access telehealth services wherever they are located; and (2) provide for the use of accessible devices and technologies, with appropriate privacy and security protections, for connecting physicians and patients.

The following additional elements were proposed for the second Resolve. Paragraphs a and b were referred. Paragraphs c and d were referred for decision.

- a) promote continuity of care by preventing payors from using cost-sharing or other policies to prevent or disincentivize patients from receiving care via telehealth from the physician of the patient's choice.
- b) ensure qualifications of physicians duly licensed in the state where the patient is located to provide such services in a secure environment.
- c) provide equitable payment for telehealth services that are comparable to in-person services.
- d) promote continuity of care by allowing physicians to provide telehealth services, regardless of current location, to established patients with whom the physician has had previous face-to-face professional contact.

The Board of Trustees asked the Council on Medical Service to address Paragraphs (a)-(d) in reports back to the House of Delegates at the 2021 June Special Meeting. This report is specifically responding to Paragraphs (b) and (d); Council on Medical Service Report 7, also being considered at this meeting, is addressing Paragraphs (a) and (c).

This report provides an overview of physician licensure and telehealth, describes exceptions to licensing laws authorized by states before and during the novel coronavirus (COVID-19) pandemic, summarizes relevant AMA policy, and makes policy recommendations. For the purposes of this report, the term "telehealth" refers to digital health solutions that connect patients and clinicians through real-time audio and video technology.



## BACKGROUND

In response to the spread of COVID-19, widespread stay-at-home orders, and federal and state policy changes instituted last spring, the use of telehealth by physicians and other health professionals expanded exponentially. Swift adoption of telehealth across most practices and settings enabled physicians to provide uninterrupted continuity of care while adhering to social distancing that protected patients and health professionals from exposure to the virus. The surge in telehealth is reflected in data from recent biennial AMA Physician Practice Benchmark Surveys, which are nationally representative samples of non-federal physicians who provide care to patients at least 20 hours per week. Benchmark Survey data show a substantial increase in the use of telehealth between 2018 and 2020, with 79 percent of physicians reporting use of telehealth in their practice in 2020, up from 25 percent in 2018.<sup>1</sup> Additionally, last summer more than 75 percent of respondents to the Telehealth Impact Physician Survey said that telehealth enabled them to provide quality care for COVID-19-related care, acute care, chronic disease management, hospital or emergency department follow-up, care coordination, preventive care, and mental or behavioral health.<sup>2</sup> Sixty percent of physicians reported that telehealth has improved the health of their patients, while 55 percent indicated that telehealth has improved their work satisfaction.<sup>3</sup> Payment (73 percent) and technology challenges for patients (64 percent) were cited by a majority of physicians as barriers to maintaining telehealth after the pandemic, while 18 percent of physicians cited licensure as a barrier.<sup>4</sup>

The Council anticipates that many physicians who increased their use of telehealth during the pandemic will want to continue the practice after COVID-19 is under control, not as a replacement for in-person care but as part of a hybrid model in which physicians utilize both in-person and telehealth visits to support optimal care. The AMA continues to study telehealth use to better understand the needs of patients and physicians as well as the overall impact of telehealth on care quality and patient outcomes. At the same time, the AMA engages in robust federal and state advocacy on telehealth, weighing in on a range of policy proposals including the temporary flexibilities put in place during the public health emergency as well as proposals that will shape the practice of telehealth post-pandemic.

Interstate licensure and telehealth were addressed in [Council Report 1-I-19, Established Patient Relationships and Telemedicine](#), which highlighted concerns raised by physicians that the nation's state-based licensure system has impeded growth in telehealth use by medical homes and other physician practices, including those wishing to provide telehealth services to their regular patients when those patients travel to another state. In adopting the Council's 2019 report, the House of Delegates reaffirmed long-standing AMA policy maintaining that physicians delivering telemedicine services must be licensed in the state where the patient receives services (Policies H-480.946 and H-480.969). Additionally, by adopting the recommendations in the report, the House established Policy D-480.964, which directs the AMA to work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact (IMLC) to consider joining; advocate for reduced application and state licensure(s) fees processed through the IMLC; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services.

Council Report 1-I-19 highlighted the rationale behind state oversight of the practice of medicine and the licensure of physicians to practice within a state's borders. State authority to protect the health, safety and general welfare of its citizens was granted in 1791 under the 10th Amendment of the US Constitution, with formal licensing of physicians through state medical boards dating back to the 1800s.<sup>5</sup> The primary goals of state medical boards are to protect patients, ensure quality health care, and foster the professional practice of medicine. In addition to issuing licenses, state

1 medical boards are authorized to investigate complaints and take disciplinary action against the  
 2 licenses of those who violate state law. States also license a range of other health professionals,  
 3 including physician assistants and nurses, and establish scope of practice parameters within the  
 4 state to safeguard the practice of medicine.

5  
 6 The prevailing standard for medical licensure found in the medical practice acts of each state  
 7 affirms that the practice of medicine is determined to occur where the patient is located. This  
 8 standard enables states to ensure that health professionals adhere to that state's laws and  
 9 regulations (e.g., licensing requirements and scope of practice parameters) and to protect the public  
 10 from the unprofessional and improper practice of medicine. Because the standards and scope of  
 11 telehealth services should be consistent with related in-person services (consistent with Policy  
 12 H-480.946), most states similarly require physicians utilizing telehealth to be licensed in all  
 13 jurisdictions where patients receive care. Licensure requirements established by state medical  
 14 boards may vary but, according to the Federation of State Medical Boards (FSMB), 49 state  
 15 boards—as well as the medical boards of the District of Columbia, Puerto Rico, and the Virgin  
 16 Islands—require physicians practicing telehealth to be licensed in the state in which the patient is  
 17 located.<sup>6</sup>

## 18 19 INTERSTATE LICENSURE

20  
 21 Recognizing the costs and burdens associated with obtaining physician licenses to practice  
 22 medicine in multiple states, the AMA has long supported making it easier to obtain licenses to  
 23 practice across state lines, and addressing the cost, time and administrative burdens while  
 24 preserving the ability of states to oversee the care provided to patients within their borders.  
 25 Advances in telehealth, and the potential to increase access to virtual care among people in rural  
 26 and underserved communities, increasingly motivated stakeholders to seek solutions that would  
 27 streamline licensure processes across state lines. Ultimately, these efforts culminated in the  
 28 development of the IMLC.

### 29 30 *Interstate Medical Licensure Compact*

31  
 32 In 2017, the IMLC became operational establishing a new expedited pathway to licensure for  
 33 qualifying physicians seeking to practice in multiple states. From the beginning, the AMA strongly  
 34 supported the IMLC as a means of facilitating expedited licensure while ensuring that states retain  
 35 the authority to regulate the practice of medicine and protect patient welfare. The IMLC adopts the  
 36 prevailing standard that the practice of medicine occurs where the patient is located at the time of  
 37 the physician-patient encounter. A physician practicing under a license facilitated by the IMLC is  
 38 thus bound to comply with the statutes, rules, and regulations of each state wherein he/she chooses  
 39 to practice medicine.

40  
 41 At the time this report was written, the IMLC was an agreement among the following 30 states, the  
 42 District of Columbia and the Territory of Guam: Alabama, Arizona, Colorado, Georgia, Idaho,  
 43 Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Mississippi,  
 44 Montana, Nebraska, Nevada, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South  
 45 Dakota, Tennessee, Utah, Vermont, Washington, West Virginia, Wisconsin, and Wyoming.<sup>7</sup>  
 46 Compact authorizing legislation has been introduced in Missouri, New Jersey, New York, North  
 47 Carolina, Ohio, Oregon, Rhode Island and Texas, with other states expected to introduce legislation  
 48 during 2021 legislative sessions.<sup>8</sup>

49  
 50 Over 17,000 licenses have been issued by IMLC,<sup>9</sup> and the IMLC Commission estimates that 80  
 51 percent of physicians in Compact states meet the criteria for licensure.<sup>10</sup> However, physicians

practicing in several heavily populated states—e.g., California, Florida, Massachusetts, New York and Texas—are unable to apply for expedited licenses through the IMLC since those states have not passed authorizing legislation to join the Compact. Physicians practicing in Compact states are similarly unable to use the IMLC to obtain expedite licenses in these non-Compact states.

Costs associated with Compact licenses/renewals remain an additional barrier to increased licensing via the IMLC, since physicians who want to apply must pay an initial \$700 fee plus cover the costs and renewal fees of the license(s) in Compact state(s) where the physician wants to practice.<sup>11</sup> Licensing fees in Compact states range from \$75 in Alabama and Wisconsin to \$790 in Maryland, with most states charging several hundred dollars. These costs may be beyond the budgets of many physician practices—particularly small practices—that continue to face COVID-19-related financial pressures. A nationwide physician survey conducted by the AMA in July-August 2020 found that practice revenue had dropped by a third, on average, and spending on personal protective equipment (PPE) had increased 57 percent.<sup>12</sup> Despite an increase in telehealth use, almost 70 percent of physicians were still providing fewer total visits (in-person plus telehealth) at the time of the survey than before the pandemic.<sup>13</sup>

#### *Exceptions to State Licensing Laws Pre-COVID-19*

Prior to the pandemic, physicians licensed by states that had not joined the IMLC or who wanted to practice in a non-Compact state were generally required to go through that state’s traditional, often lengthy, licensure application process. Allowances for circumstances under which out-of-state physicians may practice in a state without being licensed vary by state and were predominantly limited pre-pandemic to physicians consulting with in-state physicians and physicians practicing in emergencies or responding to natural disasters. Although licensing requirements across states share many commonalities, each state has its own rules and exceptions to those rules. Colorado’s Medical Practice Act [§ 12-240-107(3)(b)], for example, uniquely permits physicians licensed and lawfully practicing medicine in another state to provide “occasional services” in Colorado, provided they do not have a regular practice in Colorado and maintain malpractice insurance.<sup>14</sup>

Some states had licensure policies specific to interstate telehealth in place before the pandemic. According to FSMB, 12 state medical boards issue a special purpose license, telemedicine license or certificate, or license to practice medicine across state lines, while six state boards require physicians to register if they wish to practice across states.<sup>15</sup> Florida is an example of the latter. Despite opposition from the Florida Medical Association and other health providers, Florida enacted a law in 2019 allowing out-of-state health professionals to provide telehealth services in the state without a Florida license if they register with the state medical board.

The Uniform Emergency Volunteer Health Practitioners Act (UEVHP) allows properly registered out-of-state volunteer health professionals providing disaster relief in a state to provide services without having to seek a license in the state that has declared an emergency; however, participation is limited to the 18 states plus the District of Columbia that have enacted the Act.<sup>16</sup> Some states have enacted universal licensure recognition laws to allow people holding certain out-of-state occupational licenses to practice in that state, although these laws have generally been limited to emergencies and accommodations for military spouses.<sup>17</sup>

Physicians and other health professionals employed by the US Veterans Administration, the Indian Health Service and the US Department of Defense are generally permitted by these health systems to practice—including via telehealth—outside of the state where they are licensed. States also recognize the licenses of National Disaster Medical System physician team members. The Sports Medicine Licensure Clarity Act, passed by Congress in 2018, enabled sports medicine

professionals to provide medical care to athletes and team members while traveling with an athletic team in a state in which they are not licensed. Under this law, services provided by a sports medicine professional are deemed to have occurred in the professional's primary state of licensure. The law further extends medical professional liability insurance to cover the professional with respect to medical care provided while out of state with the team.<sup>18</sup>

Liability concerns are integral to licensure discussions because liability insurance policies vary in terms of coverage for care across state lines. Most insurers provide coverage for actions undertaken in any state, although the intent is to ensure coverage for one-off situations where a physician provides a limited amount of care outside the jurisdiction where they are licensed. Accordingly, it is important for physicians to speak to their insurers if they intend to treat patients in other states on a regular basis so the insurer can verify whether their coverage extends to those states.

#### *Licensing Waivers in Response to COVID-19*

COVID-19 led to a slew of federal and state temporary waivers of telehealth coverage and payment regulations intended to expand the scale and reach of telehealth, thereby meeting the increased demand for virtual medical care. Federal and state licensure requirements were also waived, enabling health care professionals to work across state lines and provide care in areas hardest hit by the pandemic without having to seek licenses in those states. After the President and US Department of Health and Human Services Secretary declared a public health emergency in March 2020, CMS used its 1135 waiver authority to temporarily waive requirements that out-of-state physicians and other health professionals be licensed in the state where they are providing services when they are licensed in another state. Licensing requirements were waived for physicians and other health professionals participating in the Medicare, Medicaid and Children's Health Insurance Program programs and meeting the following four conditions: 1) must be enrolled as such in the Medicare program; 2) must possess a valid license to practice in the state; 3) is furnishing services—whether in person or via telehealth—in a state in which the emergency is occurring in order to contribute to relief efforts in his or her professional capacity; and 4) is not affirmatively excluded from practice in the state or any other state that is part of the emergency area.<sup>19</sup>

CMS' actions did not waive state or local licensure requirements, which remain in effect unless also waived. Accordingly, for a physician or other health professional to avail him- or herself of the CMS waiver under the conditions described above, the state would also have to have modified its licensure requirements. Many states did so by implementing temporary changes that to varying degrees permit physicians licensed in other states to provide medical services during the public health emergency. Some states issued broad reciprocity waivers permitting physicians and other health professionals possessing an active license in good standing in another state to provide care without obtaining a license, temporary or otherwise, in that state. Other states required registration with or approval by the state medical board. Some waivers were more targeted, presumably based on a state's needs, and several states established emergency temporary licensure or certification processes that out-of-state providers must go through to seek permission to practice. A few states specified that telehealth could be used by out-of-state physicians to provide continuity of care to patients in that state, or by physicians in contiguous states that have existing patient relationships with state residents. At the time this report was written, a few states had already rescinded their temporary licensure waivers while Idaho's Governor, via executive order, had declared that all the state's waivers, including the change allowing out-of-state physicians to provide telehealth services to Idaho residents, be made permanent. [States modifying licensure requirements for physicians in response to COVID-19](#), and [states waiving telehealth licensure requirements](#), are tracked by FSMB.

The AMA has supported the need for flexibilities to effectively respond to COVID-19 but does not currently support extending the CMS licensure waiver beyond the end of the public health emergency. To protect patients, the AMA has long advocated that physicians and other health professionals providing care via telehealth must be licensed or otherwise authorized to practice in the state where the patient is receiving care to ensure that state medical practice acts, informed consent, and scope of practice laws apply, and that the state has oversight of medical practice.

#### *Providing telehealth services in a “secure environment”*

Aside from licensure, the referred item (b) also specifies that telehealth services should be provided in a secure environment, which may be relevant to temporary changes to Health Insurance Portability and Accountability Act (HIPAA) privacy and security rules. To help physicians and other health professionals quickly adopt telehealth, the Office for Civil Rights (OCR) announced early in the pandemic that it would exercise discretion in enforcing violations of HIPAA privacy and security rules for physicians and hospitals who, in good faith, utilized telemedicine platforms and applications to connect with their patients. This policy allows health professionals and patients to use technologies that may not meet all HIPAA requirements, such as Skype, FaceTime and Google Hangouts, to provide care. The AMA supported this policy because it helped physicians quickly adopt telehealth without needing to first implement contracts and security reviews that are often complex and time-consuming. However, while HIPAA compliance may seem onerous and burdensome, it is a necessary ingredient to the successful use of telehealth over the long term.

HIPAA’s requirements are intended to ensure that both health professionals and their business associates are accountable for the privacy and security of patient information, thereby fortifying the trust that is central to the patient-physician relationship. Accordingly, when the public health emergency ends, the AMA has urged OCR to not continue its enforcement discretion policy, but rather to establish a glide path to compliance with HIPAA obligations. This would mean that, if the emergency ends on September 30, rather than requiring physicians to be fully in compliance on October 1, OCR should instead allow providers to begin taking steps toward compliance (e.g., engage their vendors in discussions about business associate agreements and initiate or implement their security risk analysis of a new telehealth platform). Additionally, the AMA has advocated that OCR should ensure that physicians and other health professionals are held harmless for actions taken in good faith during the public health emergency.

#### RELEVANT AMA POLICY

A key safeguard included in Policy H-480.946, which was established through [Council Report 7-A-14, Coverage and Payment for Telemedicine](#), stipulates that physicians and other health practitioners must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by the state’s medical board. In addition, this policy requires physicians to abide by state licensure laws, state medical practice acts and other requirements in the state where the patient receives services and maintains that the delivery of telemedicine must be consistent with scope of practice laws. The full text of Policy H-480.946 and other relevant policies is appended.

Long-standing AMA policy maintains that state and territorial medical boards should require a full and unrestricted license in the state for the practice of telemedicine unless there are other appropriate state-based licensing methods (Policy H-480.969). This policy also delineates exemptions from such licensure requirements for “curbside consultations” that are provided without expectation of compensation, and in the event of emergent or urgent circumstances.

Policy D-480.999 opposes a single national federalized system of medical licensure. Policy H-480.974 states that our AMA will work with FSMB and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries. Policy D-480.969 states that our AMA will work with the FSMB to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board. Policy D-275.994 supports the IMLC.

#### Policies

H-275.978 and H-275.955 urge licensing jurisdictions to adopt laws and regulations facilitating the movement of licensed physicians between states. Policy D-480.963 directs the AMA to continue to advocate for the widespread adoption of telehealth services in the practice of medicine for physicians and physician-led teams post-pandemic.

Policy H-130.941 encourages physicians who are interested in volunteering during a disaster to register with their state's Emergency System for Advance Registration of Volunteer Health Professionals program, local Medical Reserve Corps unit, or similar registration systems capable of verifying that practitioners are licensed and in good standing at the time of deployment; and supports the Uniform Emergency Volunteer Health Practitioners Act. Policy H-275.922 encourages FSMB to develop model policy for state licensure boards to streamline and standardize the process by which a physician who holds an unrestricted license in one state may participate in physician volunteerism in another state.

The AMA has substantial scope of practice policy, including Policies D-160.995, H-270.958, and H-160.949. Principles for the supervision of nonphysician providers when telemedicine is used are outlined in Policy H-160.937. Code of Medical Ethics Opinion 1.2.12 states that physicians who provide clinical services through telemedicine must uphold the standards of professionalism expected in in-person interactions, follow appropriate ethical guidelines of relevant specialty societies and adhere to applicable law governing the practice of telemedicine. HIPAA is addressed by Policies H-478.997, D-190.983, and H-315.964.

#### AMA RESOURCES AND ADVOCACY

Consistent with AMA policy, AMA model state legislation provides a framework for a modern state medical practice act that facilitates physician adoption of telemedicine. The Telemedicine Act clarifies licensure requirements for physicians treating patients via telemedicine, ensuring that, with certain exceptions (e.g., curbside consultations, volunteer emergency medical care), physicians and other health professionals practicing telemedicine are licensed in the state where the patient receives services or are providing these services as otherwise authorized by that state's medical board. The model bill also outlines steps through which a physician can establish a relationship with a new patient via telemedicine and addresses informed consent and privacy.

The AMA has created numerous resources to help guide physician practices through the successful implementation of telehealth, including a [Telemedicine Quick Guide](#), [Telehealth Implementation Playbook](#), and [Continuing Medical Education \(CME\) modules](#) available on the AMA Ed Hub. The AMA has also developed [HIPAA privacy and security resources](#) to help walk physicians through what is needed to comply with the required HIPAA privacy and security rules. The [AMA Physician Profile Service](#) is used extensively by organizations that verify physician credentials directly (e.g., licensing boards, hospitals, group practices, managed care organizations and physician recruiters).



At the beginning of the pandemic, the AMA also made available a [COVID-19 State Policy Guidance on Telemedicine](#), which outlined AMA policy recommendations for telemedicine on a range of issues, including licensure, in response to COVID-19. As noted previously, the AMA engages in robust federal and state telehealth advocacy and routinely weighs in on a range of telehealth policy proposals related to licensure, payment, coverage, technology and equity. Federal legislation addressing licensure includes the Temporary Reciprocity to Ensure Access to Treatment Act or the TREAT Act (S 168/HR 708), which would provide nationwide temporary licensing reciprocity for telehealth and in-person care during the public health emergency and for 180 days thereafter. The AMA is neutral on this legislation because it specifies that health professionals providing care across state lines will be subject to the jurisdiction of the state in which the patient is located. The Equal Access to Care Act (S 155/HR 688) would allow health professionals in one state to provide telemedicine in states where they are not licensed during the public health emergency and for 180 days thereafter. The site of care in this legislation is considered to be the state where the health professional is located. More broadly, in response to the COVID-19 pandemic the AMA has:

- sought and secured broad telehealth coverage expansion and improved payments at the federal and state levels to increase access to care and provide patients with a safer way to receive care;
- secured introduction of legislation to make key telehealth policy changes permanent; and
- obtained permanent ability to use smart phones for Medicare telehealth services.

## DISCUSSION

Once the COVID-19 pandemic was declared a public health emergency, many states quickly waived licensure requirements so that physicians licensed in one state could provide medical care—including via telehealth—to patients in another state. Scores of executive orders and regulatory actions that expanded coverage for and payment of telehealth led to a substantial surge in virtual services, enabling physicians to provide uninterrupted continuity of care amidst stay-at-home orders and helping to ease physician shortages in areas hardest hit by COVID-19. The AMA continues to hear success stories from patients and physicians who view the expansion of telehealth positively and are more comfortable with telehealth than ever before. The Council encourages continued assessment of the experiences of physicians who have used licensing flexibilities to provide telehealth across state lines as well as the impact of virtual services on care quality and patient outcomes. The Council also understands the challenges facing physician practices trying to compete with corporate telehealth entities—including those contracting with payers to provide telehealth—and how these challenges may increase post-pandemic.

The Council is mindful that physicians hold strong, divergent opinions about interstate telehealth and whether the licensure flexibilities put in place during the public health emergency should be made permanent. Some proponents want to abandon the prevailing standard that physicians must be licensed in the state where the patient is located and move toward national licensure and/or federal oversight of interstate telehealth. Other physicians prefer to uphold the state-based licensing structure—which dates to the 1800s and is embedded in state authority granted by the 10th Amendment—and continue treating the location of the patient (originating site) as the site of service. The Council continues to believe that patient safety should remain the primary consideration and that licensure of physicians and other health professionals should remain within the purview of each state. Proposals to change which state is responsible for overseeing the physician from the state where the patient is located to the physician's home state would likewise change which state's medical practice and scope laws apply to the care rendered. Such proposals would interfere with states' investigative and disciplinary authorities and also raise enforcement

1 concerns since states are generally unable to investigate incidents that happen in another state.<sup>20</sup>  
2 Similarly, states cannot take action against the license of a physician in another state.  
3

4 Considering the differing views among physicians and the issues raised in paragraphs (b) and (d) of  
5 the second Resolve of Alternate Resolution 203-Nov-20, the Council focused its deliberations on  
6 helping physicians, practices and patients by allowing physicians to treat existing patients wherever  
7 they are, thereby preserving those patient relationships, ensuring continuity of care, and permitting  
8 specialist care for complex patients and the seriously ill. Consistent with Policy H-480.969, the  
9 Council affirmed in its 2019 report that, where there is an established patient relationship, a  
10 physician should be able to use telemedicine to provide quality emergent or urgent care for a  
11 patient's existing condition when that patient is traveling in another state. In this report, the Council  
12 suggests broadening the scope of that statement and address a frustration common among  
13 physicians—that they are prohibited by most states from using telehealth to provide longitudinal  
14 care to existing patients whom they have seen in the office but who may live across a state border,  
15 attend college in another state, or travel for work or seasonally. The Council believes that multiple  
16 pathways are available to states to facilitate interstate telehealth for continuity of care purposes,  
17 including exceptions to state licensing laws, reciprocity agreements, or possibly other solutions not  
18 yet proffered. Accordingly, the Council recommends that the AMA work with FSMB, state  
19 medical associations and other stakeholders to encourage states to allow an out-of-state physician  
20 to use telehealth to provide continuity of care to an existing patient if certain conditions are met.  
21 The Council further recommends amending Policy H-480.969 by addition to codify the previous  
22 recommendation in AMA telehealth licensure policy. Because Policy H-480.969 currently  
23 prohibits the use of telehealth to provide medical opinions and e-consults between physicians in  
24 different states, the Council recommends additional amendments by deletion to update this policy  
25 to reflect current practice.  
26

27 The Council believes these recommendations will increase physician and patient satisfaction with  
28 health care, reduce physician licensure-related costs and administrative burdens, help sustain  
29 physician practices as they continue to recover from the economic impacts of COVID-19, and  
30 address the needs of individuals with disabilities or complex health conditions who lack access to  
31 specialty care locally and would benefit from virtual visits with out-of-state specialist physicians.  
32 Additionally, as discussed in Council on Medical Service Report 7-JUN-21, these  
33 recommendations have the potential to address long-standing health inequities among marginalized  
34 and minoritized communities.  
35

36 The Council is aware of efforts at the state level to streamline or otherwise facilitate interstate  
37 licensure through reciprocity or other means. To ensure that our AMA can support such efforts if  
38 they align with existing policy, the Council recommends continued support for state efforts to  
39 expand physician licensure recognition across state lines in accordance with the standards and  
40 safeguards outlined in Policy H-480.946. The Council continues to support the IMLC as an  
41 important licensure solution and hopes that the states that have not joined the Compact elect to do  
42 so. Accordingly, the Council recommends that Policy H-480.946 be reaffirmed. Finally, the  
43 Council recommends reaffirmation of Policy H-480.946, which delineates standards and  
44 safeguards that should be met for the coverage and payment of telemedicine.  
45

## 46 RECOMMENDATIONS

47

48 The Council on Medical Service recommends that the following be adopted in lieu of Resolve 2,  
49 Items (b) and (d) of Alternate Resolution 203-Nov-20, and that the remainder of the report be filed.



- 1 1. That our American Medical Association (AMA) work with the Federation of State Medical  
2 Boards, state medical associations and other stakeholders to encourage states to allow an out-  
3 of-state physician to use telehealth to provide continuity of care to an existing patient in the  
4 state without penalty if the following conditions are met:  
5 a) The physician has an active license to practice medicine in a state or US territory and  
6 has not been subjected to disciplinary action.  
7 b) There is a pre-existing and ongoing physician-patient relationship.  
8 c) The physician has had an in-person visit(s) with the patient.  
9 d) The telehealth services are incident to an existing care plan or one that is being  
10 modified.  
11 e) The physician maintains liability coverage for telehealth services provided to patients  
12 in states other than the state where the physician is licensed.  
13 f) Telehealth use complies with Health Insurance Portability and Accountability Act  
14 privacy and security rules. (Directive to Take Action)  
15  
16 2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:  
17  
18 The Promotion of Quality Telemedicine H-480.969  
19 (1) It is the policy of the AMA that medical boards of states and territories should require a full  
20 and unrestricted license in that state for the practice of telemedicine, unless there are other  
21 appropriate state-based licensing methods, with no differentiation by specialty, for physicians  
22 who wish to practice telemedicine in that state or territory. This license category should adhere  
23 to the following principles:  
24 ~~(a) application to situations where there is a telemedical transmission of individual patient data~~  
25 ~~from the patient's state that results in either (i) provision of a written or otherwise documented~~  
26 ~~medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient~~  
27 ~~within the board's state;~~  
28 ~~(ba) exemption from such a licensure requirement for traditional informal physician-to-~~  
29 ~~physician consultations ("curbside consultations") that are provided without expectation of~~  
30 ~~compensation;~~  
31 ~~(eb) exemption from such a licensure requirement for telemedicine practiced across state lines~~  
32 ~~in the event of an emergent or urgent circumstance, the definition of which for the purposes of~~  
33 ~~telemedicine should show substantial deference to the judgment of the attending and consulting~~  
34 ~~physicians as well as to the views of the patient; and~~  
35 (c) allowances, by exemption or other means, for out-of-state physicians providing continuity  
36 of care to a patient, where there is an established ongoing relationship and previous in-person  
37 visits, for services incident to an ongoing care plan or one that is being modified.  
38 (d) application requirements that are non-burdensome, issued in an expeditious manner, have  
39 fees no higher than necessary to cover the reasonable costs of administering this process, and  
40 that utilize principles of reciprocity with the licensure requirements of the state in which the  
41 physician in question practices. (Modify Current AMA Policy)  
42  
43 3. That our AMA continue to support state efforts to expand physician licensure recognition  
44 across state lines in accordance with the standards and safeguards outlined in Policy  
45 H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)  
46  
47 4. That our AMA reaffirm Policy D-480.964, which directs the AMA to work with state medical  
48 associations to encourage states that are not part of the Interstate Medical Licensure Compact  
49 to consider joining the Compact; advocate for reduced application and state licensure(s) fees  
50 processed through the Interstate Medical Licensure Compact; and work with interested state

- 1 medical associations to encourage states to pass legislation enhancing patient access to and
- 2 proper regulation of telemedicine services. (Reaffirm HOD Policy)
- 3
- 4 5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that
- 5 should be met for the coverage and payment of telemedicine, including that physicians and
- 6 other health practitioners must be licensed in the state where the patient receives services, or be
- 7 providing these services as otherwise authorized by the state's medical board. (Reaffirm HOD
- 8 Policy)

Fiscal Note: Less than \$6,000

## REFERENCES

- <sup>1</sup> Kane, C. Key Findings from the AMA 2012-2020 Physician Practice Benchmark Surveys.
- <sup>2</sup> COVID-19 Healthcare Coalition. Telehealth Impact: Physician Survey Analysis. Last updated Nov. 2020. Available online at: <https://c19hcc.org/static/catalog-resources/telehealth-physician-survey-analysis-c19hcc.pdf>.
- <sup>3</sup> *Ibid.*
- <sup>4</sup> *Ibid.*
- <sup>5</sup> Federation of State Medical Boards. Understanding Medical Regulation in the United States. Available online at: <https://www.fsmb.org/siteassets/education/pdf/best-module-text-intro-to-medical-regulation.pdf>.
- <sup>6</sup> Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. July 2020. Available online at: [https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine\\_policies\\_by\\_state.pdf](https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf).
- <sup>7</sup> The Interstate Medical Licensure Compact website: <https://imlcc.org/>.
- <sup>8</sup> *Ibid.*
- <sup>9</sup> Federation of State Medical Boards. Advocacy Network News. April 1, 2020.
- <sup>10</sup> The Interstate Medical Licensure Compact website: <https://www.imlcc.org/information-for-states/>
- <sup>11</sup> The Interstate Medical Licensure Compact website: <https://www.imlcc.org/what-does-it-cost/>
- <sup>12</sup> American Medical Association. COVID-19 Physician practice financial impact survey. 2020. Available online at: <https://www.ama-assn.org/system/files/2020-10/covid-19-physician-practice-financial-impact-survey-results.pdf>
- <sup>13</sup> *Ibid.*
- <sup>14</sup> Colorado's Medical Practice Act [§ 12-240-107(3)(b)]
- <sup>15</sup> Federation of State Medical Boards. Telemedicine Policies: Board by Board Overview. July 2020. Available online at: [https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine\\_policies\\_by\\_state.pdf](https://www.fsmb.org/siteassets/advocacy/key-issues/telemedicine_policies_by_state.pdf).
- <sup>16</sup> Uniform Law Commission. Emergency Volunteer Health Practitioners Act. Available online at: <https://www.uniformlaws.org/committees/community-home?CommunityKey=565933ce-965f-4d3c-9c90-b00246f30f2d>
- <sup>17</sup> National Conference of State Legislatures. Universal Licensure Recognition. March 2, 2021. Available online at: <https://www.ncsl.org/research/labor-and-employment/universal-licensure-recognition.aspx>
- <sup>18</sup> Sports Medicine Licensure Clarity Act of 2018. Available online at: <https://www.congress.gov/bill/115th-congress/house-bill/302?q=%7B%22search%22%3A%5B%22Sports+Medicine+Licensure+Clarity+Act%22%5D%7D&r=1>
- <sup>19</sup> Centers for Medicare & Medicaid Services. COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers. Available online at: <https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf>
- <sup>20</sup> Mehrotra A, Nimgaonkar BA and Richman B. Telemedicine and Medical Licensure — Potential Paths for Reform. *New England Journal of Medicine*, Feb. 25, 2021. Available online at: <https://www.nejm.org/doi/full/10.1056/NEJMp2031608?query=TOC>

### **Appendix: Relevant AMA Policy**

#### **Policy H-480.946, "Coverage of and Payment for Telemedicine"**

1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:

a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:

- A face-to-face examination, if a face-to-face encounter would otherwise be required in the provision of the same service not delivered via telemedicine; or
- A consultation with another physician who has an ongoing patient-physician relationship with the patient. The physician who has established a valid physician-patient relationship must agree to supervise the patient's care; or
- Meeting standards of establishing a patient-physician relationship included as part of evidence-based clinical practice guidelines on telemedicine developed by major medical specialty societies, such as those of radiology and pathology.

Exceptions to the foregoing include on-call, cross coverage situations; emergency medical treatment; and other exceptions that become recognized as meeting or improving the standard of care. If a medical home does not exist, telemedicine providers should facilitate the identification of medical homes and treating physicians where in-person services can be delivered in coordination with the telemedicine services.

b) Physicians and other health practitioners delivering telemedicine services must abide by state licensure laws and state medical practice laws and requirements in the state in which the patient receives services.

c) Physicians and other health practitioners delivering telemedicine services must be licensed in the state where the patient receives services, or be providing these services as otherwise authorized by that state's medical board.

d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.

e) The delivery of telemedicine services must be consistent with state scope of practice laws.

f) Patients receiving telemedicine services must have access to the licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.

g) The standards and scope of telemedicine services should be consistent with related in-person services.

h) The delivery of telemedicine services must follow evidence-based practice guidelines, to the degree they are available, to ensure patient safety, quality of care and positive health outcomes.

i) The telemedicine service must be delivered in a transparent manner, to include but not be limited to, the identification of the patient and physician in advance of the delivery of the service, as well as patient cost-sharing responsibilities and any limitations in drugs that can be prescribed via telemedicine.

j) The patient's medical history must be collected as part of the provision of any telemedicine service.

k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.

l) The provision of telemedicine services must include care coordination with the patient's medical home and/or existing treating physicians, which includes at a minimum identifying the patient's existing medical home and treating physicians and providing to the latter a copy of the medical record.

m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.

2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.

3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.
4. Our AMA supports additional pilot programs in the Medicare program to enable coverage of telemedicine services, including, but not limited to store-and-forward telemedicine.
5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how telemedicine can be integrated into new payment and delivery models.
6. Our AMA encourages physicians to verify that their medical liability insurance policy covers telemedicine services, including telemedicine services provided across state lines if applicable, prior to the delivery of any telemedicine service.
7. Our AMA encourages national medical specialty societies to leverage and potentially collaborate in the work of national telemedicine organizations, such as the American Telemedicine Association, in the area of telemedicine technical standards, to the extent practicable, and to take the lead in the development of telemedicine clinical practice guidelines. (CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed in lieu of Res. 815, I-15; Reaffirmed: CME Rep. 06, A-16; Reaffirmed: CMS Rep. 06, I-16; Reaffirmed: Res. 111, A-17; Reaffirmation: A-18; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.964, “Established Patient Relationships and Telemedicine”

Our AMA will: (1) work with state medical associations to encourage states that are not part of the Interstate Medical Licensure Compact to consider joining the Compact as a means of enhancing patient access to and proper regulation of telemedicine services; (2) advocate to the Interstate Medical Licensure Compact Commission and Federation of State Medical Boards for reduced application fees and secondary state licensure(s) fees processed through the Interstate Medical Licensure Compact; and (3) work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services, in accordance with AMA Policy H-480.946, “Coverage of and Payment for Telemedicine.” (CMS Rep. 1, I-19)

Policy H-480.969, “The Promotion of Quality Telemedicine”

(1) It is the policy of the AMA that medical boards of states and territories should require a full and unrestricted license in that state for the practice of telemedicine, unless there are other appropriate state-based licensing methods, with no differentiation by specialty, for physicians who wish to practice telemedicine in that state or territory. This license category should adhere to the following principles:

- (a) application to situations where there is a telemedical transmission of individual patient data from the patient’s state that results in either (i) provision of a written or otherwise documented medical opinion used for diagnosis or treatment or (ii) rendering of treatment to a patient within the board’s state;
- (b) exemption from such a licensure requirement for traditional informal physician-to-physician consultations (“curbside consultations”) that are provided without expectation of compensation;
- (c) exemption from such a licensure requirement for telemedicine practiced across state lines in the event of an emergent or urgent circumstance, the definition of which for the purposes of telemedicine should show substantial deference to the judgment of the attending and consulting physicians as well as to the views of the patient; and
- (d) application requirements that are non-burdensome, issued in an expeditious manner, have fees no higher than necessary to cover the reasonable costs of administering this process, and that utilize principles of reciprocity with the licensure requirements of the state in which the physician in question practices.

(2) The AMA urges the FSMB and individual states to recognize that a physician practicing certain forms of telemedicine (e.g., teleradiology) must sometimes perform necessary functions in the licensing state (e.g., interaction with patients, technologists, and other physicians) and that the

interstate telemedicine approach adopted must accommodate these essential quality-related functions.

(3) The AMA urges national medical specialty societies to develop and implement practice parameters for telemedicine in conformance with: Policy 410.973 (which identifies practice parameters as “educational tools”); Policy 410.987 (which identifies practice parameters as “strategies for patient management that are designed to assist physicians in clinical decision making,” and states that a practice parameter developed by a particular specialty or specialties should not preclude the performance of the procedures or treatments addressed in that practice parameter by physicians who are not formally credentialed in that specialty or specialties); and Policy 410.996 (which states that physician groups representing all appropriate specialties and practice settings should be involved in developing practice parameters, particularly those which cross lines of disciplines or specialties). (CME/CMS Rep., A-96; Amended: CME Rep. 7, A-99; Reaffirmed: CME Rep. 2, A-09; Reaffirmed: CME Rep. 6, A-10; Reaffirmed: CME Rep. 6, A-12; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed: BOT Rep. 22, A-13; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: BOT Rep. 3, I-14; Reaffirmed: CMS Rep. 1, I-19)

Policy D-480.969, “Insurance Coverage Parity for Telemedicine Service”

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
2. Our AMA will develop model legislation to support states’ efforts to achieve parity in telemedicine coverage policies.
3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state’s medical practice statutes and its regulation falls under the jurisdiction of the state medical board. (Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19)

Policy H-480.974, “Evolving Impact of Telemedicine”

Our AMA:

- (1) will evaluate relevant federal legislation related to telemedicine;
- (2) urges CMS, AHRQ, and other concerned entities involved in telemedicine to fund demonstration projects to evaluate the effect of care delivered by physicians using telemedicine-related technology on costs, quality, and the physician-patient relationship;
- (3) urges professional organizations that serve medical specialties involved in telemedicine to develop appropriate practice parameters to address the various applications of telemedicine and to guide quality assessment and liability issues related to telemedicine;
- (4) encourages professional organizations that serve medical specialties involved in telemedicine to develop appropriate educational resources for physicians for telemedicine practice;
- (5) encourages development of a code change application for CPT codes or modifiers for telemedical services, to be submitted pursuant to CPT processes;
- (6) will work with CMS and other payers to develop and test, through these demonstration projects, appropriate reimbursement mechanisms;
- (7) will develop a means of providing appropriate continuing medical education credit, acceptable toward the Physician’s Recognition Award, for educational consultations using telemedicine;
- (8) will work with the Federation of State Medical Boards and the state and territorial licensing boards to develop licensure guidelines for telemedicine practiced across state boundaries; and
- (9) will leverage existing expert guidance on telemedicine by collaborating with the American Telemedicine Association ([www.americantelemed.org](http://www.americantelemed.org)) to develop physician and patient specific content on the use of telemedicine services--encrypted and unencrypted. (CMS/CME Rep., A-94; Reaffirmation A-01; Reaffirmation A-11; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed in lieu of

Res. 805, I-12; Appended: BOT Rep. 26, A-13; Modified: BOT Rep. 22, A-13; Reaffirmed: CMS Rep. 7, A-14; Reaffirmed: CME Rep. 06, A-16; Reaffirmation: A-18)

State Authority and Flexibility in Medical Licensure for Telemedicine D-480.999

Our AMA will continue its opposition to a single national federalized system of medical licensure. (CME Rep. 7, A-99; Reaffirmed and Modified: CME Rep. 2, A-09; Reaffirmed in lieu of Res. 920, I-13; Reaffirmed: BOT Rep. 3, I-14)

Policy D-275.994, "Facilitating Credentialing for State Licensure"

Our AMA: (1) encourages the Federation of State Medical Boards to urge its Portability Committee to complete its work on developing mechanisms for greater reciprocity between state licensing jurisdictions as soon as possible; (2) will work with the Federation of State Medical Boards (FSMB) and the Association of State Medical Board Executive Directors to encourage the increased standardization of credentials requirements for licensure, and to increase the number of reciprocal relationships among all licensing jurisdictions; (3) encourages the Federation of State Medical Boards and its licensing jurisdictions to widely disseminate information about the Federation's Credentials Verification Service, especially when physicians apply for a new medical license; and (4) supports the FSMB Interstate Compact for Medical Licensure and will work with interested medical associations, the FSMB and other interested stakeholders to ensure expeditious adoption by the states of the Interstate Compact for Medical Licensure and creation of the Interstate Medical Licensure Compact Commission. (Res. 302, A-01; Reaffirmed: CME Rep. 2, A-11; Reaffirmed: CME Rep. 6, A-12; Appended: BOT Rep. 3, I-14)

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101  
(JUN-21)

Introduced by: New York

Subject: Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits

Referred to: Reference Committee A

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1 Whereas, According to the AMA Council on Medical Service (CMS), employers and insurance  
2 companies are increasingly implementing programs (i.e., Financial Incentive Programs or FIPs)  
3 that offer patients financial incentives when they use shopping tools to compare prices on health  
4 care items and services and choose lower-cost options; and

5  
6 Whereas, According to the CMS, empowering patients to pursue health care can minimize  
7 financial burden and reduce societal health care costs; and

8  
9 Whereas, According to the CMS, while considering these potential benefits of FIPs, it is critical  
10 to ensure that patients are empowered to make fully informed decisions about their health care,  
11 that they are never coerced into accepting lower-cost care if it could jeopardize their health, and  
12 that programs that influence patient decision-making should be transparent about quality and  
13 cost; and

14  
15 Whereas, Multiple studies have shown that, on average, Medicaid recipients use emergency  
16 rooms (ERs) more often than those with private insurance for non-urgent conditions; and

17  
18 Whereas, Some states have implicated a copay system in an attempt to deter the overutilization  
19 of ERs, but there is concern that such costs have been shown to cause people, especially those  
20 within low-income and vulnerable populations, to forgo necessary care; and

21  
22 Whereas, One multistate [study](#) found that charging higher copayments did not reduce ER use  
23 by Medicaid recipients and reasons postulated for this finding include that copays are hard to  
24 enforce, since ERs are legally obligated to examine anyone who walks through the doors,  
25 whether or not they can pay; and

26  
27 Whereas, One concept that has been implemented in a few states provides Medicaid recipients  
28 with a prepaid card to cover a certain number of copays for ER visits and that any unutilized  
29 amount on that copay card could be converted to a financial reward at the end of the year; and

30  
31 Whereas, Some states have set up a 24-hour hotline staffed by nurses who can advise people  
32 about whether they are having a true medical emergency; and

33  
34 Whereas, There is also a compelling need to be very cautious regarding the creation of  
35 disincentives for patients who are in need of care; therefore be it

- 1 RESOLVED, That our American Medical Association study and report on the positive and  
 2 negative experiences of programs in various states that provide Medicaid beneficiaries with  
 3 incentives for choosing alternative sites of care when it is appropriate to their symptoms and/or  
 4 condition instead of hospital emergency departments. (Directive to Take Action)

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

Received: 03/31/21

#### AUTHOR'S STATEMENT OF PRIORITY

Physicians and other health care professionals understand that Emergency Rooms should be used for true emergency care. The COVID pandemic amply demonstrated that healthcare for patients with non-emergent issues needs to be addressed by alternative health care sites. Physicians and other emergency room personnel need to be able to focus on the life and death situations that present themselves at emergency rooms. Information on what have been successful alternatives for providing care to Medicaid beneficiaries and what incentives have worked to induce Medicaid beneficiaries to use those alternatives will arm health care networks around the country with information to provide better healthcare to that population. By adapting to what works well for the Medicaid population, use of emergency rooms for their intended purpose will improve as will the work environment of physicians and healthcare personnel who work there. Such a report has the power to improve the healthcare for so many.

#### **RELEVANT AMA POLICY**

##### **Addressing Financial Incentives to Shop for Lower-Cost Health Care H-185.920**

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
  - a. Collaborate with the physician community in the development and implementation of patient incentives.
  - b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
  - c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
  - d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
  - e. Provide referring and/or primary care physicians with the full record of the service encounter.
  - f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
  - g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
  - a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
  - b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
  - c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
  - d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
  - e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
  - f. Provide meaningful transparency of prices and vendors.
  - g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
  - h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to



undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.

i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.

3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.

4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.

5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.

6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:

a. Patient outcomes/the quality of care provided with shopped services;

b. Patient utilization of shopped services;

c. Patient satisfaction with care for shopped services;

d. Patient choice of health care provider;

e. Impact on physician administrative burden; and

f. Overall/systemic impact on health care costs and care fragmentation.

Citation: CMS Rep. 2, I-19

### **Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured H-290.982**

AMA policy is that our AMA: (1) urges that Medicaid reform not be undertaken in isolation, but rather in conjunction with broader health insurance reform, in order to ensure that the delivery and financing of care results in appropriate access and level of services for low-income patients;

(2) encourages physicians to participate in efforts to enroll children in adequately funded Medicaid and State Children's Health Insurance Programs using the mechanism of "presumptive eligibility," whereby a child presumed to be eligible may be enrolled for coverage of the initial physician visit, whether or not the child is subsequently found to be, in fact, eligible.

(3) encourages states to ensure that within their Medicaid programs there is a pluralistic approach to health care financing delivery including a choice of primary care case management, partial capitation models, fee-for-service, medical savings accounts, benefit payment schedules and other approaches;

(4) calls for states to create mechanisms for traditional Medicaid providers to continue to participate in Medicaid managed care and in State Children's Health Insurance Programs;

(5) calls for states to streamline the enrollment process within their Medicaid programs and State Children's Health Insurance Programs by, for example, allowing mail-in applications, developing shorter application forms, coordinating their Medicaid and welfare (TANF) application processes, and placing eligibility workers in locations where potential beneficiaries work, go to school, attend day care, play, pray, and receive medical care;

(6) urges states to administer their Medicaid and SCHIP programs through a single state agency;

(7) strongly urges states to undertake, and encourages state medical associations, county medical societies, specialty societies, and individual physicians to take part in, educational and outreach activities aimed at Medicaid-eligible and SCHIP-eligible children. Such efforts should be designed to ensure that children do not go without needed and available services for which they are eligible due to administrative barriers or lack of understanding of the programs;

(8) supports requiring states to reinvest savings achieved in Medicaid programs into expanding coverage for uninsured individuals, particularly children. Mechanisms for expanding coverage may include additional funding for the SCHIP earmarked to enroll children to higher percentages of the poverty level; Medicaid expansions; providing premium subsidies or a buy-in option for individuals in families with income between their state's Medicaid income eligibility level and a specified percentage of the poverty level; providing some form of refundable, advanceable tax credits inversely related to income; providing vouchers for recipients to use to choose their own health plans; using Medicaid funds to purchase private health insurance coverage; or expansion of Maternal and Child Health Programs. Such expansions must be implemented to coordinate with the Medicaid and SCHIP programs in order to achieve a seamless health care delivery system, and be sufficiently funded to provide incentive for families to obtain adequate insurance coverage for their children;

(9) advocates consideration of various funding options for expanding coverage including, but not limited to: increases in sales tax on tobacco products; funds made available through for-profit conversions of health plans and/or facilities; and the application of prospective payment or other cost or utilization management techniques to hospital outpatient services, nursing home services, and home health care services;

(10) supports modest co-pays or income-adjusted premium shares for non-emergent, non-preventive services as a means of expanding access to coverage for currently uninsured individuals;

(11) calls for CMS to develop better measurement, monitoring, and accountability systems and indices within the Medicaid program in order to assess the effectiveness of the program, particularly under managed care, in meeting the needs of patients. Such standards and measures should be linked to health outcomes and access to care;

(12) supports innovative methods of increasing physician participation in the Medicaid program and thereby increasing access, such as plans of deferred compensation for Medicaid providers. Such plans allow individual physicians (with an individual Medicaid number) to tax defer a specified percentage of their Medicaid income;

(13) supports increasing public and private investments in home and community-based care, such as adult day care,

assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

(14) supports allowing states to use long-term care eligibility criteria which distinguish between persons who can be served in a home or community-based setting and those who can only be served safely and cost-effectively in a nursing facility. Such criteria should include measures of functional impairment which take into account impairments caused by cognitive and mental disorders and measures of medically related long-term care needs;

(15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;

(16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;

(17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;

(18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and

(19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.

Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19

#### **Affordable Care Act Medicaid Expansion H-290.965**

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
  2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
  3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
  4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
  5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
  6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
  7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
  8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
  9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
  10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
  11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
  12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
  13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
- Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102  
(JUN-21)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

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

Whereas, Such “bundled” payments will go to the hospital which will then control the payments; and

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

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

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

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

New York rates this resolution as a number one priority requiring action to ensure that physicians are compensated fairly and accurately. This issue is vital and affects all physicians who have a relationship of any type with a hospital or hospital system. Physicians have no visibility to bundled payments and cannot therefore verify that their share of a payment is paid properly. Only the hospital would have information about what share of a bundled payment belonged to the appropriate physician or the hospital. The proposed 17% share of the hospital payment is inadequate in terms of payment and does not specify how the bundled payment would be disbursed. Bundled payments to hospitals do not account for how many physicians were involved in the care of a hospitalized patient and would make it very difficult for practices to claim secondary or supplemental benefits under any coordinated benefits the patient might have. This would increase physician stress since income would be affected and increased time would be required on the part of physicians to verify that they are paid fairly. Data used for the purposes of Fairhealth cost estimates could be affected by bundling of payments to hospitals. This issue would have far-reaching consequences if implemented.

**RELEVANT AMA POLICY****Health Care Reform Physician Payment Models D-385.963**

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103  
(JUN-21)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance program that allows an eligible employee and his or her dependents the continued benefits of health insurance coverage in the case that an employee loses his or her job or experiences a reduction of work hours; and

Whereas, COBRA allows former employees to obtain continued health insurance coverage at group rates that otherwise might be terminated and which are typically less expensive than those associated with individual health insurance plans; and

Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could occur when a person's employment is terminated; and

Whereas, College students enjoy similar group rate discounts with student health insurance; and

Whereas, These students, upon graduation or other termination of an enrollment, potentially face similar disruption in their healthcare coverage; therefore be it

RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution calls for an important option for recent college graduates who need to retain/obtain health insurance. Most, if not all, once graduated do not have the option of continued coverage under their parent's health insurance due to loss of student status and/or their age. EVERYONE needs to have health insurance and this has been a critically important issue as the COVID pandemic has progressed. While they are seeking employment, it would be beneficial to all if a COBRA-type program existed which would cover these new graduates/ job seekers until they are hired and covered by employer health insurance.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104  
(JUN-21)

Introduced by: New York

Subject: Medicaid Tax Benefits

Referred to: Reference Committee A

1 Whereas, There are many patients with Medicaid or no health insurance that physicians care for  
2 routinely for little or no payment; and  
3

4 Whereas, It may be politically complicated to rectify this fact directly with improved payments to  
5 physicians; and  
6

7 Whereas, One way to offset the problem would be to use tax deduction techniques; and  
8

9 Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or  
10 Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes  
11 providing tax deductions or credits for the provision of care to the medically uninsured and  
12 underinsured; therefore be it  
13

14 RESOLVED, That our American Medical Association advocate for legislation that would allow  
15 physicians who take care of Medicaid or uninsured patients to receive some financial benefit  
16 through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use  
17 the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

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

Received: 04/23/21

AUTHOR'S STATEMENT OF PRIORITY

This resolution and its goals had strong support in the MSSNY House of Delegates. This resolution is particularly important because AMA currently has contrary policy 180.965 that indicates that "the AMA will not pursue efforts to have federal laws changed to provide tax deductions or credits for the provision of care to the medically uninsured and underinsured." If AMA is to support physicians, this policy must change.

Physicians are often faced with treatment for patients having no insurance, but physicians can no longer afford to provide care as a charitable act. Payments from Medicaid do not adequately compensate physicians for patient care. Tax credits would provide incentive to continue treating uninsured patients and help to counteract patient care without payment.

## **RELEVANT AMA POLICY**

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105  
(JUN-21)

Introduced by: Florida, Mississippi, North Carolina, Oklahoma, South Carolina, Virginia,  
Alabama, District of Columbia, Texas

Subject: Effects of Telehealth Coverage and Payment Parity on Health Insurance  
Premiums

Referred to: Reference Committee A

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1 Whereas, The coverage and utilization of telehealth expanded rapidly during the COVID-19  
2 pandemic; and<sup>1</sup>

3  
4 Whereas, Many commercial health insurance companies have voluntarily expanded telehealth  
5 coverage during the pandemic, albeit in some cases on a more restrictive or less generous  
6 basis than the Medicare program; and

7  
8 Whereas, Our AMA has drafted model legislation that requires health insurance companies to  
9 offer telehealth coverage and to reimburse for those services “on the same basis and to the  
10 same extent” that the insurer would have if the same service were rendered in-person; and<sup>2</sup>

11  
12 Whereas, There are ongoing discussions across the nation regarding whether to require health  
13 insurance companies to offer telehealth coverage and whether to require health insurance  
14 companies to provide payment parity for telehealth services; and<sup>3</sup>

15  
16 Whereas, Physicians have recognized that telehealth can improve clinical outcomes, patient  
17 experience, costs, and professional satisfaction; and<sup>4</sup>

18  
19 Whereas, Insurance companies in Florida and elsewhere have argued that enacting legislation  
20 that would require them to offer telehealth coverage and to adhere to payment parity  
21 requirements will definitively, significantly increase insurance premiums; and

22  
23 Whereas, Physician advocates urgently need additional data concerning the effects of  
24 telehealth coverage requirements and payment parity requirements on health insurance  
25 premiums to respond to the cost-related concerns being propagated by insurers; and

26  
27 Whereas, Physician advocates may struggle to successfully enact telehealth coverage and  
28 payment parity legislation in the absence of research that can be used to respond to the  
29 assertion that such legislation will definitively and significantly increase health insurance  
30 premiums; and

31  
32 Whereas, Our AMA is equipped to perform or commission research concerning the effects of  
33 telehealth coverage and payment parity requirements, including the effect that such policies  
34 may have on health insurance premiums; therefore be it



- 1 RESOLVED, That our American Medical Association conduct or commission a study on the  
 2 effect that telemedicine services have had on health insurance premiums, focusing on the  
 3 differences between states that had telehealth payment parity provisions in effect prior to the  
 4 pandemic versus those that did not, and report back at the 2021 Interim Meeting of the AMA  
 5 House of Delegates. (Directive to Take Action)

Fiscal Note: Estimated cost of \$260,000 to implement resolution.

Received: 05/03/21

#### AUTHORS STATEMENT OF PRIORITY

The practice of medicine would benefit from a study that examined the effects of telehealth coverage requirements, including payment parity requirements, on health insurance premiums.

In the wake of COVID-19, physicians and patients across the nation realized the numerous, substantial benefits of greater access to telehealth. Consequently, state medical societies have become increasingly interested in permanently requiring health insurers to cover telehealth services and to pay for telehealth services at parity with in-person services. The access and patient care benefits of enacting such legislation would be considerable, as the AMA has formally recognized through its public policy positions and ongoing work initiatives.

However, health insurers have expressed opposition to such mandates, arguing that such mandates will significantly increase premiums. Currently, there is a paucity of research examining the effects of telehealth coverage requirements on insurance premiums. This makes it difficult to assess and respond to such claims. Additionally, many state lawmakers are unconcerned about record-high insurance company profits, but care deeply about avoiding legislation that will increase premiums.

Ultimately, even if the scope of the research was limited due to methodological constraints, physician advocates urgently need whatever data can be made available to them. Additionally, even a finding that the effects of such policies on premiums are “inconclusive” would still help physicians respond to claims that increasing access to telehealth will “definitively” and “significantly” raise premiums. In short, this research would help medical societies enact laws that are consistent with AMA policy by supplying advocates with much-needed data.

#### References:

1. FAIR Health Monthly Telehealth Regional Tracker, <https://www.fairhealth.org/article/fair-health-tracker-shows-continuing-growth-in-telehealth>
2. AMA Telemedicine Model Bill, 2017
3. Kaiser Family Foundation: Opportunities and Barriers for Telemedicine in the U.S. During the COVID-19 Emergency and Beyond, <https://www.kff.org/womens-health-policy/issue-brief/opportunities-and-barriers-for-telemedicine-in-the-u-s-during-the-covid-19-emergency-and-beyond/>
4. American Medical Association Telehealth Research & Key Resources: Research Findings, <https://www.ama-assn.org/practice-management/digital/telehealth-research-key-resources-research-findings>

#### **RELEVANT AMA POLICY**

##### **Insurance Coverage Parity for Telemedicine Service D-480.969**

1. Our AMA will advocate for telemedicine parity laws that require private insurers to cover telemedicine-provided services comparable to that of in-person services, and not limit coverage only to services provided by select corporate telemedicine providers.
  2. Our AMA will develop model legislation to support states' efforts to achieve parity in telemedicine coverage policies.
  3. Our AMA will work with the Federation of State Medical Boards to draft model state legislation to ensure telemedicine is appropriately defined in each state's medical practice statutes and its regulation falls under the jurisdiction of the state medical board.
- Res. 233, A-16; Reaffirmed: CMS Rep. 1, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106  
(JUN-21)

Introduced by: American College of Cardiology, American Society of Echocardiography,  
Society for Cardiovascular Angiography and Interventions,  
Society of Cardiovascular Computed Tomography, American Society of  
Nuclear Cardiology, Texas

Subject: Socioeconomics of CT Coronary Calcium: Is it Scored or Ignored?

Referred to: Reference Committee A

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1 Whereas, A coronary artery calcium score (CACS) measured by computed tomography is a  
2 noninvasive, low-radiation diagnostic test that correlates with cardiovascular outcomes<sup>1</sup>; and  
3

4 Whereas, Screening with CACS can help guide the course of clinical management in the  
5 borderline-and intermediate-risk patients with 10-year cardiovascular risk of 5% to 20%,  
6 particularly those with risk-enhancing factors, e.g., chronic kidney disease, metabolic syndrome,  
7 an elevated high sensitivity C-reactive protein, a positive ankle-brachial index, or a positive  
8 family history<sup>2,3</sup> by the American College of Cardiology and American Heart Association 2019  
9 Primary Prevention Guidelines; and  
10

11 Whereas, CACS is not covered by insurance except in the state of Texas<sup>4</sup>, and the out-of-  
12 pocket costs range from \$49-\$1209, which may represent a barrier for patients who may not be  
13 able to afford the test, but are likely to derive benefit from the results of the test; and  
14

15 Whereas, A low-cost and no-charge CACS strategy has been tested in Cleveland, Ohio<sup>5</sup>,  
16 demonstrating a striking increase in CACS utilization in lower income patients, the black  
17 population and women; therefore be it  
18

19 RESOLVED, That our American Medical Association seek national and/or state legislation  
20 and/or a national coverage determination (NCD) to include coronary artery calcium scoring  
21 (CACS) for patients who meet the screening criteria set forth by the American College of  
22 Cardiology/American Heart Association 2019 Primary Prevention Guidelines, as a first-dollar  
23 covered preventive service, consistent with the current policy in the state of Texas (Directive to  
24 Take Action); and be it further  
25

26 RESOLVED, That our AMA collaborate with the appropriate stakeholders to propose that  
27 hospitals strongly consider a no cost/nominal cost option for CACS in appropriate patients who  
28 are unable to afford this test, as a means to enhance disease detection, disease modification  
29 and management. (Directive to Take Action)

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

Received: 05/03/21

#### AUTHORS STATEMENT OF PRIORITY

Ethnic inequities in healthcare remain, particularly in cardiovascular disease. Screening for cardiovascular disease could allow earlier intervention and prevention, and should be accessible to and affordable for everyone. Self-pay or out-of-pocket screening tests may be underutilized in socioeconomically disadvantaged areas. We therefore propose 1) a national policy change to include CACS as a first-dollar covered preventive service, as it currently is in the state of Texas, and 2) that hospital systems strongly consider routinely performing this test for no cost/nominal cost in patients who are unable to afford this test, as a means to enhance disease detection, disease modification and management.

This is a top priority resolution because:

- 1) It fits squarely within our mission and strategic plan to help eliminate health care disparities.
- 2) It also calls for near-term important action and requires new policy to implement.
- 3) No current policy exists on this topic, and it is an important issue on which to have policy.
- 4) AMA action or policy statement will have a positive impact.
- 5) Negative impact possible if we do not act now.

#### **References**

1. Detrano R, Guerci AD, Carr JJ, et al. Coronary calcium as a predictor of coronary events in four racial or ethnic groups. *N Engl J Med* 2008;358:1336-1345.
2. Roberts ET, Horne A, Martin SS, et al. Cost-effectiveness of coronary artery calcium testing for coronary heart and cardiovascular disease risk prediction to guide statin allocation: the Multi-Ethnic Study of Atherosclerosis (MESA). *PLoS One* 2015;10(3):e0116377.
3. Arnett DK, Blumenthal RS, Albert MA et al. 2019 ACC/AHA Guideline on the Primary Prevention of Cardiovascular Disease: A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Circulation* 2019;140(11) e596–e646.
4. Naghavi M, Maron DJ, Kloner RA, et al. Coronary artery calcium testing: A call for universal coverage *Prev Med Rep*. 2019;15:100879. Published 2019 May 2. doi:10.1016/j.pmedr.2019.100879.
5. Al-Kindi SG, Costa M, Tashtish N et al., No Charge Coronary Calcium Risk Assessment. *J Am Coll Cardiol* 2020;76(10):1259-1262.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107  
(JUN-21)

Introduced by: Resident and Fellow Section

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

Referred to: Reference Committee A

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1 Whereas, Americans entering the workforce currently have from one quarter to one eighth of the  
2 average job tenure as workers now aging into retirement<sup>1</sup>; and  
3

4 Whereas, Trends such as a higher average worker education level and an increasing share of  
5 available jobs in industries with shorter-tenured careers are also contributing to increasing  
6 worker mobility, likely more so than any generational differences<sup>1</sup>; and  
7

8 Whereas, Union membership has been in a prolonged decline, decreasing by 50% in the last 40  
9 years, decreasing the collective bargaining power of today's workers to attain benefits such as  
10 quality health insurance<sup>2</sup>; and  
11

12 Whereas, The number of Americans that have employer-sponsored health insurance has  
13 declined steadily over the past 20 years to 66% in 2014, with the greatest decline seen among  
14 low- and middle-income families<sup>3</sup>; and  
15

16 Whereas, Even among those workers with employer-sponsored health insurance, as many as  
17 25% have out-of-pocket costs so high as to be effectively uninsured<sup>4</sup>; and  
18

19 Whereas, In addition to being increasingly inaccessible and insufficient for workers, reliance on  
20 employer-sponsored health insurance results in undesirable effects on the American worker  
21 such as "job-lock" (being unable to leave a job because of reliance on its health benefits),  
22 medical bankruptcy when a patient changes or loses their job while they or a family member  
23 requires ongoing medical treatment, and downward pressure on wages<sup>5</sup>; and  
24

25 Whereas, The predominance of employer-sponsored insurance arose by accident out of an  
26 attempt to reduce inflation during WWII by capping wage growth with the Stabilization Act of  
27 1942, and was never intended to become the principal form of health insurance in the United  
28 States<sup>6</sup>; and  
29

30 Whereas, As a result of these and other trends, reliance upon a health insurance system tied to  
31 employment is becoming increasingly untenable for large portions of the United States  
32 population; therefore be it  
33

34 RESOLVED, That our American Medical Association recognize the importance of providing  
35 avenues for affordable health insurance coverage and health care access to patients who do  
36 not have employer-sponsored health insurance, or for whom employer-sponsored health  
37 insurance does not meet their needs (New HOD Policy); and be it further

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

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

Received: 05/10/21

#### AUTHOR'S STATEMENT OR PRIORITY

This policy position would create discussion around an important weakness in our country that all patients with employer-sponsored healthcare encounter. As we face discussions with the new administration around the future of healthcare, the AMA needs to have a clear answer to whether tying insurance to employment is a requirement for our support as an organization. There is no better way for the AMA to know how to move forward in this advocacy space than to know what our members think by bringing this to the floor of the HOD before a national political fight around healthcare which many members of the Biden administration and congress incorporated into their platforms.

#### **References:**

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

#### **RELEVANT AMA POLICY**

##### **The Future of Employer-Sponsored Insurance H-165.829**

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

Citation: CMS Rep. 6, I-14

##### **Trends in Employer-Sponsored Health Insurance H-165.843**

Our AMA encourages employers to:

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

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

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108  
(JUN-21)

Introduced by: Resident and Fellow Section

Subject: Implant-Associated Anaplastic Large Cell Lymphoma

Referred to: Reference Committee A

Whereas, In 2016, the World Health Organization provisionally classified breast implant-associated anaplastic large cell lymphoma (BIA-ALCL) as a T-cell lymphoma<sup>1</sup>; and

Whereas, Policies concerning breast cancer treatment do not encompass BIA-ALCL given that this cancer is a lymphoma; and

Whereas, The 2019 National Comprehensive Cancer Care Network consensus guidelines state clearly that, "Essential to the treatment of BIA-ALCL is timely diagnosis and complete surgical excision."<sup>2</sup>; and

Whereas, Patients with BIA-ALCL suffer delays in care as they fight with their insurance companies to cover surgery to remove the cancer and their breast implants, as the insurance company may initially classify the surgery as cosmetic and not cover it;<sup>3</sup> therefore be it

**RESOLVED**, That our American Medical Association support appropriate coverage of cancer diagnosis, treating surgery and other systemic treatment options for implant-associated anaplastic large cell lymphoma. (New HOD Policy)

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

Received: 05/10/21

### AUTHOR'S STATEMENT OR PRIORITY

This policy will help bring the spotlight on a disease often overlooked by insurance companies making it harder for this population of patients to cover the costs of their care.

1. Steven H. Swerdlow, Elias Campo, Stefano A. Pileri, Nancy Lee Harris, Harald Stein, Reiner Siebert, Ranjana Advani, Michele Ghielmini, Gilles A. Salles, Andrew D. Zelenetz and Elaine S. Jaffe "The 2016 revision of the World Health Organization classification of lymphoid neoplasms, section on Mature T-cell lymphomas and NK - lymphomas." Blood. 2016, 127:2375-2390.

2. Mark W Clemens, MD, FACS, Eric D Jacobsen, MD, Steven M Horwitz, MD "2019 NCCN Consensus Guidelines on the Diagnosis and Treatment of Breast Implant-Associated Anaplastic Large Cell Lymphoma (BIA-ALCL)." Aesthetic Surgery Journal. 2019, 39 (Supplement 1):S3-S13.

3. Denise Grady. A shocking diagnosis: breast implants 'gave me cancer.' The New York Times. 2017 May 14. Available at: <https://www.nytimes.com/2017/05/14/health/breast-implants-cancer.html>

### **RELEVANT AMA POLICY** **Breast Implants H-525.984**

Our AMA: (1) supports that women be fully informed about the risks and benefits associated with breast implants and that once fully informed the patient should have the right to choose; and (2) based on current scientific knowledge, supports the continued practice of breast augmentation or reconstruction with implants when indicated.

Citation: CSA Rep. M, I-91Modified: Sunset Report, I-01Reaffirmed: Res. 727, I-02Modified: CSAPH Rep. 1, A-12

# AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109  
(JUN-21)

Introduced by: Illinois

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

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## I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right<sup>1</sup>; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access<sup>2</sup>; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than \$25,000 of annual income having access to internet as opposed to 93.5% of households with over \$50,000 of annual income<sup>3,4</sup>; and

Whereas, One in three families who earn less than \$50,000 annually do not have high-speed home internet<sup>5</sup>; and

## II. Broadband as a social determinant of health

Whereas, The United States Congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications<sup>6</sup>; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream<sup>7,8</sup>; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because "[w]hile factors such as data allowances or pricing may affect consumers' use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area."<sup>7</sup>; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health<sup>9</sup>; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health<sup>10-13</sup>; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being<sup>14</sup>; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic<sup>12,13,15,16</sup>; and

Whereas, Our AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that “optimizing the social determinants of health is an ethical obligation of a civil society”; and

### III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access<sup>17</sup>; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%;  $P=0.01$ ), were less likely to be black (24% versus 34%;  $P<0.01$ ), and had higher median household income (21% versus 32% with income  $< \$50,000$ , 54% versus 49% with income of  $\$50,000$ – $\$100,000$ , 24% versus 19% with income  $\geq \$100,000$ )<sup>18</sup>; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country<sup>19</sup>; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care<sup>20,21</sup>; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources<sup>14,20</sup>; and

### IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning<sup>5</sup>; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic<sup>20,22</sup>; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones<sup>22</sup>; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic<sup>23</sup>; and



1 V. COVID-19 pandemic has exacerbated disparities in internet access

2  
3 Whereas, The United States internet usage has increased 34% between January 2020 and  
4 April 2020 during the COVID-19 pandemic<sup>24</sup>; and

5  
6 Whereas, The FCC Lifeline program provides a choice between either discounted mobile  
7 internet access or discounted broadband access for qualifying low-income recipients<sup>25</sup>; and

8  
9 Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile  
10 broadband services are full substitutes in all cases<sup>7</sup>; and

11  
12 Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for  
13 approximately 15 of the estimated 21.3 million people that lack home internet access<sup>26,27</sup>; and

14  
15 Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized  
16 program for which there is a significant backlog in applications and delay in application  
17 approvals, as well as a lack of an automatic application or automatic appeal process<sup>25</sup>; and

18  
19 Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still  
20 only allows 1 stream of 25mbps per household, limiting access for households with more than  
21 one person working/attending school from home<sup>28</sup>; and

22  
23 Whereas, In the 2020 legislative session as of October 2020, 43 states have considered  
24 legislation on broadband access<sup>29</sup>; and

25  
26 Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in  
27 light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered  
28 government subsidized free broadband service for COVID impacted people<sup>30,31</sup>; and

29  
30 Whereas, It is probable that a stimulus package be proposed in the near future, which will likely  
31 include internet access as part of this package, between 2020 elections and the next meeting of  
32 the AMA House of Delegates<sup>32,33</sup>; and

33  
34 Whereas, AMA policy H-478.980 Increasing Access to Broadband Internet to Reduce Health  
35 Disparities sets precedent for the AMA advocating for internet access, and acknowledges the  
36 health benefit of internet access, but only asks for expansion of internet infrastructure in  
37 rural/underserved communities to provide “connectivity” rather than pushing for universal  
38 access to internet for those with significant limitations in access or financial constraints; and

39  
40 Whereas, Universal coverage of home internet access would increase accessibility to this tool  
41 that is critical for patient health and public well-being; therefore be it

42  
43 RESOLVED, That our American Medical Association recognize that internet access is a social  
44 determinant of health (New HOD Policy); and be it further

45  
46 RESOLVED, That our AMA support universal access to broadband home internet (New HOD  
47 Policy); and be it further

- 1 RESOLVED, That our AMA advocate for legislation to reduce barriers and increase access to  
 2 broadband internet, including federal, state, and local funding of broadband internet to reduce  
 3 price, the establishment of automatic applications for recipients of Medicaid or other assistance  
 4 programs, and increasing the number of devices and streams covered per household. (Directive  
 5 to Take Action)

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

Received: 05/11/21

#### AUTHOR'S STATEMENT OF PRIORITY

This is an urgent issue.

The COVID-19 pandemic created a fast and unexpected growth in telemedicine. This surge in use demonstrates that virtual visits expand access to care, especially for underserved patient populations. However, it is apparent that there can also be digital disparity when patients do not have access to consistent and accessible internet access. If our health care delivery system continues to rely on digital platforms we must ensure that our patients using these tools have the necessary access to universal and consistent internet availability.

#### **References:**

1. Human Rights Council. (2016). The promotion, protection and enjoyment of human rights on the Internet. *In: United Nations General Assembly Human Rights Council 32nd Session, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development: A/HRC/32/L20.*
2. Federal Communications Commission. (2019). 2019 Broadband Deployment Report. *Broadband definition equates to, 25.*
3. Carare, O., McGovern, C., Noriega, R., & Schwarz, J. (2015). The willingness to pay for broadband of non-adopters in the US: Estimates from a multi-state survey. *Information Economics and Policy, 30*, 19-35.
4. Mathew, T. (2017, September 18). Broadband Is Largely Inaccessible to Those Who Need it Most. Retrieved October 28, 2020, from <https://www.bloomberg.com/news/articles/2017-09-18/broadband-is-most-inaccessible-to-poor-rural-areas>
5. Alliance for Excellent Education. (2020). Students of Color Caught in the Homework Gap. Retrieved October 28, 2020, from <https://futureready.org/homework-gap/>
6. Second Broadband Progress Report. (2012, April 03). Retrieved October 28, 2020, from <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/second-broadband-progress-report>
7. Taglang, K. (2020, May 08). Did the FCC Get the Right Answers on Broadband Deployment? Retrieved October 28, 2020, from <https://www.benton.org/blog/did-fcc-get-right-answers-broadband-deployment>
8. 2020 Broadband Deployment Report. (2020, June 09). Retrieved October 28, 2020, from <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2020-broadband-deployment-report>
9. Social Determinants of Health. (2020, August 10). Retrieved October 28, 2020, from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
10. Rizga, K. (2020, September 09). What Teachers Need to Make Remote Schooling Work. Retrieved October 28, 2020, from <https://www.theatlantic.com/education/archive/2020/04/how-remote-school-can-work-covid-19-pandemic/609895/>
11. Smith, A. (2020, May 30). Searching for Jobs in the Internet Era. Retrieved October 28, 2020, from <https://www.pewresearch.org/internet/2015/11/19/searching-for-work-in-the-digital-era/>
12. Kruger, L. G., Gilroy, A. A., & Resources, Science, and Industry Division. (2003, August). Broadband internet access and the digital divide: Federal assistance programs. Congressional Research Service, the Library of Congress.
13. Council of Economic Advisers Issues Brief. (2016, March). The Digital Divide and Economic Benefits of Broadband Access. Retrieved October 28, 2020, from [https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160308\\_broadband\\_cea\\_issue\\_brief.pdf](https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160308_broadband_cea_issue_brief.pdf)
14. Centers for Disease Control and Prevention. (2020, June 10). Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic. Retrieved October 28, 2020, from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html>
15. Smith, A. (2020, May 30). Job seekers find internet essential for employment search. Retrieved October 28, 2020, from <https://www.pewresearch.org/internet/2015/11/19/1-the-internet-and-job-seeking/>
16. Smith, A. (2020, May 30). Home Broadband 2010. Retrieved October 28, 2020, from <https://www.pewresearch.org/internet/2010/08/11/home-broadband-2010/>
17. Hirko, K. A., Kerver, J. M., Ford, S., Szafranski, C., Beckett, J., Kitchen, C., & Wendling, A. L. (2020). Telehealth in response to the COVID-19 pandemic: Implications for rural health disparities. *Journal of the American Medical Informatics Association.*
18. Eberly, L. A., Khatana, S. A. M., Nathan, A. S., Snider, C., Julien, H. M., Deleener, M. E., & Adusumalli, S. (2020). Telemedicine Outpatient Cardiovascular Care during the COVID-19 Pandemic: Bridging or Opening the Digital Divide?. *Circulation.*
19. Davidson, C. M., & Santorelli, M. J. (2009). The impact of broadband on telemedicine: A study commissioned by the US Chamber of Commerce.

20. Hoffman, D. A. (2020). Increasing access to care: telehealth during COVID-19. *Journal of Law and the Biosciences*, 7(1), Isaa043.
21. Freyer, F. (2015, October 05). It costs you \$43 every time you wait for the doctor - The Boston Globe. Retrieved October 28, 2020, from <https://www.bostonglobe.com/metro/2015/10/05/study-puts-dollar-value-time-spent-waiting-for-doctor/lf7KB4aU9mkY5qK8CqDYUO/story.html>
22. Back to School: A Look at the Internet Access Gap. (2020, August 6). Retrieved October 28, 2020, from <https://research.newamericaneconomy.org/report/internet-access-covid-19/>
23. Balingit, M. (2020, August 17). 'A national crisis': As coronavirus forces many schools online this fall, millions of disconnected students are being left behind. Retrieved October 28, 2020, from [https://www.washingtonpost.com/education/a-national-crisis-as-coronavirus-forces-many-schools-online-this-fall-millions-of-disconnected-students-are-being-left-behind/2020/08/16/458b04e6-d7f8-11ea-9c3b-dfc394c03988\\_story.html](https://www.washingtonpost.com/education/a-national-crisis-as-coronavirus-forces-many-schools-online-this-fall-millions-of-disconnected-students-are-being-left-behind/2020/08/16/458b04e6-d7f8-11ea-9c3b-dfc394c03988_story.html)
24. Branscombe, M. (2020, April 15). The Network Impact of the Global COVID-19 Pandemic. Retrieved October 28, 2020, from <https://thenewstack.io/the-network-impact-of-the-global-covid-19-pandemic/>
25. Lifeline Program for Low-Income Consumers. (2020, October 19). Retrieved October 28, 2020, from <https://www.fcc.gov/general/lifeline-program-low-income-consumers>
26. SHADAC Staff. (2020, March 31). Internet Access Measures the Impact of the Digital Divide and COVID-19. Retrieved October 28, 2020, from <https://www.shadac.org/news/internet-access-measures-impact-digital-divide-and-covid-19>
27. Mikulic, M. (2020, May 4). Medicaid - Statistics & Facts. Retrieved October 28, 2020, from <https://www.statista.com/topics/1091/medicaid/>
28. Federal Communications Commission. (2019, October 07). Lifeline Minimum Service Standards and Indexed Budget Amount Announced. Retrieved October 28, 2020, from <https://www.fcc.gov/document/lifeline-minimum-service-standards-and-indexed-budget-amount-announced>
29. Morton, H. (2020, August 10). Broadband 2020 Legislation. Retrieved October 28, 2020, from <https://www.ncsl.org/research/telecommunications-and-information-technology/broadband-2020-legislation.aspx>
30. Congressman Marc Veasey (TX-33) To Introduce Legislation to Bolster Broadband Access for Low Income, Minority Groups During Pandemic. (2020, May 13). Retrieved October 28, 2020, from <https://veasey.house.gov/media-center/press-releases/congressman-marc-veasey-tx-33-to-introduce-legislation-to-bolster>
31. Falcon, E., & Trendacosta, K. (2020, May 14). House Legislation Guarantees Internet Access for Those Affected by COVID-19. Retrieved October 28, 2020, from <https://www.eff.org/deeplinks/2020/05/house-legislation-guarantees-internet-access-those-affected-covid-19>
32. The Biden Plan to Build a Modern, Sustainable Infrastructure and an Equitable Clean Energy Future. (2020, August 05). Retrieved October 28, 2020, from <https://joebiden.com/clean-energy/>
33. Menas, A. (2020, August 21). Joe Biden's 3 big ideas to close the digital divide. Retrieved October 28, 2020, from <https://educationvotes.nea.org/2020/08/23/joe-bidens-3-big-ideas-to-close-the-digital-divide/>

## RELEVANT AMA POLICY

### Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Citation: Res. 208, I-18

### Health, In All Its Dimensions, Is a Basic Right H-65.960

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society. Citation: Res. 021, A-19

### Racial and Ethnic Disparities in Health Care H-350.974

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their

own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decisionmaking process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep.1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

#### **Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896**

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

Citation: BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

#### **National Health Information Technology D-478.995**

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and

establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08;

Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep.

17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT

Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res.

721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended:

BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208,

A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16;

Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17;

Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18;

Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110  
(JUN-21)

Introduced by: Georgia

Subject: Healthcare Marketplace Plan Selection

Referred to: Reference Committee A

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1 Whereas, Insurance plans purchased on the Healthcare Marketplace often have very narrow  
2 networks; and  
3

4 Whereas, These narrow networks often require patients to only see physicians within the county  
5 in which the plan was purchased; and  
6

7 Whereas, Patients are required to purchase a plan based on the county in which they reside;  
8 and  
9

10 Whereas, Some patients must pay for care in cash outside their plan to keep their doctor of  
11 choice making their comprehensive plan more of an expensive catastrophic plan; and  
12

13 Whereas, This limits patient choice by preventing patients from choosing their plan based on  
14 access to their physician of choice; therefore be it  
15

16 RESOLVED, That our American Medical Association advocate for patients to have expanded  
17 plan options on the Healthcare Marketplace beyond the current options based solely on the zip  
18 code of their primary residence or where their physician practices, including the interstate  
19 portability of plans. (Directive to Take Action)

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

Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

The current Healthcare Marketplace plans often have very narrow networks affecting most physicians and their patients by limiting their patients' ability to choose a plan that includes their preferred physician. With patients currently required to purchase a plan based on the county in which they reside, this can result in the patients being unable to see their physician of choice if that physician does not practice in that county even if that physician practices in close proximity to the patient's residence. Ensuring that patients can utilize the physician of their choice is important in maintaining healthy patients who receive the right care at the right time. The AMA has no current policy regarding the expansion of plans that patients can choose from in the marketplace and the AMA is in the best position to advocate for these changes, especially for the many states that currently utilize the federally-run marketplaces. The public health is greatly improved where patients are able to access the physicians they are most comfortable with and this can also improve public health measures such as vaccination rates by improving patient confidence in the care they receive. Finally, with open enrollment typically occurring in late fall, any delay in adopting this policy would delay any possibility of implementing these changes to the marketplace until at least 2022, if not later.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111  
(JUN-21)

Introduced by: Senior Physicians Section

Subject: Towards Prevention of Hearing-Loss Associated Cognitive Impairment

Referred to: Reference Committee A

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1 Whereas, Our AMA holds out as a primary objective “to promote the art and science of medicine  
2 and the betterment of public health;” and  
3

4 Whereas, Our AMA has adopted policy in support of health promotion and preventive care,  
5 community preventive services, healthy lifestyles, coverage for preventive care and  
6 immunizations, health information and education, training in the principles of population-based  
7 medicine, values-based decision-making in the healthcare system, and encouragement of new  
8 advances in science and medicine via strong financial and policy support for all aspects of  
9 biomedical science and research;<sup>1-8</sup> and  
10

11 Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation<sup>9</sup> as  
12 well as for dementia treatment;<sup>10</sup> and  
13

14 Whereas, There is mounting evidence that there is a strong link between hearing impairment in  
15 middle and later life and the development of cognitive, as well as social impairments and falls,  
16 although its specific causality in relation to later cognitive loss has not yet conclusively been  
17 established;<sup>11-31</sup> and  
18

19 Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of  
20 2017, amplified by the 2020 follow-up report<sup>13-15</sup> concluded that age-related hearing loss (ARHL)  
21 may account for nine percent of all cases of dementia, making this the single largest potentially  
22 modifiable risk factor for that condition, beginning in mid-life; and  
23

24 Whereas, Compared to individuals with normal hearing, those individuals with a mild, moderate,  
25 and severe hearing impairment, respectively, have been shown to have a 2-, 3-, and 5-fold  
26 increased risk of incident all-cause dementia over 10 years of follow-up in one study;<sup>29</sup> and  
27

28 Whereas, Based on prior and pilot studies,<sup>30-31</sup> the causative link between hearing impairment in  
29 middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE<sup>32</sup>  
30 and other clinical trials now in progress; and  
31

32 Whereas, The return on investment for hearing remediation, especially but not exclusively in  
33 mid-life, will be substantial and time-sensitive insofar as it may ameliorate (by delay in onset or  
34 even prevention of cognitive decline) far more costly care for those with cognitive decline (direct  
35 and indirect costs). Delaying the onset of Alzheimer’s Disease by even one year has significant  
36 fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer’s disease  
37 would save \$113 Billion by 2030. This underscores the urgency of current action to reduce the  
38 cost of healthcare (including, and perhaps especially, to Medicare) while improving other  
39 measures influencing the quality of life;<sup>33-40</sup> and



Whereas, A generally held calculation for the yearly cost of caring for those with dementia exceeds \$307 billion as of 2010, and is expected to rise to \$624 billion in 2030 and \$1.5 trillion by 2050. The current yearly market cost of hearing aids in the US is estimated at \$9 billion. This suggests that, with a 9% increase in risk of development of cognitive loss later in life due to unaddressed hearing loss,<sup>13,15</sup> remediating even this single important element linked to cognitive decline would be cost-effective immediately, and will be increasingly so in the future;<sup>39, 40</sup> and

Whereas, The issue of hearing impairment is also a matter of health and social equity, with serious immediate and long-term consequences resulting from neglect of remediation. Unaddressed hearing loss reduces earnings potential and increases disability during gainful years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of hearing amplification and other forms of remediation is significant enough (even with over-the-counter products, which while possibly helpful do not come with professional guidance) to defer purchase and implementation by an indigent population;<sup>46</sup> and

Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention, as well as timely treatment of cognitive impairment and dementia is highly desirable for public health, for humane as well as financial reasons; and

Whereas, Congress has shown initial interest in expanding coverage for hearing remediation in the most recent bill HR 4618, "Medicare Hearing Act of 2019." The relation of hearing loss to cognitive loss was acknowledged, and the bill passed out of Committee with a favorable recommendation. The bill ultimately failed, but is likely to be refiled in the current Congressional session, affording a strategic opportunity for our AMA to more effectively advocate now for expanding coverage to include coverage of preventive strategies in middle age, promoting that as a way to mitigate future Medicare costs;<sup>41-43</sup> and

Whereas, Some developed countries such as Brazil have launched national efforts to bring hearing remediation to the masses<sup>45</sup> as a means of reducing later cognitive decline, suggesting that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and

Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing remediation are complex, and require physicians to be current, informed, and involved in the discussion with patients;<sup>44,47-48</sup> and

Whereas, a number of groups have a stake in promoting hearing remediation, including professional and citizen organizations and Federal Agencies, such as the Agency for Health Research and Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD); therefore be it

RESOLVED, That our American Medical Association promote awareness of hearing impairment as a potential contributor to the development of cognitive impairment in later life, to physicians as well as to the public (Directive to Take Action); and be it further

RESOLVED, That our AMA promote, and encourage other stakeholders, including public, private, and professional organizations and relevant governmental agencies, to promote, the conduct and acceleration of research into specific patterns and degrees of hearing loss to determine those most linked to cognitive impairment and amenable to correction (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate for increasing hearing screening and avenues for  
2 coverage for effective hearing loss remediation beginning in mid-life or whenever detected,  
3 including third party insurance coverage, especially when such loss is shown conclusively to  
4 contribute significantly to the development of, or to magnify the functional deficits of cognitive  
5 impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take  
6 Action)

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

Received: 05/11/21

#### AUTHOR'S STATEMENT OF PRIORITY

Unaddressed hearing loss has a major effect on many physicians and patients, especially seniors. Additionally, unaddressed hearing loss has been shown to have a disproportionate impact on underrepresented or disadvantaged populations, an important health care disparity issue for our AMA. Increased hearing screening and remediation is a public health issue that is very consistent with our mission and strategic plan. It is reliably estimated that at 9%, unaddressed age related hearing loss is the single most remediable cause of cognitive decline. Delaying the onset of cognitive decline by even one year has predictably VERY significant societal and fiscal benefits, and thus there is a remarkably negative societal impact for every year that this issue is not effectively addressed.

AMA has significant related policy, but important gaps exist, including education about the connection between hearing loss and cognitive decline, emphasizing the importance of hearing screening at MIDlife, in order to promote remediation, and thereby help to prevent cognitive decline. A few commercial insurers have begun to acknowledge the need. Our AMA must update policy and promote this trend. The proposed action is likely to have meaningful impact but requires new policy or modification of existing policy to implement. There is pending Congressional action that makes this a timely political issue. An AMA resolution is one of the most appropriate avenues to address the issue.

#### **REFERENCES**

1. E-8.11 Code of Medical Ethics, Health Promotion and Preventive Care
2. H-35.967 Treatment of Persons with Hearing Disorders
3. H-425.982 Training in the Principles of Population-Based Medicine
4. H-170.986 Health Information and Education
5. H-425.972 Healthy Lifestyles
6. D-425.996 Implementing the Guidelines to Community Preventive Services
7. H-460.943 Potential Impact of Health System Reform Legislative Reform Proposals on Biomedical Research and Clinical Investigation
8. H-450.938 Value-Based Decision-Making in the Health Care System
9. H-185.929 Hearing Aid Coverage
10. D-345.985 Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities  
Loughrey, D.G., Kelley, M.E., et al. (2018). Association of Age-Related Hearing Loss With Cognitive Function, Cognitive Impairment, and Dementia A Systematic Review and Meta-analysis; *AMA Otolaryngol Head Neck Surg.* 144(2):115-126. doi:10.1001/jamaoto.2017.2513. Published online December 7, 2017. Corrected on January 18, 2018.
11. Tingley, K. (Feb. 20, 2020). Can Hearing Aids Help Prevent Dementia? NY Times Magazine Section. Retrieved from [News: Can Hearing Aids Help Prevent... \(The New York Times\) - Behind the headlines - NLM \(nih.gov\)](#)
12. Livingston, D.A., Sommerlad A., et al. (Dec. 16, 2017). Dementia prevention, intervention, and care. *The Lancet*, 390, No. 10113; 2673-2734, doi: 10.1016/S0140-6736(17)31363-6
14. Frankish, H., Horton, R. (July 19, 2017). Prevention and management of dementia: a priority for public health. *The Lancet*, 390, No. 10113. doi:10.1016/S01406736(17)31756-7
15. Livingston, G., Huntley, J., et al. (July 30, 2020) Dementia prevention, intervention, and care: 2020 report of the Lancet Commission. *The Lancet*, 396, No. 10248. doi: [10.1016/S0140-6736\(20\)30367-6](#)

16. Lin, F. & Albert, M. (August 2014). Hearing Loss and Dementia – Who is Listening? *Aging Ment Health*. 18(6): 671–673. doi: 10.1080/13607863.2014.915924
17. Lin, F., Yaffe, K., et al. (Feb 25, 2013). Hearing loss and cognitive decline in older adults. *JAMA Intern Med*. 173(4):293-9. doi:10.1001/jamainternmed.2013.1868
18. Roberts, K.L., Allen, H.A. (March 1, 2016). Perception and Cognition in the Ageing Brain: A Brief Review of the Short- and Long-Term Links between Perceptual and Cognitive Decline, *Aging Neurosci*. doi: 10.3389/fnagi.2016.00039
19. Hearing Loss and Dementia: How Are They Related? Johns Hopkins Cochlear Center For Hearing and Public Health.
20. Dong, S.H., Park, J.M., et al. (2019). The Relationship between Age-Related Hearing Loss and Cognitive Disorder. *ORL* 81:265-273. doi: 10.1159/000500989
21. Slade, K., Plack, C., et al. (October 1, 2020). Review|: The Effects of Age-Related Hearing Loss on the Brain and Cognitive Function. *Trends in Neuroscience*. 43, Issue 10, 810821. doi:10.1016/j.tins.2020.07.005
22. Uchida, Y., Sugiura, S., et al. (February 2019). Age-related hearing loss and cognitive decline—The potential mechanisms linking the two. *Auris Nasus Larynx*, Volume 46, Issue 1, pages 1-9. doi.org/10.1016/j.anl.2018.08.010
23. Wayne, R. & Johnsrude, I. (September 2015). A review of causal mechanisms underlying the link between age-related hearing loss and cognitive decline. *Ageing Research Reviews*, 23, Part B, 154-166. doi.org/10.1016/j.arr.2015.06.002
24. Fortunato, S. & Forli, F. (June 2016). A review of new insights on the association between hearing loss and cognitive decline in ageing. *Acta Otorhinolaryngol Ital*, 36(3): 155–166. doi: 10.14639/0392-100X-993
25. Glick, H.A., Sharma, A. (February 2020). Cortical Neuroplasticity and Cognitive Function in Early-Stage, Mild-Moderate Hearing Loss: Evidence of Neurocognitive Benefit From Hearing Aid Use. *Neurosci*. doi: 10.3389/fnins.2020.00093
26. Golub, J., Brickman, A., et al. (November 14, 2019). Association of Subclinical Hearing Loss With Cognitive Performance. *JAMA Otolaryngol Head Neck Surg*, 2020;146(1):57-67. doi:10.1001/jamaoto.2019.3375
27. Dawes, P., Emsley, R., et al. Hearing Loss and Cognition: The Role of Hearing Aids, Social Isolation and Depression. *PLoS ONE* 10(3): e0119616. doi:10.1371/journal.pone.0119616
28. Mahmoudi, E., Basu, T., et al. (September 2019). Clinical Investigation, Can Hearing Aids Delay Time to Diagnosis of Dementia, Depression, or Falls in Older Adults? *J Am Geriatr Soc*, 67:2362–2369. doi.org/10.1111/jgs.16109
29. Lin, F.R., Metter, E.J., et al. (2011). Hearing loss and incident dementia. *Arch Neurol*, 68(2):214–220. doi:10.1001/archneurol.2010.362.
30. Deal, et al. (2017). Hearing Impairment and Incident Dementia and Cognitive Decline in Older Adults: The Health ABC Study, *J Gerontol A Biol Sci Med Sci*, Vol. 72, No. 5, 703–709. doi:10.1093/gerona/glw069
31. Deal, J.A., Albert, M.S., et al. (June 2017). A randomized feasibility pilot trial of hearing treatment for reducing cognitive decline: Results from the Aging and Cognitive Health Evaluation in Elders Pilot Study, Alzheimer's & Dementia: Translational Research & Clinical Interventions.3, 410-415, accessed 4/2/21 at <http://dx.doi.org/10.1016/j.trci.2017.06.003>
32. Aging and Cognitive Health Evaluation in Elders (ACHIEVE). Sponsor: Johns Hopkins Bloomberg School of Public Health, Collaborators: University of North Carolina, University of South Florida, University of Pittsburgh, University of Mississippi Medical Center, Wake Forest University, University of Minnesota. <https://clinicaltrials.gov/ct2/show/NCT03243422>
33. Quick Statistics About Hearing U.S. Department of Health & Human Services National Institutes of Health
34. Hearing Aids Market by Product (Receiver In The Ear, Behind The Ear, In The Canal Hearing Aids, Cochlear Implant, BAHAs implant), Types of Hearing Loss (Sensorineural, Conductive Hearing loss) & Patient (Adult, Pediatric) - Forecast to 2022 [186 Page Report].
35. Emmanuel A., Varun N., et al. (May 2, 2019). US Hearing Aid Market Wonder Report - US Hearing Aid Market - Market Growth By Channel, ask wonder.com.
36. Ruberg, K. Untreated Disabling Hearing Loss Costs Billions – in the US and the Rest of the World, Advocacy & Research May 2019 Hearing Review.
37. Shield, B. Using hearing aids contributes to better health, higher income, and better family and social life—and has a huge positive effect on Gross National Product. Hearing Loss. A report for Hear-It AISBL.
38. Reed, N. S., Altan, A., et al. (January 1, 2019). Trends in Health Care Costs and Utilization Associated With Untreated Hearing Loss Over 10 Years. *JAMA Otolaryngol Head Neck Surg*, 145(1):27-34. doi: 10.1001/jamaoto.2018.2875
39. Zissimopoulos, J., Crimmins, E., et al. (November 2014). The Value of Delaying Alzheimer's Disease Onset. *Forum Health Econ Policy*. 18(1): 25–39. doi: 10.1515/fhep2014-0013
40. Hedt, S. (June 11, 2019). Research Spotlight: Alzheimer's Disease. USC School of Pharmacy
41. Press Release (October 18, 2019). McBath-Dingell Legislation to Improve Seniors' Access to Hearing Aids Under Medicare Passes House Committee. <https://mcbath.house.gov/2019/10/mcbath-dingell-legislation-to-improve-seniors-access-to-hearing-aids-under-medicare-passes-house-committee>
42. H.R.116-326, Medicare Hearing Act of 2019, Committee Report (2019-2020).
43. Richtman, M. (September 25, 2019) Letter Supporting Medicare Dental, Vision, and Hearing Benefit Act of 2019. (President and CEO, National Committee to Preserve Social Security and Medicare)
44. H-35.967 Treatment of persons with Hearing Loss. The AMA believes that physicians should remain the primary entry point for care of patients with hearing impairment and continue to supervise and treat hearing, speech, and equilibrium disorders.
45. Lopes, P.T., Bento, R.F. (December 8, 2020). Ear Parade: A Call for Preventive Actions to Strengthen the Healthcare System against Hearing Loss, *International Archives of Otorhinolaryngology*. doi: 10.1055/s-0040-1712480
46. Stickel, A. & Tarraf, W., et al. (December 17, 2020). Hearing Sensitivity, Cardiovascular Risk, and Neurocognitive Function: The Hispanic Community Health Study/Study of Latinos (HCHS/SOL). *JAMA Otolaryngol Head Neck Surg*. doi:10.1001/jamaoto.2020.4835
47. Deal, J & Lin, F. (2021). USPSTF Recommendations for Hearing Loss Screening in Asymptomatic Older Adults – A Case of Missing Evidence and Missing Treatment Options. *JAMA Network Open*, 2021;4(3). doi:10.1001/jamanetworkopen.2021.0274
48. Sternasty, Sumitrajit, D. (March 25, 2021). Barriers to Hearing Aid Adoption Run Deep Than the Price Tag. *JAMA Otolaryngology-Head & Neck Surgery*. doi:10.1001/jamaoto.2021.0172

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112  
(JUN-21)

Introduced by: Young Physicians Section

Subject: Fertility Preservation Benefits for Active-Duty Military Personnel

Referred to: Reference Committee A

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1 Whereas, According to Pentagon figures, over 200,000 women are in the active-duty U.S.  
2 military, including 74,000 in the Army, 53,000 in the Navy, 62,000 in the Air Force, and 14,000 in  
3 the Marine Corps in 2011;<sup>1</sup> and  
4

5 Whereas, According to the U.S. Department of Veterans Affairs (VA), there were over 2 million  
6 women veterans as of September 2015;<sup>2</sup> and  
7

8 Whereas, According to the 2012 Committee Opinion on “Health care for women in the military  
9 and women Veterans” from the American College of Obstetricians and Gynecologists (ACOG),  
10 “military service is associated with unique risks to women’s reproductive health ....  
11 Obstetrician—gynecologists should be aware of high prevalence problems (e.g., posttraumatic  
12 stress disorder, intimate partner violence, and military sexual trauma) that can threaten the  
13 health and well-being of these women;”<sup>3</sup> and  
14

15 Whereas, Both men and women in our U.S. military can suffer from infertility, sometimes directly  
16 as a result of blast traumas and spinal cord injuries;<sup>4</sup> and  
17

18 Whereas, The U.S. Department of Defense (DOD) currently covers the cost of in vitro  
19 fertilization (IVF) and infertility services for certain injured active duty personnel;<sup>5</sup> and  
20

21 Whereas, Under current Tricare policy, active-duty military personnel and their dependents have  
22 some limited coverage for infertility care and oocyte cryopreservation services at six specific  
23 military treatment facilities: Walter Reed National Military Medical Center in Bethesda MD;  
24 Womack Army Medical Center at Fort Bragg in Fayetteville NC; San Antonio Military Medical  
25 Center in San Antonio TX; San Diego Naval Medical Center in San Diego CA; Tripler Army  
26 Medical Center in Honolulu HI; Wright-Patterson Air Force Base Medical Center in Dayton OH;  
27 and Madigan Army Medical Center in Seattle-Tacoma WA;<sup>6, 7</sup> and  
28

29 Whereas, This critical medical service is not fully available to active duty members of the military  
30 and those working with the DOD; and  
31

32 Whereas, AMA Policy H-150.984 (3)(4) “Infertility Benefits for Veterans” states that:  
33 3)“Our AMA encourages the Department of Defense (DOD) to offer service members fertility  
34 counseling and information on relevant health care benefits through TRICARE and the VA at  
35 pre-deployment and during the medical discharge process. 4) Our AMA supports efforts by the  
36 DOD and VA to offer service members comprehensive health care services to preserve their  
37 ability to conceive a child and provide treatment within the standard of care to address infertility  
38 due to service-related injuries”;<sup>6</sup> and

Whereas, Fertility preservation for medical indications (such as prior to cancer treatment, organ transplants, or treatment for rheumatologic diseases) are covered under the VA but not covered by the DOD; and

Whereas, AMA Policy H-185.990 "Infertility and Fertility Preservation Coverage," states that: "Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician;"<sup>7</sup> and

Whereas, AMA Policy H-185.922 "Right for Gamete Preservation Therapies" states that: "Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility;"<sup>8</sup> therefore be it

RESOLVED, That our American Medical Association work with interested organizations to encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm, oocytes, or embryos) for medical indications, for active-duty military personnel and other individuals covered by TRICARE (Directive to Take Action); and be it further

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation prior to deployment for active-duty military personnel (Directive to Take Action); and be it further

RESOLVED, That our AMA report back on this issue at the 2022 Annual Meeting of the AMA House of Delegates. (Directive to Take Action)

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

Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution asks for the AMA to work with relevant specialty societies to ensure TRICARE coverage for fertility preservation. We feel this resolution is important, especially as our brave service members deserve the best of care. However, this impacts a small number of patients and could potentially be addressed by specialty societies. The AMA also has policy on fertility preservation insurance coverage, so could potentially tackle this in DC without this specific resolution if an opportunity presented. While the current Congress is likely more receptive to reproductive health than the ones in the prior administration, we do not feel this is an urgent issue. Therefore, we feel this is a low priority resolution.

#### References:

1. "By the Numbers: Women in the U.S. Military," by CNN.com on 1/24/13, accessed at: <http://www.cnn.com/2013/01/24/us/military-women-glance/> on 10/25/15
2. Department of Veterans Affairs, Office of Public Affairs, Fact Sheet, accessed at: <http://www.va.gov/WOMENVET/docs/WomenVeteransPopulationFactSheet.pdf> on 10/25/15
3. "Health care for women in the military and women Veterans. Committee Opinion No 547. American College of Obstetricians and Gynecologists. *Obstet Gynecol* 2012; 120:1538-42.
4. "Helping Wounded Vets Start Families" by Rebecca Sokol (ASRM President) in the Baltimore Sun on 10/18/15, accessed at: <http://www.baltimoresun.com/news/opinion/oped/bs-ed-veterans-ivf-20151018-story.html> on 10/25/15.
5. "Access to Infertility Care: Challenges and Potential Solutions", by Erin Kramer (ASRM staff), ASRM 10/8/18.
6. AMA policy H-510.984 on "Infertility Benefits for Veterans"
7. AMA policy H-185.990 on "Infertility and Fertility Preservation Insurance Coverage"

8. AMA policy H-185.922 on "Right for Gamete Preservation Therapies"
9. AMA policy H-425.967 on "Disclosure of Risk to Fertility with Gonadotoxic Treatment"

## **RELEVANT AMA POLICY**

### **Infertility and Fertility Preservation Insurance Coverage H-185.990**

1. Our AMA encourages third party payer health insurance carriers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility.
2. Our AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician, and will lobby for appropriate federal legislation requiring payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Citation: (Res. 150, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep. 4, A-08; Appended: Res. 114, A-13; Modified: Res. 809, I-14)

### **Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967**

Our AMA: (1) supports as best practice the disclosure to cancer and other patients of risks to fertility when gonadotoxic treatment is used; and (2) supports ongoing education for providers who counsel patients who may benefit from fertility preservation.

Citation: Res. 512, A-19

### **Right for Gamete Preservation Therapies H-185.922**

Our AMA supports insurance coverage for gamete preservation in any individual for whom a medical diagnosis or treatment modality is expected to result in the loss of fertility.

Citation: Res. 005, A-19

### **Right for Gamete Preservation Therapies H-65.956**

1. Fertility preservation services are recognized by our AMA as an option for the members of the transgender and non-binary community who wish to preserve future fertility through gamete preservation prior to undergoing gender affirming medical or surgical therapies.
2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Citation: Res. 005, A-19

### **Infertility Benefits for Veterans H-510.984**

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.
2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.
3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.
4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.
5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

Citation: CMS Rep. 01, I-16; Appended: Res. 513, A-19

### **Veterans Administration Health System H-510.991**

Our AMA supports approaches that increase the flexibility of the Veterans Health Administration to provide all veterans with improved access to health care services.

Citation: CMS Rep. 8, A-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: CMS Rep. 01, A-19

### **Health Care for Veterans and Their Families D-510.994**

Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

Citation: (BOT Rep. 6, A-08; Reaffirmed: Sub. Res. 709, A-15)

### **Health Care Policy for Veterans H-510.990**

Our AMA encourages the Department of Veterans Affairs to continue to explore alternative mechanisms for providing quality health care coverage for United States Veterans, including an option similar to the Federal Employees Health Benefit Program (FEHBP).

Citation: (Sub. Res. 115, A-00; Reaffirmation I-03; Reaffirmed: CMS Rep. 4, A-13)

### **Ensuring Access to Safe and Quality Care for our Veterans H-510.986**

1. Our AMA encourages all physicians to participate, when needed, in the health care of veterans.
2. Our AMA supports providing full health benefits to eligible United States Veterans to ensure that they can access the Medical care they need outside the Veterans Administration in a timely manner.
3. Our AMA will advocate strongly: a) that the President of the United States take immediate action to provide timely access to health care for eligible veterans utilizing the healthcare sector outside the Veterans Administration until the Veterans Administration can provide health care in a timely fashion; and b) that Congress act rapidly to enact a bipartisan long term solution for timely access to entitled care for eligible veterans.
4. Our AMA recommends that in order to expedite access, state and local medical societies create a registry of doctors offering to see our veterans and that the registry be made available to the veterans in their community and the local Veterans Administration.
5. Our AMA supports access to clinical educational resources for all health care professionals involved in the care of veterans such as those provided by the U.S. Department of Veterans Affairs to their employees with the goal of providing better care for all veterans.
6. Our AMA will strongly advocate that the Veterans Health Administration and Congress develop and implement necessary resources, protocols, and accountability to ensure the Veterans Health Administration recruits, hires and retains physicians and other health care professionals to deliver the safe, effective and high-quality care that our veterans have been promised and are owed.

Citation: Res. 231, A-14; Reaffirmation A-15; Reaffirmed: Sub. Res. 709, A-15; Modified: Res. 820, I-18; Modified: Res. 305, I-19

### **Access to Health Care for Veterans H-510.985**

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care

within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

Citation: Sub. Res. 111, A-15; Reaffirmed: CMS Rep. 06, A-17

### **Supporting Awareness of Stress Disorders in Military Members and Their Families H-510.988**

Our AMA supports efforts to educate physicians and supports treatment and diagnosis of stress disorders in military members, veterans and affected families and continue to focus attention and raise awareness of this condition in partnership with the Department of Defense and the Department of Veterans Affairs.

Citation: Sub. Res. 401, A-10; Reaffirmed in lieu of: Res. 001, I-16



AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113  
(JUN-21)

Introduced by: Medical Student Section

Subject: Support for Universal Internet Access

Referred to: Reference Committee A

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I. Issues of internet access as a human right

Whereas, The United Nations has declared internet access as a human right<sup>1</sup>; and

Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack home internet access<sup>2</sup>; and

Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households that make less than \$25,000 of annual income having access to internet as opposed to 93.5% of households with over \$50,000 of annual income<sup>3,4</sup>; and

Whereas, One in three families who earn less than \$50,000 annually do not have high-speed home internet<sup>5</sup>; and

II. Broadband as a social determinant of health

Whereas, The United States congress defines broadband as a service that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications<sup>6</sup>; and

Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies as broadband at 25mbps upstream and 3mpbs downstream<sup>7,8</sup>; and

Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data allowances, or latency for either fixed or mobile broadband services, because "[w]hile factors such as data allowances or pricing may affect consumers' use of [broadband] or influence decisions concerning the purchase of these services in the first instance, such considerations do not affect the underlying determination of whether [broadband] has been deployed and made available to customers in a given area."<sup>7</sup>; and

Whereas, Healthy People 2020 has identified internet access as a social determinant of health<sup>9</sup>; and

Whereas, Internet access is critical for receiving telehealth services, accessing childhood education, and applying for job opportunities, all of which contribute to health<sup>10-13</sup>; and

Whereas, During the current pandemic, telehealth and virtual education have become necessary to promote health and well-being<sup>14</sup>; and

Whereas, A majority of government applications for programs and benefits which affect health are available mostly or sometimes only online, especially during the COVID pandemic<sup>12,13,15,16</sup>; and

Whereas, The AMA has committed itself to health equity and improving social determinants of health, stating in H-65.960 that “optimizing the social determinants of health is an ethical obligation of a civil society”; and

### III. Broadband use in healthcare delivery

Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the divide between patients with and without internet access<sup>17</sup>; and

Whereas, A study comparing the demographics of patients with completed telemedicine encounters in the current COVID-19 era at a large academic health system found that those with completed telemedicine video visits, when compared to telephone-only visits, were more likely to be male (50% versus 42%;  $P=0.01$ ), were less likely to be black (24% versus 34%;  $P<0.01$ ), and had higher median household income (21% versus 32% with income  $< \$50,000$ , 54% versus 49% with income of  $\$50,000$ – $\$100,000$ , 24% versus 19% with income  $\geq \$100,000$ )<sup>18</sup>; and

Whereas, A study commissioned by the US Chamber of Commerce found broadband has helped to further broaden the scope of healthcare and has led to dramatic cost savings by facilitating the fast and reliable transmission of critical health information, multimedia medical applications, and lifesaving services to many parts of the country<sup>19</sup>; and

Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher show rates, shorter wait times, increased clinical efficiency, and higher convenience – all affecting quality of patient care<sup>20,21</sup>; and

Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment (PPE), and reduce use of hospital beds and other limited resources<sup>14,20</sup>; and

### IV. Broadband use in education

Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system, forcing more than 55 million students to transition to home-based remote learning<sup>5</sup>; and

Whereas, One in five households with school-age children (ages 6-18), including 1.6 million immigrant families, do not have personal broadband internet access at home during the COVID-19 pandemic<sup>20,22</sup>; and

Whereas, There are 4.6 million households with school aged children that access internet at home solely through cell phones, and 1.5 million households with school aged children who have no internet access of any kind at all, including cell phones<sup>22</sup>; and

Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have home internet access sufficient to support online learning during the COVID-19 pandemic<sup>23</sup>; and

### V. COVID-19 pandemic has exacerbated disparities in internet access

Whereas, The United States internet usage has increased 34% between January 2020 and April 2020 during the COVID-19 pandemic<sup>24</sup>; and

1 Whereas, The FCC Lifeline program provides a choice between either discounted mobile  
2 internet access or discounted broadband access for qualifying low-income recipients<sup>25</sup>; and  
3

4 Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile  
5 broadband services are full substitutes in all cases<sup>7</sup>; and  
6

7 Whereas, At least 21% of patients on Medicaid lack home internet access, accounting for  
8 approximately 15 of the estimated 21.3 million people that lack home internet access <sup>26,27</sup>; and  
9

10 Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized  
11 program for which there is a significant backlog in applications and delay in application  
12 approvals, as well as a lack of an automatic application or automatic appeal process<sup>25</sup>; and  
13

14 Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still  
15 only allows 1 stream of 25mbps per household, limiting access for households with more than  
16 one person working/attending school from home<sup>28</sup>; and  
17

18 Whereas, In the 2020 legislative session as of October 2020, 43 states have considered  
19 legislation on broadband access<sup>29</sup>; and  
20

21 Whereas, In 2020, multiple failed legislative efforts supported access to broadband internet in  
22 light of COVID pandemic, including the Emergency Broadband Benefit Program, which offered  
23 government subsidized free broadband service for COVID impacted people<sup>30,31</sup>; and  
24

25 Whereas, It is probable that a stimulus package be proposed in the near future, which will likely  
26 include internet access as part of this package, between 2020 elections and the next meeting of  
27 the AMA House of Delegates<sup>32,33</sup>; and  
28

29 Whereas, AMA policy H-478.980, "Increasing Access to Broadband Internet to Reduce Health  
30 Disparities," sets precedent for the AMA advocating for internet access, and acknowledges the  
31 health benefit of internet access, but only asks for expansion of internet infrastructure in  
32 rural/underserved communities to provide "connectivity" rather than pushing for universal  
33 access to internet for those with significant limitations in access or financial constraints; and  
34

35 Whereas, Universal coverage of home internet access would increase accessibility to this tool  
36 that is critical for patient health; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-478.980, "Increasing  
2 Access to Broadband Internet to Reduce Health Disparities," by addition and deletion to read as  
3 follows:

4  
5 INCREASING ACCESS TO BROADBAND INTERNET TO REDUCE HEALTH  
6 DISPARITIES, H-478.980

7 1. Our AMA recognizes internet access as a social determinant of health and will  
8 advocate for universal and affordable access to the expansion of broadband and  
9 high-speed and wireless internet and voice connectivity, especially in to all rural  
10 and underserved areas of the United States while at all times taking care to  
11 protecting existing federally licensed radio services from harmful interference that  
12 can be caused by broadband and wireless services.

13 2. Our AMA will advocate for federal, state, and local policies to support  
14 infrastructure that reduces the cost of broadband and wireless connectivity and  
15 covers multiple devices and streams per household. (Modify Current HOD Policy)

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

Date Received: 05/12/21

AUTHORS STATEMENT OF PRIORITY

This resolution addresses the issue of internet access within healthcare and education, especially given the context of the COVID-19 pandemic. Our delegation considers this resolution a priority given our nation's increased usage of internet and need to mitigate rising disparities. The resolution highlights how much of day-to-day healthcare and education access has shifted to an online format. While the United States internet usage has increased 34% between January and April 2020 during the COVID-19 pandemic among families with access to broadband, one in five households with school-age children (ages 6-18) still do not have personal broadband internet access at home during the COVID-19 pandemic.

Moreover, the current administration is considering a \$100B proposal for broadband infrastructure. This resolution provides our AMA the opportunity to highlight and support legislation to reduce barriers and increase access to broadband internet to reduce healthcare inequities.

**References:**

1. Human Rights Council. (2016). The promotion, protection and enjoyment of human rights on the Internet. *In: United Nations General Assembly Human Rights Council 32nd Session, Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development: A/HRC/32/L20.*
2. Federal Communications Commission. (2019). 2019 Broadband Deployment Report. *Broadband definition equates to, 25.*
3. Carare, O., McGovern, C., Noriega, R., & Schwarz, J. (2015). The willingness to pay for broadband of non-adopters in the US: Estimates from a multi-state survey. *Information Economics and Policy, 30*, 19-35.
4. Mathew, T. (2017, September 18). Broadband Is Largely Inaccessible to Those Who Need it Most. Retrieved October 28, 2020, from <https://www.bloomberg.com/news/articles/2017-09-18/broadband-is-most-inaccessible-to-poor-rural-areas>
5. Alliance for Excellent Education. (2020). Students of Color Caught in the Homework Gap. Retrieved October 28, 2020, from <https://futureready.org/homework-gap/>
6. Second Broadband Progress Report. (2012, April 03). Retrieved October 28, 2020, from <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/second-broadband-progress-report>
7. Taglang, K. (2020, May 08). Did the FCC Get the Right Answers on Broadband Deployment? Retrieved October 28, 2020, from <https://www.benton.org/blog/did-fcc-get-right-answers-broadband-deployment>
8. 2020 Broadband Deployment Report. (2020, June 09). Retrieved October 28, 2020, from <https://www.fcc.gov/reports-research/reports/broadband-progress-reports/2020-broadband-deployment-report>

9. Social Determinants of Health. (2020, August 10). Retrieved October 28, 2020, from <https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health>
10. Rizga, K. (2020, September 09). What Teachers Need to Make Remote Schooling Work. Retrieved October 28, 2020, from <https://www.theatlantic.com/education/archive/2020/04/how-remote-school-can-work-covid-19-pandemic/609895/>
11. Smith, A. (2020, May 30). Searching for Jobs in the Internet Era. Retrieved October 28, 2020, from <https://www.pewresearch.org/internet/2015/11/19/searching-for-work-in-the-digital-era/>
12. Kruger, L. G., Gilroy, A. A., & Resources, Science, and Industry Division. (2003, August). Broadband internet access and the digital divide: Federal assistance programs. Congressional Research Service, the Library of Congress.
13. Council of Economic Advisers Issues Brief. (2016, March). The Digital Divide and Economic Benefits of Broadband Access. Retrieved October 28, 2020, from [https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160308\\_broadband\\_cea\\_issue\\_brief.pdf](https://obamawhitehouse.archives.gov/sites/default/files/page/files/20160308_broadband_cea_issue_brief.pdf)
14. Centers for Disease Control and Prevention. (2020, June 10). Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic. Retrieved October 28, 2020, from <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html>
15. Smith, A. (2020, May 30). Job seekers find internet essential for employment search. Retrieved October 28, 2020, from <https://www.pewresearch.org/internet/2015/11/19/1-the-internet-and-job-seeking/>
16. Smith, A. (2020, May 30). Home Broadband 2010. Retrieved October 28, 2020, from <https://www.pewresearch.org/internet/2010/08/11/home-broadband-2010/>
17. Hirko, K. A., Kerver, J. M., Ford, S., Szafranski, C., Beckett, J., Kitchen, C., & Wendling, A. L. (2020). Telehealth in response to the COVID-19 pandemic: Implications for rural health disparities. *Journal of the American Medical Informatics Association*.
18. Eberly, L. A., Khatana, S. A. M., Nathan, A. S., Snider, C., Julien, H. M., Deleener, M. E., & Adusumalli, S. (2020). Telemedicine Outpatient Cardiovascular Care during the COVID-19 Pandemic: Bridging or Opening the Digital Divide?. *Circulation*.
19. Davidson, C. M., & Santorelli, M. J. (2009). The impact of broadband on telemedicine: A study commissioned by the US Chamber of Commerce.
20. Hoffman, D. A. (2020). Increasing access to care: telehealth during COVID-19. *Journal of Law and the Biosciences*, 7(1), Isaa043.
21. Freyer, F. (2015, October 05). It costs you \$43 every time you wait for the doctor - The Boston Globe. Retrieved October 28, 2020, from <https://www.bostonglobe.com/metro/2015/10/05/study-puts-dollar-value-time-spent-waiting-for-doctor/lf7KB4aU9mkY5qK8CqDYUO/story.html>
22. Back to School: A Look at the Internet Access Gap. (2020, August 6). Retrieved October 28, 2020, from <https://research.newamericaneconomy.org/report/internet-access-covid-19/>
23. Balingit, M. (2020, August 17). 'A national crisis': As coronavirus forces many schools online this fall, millions of disconnected students are being left behind. Retrieved October 28, 2020, from [https://www.washingtonpost.com/education/a-national-crisis-as-coronavirus-forces-many-schools-online-this-fall-millions-of-disconnected-students-are-being-left-behind/2020/08/16/458b04e6-d7f8-11ea-9c3b-dfc394c03988\\_story.html](https://www.washingtonpost.com/education/a-national-crisis-as-coronavirus-forces-many-schools-online-this-fall-millions-of-disconnected-students-are-being-left-behind/2020/08/16/458b04e6-d7f8-11ea-9c3b-dfc394c03988_story.html)
24. Branscombe, M. (2020, April 15). The Network Impact of the Global COVID-19 Pandemic. Retrieved October 28, 2020, from <https://thenewstack.io/the-network-impact-of-the-global-covid-19-pandemic/>
25. Lifeline Program for Low-Income Consumers. (2020, October 19). Retrieved October 28, 2020, from <https://www.fcc.gov/general/lifeline-program-low-income-consumers>
26. SHADAC Staff. (2020, March 31). Internet Access Measures the Impact of the Digital Divide and COVID-19. Retrieved October 28, 2020, from <https://www.shadac.org/news/internet-access-measures-impact-digital-divide-and-covid-19>
27. Mikulic, M. (2020, May 4). Medicaid - Statistics & Facts. Retrieved October 28, 2020, from <https://www.statista.com/topics/1091/medicaid/>
28. Federal Communications Commission. (2019, October 07). Lifeline Minimum Service Standards and Indexed Budget Amount Announced. Retrieved October 28, 2020, from <https://www.fcc.gov/document/lifeline-minimum-service-standards-and-indexed-budget-amount-announced>
29. Morton, H. (2020, August 10). Broadband 2020 Legislation. Retrieved October 28, 2020, from <https://www.ncsl.org/research/telecommunications-and-information-technology/broadband-2020-legislation.aspx>
30. Congressman Marc Veasey (TX-33) To Introduce Legislation to Bolster Broadband Access for Low Income, Minority Groups During Pandemic. (2020, May 13). Retrieved October 28, 2020, from <https://veasey.house.gov/media-center/press-releases/congressman-marc-veasey-tx-33-to-introduce-legislation-to-bolster>
31. Falcon, E., & Trendacosta, K. (2020, May 14). House Legislation Guarantees Internet Access for Those Affected by COVID-19. Retrieved October 28, 2020, from <https://www.eff.org/deeplinks/2020/05/house-legislation-guarantees-internet-access-those-affected-covid-19>
32. The Biden Plan to Build a Modern, Sustainable Infrastructure and an Equitable Clean Energy Future. (2020, August 05). Retrieved October 28, 2020, from <https://joebiden.com/clean-energy/>
33. Menas, A. (2020, August 21). Joe Biden's 3 big ideas to close the digital divide. Retrieved October 28, 2020, from <https://educationvotes.nea.org/2020/08/23/joe-bidens-3-big-ideas-to-close-the-digital-divide/>

## RELEVANT AMA POLICY

### Increasing Access to Broadband Internet to Reduce Health Disparities H-478.980

Our AMA will advocate for the expansion of broadband and wireless connectivity to all rural and underserved areas of the United States while at all times taking care to protecting existing federally licensed radio services from harmful interference that can be caused by broadband and wireless services. Res. 208, I-18

**Health, In All Its Dimensions, Is a Basic Right H-65.960**

Our AMA acknowledges: (1) that enjoyment of the highest attainable standard of health, in all its dimensions, including health care is a basic human right; and (2) that the provision of health care services as well as optimizing the social determinants of health is an ethical obligation of a civil society.

Res. 021, A-19

**Racial and Ethnic Disparities in Health Care H-350.974**

1. Our AMA recognizes racial and ethnic health disparities as a major public health problem in the United States and as a barrier to effective medical diagnosis and treatment. The AMA maintains a position of zero tolerance toward racially or culturally based disparities in care; encourages individuals to report physicians to local medical societies where racial or ethnic discrimination is suspected; and will continue to support physician cultural awareness initiatives and related consumer education activities. The elimination of racial and ethnic disparities in health care is an issue of highest priority for the American Medical Association.

2. The AMA emphasizes three approaches that it believes should be given high priority:

A. Greater access - the need for ensuring that black Americans without adequate health care insurance are given the means for access to necessary health care. In particular, it is urgent that Congress address the need for Medicaid reform.

B. Greater awareness - racial disparities may be occurring despite the lack of any intent or purposeful efforts to treat patients differently on the basis of race. The AMA encourages physicians to examine their own practices to ensure that inappropriate considerations do not affect their clinical judgment. In addition, the profession should help increase the awareness of its members of racial disparities in medical treatment decisions by engaging in open and broad discussions about the issue. Such discussions should take place in medical school curriculum, in medical journals, at professional conferences, and as part of professional peer review activities.

C. Practice parameters - the racial disparities in access to treatment indicate that inappropriate considerations may enter the decision making process. The efforts of the specialty societies, with the coordination and assistance of our AMA, to develop practice parameters, should include criteria that would preclude or diminish racial disparities

3. Our AMA encourages the development of evidence-based performance measures that adequately identify socioeconomic and racial/ethnic disparities in quality. Furthermore, our AMA supports the use of evidence-based guidelines to promote the consistency and equity of care for all persons.

4. Our AMA: (a) actively supports the development and implementation of training regarding implicit bias, diversity and inclusion in all medical schools and residency programs; (b) will identify and publicize effective strategies for educating residents in all specialties about disparities in their fields related to race, ethnicity, and all populations at increased risk, with particular regard to access to care and health outcomes, as well as effective strategies for educating residents about managing the implicit biases of patients and their caregivers; and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03;

Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19

**Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in Payment Models H-160.896**

Our AMA supports payment reform policy proposals that incentivize screening for social determinants of health and referral to community support systems.

BOT Rep. 39, A-18; Reaffirmed: CMS Rep. 10, A-19

**National Health Information Technology D-478.995**

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.

2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this

technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.

3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.

4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.

5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.

6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.

7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.

8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.

9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.

Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation, A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation, A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation, I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114  
(JUN-21)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

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1 Whereas, School based health centers (SBHCs) are facilities located within the academic  
2 setting, primarily for those in kindergarten through 12th grade, that provide an array of high  
3 quality health care services to students, ranging from primary medical care to dental, vision, and  
4 behavioral health services<sup>1</sup>; and

5  
6 Whereas, SBHCs were originally created to increase access to primary health care and  
7 preventative health services, often for the most vulnerable underserved populations<sup>1</sup>; and

8  
9 Whereas, Due to their focus on preventative care and health maintenance, SBHCs are well  
10 suited to address the negative consequences of health disparities in low income urban and rural  
11 communities, such as depression, obesity, chronic metabolic issues, which are further  
12 associated with poor academic performance<sup>2</sup>; and

13  
14 Whereas, SBHCs are cost-effective because they increase access to preventive care and  
15 reduce utilization of acute care services, leading to a net savings for Medicaid of \$30 to \$969  
16 per visit<sup>3</sup>; and

17  
18 Whereas, In a systematic review, SBHCs were also found to substantially reduce the number of  
19 ED visits and hospital utilizations<sup>2</sup>; and

20  
21 Whereas, SBHCs are considered a provider type in only seven states, making it difficult for  
22 them to receive proper Medicaid reimbursements<sup>4</sup>; and

23  
24 Whereas, As a result of difficulties in obtaining Medicaid reimbursements, many SBHCs must  
25 rely on public funding to continue to provide important healthcare services<sup>5</sup>; and

26  
27 Whereas, SBHCs are not differentiated on Medicaid claims data making it impossible to identify  
28 what services were rendered by an SBHC versus a different type of provider and thus making it  
29 difficult to track and attribute improvements in quality of care or outcomes to SBHCs; and

30  
31 Whereas, Current AMA policy “supports the concept of ... SBHCs” (H-60.921) and recommends  
32 minimum standards for school-based health services (H-60.991) but does not support the  
33 expansion of these centers or methods to increase funding, therefore be it



1 RESOLVED, That our American Medical Association promote the implementation, use, and  
 2 maintenance of school based health centers by amending H-60.921, "School-Based and  
 3 School-Linked Health Centers," by addition and deletion to read as follows:

4  
 5 **School-Based and School-Linked Health Centers, H-60.921**

6 1. Our AMA supports the concept of adequately equipped and staffed the  
 7 implementation, maintenance, and equitable expansion of school-based or school-linked  
 8 health centers (SBHCs) for the comprehensive management of conditions of childhood  
 9 and adolescence.

10 2. Our AMA recognizes that school-based health centers increase access to care in  
 11 underserved child and adolescent populations.

12 3. Our AMA supports identifying SBHCs in claims data from Medicaid and other payers  
 13 for research and quality improvement purposes.

14 4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health  
 15 centers at the state and federal level, including, but not limited to the recognition of  
 16 school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

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

Date Received: 05/12/21

**AUTHORS STATEMENT OF PRIORITY**

Our AMA recognizes health care as a human right and strives to increase access through various methods. School-Based Health Centers (SBHCs) are an important tool for providing healthcare for kids in kindergarten through 12<sup>th</sup> grade, especially for underserved populations. However, it is difficult for SBHCs to bill Medicaid, leading to financial problems for these critical safety nets. Our AMA has previously supported the concept of SBHCs but not addressed their difficulty in obtaining funding. This resolution will amend current policy to support the expansion of these centers, enable future research on quality improvement methods, and enable SBHCs to receive reimbursement from Medicaid. These asks aligns with the AMA's new focus on equity in healthcare and we believe should be considered a priority for the House of Delegates.

**References:**

1. Arenson M, Hudson P, Lee N, Lai B. The Evidence on School-Based Health Centers: A Review. *Glob Pediatr Health*. 2019;6:2333794X1982874. doi:10.1177/2333794x19828745
2. Knopf JA, Finnie RK, Peng Y, et al. School-Based Health Centers to Advance Health Equity: A Community Guide Systematic Review. *Am J Prev Med*. 2016;51(1):114-126. doi:10.1016/j.amepre.2016.01.009
3. Ran T et al. Economic evaluation of school-based health centers: A community guide systematic review. *Am J Prev Med*. 2016;51(1):129-138. doi:10.1016/j.amepre.2016.01.017
4. School-Based Health Alliance. Medicaid Policies that Work for SBHCs. Accessible at <https://www.sbh4all.org/advocacy/medicaid-policies-that-work-for-sbhcs/>.
5. Kanaan SB. Making the grade: State and local partnerships to establish school-based health centers [Internet]. Princeton (NJ): Robert Wood Johnson Foundation; 2007. Available for download from: <https://www.rwjf.org/en/library/research/2007/02/making-the-grade.html>

**RELEVANT AMA POLICY**

**School-Based and School-Linked Health Centers H-60.921**

Our AMA supports the concept of adequately equipped and staffed school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

**Providing Medical Services through School-Based Health Programs H-60.991**

1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a physician should be accessible to administer care on a regular basis. (b) On-site services should be provided by a professionally prepared school nurse or similarly qualified health professional. Expertise in child and adolescent development, psychosocial and behavioral problems, and emergency care is desirable. Responsibilities of this professional would include coordinating the health care of students with the student, the parents, the school and the student's personal physician and assisting with the development and presentation of health education programs in the classroom. (c) There should be a written policy to govern provision of health services in the school. Such a policy should be developed by a school health council consisting of school and community-based physicians, nurses, school faculty and administrators, parents, and (as appropriate) students, community leaders and others. Health services and curricula should be carefully designed to reflect community standards and values, while emphasizing positive health practices in the school environment. (d) Before patient services begin, policies on confidentiality should be established with the advice of expert legal advisors and the school health council. (e) Policies for ongoing monitoring, quality assurance and evaluation should be established with the advice of expert legal advisors and the school health council. (f) Health care services should be available during school hours. During other hours, an appropriate referral system should be instituted. (g) School-based health programs should draw on outside resources for care, such as private practitioners, public health and mental health clinics, and mental health and neighborhood health programs. (h) Services should be coordinated to ensure comprehensive care. Parents should be encouraged to be intimately involved in the health supervision and education of their children.

## AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115  
(JUN-21)

Introduced by: Medical Student Section

Subject: Federal Health Insurance Funding and Co-Payments for People Experiencing Incarceration

Referred to: Reference Committee A

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1 Whereas, There are over 2.2 million incarcerated people in the United States<sup>1</sup>; and

2  
3 Whereas, Incarceration is associated with increased rates of stress-related illness, obesity,  
4 infection, and transmission of communicable diseases with resultant increases in mortality, even  
5 after adjusting for socioeconomic factors, tobacco and alcohol use, and adverse life events<sup>2-7</sup>;  
6 and

7  
8 Whereas, The Social Security Act currently prohibits the use of federal services such as  
9 Medicaid for inmates in jails and prisons unless treatment occurs at an outside institution for at  
10 least 24hrs, thereby limiting access to healthcare for the duration of incarceration<sup>8,9</sup>; and

11  
12 Whereas, 65% of the 10.6 million people admitted to local jails in 2016 were presumed innocent  
13 and awaiting trial, signifying that the suspension of federal benefits disproportionately impacts  
14 those who cannot afford to post bail in spite of their presumed innocence and thereby  
15 contributes to significant disruptions in care<sup>10-12</sup>; and

16  
17 Whereas, Inmates and their families are charged a variety of fees to help offset correctional  
18 costs, including booking, room and meals, hygiene supplies, phone calls, and medical care<sup>13-17</sup>;  
19 and

20  
21 Whereas, Both the Federal Bureau of Prisons and prisons in at least 35 states require a  
22 copayment (copay) to access healthcare with the average co-pay across the 50 states being  
23 \$3.47<sup>13,18</sup>; and

24  
25 Whereas, Prisoners receive an average minimum wage of only 14 cents per hour with at least 7  
26 states offering no salary at all, thus requiring about 25 hours of work to afford the copayment for  
27 medical care<sup>18,19</sup>; and

28  
29 Whereas, Co-payments that are difficult to afford can prevent prisoners from seeking necessary  
30 treatment to the detriment of themselves and of the wider prison population in the case of  
31 communicable diseases<sup>20</sup>; and

32  
33 Whereas, An analysis by Pew Charitable Trusts found that states collectively spent  
34 approximately 7.7 billion dollars for inmate healthcare in 2011, and states reported that they  
35 only recouped between \$190,000 and \$500,000 a year from prisoner co-pays, indicating co-  
36 pays are not an effective means of offsetting correctional costs while remaining a barrier to  
37 accessing care<sup>20</sup>; and

1 Whereas, Permitting the use of federal services during incarceration could further reduce  
2 coverage gaps, minimize the administrative burden associated with suspension/termination, and  
3 improve health outcomes<sup>21-24</sup>; and  
4

5 Whereas, If federal services are made available during incarceration, jails and prisons  
6 requesting federal reimbursement would be required to meet appropriate national standards for  
7 minimum care pursuant to the Social Security Act<sup>21,25,26</sup>; and  
8

9 Whereas, Our AMA encourages adoption of national standards to help ensure quality, equitable  
10 healthcare for all incarcerated patients (D-430.997); and  
11

12 Whereas, During the COVID-19 pandemic, Illinois, South Carolina, and California submitted  
13 Section 1115 waivers asking to waive the Medicaid inmate exclusion for COVID-19 testing and  
14 treatment, with Illinois citing that public health benefits will exceed costs<sup>25,27-29</sup>; and  
15

16 Whereas, An interruption in insurance coverage also adds to the difficulty of post-release  
17 transitions of care and is associated with poor chronic disease management, significant  
18 infectious disease transmission, and increased mortality<sup>30-33</sup>; and  
19

20 Whereas, An estimated 57% of individuals released from prison are either Medicaid-eligible or  
21 eligible for federal tax credits under the Affordable Care Act, so disease complications and  
22 transmission due to lapses in access to care during and immediately following incarceration  
23 incur significant costs to the federal government<sup>34,35</sup>; and  
24

25 Whereas, Recently incarcerated individuals who are enrolled in Medicaid at time of release are  
26 more likely to access and receive community services, have fewer repeat detentions, and  
27 greater time between detentions<sup>36,37</sup>; and  
28

29 Whereas, Permitting the use of federal funding to match inmate health expenses would help  
30 states maintain a balanced budget while adequately addressing inmate health needs, as  
31 evidenced by estimated annual savings of up to \$4.7 billion if Medicaid expansion states are  
32 able to cost-share their corrections budgets<sup>38-40</sup>; therefore be it  
33

34 RESOLVED, That our American Medical Association advocate for the continuation of federal  
35 funding for health insurance benefits, including Medicaid, Medicare, and the Children's Health  
36 Insurance Program, for otherwise eligible individuals in pre-trial detention (Directive to Take  
37 Action); and be it further  
38

39 RESOLVED, That our AMA advocate for the prohibition of the use of co-payments to access  
40 healthcare services in correctional facilities (Directive to Take Action); and be it further

1 RESOLVED, That our AMA amend policy H-430.986 by addition to read as follows:

2  
3 HEALTH CARE WHILE INCARCERATED, H-430.986

4 1. Our AMA advocates for adequate payment to health care providers, including  
5 primary care and mental health, and addiction treatment professionals, to encourage  
6 improved access to comprehensive physical and behavioral health care services to  
7 juveniles and adults throughout the incarceration process from intake to re-entry into  
8 the community.

9 2. Our AMA supports partnerships and information sharing between correctional  
10 systems, community health systems and state insurance programs to provide access to  
11 a continuum of health care services for juveniles and adults in the correctional system.

12 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid  
13 applications from juveniles and adults who are incarcerated.

14 4. That our AMA encourage state Medicaid agencies to work with their local  
15 departments of corrections, prisons, and jails to assist incarcerated juveniles and adults  
16 who may not have been enrolled in Medicaid at the time of their incarceration to apply  
17 and receive an eligibility determination for Medicaid.

18 5. That our AMA advocate for the repeal of the Medicaid Inmate Exclusion Policy.

19 ~~56.~~ Our AMA encourages states not to suspend rather than terminate Medicaid  
20 eligibility of juveniles and adults upon intake into the criminal justice system and  
21 throughout the incarceration process, and to reinstate coverage when the individual  
22 transitions back into the community.

23 ~~67.~~ Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS),  
24 and state Medicaid agencies to provide Medicaid coverage for health care, care  
25 coordination activities and linkages to care delivered to patients up to 30 days before  
26 the anticipated release from adult and juvenile correctional facilities in order to help  
27 establish coverage effective upon release, assist with transition to care in the  
28 community, and help reduce recidivism.

29 ~~78.~~ Our AMA advocates for necessary programs and staff training to address the  
30 distinctive health care needs of incarcerated women and adolescent females, including  
31 gynecological care and obstetrics care for pregnant and postpartum women.

32 ~~89.~~ Our AMA will collaborate with state medical societies and federal regulators to  
33 emphasize the importance of hygiene and health literacy information sessions for both  
34 inmates and staff in correctional facilities.

35 ~~910.~~ Our AMA supports: (a) linkage of those incarcerated to community clinics upon  
36 release in order to accelerate access to comprehensive health care, including mental  
37 health and substance abuse disorder services, and improve health outcomes among  
38 this vulnerable patient population, as well as adequate funding; and (b) the  
39 collaboration of correctional health workers and community health care providers for  
40 those transitioning from a correctional institution to the community. (Modify Current  
41 HOD Policy)

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

Date Received: 05/12/21

#### AUTHOR'S STATEMENT OF PRIORITY

This resolution asks our AMA to advocate for people who have been incarcerated to continue to (1) receive federal health insurance benefits both prior to trial and throughout the duration of their incarceration and (2) minimize any co-payments made in prison. It highlights a gap in the coverage of incarcerated individuals and the subsequent impact on treatment of chronic conditions, public health of communities of color, and increased federal government spending as a result of this interruption in federal services.

The topic has its foundations in the AMA's commitment to protecting vulnerable populations, which objectively includes incarcerated persons. Disparities in access to care for vulnerable populations in prison facilities are clearly within the AMA's purview, and there is clearly a strong existing relationship between the AMA and the National Commission on Correctional Health Care which is opposed to copayments. As detailed in this resolution copayments in prison facilities do not appear to add economic value or improve quality in correctional facilities' provision of healthcare, and that the cost of administering these copayment programs is greater than the amount collected, thereby contributing to rather than reducing healthcare costs.

#### **References:**

1. Wildeman, C., Wang, E. A. Mass incarceration, public health, and widening inequality in the USA. *The Lancet*, 2017;389(10077), 1464–1474. [https://doi.org/10.1016/S0140-6736\(17\)30259-3](https://doi.org/10.1016/S0140-6736(17)30259-3)
2. Udo T. Chronic medical conditions in U.S. adults with incarceration history. *Health Psychology*. 2019;38(3):217–225. <https://doi.org/10.1037/hea0000720>
3. Michael Massoglia. Incarceration as Exposure: The Prison, Infectious Disease, and Other Stress-Related Illnesses. *J Health Soc Behav*. 2008;49(1):56. <https://doi.org/10.1177/002214650804900105>. Accessed September 20, 2019.
4. Houle, B. The Effect of Incarceration on Adult Male BMI Trajectories, United States, 1981–2006. *J Racial Ethn Health Disparities*. 2014 Mar;1(1):21–28. <https://doi.org/10.1007/s40615-013-0003-1>. Accessed September 20, 2019.
5. Massoglia M, Pridemore WA. Incarceration and Health. *Annu Rev Sociol*. 2015;41:291–310. <https://dx.doi.org/10.1146%2Fannurev-soc-073014-112326>. Accessed September 20, 2019.
6. Harzke AJ, Baillargeon JG, Kelley MF, Pruitt SL, Pulvino JS, Paar DP. Leading medical causes of mortality among male prisoners in Texas, 1992–2003. *J. Correct. Health Care*. 2011;17(3):241–253. <https://doi.org/10.1177/1078345811401362>. Accessed September 20, 2019.
7. Ndeffo-Mbah ML, Vigliotti VS, Skrip LA, Dolan K, Galvani AP. Dynamic Models of Infectious Disease Transmission in Prisons and the General Population. *Epidemiol Rev*. 2018;40(1):40–57. <https://dx.doi.org/10.1093%2Fepirev%2Fmxx014>. Accessed September 20, 2019.
8. Pryor WH, Barkow RE, Breyer CR, Reeves DC, Smoot JPW, Bolitho Z, Cohen KP. Mandatory Minimum Penalties for Drug Offenses in the Federal System. United States Sentencing Commission. October 2017. Accessible via: [https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171025\\_Drug-Mand-Min.pdf](https://www.ussc.gov/sites/default/files/pdf/research-and-publications/research-publications/2017/20171025_Drug-Mand-Min.pdf)
9. How and When Medicaid Covers People Under Correctional Supervision. Pew website. August 2, 2016. <https://www.pewtrusts.org/en/research-and-analysis/issue-briefs/2016/08/how-and-when-medicare-covers-people-under-correctional-supervision>. Accessed September 20, 2019.
10. National Association of Counties/National Sheriffs Association Joint Task Force. Addressing the Federal Medicaid Inmate Exclusion Policy. 2020. Accessible via: <https://www.naco.org/resources/featured/naco-nsa-joint-task-force-report-addressing-federal-medicare-inmate-exclusion-policy#go>
11. Equity in Pretrial Medicaid Coverage Act, S.2628 (10/17/2019).
12. Restoring Health Benefits for Justice-Involved Individuals, S.2626 (10/17/2019).
13. Andrews, M. Even in Prison, Healthcare Often Comes With a Copay. *NPR*. September 30, 2015. <https://www.npr.org/sections/health-shots/2015/09/30/444451967/even-in-prison-health-care-often-comes-with-a-copay>. Accessed August 23, 2019.
14. Eisen L-B. Paying for Your Time: How Charging Inmates Fees behind Bars May Violate the Excessive Fines Clause. *Loyola Journal of Public Interest Law*. 2013;(Issue 2):319. <https://www.brennancenter.org/analysis/paying-your-time-how-charging-inmates-fees-behind-bars-may-violate-excessive-fines-clause> Accessed September 20, 2019.
15. Eisen L-B. Charging Inmates Perpetuates Mass Incarceration. The Brennan Center for Justice Website. May 21, 2015. [https://www.brennancenter.org/sites/default/files/blog/Charging\\_Inmates\\_Mass\\_Incarceration.pdf](https://www.brennancenter.org/sites/default/files/blog/Charging_Inmates_Mass_Incarceration.pdf). Accessed September 20, 2019.
16. 50-State Criminal Justice Debt Reform Builder. Harvard Law School Criminal Justice Policy Program. <https://cjdebtreform.org/state/108>. Accessed September 20, 2019.

17. Marimow, M. A new law promised Maryland's female inmates free tampons. They're still paying. *The Washington Post*. June 5, 2019. [https://www.washingtonpost.com/local/legal-issues/a-new-law-promised-marylands-female-inmates-free-tampons-theyre-still-paying/2019/06/04/cc5442da-86d7-11e9-a491-25df61c78dc4\\_story.html](https://www.washingtonpost.com/local/legal-issues/a-new-law-promised-marylands-female-inmates-free-tampons-theyre-still-paying/2019/06/04/cc5442da-86d7-11e9-a491-25df61c78dc4_story.html). Accessed September 20, 2019.
18. Sawyer, W. The Steep Cost of Medical Co-pays in Prison Puts Health at Risk. Prison Policy Initiative website. April 19, 2017. Updated April 28, 2017. <https://www.prisonpolicy.org/blog/2017/04/19/copays/>. Accessed August 23, 2019.
19. Sawyer, W. How Much Do Incarcerated People Earn in Each State? Prison Policy Initiative website. April 10, 2017. <https://www.prisonpolicy.org/blog/2017/04/10/wages/>. Accessed August 23, 2019.
20. Ollove, M. No Escaping Medical Copayments, Even in Prison. Pew website. July 22, 2015. <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2015/07/22/no-escaping-medical-copayments-even-in-prison>. Accessed August 23, 2019.
21. Huh K, Boucher A, McGaffey F, McKillop M, Schiff M. Prison Health Care: Costs and Quality. The Pew Charitable Trusts. 2017. Accessible via: [http://www.pewtrusts.org/~media/assets/2017/10/sfh\\_prison\\_health\\_care\\_costs\\_and\\_quality\\_final.pdf](http://www.pewtrusts.org/~media/assets/2017/10/sfh_prison_health_care_costs_and_quality_final.pdf)
22. Jannetta J, Dorn S, Kurs E, Reginal T, Marks J, Serafi K, Guyer J, Cantrell C. Strategies for Connecting Justice-Involved Populations to Health Coverage and Care. Urban Institute Health Policy Center and Justice Policy Center. 2018. Accessible via: [https://www.urban.org/sites/default/files/publication/97041/strategies\\_for\\_connecting\\_justice-involved\\_populations\\_to\\_health\\_coverage\\_and\\_care.pdf](https://www.urban.org/sites/default/files/publication/97041/strategies_for_connecting_justice-involved_populations_to_health_coverage_and_care.pdf)
23. Guyer J, Serafi K, Bachrach D, Gould A. State Strategies for Establishing Connections to Health Care for Justice-Involved Populations: The Central Role of Medicaid. Commonwealth Fund. 2019. Accessible via: <https://www.commonwealthfund.org/publications/issue-briefs/2019/jan/state-strategies-health-care-justice-involved-role-medicare>
24. Ibertson EM, Scannell C, Ashtari N, Barnert E, "Eliminating Gaps in Medicaid Coverage During Reentry After Incarceration. *American Journal of Public Health*. 2020;110(3):317-321. doi: 10.2105/AJPH.2019.305400.
25. Olson MG, Khatri UG, Winkelman TNA. Aligning Correctional Health Standards With Medicaid-Covered Benefits. *JAMA Health Forum*. Published online July 27, 2020. doi:10.1001/jamahealthforum.2020.0885
26. Fiscella K, Beletsky L, Wakeman SE. The inmate exception and reform of correctional health care. *Am J Public Health*. 2017;107(3):384–5. doi:10.2105/AJPH.2016.303626
27. Request for Setion 1115 Demonstration Authority Related to the COVID-19 Public Health Emergency. State of CA HHS Agency. April 3, 2020. Available via: <https://www.dhcs.ca.gov/Documents/COVID-19/CMS-Ltr-and-CA-COVID-19-1115-Waiver-040320.pdf>
28. Illinois COVID-19 Section 1115(a) Demonstration Application. March 26, 2020. Available via: <https://www.illinois.gov/hfs/SiteCollectionDocuments/03262020IllinoisCOVID19Section1115DemonstrationProposalFinal.pdf>
29. COVID-19 Section 1115(a) Demonstration Application Template. SC HHS Department. March 27, 2020. Available via: <https://mssp.scdhhs.gov/covid19/sites/default/files/%282020-03-27%29%20SC%201115%20Inpatient%20COVID19.pdf>
30. Fahmy N, Kouyoumdjian F, Berkowitz J, Fahmy S, Neves CM, Hwang SW, Martin RE. Access to Primary Care for Persons Recently Released From Prison. *The Annals of Family Medicine*. 2018;16(6):549–551. doi:10.1370/afm.2314.
31. Grodensky CA, Rosen DL, Blue CM, Miller AR, Bradley-Bull S, Powell WA, Domino ME, Golin CE, Wohl DA. Medicaid Enrollment among Prison Inmates in a Non-expansion State: Exploring Predisposing, Enabling, and Need Factors Related to Enrollment Pre-incarceration and Post-Release. *J Urban Health*. 2018;95(4):454-466. doi: 10.1007/s11524-018-0275-1.
32. Maruschak LM, Berzofsky M. Medical Problems of State and Federal Prisoners and Jail Inmates, 2011-2012. U.S. Department of Justice, Office of Justice Programs, Bureau of Statistics. 2015. Accessible via: <https://www.bjs.gov/content/pub/pdf/mpsfpi1112.pdf>
33. Binswanger IA, Stern MF, Deyo RA, Heagerty PJ, Cheadle A, Elmore JG, et al. Release from prison--a high risk of death for former inmates. *N Engl J Med*. 2007;356(2):157–65.
34. Venters, H. A Three-Dimensional Action Plan to Raise the Quality of Care of US Correctional Health and Promote Alternatives to Incarceration. *American Journal of Public Health*. 2016. 106, 613–614. <https://doi.org/10.2105/AJPH.2016.303076>
35. Cuellar AE, Cheema J. As roughly 700,000 prisoners are released annually, about half will gain health coverage and care under federal laws. *Health Affairs (Millwood)* 2012;31(5):931–938. <https://doi.org/10.1377/hlthaff.2011.0501>
36. Morrissey JP, Cuddeback GS, Cuellar AE, Steadman HJ. The role of Medicaid enrollment and outpatient service use in jail recidivism among persons with severe mental illness. *Psychiatric Services*. 2007;58(6):794–801.
37. Morrissey JP, Steadman HJ, Dalton KM, et al.: Medicaid enrollment and mental health service use following release of jail detainees with severe mental illness. *Psychiatr Serv* 2006; 57:809–815
38. COVID-19 Section 1115(a) Demonstration Application Template. SC HHS Department. March 27, 2020. Available via: <https://mssp.scdhhs.gov/covid19/sites/default/files/%282020-03-27%29%20SC%201115%20Inpatient%20COVID19.pdf>
39. Bachrach D, Boozang P, Glanz D. States Expanding Medicaid See Significant Budget Savings and Revenue Gains. State Health Reform Assistance Network. 2016. Accessible via: <http://shvs.org/wp-content/uploads/2016/03/State-Network-Manatt-States-Expanding-Medicaid-See-Significant-Budget-Savings-and-Revenue-Gains-March-2016.pdf>
40. Urahn, S, Ettlinger, M, et. al. State Prison Health Care Spending: An Examination. Pew Charitable Trusts. July 2014. Available via: <https://www.pewtrusts.org/~media/assets/2014/07/stateprisonhealthcarespendingreport.pdf>

## RELEVANT AMA POLICY

### Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.

2. Our AMA supports partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. That our AMA encourage state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA encourages states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal justice system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA urges Congress, the Centers for Medicare & Medicaid Services (CMS), and state Medicaid agencies to provide Medicaid coverage for health care, care coordination activities and linkages to care delivered to patients up to 30 days before the anticipated release from adult and juvenile correctional facilities in order to help establish coverage effective upon release, assist with transition to care in the community, and help reduce recidivism.
7. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of incarcerated women and adolescent females, including gynecological care and obstetrics care for pregnant and postpartum women.
8. Our AMA will collaborate with state medical societies and federal regulators to emphasize the importance of hygiene and health literacy information sessions for both inmates and staff in correctional facilities.
9. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.

CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19

### **Health Status of Detained and Incarcerated Youth H-60.986**

Our AMA (1) encourages state and county medical societies to become involved in the provision of adolescent health care within detention and correctional facilities and to work to ensure that these facilities meet minimum national accreditation standards for health care as established by the National Commission on Correctional Health Care;

(2) encourages state and county medical societies to work with the administrators of juvenile correctional facilities and with the public officials responsible for these facilities to discourage the following inappropriate practices: (a) the detention and incarceration of youth for reasons related to mental illness; (b) the detention and incarceration of children and youth in adult jails; and (c) the use of experimental therapies, not supported by scientific evidence, to alter behavior.

(3) encourages state medical and psychiatric societies and other mental health professionals to work with the state chapters of the American Academy of Pediatrics and other interested groups to survey the juvenile correctional facilities within their state in order to determine the availability and quality of medical services provided.

(4) advocates for increased availability of educational programs by the National Commission on Correctional Health Care and other community organizations to educate adolescents about sexually transmitted diseases, including juveniles in the justice system.

CSA Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Appended: Res. 401, A-01; Reaffirmed: CSAPH Rep. 1, A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: Res. 917, I-16



**Disease Prevention and Health Promotion in Correctional Institutions H-430.989**

Our AMA urges state and local health departments to develop plans that would foster closer working relations between the criminal justice, medical, and public health systems toward the prevention and control of HIV/AIDS, substance abuse, tuberculosis, and hepatitis. Some of these plans should have as their objectives: (a) an increase in collaborative efforts between parole officers and drug treatment center staff in case management aimed at helping patients to continue in treatment and to remain drug free; (b) an increase in direct referral by correctional systems of parolees with a recent, active history of intravenous drug use to drug treatment centers; and (c) consideration by judicial authorities of assigning individuals to drug treatment programs as a sentence or in connection with sentencing.

CSA Rep. 4, A-03; Modified: CSAPH Rep. 1, A-13

**Standards of Care for Inmates of Correctional Facilities H-430.997**

Our AMA believes that correctional and detention facilities should provide medical, psychiatric, and substance misuse care that meets prevailing community standards, including appropriate referrals for ongoing care upon release from the correctional facility in order to prevent recidivism.

Res. 60, A-84; Reaffirmed by CLRPD Rep. 3 - I-94; Amended: Res. 416, I-99; Reaffirmed: CEJA Rep. 8, A-09; Reaffirmation I-09; Modified in lieu of Res. 502, A-12; Reaffirmation: I-12

**Support for Health Care Services to Incarcerated Persons D-430.997**

Our AMA will:

(1) express its support of the National Commission on Correctional Health Care Standards that improve the quality of health care services, including mental health services, delivered to the nation's correctional facilities;

(2) encourage all correctional systems to support NCCHC accreditation;

(3) encourage the NCCHC and its AMA representative to work with departments of corrections and public officials to find cost effective and efficient methods to increase correctional health services funding;

(4) continue support for the programs and goals of the NCCHC through continued support for the travel expenses of the AMA representative to the NCCHC, with this decision to be reconsidered every two years in light of other AMA financial commitments, organizational memberships, and programmatic priorities;

(5) work with an accrediting organization, such as National Commission on Correctional Health Care (NCCHC) in developing a strategy to accredit all correctional, detention and juvenile facilities and will advocate that all correctional, detention and juvenile facilities be accredited by the NCCHC no later than 2025 and will support funding for correctional facilities to assist in this effort; and

(6) support an incarcerated person's right to: (a) accessible, comprehensive, evidence-based contraception education; (b) access to reversible contraceptive methods; and (c) autonomy over the decision-making process without coercion.

Res. 440, A-04; Amended: BOT Action in response to referred for decision Res. 602, A-00; Reaffirmation I-09; Reaffirmation A-11; Reaffirmed: CSAPH Rep. 08, A-16; Reaffirmed: CMS Rep. 02, I-16; Appended: Res. 421, A-19; Appended: Res. 426, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116  
(JUN-21)

Introduced by: Medical Student Section

Subject: Caps on Insulin Co-Payments for Patients with Insurance

Referred to: Reference Committee A

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Whereas, Diabetes affects approximately 9.4% of the population and is the seventh leading cause of death nationally<sup>1,2</sup>; and

Whereas, Direct medical costs for diagnosed diabetes were estimated at \$327.2 billion in 2017, with nearly \$102 billion lost due to lower productivity resulting from diabetes<sup>3</sup>; and

Whereas, The annual average medical cost per person with diabetes is \$13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin<sup>4</sup>; and

Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13 cents per unit to 25 cents per unit, translating to a daily cost increase from \$7.80 to \$15 for a Type 1 diabetic patient using an average amount of insulin (60 units per day)<sup>5</sup>; and

Whereas, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient's prescription drug coverage plan<sup>6</sup>; and

Whereas, Patients who report cost-related underuse were more likely to have poor glycemic control, which is associated with an increased risk for complications such as hypertension, chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression, and cancer<sup>6,7</sup>; and

Whereas, Seven states have approved legislation on insulin copayment caps since April 2020, instituting a \$35-\$100 maximum copayment for a 30-day insulin supply<sup>8</sup>; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin prescription costs through Medicaid Part D for the 2021 plan year to a maximum \$35 copay for a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%<sup>9</sup>; and

Whereas, Individual and family savings resulting from caps on insulin copayments have the potential to alleviate financial burden<sup>10</sup>; and

Whereas, The AMA has policy consistent with the principle of increasing access to prescription medications including insulin for patients<sup>11-16</sup>; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers, without any increased cost to their insurance premium or plan<sup>17</sup>; therefore be it

RESOLVED, That our American Medical Association amend policy H-110.984, "Insulin Affordability," by addition and deletion to read as follows:

#### **Insulin Affordability H-110.984**

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; ~~and~~ (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies; (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

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

Date Received: 05/12/21

#### **AUTHOR'S STATEMENT OF PRIORITY**

Insulin cost and access is a very urgent issue for many of our patients, and we anticipate that this policy may spur state and local efforts to implement copay caps. This resolution asks the AMA to address the issue of rising monthly copayments of insured patients by amending existing policy titled "Insulin Affordability H-110.984." In advocacy, we have seen that drug pricing, particularly insulin prices, is a very active topic in legislation and policy reform. It would be relevant and timely for the AMA to speak on this issue.

#### **References:**

1. National and State Diabetes Trends. Centers for Disease Control and Prevention. Published June 10, 2019. Accessed September 20, 2020. <https://www.cdc.gov/diabetes/library/reports/reportcard/incidence-2017.html>.
2. Centers for Disease Control and Prevention. National Diabetes Statistics Report: Estimates of Diabetes and Its Burden in the United States. Atlanta, GA: U.S. Department of Health and Human Services; 2017.
3. Dall T, et al. The Economic Burden of Elevated Blood Glucose Levels in 2017: Diagnosed and Undiagnosed Diabetes, Gestational Diabetes, and Prediabetes. Diabetes Care 2019 Apr; dc181226. <https://doi.org/10.2337/dc18-1226>.
4. 2014 Diabetes Health Care Cost and Utilization Report. Health Care Cost Institute, Inc. <https://healthcostinstitute.org/images/pdfs/2016-D-HCCUR-FINAL-7.21.16.pdf>. Published June 2016. Accessed September 20, 2020.
5. Biniek JF, Johnson W. Spending on Individuals with Type 1 Diabetes and the Role of Rapidly Increasing Insulin Prices. *Health Care Cost Institute*. Published January 21, 2019. Accessed February 6, 2020.
6. Herkert D, Vijayakumar P, Luo J, et al. Cost-Related Insulin Underuse Among Patients with Diabetes. JAMA Intern Med. 2019;179(1):112-114. doi:10.1001/jamainternmed.2018.5008.
7. Zheng Y, Ley SH, Hu FB. Global aetiology and epidemiology of type 2 diabetes mellitus and its complications. Nat Rev Endocrinol. 2018;14(2):88-98.
8. "Insulin Copay Caps Approved in Five More States." Diabetes.org. <https://www.diabetes.org/blog/insulin-copay-caps-approved-five-more-states?fbclid=IwAR23GLb1pUNHSO2IO2HZGpnxkl0fagTrl9alfOzDJITpgs8wXhFCCxQ8XqA>. Published April 7, 2020. Accessed September 20, 2020.
9. Centers for Medicaid and Medicaid Services. "President Trump Announces Lower Out of Pocket Insulin Costs for Medicare's Seniors." CMS.gov. [https://www.cms.gov/newsroom/press-releases/president-trump-announces-lower-out-pocket-insulin-costs-medicare-seniors?fbclid=IwAR2hg8Y\\_lbc0ZMQ4dyDtW1a4dy07whlZd3tchYZxTGpx8xDQ4VXNo-BPXGo](https://www.cms.gov/newsroom/press-releases/president-trump-announces-lower-out-pocket-insulin-costs-medicare-seniors?fbclid=IwAR2hg8Y_lbc0ZMQ4dyDtW1a4dy07whlZd3tchYZxTGpx8xDQ4VXNo-BPXGo). Published May 26, 2020. Accessed September 20, 2020.
10. Chua K, Lee JM, Conti RM. Potential Change in Insulin Out-of-Pocket Spending Under Cost-Sharing Caps Among Pediatric Patients With Type 1 Diabetes. JAMA Pediatr. 2020. doi:10.1001/jamapediatrics.2020.1065. Accessed September 20, 2020.
11. American Medical Association. Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980. <https://policysearch.ama-assn.org/policyfinder/detail/drug%20pricing?uri=%2FAMADoc%2FHOD.xml-H-110.980.xml>. Accessed February 15, 2020.
12. American Medical Association. Insulin Affordability H-110.984. <https://policysearch.ama-assn.org/policyfinder/detail/insulin?uri=%2FAMADoc%2FHOD.xml-H-110.984.xml>. Accessed February 13, 2020.

13. American Medical Association. Pharmaceutical Costs H-110.987. <https://policysearch.ama-assn.org/policyfinder/detail/prescription%20drug%20price?uri=%2FAMADoc%2FHOD.xml-0-101.xml>. Accessed February 15, 2020.
14. American Medical Association. Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988. <https://policysearch.ama-assn.org/policyfinder/detail/prescription%20drug%20price?uri=%2FAMADoc%2FHOD.xml-0-102.xml>. Accessed February 15, 2020.
15. American Medical Association. Cost of Prescription Drugs H-110.997. <https://policysearch.ama-assn.org/policyfinder/detail/H-110.997?uri=/AMADoc/HOD.xml-0-111.xml>. Accessed February 15, 2020.
16. American Medical Association. Reducing Prescription Drug Prices D-110.993. [https://policysearch.ama-assn.org/policyfinder/detail/Reducing Prescription Drug Prices D-110.993?uri=/AMADoc/directives.xml-0-49.xml](https://policysearch.ama-assn.org/policyfinder/detail/Reducing%20Prescription%20Drug%20Prices%20D-110.993?uri=/AMADoc/directives.xml-0-49.xml). Accessed February 15, 2020.
17. Cigna and Express Scripts Introduce Patient Assurance Program to Cap Out of Pocket Costs at \$25 per 30-Day Insulin Prescription. <https://www.cigna.com/newsroom/news-releases/2019/cigna-and-express-scripts-introduce-patient-assurance-program-to-cap-out-of-pocket-costs-at-25-per-30-day-insulin-prescription>. Published April 3, 2019. Accessed February 15, 2020.

## RELEVANT AMA POLICY

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

1. Our AMA will advocate that the use of arbitration in determining the price of prescription drugs meet the following standards to lower the cost of prescription drugs without stifling innovation:
    - a. The arbitration process should be overseen by objective, independent entities;
    - b. The objective, independent entity overseeing arbitration should have the authority to select neutral arbitrators or an arbitration panel;
    - c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to minimize actual and potential conflicts of interest to ensure that they do not undermine the integrity and legitimacy of the arbitration process;
    - d. The arbitration process should be informed by comparative effectiveness research and cost-effectiveness analysis addressing the drug in question;
    - e. The arbitration process should include the submission of a value-based price for the drug in question to inform the arbitrator's decision;
    - f. The arbitrator should be required to choose either the bid of the pharmaceutical manufacturer or the bid of the payer;
    - g. The arbitration process should be used for pharmaceuticals that have insufficient competition; have high list prices; or have experienced unjustifiable price increases;
    - h. The arbitration process should include a mechanism for either party to appeal the arbitrator's decision; and
    - i. The arbitration process should include a mechanism to revisit the arbitrator's decision due to new evidence or data.
  2. Our AMA will advocate that any use of international price indices and averages in determining the price of and payment for drugs should abide by the following principles:
    - a. Any international drug price index or average should exclude countries that have single-payer health systems and use price controls;
    - b. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;
    - c. The use of any international drug price index or average should preserve patient access to necessary medications;
    - d. The use of any international drug price index or average should limit burdens on physician practices; and
    - e. Any data used to determine an international price index or average to guide prescription drug pricing should be updated regularly.
  3. Our AMA supports the use of contingent exclusivity periods for pharmaceuticals, which would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list price at the time of market introduction.
- CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

**Insulin Affordability H-110.984**

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.

CMS Rep. 07, A-18

**Pharmaceutical Costs H-110.987**

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.
2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.
3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.
4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.
5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.
6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.
7. Our AMA supports legislation to shorten the exclusivity period for biologics.
8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.
9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.
10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.
11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.
12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.
13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19

**Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988**

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.
2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.

3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
  4. Our AMA supports measures that increase price transparency for generic prescription drugs.
- Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17; Reaffirmed: BOT Rep. 14, A-18

### **Cost of Prescription Drugs H-110.997**

Our AMA:

- (1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs;
- (2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost considerations in making these choices;
- (3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs and will assist physicians in this regard by regularly publishing a summary list of the patient expiration dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
- (4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and necessary medical therapies;
- (5) will monitor the ongoing study by Tufts University of the cost of drug development and its relationship to drug pricing as well as other major research efforts in this area and keep the AMA House of Delegates informed about the findings of these studies;
- (6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA A-rated generic); and
- (7) encourages all physicians to become familiar with the price in their community of the medications they prescribe and to consider this along with the therapeutic benefits of the medications they select for their patients.

BOT Rep. O, A-90; Sub. Res. 126 and Sub. Res. 503, A-95; Reaffirmed: Res. 502, A-98; Reaffirmed: Res. 520, A-99; Reaffirmed: CMS Rep. 9, I-99; Reaffirmed: CMS Rep. 3, I-00; Reaffirmed: Res. 707, I-02; Reaffirmation: A-04; Reaffirmed: CMS Rep. 3, I-04; Reaffirmation: A-06; Reaffirmed in lieu of Res. 814, I-09; Reaffirmed in lieu of Res. 201, I-11; Reaffirmed in lieu of Res. 207, A-17; Reaffirmed: BOT Rep. 14, A-18

### **Reducing Prescription Drug Prices D-110.993**

Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

CMS Rep. 3, I-04; Modified: CMS Rep. 1, A-14; Reaffirmation: A-14; Reaffirmed in lieu of Res. 229, I-14

### **Prescription Drug Prices and Medicare D-330.954**

1. Our AMA will support federal legislation which gives the Secretary of the Department of Health and Human Services the authority to negotiate contracts with manufacturers of covered Part D drugs.
2. Our AMA will work toward eliminating Medicare prohibition on drug price negotiation.
3. Our AMA will prioritize its support for the Centers for Medicare & Medicaid Services to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Res. 211, A-04; Reaffirmation: I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117  
(JUN-21)

Introduced by: Medical Student Section

Subject: Addressing Healthcare Accessibility for Current and Aged-Out Youth in the Foster Care System

Referred to: Reference Committee A

Whereas, More than 33% of youth entering foster care have a chronic medical condition and up to 80% struggle with significant mental health conditions, requiring sophisticated long-term medical attention well past the age of 18 <sup>1,2</sup>; and

Whereas, Many youths in the foster care system struggle to receive regular health care as they frequently change caregivers and locations, often leading to gaps in their medical and immunization records and poor long term treatment follow through <sup>1</sup>; and

Whereas, Nearly 20,000 children age out of the foster system each year, with the majority leaving with inadequate educational, social and financial support amongst other necessities <sup>3,4</sup>; and

Whereas, Around 26,000 former foster youth face significant challenges in receiving health care each year <sup>5,6</sup>; and

Whereas, Children aged out of the foster system are at increased risk for a lifetime of health problems including severe obesity, diabetes, and stroke amongst others due to adverse childhood experiences<sup>7</sup>; and

Whereas, The Affordable Care Act requires states to provide Medicare coverage for youth who have aged out of the foster care system in their state until their 26th birthday <sup>8</sup>; and

Whereas, Currently 37 states interpret the law to require Medicaid coverage for 18 to 26-year-old youths who aged out of the foster care system in their own state, not any other state <sup>8,9</sup>; and

Whereas, AMA policy supports comprehensive, evidence-based care only for children currently in foster care (H-60.910); therefore be it

RESOLVED, That our American Medical Association amend policy H-60.910, by addition and deletion to read as follows:

**Addressing Healthcare Needs of ~~Youth Children~~ in Foster Care, H-60.910**

1. Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of ~~children~~ youth in foster care.

2. Our AMA advocates that all youth currently in foster care remain eligible for Medicaid of other publicly funded health coverage in their state until at least 26 years of age. (Modify Current HOD Policy)

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

Date Received: 05/12/21

**AUTHOR'S STATEMENT OF PRIORITY**

Our delegation prioritizes health protections and access for vulnerable populations, including youth of the foster care system. This resolution turns AMA's attention to a large, at-risk population needing more consistent access to care, especially with the possibility of anticipated changes in healthcare policy approaches at the federal and state level. Current AMA policy is light on the subjects of transitions of care and foster youth; therefore, this resolution addresses an important policy gap and expands the reach of AMA's advocacy efforts.

While existing resolutions H-60.910 and H-185.929 are broadly inclusive of infants and children, they are not inclusive of aged-out foster care individuals.

This resolution reveals the lack of homogeneity in Medicaid policy: 37 of the 50 states limit coverage to those who have aged-out from the foster care system within their own state. Aged-out individuals across the nation can receive timely detection and treatment for chronic health illness and mental health problems, both of which are reported at higher rates than the general populace. Efforts by the AMA to increase care will also identify those who did not receive appropriate immunization since exiting the foster care system.

The new language will help ensure that all aged-out foster care individuals are supported until the age of 26, regardless of residence. Thus, we urge that our AMA consider this resolution and place this marginalized population on a trajectory towards a better quality of life with physical and mental wellbeing.

**References:**

1. McGill N. Making health a priority for children in foster care system: Connecting to care, wherever kids are. Nations Health. 2016;46(7).
2. American Academy of Pediatrics. Fostering Health: Health Care for Children and Adolescents in Foster Care. 2nd ed. New York, NY: American Academy of Pediatrics; 2005.
3. Administration of Children and Families: AFCARS Report #27; 2020.
4. Youth Who Relocate From Another State. FosterClub; 2018.
5. Wilson-Simmons R, Dworsky A, Tongue D, Hulbutta M. NCCP | Fostering Health: The Affordable Care Act, Medicaid, and Youth Transitioning from Foster Care; 2016.
6. Gorman A. Kaiser Health News. For Former Foster Kids, Moving Out Of State Can Mean Losing Medicaid; 2015.
7. Guzman D, Ann-Yi S, Bruera E, et al. Enhancing palliative care patient access to psychological counseling through outreach telehealth services. Psychooncology. 2020;29(1):132-138. doi:10.1002/pon.5270
8. Ensuring Access to Medicaid Coverage for Former Foster Care Youth. Medicaid and CHIP; 2017.
9. Weiner J. Medicaid for Some Former Foster Youth...But Not All. University of Pennsylvania; 2014.

**RELEVANT AMA POLICY****Addressing Healthcare Needs of Children in Foster Care H-60.910**

Our AMA advocates for comprehensive and evidence-based care that addresses the specific health care needs of children in foster care.

Res. 907, I-17