WHEREAS, Our professionalism is the basis of medicine’s contract with society and trust between physicians and patients is based on the premise that physicians will put the patient’s needs first; and

WHEREAS, It is imperative to preserve the public faith in the independence and objectivity of physicians; and

WHEREAS, There has been a rapid restructuring of medical care over the past ten years, moving away from fee-for-service payment and toward value-based payment models (for example, accountable care organizations) and capitation (for example, Medicare Advantage), making physicians both caregiver and cost manager; and

WHEREAS, These payment models are fundamentally disruptive to the ethical framework of patient care; and

WHEREAS, A conflict of interest exists when a reasonable person would interpret the financial incentives applied to physicians, whether withhold or bonus, are sufficient to influence their judgment; and

WHEREAS, It is the professional responsibility of every physician to manage any potential conflicts of interest that could compromise the primacy of patients; and

WHEREAS, The cover nature of these payment arrangement means patients are completely ignorant and have no source of protection against their hidden imposition; and

WHEREAS There are no patient disclosure requirements regarding these payment arrangements; therefore be it

RESOLVED, That our American Medical Association seek legislation requiring complete disclosure of potential conflicts of interest by:

1. All insurance plans: Medicare (Medicare Advantage), Medicaid, and commercial insurers;
2. Employers of physicians (for example, accountable care organizations in the Medicare Shared Savings Program);
3. Pharmacy benefit managers;
(Directive to Take Action); and be it further
RESOLVED, That our AMA advocate that disclosure of potential conflicts of interest are to be written in plain language and detail the following:

1. The type of physician incentive arrangement, whether withhold, bonus, or capitation;
2. The percentage of the withhold or bonus as the intensity of the incentives clearly effect the extent of the physician’s conflict of interest;
3. The amount and type of stop-loss protection;
4. A breakdown of capitation payments by the percentages for primary care, specialty care, hospital care, or other services;
5. Whether physicians are at significant risk for services not personally provided by them;
6. The possibility of a reduction in care that has a positive expected benefit but is not deemed cost-effective;
7. Disclosure of “shared” savings that may be earned by the individual physician from limiting patient options, access to specialist referrals, diagnostic tests and treatment;

(Directive to Take Action).

Fiscal Note: TBD

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References:
RELEVANT AMA POLICY

Physician Pay-for-Performance Programs H-140.872

Physician pay-for-performance (PFP) compensation arrangements should be designed to improve health care quality and patient safety by linking remuneration to measures of individual, group, or organizational performance. To uphold their ethical obligations, physicians who are involved with PFP programs must take appropriate measures to promote patients’ well-being.

(1) Physicians who are involved in the design or implementation of PFP programs should advocate for:
(a) incentives that are intended to promote health care quality and patient safety, and are not primarily intended to contain costs;
(b) program flexibility that allows physicians to accommodate the varying needs of individual patients;
(c) adjustment of performance measures by risk and case-mix in order to avoid discouraging the treatment of high-risk individuals and populations;
(d) processes to make practice guidelines and explanations of their intended purposes and the clinical findings upon which they are based available to participating physicians.

(2) Practicing physicians who participate in PFP programs while providing medical services to patients should:
(a) maintain primary responsibility to their patients and provide competent medical care, regardless of financial incentives;
(b) support access to care for all people and avoid selectively treating healthier patients for the purpose of bolstering their individual or group performance outcomes;
(c) be aware of evidence-based practice guidelines and the findings upon which they are based;
(d) always provide care that considers patients’ individual needs and preferences, even if that care conflicts with applicable practice guidelines;
(e) not participate in PFP programs that incorporate incentives that conflict with physicians’ professional values or otherwise compromise physicians’ abilities to advocate for the interests of individual patients.

Citation: CEJA Rep. 3, I05; Reaffirmed: A-06; Reaffirmed: I-06; Reaffirmed: CEJA Rep. 3, A-16; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17

Informed Consent and Decision-Making in Health Care H-140.989

(1) Health care professionals should inform patients or their surrogates of their clinical impression or diagnosis; alternative treatments and consequences of treatments, including the consequence of no treatment; and recommendations for treatment. Full disclosure is appropriate in all cases, except in rare situations in which such information would, in the opinion of the health care professional, cause serious harm to the patient.

(2) Individuals should, at their own option, provide instructions regarding their wishes in the event of their incapacity. Individuals may also wish to designate a surrogate decision-maker. When a patient is incapable of making health care decisions, such decisions should be made by a surrogate acting pursuant to the previously expressed wishes of the patient, and when such wishes are not known or ascertainable, the surrogate should act in the best interests of the
(3) A patient's health record should include sufficient information for another health care professional to assess previous treatment, to ensure continuity of care, and to avoid unnecessary or inappropriate tests or therapy.

(4) Conflicts between a patient's right to privacy and a third party's need to know should be resolved in favor of patient privacy, except where that would result in serious health hazard or harm to the patient or others.

(5) Holders of health record information should be held responsible for reasonable security measures through their respective licensing laws. Third parties that are granted access to patient health care information should be held responsible for reasonable security measures and should be subject to sanctions when confidentiality is breached.

(6) A patient should have access to the information in his or her health record, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to other people.

(7) Disclosures of health information about a patient to a third party may only be made upon consent by the patient or the patient's lawfully authorized nominee, except in those cases in which the third party has a legal or predetermined right to gain access to such information.


The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987

1. Our AMA supports the active regulation of pharmacy benefit managers (PBMs) under state departments of insurance.
2. Our AMA will develop model state legislation addressing the state regulation of PBMs, which shall include provisions to maximize the number of PBMs under state regulatory oversight.
3. Our AMA supports requiring the application of manufacturer rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to drug prices at the point-of-sale.
4. Our AMA supports efforts to ensure that PBMs are subject to state and federal laws that prevent discrimination against patients, including those related to discriminatory benefit design and mental health and substance use disorder parity.
5. Our AMA supports improved transparency of PBM operations, including disclosing:
   - Utilization information;
   - Rebate and discount information;
   - Financial incentive information;
   - Pharmacy and therapeutics (P&T) committee information, including records describing why a medication is chosen for or removed in the P&T committee’s formulary, whether P&T committee members have a financial or other conflict of interest, and decisions related to tiering, prior authorization and step therapy;
   - Formulary information, specifically information as to whether certain drugs are preferred over others and patient cost-sharing responsibilities, made available to patients and to prescribers at the point-of-care in electronic health records;
- Methodology and sources utilized to determine drug classification and multiple source generic pricing; and
- Percentage of sole source contracts awarded annually.

6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.

Citation: CMS Rep. 5, A-19; Reaffirmed: CMS Rep. 6, I-20