DISCLAIMER

The following is a preliminary report of actions taken by the House of Delegates at its June 2021 Special Meeting and should not be considered final. Only the Official Proceedings of the House of Delegates reflect official policy of the Association.

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES
(J21 Special Meeting)

Report of Reference Committee A

Jayne E. Courts, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Council on Medical Service Report 2 – Continuity of Care for Patients Discharged from Hospital Settings
2. Council on Medical Service Report 8 – Licensure and Telehealth

RECOMMENDED FOR ADOPTION AS AMENDED OR SUBSTITUTED

3. Council on Medical Service Report 7 – Addressing Equity in Telehealth
4. Resolution 121 – Medicaid Dialysis Policy for Undocumented Patients

RECOMMENDED FOR REFERRAL

5. Resolution 122 – Developing Best Practices for Prospective Payment Models
6. Resolution 123 – Medicare Eligibility at Age 60

RECOMMENDED FOR REFERRAL FOR DECISION

7. Resolution 105 – Effects of Telehealth Coverage and Payment Parity on Health Insurance Premiums

Amendments
If you wish to propose an amendment to an item of business, click here: Submit New Amendment

RECOMMENDED FOR ADOPTION

(1) COUNCIL ON MEDICAL SERVICE REPORT 2 – CONTINUITY OF CARE FOR PATIENTS DISCHARGED FROM HOSPITAL SETTINGS

RECOMMENDATION:

Recommendations in Council on Medical Service Report 2 be adopted and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 2 adopted and the remainder of the Report filed.

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)

Your Reference Committee heard testimony that was supportive of Council on Medical Service Report 2. A member of the Council on Medical Service introduced the report by noting that the Council reviewed a variety of strategies used by hospitals to ensure continuity of care after discharge, including medication reconciliation prior to discharge and programs that provide transitional supplies of discharge medications to patients. Testimony from the Council and others highlighted real-time pharmacy benefit tools as especially promising for improving continuity of care during the discharge period given that problems ensuring coverage of discharge medications can hold up hospital discharge. Your Reference Committee believes a minor amendment to add "prior to discharge" to Recommendation 2 is unnecessary since the recommendation already includes the language "prior to hospital discharge." Accordingly, your Reference Committee recommends that the recommendations of Council on Medical Service Report 2 be adopted.

(2) COUNCIL ON MEDICAL SERVICE REPORT 8 – LICENSURE AND TELEHEALTH

RECOMMENDATION:

Recommendations in Council on Medical Service Report 8 be <u>adopted</u> and the remainder of the Report be <u>filed</u>.

HOD ACTION: Recommendation 1 in Council on Medical Service Report 8 <u>referred for decision</u>. The rest of the recommendations in Council on Medical Service Report 8 <u>adopted</u> and the remainder of the Report <u>filed</u>.

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

1. That our American Medical Association (AMA) work with the Federation of State Medical Boards, state medical associations 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 in the state without penalty if the following conditions are met:

a) The physician has an active license to practice medicine in a state or US territory and has not been subjected to disciplinary action.

b) There is a pre-existing and ongoing physician-patient relationship.
c) The physician has had an in-person visit(s) with the patient.
d) The telehealth services are incident to an existing care plan or one that is being modified.
e) The physician maintains liability coverage for telehealth services provided to patients in states other than the state where the physician is licensed.
f) Telehealth use complies with Health Insurance Portability and Accountability Act privacy and security rules. (Directive to Take Action)

2. That our AMA amend Policy H-480.969[1] by addition and deletion as follows:

The Promotion of Quality Telemedicine H-480.969
(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~~a) exemption from such a licensure requirement for ~~traditional informal~~ physician-to-physician consultations ~~("curbside consultations") that are provided without expectation of compensation~~;
(~~c~~b) 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
(c) allowances, by exemption or other means, for out-of-state physicians providing continuity of care to a patient, where there is an established ongoing relationship and previous in-person visits, for services incident to an ongoing care plan or one that is being modified.
(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. (Modify Current AMA Policy)

3. That our AMA continue to support state efforts to expand physician licensure recognition across state lines in accordance with the standards and safeguards outlined in Policy H-480.946, Coverage and Payment for Telemedicine. (New HOD Policy)

4. That our AMA reaffirm 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 to consider joining the Compact; advocate for reduced application and state licensure(s) fees processed through the Interstate Medical Licensure Compact; and work with interested state medical associations to encourage states to pass legislation enhancing patient access to and proper regulation of telemedicine services. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-480.946, which delineates standards and safeguards that should be met for the coverage and payment of telemedicine, including 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. (Reaffirm HOD Policy)

Testimony was generally supportive of Council on Medical Service Report 8. A member of the Council on Medical Service introduced the report by emphasizing that this is the Council's second report on licensure and telehealth in as many years. As highlighted by the Council member, the report seeks to strike the right balance between strengthening telehealth options while protecting patients and physician-patient relationships. A member of the Council on Legislation testified in support of the report and its recommendations that encourage interstate telehealth while also recognizing the important roles of states, state medical boards, and the Interstate Medical Licensure Compact.

In response to a proposed amendment to add "practice" after "physician" to Recommendation 1(b) and (c), a Council on Medical Service member explained that the Council had focused its deliberations on the importance of maintaining established physician-patient relationships and therefore chose to use the term "physician-patient" instead of "practice-patient" to describe that relationship. The Council member stressed that the proposed amendment could open a loophole to corporate providers. It was also noted by the Council member that a physician who is covering another physician acts as that physician's proxy in the physician-patient relationship and that a change to the recommendation is not needed.

A Council on Medical Service member also testified against an amendment recommending that the AMA explore opportunities for expanding telehealth to include out-of-state physicians' use of telehealth to provide initial consultation for care that may not be available in the patient's home state. The Council member emphasized that using telehealth to provide care to patients across state lines where there is not an established physician-patient relationship would require additional scrutiny. Your Reference Committee believes that while this may be an issue worthy of further study, this amendment may be beyond the current report's focus on interstate telehealth for continuity of care where there are established physician-patient relationships.

Your Reference Committee also heard sufficient concerns regarding the proposed amendment to add "practice" to Recommendation 1(b) and (c) and therefore does not recommend that change. In response to a speaker's concern that Recommendation 1(d) would preclude using telehealth to treat an established patient who is seeking care for a new condition, your Reference Committee believes that the recommendation as written is sufficient because it specifies that care can be incident to an existing care plan or one that is being modified. Because a preponderance of the testimony supported the report recommendations as written, your Reference Committee recommends that the Council on Medical Service Report 8 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(3) COUNCIL ON MEDICAL SERVICE REPORT 7 – ADDRESSING EQUITY IN TELEHEALTH

RECOMMENDATION A:

Recommendation 7 in Council on Medical Service Report 7 be <u>amended by addition</u> to read as follows:

7. That our AMA encourage hospitals, health systems and health plans to invest in initiatives aimed at designing access to care via telehealth with and for historically marginalized and minoritized communities, including improving physician and <u>non-physician</u> 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. (New HOD Policy)

RECOMMENDATION B:

Recommendation 8 in Council on Medical Service Report 7 be <u>amended by addition and deletion</u> to read as follows:

8. That our AMA support expanding physician practice eligibility for programs that assist ~~providers~~ <u>qualifying health care entities, including physician practices,</u> in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)

RECOMMENDATION C:

Recommendation 12 in Council on Medical Service Report 7 be <u>amended by addition and deletion</u> to read as follows:

12. That our AMA advocate that <u>physician</u> payments ~~should consider the resource costs required to provide all physician visits and payments~~ should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

RECOMMENDATION D:

Council on Medical Service Report 7 be amended by addition of a new Recommendation to read as follows:

That our AMA recognize access to broadband internet as a social determinant of health. (New HOD Policy)

RECOMMENDATION E:

Recommendations in Council on Medical Service Report 7 be adopted as amended and the remainder of the Report be filed.

HOD ACTION: Recommendations in Council on Medical Service Report 7 adopted as amended and the remainder of the Report filed.

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)

4. That our AMA encourage telehealth solution and service providers to implement design functionality, content, user interface, and service access best practices with and for historically minoritized and marginalized communities, including addressing culture, language, technology accessibility, and digital literacy within these populations. (New HOD Policy)

5. That our AMA support efforts to design telehealth technology, including voice-activated technology, with and for those with difficulty accessing technology, such as older adults, individuals with vision impairment and individuals with disabilities. (New HOD Policy)

6. That our AMA reaffirm 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. (Reaffirm HOD Policy)

7. That our AMA encourage hospitals, health systems and health plans 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. (New HOD Policy)

8. That our AMA support expanding physician practice eligibility for programs that assist providers in purchasing necessary services and equipment in order to provide telehealth services to augment the broadband infrastructure for, and increase connected device use among historically marginalized, minoritized and underserved populations. (New HOD Policy)

9. That our AMA reaffirm Policy D-480.969, which 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. (Reaffirm HOD Policy)

10. That our AMA support efforts to ensure payers allow all contracted physicians to provide care via telehealth. (New HOD Policy)

11. That our AMA oppose efforts by health plans to use cost-sharing as a means to incentivize or require the use of telehealth or in-person care or incentivize care from a separate or preferred telehealth network over the patient's current physicians. (New HOD Policy)

12. That our AMA advocate that payments should consider the resource costs required to provide all physician visits and payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person. (New HOD Policy)

There was highly supportive testimony on Council on Medical Service Report 7. In introducing the report, the chair of the Council on Medical Service stated that the report recommendations underscore 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 with and for patients with varying digital literacy levels and health care needs to participate in two-way audio-video telehealth. Significantly, the chair of the Council on Medical Service stressed that 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.

A member of the Council on Legislation, testifying in support of the report, highlighted that the AMA has been a leader in advocating for expanded access to telehealth services for Americans because it has the capacity to improve access to care for many historically marginalized and minoritized populations and improve outcomes for at-risk

patients, particularly those with chronic diseases and/or functional impairments. In conjunction with expanded access to telehealth services, the AMA has supported Congressional efforts to expand high-speed broadband internet access to underserved communities and increase digital literacy education efforts. The member of the Council on Legislation stated that the report recommendations recognize how AMA advocacy must move forward in the telehealth space.

Minor amendments were offered to the seventh and eighth recommendations of the report to clarify the distinction between physicians and other health care providers. Your Reference Committee accepted the offered amendment to the seventh recommendation, but presents alternate amendment language for the eighth recommendation, to accurately reflect the entities currently eligible for the programs referenced in the recommendation, which range from county health departments to rural health clinics.

In addition, there was a proposed amendment to delete the reference to the consideration of resource costs in the twelfth recommendation of the report. Concerns were raised that the inclusion of the reference to resource costs in this recommendation may adversely impact efforts to ensure adequate payment for audio-only visits. There was opposition to this amendment, underscoring that consideration of resource costs aligns with the methodology of the RVS Update Committee (RUC) in ensuring credible, appropriate, and accurate recommendations to the Centers for Medicare and Medicaid Services (CMS). Testimony noted that an in-person visit includes medical supplies and specific in-person nurse tasks and time that may not be utilized in an audio-only visit. In addition, testimony highlighted that appropriate resource consideration is a long-standing precedent within the Medicare Physician Payment Schedule and important to CMS and policymakers. Ultimately, your Reference Committee accepted the amendment, as the original wording of the twelfth recommendation could have unintended impacts on advocacy efforts on the state and federal levels pertaining to equitable telehealth payment and payment for audio-only visits.

Another amendment was offered to recognize broadband access as a social determinant of health, which your Reference Committee found timely and extremely complementary to the recommendations of this report. Your Reference Committee believes that the other amendments offered are addressed by existing AMA policy, including Policy D-480.963, or are topics best served by the introduction of resolutions at a future meeting.

Your Reference Committee believes that the recommendations of Council on Medical Service Report 7 should be adopted as amended. Your Reference Committee believes that this report and its recommendations are highly 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."

(4) RESOLUTION 121 – MEDICAID DIALYSIS POLICY FOR UNDOCUMENTED PATIENTS

RECOMMENDATION A:

Resolution 121 be amended by addition and deletion to read as follows:

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and state Medicaid programs to cover scheduled outpatient maintenance dialysis ~~develop a dialysis policy~~ for undocumented patients with end stage kidney disease ~~as an emergency condition covered~~ under Emergency Medicaid. (Directive to Take Action)

RECOMMENDATION B:

Resolution 121 be adopted as amended.

HOD ACTION: Resolution 121 adopted as amended.

RESOLVED, That our American Medical Association work with the Centers for Medicare and Medicaid Services and state Medicaid programs to develop a dialysis policy for undocumented patients with end stage kidney disease as an emergency condition covered under Medicaid. (Directive to Take Action)

Testimony was very supportive of the intent of Resolution 121 and the need to expand dialysis coverage to undocumented patients with end stage kidney disease. Speakers noted that undocumented patients often present in emergency departments when they are acutely ill and in urgent need of dialysis and, at times, inpatient care that is significantly more costly than dialysis provided in the outpatient setting. Amended Resolve clauses were offered by both the AMA Medical Student Section and the Council on Medical Service to clarify the resolution's intent. Your Reference Committee believes that both amendments achieve the same goals, and the language proffered by the AMA Medical Student Section is clearer about the need for coverage for outpatient dialysis. Accordingly, your Reference Committee recommends that Resolution 121 be adopted as amended.

RECOMMENDED FOR REFERRAL

(5) RESOLUTION 122 – DEVELOPING BEST PRACTICES FOR PROSPECTIVE PAYMENT MODELS

RECOMMENDATION:

Resolution 122 be referred.

HOD ACTION: Resolution 122 referred.

RESOLVED, That our American Medical Association study and identify best practices for financially viable models for prospective payment health insurance, including but not limited to appropriately attributing and allocating patients to physicians, elucidating best practices for systems with multiple payment contracts, and determining benchmarks for adequate infrastructure, capital investment, and models that accommodate variations in existing systems and practices (Directive to Take Action); and be it further

RESOLVED, That our AMA use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models (Directive to Take Action)

Testimony was generally supportive of Resolution 122 and the need for data and study of best practices regarding prospective payment models. Speakers highlighted the timeliness of Resolution 122 given the considerable challenges posed by the COVID-19 pandemic as fewer patients sought care, decreasing revenues of practices operating under fee-for-service. There was a suggestion to delete the second Resolve clause. Other amendments were offered to provide clarity about what to include in the proposed study. Speakers cited the AMA's history of embracing pluralism and the fact that payment systems are complex and may affect various medical specialties differently. Your Reference Committee heard sufficient support for referral and therefore recommends that Resolution 122 be referred.

(6) RESOLUTION 123 – MEDICARE ELIGIBILITY AT AGE 60

RECOMMENDATION:

Resolution 123 be referred.

HOD ACTION: Resolution 123 referred, with report back at the November 2021 Meeting of the House of Delegates.

RESOLVED, That our American Medical Association advocate that the eligibility threshold to receive Medicare as a federal entitlement be lowered from age 65 to age 60. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 123. Supportive testimony stressed that lowering the Medicare eligibility age to 60 could serve as a

pathway to cover the uninsured ages 60 to 64 and could impact patient health care costs. Testimony in support also raised the timeliness of this resolution, due to the debate in Congress surrounding budget reconciliation, and the potential advancement of this proposal alongside that which makes the American Rescue Plan changes to the ACA permanent.

However, members of the Council on Medical Service and Council on Legislation called for reaffirmation of existing AMA policy underpinning AMA's plan to cover the uninsured in lieu of this item. Notably, members of both Councils underscored that AMA's plan to cover the uninsured already includes ways to improve coverage of the uninsured in this age cohort - half of whom are eligible for ACA premium tax credits, and 20 percent of whom are eligible for Medicaid. In sum, members of both Councils stressed that individuals ages 60 to 64 are not left behind in our AMA's plan to cover the uninsured. As such, a member of the Council on Legislation testified that helping the uninsured ages 60 to 64 does not require risking the consequences of lowering the Medicare eligibility age to 60, especially when the evidence shows that doing so would only have a very modest impact on coverage, at best. A member of the Council on Medical Service highlighted a RAND study that showed that a Medicare buy-in has little to no effect on total health insurance enrollment, as more older adults enrolling in health insurance pursuant to the establishment of the buy-in is countered by additional younger adults becoming uninsured due to the proposal's impact on premiums. In addition, a Kaiser Family Foundation report found that the effect on coverage, access and affordability of lowering the Medicare eligibility age to 60 will depend on what type of premium and cost-sharing assistance is provided to newly eligible adults. Notably, the Council member raised that most individuals currently enrolled in traditional Medicare are also enrolled in a supplemental plan – a Medicare supplemental plan, through their employer, or Medicaid – to help with out-of-pocket costs.

As evidence of potential consequences of lowering the Medicare eligibility age to 60, it was highlighted that the Kaiser Family Foundation this year found that the policy to lower the age of Medicare eligibility could potentially shift 11.7 million people with employer coverage and 2.4 million with non-group coverage into Medicare. Testimony stressed that this would not only impact the payer mix of physician practices. Those who transition out of employer coverage to Medicare if the eligibility age were lowered would take their health spending with them as well. As a result, a large proportion of their health spending would fall under the federal budget, as Medicare is partially funded by general revenues. This shift from employer coverage to Medicare could exacerbate the financial challenges facing the Medicare Trust Fund.

Testimony also highlighted that the temporary ACA improvements included in the American Rescue Plan raise questions as to the ultimate impacts of lowering the Medicare eligibility age to 60. Due to the unintended consequences cited in testimony of lowering the Medicare eligibility age to 60, as well as the evolving coverage environment due to recently enacted ACA improvements, your Reference Committee recommends that Resolution 123 be referred. Your Reference Committee is hopeful that the resulting report will examine the impacts of a Medicare buy-in in addition to lowering the Medicare eligibility to 60, reflecting testimony offered on this item.

RECOMMENDED FOR REFERRAL FOR DECISION

(7) RESOLUTION 105 – EFFECTS OF TELEHEALTH COVERAGE AND PAYMENT PARITY ON HEALTH INSURANCE PREMIUMS

RECOMMENDATION:

Resolution 105 be referred for decision.

HOD ACTION: Resolution 105 referred for decision.

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

Your Reference Committee heard mixed testimony on Resolution 105. Supporters of the resolution stressed that additional data is needed to support efforts on the state level to support fair and equitable payment for telehealth. Specifically, testimony highlighted that some opposition to advocacy efforts on the state level to improve payment for telehealth is rooted in concerns regarding the impact of equitable physician payment for telehealth on health insurance premiums.

However, concerns were raised that the study called for in the resolution may not yield helpful data or the data desired by state medical associations and national medical specialty societies. Also, testimony underscored that there are numerous inputs to health insurance premiums, which may cause the specific impact of equitable payment for telehealth to be difficult to measure. Testimony also highlighted the high fiscal note of the resolution.

There were calls for referral as well as referral for decision. Notably, one of the state medical association sponsors of Resolution 105 supported referral for decision. A member of the Council on Medical Service, in calling for referral for decision, stated that further examination is warranted to ascertain what kind of investment by the AMA is necessary to assess the impact of telehealth services on health insurance premiums. In addition, the Council member stressed that our AMA needs to ensure that state medical associations, regardless of whether their states already have equitable payment provisions in place, can benefit from any data that the AMA is able to provide. A member of the Council on Legislation underscored that there is a need to make sure that state medical associations and national medical specialty societies have the right data and information as they advocate in this space. Importantly, the Council member raised the need to ensure that the AMA's role and investment in this effort is appropriate. Your Reference Committee agrees with concerns raised in testimony, and recommends that Resolution 105 be referred for decision.

Mister Speaker, this concludes the report of Reference Committee A. I would like to thank Christine Bishof, MD, Gregory M. Fuller, MD, Andrea Hillerud, MD, Dale M. Mandel, MD, Joshua Rosenow, MD, Vinita Shivakumar, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, and Jane Ascroft, MPA.

Christine Bishof, MD
Illinois

Dale M. Mandel, MD (Alternate)
Pennsylvania

Gregory M. Fuller, MD
Texas

Joshua Rosenow, MD
American Association of Neurological Surgeons

Andrea Hillerud, MD
Minnesota

Vinita Shivakumar (Alternate)
California

Jayne E. Courts, MD
Michigan
Chair