

NATIONAL ADVOCACY WEEK 2022

OCT. 10-14



Educate Yourself on the Issues

This document is for you to learn about the issues we will be focusing on during National Advocacy Week. The below information is for your own information only. When communicating with your Congressional representatives, use the official issue briefs (linked on our web page) to give to or send as follow-up. When speaking on behalf of the American Medical Association, we are able to make a large impact by communicating the same, effective messages to legislators. The issue briefs are created based on what message is resonating on Capitol Hill and is in line with what AMA lobbying staff is communicating.

Improve future financial security for students

In 2020, about 42 million Americans, or one in eight, had student loans with the entire amount of student debt equaling around \$1.5 trillion. With Americans feeling the weight of student loan debt, many choose to forgo contributing to their retirement plans, jeopardizing their future financial security. The Retirement Parity for Student Loans Act would permit 401(k), 403(b), SIMPLE, and governmental 457(b) retirement plans to make voluntary matching contributions to workers as if their student loan payments were salary reduction contributions. For example, if someone pays \$300 in student loans in a given month, their employer could contribute \$300 or a percentage to their retirement account.

Of the outstanding \$1.5 trillion in student loan debt, about 25 percent of those borrowers went to graduate school and account for half of the outstanding debt. Specifically, in 2019, 73 percent of medical students graduated with an average of about \$200,000 in student loan debt. This number will significantly increase as the cost of medical school goes up every year. In fact, for first year students in 2020-2021, the average cost of attendance increased from the prior year for public medical schools by 10.3 percent, making it likely that medical students will have to carry even larger student loans in the future in order to graduate. With medical students being forced to take on low-paying residency and fellowship positions for up to eight years post-graduation, this generation of students is having to choose between paying back student loans or contributing to their retirement.

A study found that [student debtors save significantly less for retirement](#) than non-debtors by age 30 and that this gap continues to grow over the student debtors' lifetime. Moreover, 73 percent of Americans say they expect to begin, or increase, their retirement contributions once their student loans are paid off. However, with most Americans unable to pay off student loans [until they are in their 40s](#), decades will pass before individuals are able to invest for their retirement. By delaying saving for retirement, individuals miss out on many of the long-term benefits of compound interest, which will either force them to have to save about 40 percent of their income, if they begin investing for their retirement in their 40s, in order to adequately support themselves in their retirement, or lead to an unsustainable reliance on Social Security, which itself is [under threat of being depleted by 2037](#). Comprehensive solutions are needed to ensure that this generation and generations to come can properly save for retirement throughout their career.

The Retirement Parity for Student Loans Act would permit 401(k), 403(b), SIMPLE, and governmental 457(b) retirement plans to make voluntary employer-matching contributions to workers as if their student loan payments were salary reduction contributions. This bill - H.R.2954 - Securing a Strong Retirement Act of 2021 has passed the House of Representatives and our efforts for National Advocacy Week will be utilized to urge your senators to cosponsor and support S. 4808, the "Enhancing American Retirement Now Act"

Tell the Senate to extend Medicare Telehealth payment and regulatory flexibilities through the end of 2024

The COVID-19 public health emergency has made clear that there are longitudinal benefits of telehealth, even in moments where there is not an acute public health crisis. Telehealth can help increase access to care in rural and underserved populations. For example, prior to COVID, [a 2016 study](#) in the state of Texas demonstrated that telemedicine has expanded access to acute stroke care for 1.5 million Texans, with no evidence of racial or ethnic disparities.

However, unless Congress acts, most Medicare beneficiaries will [abruptly lose access to these telehealth services](#) 151-days after the public health emergency ends. That is because under section 1834(m) of the Social Security Act, Medicare patients must live in an eligible rural location, and travel to an eligible "originating site"—a qualified health care facility—in order to access telehealth services covered by the Medicare program. Congress authorized the Secretary of the Department of Health and Human Services (HHS) to waive these restrictions and in March 2022, Congress passed legislation to extend the telehealth flexibilities 151 days after the end of the COVID-19 Public Health Emergency (PHE). While this provided certainty for 2022, the PHE is likely to end in 2023. Unless Congress acts again this year, Medicare beneficiaries may abruptly lose access to these services mid-year when the public health emergency ends. Physicians must weigh the costs of investing in the technological and clinical infrastructure required to maintain telehealth programs at scale against the uncertainty of when these telehealth policies may end.

On July 27, the House of Representatives by a vote of 416-12 passed the Advancing Telehealth Beyond COVID-19 Act (H.R. 4040) to provide a two-year extension through the end of 2024 of Medicare telehealth flexibilities. This overwhelming vote demonstrates that access to telehealth services remains a bipartisan issue and is highly valued by patients across the country.

During National Advocacy Week, the AMA is urging the Senate to pass a similar two-year extension of these important telehealth policies, while continuing to push for a permanent extension, that includes provisions to: lift provider and patient location limitations and remove in-person requirements for telemental health.

While our focus for National Advocacy Week is on convening medical students across the country to push for a two-year extension, the AMA recognizes that telehealth can result in better outcomes for patients in managing their chronic conditions and to more quickly receive specialty care in an emergency. Thus, the American Medical Association (AMA) also supports legislation that would permanently fix the originating site and geographic restriction on telehealth coverage for Medicare patients, thereby ensuring patients can continue to access telehealth services regardless of where they are located, including:

- H.R. 1332/S. 368, the **Telehealth Modernization Act of 2021**, which would lift the rural-only restriction and add any site where a patient is located as a potential originating site
- H.R. 2903/S. 1512, the **CONNECT for Health Act**, which would lift the rural-only restriction, add the home as an originating site, establish a process for the Secretary of the HSS to add originating sites, and provide HHS with the permanent authority to waive section 1834(m) restrictions.

The AMA also supports H.R. 4058/S. 2061, the **Telemental Health Care Access Act**. This important, bipartisan bill would repeal a new requirement that a patient must see a provider in person within six months of receiving a mental health telehealth service. This medically unnecessary requirement was included in the December 2020 OMNIBUS legislation without vetting from expert stakeholders. Multiple studies indicate that there are no significant differences between telehealth and in-person care for adults with anxiety, depression, substance use disorder, and post-traumatic stress disorder for symptom improvement, patient satisfaction, quality of life, and medication and treatment adherence. Requiring in-person interaction with no increase in quality of care decreases access to care and prevents patients from receiving needed mental health services. The Telemental Health Care Access Act should be repealed before it takes effect when the Public Health Emergency expires.

Utilize National Advocacy Week to urge your Senator to help ensure greater coverage certainty for telehealth services by supporting a two-year extension of telehealth flexibilities through the end of 2024, similar to House-passed H.R. 4040. In addition, ask your Members of Congress to cosponsor the following bills to provide permanent telehealth coverage:

- H.R. 1333/S. 368 the Telehealth Modernization Act of 2021
- H.R. 2903/S. 1512, the CONNECT for Health Act

Reducing prior authorization burdens

Prior authorization, or the practice of insurance companies reviewing and potentially denying coverage of medical services and pharmaceuticals prior to treatment, remains a principal frustration for physicians and jeopardizes patient care. According to a 2021 American Medical Association (AMA) survey, physicians complete an average of 41 prior authorizations per week, an administrative burden that consumes nearly two business days of physician and staff time. The burden has become so substantial that 40% of physician survey respondents hired staff to work exclusively on prior authorization requirements.

Medically necessary clinical services and prescriptions covered by health insurance plans should be administered without delay. Prior authorization undermines physicians' medical expertise and leads to considerable delays in patient care which can then lead to avoidable consequences for our patients' health. According to the 2021 survey, 93% of physicians reported care delays associated with prior authorization, and 82% said these requirements can at least sometimes lead to patients abandoning treatment.

Failure to administer medically necessary care can and does lead to poor health care outcomes. Most startlingly, 34% of AMA survey participants reported that prior authorization led to a serious adverse event, such as hospitalization, disability and permanent bodily damage, or death, for a patient in their care.

Improving prior authorization in Medicare Advantage

Medicare Advantage refers to a group of plans that have existed since the 1970's including HMO's, PPO's, and others which contract a patient's traditional Medicare coverage to a commercial insurer. Rather than the traditional Medicare fee-for-service model, in Medicare Advantage plans the federal government pays a capitated rate to the insurer. These plans have been described as capable of controlling costs and do have important benefits to the patient: eliminate the need for supplemental coverage, set out-of-pocket maximums, and covered non-medical benefits. However, some challenges include limited provider networks, referral requirements, and--you guessed it--prior authorization. Patients in these plans utilize specialty care at lower rates, perhaps because of these barriers. Importantly, enrollment in these plans is growing and expected to reach [42% by 2028](#).

Since Congress is increasingly concerned about the negative impact of prior authorization on patients and physicians within federal health care programs, a bipartisan collection of House and Senate lawmakers introduced H.R. 8487, the Improving Seniors' Timely Access to Care Act of 2022. This bill reduces unnecessary delays in care by streamlining and standardizing prior authorization under the Medicare Advantage program, providing much-needed oversight and transparency of health insurance for America's seniors. In addition, the legislation incorporates all major elements of a 2018 consensus statement developed by leading physician, hospital, medical group, health plan, and pharmacy stakeholders.

More specifically, the bill would:

- Require Medicare Advantage plans to implement electronic prior authorization programs that adhere to newly developed federal standards and are capable of seamlessly integrating into electronic health systems (vs. proprietary health plan portals), as well as establish real-time decision-making processes for items and services that are routinely approved.
- Mandate that plans report to the Centers for Medicare & Medicaid Services on the extent of their use of prior authorization and the rate of approvals and denials.
- Require plans to adopt transparent prior authorization programs that are reviewed annually, adhere to evidence-based guidelines, permit gold carding, and include continuity of care for individuals transitioning between coverage policies to minimize any care disruptions.
- Hold plans accountable for making timely prior authorization determinations and providing rationales for denials.

H.R. 8487, the Improving Seniors' Timely Access to Care Act of 2022 overwhelmingly passed the House of Representatives by a bipartisan voice vote on September 14 and is now heading to the senate. Our efforts for National Advocacy Week will be utilized to urge your senators to cosponsor and support S. 3018, a companion bill for H.R. 8487,

To access the AMA's prior authorization research and advocacy resources, visit [**ama-assn.org/prior-auth**](http://ama-assn.org/prior-auth).