

REPORTS OF THE COUNCIL ON MEDICAL SERVICE

The following reports were presented by Asa C. Lockhart, MD, MBA, Chair:

1. COUNCIL ON MEDICAL SERVICE SUNSET REVIEW OF 2012 HOUSE POLICIES

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED REMAINDER OF REPORT FILED

Policy G-600.110, “Sunset Mechanism for AMA Policy,” calls for the decennial review of American Medical Association (AMA) policies to ensure that our AMA’s policy database is current, coherent, and relevant. Policy G-600.010 reads as follows, laying out the parameters for review and specifying the procedures to follow:

1. As the House of Delegates adopts policies, a maximum ten-year time horizon shall exist. A policy will typically sunset after ten years unless action is taken by the House of Delegates to retain it. Any action of our AMA House that reaffirms or amends an existing policy position shall reset the sunset “clock,” making the reaffirmed or amended policy viable for another 10 years.
2. In the implementation and ongoing operation of our AMA policy sunset mechanism, the following procedures shall be followed: (a) Each year, the Speakers shall provide a list of policies that are subject to review under the policy sunset mechanism; (b) Such policies shall be assigned to the appropriate AMA councils for review; (c) Each AMA council that has been asked to review policies shall develop and submit a report to the House of Delegates identifying policies that are scheduled to sunset; (d) For each policy under review, the reviewing council can recommend one of the following actions: (i) retain the policy; (ii) sunset the policy; (iii) retain part of the policy; or (iv) reconcile the policy with more recent and like policy; (e) For each recommendation that it makes to retain a policy in any fashion, the reviewing council shall provide a succinct, but cogent justification; or (f) The Speakers shall determine the best way for the House of Delegates to handle the sunset reports.
3. Nothing in this policy shall prohibit a report to the HOD or resolution to sunset a policy earlier than its 10-year horizon if it is no longer relevant, has been superseded by a more current policy, or has been accomplished.
4. The AMA councils and the House of Delegates should conform to the following guidelines for sunset: (a) when a policy is no longer relevant or necessary; (b) when a policy or directive has been accomplished; or (c) when the policy or directive is part of an established AMA practice that is transparent to the House and codified elsewhere such as the AMA Bylaws or the AMA House of Delegates Reference Manual: Procedures, Policies and Practices.
5. The most recent policy shall be deemed to supersede contradictory past AMA policies.
6. Sunset policies will be retained in the AMA historical archives.

RECOMMENDATION

The Council on Medical Service recommends that the House of Delegates policies that are listed in the appendix to this report be acted upon in the manner indicated and the remainder of this report be filed.

APPENDIX - Recommended Actions

Policy #	Title	Text	Recommendation
D-165.957	State Options to Improve Coverage for the Poor	Our AMA (1) urges national medical specialty societies, state medical associations, and county medical societies to become actively involved in and support state-based demonstration projects to expand health insurance coverage to low-income persons; and (2) encourages state governments to maintain an inventory of private	Rescind. Superseded by Policies D-165.942 and H-165.839 , which state: Empowering State Choice D-165.942

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		<p>health plans and design an easily accessible, consumer-friendly information clearinghouse for individuals, families, and small businesses on available plans for expanding health insurance coverage. (CMS Rep. 1, A-05; Reaffirmed in lieu of Res. 105, A-12)</p>	<p>Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan, and c) include reforms that eliminate denials for pre-existing conditions.</p> <p>Health Insurance Exchange Authority and Operation H-165.839</p> <p>1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges:</p> <p>A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.</p> <p>B) Any benefits standards implemented for plans participating in the exchange and/or to determine minimum creditable coverage for an individual mandate should be designed with input from patients and actively practicing physicians.</p> <p>C) Physician and patient decisions should drive the treatment of individual patients.</p> <p>D) Actively practicing physicians should be significantly involved in the development of any regulations addressing physician payment and practice in the exchange environment, which would include any regulations addressing physician payment by participating public, private or non-profit health insurance options.</p> <p>E) Regulations addressing physician participation in public, private or non-profit health insurance options in the exchange that impact physician practice should ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process.</p> <p>F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of</p>

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			<p>state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.</p> <p>2. Our AMA: (A) supports using the open marketplace model for any health insurance exchange, with strong patient and physician protections in place, to increase competition and maximize patient choice of health plans, (B) will advocate for the inclusion of actively practicing physicians and patients in health insurance exchange governing structures and against the categorical exclusion of physicians based on conflict of interest provisions; (C) supports the involvement of state medical associations in the legislative and regulatory processes concerning state health insurance exchanges; and (D) will advocate that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information.</p>
D-165.974	Achieving Health Care Coverage for All	Achieving Health Care Coverage for All -- Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy. (Res. 733, I-02; Modified: CCB/CLRPD Rep. 4, A-12)	<p>Rescind. Superseded by Policy H-165.838, which states:</p> <ol style="list-style-type: none"> I. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy: <ol style="list-style-type: none"> a. Health insurance coverage for all Americans b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials d. Investments and incentives for quality improvement and prevention and wellness initiatives e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care

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			<p>f. Implementation of medical liability reforms to reduce the cost of defensive medicine</p> <p>g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens</p> <p>2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions is understood to include rescission of insurance coverage for reasons not related to fraudulent representation.</p> <p>3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering and bold efforts to promote AMA policies for health system reform in the United States.</p> <p>4. Our American Medical Association supports health system reform alternatives that are consistent with AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for patients.</p> <p>5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians.</p> <p>6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right of patients and physicians to privately contract, without penalty to patient or physician.</p> <p>7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals.</p> <p>8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the following provisions in health system reform legislation:</p> <p>a. Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems</p>

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			<p>still have not been corrected by the Centers for Medicare and Medicaid Services</p> <p>b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system</p> <p>c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-adjusted</p> <p>d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate</p> <p>e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another</p> <p>f. Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest</p> <p>9. Our AMA will continue to actively engage grassroots physicians and physicians in training in collaboration with the state medical and national specialty societies to contact their Members of Congress, and that the grassroots message communicate our AMA’s position based on AMA policy.</p> <p>10. Our AMA will use the most effective media event or campaign to outline what physicians and patients need from health system reform.</p> <p>11. AMA policy is that national health system reform must include replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula, and that the AMA initiate a “call to action” with the Federation to advance this goal.</p> <p>12. AMA policy is that creation of a new single payer, government-run health care system is not in the best interest of the country and must not be part of national health system reform.</p>

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Policy #	Title	Text	Recommendation
			13. AMA policy is that effective medical liability reform that will significantly lower health care costs by reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any national health system reform.
D-185.985	Patient Access to Therapeutics	Our AMA will work with other interested parties to ensure that payment for prescription medications and durable medical equipment not be denied based solely on the use of a properly suffixed institutional Drug Enforcement Agency number or similar identifier. (Res. 121, A-12)	Retain. Still relevant.
D-260.995	Improvements to Reporting of Clinical Laboratory Results	<p>1. Our AMA will: (a) make its involvement with the Office of the National Coordinator for Health Information Technology and its Health Information Technology Policy and Standards Committees a high priority; and (b) become involved in and/or provide input into policies involving electronic transmission of clinical laboratory results.</p> <p>2. Our AMA will encourage the College of American Pathologists, Health Level 7, the National Institute for Standards and Technology, and the Agency for Healthcare Research and Quality to urgently address usability and standardization of laboratory report results for physicians and non-physician practitioners to ensure patient safety.</p> <p>3. Our AMA will support the continued efforts of relevant national medical specialty societies, such as the American College of Radiology, the American Osteopathic College of Radiology and other like organizations whose members generate reports electronically to clarify terminology and work in consultation with physicians likely to be end users toward producing a standardized format with appropriate standard setting bodies for the presentation of radiology results, including clearly identifiable diagnoses and test results.</p> <p>4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization. (BOT Rep. 16, I-06; Modified: CMS Rep. 2, I-12)</p>	Retain-in-part. The following subsection was accomplished and should be rescinded. 4. Our AMA will report back to the House of Delegates on progress with regard to medical record and reporting standardization.
D-285.965	Small Businesses and Health Reform	Our AMA will: (1) advocate that stop-loss coverage of self-insured plans have minimum attachment points that are high enough to ensure the adequacy and financial security of health insurance coverage of enrollees, and be provided by stop-loss insurers that are legitimate and financially secure and solvent; and (2) encourage states to monitor the rate at which small employers self-insure, and the impact of such self-insurance on the viability and purchasing power on SHOP exchanges. (CMS Rep. 6, A-12)	Retain. Still relevant.
D-290.980	Medicare-Medicaid Dual Eligible Demonstration Program	1. Our AMA will advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate	Retain-in-part. The following subsection is out-of-date and should be rescinded. The Centers for Medicare & Medicaid (CMS) has been implementing demonstration programs for dually eligible

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		<p>and comment on the “State Demonstrations to Integrate Care for Dual Eligible Individuals” initiative.</p> <p>2. Because Medicare-Medicaid dual eligibles often have complex medical and social needs, our AMA will advocate to CMS and the states that established patient-provider relationships and current treatment plans will not be disrupted by the dual eligible Financial Alignment Initiative so as to preserve robust, patient-centered continuity of care.</p> <p>3. Our AMA will advocate to CMS and the states that the Medicare-Medicaid dual eligibles Financial Alignment Initiative should operate as a true demonstration program, and therefore it should not enroll a majority of dual eligibles in any state, and there must be a rigorous evaluation plan to be consistent with the design of a demonstration that can provide useful information to policymakers.</p> <p>4. Our AMA will advocate to CMS and states against automatically enrolling Medicare-Medicaid dual eligibles in a coordinated care program without their prior approval or consent.</p> <p>5. Our AMA will work with CMS and the states to ensure that the Medicare-Medicaid dual eligibles Financial Alignment Initiative demonstrates potential ways of achieving efficiencies in organizing the care of dual eligibles, and any savings from coordination of care to dual eligibles should arise from better health outcomes and efficiencies gained by reducing duplicative, unnecessary, or inappropriate care. The Initiative should not be employed as a policy lever simply to reduce provider payment rates, which could significantly harm beneficiary access. Res. 123, A-12</p>	<p>enrollees, including Financial Alignment Initiative demonstrations, since 2012.</p> <p>1. Our AMA will advocate that the Centers for Medicare & Medicaid Services and the states delay implementation of the Medicare-Medicaid dual eligible demonstration program for at least one year to allow beneficiaries and provider stakeholders to better understand and evaluate and comment on the “State Demonstrations to Integrate Care for Dual Eligible Individuals” initiative.</p>
D-290.986	Capitation of Medicaid Funding for Guam and Other US Territorial Possessions	<p>The AMA will support:</p> <p>(1) Repeal of 42 USC 1308(f) and to allow Guam and other Territorial Possessions and Island Nations to participate in the Medicaid program on the same terms as the States, without capitation of matching funds;</p> <p>(2) Amending 42 USC 1396(d)(b)(2) by striking “50 per centum” and by inserting in lieu thereof: “determined in the same manner as such percentage is determined for the States under this subsection”; this will allow the Territories to participate in the Medicaid program on the same terms as the States; and</p> <p>(3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD. (BOT Action in response to referred for decision Res. 215, I-00; Reaffirmed: BOT Rep. 6, A-10; Reaffirmation A-12)</p>	<p>Retain-in-part. The following subsection is out-of-date and should be rescinded.</p> <p>(3) Federal legislative language introduced during the 107th Congress that has provisions equivalent to those included in H.R. 5126, introduced during the last Congress by Virgin Islands Delegate Donna Christensen, MD.</p>

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D-330.918	Appropriateness of National Coverage Decisions	<p>1. Our AMA will work with the national medical specialty societies and the Centers for Medicare and Medicaid Services (CMS) and their intermediaries to identify outdated coverage decisions that create obstacles to clinically appropriate patient care.</p> <p>2. Our AMA will work with CMS to suspend recovery actions for technologies and treatments for which sufficient comparative effectiveness research or other quality evidence exists to update a National Coverage Determination (NCD) or Local Coverage Determination (LCD) to reflect the available scientific evidence and contemporary practice. (Sub. Res. 120, A-11; Reaffirmed in lieu of Res. 125, A-12)</p>	Retain. Still relevant.
D-373.995	Shared Decision Making Resource Centers	Our AMA will advocate for full funding for section 3506 of the Affordable Care Act. (Res. 812, I-12)	Retain. Still relevant.
D-385.959	Billing Codes for Filling Out Forms	Our AMA will lobby the Centers for Medicare & Medicaid Services and other national payers to reimburse those physicians who utilize billing code 99080 for filling out various forms requested by patients. (Res. 803, I-12)	Retain. Still relevant.
D-390.956	MedPAC Recommendations from June 15, 2011	<p>1. Our AMA will oppose any policy that applies a payment reduction to professional component of diagnostic services where multiple imaging studies are interpreted by the same practitioner during the same session and will oppose any policy that reduces the physician work component of imaging and other diagnostic tests that are ordered and interpreted by the same practitioner.</p> <p>2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS. (BOT action in response to referred for decision Res. 124, A-11; Appended: Res. 214, A-12)</p>	Retain-in-part. The following subsection is out-of-date and should be rescinded. 2. Our AMA will: (A) actively support legislation to repeal the 25 percent multiple procedure payment reduction (MPPR) recently implemented by the Centers for Medicare & Medicaid Services (CMS) as part of its 2012 Fee Schedule; and (B) work to prevent further broadening of CMS MPPR proposals until thoroughly studied by CMS.
D-410.992	Evidence-Based Utilization of Services	Our AMA supports physician-led, evidence based, efforts to improve appropriate utilization of medical services and will educate member physicians, hospitals, health care leaders and patients about the need for physician-led, evidence based, efforts to improve appropriate utilization of medical services. Res. 815, I-12	Rescind. Superseded by Policy H-285.931 . The Critical Role of Physicians in Health Plans and Integrated Delivery Systems H-285.931 Our AMA adopts the following organizational principles for physician involvement in health plans and integrated delivery systems (IDS): (1) Practicing physicians participating in a health plan/IDS must: (a) be involved in the selection and removal of their leaders who are involved in governance or who serve on a council of advisors to the governing body or management;

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			<p>(b) be involved in the development of credentialing criteria, utilization management criteria, clinical practice guidelines, medical review criteria, and continuous quality improvement, and their leaders must be involved in the approval of these processes;</p> <p>(c) be accountable to their peers for professional decisions based on accepted standards of care and evidence-based medicine;</p> <p>(d) be involved in development of criteria used by the health plan in determining medical necessity and coverage decisions; and</p> <p>(e) have access to a due process system.</p> <p>(2) Representatives of the practicing physicians in a health plan/IDS must be the decision-makers in the credentialing and recredentialing process.</p> <p>(3) To maximize the opportunity for clinical integration and improvement in patient care, all of the specialties participating in a clinical process must be involved in the development of clinical practice guidelines and disease management protocols.</p> <p>(4) A health plan/IDS has the right to make coverage decisions, but practicing physicians participating in the health plan/IDS must be able to discuss treatment alternatives with their patients to enable them to make informed decisions.</p> <p>(5) Practicing physicians and patients of a health plan/IDS should have access to a timely, expeditious internal appeals process. Physicians serving on an appeals panel should be practicing participants of the health plan/IDS, and they must have experience in the care under dispute. If the internal appeal is denied, a plan member should be able to appeal the medical necessity determination or coverage decision to an independent review organization.</p> <p>(6) The quality assessment process and peer review protections must extend to all sites of care, e.g., hospital, office, long-term care and home health care.</p> <p>(7) Representatives of the practicing physicians of a health plan/IDS must be involved in the design of the data collection systems and interpretation of the data so produced, to ensure that the information will be beneficial to physicians in their daily</p>

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			<p>practice. All practicing physicians should receive appropriate, periodic, and comparative performance and utilization data.</p> <p>(8) To maximize the opportunity for improvement, practicing physicians who are involved in continuous quality improvement activities must have access to skilled resource people and information management systems that provide information on clinical performance, patient satisfaction, and health status. There must be physician/manager teams to identify, improve and document cost/quality relationships that demonstrate value.</p> <p>(9) Physician representatives/leaders must communicate key policies and procedures to the practicing physicians who participate in the health plan/IDS. Participating physicians must have an identified process to access their physician representative.</p> <p>(10) Consideration should be given to compensating physician leaders/representatives involved in governance and management for their time away from practice. Our AMA aggressively advocates to private health care accreditation organizations the incorporation of the organizational principles for physician involvement into their standards for health plans, networks and integrated delivery systems.</p>
D-410.993	Need to Include Assessment of Economic Impact in Practice Guidelines	Our AMA will continue to monitor the methodological guidance, data collection, and data synthesis applied to evaluating the economic impact of implementing guidelines into clinical practice. (BOT Rep. 13, A-12)	Retain. Still relevant.
H-35.996	Status and Utilization of New or Expanding Health Professionals in Hospitals	(1) The services of certain new health professionals, as well as those professionals assuming an expanded medical service role, may be made available for patient care within the limits of their skills and the scope of their authorized practice. The occupations concerned are those whose patient care activities involve medical diagnosis and treatment to such an extent that they meet the three criteria specified below: (a) As authorized by the medical staff, they function in a newly expanded medical support role to the physician in the provision of patient care. (b) They participate in the management of patients under the direct supervision or direction of a member of the medical staff who is responsible for the patient's care. (c) They make entries on patients' records, including progress notes, only to the extent established by the medical staff. Thus this statement covers regulation of such categories as	Retain. Still relevant.

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		<p>the new physician-support occupations generically termed physician assistants, nurse practitioners, and those allied health professionals functioning in an expanded medical support role.</p> <p>(2) The hospital governing authority should depend primarily on the medical staff to recommend the extent of functions which may be delegated to, and services which may be provided by, members of these emerging or expanding health professions. To carry out this obligation, the following procedures should be established in medical staff bylaws: (a) Application for use of such professionals by medical staff members must be processed through the credentials committee or other medical staff channels in the same manner as applications for medical staff membership and privileges. (b) The functions delegated to and the services provided by such personnel should be considered and specified by the medical staff in each instance, and should be based upon the individual's professional training, experience, and demonstrated competency, and upon the physician's capability and competence to supervise such an assistant. (c) In those cases involving use by the physician of established health professionals functioning in an expanded medical support role, the organized medical staff should work closely with members of the appropriate discipline now employed in an administrative capacity by the hospital (for example, the director of nursing services) in delineating such functions. (BOT Rep. G, A-73; Reaffirmed: CLRPD Rep. C, A-89; Reaffirmed: Sunset Report, A-00; Modified: CMS Rep. 6, A-10; Reaffirmation A-12)</p>	
H-70.924	Litigation Center Cases to Combat Automatic Downcoding and/or Recoding	The Litigation Center continues to initiate or support lawsuits that seek redress from insurers who engage in inappropriate or inaccurate downcoding and/or recoding practices. (BOT Rep. 31, A-02; Reaffirmed: CMS Rep. 4,	Retain. Still relevant.
H-70.925	CPT Editorial Panel Representation	<p>(1) The CPT Editorial Panel shall be kept at a size compatible with its functioning as an efficient and effective editorial board and should not be subject to the requirement of formal slotted seats for individual specialty societies.</p> <p>(2) While the role of the CPT Advisory Committee as clinical and technical experts to the CPT Editorial Panel is important, necessary, and currently of satisfactory composition, the need to expand as the practice of medicine changes or the scope of the CPT code set changes should be regularly evaluated. (BOT Rep. 34,</p>	Retain. Still relevant.
H-155.966	Controlling Cost of Medical Care	The AMA urges the American Hospital Association and all hospitals to encourage the administrators and medical directors to provide to the members of the medical staffs, house staff and medical students the charges for tests, procedures, medications and durable medical equipment in such a fashion as to emphasize cost	Retain. Still relevant.

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		and quality consciousness and to maximize the education of those who order these items as to their costs to the patient, to the hospital and to society in general. (Sub. Res. 75, I-81; Reaffirmed: CLRPD Rep. F, I-91; Res. 801, A-93; CMS Rep. 12, A-95; Reaffirmed by Rules & Credentials Cmt., A-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation A-08; Reaffirmed in lieu of Res. 5, A-12)	
H-155.998	Voluntary Health Care Cost Containment	(1) All physicians, including physicians in training, should become knowledgeable in all aspects of patient-related medical expenses, including hospital charges of both a service and professional nature. (2) Physicians should be cost conscious and should exercise discretion, consistent with good medical care, in determining the medical necessity for hospitalization and the specific treatment, tests and ancillary medical services to be provided a patient. (3) Medical staffs, in cooperation with hospital administrators, should embark now upon a concerted effort to educate physicians, including house staff officers, on all aspects of hospital charges, including specific medical tests, procedures, and all ancillary services. (4) Medical educators should be urged to include similar education for future physicians in the required medical school curriculum. (5) All physicians and medical staffs should join with hospital administrators and hospital governing boards nationwide in a conjoint and across-the-board effort to voluntarily contain and control the escalation of health care costs, individually and collectively, to the greatest extent possible consistent with good medical care. (6) All physicians, practicing solo or in groups, independently or in professional association, should review their professional charges and operating overhead with the objective of providing quality medical care at optimum reasonable patient cost through appropriateness of fees and efficient office management, thus favorably moderating the rate of escalation of health care costs. (7) The AMA should widely publicize and disseminate information on activities of the AMA and state, county and national medical specialty societies which are designed to control or reduce the costs of health care. (Res. 34, A-78; Reaffirmed: CLRPD Rep. C, A-89; Res. 100, I-89; Res. 822, A-93; Reaffirmed: BOT Rep. 40, I-93; CMS Rep. 12, A-95; Reaffirmed: Res. 808, I-02; Modified: CMS Rep. 4, A-12)	Retain. Still relevant.
H-160.913	Medicaid Patient-Centered Medical Home Models	Our AMA: (1) recognizes that the physician-led medical home model, as described by Policy H-160.919, has demonstrated the potential to enhance the value of health care by improving access, quality and outcomes while reducing costs; and (2) will work with state medical associations to explore, and where feasible, implement physician-led Medicaid patient-centered medical home models based on the	Retain. Still relevant.

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		unique needs of the physicians and patients in their states. (CMS Rep. 3, A-12)	
H-160.914	Support of Multilingual Assessment Tools for Medical Professionals	Our AMA will encourage the publication and validation of standard patient assessment tools in multiple languages. (Res. 703, A-12)	Retain. Still relevant.
H-165.832	Basic Health Program	<p>1. Our AMA supports the adoption of 12-month continuous eligibility across Medicaid, Children’s Health Insurance Program, and exchange plans to limit patient churn and promote the continuity and coordination of patient care.</p> <p>2. Our AMA adopts the following principles for the establishment and operation of state Basic Health Programs:</p> <p>A. State Basic Health Programs (BHPs) should guarantee ample health plan choice by offering multiple standard health plan options to qualifying individuals. Standard health plans offered within a BHP should provide an array of choices in terms of benefits covered, cost-sharing levels, and other features.</p> <p>B. Standard health plans offered under state BHPs should offer enrollees provider networks that have an adequate number of contracted physicians and other health care providers in each specialty and geographic region.</p> <p>C. Standard health plans offered in state BHPs should include payment rates established through meaningful negotiations and contracts.</p> <p>D. State BHPs should not require provider participation, including as a condition of licensure.</p> <p>E. Actively practicing physicians should be significantly involved in the development of any policies or regulations addressing physician payment and practice in the BHP environment.</p> <p>F. State medical associations should be involved in the legislative and regulatory processes concerning state BHPs.</p> <p>G. State BHPs should conduct outreach and educational efforts directed toward physicians and their patients, with adequate support available to assist physicians with the implementation process. (CMS Rep. 5, A-12)</p>	Retain. Still relevant.
H-165.845	State Efforts to Expand Coverage to the Uninsured	<p>Our AMA supports the following principles to guide in the evaluation of state health system reform proposals:</p> <p>1. Health insurance coverage for state residents should be universal, continuous, and portable. Coverage should be mandatory only if health insurance subsidies are available for those living below a defined poverty level.</p> <p>2. The health care system should emphasize patient choice of plans and health benefits, including mental health, which should be value-based. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as references when considering if</p>	<p>Rescind. Superseded by Policy D-165.942, which states:</p> <p>Our AMA will advocate that state governments be given the freedom to develop and test different models for covering the uninsured, provided that their proposed alternatives a) meet or exceed the projected percentage of individuals covered under an individual responsibility requirement while maintaining or improving upon established levels of quality of care, b) ensure and maximize patient choice of physician and private health plan,</p>

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		<p>a given plan would provide meaningful coverage.</p> <p>3. The delivery system should ensure choice of health insurance and physician for patients, choice of participation and payment method for physicians, and preserve the patient/physician relationship. The delivery system should focus on providing care that is safe, timely, efficient, effective, patient-centered, and equitable.</p> <p>4. The administration and governance system should be simple, transparent, accountable, and efficient and effective in order to reduce administrative costs and maximize funding for patient care.</p> <p>5. Health insurance coverage should be equitable, affordable, and sustainable. The financing strategy should strive for simplicity, transparency, and efficiency. It should emphasize personal responsibility as well as societal obligations. (CMS Rep. 3, I-07; Reaffirmed: Res. 239, A-12)</p>	and c) include reforms that eliminate denials for pre-existing conditions.
H-165.904	Universal Health Coverage	<p>Our AMA: (1) seeks to ensure that federal health system reform include payment for the urgent and emergent treatment of illnesses and injuries of indigent, non-U.S. citizens in the U.S. or its territories; (2) seeks federal legislation that would require the federal government to provide financial support to any individuals, organizations, and institutions providing legally-mandated health care services to foreign nationals and other persons not covered under health system reform; and (3) continues to assign a high priority to the problem of the medically uninsured and underinsured and continues to work toward national consensus on providing access to adequate health care coverage for all Americans. (Sub. Res. 138, A-94; Appended: Sub. Res. 109, I-98; Reaffirmation A-02; Reaffirmation A-07; Reaffirmation I-07; Reaffirmed: Res. 239, A-12)</p>	Retain. Still relevant.
H-180.964	Health Care Coverage of Young Adults Under Their Parents' Family Policies	<p>Our AMA encourages the health insurance industry, employers and health plans to make available to young adults who do not have health insurance extended family health expense coverage to age 28 that conforms to the following characteristics: (1) The option to extend coverage under the parents' family policy or plan from the usual cut-off age to age 28 should be available for a specified initial enrollment period beyond the usual cut-off age under the plan.</p> <p>(2) Enrollment in the family coverage other than during this initial period should be available without a preexisting condition limitation to those individuals (to age 28) seeking the coverage because of loss of previous insurance protection within a specified time after loss of the previous protection, and should be available with a preexisting condition limitation to those seeking the coverage for other reasons at any time.</p>	Retain. Still relevant.

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		<p>(3) Status as a full-time student should not be a requirement for extension of or first-time enrollment in the parents' coverage.</p> <p>(4) To the extent that premiums for such a plan are higher, the extended coverage should be made available as a separate extra-cost rider.</p> <p>(CMS Rep. 1, I-95; Reaffirmed by CMS Rep. 7, A-97; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	
H-180.978	Access to Affordable Health Care Insurance through Deregulation of State Mandated Benefits	<p>Our AMA (1) through its coalition with business and industry and its state federation, supports giving priority attention to a partial and rational deregulation of the insurance industry in order to expand access to affordable health care coverage; and</p> <p>(2) reaffirms its commitment to private health care insurance using pluralistic, free enterprise mechanisms rather than government mandated and controlled programs. (Res. 129, A-89; Reaffirmed: CLRPD Rep. 2, I-99; Reaffirmed: CMS Rep. 5, A-09; Reaffirmed: Res. 239, A-12)</p>	<p>Rescind. Superseded by Policies H-165.846 and H-165.825, which state:</p> <p>Adequacy of Health Insurance Coverage Options H-165.846</p> <p>1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options:</p> <p>A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.</p> <p>B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.</p> <p>C. Provisions must be made to assist individuals with low-incomes or unusually high medical costs in obtaining health insurance coverage and meeting cost-sharing obligations.</p> <p>D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.</p> <p>2. Our AMA advocates that the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program be used as the model for any essential health benefits package for children.</p> <p>3. Our AMA: (a) opposes the removal of categories from the essential health benefits (EHB) package and their associated protections against annual and lifetime limits, and out-of-pocket expenses; and (b) opposes waivers of EHB requirements that lead to the elimination of EHB categories and</p>

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			<p>their associated protections against annual and lifetime limits, and out-of-pocket expenses.</p> <p>Ensuring Marketplace Competition and Health Plan Choice H-165.825 Our AMA will: (1) support health plans offering coverage options for individuals and small groups competing on a level playing field, including providing coverage for pre-existing conditions and essential health benefits; (2) oppose the sale of health insurance plans in the individual and small group markets that do not guarantee: (a) pre-existing condition protections and (b) coverage of essential health benefits and their associated protections against annual and lifetime limits, and out-of-pocket expenses, except in the limited circumstance of short-term limited duration insurance offered for no more than three months; and (3) support requiring the largest two Federal Employees Health Benefits Program (FEHBP) insurers in counties that lack a marketplace plan to offer at least one silver-level marketplace plan as a condition of FEHBP participation.</p>
H-190.988	Medicare Claims Processing Accuracy	<p>Our AMA will: (1) continue efforts to assure that Medicare carriers accurately process claims; (2) continue to pursue legislation to require local physician input on the adequacy of carrier performance; (3) continue to pursue legislation to allow individual physicians to request and receive an administrative law hearing to challenge carrier performance of administrative and other policy requirements; and (4) take other appropriate actions that will result in penalties for carriers that process claims inaccurately. (BOT Rep. C, A-92; Reaffirmed: Res. 712, A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Rescind. No longer relevant.
H-210.989	Medicare Physician Reimbursement for Home Health Visits	<p>It is the policy of the AMA: (1) to urge Congress and CMS to adjust reimbursement for physician home visits so that the payment made to physicians is consistent with the services involved in treating patients at home; and (2) that physician reimbursement should appropriately reflect the relative differences in the training and skill of physicians and other home health care providers. (Res. 109, A-91; Reaffirmation A-97; Reaffirmation I-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain. Still relevant.

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H-215.982	Interpretive Services	Our AMA encourages hospitals and pharmacies that serve populations with a significant number of non-English speaking or hearing-impaired patients to provide trained interpretive services. (BOT Rep. D, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed: CMS Rep. 7, A-11; Modified: Res. 702, A-12)	Rescind. Superseded by Policy H-160.924 , which states: Use of Language Interpreters in the Context of the Patient-Physician Relationship H-160.924 AMA policy is that: (1) further research is necessary on how the use of interpreters-- both those who are trained and those who are not-- impacts patient care; (2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive; (3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication--including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations-- to aid LEP patients' involvement in meaningful decisions about their care; and (4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services' policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third-party payers and physicians shall not be required to participate in payment arrangements.
H-225.951	The Importance of Local Control of Hospitals	Our AMA will establish policy and advocate for local governing boards to continue to exist for individual hospitals within multi-hospital systems to ensure that community needs, the needs of local medical staff and patient care needs are met within those communities whenever possible. (Res. 719, A-12)	Retain. Still relevant.
H-225.964	Hospital Employed/Contracted Physicians Reimbursement	AMA policy states that: (1) all hospital employed/contracted physicians be prospectively involved if the hospital negotiates for them for capitation and global billing contracts; (2) hospital employed/contracted physicians be informed about the actual payment amount allocated to the physician component of the total hospital payment received by the contractual arrangement; and (3) all potential hospital/contracted physicians request a bona fide hospital plan which delineates the actual payment amount allocated to the employed or contracted physicians. (Sub. Res. 723, I-96;	Retain. Still relevant.

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		Reaffirmed: Res. 812, A-02; Reaffirmed: CMS Rep. 4, A-12; Reaffirmed: BOT Rep. 4, I-12)	
H-225.973	Financial Arrangements Between Hospitals and Physicians	<p>Our AMA: (1) opposes financial arrangements between hospitals and physicians that are unrelated to professional services, or to the time, skill, education and professional expertise of the physician;</p> <p>(2) opposes any requirement which states that fee-for-services payments to physicians must be shared with the hospital in exchange for clinical privileges;</p> <p>(3) opposes financial arrangements between hospitals and physicians that (a) either require physicians to compensate hospitals in excess of the fair market value of the services and resources that hospitals provide to physicians, (b) require physicians to compensate hospitals even at fair market value for hospital provided services that they neither require nor request, or (c) require physicians to accept compensation at less than the fair market value for the services that physicians provide to hospitals;</p> <p>(4) opposes financial arrangements between hospitals and pathologists that force pathologists to accept no or token payment for the medical direction and supervision of hospital-based clinical laboratories; and</p> <p>(5) urges state medical associations, HHS, the AHA and other hospital organizations to take actions to eliminate financial arrangements between hospitals and physicians that are in conflict with the anti-kickback statute of the Social Security Act, as well as with AMA policy. (CMS Rep. C, A-91; Reaffirmed: Sunset Report, I-01; Reaffirmed and Appended: CMS Rep. 2, I-02; Reaffirmed: CMS Rep. 4, A-12)</p>	Retain. Still relevant.
H-285.923	Elimination of Mental Health and Chemical Dependency Carve-Outs	Our AMA opposes and will work to eliminate mental health and chemical dependency carve-outs. (Sub. Res. 702, I-00; Reaffirmed: CMS 7, A-02; Reaffirmed: CMS Rep. 4, A-12)	<p>Rescind. Superseded by Policies H-185.974, D-180.998, H-95.914, D-110.987, and H-385.915 which state:</p> <p>Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974</p> <p>Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.</p> <p>Insurance Parity for Mental Health and Psychiatry D-180.998</p> <p>Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of</p>

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			<p>mental illness, alcoholism, and substance abuse.</p> <p>Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.</p> <p>The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> - 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

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			<p>- Percentage of sole source contracts awarded annually.</p> <p>6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.</p> <p>Integrating Physical and Behavioral Health Care H-385.915</p> <p>Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.</p>
H-285.956	Mental Health “Carve-Outs”	<p>Our AMA is opposed to mental health carve-outs. However, in order to protect the large number of patients currently covered by carve-out arrangements, the AMA advocates that all managed care plans that provide or arrange for behavioral health care adhere to the following principles, and that any public or private entities that evaluate such plans for the purposes of certification or accreditation utilize these principles in conducting their evaluations: (1) Plans should assist participating primary care physicians to recognize and diagnose the behavioral disorders commonly seen in primary care practice.</p> <p>(2) Plans should reimburse qualified participating physicians in primary care and other non-psychiatric physician specialties for the behavioral health services provided to plan enrollees.</p> <p>(3) Plans should utilize practice guidelines developed by physicians in the appropriate specialties, with local adaptation by plan physicians as appropriate, to identify the clinical circumstances under which treatment by the primary care physician, direct referral to psychiatrists or other addiction medicine physicians, and referral back to the primary care</p>	<p>Rescind. Superseded by Policies H-185.974, D-180.998, H-95.914, D-110.987, and H-385.915 which state:</p> <p>Parity for Mental Illness, Alcoholism, and Related Disorders in Medical Benefits Programs H-185.974</p> <p>Our AMA supports parity of coverage for mental illness, alcoholism, substance use, and eating disorders.</p> <p>Insurance Parity for Mental Health and Psychiatry D-180.998</p> <p>Our AMA in conjunction with the American Psychiatric Association and other interested organizations will develop model state legislation for the use of state medical associations and specialty societies to promote legislative changes assuring parity for the coverage of</p>

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		<p>physician for care of behavioral disorders is indicated, and should pay for all physician care provided in conformance with such guidelines. In the absence of such guidelines, direct referral by the primary care physician to the psychiatrist or other addiction medicine physician should be allowed when deemed necessary by the referring physician.</p> <p>(4) Plans should foster continuing and timely collaboration and communication between primary care physicians and psychiatrists in the care of patients with medical and psychiatric comorbidities.</p> <p>(5) Plans should encourage a disease management approach to care of behavioral health problems.</p> <p>(6) Participating health professionals should be able to appeal plan-imposed treatment restrictions on behalf of individual enrollees receiving behavioral health services, and should be afforded full due process in any resulting plan attempts at termination or restriction of contractual arrangements.</p> <p>(7) Plans using case managers and screeners to authorize access to behavioral health benefits should restrict performance of this function to appropriately trained and supervised health professionals who have the relevant and age group specific psychiatric or addiction medicine training, and not to lay individuals, and in order to protect the patient's privacy and confidentiality of patient medical records should elicit only the patient information necessary to confirm the need for behavioral health care.</p> <p>(8) Plans assuming risk for behavioral health care should consider "soft" capitation or other risk/reward-sharing mechanisms so as to reduce financial incentives for undertreatment.</p> <p>(9) Plans should conduct ongoing assessment of patient outcomes and satisfaction, and should utilize findings to both modify and improve plan policies when indicated and improve practitioner performance through educational feedback.</p> <p>(CMS Rep. 2, A-96; Modified: CMS Rep. 6, I-00; Reaffirmed: CMS Rep. 9, A-01; Reaffirmed Res. 702, I-01; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)</p>	<p>mental illness, alcoholism, and substance abuse.</p> <p>Opioid Mitigation H-95.914 Our AMA urges state and federal policymakers to enforce applicable mental health and substance use disorder parity laws.</p> <p>The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> - 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

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			<p>- Percentage of sole source contracts awarded annually.</p> <p>6. Our AMA encourages increased transparency in how DIR fees are determined and calculated.</p> <p>Integrating Physical and Behavioral Health Care H-385.915</p> <p>Our American Medical Association: (1) encourages private health insurers to recognize CPT codes that allow primary care physicians to bill and receive payment for physical and behavioral health care services provided on the same day; (2) encourages all state Medicaid programs to pay for physical and behavioral health care services provided on the same day; (3) encourages state Medicaid programs to amend their state Medicaid plans as needed to include payment for behavioral health care services in school settings; (4) encourages practicing physicians to seek out continuing medical education opportunities on integrated physical and behavioral health care; and (5) promotes the development of sustainable payment models that would be used to fund the necessary services inherent in integrating behavioral health care services into primary care settings.</p>
H-285.979	Managed Care Insurance Company Credentialing	<p>The AMA: (1) supports the development and utilization by all health insurance plans and managed care organizations of both a uniform application form and a reapplication form; (2) will work with the centralized credentialing collection services established by state and county medical societies to implement the acceptance of uniform application and reapplication forms; (3) urges managed care organizations to recredential participating physicians no more frequently than every two years; (4) urges hospitals, managed care organizations and insurance companies to utilize state and county central credentialing services, where available, for purposes of credentialing plan physician applicants, and will identify all state and county central credentialing services and make this information available to all interested parties including hospital and managed care/physician credentialing committees; (5) supports state and county medical society initiatives to promulgate a uniform reappointment cycle for hospitals and managed care plans; and (6) opposes any legislative or regulatory initiative to mandate accreditation for CVOs by the NCQA or any other agency until a fair,</p>	Retain. Still relevant.

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		equitable, reasonable and appropriately inclusive process for such accreditation exists. (Sub. Res. 703, A-94; Amended in lieu of Res. 705, I-94; Amended by Res. 716, I-96; Reaffirmed: Res. 809, I-02; Reaffirmed: CMS Rep. 4, A-12)	
H-290.975	State and Federal Medicaid Physician Advisory Bodies	Our AMA supports the creation of state Medicaid Physician Advisory Commissions that would advise states on payment policies, utilization of services, and other relevant policies impacting physicians and patients. (BOT Rep. 13, I-02; Modified: CMS Rep. 4, A-12)	Rescind. Superseded by Policy H-165.855 [8], which states: Medical Care for Patients with Low Incomes H-165.855 It is the policy of our AMA that: ... (8) our AMA should encourage states to support a Medicaid Physician Advisory Commission to evaluate and monitor access to care in the state Medicaid program and related pilot projects.
H-330.889	Strengthening Medicare for Current and Future Generations	1. It is the policy of our AMA that a Medicare defined contribution program should include the following: a. Enable beneficiaries to purchase coverage of their choice from among competing health insurance plans, which would be subject to appropriate regulation and oversight to ensure strong patient and physician protections. b. Preserve traditional Medicare as an option. c. Offer a wide range of plans (e.g., HMOs, PPOs, high-deductible plans paired with health savings accounts), as well as traditional Medicare. d. Require that competing private health insurance plans meet guaranteed issue and guaranteed renewability requirements, be prohibited from rescinding coverage except in cases of intentional fraud, follow uniform marketing standards, meet plan solvency requirements, and cover at least the actuarial equivalent of the benefit package provided by traditional Medicare e. Apply risk-adjustment methodologies to ensure that affordable private health insurance coverage options are available for sicker beneficiaries and those with higher projected health care costs. f. Set the amount of the baseline defined contribution at the value of the government's contribution under traditional Medicare. g. Ensure that health insurance coverage is affordable for all beneficiaries by allowing for adjustments to the baseline defined contribution amount. In particular, individual defined contribution amounts should vary based on beneficiary age, income and health status. Lower income and sicker beneficiaries would receive larger defined contributions. h. Adjust baseline defined contribution amounts annually to ensure that health insurance coverage remains affordable for all beneficiaries. Annual adjustments should reflect changes in health care costs and the cost of obtaining health insurance. i. Include implementation time frames that	Rescind. Superseded by Policy H-330.896 , which states: Strategies to Strengthen the Medicare Program H-330.896 Our AMA supports the following reforms to strengthen the Medicare program, to be implemented together or separately, and phased-in as appropriate: 1. Restructuring beneficiary cost-sharing so that patients have a single premium and deductible for all Medicare services, with means-tested subsidies and out-of-pocket spending limits that protect against catastrophic expenses. The cost-sharing structure should be developed to provide incentives for appropriate utilization while discouraging unnecessary or inappropriate patterns of care. The use of preventive services should also be encouraged. Simultaneously, policymakers will need to consider modifications to Medicare supplemental insurance (i.e., Medigap) benefit design standards to ensure that policies complement, rather than duplicate or undermine, Medicare's new cost-sharing structure. 2. Offering beneficiaries a choice of plans for which the federal government would contribute a standard amount toward the purchase of traditional fee-for-service Medicare or another health insurance plan approved by Medicare. All plans would be subject to the same fixed contribution amounts and regulatory requirements. Policies would need to be developed, and sufficient resources allocated, to ensure appropriate government standard setting and regulatory oversight of plans. 3. Restructuring age-

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		<p>ensure a phased-in approach.</p> <p>2. Our AMA will advocate that any efforts to strengthen the Medicare program ensure that mechanisms are in place for financing graduate medical education at a level that will provide workforce stability and an adequate supply of physicians to care for all Americans.</p> <p>3. Our AMA will continue to explore the effects of transitioning Medicare to a defined contribution program on cost and access to care. (CMS Rep. 5, I-12)</p>	eligibility requirements and incentives to match the Social Security schedule of benefits
H-330.890	Decoupling Social Security from Medicare	Our AMA supports abrogation of any connection between Medicare and Social Security benefits. (Res. 221, I-12)	Retain. Still relevant.
H-330.908	CMS Required Diabetic Supply Forms	Our AMA requests that CMS change its requirement so that physicians need only re-write prescriptions for glucose monitors every twelve months, instead of a six month requirement, for Medicare covered diabetic patients and make the appropriate diagnosis code sufficient for the determination of medical necessity. (Sub. Res. 102, A-00; Reaffirmation and Amended: Res. 520, A-02; Modified: CMS Rep. 4, A-12)	Retain. Still relevant.
H-335.970	Medicare Integrity Program	Our AMA strongly urges CMS to adhere to the following principles during the implementation of the Medicare Integrity Program (MIP): (1) continue support for physician development of local medical review policy through strong Carrier Advisory Committees; (2) provide access to a Medical Director in each state; (3) provide a mechanism for close surveillance and monitoring of the performance of the MIP contractors to assure their accountability to questions and concerns raised by patients and physicians about coverage and other issues; (4) continue due process and appeals mechanisms for physicians; and (5) initiate a widespread and comprehensive effort to educate physicians about all aspects of the MIP. (CMS Rep. 4, A-97; Reaffirmed: CMS Rep. 1, A-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Rescind. Policy is out-of-date. Medicare Integrity Program is no longer active.
H-383.997	Hospital-Based Physician Contracting	<p>(1) It is the policy of the AMA that agreements between hospitals and hospital-based physicians should adhere to the following principles: (a) Physicians should have the right to negotiate and review their own portion of agreements with managed care organizations.</p> <p>(b) Physicians should have the right to set the parameters and acceptable terms for their contracts with managed care plans in advance of contract negotiations.</p> <p>(c) Physicians representing all relevant specialties should be involved in negotiating and reviewing agreements with managed care organizations when the agreements have an impact on such issues as global pricing arrangements, risks to the physician specialists, or expectations of special service from the</p>	<p>Retain-in-part. The publications listed in subsection 3 are out-of-print, making the subsection out-of-date. Subsection 3 should be rescinded.</p> <p>(3) Our AMA encourages physicians to avail themselves of the contracting resources available through their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals.</p>

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		<p>specialty.</p> <p>(d) Physicians should have the opportunity to renegotiate contracts with the hospital whenever the hospital enters into an agreement with a managed care plan that materially impacts the physician unfavorably.</p> <p>(e) The failure of physicians to reach an agreement with managed care organizations should not constitute a breach of its agreement with the hospital, nor serve as grounds for termination.</p> <p>(f) Physicians should seek a provision that allows them to opt out from managed care plans that pose unacceptable professional liability risks.</p> <p>(g) Physicians should seek a provision to refuse to contract with, to modify contracts with, and/or to terminate contracts with managed care plans that are showing financial instability, or should seek a guarantee from the hospital that the plan will make timely payments.</p> <p>(h) Physicians should receive advance notice of the hospital's intent to enter into any package or global pricing arrangements involving their specialties, and have the opportunity to advise the hospital of their revenue needs for each package price.</p> <p>(i) Physicians should have the opportunity to request alternative dispute resolution mechanisms to resolve disputes with the hospital concerning managed care contracting.</p> <p>(j) If the hospital negotiates a package pricing arrangement and does not abide by the pricing recommendations of the physicians, then the physicians should be entitled to a review of the hospital's actions and to opportunities to seek additional compensation.</p> <p>(k) Physicians should be entitled to information regarding the level of discount being provided by the hospital and by other participating physicians.</p> <p>(2) Our AMA urges physicians who believe hospitals are negotiating managed care contracts on their behalf without appropriate input, and who feel coerced into signing such contracts, to contact the AMA/State Medical Society Litigation Center, their state medical association, and/or legal counsel.</p> <p>(3) Our AMA encourages physicians to avail themselves of the contracting resources available <u>through</u> their relevant specialty societies, as well as the AMA Model Medical Services Agreement, and the Young Physician Section pamphlet entitled "Contracts: What You Need to Know," to evaluate and respond to contract proposals. (CMS Rep. 3, A-00; Reaffirmed: BOT Rep. 13, I-06; Reaffirmed: BOT Rep. 4, I-12)</p>	
H-385.922	Payment Terminology	It is AMA policy to change the terminology used in compensating physicians from "reimbursement" to "payment." (Res. 138, A-07; Reaffirmation A-12)	Retain. Still relevant.

Policy #	Title	Text	Recommendation
H-385.958	Payment for Services Not Authorized by Health Plans	Our AMA advocates that all health plan contracts contain a provision to permit the direct billing of patients for medical services for which authorization was denied by a health plan, which the rendering physician, based upon reasonable evidence, determines to be essential for the welfare of the patient and for which prior patient consent was obtained. (Sub. Res. 705, I-93; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-385.961	Medicare Private Contracting	Our AMA will: (1) continue to pursue legal and administrative efforts to permit patients to contract privately with their physicians in appropriate circumstances; and (2) support repeal of the restrictions placed on private contracts between physicians and Medicare beneficiaries to ensure that there is no interference with Medicare beneficiaries' freedom to choose a physician to provide covered services and give priority to this goal as a legislative objective. (BOT Rep. OO, A-93; Reaffirmed: Sub. Res. 132, A-94; Appended: Res. 203, I-98; Reaffirmation A-99; Reaffirmation I-99; Reaffirmation I-00; Reaffirmation I-00; Reaffirmation A-01; Reaffirmation A-02; Reaffirmation A-04; Reaffirmation A-08; Reaffirmed: CMS Rep. 5, I-12)	Rescind. Superseded by Policy D-380-997 , which states: 1. It is the policy of the AMA: (a) that any patient, regardless of age or health care insurance coverage, has both the right to privately contract with a physician for wanted or needed health services and to personally pay for those services; (b) to pursue appropriate legislative and legal means to permanently preserve that patient's basic right to privately contract with physicians for wanted or needed health care services; (c) to continue to expeditiously pursue regulatory or legislative changes that will allow physicians to treat Medicare patients outside current regulatory constraints that threaten the physician/patient relationship; and (d) to seek immediately suitable cases to reverse the limitations on patient and physician rights to contract privately that have been imposed by CMS or the private health insurance industry. 2. Our AMA strongly urge CMS to clarify the technical and statutory ambiguities of the private contracting language contained in Section 4507 of the Balanced Budget Act of 1997. 3. Our AMA reaffirms its position in favor of a pluralistic health care delivery system to include fee-for-service medicine, and will lobby for the elimination of any restrictions and physician penalties for provision of fee-for-service medicine by a physician to a consenting patient, including patients covered under Medicare
H-385.984	Fee for Services When Fulfilling Third Party Payer Requirements	The AMA believes that the attending physician should perform without charge simple administrative services required to enable the patient to receive his benefits. When more complex administrative services are required by third parties, such as obtaining preadmission certification, second opinions on elective surgery, certification for extended length of stay, and other authorizations as a condition of payer coverage, it is the right of the physician to be	Rescind. Superseded by Policy H-285.943 , which states that the AMA (1) opposes managed care contract provisions that prohibit physician payment for the provision of administrative services; (2) encourages physicians entering into: (a) capitated arrangements with managed care plans to seek the inclusion of a separate capitation

Policy #	Title	Text	Recommendation
		recompensed for his incurred administrative costs. (CMS Rep. J, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmation I-08; Reaffirmation A-10; Reaffirmed: CMS Rep. 3, I-12)	rate (per member per month payment) for the provision of administrative services, and (b) fee-for-service arrangements with managed care plans to seek a separate case management fee or higher level of payment to account for the provision of administrative services; and (3) supports the concept of a time-based charge for administrative duties (such as phone precertification, utilization review activities, formulary review, etc.), to be assessed to the various insurers.
H-385.985	Denial of Payment for Medical Services Based Solely on Fiscal Considerations	Our AMA: (1) affirms that medical judgment as to the need for an assistant in any surgical procedure, or the need to provide any form of medical care, should be made by the physician based on what is best for the health and welfare of the patient and not on fiscal restraints or considerations; and (2) opposes any law, rule or regulation, or any decision by a third party carrier which denies payment for medical services due solely to fiscal considerations and which does not have as its primary purpose the health and safety of the patient. (Res. 12, A-86; Reaffirmed: Sunset Report, I-96; Reaffirmed: BOT Rep. 32, A-99; Reaffirmation A-02; Reaffirmed: CMS Rep. 4, A-12)	Retain. Still relevant.
H-390.845	Mandatory Physician Enrollment in Medicare	Our AMA supports every physician's ability to choose not to enroll in Medicare and will seek the right of patients to collect from Medicare for covered services provided by unenrolled or disenrolled physicians. (Res. 223, I-12)	Retain. Still relevant.
H-390.846	Three-Day Payment Window Rule	Our AMA will: (1) work with the Centers for Medicare & Medicaid Services (CMS) to request a further delay in implementation of the 3-day Payment Window rule beyond the current delay of July 1, 2012; (2) thoroughly investigate all legislative and regulatory actions taken by Congress and CMS associated with the 3-Day Payment Window during this delay and determine whether additional legislative and/or regulatory actions are warranted to include overturning the current rule; and (3) work with other appropriate stakeholders to continue seeking a delay or modification of the three-day payment window rule; encourage CMS to clarify to whom and how this rule applies; and communicate the specifics about this rule to the physician community. (Res. 226, A-12)	Rescind. This policy was accomplished in 2012 and is out-of-date.
H-390.874	Repayment of Medicare Overpayments Made in Error	1. The AMA will request CMS to require Medicare carriers to be financially responsible for repayment to CMS of any overpayments made by the carrier to physicians where physicians could not reasonably be aware that the payments were overpayments or in error and where the physicians relied on calculations by the carrier. 2. Our AMA will: (A) communicate to the US Department of Health and Human Services (DHHS) its strong objection to the proposed	Rescind. Subsection 1 is superseded by Policy H-390.880 , and Subsection 2 is out-of-date. Interest Rates Charged and Paid by CMS H-390.880 1. (A) Our AMA will (1) determine if the recent interest rate changes implemented by CMS comply with current Medicare laws; (2) seek to ensure that CMS's interest charges do not exceed legal limits; and (3)

Policy #	Title	Text	Recommendation
		<p>plan to collect overpayment of Medicare services within 60 days of discovery, regardless of how this might affect the cash flow and the solvency of a medical practice; and (B) express to DHHS its strong objection to the proposed rule which would require practices or auditors to report any overpayments that were discovered within ten years of the date the funds were received instead of the current six-year requirement, due to the burden this would place on physicians' practices, which in essence is another unfunded mandate. (Res. 224, I-93; Reaffirmed: CMS Rep. 10, A-03; Appended: Res. 212, A-12)</p>	<p>work with CMS to ensure parity in interest rates assessed against physicians by CMS and interest rates paid to physicians by CMS. (B) If an agreement cannot be reached with CMS, the AMA will seek legislation to correct this situation.</p> <p>2. Our AMA supports amending federal Medicare law to require that interest on both overpayments and underpayments to providers attaches upon notice of the error to the appropriate party in either instance.</p>
H-40.969	CHAMPUS Payment	<p>(1) The AMA urges the Department of Defense to raise to at least Medicare levels those CHAMPUS maximum allowable charges (CMACs) that are presently below Medicare allowable charges. (2) The AMA urges the Department of Defense to eliminate price controls and encourage competition under TRICARE through true pluralism in the health plan choices available to beneficiaries, consistent with AMA Policy H-165.890, which proposes advocating transformation of the current Medicare program through an invigorated marketplace. Consistent with Policy H-165.890, this approach should use a defined contribution by CHAMPUS, regardless of the health plan chosen. (3) Until TRICARE introduces a contracting approach that increases competition and sets physician payments through the marketplace, the AMA urges the Department of Defense to assure that all TRICARE programs pay physicians at a minimum of CMAC levels, consistent with Policy H-40.972. (BOT Rep. 1, I-96; Reaffirmed: CMS Rep. 8, A-06; Reaffirmed: CMS Rep. 2, I-08; Reaffirmation A-12)</p>	<p>Rescind. Superseded by Policy D-40.991, which states: Our AMA:</p> <ol style="list-style-type: none"> 1. Encourages state medical associations and national medical specialty societies to educate their members regarding TRICARE, including changes and improvements made to its operation, contracting processes and mechanisms for dispute resolution. 2. Encourages the TRICARE Management Activity to improve its physician education programs, including those focused on non-network physicians, to facilitate increased civilian physician participation and improved coordination of care and transfer of clinical information in the program. 3. Encourages the TRICARE Management Activity and its contractors to continue and strengthen their efforts to recruit and retain mental health and addiction service providers in TRICARE networks, which should include providing adequate reimbursement for mental health and addiction services. 4. Strongly urges the TRICARE Management Activity to implement significant increases in physician payment rates to ensure all TRICARE beneficiaries, including service members and their families, have adequate access to and choice of physicians. 5. Strongly urges the TRICARE Management Activity to alter its payment formula for vaccines for routine childhood immunizations, so that payments for vaccines reflect the published CDC retail list price for vaccines. 6. Continues to encourage state medical associations and national medical specialty societies to

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			<p>respond to requests for information regarding potential TRICARE access issues so that this information can be shared with TRICARE representatives as they develop their annual access survey.</p> <p>7. Continues to advocate for changes in TRICARE payment policies that will remove barriers to physician participation and support new, more effective care delivery models, including: (a) establishing a process to allow midlevel providers to receive 100 percent of the TRICARE allowable cost for services rendered while practicing as part of a physician-led health care team, consistent with state law; and (b) paying for transitional care management services, including payment of copays for services provided to TRICARE for Life beneficiaries receiving primary coverage through Medicare.</p> <p>8. Continues to advocate for improvements in the communication and implementation of TRICARE coverage policies to ensure continued patient access to necessary services, including: (a) consistently approving full payment for services rendered for the diagnosis and treatment of common mental health conditions, regardless of the specialty of the treating physician; and (b) clarifying policies with respect to coverage for age appropriate doses of vaccines that have been recommended and adopted by the Advisory Committee on Immunization Practices.</p>
H-440.903	Public Health Care Benefits	Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all legal immigrants. (Res. 219, A-98; Reaffirmation A-02; Reaffirmed: BOT Rep. 19, A-12)	<p>Retain-in-part. Update language from “legal” to “lawfully present,” as follows: Our AMA actively lobby the federal and state governments to restore and maintain funding for public health care benefits for all <u>legal lawfully present</u> immigrants.</p>
H-480.961	Teleconsultations and Medicare Reimbursement	Our AMA demands that CMS reimburse telemedicine services in a fashion similar to traditional payments for all other forms of consultation, which involves paying the various providers for their individual claims, and not by various “fee splitting” or “fee sharing” reimbursement schemes. (Res. 144, A-93; Reaffirmed: CMS Rep. 10, A-03; Reaffirmation A-07; Reaffirmed in lieu of Res. 805, I-12; Reaffirmed in lieu of Res. 806, I-12)	<p>Rescind. Superseded by Policies H-480.937 and H-480.946.</p> <p>Addressing Equity in Telehealth H-480.937 Our AMA: (1) recognizes access to broadband internet as a social determinant of health; (2) encourages initiatives to measure and strengthen digital literacy, with an emphasis on programs designed with and for historically</p>

Policy #	Title	Text	Recommendation
			<p>marginalized and minoritized populations;</p> <p>(3) encourages 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;</p> <p>(4) supports 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;</p> <p>(5) encourages 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 non-physician 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;</p> <p>(6) supports expanding physician practice eligibility for programs that assist qualifying health care entities, including physician practices, 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;</p> <p>(7) supports efforts to ensure payers allow all contracted physicians to provide care via telehealth;</p> <p>(8) opposes 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; and</p> <p>(9) will advocate that physician payments should be fair and equitable, regardless of whether the service is performed via audio-only, two-way audio-video, or in-person.</p> <p>Coverage of and Payment for Telemedicine H-480.946</p>

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Policy #	Title	Text	Recommendation
			<p>1. Our AMA believes that telemedicine services should be covered and paid for if they abide by the following principles:</p> <p>a) A valid patient-physician relationship must be established before the provision of telemedicine services, through:</p> <ul style="list-style-type: none"> - 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. <p>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.</p> <p>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.</p> <p>d) Patients seeking care delivered via telemedicine must have a choice of provider, as required for all medical services.</p> <p>e) The delivery of telemedicine services must be consistent with state scope of practice laws.</p> <p>f) Patients receiving telemedicine services must have access to the</p>

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Policy #	Title	Text	Recommendation
			<p>licensure and board certification qualifications of the health care practitioners who are providing the care in advance of their visit.</p> <p>g) The standards and scope of telemedicine services should be consistent with related in-person services.</p> <p>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.</p> <p>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.</p> <p>j) The patient’s medical history must be collected as part of the provision of any telemedicine service.</p> <p>k) The provision of telemedicine services must be properly documented and should include providing a visit summary to the patient.</p> <p>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.</p> <p>m) Physicians, health professionals and entities that deliver telemedicine services must establish protocols for referrals for emergency services.</p> <p>2. Our AMA believes that delivery of telemedicine services must abide by laws addressing the privacy and security of patients' medical information.</p> <p>3. Our AMA encourages additional research to develop a stronger evidence base for telemedicine.</p> <p>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.</p> <p>5. Our AMA supports demonstration projects under the auspices of the Center for Medicare and Medicaid Innovation to address how</p>

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Policy #	Title	Text	Recommendation
			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.

2. PROSPECTIVE PAYMENT MODEL BEST PRACTICES FOR INDEPENDENT PRIVATE PRACTICE (RESOLUTION 122-JUN-21)

Reference committee hearing: see report of Reference Committee G.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS
IN LIEU OF RESOLUTION 122-JUN-21
REMAINDER OF REPORT FILED**

See Policies H-165.844, H-285.957, H-385.904, H-385.907, H-385.913, H-385.926, H-478.980, H-478.984, and H-480.946

At the June 2021 Special Meeting, the House of Delegates referred Resolution 122, “Developing Best Practices for Prospective Payment Models,” which was sponsored by the Integrated Physician Practice Section. Resolution 122-J-21 asked the American Medical Association (AMA) to “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” and to “use recommendations generated by its research to actively advocate for expanded use and access to prospective payment models.”

Testimony was generally supportive of the intent of Resolution 122-J-21. Testimony also cited longstanding AMA support for pluralism and noted that payment systems are complex and may affect various medical specialties differently. The Board of Trustees assigned this item to the Council on Medical Service for a report back to the House of Delegates. This report acknowledges a vast wealth of AMA policy outlining best practices for prospective payment models. In addition, physicians practicing in large integrated systems have those systems to provide guidance. Accordingly, while addressing practices that affect large integrated systems, the Council also focuses this report on the development of principles to guide physicians in non-integrated (independent) private practice wishing to enter into contractual agreements with other physician practices to form clinically integrated networks (CINs) for the purposes of engaging in prospective payment models.

BACKGROUND

The move to value-based payment by both public and private payers has been advancing for more than a decade, driven by concerns with quality outcomes and accelerating health care costs. The AMA, in two qualitative studies conducted with the RAND Corporation, has examined the effects of these new payment models, often referred to as

“Alternative Payment Models” or APMs, on physician practices and found that as recently as 2018, there remained significant barriers to the adoption of such models.¹ These barriers include:

- Lack of timely/accessible data for practices;
- Operational errors in payment models;
- Challenges related to interactions between payment models;
- Accelerated pace of change in payment models;
- Sudden or unexpected discontinuations of APMs; and
- Increasing complexity of payment models.

With the onset of the COVID-19 pandemic in 2020, adoption of value-based payment models slowed as the health care system managed the intense pressure of providing critical care for millions of severely ill patients. Most health care offices were forced to limit visits, many patients avoided and delayed seeking treatment, and many hospitals and outpatient facilities greatly reduced or canceled elective surgeries.² While all health care facilities and practices experienced serious financial disruption and many were forced to furlough or eliminate staff, suggestions have arisen that primary care practices who were in prospective payment models, such as per-member-per-month (PMPM), were able to manage the financial disruption more readily than those who were mostly dependent on fee-for-service (FFS) payments.³

Appropriately funded prospective payment models offer one solution to provide potential stability and predictability of payment for some practices when demand for services decreases. Such models include capitation, global payments, PMPM payments and can provide physicians with more predictable financial resources to conduct care coordination activities that can improve outcomes, decrease more costly visits to hospitals, and reduce readmissions. Funding for these models should be sufficient to address the social determinants of health (SDOH) for the target population.

Prospective payment models can take many forms. They can coexist with shared savings models and can be found among APMs. Numerous prospective payment models are being implemented currently, while others have been cancelled. In the Medicare program, Medicare Advantage plans receive capitation payments, and some pay their network physicians on a capitated basis, although many still pay on a per-service basis. For a listing of models in the traditional Medicare program, please visit the Centers for Medicare & Medicaid Services (CMS) sites for [approved Alternative Payment Models](#) and the [CMS Center for Medicare & Medicaid Innovation](#) (CMMI).^{5,6}

CONSIDERATIONS FOR PROSPECTIVE PAYMENT MODELS

Consistent with robust AMA policy, the AMA has been highly engaged with CMS, CMMI, and commercial health plans regarding physician concerns that payment reform models should enable rather than impede the provision of appropriate and necessary care. Longstanding AMA Policy H-385.926 supports the freedom of physicians to choose their method of earning a living, a concern raised during testimony on Resolution 122-J-21. For physicians exploring the opportunities to engage in prospective payment models, the following factors should be considered.

Attribution

Current retrospective statistical attribution methodologies often fail to accurately assign to physicians the patients they cared for and the services they delivered. The purpose of attribution and corresponding performance measures should be to ensure that physicians are responsible only for the costs they can control and not for costs they cannot control. Physicians in private practice can be particularly impacted when inpatient and specialty care are inappropriately attributed to them. These are costs that such physicians might not be able to control.

Attribution methods that rely solely on retrospective claims are problematic. Physicians providing telehealth services and fewer in-person visits need to use an additional payment code (i.e., modifier 95) to have the patient attributed to them. Various attribution methods could provide mixed results for physicians regarding who is responsible for delivering efficient care. Any delay in providing physicians with lists of attributed patients in real-time stifles timely care coordination. Additionally, errors can occur where patients rarely or never seen by a physician are attributed to them, or conversely, patients to whom they have provided extensive services to are attributed to someone else. Adjudicating these attribution lists can be extremely time consuming, particularly for private practices with limited staffing and resources. Furthermore, such inaccuracies may negatively affect a physician’s payment rate especially if the corresponding quality and cost of care data associated with these patients are adverse.

Performance Targets

It is a priority that performance targets are clinically meaningful and parsimonious for physicians, including privately practicing physicians. Performance targets must be logically relevant for each specialty and evidence-based. Unachievable and irrelevant performance targets may discourage physicians from participating in evolving payment models and undermine the goals of value-based payment.

Risk Adjustment

The resources needed to achieve appropriate patient outcomes during an episode of care depend heavily on the individual needs of each patient as well as their ability to access care and properly adhere to prescribed treatment plans. Many risk adjustment methods only explain a small amount of variation, and typically focus on variation in spending, not on patient factors. Risk adjustment generally relies on historical claims data, so it may not account for significant changes in the patient's health status that affect their current needs for services. Further exacerbating data deficiencies is that most risk adjustment systems give little or no consideration to the factors other than health status that can affect patient needs, such as functional limitations, access to health care services, and other SDOH.

An additional concern is that most risk adjustment methods do not adequately account for socio-demographic factors, such as community supports, on the cost and outcomes of care. Flawed risk adjustment methods have the unwanted effect of inappropriately penalizing the physicians and health systems caring for sicker patients and individuals with socio-demographic challenges while rewarding those who do not care for these patients. As an unintended consequence, it may be harder for higher-need patients to access care and for physicians caring for these patients to maintain a sustainable practice.

Data and Health Information Technology

Costly health information technology (IT) continues to be one of the greatest drags on efficiency and satisfaction in the practice of medicine and a significant barrier to the development and implementation of care delivery and payment reform. Independently practicing physicians may lack IT systems sufficient to engage in a prospective payment model. Alternatively, any practice with a robust IT system still requires reliable data to reach their potential. Innovative payment models depend on access to high quality, real-time actionable data at the point of care. Physicians' ability to participate in new payment models often hinge on health IT systems that support and streamline participation. Without the appropriate tools, physicians will continue to struggle to track the metrics necessary to inform and improve care delivery. Physicians must have the guidance and technical assistance to meaningfully participate in prospective payment models and other APMs. Barriers to interoperability and access to patient data must be overcome if APMs are to enjoy widespread acceptance and participation.

Telehealth

The COVID-19 pandemic accelerated uptake of telehealth. In 2020, physicians and health systems quickly deployed and expanded telehealth technology to diagnose, treat, and advise millions of patients. Before the pandemic, telehealth accounted for less than one percent of Medicare expenditures for physician services. It rose to as high as 16 percent during the spring of 2020 and then stabilized at between four and six percent for the remainder of that year. Medicare spent \$4.1 billion on physician telehealth services in all of 2020 and \$2 billion in the first six months of 2021.⁴

The adoption of telehealth illustrates how payment policy can serve as a catalyst to reform. The rapid expansion of telehealth services in response to the COVID-19 pandemic was possible after long-standing payment barriers were removed. Telehealth payment enables physicians to provide needed services to homebound and remote patients, as well as minimizing patient time away from work and other responsibilities.

Increasingly, physicians and patients deploy telehealth services. AMA Physician Practice Benchmark Survey data show that, in 2020, 79 percent of physicians were in practices that used any type of telehealth and 70 percent were in one that used video conferencing with patients. Still, some patients lack the access to technology such as broadband, which is necessary to deploy advanced telehealth technologies and many lack the skills needed to receive care via telehealth. Similarly, many physicians and health systems lack the capital needed to purchase necessary services and equipment to provide secure telehealth services. Ultimately, these barriers disproportionately impact physicians in rural areas, safety net providers, and patients from historically marginalized and minoritized communities.

AMA POLICY

The AMA has a wealth of policy directly related to prospective payment models, including policy addressing persistent concerns with value-based payment and APMs (Policies D-385.963, H-385.913, H-385.908, and H-390.849), specific physician-led payment reforms (Policies D-390.953, H-390.844, H-450.931, H-450.961, and D-35.985), the importance of physician involvement in health IT (Policies D-478.972, D-478.995, D-478.996, H-450.933, and H-478.984), telehealth (Policies D-480.963, H-478.980, H-478.996, D-480.965, H-480.946, H-390.889, D-480.969, H-450.941, and Policy D-155.987), and improving risk adjustment (Policy H-385.907 and H-285.957).

In addition, Policies H-165.844 and H-385.926 reiterate the AMA's long-standing commitment to pluralism and physician freedom of enterprise.

AMA ADVOCACY

The AMA continues to carefully examine APMs that are developed by CMS and provides feedback to the agency regarding needed modifications to enable physicians to deliver high-quality care. The AMA has also expressed concern if APMs could impose unreasonable requirements on physicians or require them to shoulder excessive financial risk. When the AMA identifies problems with an APM, it advocates for appropriate changes which have resulted in improvements in some current APMs. Examples of AMA advocacy to improve Medicare APMs include:

- The AMA has testified to Congress about the importance of having physicians involved in designing APMs in order for the APMs to be successful.
- AMA regularly submits comments to CMS identifying problems with the APMs that CMS has developed, including recommendations for improvements.
- AMA submits comments to CMS each year describing ways to improve the overall regulations that define what qualifies as an APM and what physicians must do to meet the requirements of Medicare's Quality Payment Program.
- AMA has worked closely with national medical specialty societies and other national organizations, as well as state medical associations, to develop and recommend changes in public policy on APMs.

CMMI recently published its "[strategy refresh](#)," describing new objectives for CMMI based on its experience with APMs during its first 10 years.⁷ A number of the policies outlined in the CMMI strategy are encouraging as they would implement recommendations made to CMMI leadership in a May 2021 [letter](#) from the AMA and many national specialty societies, as well as in several meetings.⁸ These include CMMI plans to:

- Make APM parameters, requirements, and other critical details as transparent and easily understandable as possible for participants;
- Reduce administrative burdens from APM participation requirements;
- Make available and increase uptake of actionable data, learning collaboratives, and payment and regulatory flexibilities to participants, especially those treating the underserved;
- Improve testing and analysis of benchmarks and risk adjustment methods;
- Deepen and sustain outreach and solicitation of input from patient and physician groups;
- Explore model tests for specialty care payment models; and
- Identify ways to align or integrate episode payment models with accountable care models.

AMA Physician Practice Benchmark Survey

The AMA's Physician Practice Benchmark Survey has been conducted on a biennial basis starting in 2012. The 6th iteration of this nationally representative survey is planned for fall 2022. A primary focus of the survey is physician practice characteristics including employment status (whether a physician is an employee, an owner/partner, or an independent contractor), practice type (e.g., solo practice, single specialty practice, or multi-specialty practice), practice ownership (e.g., physician-owned or hospital/health system-owned), practice size (measured by number of physicians), and use of non-physician providers. A second focus of the survey is the payment methods in place between practices and payers. Methods asked about include FFS, pay-for-performance, bundled payments, shared savings, and capitation. Reports based on these topics are available on the [AMA website](#).⁹ Relevant to Resolution 122-J-21, in 2020, an average of 6 percent of practice revenue was paid through capitation.

Professional Satisfaction and Practice Sustainability

The AMA's Professional Satisfaction and Practice Sustainability (PS2) unit continues to support effective development and implementation of sustainable physician payment models through research, development of tools and resources, and support of the spread of effective models through learning collaboratives and engagement with commercial health plans and large employers. An enhanced focus on sustainable physician-owned practices has been launched through its Private Practice Initiative, which offers resources such as its new series on [Payor Contracting](#) and forming [Clinically Integrated Networks](#).^{10,11}

DISCUSSION

The AMA has robust policy articulating best practices and principles for APMs, including prospective payment models (see Appendix). These policies guide continued AMA advocacy for the development and implementation of such models, including the necessary resources to make them successful. The Council recommends reaffirming policies that support a commitment to pluralism and the ability of physicians to choose their method of earning a living. The Council also recommends reaffirming policies that address the areas of concern highlighted by Resolution 122-J-21, as detailed in the Appendix regarding attribution, risk adjustment, physician involvement in contract negotiations, access to data reports, infrastructure, and capital investment (including for the delivery of telehealth), technical support and payment updates.

Consistent with Resolution 122-J-21, the Council recommends new policy to support increased inclusion of elements of prospective payment models for independent practices in the development of payment reform. The Council also recommends new principles to address the unique needs of independently practicing physicians wishing to address the challenges of contracting for prospective payments with other independent physicians. Principles should include the following:

- Compensation should incentivize the interdependence of the physician group members and foster collegiality between specialties.
- Attribution, performance targets and risk adjustment are likely to benefit from clinical data in addition to claims data.
- Any quality metrics should be clinically meaningful and developed with physician input.
- Models should strive to address community social determinants of health, with attention to patient attribution and contracted payers.
- Physicians should be leaders in their model's governance, which must be autonomous to monitor performance targets and price transparency, and to ensure that socio-demographic factors impacting overall patient health are addressed. In addition, model governance should address the purchase and leverage of high-quality health IT for better patient care and leverage group purchasing organizations to lower cost of telehealth technology.

The Council encourages the AMA and other entities, such as state and specialty medical societies, to continue to provide the guidance and infrastructure needed to allow physicians to join with other physicians.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 122-J-21, and the remainder of the report be filed:

1. That our American Medical Association (AMA) support the consideration of prospective payment elements in the development of payment and delivery reform that are consistent with AMA principles.
2. That our AMA support the following principles to support physicians who choose to participate in prospective payment models:
 - a. The AMA, state medical associations, and national medical specialty societies should be encouraged to continue to provide guidance and support infrastructure that allow independent physicians to join with other physicians in clinically integrated networks, independent of any hospital system.
 - b. Prospective payment model compensation should incentivize specialty and primary care collegiality among independently practicing physicians.

- c. Prospective payment models should take into consideration clinical data, where appropriate, in addition to claims data.
 - d. Governance within the model must be physician-led and autonomous.
 - e. Physician practices should be encouraged to work with field advisors on patient attributions and a balanced mix of payers.
 - f. Quality metrics used in the model should be clinically meaningful and developed with physician input.
 - g. Administrative burdens, such as those related to prior authorization, should be reduced for participating physicians.
3. That our AMA identify financially viable prospective payment models and develop educational opportunities for physicians to learn and collaborate on best practices for such payment models for physician practice, including but not limited to independent private practice.
 4. That our AMA reaffirm Policies H-165.844 and H-385.926, which support pluralism and the freedom of physician enterprise.
 5. That our AMA reaffirm Policy H-385.907, which supports fair and accurate risk adjustment.
 6. That our AMA reaffirm Policies H-385.913, D-478.972, D-478.995, H-478.984, H-478.980, D-480.965, H-480.946, D-480.969 and H-285.957, which collectively address the concerns raised in Resolution 122-I-21.

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APPENDIX – Policy on Prospective Payment Model Best Practices for Independent Private Practice

Policy H-165.844, Educating the American People About Health System Reform

Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system. (Res. 717, I-07 Reaffirmation A-09 Reaffirmed: CMS Rep. 01, A-19)

Policy H-285.957, Use of Risk-Adjustment Mechanisms for Physician Compensation Under Capitation Contracts

The AMA will work with interested medical organizations in urging state Medicaid programs and other third party payers to assure the inclusion of risk adjustment mechanisms in capitation rates paid to physicians providing care to chronically ill children and adults enrolled in managed care plans. (Sub. Res. 128, A-96 Reaffirmed: CMS Rep. 8, A-06 Modified: CMS Rep. 01, A-16)

Policy H-385.907, Improving Risk Adjustment in Alternative Payment Models

Our AMA supports:

- (1) risk stratification systems that use fair and accurate payments based on patient characteristics, including socioeconomic factors, and the treatment that would be expected to result in the need for more services or increase the risk of complications;
- (2) risk adjustment systems that use fair and accurate outlier payments if spending on an individual patient exceeds a pre-defined threshold or individual stop loss insurance at the insurer's cost;
- (3) risk adjustment systems that use risk corridors that use fair and accurate payment if spending on all patients exceeds a pre-defined percentage above the payments or support aggregate stop loss insurance at the insurer's cost;
- (4) risk adjustment systems that use fair and accurate payments for external price changes beyond the physician's control;
- (5) accountability measures that exclude from risk adjustment methodologies any services that the physician does not deliver, order, or otherwise have the ability to influence; and
- (6) risk adjustment mechanisms that allow for flexibility to account for changes in science and practice as to not discourage or punish early adopters of effective therapy. (CMS Rep. 03, I-19)

Policy H-385.913, Physician-Focused Alternative Payment Models

1. Our AMA recognizes that the physician is best suited to assume a leadership role in transitioning to alternative payment models (APMs).

2. Our AMA supports that the following goals be pursued as part of an APM:

- A. Be designed by physicians or with significant input and involvement by physicians;
- B. Provide flexibility to physicians to deliver the care their patients need;
- C. Promote physician-led, team-based care coordination that is collaborative and patient-centered;
- D. Reduce burdens of Health Information Technology (HIT) usage in medical practice;
- E. Provide adequate and predictable resources to support the services physician practices need to deliver to patients, and should include mechanisms for regularly updating the amounts of payment to ensure they continue to be adequate to support the costs of high-quality care for patients;
- F. Limit physician accountability to aspects of spending and quality that they can reasonably influence;
- G. Avoid placing physician practices at substantial financial risk;
- H. Minimize administrative burdens on physician practices; and
- I. Be feasible for physicians in every specialty and for practices of every size to participate in.

3. Our AMA supports the following guidelines to help medical societies and other physician organizations identify and develop feasible APMs for their members:

- A. Identify leading health conditions or procedures in a practice;
- B. Identify barriers in the current payment system;
- C. Identify potential solutions to reduce spending through improved care;
- D. Understand the patient population, including non-clinical factors, to identify patients suitable for participation in an APM;
- E. Define services to be covered under an APM;
- F. Identify measures of the aspects of utilization and spending that physicians can control;
- G. Develop a core set of outcomes-focused quality measures including mechanisms for regularly updating quality measures;
- H. Obtain and analyze data needed to demonstrate financial feasibility for practice, payers, and patients;
- I. Identify mechanisms for ensuring adequacy of payment; and
- J. Seek support from other physicians, physician groups, and patients.

4. Our AMA encourages CMS and private payers to support the following types of technical assistance for physician practices that are working to implement successful APMs:

- A. Assistance in designing and utilizing a team approach that divides responsibilities among physicians and supporting allied health professionals;
- B. Assistance in obtaining the data and analysis needed to monitor and improve performance;
- C. Assistance in forming partnerships and alliances to achieve economies of scale and to share tools, resources, and data without the need to consolidate organizationally;
- D. Assistance in obtaining the financial resources needed to transition to new payment models and to manage fluctuations in revenues and costs; and
- E. Guidance for physician organizations in obtaining deemed status for APMs that are replicable, and in implementing APMs that have deemed status in other practice settings and specialties.

5. Our AMA will continue to work with appropriate organizations, including national medical specialty societies and state medical associations, to educate physicians on alternative payment models and provide educational resources and support that encourage the physician-led development and implementation of alternative payment models. (CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 10, A-17 Reaffirmed: CMS Rep. 10, A-19 Reaffirmed: BOT Rep. 13, I-20)

Policy H-385.926, Physician Choice of Practice

Our AMA: (1) encourages the growth and development of the physician/patient contract;
 (2) supports the freedom of physicians to choose their method of earning a living (fee-for-service, salary, capitation, etc.);
 (3) supports the right of physicians to charge their patients their usual fee that is fair, irrespective of insurance/coverage arrangements between the patient and the insurers. (This right may be limited by contractual agreement.) An accompanying responsibility of the physician is to provide to the patient adequate fee information prior to the provision of the service. In circumstances where it is not feasible to provide fee information ahead of time, fairness in application of market-based principles demands such fees be subject, upon complaint, to expedited professional review as to appropriateness; and
 (4) encourages physicians when setting their fees to take into consideration the out-of-pocket expenses paid by patients under a system of individually selected and owned health insurance.
 (BOT Rep. QQ, I-91 Reaffirmed: BOT Rep. TT, I-92 Reaffirmed: Ref. Cmte. A, A-93 Reaffirmed: BOT Rep. UU, A-93 Reaffirmed: CMS Rep. G, A-93 Reaffirmed: CMS Rep. E, A-93 Reaffirmed: Sub. Res. 701, A-93 Reaffirmation A-93 Reaffirmed: BOT Rep. 25, I-93 Reaffirmed: CMS Rep. 5, I-93 Reaffirmed: CMS Rep. 10, I-93 Reaffirmed: BOT Rep. 40, I-93 Reaffirmed: Sub. Res. 107, I-93 Res. 124, I-93 Reaffirmed: Sub. Res. 127, A-94 Reaffirmed: BOT Rep. 46, A-94 Reaffirmed: Sub. Res. 132, A-94 Reaffirmed: BOT Rep. 16, I-94 Reaffirmed: CMS Rep. 8, A-95 Reaffirmed: Sub. Res. 109, A-95 Reaffirmed: Sub. Res. 125, A-95 Reaffirmed: Sub. Res. 109, I-95 Reaffirmation A-96 Reaffirmation I-96 Reaffirmation A-97 Reaffirmation I-98 Reaffirmation A-99 Appended by Res. 127, A-98 Reaffirmed: CMS Rep. 6, A-99 Reaffirmation A-00 Reaffirmation A-00 Sub. Res. 116, I-00 Reaffirmation & Reaffirmed: Res. 217, A-01 Reaffirmation A-04 Consolidated and Renumbered: CMS Rep. 7, I-05 Reaffirmation A-07 Reaffirmation A09 Reaffirmed: CMS Rep. 3, I-09 Reaffirmed in lieu of Res. 127, A-10 Reaffirmation I-13 Reaffirmation A-15 Reaffirmed: CMS Rep. 5, I-15 Reaffirmed: CMS Rep. 09, A-16 Reaffirmed: CMS Rep. 07, A-17 Reaffirmed: CMS Rep. 6, A-21)

Policy D-478.972, EHR Interoperability

Our AMA:

(1) will enhance efforts to accelerate development and adoption of universal, enforceable electronic health record (EHR) interoperability standards for all vendors before the implementation of penalties associated with the Medicare Incentive Based Payment System;
 (2) supports and encourages Congress to introduce legislation to eliminate unjustified information blocking and excessive costs which prevent data exchange;
 (3) will develop model state legislation to eliminate pricing barriers to EHR interfaces and connections to Health Information Exchanges;
 (4) will continue efforts to promote interoperability of EHRs and clinical registries;
 (5) will seek ways to facilitate physician choice in selecting or migrating between EHR systems that are independent from hospital or health system mandates;
 (6) will seek exemptions from Meaningful Use penalties due to the lack of interoperability or decertified EHRs and seek suspension of all Meaningful Use penalties by insurers, both public and private;
 (7) will continue to take a leadership role in developing proactive and practical approaches to promote interoperability at the point of care;
 (8) will seek legislation or regulation to require the Office of the National Coordinator for Health Information Technology to establish regulations that require universal and standard interoperability protocols for electronic health record (EHR) vendors to follow during EHR data transition to reduce common barriers that prevent physicians from changing EHR vendors, including high cost, time, and risk of losing patient data; and
 (9) will review and advocate for the implementation of appropriate recommendations from the “Consensus Statement: Feature and Function Recommendations to Optimize Clinician Usability of Direct Interoperability to Enhance Patient Care,” a physician-directed set of recommendations, to EHR vendors and relevant federal offices such as, but not limited to, the Office of the National Coordinator, and the Centers for Medicare and Medicaid Services. (Sub. Res. 212, I-15 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: Res. 221, I-16 Reaffirmed in lieu of: Res. 243, A-17 Reaffirmed: CMS Rep. 10, A-17 Appended: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Appended: Res. 202, A-18 Appended: Res. 226, I-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

Policy H-478.980, Increasing Access to Broadband Internet to Reduce Health Disparities

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 Reaffirmed: CMS Rep. 7, A-21)

Policy H-478.984, Prohibition of Clinical Data Blocking

Our AMA will advocate for the adoption of federal and state legislation and regulations to prohibit health care organizations and networks from blocking the electronic availability of clinical data to non-affiliated physicians who participate in the care of shared patients, thereby interfering with the provision of optimal, safe and timely care. (Res. 222, I-16 Reaffirmed: CMS Rep. 10, A-17)

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)

Policy D-478.996, Information Technology Standards and Costs

1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.
2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards. (Res. 717, A-04 Reaffirmation, A-05 Appended: Sub. Res. 707, A-06 Reaffirmation A-07 Reaffirmed in lieu of Res. 818, I-07 Reaffirmed in lieu of Res. 726, A-08 Reaffirmation I-08 Reaffirmation I-09 Reaffirmation A-10 Reaffirmation I-10 Reaffirmed: Res. 205, A-11 Reaffirmed in lieu of Res. 714, A-12 Reaffirmed in lieu of Res. 715, A-12 Reaffirmed in lieu of Res. 724, A-13 Reaffirmation I-13 Reaffirmation A-14 Reaffirmed: BOT Rep. 03, I-16 Reaffirmed: BOT Rep. 05, I-16 Appended: Res. 204, I-17 Reaffirmation: I-17 Reaffirmed: BOT Rep. 45, A-18 Reaffirmed: BOT Rep. 19, A-18 Reaffirmation: A-19 Reaffirmed: CMS Rep. 7, I-20)

Policy D-480.965, Reimbursement for Telehealth

Our AMA will work with third-party payers, the Centers for Medicare and Medicaid Services, 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.
(Res. 122, A-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 Reaffirmed: CMS Rep. 7, A-21)

3. PREVENTING COVERAGE LOSSES AFTER THE PUBLIC HEALTH EMERGENCY ENDS

Reference committee hearing: see report of Reference Committee A.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS REMAINDER OF REPORT FILED

See Policies H-165.855, H-285.952, and H-290.955

During the COVID-19 public health emergency (PHE), states have been required to provide continuous coverage to nearly all Medicaid/Children's Health Insurance Program (CHIP) enrollees as a condition of receiving a temporary increase in federal matching funds. With disenrollments effectively frozen, churn in and out of the program has temporarily ceased and enrollees have experienced two years of coverage stability. Once the PHE and continuous enrollment requirement expire, states will begin redetermining eligibility for all Medicaid /CHIP enrollees and, ideally, retaining eligible enrollees and transitioning those no longer eligible to other affordable coverage, such as through Affordable Care Act (ACA) marketplaces. The mass of impending eligibility redeterminations will be operationally challenging for states and may put significant numbers of Medicaid/CHIP enrollees at risk of losing coverage and becoming uninsured. The Council on Medical Service initiated this report to develop American Medical Association (AMA) policy supportive of strategies that will help ensure continuity of coverage after the PHE ends. This report describes strategies to prevent coverage losses as the PHE unwinds, summarizes relevant AMA policy, and makes policy recommendations.

BACKGROUND

Although Medicaid enrollment had been declining between 2017 and 2019, the arrival of COVID-19 in early 2020 led to rapid and steady enrollment increases that have continued throughout the PHE. Between February 2020 and September 2021 (the latest month for which enrollment data are available), enrollment in Medicaid/CHIP increased by 14.1 million individuals. Most of this growth was in Medicaid, which increased by nearly 13.8 million individuals or 21.6 percent. Total Medicaid/CHIP enrollment in September 2021 topped 84 million, with Medicaid enrolling more than 77 million people.¹

Experts agree that the growth in Medicaid enrollment has been driven by two factors. First, pandemic-related job losses, especially during the pandemic's first year, made many people newly eligible for Medicaid based on income. Second, provisions in the Families First Coronavirus Response Act (FFCRA) provided a temporary 6.2 percentage point increase in federal Medicaid matching funds to states that meet certain maintenance of eligibility (MOE) requirements, including maintaining continuous coverage of most enrollees throughout the PHE. Because states have not been able to disenroll anyone enrolled in Medicaid on or after March 18, 2020, enrollment has been increasing month over month for well over two years.

At the time this report was written, the PHE had been extended through mid-July 2022. Although it is impossible to know exactly what will happen to Medicaid enrollment after the PHE expires, the number of people covered by Medicaid could decrease substantially. Prior to the pandemic, it was not uncommon for people to lose Medicaid coverage for procedural reasons (e.g., because they did not respond to requests for information needed by the Medicaid agency to complete eligibility renewals or because they missed a paperwork submission deadline).² According to *Kaiser Health News*, Colorado officials anticipate that, of the 500,000 people whose eligibility will need to be reviewed post-PHE, 40 percent may lose Medicaid due to income while 30 percent will be at risk of losing coverage because of outstanding requests for information.³

Workforce challenges across many state Medicaid agencies, and fiscal pressures that may drive some states to complete their redeterminations in an abbreviated timeframe, add to concerns that, post-PHE, Medicaid/CHIP coverage and continuity of care could be disrupted for potentially millions of Americans. Urban Institute has projected that Medicaid enrollment could decline by 13 to 16 million people, depending on the PHE's end date.⁴ Additionally, a report from the Georgetown University Health Policy Institute estimated that more than 6 million of the 39.6 million children enrolled in Medicaid/CHIP could lose coverage.⁵ Urban Institute projects that one-third of adults losing

Medicaid coverage post-PHE could be eligible for premium tax credits for marketplace plans (the American Rescue Plan Act's [ARPA's] enhanced tax credits and elimination of the "subsidy cliff" are currently scheduled to expire after 2022), and an additional 65 percent could have an offer of employer-sponsored coverage in their family. Additionally, Urban Institute estimates that more than half (57 percent) of children losing Medicaid coverage could qualify for CHIP coverage, while an additional 9 percent would be eligible for subsidized marketplace coverage.⁶ According to these estimates, most people leaving Medicaid should be eligible for alternate coverage through the marketplace, CHIP, or an employer-sponsored plan. However, without proper notice and assistance, not all will enroll in alternate coverage.

Throughout the pandemic, the Centers for Medicare & Medicaid Services (CMS) has provided periodic guidance to states to support their planning for the eventual end of the PHE in a manner that mitigates coverage disruptions and bolsters consumer protections. CMS guidance⁷ includes the following directives:

- States must initiate all Medicaid/CHIP renewals and outstanding eligibility and enrollment actions within 12 months after the month in which the PHE ends and will have two additional months (14 months total) to complete all actions.
- States can begin their unwinding periods up to two months prior to the end of the month in which the PHE ends but cannot terminate enrollees' Medicaid/CHIP coverage before the first day of the month following the end of the PHE. States that begin disenrolling before then can no longer claim the temporary Federal Medical Assistance Percentages (FMAP) increase.
- States must develop an "unwinding operational plan" and determine how they will prioritize and carry out their eligibility redeterminations.
- States should initiate no more than 1/9 of their total Medicaid/CHIP renewals in a given month during the unwinding period.
- States are required to take steps to transition enrollees who are determined ineligible for Medicaid to other insurance affordability programs, such as through ACA marketplaces. As such, states must promptly assess an individual's potential eligibility for marketplace coverage and transfer that individual's electronic account to the marketplace.
- To minimize coverage disruptions among Medicaid enrollees who became eligible for, but did not enroll in, Medicare coverage during the PHE, states are encouraged to reach out and encourage these people to enroll in Medicare.⁸

Policy changes relevant to the end of the PHE were also included in the US House of Representatives-passed Build Back Better Act, although the Senate had not acted by the time this report was written and it is unclear whether any of the House-passed provisions will be considered in a separate bill. In addition to closing the Medicaid coverage gap—by allowing people with incomes below 138 percent of the federal poverty level to obtain zero-premium marketplace coverage through 2025—the House-passed provisions would extend premium tax credit generosity, cost-sharing assistance and elimination of the subsidy cliff provided under ARPA to the end of 2025 and require 12 months of continuous eligibility for children under Medicaid/CHIP.

HEALTH EQUITY CONCERNS

Before the pandemic, available state Medicaid data showed that more than 60 percent of enrollees identified as Black, Latino/a, or other individuals of color, with studies finding that children of color experienced coverage disruptions at higher rates⁹ and enrollees of color experienced poorer outcomes and more barriers to care than whites.¹⁰ It will be critical for state and federal policymakers to address the health equity implications of the PHE unwinding and how to prevent exacerbation of existing health care inequities.

As noted in [Council on Medical Service Report 5-Nov-20, Medicaid Reform](#), the pandemic disproportionately impacted Black, Latino/a and Native American communities and highlighted longstanding health inequities that disproportionately affect minoritized communities. Social drivers including racism contribute to higher rates of chronic diseases, lower access to health care, and lack of or inadequate health insurance, which help propel disparate health outcomes. Black and Latino/a people also experienced the pandemic's economic impacts that contributed to higher unemployment and housing instability, especially among groups that struggle against economic marginalization.¹¹ Frequent changes in employment may put people at risk of losing Medicaid coverage as the PHE unwinds because income volatility can lead to procedural hurdles and multiple requests for income verification and notices from the state Medicaid agency. People who experience housing instability may also be at risk of being disenrolled by Medicaid if the state is not able to reach them because of outdated contact information.¹² Importantly,

disenrollment may also have a particularly damaging impact on people with disabilities, for whom Medicaid can at times be the difference between living independently and in a facility.

STRATEGIES FOR PREVENTING COVERAGE LOSSES AFTER THE PHE ENDS

Because Medicaid is a joint federal-state program, eligibility and enrollment rules, and the processes for implementing these rules, can vary significantly by state. Accordingly, the potential for coverage losses and the ability to transition those disenrolled from Medicaid to other affordable coverage will be highly dependent on how each state performs during the post-PHE period. The following strategies may help ensure that, after the PHE ends, people still eligible for Medicaid/CHIP are appropriately retained while those found ineligible are seamlessly transitioned to subsidized ACA marketplace plans or other affordable coverage for which they are eligible.

Streamline Enrollment/Redetermination/Renewal Processes

Since Medicaid enrollees can lose coverage because they did not receive a renewal form or return information on time, it is important that states improve redetermination processes by maximizing the use of automatic renewals based on available data sources such as Internal Revenue Service and quarterly wage data, unemployment claims, or information from the Supplemental Nutrition Assistance Program or Temporary Assistance for Needy Families (TANF). The use of data sources to verify continued eligibility is known as *ex parte* renewal and it minimizes churn because it reduces administrative errors and does not require action by the enrollee. Medicaid rules generally require states to attempt to confirm eligibility *ex parte* before sending out renewal documents and requiring enrollees to respond.¹³ However, if an *ex parte* renewal cannot be completed, state Medicaid agencies must contact enrollees directly to request information needed to verify eligibility. Completing renewals by traditional means (e.g., forms transmitted through the mail) can be problematic when enrollees are not aware of the steps they need to take to retain coverage or if they have moved or have outdated contact information on file with the state.

Notably, state implementation of Medicaid rules intended to streamline renewal processes vary significantly across states, as does the percentage of completed *ex parte* renewals, with some states completing under a quarter of renewals *ex parte* and others renewing 75-90 percent using existing data sources.¹⁴ While states will always have enrollees with complex situations or who otherwise must be renewed using traditional formats—either online, in-person or by phone—states should be encouraged to streamline renewals and improve *ex parte* renewal rates.

Invest in Outreach and Enrollment Assistance

Effective communications between states and Medicaid/CHIP enrollees, physicians and other providers, health plans, and community organizations will be important to ensuring that everyone is aware of and engaged in state preparations for the mass eligibility redeterminations. CMS has encouraged states to conduct outreach to remind enrollees to update contact information on file with the state Medicaid agency.¹⁵ Without such information, enrollees who have moved during the pandemic may not receive renewal notices and could be disenrolled from Medicaid while still actually eligible. States that effectively communicate with Medicaid enrollees may prevent coverage losses by making people aware of upcoming redeterminations and actions they must take to retain coverage.

It will also be important for states to target specific outreach to people with disabilities or limited English proficiency and enrollees experiencing homelessness. Many states have planned outreach campaigns to encourage people to make sure their contact information in the state health care database is accurate and up to date. CMS has encouraged states to partner with health plans to update contact information and communicate with Medicaid enrollees, using multiple modalities—mail, email, and text—to reach people. Equally as important, states will need to communicate with enrollees no longer deemed eligible for Medicaid that they may be eligible for no- or low-cost marketplace plans and inform them how to enroll. Navigators embedded across community-based organizations and health plans may be utilized to help conduct outreach and empower people to enroll in marketplace plans.

Adopt Continuous Eligibility

Continuous eligibility policies, which allow enrollees in Medicaid, CHIP and marketplace plans to maintain coverage for 12 months, have long been supported by the AMA as a strategy to reduce churn that occurs when people lose coverage and then re-enroll within a short period of time. Churn-induced coverage disruptions are most pronounced

in Medicaid, both because income fluctuations are common and because Medicaid enrollees can lose coverage for procedural reasons.¹⁶

Once the PHE and FFCRA continuous enrollment requirements expire, continuous eligibility will remain an option for states through Section 1115 waivers. While more states may be looking into this option, at the time this report was written only New York and Montana had continuous eligibility policies in place for adult enrollees. States have had the option to adopt continuous eligibility for children with Medicaid and CHIP coverage since 1997 and many—but not all—states have done so. At the time this report was written, 27 states had implemented continuous eligibility for children enrolled in CHIP while 25 states had it for children enrolled in Medicaid.¹⁷

Providing continuous eligibility to individuals who remain eligible after post-PHE redeterminations would ensure continuity of Medicaid/CHIP coverage for large numbers of people. Importantly, without continuous enrollment policies in place, states will return to normal procedures that base Medicaid eligibility on a family's current monthly income. Typically, states check data sources and require enrollees to report even small income fluctuations that may put them just above the Medicaid income threshold in some months. An important example of continuous eligibility for a subsection of Medicaid enrollees is the option for states—made available under ARPA—to extend postpartum coverage to 12 months. Consistent with AMA policy, this option is intended to improve maternal health and coverage stability and to help address racial disparities in maternal health.¹⁸

Encourage Auto-Enrollment

Auto-enrollment in marketplace coverage, Medicaid/CHIP, and employer-sponsored coverage was addressed by the [Council in Council on Medical Service Report 1-Nov-20](#) as a means of expanding coverage. Maryland's Easy Enrollment Health Insurance Program is an auto-enrollment initiative that facilitates health coverage through tax filing by allowing filers to share insurance status and income on tax forms and authorize the state to determine whether they are eligible for Medicaid or subsidized marketplace plans.¹⁹ During the first year of implementation in 2020, over 60,000 Marylanders shared their information via Easy Enrollment. Most were found eligible for Medicaid or marketplace coverage and over 4,000 people were auto-enrolled in coverage.²⁰ Other states considering similar "easy enrollment" programs include Colorado and New Jersey.²¹

State departments of motor vehicles and unemployment insurance systems have also been identified as potential avenues for leveraging auto-enrollment in health coverage. Legislation adopted in Maryland and under consideration in New Jersey would allow individuals applying for unemployment to share information and permit the state to offer Medicaid or marketplace coverage to eligible individuals.²² While several states have expressed interest in various approaches to auto-enrollment, income verification and citizenship attestation have been identified as barriers to implementation.²³

Facilitate Coverage Transitions, Including Automatic Transitions

As states undertake redeterminations of all Medicaid and CHIP enrollees once the PHE expires, many people disenrolled because their incomes have risen will be eligible for subsidized coverage through state or federally facilitated marketplaces or through a Basic Health Program (BHP) in states that operate a BHP (Minnesota and New York). However, in most states transitioning people to marketplace coverage from Medicaid is not automatic and may be difficult for people to navigate. Additionally, some people disenrolled from Medicaid may not know that they are eligible for subsidized marketplace coverage or may think the plans are unaffordable.²⁴ Although ARPA increased subsidies for all those eligible, including newly eligible over 400 percent of the federal poverty level, these provisions will expire at the end of 2022 unless Congress extends them. If the ARPA subsidies expire, people enrolled in subsidized marketplace plans this year may be at risk of coverage lapses next year once eligibility and premiums are reset for their marketplace plans.

Before the ACA, Massachusetts implemented its own subsidized health insurance exchange (Commonwealth Care) along with a policy that automatically switched premium lapsed into a free plan, if one was available, rather than disenrolling them. Researchers found that this policy prevented coverage losses among 14 percent of enrollees eligible for zero premium plans and that those retained were younger, healthier, and less costly to insure.²⁵ Another Massachusetts policy temporarily associated with its pre-ACA exchange auto-enrolled people who were found eligible for Commonwealth Care—through either an application for the exchange or a Medicaid redetermination—but who

did not actively choose a plan. This policy, which applied only to people with incomes below 100 percent of the federal poverty level, was found to significantly increase enrollment.²⁶

Some state Medicaid agencies already partner with their state's marketplace to identify strategies for improving transitions from Medicaid to marketplace coverage and identifying barriers to seamless transitions. Information technology (IT) challenges can present barriers to smooth coverage transitions, especially in states that have not updated and/or integrated their IT systems so they are able to share eligibility information between Medicaid/CHIP and the marketplace.²⁷ Those states that already have integrated IT systems in place may have an easier time auto-transitioning people from Medicaid to the marketplace, or from marketplace plans to Medicaid. However, at the time this report was written, most states had not integrated their Medicaid and marketplace eligibility systems, which could make it more difficult to switch people from one source of coverage to another. The degree to which state Medicaid and marketplace agencies work together matters greatly but varies across states and may be more challenging in states that do not run their own marketplaces.

Provide Monitoring and Oversight

It will be critical that states monitor the effectiveness of their policies and plans as the PHE unwinds so they become aware of concerning indicators signaling a need for the state to intervene or change course. In particular, states should monitor Medicaid/CHIP enrollment and disenrollment data and whether individuals are being disenrolled appropriately due to income or because of procedural or paperwork issues. States experiencing unusually high levels of churn may need to take steps to ensure that enrollees still eligible for Medicaid/CHIP are being appropriately retained. Similarly, increases in the numbers of newly uninsured individuals should suggest to states that new policy or action may be needed to address avoidable churn and/or whether new procedures are needed to facilitate transitions between coverage programs. CMS has indicated that the agency will monitor a state's progress in completing its redeterminations and that states will need to submit baseline and then monthly data during the unwinding period.²⁸ At a minimum, states should be encouraged to track and make available key enrollment data to ensure appropriate monitoring and oversight of Medicaid/CHIP retention and disenrollment, successful transitions to new coverage, and numbers and rates of uninsured.

EXAMPLES OF STATE PLANS FOR THE UNWINDING OF THE PHE

At the time this report was written, the PHE remained in effect and states were in various stages of planning for the unwinding. In a January 2022 survey conducted by the Kaiser Family Foundation and Georgetown University Center for Children and Families, 27 states indicated that they had developed plans for resuming redeterminations once the continuous coverage requirement is lifted.²⁹ This survey also found that 39 states intend to take up to a full year to process redeterminations (9 states plan to do so more quickly); 46 states are planning to update enrollee mailing addresses before the PHE expires; and 30 states are taking steps to increase agency staffing in order to process the renewals. Among states that were able to project anticipated disenrollments as the PHE unwinds, estimates varied widely across states and ranged from 8 percent to 30 percent of total enrollees potentially losing Medicaid coverage.³⁰

Washington State plans to use most of the time allotted by CMS after the PHE ends to complete its redeterminations. The State of Washington Health Care Authority has been keeping up with renewals throughout the PHE (without disenrolling anyone) and, once it expires, will attempt to auto-renew enrollees using the state's Healthplanfinder system.³¹ Because Healthplanfinder is an integrated system, it can help facilitate transitions of enrollees who are no longer Medicaid-eligible to marketplace plans for which they are eligible. Additionally, the State of Washington has over 900 navigators located at clinics and community support organizations around the state and over 1600 state-certified brokers available to help people stay covered.³²

By the fall of 2021, California's Department of Health Care Services was already preparing for redeterminations of nine to ten million Medi-Cal recipients by, among other strategies, working with health navigators, advocates, managed care plans and community-based organizations to communicate the need for enrollees to update their contact information.³³ Under state legislation (S.B. 260) passed in 2019, the state's health insurance exchange—Covered California—is required to automatically enroll individuals no longer eligible for Medicaid (Medi-Cal) into the lowest cost silver plan before they are terminated.³⁴ As the PHE unwinds, California's Healthcare Eligibility, Enrollment, and Retention System (CalHEERS)—an integrated system supporting eligibility, enrollment, and retention for Covered California, Medi-Cal, and Healthy Families—will be used to auto-transition individuals no longer eligible for Medi-Cal into subsidized Covered California plans.³⁵

In Ohio, the state legislature included language in its biennial budget bill that set parameters around the state's post-COVID Medicaid redeterminations. As passed by the General Assembly, H.B. 110 requires the Ohio Department of Medicaid to conduct eligibility redeterminations of all Ohio Medicaid recipients within 90 days after the PHE expires. The legislation further requires expedited eligibility reviews of enrollees identified as likely ineligible for Medicaid within 90 days and—to the extent permitted under federal law—disenroll those people who are no longer eligible.³⁶ Multiple media outlets have reported that \$35 million was appropriated by the state to contract with an outside vendor (Boston-based Public Consulting Group) to automate its eligibility redeterminations in exchange for a share of the savings.^{37,38}

RELEVANT AMA POLICY

The AMA's long-standing goals to cover the uninsured and improve health insurance affordability are reflected in a plethora of AMA policies and the AMA proposal for reform. Among the most relevant policies are those that support the adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and coordination of patient care (Policies H-165.832 and H-165.855). AMA policy also supports investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971, H-290.982 and D-290.982). Policy H-290.982 calls for states to streamline enrollment in Medicaid/CHIP by, for example, developing shorter applications, coordinating Medicaid and TANF application processes, and placing eligibility workers where potential enrollees work, go to school, and receive medical care, and urges CMS to ensure that outreach efforts are culturally sensitive. This policy also urges states to undertake, and state medical associations to take part in, educational and outreach activities aimed at Medicaid and CHIP-eligible children. The role of community health workers is addressed under Policy H-440.828, while Policy H-373.994 delineates guidelines for patient navigator programs.

Policy D-290.979 directs the AMA to work with state and specialty medical societies to advocate at the state level in support of Medicaid expansion. Policy D-290.974 supports the extension of Medicaid and CHIP coverage to at least 12 months after the end of pregnancy. Policy H-290.958 supports increases in states' FMAP or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment. Medicaid and incarcerated individuals addressed by Policy H-430.986. Policy H-290.961 opposes work requirements as a criterion for Medicaid eligibility.

Policy H-165.839 advocates that health insurance exchanges address patient churning between health plans by developing systems that allow for real-time patient eligibility information. Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt out after being auto-enrolled, and targeted outreach and streamlined enrollment. Under this policy, individuals should only be auto-enrolled in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies. Candidates for auto-enrollment would therefore include individuals eligible for Medicaid/CHIP or zero-premium marketplace coverage. Individuals eligible for zero-premium marketplace coverage would be randomly assigned among the zero-premium plans with the highest actuarial values. Policy H-165.823 also outlines standards that any public option to expand health insurance coverage, as well any approach to cover individuals in the coverage gap, must meet. Principles for the establishment and operation of state Basic Health Programs are outlined in Policy H-165.832.

Under Policy H-165.824, the AMA supports adequate funding for and expansion of outreach efforts to increase public awareness of advance premium tax credits and encourages state innovation, including considering state-level individual mandates, auto-enrollment and/or reinsurance, to maximize the number of individuals covered and stabilize health insurance premiums without undercutting any existing patient protections. Policy H-165.824 further supports: (a) eliminating the subsidy "cliff", thereby expanding eligibility for premium tax credits beyond 400 percent of the federal poverty level; (b) increasing the generosity of premium tax credits; (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing reductions.

Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet critical health needs and the underlying social determinants of health; (2) supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs; and (3) encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health. Policy H-180.944 states that "health equity," defined as optimal health for all, is a goal toward which our AMA will work by advocating for health

care access, research and data collection; promoting equity in care; increasing health workforce diversity; influencing determinants of health; and voicing and modeling commitment to health equity.

DISCUSSION

Medicaid is the largest health insurance program in the US; the leading payer of medical costs associated with births, mental health services and long-term care; and an indispensable safety net for people exposed to poverty. Throughout the PHE, Medicaid and CHIP have provided health coverage and care to more than 80 million people, including individuals affected by COVID-19 and those who experienced pandemic-related job losses. Because of the Medicaid continuous enrollment requirement and enhanced FMAP provided under the FFCRA, states have largely maintained Medicaid/CHIP coverage stability and prevented increases in uninsured rates that would otherwise be expected during a once-in-a-lifetime PHE. The loss of enhanced federal matching funds once the PHE expires will compound the many pressures already facing states and their Medicaid agencies, including budgetary concerns, the duration of time that has passed since the state has had contact with many enrollees, and an ongoing shortage of human services workers trained to complete eligibility redeterminations.

The Council recognizes that states and state Medicaid programs have been operating under considerable financial and administrative strain during the pandemic and that state Medicaid spending may increase when the enhanced federal match dries up at the end of the quarter in which the PHE expires. Most states have experienced substantial enrollment increases over the last two years and many individuals, whose incomes have risen above Medicaid eligibility thresholds, will appropriately be disenrolled as states right-size their programs. The Council maintains that people should be properly enrolled in quality affordable coverage for which they are eligible. At the same time, the Council is concerned that the impending eligibility redeterminations will trigger excessive churn and coverage losses in some states at a time when many enrollees, and state and local governments, are still struggling with the aftereffects of COVID-19. As the PHE unwinds, physicians and other providers may see more patients who do not realize that they are uninsured because they are no longer covered by Medicaid/CHIP. Because even brief gaps in coverage can be costly in terms of interrupting continuity of care and necessary treatments, the Council hopes that states will employ strategies that help them retain Medicaid/CHIP-eligible enrollees and transition those no longer eligible into other affordable health plans.

The [appended policy crosswalk](#) outlines the strategies described in this report along with AMA policy that supports adoption of these strategies. As noted, it is anticipated that most people who lose Medicaid/CHIP coverage as the PHE unwinds will qualify for subsidized coverage through the marketplace or for employer-sponsored insurance. Although the ACA expanded the availability of coverage options, transitioning between Medicaid, marketplace and employer-sponsored coverage remains challenging to navigate. Accordingly, the Council recommends encouraging states to facilitate coverage transitions, including automatic transitions, to alternate coverage for which individuals are eligible. If adopted, this new policy would support more seamless coverage transitions among individuals found ineligible for Medicaid/CHIP into other affordable plans. Notably, the recommended policy would also support other coverage transitions, such as: newly unemployed individuals transitioning into Medicaid or marketplace coverage; young adults aging out of CHIP or family coverage securing other affordable coverage for which they may be eligible; and individuals whose marketplace coverage has lapsed because of premium increases moving into a more affordable marketplace plan or Medicaid, if they are eligible. In all circumstances, the Council emphasizes that individuals should be transitioned into the best affordable plans for which they are eligible.

The Council understands that states vary in terms of their ability to facilitate transitions from one source of coverage to another, and that few states are currently prepared to auto-transition people from Medicaid to marketplace coverage. However, we hope that states continue to pursue more seamless coverage transitions in the future. To that end, the Council believes that coordination among state agencies overseeing Medicaid, marketplace plans, and workforce/unemployment offices is integral to helping individuals maintain continuity of care across coverage programs. Accordingly, the Council recommends supporting coordination among state Medicaid, marketplace and workforce agencies that will help facilitate health coverage transitions. The Council also believes strongly that monitoring and oversight will be critical to preventing unnecessary coverage losses and recommends supporting federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.

Finally, the Council recommends reaffirmation of AMA policies calling for streamlined Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982) and adoption of 12-month continuous eligibility across Medicaid,

CHIP, and exchange plans (Policy H-165.855) to minimize churn and ensure that states are appropriately retaining Medicaid/CHIP enrollees. The Council also recommends reaffirming AMA policy that encourages states to pursue auto-enrollment in health insurance coverage (Policy H-165.823) as a means of expanding coverage.

RECOMMENDATIONS

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

1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
 - a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
 - b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
 - d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods.
 - g. Auto-transitions should preserve existing medical home and patient-physician relationships whenever possible.
 - h. Individuals auto-transitioned into a plan that does not include their physicians in-network should be able to receive transitional continuity of care from those physicians, consistent with Policy H-285.952.
2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage.
3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates.
4. That our AMA reaffirm Policy H-290.982, which calls for states to streamline Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts.
5. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of care.
6. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails.
7. That our AMA reaffirm Policy H-285.952, which supports patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals.

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APPENDIX - AMA Policy and Strategies to Prevent Coverage Losses After the Public Health Emergency Ends

Strategy	AMA Policy
Streamline redetermination/renewal processes	Policy H-290.982 calls for states to streamline enrollment processes within Medicaid/CHIP and use simplified application forms.
Invest in outreach and enrollment assistance	Policy H-290.982 urges states to undertake educational and outreach activities and ensure that Medicaid/CHIP outreach efforts are appropriately sensitive to cultural and language diversities.
Adopt continuous eligibility	Policy H-165.855 states that in order to limit patient churn and assure continuity and coordination of care, there should be adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans.
Encourage auto-enrollment	Policy H-165.823 supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to cost of coverage, individual consent, opportunity to opt-out, and targeted outreach and streamlined enrollment.
Facilitate coverage transitions, including automatic transitions to alternate coverage	No relevant AMA policy. New policy recommended (see Recommendations 4 and 5)
Provide monitoring and oversight	No relevant AMA policy. New policy recommended (see Recommendation 6)

4. PARAMETERS OF MEDICARE DRUG PRICE NEGOTIATION (ALTERNATE RESOLUTION 113-NOV-21)

Reference committee hearing: see report of Reference Committee A.

**HOUSE ACTION: RECOMMENDATIONS ADOPTED
IN LIEU OF RESOLVE 2 OF ALTERNATE RESOLUTION 113-NOV-21
REMAINDER OF REPORT FILED**

See Policies H-110.980, H-110.983, H-330.894, and D-330.954

At the November 2021 Special Meeting, the House of Delegates referred the second resolve of Alternate Resolution 113, Supporting Medicare Drug Price Negotiation, as well as an amendment proffered during consideration of Alternate Resolution 113. The second resolve of Alternate Resolution 113 asked that our American Medical Association (AMA) reaffirm Policy H-110.980, Additional Mechanisms to Address High and Escalating Pharmaceutical Prices, which outlines principles guiding the use of international price indices and averages in determining the price of and payment for drugs, including those covered in Medicare Parts B and D. In contrast, the amendment to Alternate Resolution 113 opposed reaffirmation of Policy H-110.980, and instead asked our AMA to advocate for Medicare drug price negotiation to reduce prices paid by Medicare for medications in Part B and Part D and physician acquisition costs for medications in Part B.

In addition, the amendment proposed to amend Policy H-110.980[2(a)] by addition and deletion to read as follows:

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;~~

a. Any international drug price index used to determine Medicare Part D drug prices should be based on a reasonable percentage of the drug's volume weighted net average price in at least six large western industrialized nations;

This report provides background on the impacts of high and escalating prescription drug prices and costs; outlines proposals to leverage an international price index in Medicare Parts B and D; summarizes significant AMA policy and advocacy on prescription drug pricing; and presents policy recommendations.

BACKGROUND

The Council understands that the intent of the amendments proposed to Policy H-110.980 was to take significant and concrete action to lower Medicare Parts D and B drug prices and associated patient cost-sharing. Some recent legislative proposals that incorporate international price indices and averages in Medicare drug price negotiation, addressed by Policy H-110.980, would not only extend negotiated prices to Medicare and Medicare Advantage, but also to private health insurance unless the insurer opts out. The Council agrees wholeheartedly that unsustainably high and escalating prescription drug prices and costs constitute a consistent and paramount concern for patients and their physicians, employers, states, and the federal government, underpinning the introduction of legislation, or promulgation of regulations, on both the federal and state levels.

Spending on retail prescription drugs totaled \$348.4 billion in 2020, accounting for eight percent of total health spending.¹ Other estimates suggest that spending on prescription drugs as a percent of total health spending is greater when other factors, including the non-retail drug markets and gross profits of other stakeholders involved in drug distribution, payment, and reimbursement are included. Significantly, spending on specialty drugs now constitutes more than one-half of drug spending (53 percent).² The most recent National Health Expenditure data showed that retail prescription drug spending was estimated to have increased by three percent in 2020. Drivers behind the lower rate of growth in prescription drug spending include a slower overall utilization of prescription drugs and a higher use of coupons, which resulted in a reduction in out-of-pocket expenditures.³

Approximately 6.3 billion prescriptions were dispensed in the United States (US) in 2020, 90 percent of which were dispensed as generics.⁴ The retail price differentials between specialty, brand-name and generic drugs are noteworthy. Examining the retail prices of drugs widely used by older Americans in 2020—most of whom are Medicare beneficiaries who would be impacted by the proposed, referred amendments to Policy H-110.980—the average annual retail price of therapy with specialty drugs was \$84,442, dropping to \$6,604 for brand-name drugs, both dwarfing the annual price of therapy for generics.⁵

In Medicare, patients face different cost-sharing for prescription drugs, depending on whether the drugs are covered under Medicare Part B or D. In general, Medicare Part B covers prescription drugs that typically are not self-administered; Part B drugs can be provided in a physician's office as part of their service. In addition, Part B covers limited outpatient prescription drugs, including certain oral cancer drugs. Most other retail prescription drugs for medically accepted indications that are not covered by other parts of Medicare fall under Medicare Part D. Within Medicare Part D, the typical formulary design consists of five tiers: preferred generics, generics, preferred brands, non-preferred drugs, and specialty drugs. Within these tiers, among all stand-alone Medicare Part D prescription drug plans, median standard cost sharing in 2022 is \$0 for preferred generics, \$5 for generics, \$42 for preferred brands, 40 percent coinsurance for non-preferred drugs, and 25 percent coinsurance for specialty drugs.⁶ For prescription drugs covered under Medicare Part B, for traditional Medicare beneficiaries without a supplemental plan, cost-sharing for covered Part B drugs equates to 20 percent of the Medicare-approved amount after paying any applicable Part B deductible, with no out-of-pocket limit.⁷

Overall, in the Medicare program, between 2007 and 2019, Part D program spending grew by an average annual rate of 5.5 percent and amounted to \$88.4 billion in 2019. Premiums paid by Part D enrollees for basic benefits (not including low-income subsidy enrollees) amounted to \$13.9 billion in 2019, a decrease of 2.1 percent from 2018, before which premiums paid by enrollees had been growing by an average of 12 percent per year.⁸ Under Medicare Part B, total drug spending amounted to \$37 billion in 2019, with the top 50 drugs ranked by total spending accounting for 80 percent of total Medicare Part B drug spending.⁹

Relevant to legislative proposals that extend drug prices achieved by Medicare drug price negotiation to private health insurance, employer-sponsored health plans as well as health plans sold in the individual market have also had to

absorb the higher costs of prescription drugs. Higher costs of prescription drugs often translate to higher premiums, higher prescription drug cost-sharing, and additional prescription drug tiers to accommodate the higher costs of specialty and certain generic drugs. In 2021, 88 percent of employees were enrolled in plans with three, four or more cost-sharing tiers for prescription drugs.¹⁰

Overall, patient out-of-pocket costs for retail prescription drugs reached \$61 billion in 2020, with non-retail out-of-pocket costs amounting to \$16 billion. Across Medicare, Medicaid and commercial health plans, eight percent of patients pay more than \$500 per year out-of-pocket for prescriptions. Medicare beneficiaries have a notably higher incidence rate of high out-of-pocket expenses for prescription drugs, with 17 percent paying more than \$500 out-of-pocket.¹¹

The higher costs of prescription drugs impact patient health outcomes and physician practices. Ultimately, prescription drug costs can impact the ability of physicians to place their patients on the best treatment regimen, due to the regimen being unaffordable for the patient, or being subject to coverage limitations and restrictions, as well as utilization management requirements, by the patient's health plan. In the worst-case scenario, patients entirely forgo necessary treatments involving drugs and biologics due to their high cost.

Increasing patient cost-sharing is associated with declines in medication adherence, which in turn can lead to poorer health outcomes. Among those currently taking prescription drugs, approximately a quarter of adults and seniors have reported difficulties in affording their prescription drugs. Approximately 30 percent of all adults have reported not taking their medications as prescribed at some point in the past year due to cost. Drilling down further, 16 percent of adults have not filled a prescription in the past year due to cost, 22 percent chose to take an over-the-counter medication instead, and 13 percent cut pills in half or skipped doses.¹²

Notably, out-of-pocket costs for prescription drugs are linked to the rate at which patients newly prescribed a drug either do not pick up their prescription or switch to another product. Many health plans have a formulary design with fixed copays for brand drugs of less than \$30 for preferred products, with a rate of abandonment of 12 percent or less. For non-preferred brand drugs with a copay of \$75, the rate of abandonment is 26 percent or higher. Fifty-six percent of prescriptions with a final cost of over \$500 are not picked up by patients.¹³

LEVERAGING AN INTERNATIONAL PRICE INDEX IN MEDICARE PARTS B AND D

Proposals previously put forward by the Trump Administration and members of Congress attempted to lower US drug costs by tying them to international prices, and/or would have used an average of international prices, or an international reference price, to help define whether a price of a drug is excessive. While significant legislation addressing drug pricing has passed in the House of Representatives, negotiations have stalled following House passage. The Biden Administration has also stated that it will not implement a model utilizing an international price index in Medicare Part B without further rulemaking.

Current Status of Prescription Drug Price Negotiation in Medicare Parts D and B

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

In efforts to lower drug prices and patient out-of-pocket costs in Medicare Part D, multiple bills have been introduced in Congress to enable and/or require the Secretary of HHS to negotiate covered Part D drug prices on behalf of Medicare beneficiaries. However, historically, the Congressional Budget Office (CBO), as well as Centers for Medicare & Medicaid Services (CMS) actuaries, have estimated that providing the Secretary of HHS broad

negotiating authority by itself would not have any effect on negotiations taking place between Part D plans and drug manufacturers or the prices that are ultimately paid by Part D.^{14,15}

In fact, CBO has previously acknowledged that, in order for the Secretary to have the ability to obtain significant discounts in negotiations with drug manufacturers, the Secretary would also need the “authority to establish a formulary, set prices administratively, or take other regulatory actions against firms failing to offer price reductions. In the absence of such authority, the Secretary’s ability to issue credible threats or take other actions in an effort to obtain significant discounts would be limited.”¹⁶ CMS actuaries have concurred, stating “the inability to drive market share via the establishment of a formulary or development of a preferred tier significantly undermines the effectiveness of this negotiation. Manufacturers would have little to gain by offering rebates that are not linked to a preferred position of their products, and we assume that they will be unwilling to do so.”¹⁷

The Council underscores that recent legislative and regulatory proposals that aimed to incorporate international drug price indices or averages in Medicare have targeted Part B in addition to Part D; therefore, it is imperative to understand how prices of Part B drugs are determined as well. Under current law, the Secretary of HHS also does not negotiate prices of and payment for Part B drugs. Instead, Medicare reimburses physicians and hospitals for the cost of Part B drugs at a rate tied to the average sales price (ASP) for all purchasers—including those that receive large discounts for prompt payment and high-volume purchases—plus a percentage of the ASP. Accordingly, any proposal to change how Part B drugs are priced—including the incorporation of international drug price indices and/or averages—also could significantly change how and the level at which physicians are paid for Part B drugs.

Recent Significant Legislative Developments

Legislation preceding Build Back Better, H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act, which passed the House of Representatives during the 116th Congress, would have opened the door to the Secretary of HHS to negotiate the prices of certain drugs. Title I of H.R. 3 would require the Secretary of HHS to directly negotiate with manufacturers to establish a maximum fair price for drugs selected for negotiation, which would be applied to Medicare, with flexibility for Medicare Advantage and Medicare Part D plans to use additional tools to negotiate even lower prices. Under H.R. 3, the Secretary of HHS would be required to negotiate maximum prices for: (1) insulin products; (2) with respect to 2023, at least 25 single-source, brand-name drugs that do not have generic competition and that are among either the 125 drugs that account for the greatest national spending or the 125 drugs that account for the greatest spending under the Medicare prescription drug benefit and Medicare Advantage (MA); (3) beginning in 2024, at least 50 such single-source, brand-name drugs; and (4) newly approved single-source, brand-name drugs with wholesale acquisition costs equal to or greater than the median household income. The negotiated prices would be offered under Medicare and Medicare Advantage, as well as under private health insurance unless the insurer opts out. An “average international market price” would be established to serve as an upper limit for the price reached in any negotiation, if practicable for the drug at hand, defined as no more than 120 percent of the drug’s volume-weighted net average price in six countries—Australia, Canada, France, Germany, Japan and the United Kingdom.¹⁸

Showing the impact of negotiating leverage, the December 10, 2019 CBO cost estimate “Budgetary Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act” stated that Title I of the legislation would reduce federal direct spending for Medicare by \$448 billion over the 2020-2029 period.¹⁹ In its October 11, 2019 estimate, CBO estimated that the largest savings would be the result of lower prices for existing drugs that are sold internationally, which would be impacted by the application of the “average international market price” outlined in the bill.²⁰ CBO also estimated that due to the collective provisions of H.R. 3, approximately eight fewer drugs would be introduced to the US market over the 2020-2029 period, with approximately 30 fewer drugs introduced to the US market over the following decade.²¹ There would be a reduction of drugs introduced in the US market due to the enactment of H.R. 3 “because the potential global revenues for a new drug over its lifetime would decline as a result of enactment, and in some cases the prospect of lower revenues would make investments in research and development less attractive to pharmaceutical companies....The effects would be larger in the 2030s because of the considerable time needed to develop new drugs and because of the larger effects that would occur when more phases of development are affected.”²² In addition, CBO estimated that “[t]he introduction of new drugs would tend to be delayed in the six reference countries: Australia, Canada, France, Germany, Japan, and the United Kingdom. Prices of new drugs in those countries would rise somewhat.”²³

While H.R. 3 was reintroduced in this Congress, the latest congressional action on drug pricing was a part of H.R. 5376, the Build Back Better Act, which passed the House of Representatives in November 2021. If enacted into law,

the House-passed version of Build Back Better would allow the Secretary of HHS to negotiate the prices of a small number of high-cost drugs covered under Medicare Part D (starting in 2025) and Part B (starting in 2027). The negotiation process would apply to no more than 10 single-source brand-name drugs or biologics that lack generic or biosimilar competitors in 2025, ramping up to no more than 20 in 2028 and later years. The drugs selected for negotiation would be required to be among the 50 drugs with the highest total Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending. All insulin products would also be subject to negotiation.²⁴

Certain drugs would be exempt from negotiation, including those that are less than nine years (for small-molecule drugs) or 13 years (for biological products) from their U.S. Food and Drug Administration (FDA)-approval or licensure date. “Small biotech drugs” would also be exempt from negotiation until 2028; these drugs are defined as those which account for 1 percent or less of Part D or Part B spending and account for 80 percent or more of spending under each part on that manufacturer’s drugs. In addition, the legislation exempts from negotiation drugs with Medicare spending of less than \$200 million in 2021 (increased by the Consumer Price Index for All Urban Consumers (CPI-U) for subsequent years) and drugs with an orphan designation as their only FDA-approved indication.²⁵

Due to lack of congressional support for incorporating international price indices/averages into the Medicare drug price negotiation process for drugs covered under Medicare Parts D and B, the Build Back Better Act as passed by the House of Representatives instead establishes an upper limit for the negotiated price (the “maximum fair price”) equal to a percentage of the non-federal average manufacturer price (AMP)—the average price wholesalers pay manufacturers for drugs distributed to non-federal purchasers. The “maximum fair price” is defined as 75 percent of the non-federal AMP for small-molecule drugs more than 9 years but less than 12 years beyond approval; 65 percent for drugs between 12 and 16 years beyond approval or licensure; and 40 percent for drugs more than 16 years beyond approval or licensure. The payment for Part B drugs selected for negotiation would be based on the maximum fair price, versus ASP under current law.²⁶ The Council underscores that at the time this report was written, there remains insufficient support in the House of Representatives and Senate to incorporate international price indices/averages into the Medicare drug price negotiation process for drugs covered under Medicare Parts D and B.

The significant differences between the drug negotiation provisions of the Build Back Better Act and H.R. 3 cause more limited cost savings and impacts on drug development under the Build Back Better Act. CBO estimated \$78.8 billion in Medicare savings in the 2022-2031 period from the drug negotiation provisions in the Build Back Better Act. In addition, CBO estimated that one fewer drug would come to the US market over the 2022-2031 period, four fewer over the subsequent decade, and approximately five fewer the decade after that.²⁷

Recent Regulatory Activity

The regulatory process is a pathway that cannot be ignored in its potential to change the way and level at which drugs are paid for under Medicare Part B through the incorporation of international drug price indices or averages. Notably, the AMA has been active in its advocacy efforts in response to regulatory proposals to date. In October of 2018, the Trump Administration released an Advance Notice of Proposed Rulemaking (ANPRM) entitled “International Pricing Index Model for Part B Drugs.” The ANPRM did not represent a formal proposal, but rather outlined the Administration’s thinking at the time, and sought stakeholder input on a variety of topics and questions related to this new drug pricing model prior to entering formal rulemaking. The ANPRM outlined a new payment model for physician-administered drugs paid under Medicare Part B that would transition Medicare payment rates for certain Part B drugs to lower rates that are tied to international reference prices—referred to as the “international pricing index”—except where the ASP is lower. The international reference price would partly be based on an average of prices paid by other countries. To accomplish this, the proposal would create a mandatory demonstration through the Centers for Medicare & Medicaid Innovation (CMMI), which would apply to certain randomly selected geographic areas, representing approximately 50 percent of Medicare Part B drug spending. Initially, the program would apply only to sole-source drug products and some biologics for which there is robust international pricing data available.

In geographic areas included in the demonstration, CMS would contract with private-sector vendors that would negotiate for, purchase, and supply providers with drug products that are included in the demonstration. CMS would directly reimburse the vendor for the included drugs, starting with an amount that is more heavily weighted toward the ASP instead of the international pricing index, and transitioning toward a target price that is heavily based on the international pricing index. Providers would select vendors from which to receive included drugs, but would not be responsible for buying from and billing Medicare for the drug product. Instead, providers would continue to be entitled to bill a drug administration fee, and would also be entitled to receive a drug add-on fee. While the ANPRM was

somewhat short on detail on exactly how this add-on fee would be calculated, it appears the add-on fee would be a flat fee that is based on six percent of the historical average sales price for the drug in question.²⁸

In September 2020, an executive order, “Lowering Drug Prices by Putting America First,” was issued, and called for testing of payment models to apply international price benchmarking to Part B and Part D prescription drugs and biological products. For Part B, the executive order instructed the Secretary of HHS to implement rulemaking to test a payment model under which “Medicare would pay, for certain high-cost prescription drugs and biological products covered by Medicare Part B, no more than the most-favored-nation price.” The executive order defined the “most-favored-nation price” as “the lowest price, after adjusting for volume and differences in national gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a member country of the Organisation for Economic Co-operation and Development (OECD) that has a comparable per-capita gross domestic product.” For Part D, the executive order instructed the Secretary of HHS to develop and implement rulemaking to test a payment model for high-cost Part D drugs, limiting payment to these drugs to the most-favored-nation price, to the extent feasible.²⁹

In November of 2020, the Trump Administration issued an interim final rule entitled “Most Favored Nation (MFN) Model” to establish a model through CMMI that would phase in changing Medicare’s payment for approximately 50 Part B drugs that make up a high percentage of Part B spending from paying solely based on manufacturers’ ASP to the lowest adjusted international price for the drug, defined as the lowest gross domestic product (GDP)-adjusted price paid by an OECD member country with a GDP per capita (based on purchasing power parity) that is at least 60 percent of the US GDP per capita. Addressing physician payment, the add-on payment based on six percent of ASP for the individual drug would be replaced with a flat payment per dose that would be uniform for all included drugs in the MFN Model. As the model was scheduled to become effective January 1, 2021, on December 28, 2020, the US District Court for the Northern District of California issued a nationwide preliminary injunction in *Biotechnology Innovation Organization v. Azar*, which preliminarily enjoined HHS from implementing the Most Favored Nation Rule. Given this preliminary injunction, the MFN Model was not implemented on January 1, 2021. The interim final rule was formally rescinded in December 2021 and will not be implemented without further rulemaking.³⁰

RELEVANT AMA POLICY

AMA policy on prescription drug pricing is diverse, multifaceted, and allows the AMA to advocate on a breadth of issues to tackle high and escalating drug pricing, not limited to Medicare drug price negotiation or opening the door for the use of international drug price indices and averages in Medicare Parts D and B. This strong foundation of AMA policy addressing prescription drug pricing, coverage and payment has allowed the AMA to actively engage on legislative and regulatory proposals on drug pricing on both the federal and state levels.

Significantly, Policy H-110.987 supports legislation that limits Medicare annual drug price increases to the rate of inflation—a significant provision that has been included in recent legislation addressing prescription drug prices. The policy also supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations, as well as for biologics. The policy also supports 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 percent or more each year or per course of treatment and provide justification for the price increase; 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 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 percent or more each year or per course of treatment. In addition, it advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase. Finally, it states that 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.

Policy H-110.980[3] 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. Policy D-100.983 outlines standards for the importation of prescription drug products. Policy H-110.986 supports value-based pricing programs, initiatives and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based prices of pharmaceuticals should be determined by objective, independent entities;

(b) value-based prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs and data that incorporate rigorous scientific methods, including clinical trials, clinical data registries, comparative effectiveness research, and robust outcome measures that capture short- and long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must be transparent, easily accessible to physicians and patients, and provide practicing physicians and researchers a central and significant role; (d) processes to determine value-based prices of pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to determine value-based prices of pharmaceuticals should incorporate affordability criteria to help assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based pricing of pharmaceuticals should allow for patient variation and physician discretion.

Policy H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness analysis in comparative effectiveness research. Finally, it supports direct purchasing of pharmaceuticals used to treat or cure diseases that pose unique public health threats, including Hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

Numerous policies aim to improve generic drug pricing and access. Policy H-110.988 states that our AMA will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the FDA, the U.S. Federal Trade Commission (FTC), and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs. The policy also states that our AMA will work 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. In addition, the policy encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs; and supports measures that increase price transparency for generic prescription drugs. Policy H-100.950 states that our AMA will advocate with interested parties for legislative or regulatory measures that require prescription drug manufacturers to seek FDA and FTC approval before establishing a restricted distribution system; will support requiring pharmaceutical companies to allow for reasonable access to and purchase of appropriate quantities of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; and will advocate with interested parties for legislative or regulatory measures that expedite the FDA approval process for generic drugs, including but not limited to application review deadlines and generic priority review voucher programs. Policy H-110.989 supports: (1) the FTC in its efforts to stop “pay for delay” arrangements by pharmaceutical companies; and (2) federal legislation that makes tactics delaying conversion of medications to generic status, also known as “pay for delay,” illegal in the United States.

AMA policy also addresses other primary stakeholders in the prescription drug pricing arena, including pharmacy benefit managers (PBMs). Policy D-110.987 supports the active regulation of PBMs under state departments of insurance; 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; encourages increased transparency in how DIR fees are determined and calculated; and 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. In addition, the policy outlines provisions to be disclosed as part of improved transparency of PBM operations.

Addressing the impact of prescription cost-sharing requirements on rates of prescription abandonment by patients, Policy H-125.979 contains significant AMA policy provisions promoting improved prescription drug formulary transparency, which address mid-year formulary changes, utilization management requirements and access to accurate, real-time formulary data at the point of prescribing. Policy D-155.994 advocates for third-party payers and purchasers to make cost data available to physicians in a useable form at the point of service and decision-making, including the cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the respective patient. Policy H-120.919 supports efforts to publish a Real-Time Prescription Benefit (RTPB) standard that meets the needs of physicians, utilizing any electronic health record, and prescribing on behalf of all patients.

AMA policy also recognizes that benefit design can be leveraged to ensure improved prescription drug cost-sharing affordability to promote improved patient adherence to prescribed medication regimens. Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby patient cost-sharing requirements are determined based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Similarly, Policy H-110.990 states that cost-sharing requirements for prescription drugs should be based on considerations such

as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance.

Shifting to policies directly applicable to the referrals responded to by this report, Policy D-330.954 states that: (1) our American Medical Association (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; and (3) our AMA will prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS.

Council on Medical Service Report 4-I-19 established a set of safeguards in AMA policy, now Policy H-110.980[2], pertaining to the use of international price indices and averages in determining the price of and payment for drugs. The following principles established in the policy are applicable to the pricing of prescription drugs under any health plan or proposal, and are not solely relevant to drugs covered under Medicare Part D, or even Medicare more broadly:

- 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.

Significantly, Policy H-110.980[1] advocates standards guiding the use of arbitration in determining the price of prescription drugs 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.

Policy H-155.962 opposes the use of price controls in any segment of the health care industry and continues to promote market-based strategies to achieve access to and affordability of health care goods and services. Applicable to any vendor program that would be established in Medicare Part B to implement a pilot or permanent model implementing international price averages or indices, Policy H-110.983 advocates that any revised Medicare Part B Competitive Acquisition Program meet the following standards to improve the value of the program by lowering the cost of drugs without undermining quality of care:

- it must be genuinely voluntary and not penalize practices that choose not to participate;
- it should provide supplemental payments to reimburse for costs associated with special handling and storage for Part B drugs;

- it must not reduce reimbursement for services related to provision/administration of Part B drugs, and reimbursement should be indexed to an appropriate health care inflation rate;
- it should permit flexibility such as allowing for variation in orders that may occur on the day of treatment, and allow for the use of (CAP)-acquired drugs at multiple office locations;
- it should allow practices to choose from multiple vendors to ensure competition, and should also ensure that vendors meet appropriate safety and quality standards;
- it should include robust and comprehensive patient protections which include preventing delays in treatment, helping patients find assistance or alternative payment arrangements if they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-payment of patient copayments in a way that does not penalize the physician;
- it should not allow vendors to restrict patient access using utilization management policies such as step therapy; and
- it should not force disruption of current systems which have evolved to ensure patient access to necessary medications.

AMA ADVOCACY ON PRESCRIPTION DRUG PRICING

The Council understands that the introduction of original Resolution 113-N-21, as well as amendments made during consideration of Alternate Resolution 113-N-21, stemmed from strong support in the House of Delegates for the AMA to more actively and strongly advocate on the issue of prescription drug pricing. The AMA has been “at the table,” advocating for the enactment of AMA policy pertaining to drug pricing with Congress via meetings with legislators and their staff as well as through letters and other communications. The AMA also has engaged the Administration through comment letters in response to regulatory activity as well as direct interactions and meetings. Finally, the AMA and members of the Federation have similarly advocated at the state level.

Showing the diversity and comprehensiveness of AMA policy and advocacy on drug pricing, the Council is providing a summary below to the House of Delegates of recent significant comments, letters and testimony addressing the introduction of and discussions surrounding prescription drug pricing legislation, and the promulgation of regulations addressing drug pricing.

- In March 2022, the AMA submitted a comment [letter](#) in response to the proposed rule outlining Medicare Advantage and prescription drug benefit policies for contract year 2023, in which the AMA supported the proposal to require the application of all pharmacy price concessions, including DIR fees, to drug prices in Medicare Part D at the point-of-sale.
- In August 2021, the AMA submitted a [letter](#) to congressional leadership to provide our perspective on health care issues related to the budget reconciliation proposal (Build Back Better). The letter supported efforts to eliminate prohibitions on the negotiation of prescription drug prices within the Medicare program and outlined AMA policy addressing the parameters of Medicare drug price negotiation, including the use of international drug price averages/indices, arbitration and value-based drug pricing. The letter also supported efforts to increase transparency in all aspects of the drug pricing process, as well as measures to address increases in prescription drug prices that exceed the rate of inflation. In addition, the letter outlined AMA policy on and support for efforts to cap patient out-of-pocket prescription drug expenses; pay-for-delay agreements between brand and generic drug manufacturers; and limit the use of drug utilization management tools by payers.
- In December 2020, the AMA submitted a comment [letter](#) in response to the MFN Model interim final rule, outlining significant concerns regarding the MFN Model and its impact on patient access to essential treatments, as well as the model’s financial impact on physician practices.
- In March 2020, the AMA submitted a comment [letter](#) in response to the Importation of Prescription Drugs proposed rule.
- In February 2020, the AMA submitted a comment [letter](#) in response to released draft guidance regarding the importation of certain FDA-approved human prescription drug and biological products.
- In May of 2019, the AMA [testified](#) as part of the hearing before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health titled, “Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain,” submitting [answers](#) to follow-up questions after the hearing in August.
- In April 2019, the AMA submitted a comment [letter](#) in response to the proposed rule, “Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in Price on Prescription Pharmaceuticals and Certain Pharmacy Benefit Manager Service Fees.

- In March 2019, the AMA submitted a [letter](#) to the leadership of the House Energy and Commerce Committee in support of its efforts, and pending legislation, to address the escalating prices of prescription medication by removing barriers to market entry for affordable prescription medication and shining a light on anticompetitive practices in the pharmaceutical supply chain that can lead to price escalations.
- In December 2018, the AMA submitted a comment [letter](#) in response to the ANPRM on an International Pricing Index Model (IPI model) for Medicare Part B Drugs, in which the AMA highlighted the need for significant reforms to the Medicare Part B competitive acquisition program (CAP) and the IPI model to ensure that beneficiaries have timely access to necessary treatments. The AMA also raised strong concerns with the proposed add-on formula, stating that “reimbursement models based on an ‘add-on’ formula are intended to adequately reimburse physicians for the costs of acquisition, proper storage and handling, and other administrative costs associated with providing these treatment options for patients. Many drugs included in this model, such as biological products, are complicated drug products that require special attention to handling and storage to remain stable and viable for administration to patients. Drugs that require specific conditions for shipping, storage, and handling result in significantly higher administrative costs to physician practices than many small molecule-type drugs. Due to the special nature of these products, these costs are fixed, and will not decrease as the price of the drug goes down. Given these fixed administrative costs, we are very concerned that, should drug prices decrease as this model predicts, any add-on payment based on an ASP would ultimately decrease with the price of the drug and would no longer be sufficient to cover the administrative costs to the practice. If add-on reimbursement decreases enough that it is no longer sufficient to cover the expenses associated with providing these treatment options, it is likely that practices will no longer be able to offer these options for patients. We strongly urge CMS to consider the impact on the add-on as the IPI model over time could reduce this amount below actual clinician cost.”
- In July 2018, the AMA submitted a comment [letter](#) in response to *American Patients First, The Trump Administration Blueprint to Lower Drug Prices and Reduce Out-of-Pocket Costs* (Blueprint) Request for Information (RFI). In the letter, the AMA strongly supported a select number of Blueprint provisions to the extent that they would promote the following and recommended prompt regulatory action to: (1) require pharmaceutical supply chain transparency; (2) accelerate and expand regulatory action to increase pharmaceutical market competition and combat anti-competitive practices; (3) ensure prescribers have accurate point-of-care coverage and patient cost-sharing information as part of their workflow, including in the electronic health record; and (4) ensure federal programs and commercial practices billed as lowering prescription medication prices do so for patients directly. The AMA opposed Blueprint proposals that increased patient costs and erected barriers, including onerous insurer paperwork requirements that impede timely patient access to affordable and medically necessary medications and treatments. Further, the AMA opposed policies that would financially penalize physicians and pharmacists for high-cost prescription medication.

DISCUSSION

Since 2004, AMA Policy D-330.954 has supported giving the Secretary of HHS the authority to negotiate contracts with manufacturers of covered Part D drugs, and in 2017, formally prioritized AMA’s support for the CMS to negotiate pharmaceutical pricing for all applicable medications covered by CMS. As previously referenced in the report, the CBO and CMS actuaries have estimated that providing the Secretary of HHS broad negotiating authority by itself would not have any effect on negotiations taking place between Part D plans and drug manufacturers or the prices that are ultimately paid by Part D. In order for the Secretary to have the ability to obtain significant discounts in negotiations with drug manufacturers, CBO stated that the Secretary would also need the “authority to establish a formulary, set prices administratively, or take other regulatory actions against firms failing to offer price reductions.”

Addressing the need for administrative leverage in Medicare drug price negotiations, the Council recognizes that incorporating international drug price indices and averages has become a popular proposal to significantly lower drug prices through said negotiations. However, the Council notes that recent legislative and regulatory proposals have not stopped at incorporating international prescription drug prices in Part D—they have extended to Medicare Part B, as well as to private health plans, unless they opt out. In fact, the proposal closest to being implemented in this arena has been via regulation, and solely addressing payment for prescription drugs in Medicare Part B. Therefore, AMA policy addressing the use of international drug price indices and averages in determining domestic drug prices needs to be consistent across not only all of Medicare, but across all health plans.

Recent legislative and regulatory proposals have not met the criteria established in Policy H-110.980, which guides AMA support for the use of international drug price averages/indices in determining domestic drug prices. Ultimately,

the priority for the AMA in its advocacy efforts has been to preserve patient access to necessary medications, and limit burdens on and protect physician practices. While recent legislative and regulatory proposals have not met these and other important thresholds outlined in the policy, the Council believes that is not a reason to change AMA policy. In addition, the Council stresses that on the legislative front, at the time this report was written, there remains insufficient support in the House of Representatives and Senate to incorporate international price indices/averages into the Medicare drug price negotiation process for drugs covered under Medicare Parts D and B. Therefore, AMA policy moving forward needs to be able to respond to the more likely path to incorporate international drug price averages and/or indices in Medicare drug pricing—through regulation, targeting Medicare Part B drug payment.

The amendments proposed to Policy H-110.980 would have significant, negative, unintended consequences for the pricing of and payment for drugs under Medicare Part B, impacting patient access and physician practices. It also could set a dangerous precedent guiding the future payment of physician services. The Council instead firmly supports using arbitration as a lever in prescription drug price negotiations, including in Medicare, instead of a price ceiling based on international prices that does not meet existing policy principles. As such, the Council recommends the reaffirmation of Policy H-110.980. The Council also recommends the reaffirmation of Policy H-110.983, which advocates standards that any revised Medicare Part B Competitive Acquisition Program must meet, as a vendor program has often been proposed along with a model or new program to incorporate international drug price averages or indices in Medicare Part B.

To make patient cost-sharing obligations in the Medicare program more affordable, the Council believes that there is tremendous promise for models under the auspices of the CMMI to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent and predictable out-of-pocket costs for select prescription drugs. The Part D Senior Savings Model,³¹ which is testing the impact of offering beneficiaries an increased choice of enhanced alternative Part D plan options that offer lower out-of-pocket costs for insulin, is a needed first step in the right direction.

On the whole, there is significant potential for other components of the AMA prescription drug pricing policy agenda to be implemented through legislation and/or regulations, and your Council believes that the focus of AMA advocacy efforts must continue to be multifaceted, diverse and nimble to achieve results for our patients and the physicians who provide their care. Medicare prescription drug price negotiation is only a piece of the larger drug pricing puzzle, which requires interventions to improve transparency and competition in the pharmaceutical marketplace; strengthen regulation of PBMs; limit drug price increases in Medicare to the rate of inflation; and ensure benefit design improves patient medication adherence.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of the second resolve of Alternate Resolution 113-N-21, as well as the referred amendment proffered during consideration of Alternate Resolution 113-N-21, and that the remainder of the report be filed.

1. That our American Medical Association (AMA) reaffirm Policy D-330.954, which states that 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; work toward eliminating Medicare prohibition on drug price negotiation; and prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate pharmaceutical pricing for all applicable medications covered by CMS.
2. That our AMA amend Policy H-110.980[2] by addition and deletion to read as follows
 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;~~
 - ~~a~~ **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;
 - ~~b~~ **e.** The use of any international drug price index or average should preserve patient access to necessary medications;
 - ~~c~~ **d.** The use of any international drug price index or average should limit burdens on physician practices; and

d e. Any data used to determine an international price index or average to guide prescription drug pricing should be transparent and updated regularly.

3. That our AMA reaffirm Policy H-110.983, which advocates standards that any revised Medicare Part B Competitive Acquisition Program must meet.
4. That our AMA encourage the development of models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs.

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5. POVERTY-LEVEL WAGES AND HEALTH (RESOLUTION 203-NOV-21)

Reference committee hearing: see report of Reference Committee G.

HOUSE ACTION: RECOMMENDATIONS ADOPTED AS FOLLOWS IN LIEU OF RESOLUTION 203-NOV-21 REMAINDER OF REPORT FILED

See Policies H-165.822, H-440.803, and D-440.922

At the November 2021 Special Meeting, the House of Delegates referred Resolution 203, which was sponsored by the Medical Student Section. Resolution 203-N-21 asked the American Medical Association (AMA) to support federal minimum wage regulation such that the minimum wage increases at least with inflation in order to prevent full-time workers from experiencing the adverse health effects of poverty. Testimony at the November 2021 Special Meeting regarding the resolution was mixed, with significant testimony both supporting and opposing Resolution 203. Testimony placed Resolution 203 within the context of the AMA's advocacy regarding social determinants of health (SDOH). Testimony supporting Resolution 203 explained that a living wage is essential to promoting health and equity, while testimony in opposition indicated that increasing the federal minimum wage could cause some employers to reduce their number of employees, causing some low-wage workers to become jobless and their family incomes to fall. This report studies the impacts of poverty and minimum wage policies, highlights essential AMA policy, and presents new policy recommendations.

BACKGROUND

In the United States (US), one in 10 people lives in poverty, and despite being employed with steady work, many cannot afford things they need to stay healthy. Healthy People 2030 set a goal of economic stability to “Help people earn steady incomes that allow them to meet their health needs.”¹ According to Healthy People 2030, the SDOH are “conditions in the environment in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality of life outcomes and risk.”² The SDOH include education, housing, wealth, income, and employment, and they are impacted by larger, powerful systems that lead to discrimination, exploitation, marginalization, exclusion, and isolation.³ The COVID-19 pandemic has created a concurrent public health and economic crisis that has exposed and exacerbated pervasive and severe access to care issues and social inequities. Not only has the pandemic disproportionately impacted minoritized and marginalized communities, but economic insecurity, housing insecurity, and food insecurity have disproportionately burdened communities of color and other underserved populations (e.g., people living in rural areas).

The large number of confounding variables makes it challenging to directly attribute changes in minimum wage policies to health outcomes, but there is widespread consensus that populations with low incomes have worse health outcomes.⁴ This exacerbates health inequities because women and people of color (many of whom provide for families) are more likely to earn low wages. Black and Hispanic individuals and families specifically are disproportionately represented among minimum wage workers. In addition, studies have found that populations with high and rising income inequality are associated with lower life expectancy, higher rates of infant mortality, obesity, mental illness, homicide, and other measures compared to populations with a more equitable income distribution.⁵ A large body of research on wage, income, and health finds that policy interventions striving to increase the incomes of low-income populations will improve both economic measures (increasing income equality and economic security)

and health measures (lower mortality rates, improve overall population health status, decrease health inequity, and lower overall health care costs).⁶

Many assume that low-wage workers are predominantly teenagers earning supplementary or optional income, but this is not accurate. Approximately 88 percent of minimum wage workers in the US are over 20 years old, and the average age is 35.⁷ Based on 2019 data, approximately 48 percent of the people earning at or below the federal minimum wage have some college education, nearly 67 percent are female, and approximately 45 percent work full-time.⁸ Most workers are in food service occupations (55 percent), and many others work in sales and related occupations (8.5 percent) or personal care and service roles (6.6 percent). Particularly relevant to physician practices, only 2.6 percent of minimum wage workers are characterized as having a “healthcare support” occupation, with another 4.6 percent generally characterized as holding “office and administrative” occupations.⁹ Approximately 28 percent of low-wage workers have children, which places many children at risk of living in poverty.¹⁰ Researchers have estimated that there would be 2,790 fewer low-birthweight births and 518 fewer postneonatal deaths annually if all states raised the minimum wage by one dollar. It is also critical to recognize the impact of racial, ethnic, and gender inequity. Although women make up 47 percent of the workforce overall, 64 percent of workers in frontline industries are women.¹¹ Moreover, while women of color make up 17 percent of the workforce overall, they are 26 percent of the frontline workforce. This inequity takes on heightened significance in light of these workers’ service amidst the COVID-19 pandemic.

The current federal minimum wage of \$7.25 per hour translates to an annual wage of \$15,080, if working 40 hours per week for all 52 weeks of the year.¹² Workers striving to support a family on the federal minimum wage qualify for federal poverty assistance. Currently, full-time work at the federal minimum wage rate is insufficient for a single parent to support even a single child above the federal poverty line, but in 1968, the federal minimum wage was sufficient to keep a family of three out of poverty. The federal minimum wage hit its peak in inflation-adjusted terms in 1968, and since then, increases have been too small to counter the decline in value due to inflation.¹³ Although current low-wage workers tend to be older (offering more experience) and more educated than their 1968 counterparts, the reduced purchasing power of the federal minimum wage means that workers must work longer hours to achieve the standard of living that was considered the minimum half a century ago. The declining value of the minimum wage has been found to be the key driver of the growth of inequality between low-wage and middle-wage workers since the late 1970s. In contrast, a federal minimum wage of \$15 per hour has been predicted to raise family income for 14.4 million children, or nearly one-fifth of all US children.

HISTORY AND CURRENT STATUS OF MINIMUM WAGE

The Fair Labor Standards Act (FLSA) was enacted in 1938 and is the federal law that establishes the minimum hourly wage that must be paid to all covered workers.¹⁴ One of the goals of the FLSA and, specifically, the minimum wage, is to “correct and as rapidly as practicable to eliminate” labor conditions “detrimental to the maintenance of the minimum standard of living for health, efficiency, and general well-being of workers.”¹⁵ However, determining what a “minimum standard of living” is, and what dollar amount is needed to support that, is a policy choice, and one that has been subject to voluminous debate. Moreover, the minimum wage is only one of many variables that influence a standard of living. The minimum wage rate has been raised 22 times, most recently in 2007 (P.L. 110-28), which increased the minimum wage to its current level of \$7.25 per hour.¹⁶ The FLSA was intended to both protect workers and stimulate the economy, and it covers approximately 139 million workers, or 85 percent of all wage and salary workers. Under the FLSA, if states enact minimum wage, overtime, or child labor laws that are more protective of employees than the FLSA, the state law applies. As of this writing, 30 states and the District of Columbia have minimum wage laws that set the minimum wage above the federal minimum. Two states have laws that would set minimum wages below the federal rate, and five states have no minimum wage requirement. The remaining 13 states have minimum wage rates equal to the federal rate.¹⁷ Localities (cities and counties) can also choose to establish higher minimum wages. As of this writing, 45 localities have adopted minimum wages above their state minimum wage.¹⁸ Accordingly, the federal minimum wage serves as the wage floor for approximately 39 percent of the labor force.¹⁹ However, the number of hourly paid workers who are earning the federal minimum wage is relatively small and decreasing in recent years (down from 1.9 percent in 2019 to 1.5 percent in 2020).²⁰ In 2020, 1.1 million workers earned the federal minimum wage.²¹

Given the varying mechanisms that states may have in place to adjust their minimum wage, in any year, the number of states with minimum wage rates that exceed the federal minimum can vary.²² Generally, a legislature can adjust minimum wage in one of two ways.²³ First, a legislature may choose specific dates by which a minimum wage will

increase by a specific amount. Future legislative action is then needed to subsequently increase the minimum wage. This is the approach that the federal government took with P.L. 110-28, which raised the minimum wage from \$5.15 per hour in 2007 to \$7.25 per hour in 2009 through three phases. Twelve of the 30 states and District of Columbia that have minimum wage rates above the federal rate follow this approach, as well. When a minimum wage is set to a specific fixed amount, inflation will cause its value to erode over time. Accordingly, as the sponsors of Resolution 203-N-21 suggest, several states have taken a second approach to minimum wage, striving to maintain the value of the minimum wage over time by linking their minimum wage to some measure of inflation. Critically, though, choosing a measure of inflation and a point at which to begin indexing minimum wage to inflation is complex, with dramatically varying results. Of the 18 states and the District of Columbia that currently or are scheduled to index their state minimum wages to inflation, six different measures of inflation have been chosen. In addition to selecting an index, policy proposals to link a minimum wage to inflation must also consider the initial value (starting point for indexation), limits to the changes, triggers for change, and periodicity of change.²⁴ To illustrate the importance of these detailed decisions, if the federal minimum wage had been indexed to the Consumer Price Index for All Urban Consumers (CPI-U) at the time of its enactment in 1938, when minimum wage was \$0.25 per hour, the federal minimum wage would have been \$4.23 per hour in 2016. In contrast, if the federal minimum wage were indexed to the CPI-U in 1968 when the rate was \$1.60 per hour, it would have been \$10.98 per hour in 2016. Congress has considered indexing the federal minimum wage several times but has not chosen to do so.²⁵ Indexation is used, however, for some federal programs, such as Social Security and Supplemental Nutrition Assistance (SNAP) benefits and in other federal wage regulations, such as the minimum wage for employees on certain federal contracts.

There have been several recent initiatives aimed at increasing the federal minimum wage. In July 2019, the House passed H.R. 582 which would increase the federal minimum wage to \$15 per hour by 2025, index the minimum wage to changes in the median hourly wage, and phase out subminimum wages for some individuals currently exempt from the minimum wage.²⁶ In January 2021, the Raise the Wage Act of 2021 (H.R. 603) was introduced, which would incrementally raise the federal minimum wage to \$15 per hour by 2025.²⁷ In April 2021, President Biden issued an executive order that will require federal contractors to pay a \$15 per hour minimum wage for workers who are working on federal contracts.²⁸

Increasing the federal minimum wage is popular among Americans – in a recent study, 80 percent of those polled believed that \$7.25 per hour is too low.²⁹ According to the Pew Research Center, 62 percent of Americans support raising the federal minimum wage to \$15 per hour.³⁰ Large employers including Amazon, Target, and Costco have voluntarily raised their minimum wages,³¹ and a growing number of small and medium sized businesses have been committing to incrementally raising wages to \$15 per hour.³² However, Amazon is a critical example of how increased wages alone may not always translate to improvements in health or quality of life for employees. Specifically, a recent study found that Amazon warehouse workers were not only injured more often than non-Amazon warehouse workers, they were also injured more severely, and they took longer to recover than others in the warehouse industry.³³

POLITICAL AND ECONOMIC DEBATE

Although the effects of the minimum wage have been well-studied, resulting in hundreds of academic and non-academic publications, there is no consensus on the causal relationship between changes in minimum wage and other economic outcomes.³⁴ The question, “Does a minimum wage cause unemployment?” has been described as, “one of the most studied questions in all of economics since at least 1912, when Massachusetts became the first state to create a minimum wage.”³⁵ Illustrating this lack of expert consensus, when a panel of experts in economics was asked if a \$15 federal minimum wage would increase unemployment, only five percent of the panel had a strong opinion and nearly 40 percent were uncertain.³⁶ For example, a Chicago Booth professor strongly agreed, an MIT professor disagreed, and a Harvard professor was uncertain. Economics research reflects this. For example, two recent studies of Seattle’s minimum wage suggested opposite effects.³⁷ Proponents argue that raising the minimum wage would increase worker productivity, reduce poverty and income inequality (which is partly due to structural racism and/or sexism), spur economic growth, promote education and self-improvement, and improve employee retention/reduce turnover costs.³⁸ In contrast, opponents argue that increasing the minimum wage would reduce private sector employment, increase labor costs, lead to small business and industry job loss, and increase outsourcing, unemployment, poverty, and cost of living.³⁹

In addition to the often-cited minimum wage debate positions, several additional factors are noteworthy. For example, some argue that it is not an increase to the *federal* minimum wage that is most important, but rather local or regional adjustments. Given the vastly different costs of living across the US, a \$7.25 minimum wage affords significantly

differing access to essential goods and services. For example, daily parking can cost approximately \$35 in Boston or \$1 in Cincinnati.⁴⁰ Monthly rent may average \$4,500 in San Francisco or \$870 in Rapid City, SD. Under a regional minimum wage theory, the minimum wage could account for differences in costs of living, set high enough to lift the maximum number of full-time workers out of poverty, but not so high as to increase automation, a reduction in workers' hours, or off-shoring.⁴¹ On the other hand, a federal mandate to increase minimum wages may be necessary to elevate the quality of life that minimum wage affords in areas of the country where systemic racism, sexism, and similar factors have contributed to low wages, and it may be necessary to avoid low-wage areas from being "trapped in a second-tier economy."⁴²

Related, wages may fail to adequately compensate workers for the skill and/or risk inherent in their work. A recent study highlighted that skills that are usually associated with managerial and knowledge work, such as critical thinking, active learning, problem-solving, time management, and decision-making, are also important elements of low-wage positions.⁴³ If undervalued skills were taken into account in determining wages, the average hourly wage was predicted to be \$16.52.⁴⁴ The undervaluing of low-wage workers takes on heightened relevance in the context of the COVID-19 pandemic. Throughout the COVID-19 pandemic, the US has relied upon essential workers to perform jobs vital to the economy, under conditions that jeopardize health and safety for workers and their households. Yet, according to the Brookings Institution, essential workers comprised approximately half of all workers in occupations with a median wage of less than \$15 per hour, and workers of color are disproportionately impacted.⁴⁵ Wages for care workers (e.g., home health aides) are so low that nearly 20 percent of care workers live in poverty, and more than 40 percent rely on some form of public assistance.⁴⁶ Factoring public assistance into the minimum wage debate raises another important point: if minimum wage workers are earning so little that they must rely on taxpayer-funded benefits to survive, that is shifting the economic burden from the employers who benefit from employees' time and service to taxpayers. According to recent estimates, raising the federal minimum wage to \$15 per hour would reduce government expenditures on public assistance between \$13.4 and \$31 billion, and the majority of the workers who would benefit from the increased minimum wage are essential and frontline workers.⁴⁷

ADDRESSING ADDITIONAL SDOH TO REDUCE HEALTH IMPACTS OF POVERTY

Income is a critical SDOH, but it is inherently intertwined with other essential SDOH. Affordable housing, transportation, nutritious food, and childcare, as well as educational and job opportunities can be more difficult for low-wage workers to obtain.⁴⁸ For example, as affordable housing becomes less accessible in many urban centers, homelessness (a well-established cause of poorer health outcomes) increases, and also causes low-wage workers to move farther from urban centers to access affordable housing. Extended commutes to work increase transportation costs, which decrease the portion of wages remaining to purchase other necessities, such as nutritious food and childcare. Moreover, low-wage work is often unpredictable and inconsistent, which causes many individuals to work multiple jobs, and gives them little control over their schedules. These erratic schedules can trap people in cycles of part-time work, limiting their ability to pursue educational or occupational opportunities, secure safe and affordable childcare, or attend to their health care needs. Accordingly, to increase the economic security of low-wage workers and families living in poverty, alongside minimum wage policy changes, additional changes to address non-occupational SDOH are required, and integrated public health programs can help. Research indicates that minimum wage increases are most successful in decreasing poverty and improving health when they are combined with other structural improvements that maintain or increase the purchasing power of wages.⁴⁹ Specifically, policy proposals should also consider public benefit programs, tax credits, job-creation policies,⁵⁰ employment programs, career counseling, and education to reduce poverty and improve health and wellbeing.⁵¹ Policies that do not recognize the importance of these multiple SDOH may lead to missed opportunities to improve the economic resources of people in low-income households and advance health equity among the most historically disadvantaged low-wage earners.⁵²

It is also essential to consider the unintended consequences incremental increases in minimum wage can have on low-wage workers. While increased wages have the potential to reduce workers' and their families' need for public assistance, minimal increases in wages could be sufficient to reduce or eliminate workers' eligibility for public assistance, but without providing enough in wages to purchase the same basket of goods and services otherwise secured with public assistance, a challenge known as the "benefit cliff." The benefit cliff can harm both employees struggling to meet their basic needs and employers struggling to hire and promote employees.⁵³ Consider the case of a recent widow with three children. She excelled in her position at a local grocery store, where she earned \$15 per hour, and relied on Medicaid and SNAP to help support her family.⁵⁴ She was offered a promotion to become a supervisor and earn \$18 per hour, but she had to decline the promotion because the increased income would have increased her Medicaid premiums, decreased her SNAP payments, and decreased her tax refund, impairing her ability

to provide for her family. Public assistance programs are often rooted in federal statute and administered by federal, state, and local agencies. To resolve the benefits cliff and optimally support low-wage workers and their employers, these intersecting programs must evolve in concert. Moreover, resolving the benefits cliff is essential to promote equity, as workers of color are disproportionately likely to work in low-wage jobs, and disproportionately likely to rely on public benefits, resulting in higher marginal tax rates, and making it more challenging for families of color living at or near the poverty level to climb the economic ladder. Policymakers striving to reduce poverty must assess how minimum wage policy interacts with other social policies and supports to ensure that new policies do not result in new harm to the low-income populations they want to serve.

AMA POLICY

The AMA has extensive policy on health inequities and diversity, and the AMA continues to provide strong leadership striving to eliminate health care inequities. (Examples include Policies H-65.952, H-65.963, H-350.974, D-350.991, D-350.995, D-420.993, H-65.973, H-60.917, H-440.869, D-65.995, H-150.944, H-185.943, H-450.924, H-350.953, H-350.957, D-350.996, H-350.959). Related, Policy H-280.945 calls for better integration of health care and social services and supports. AMA policy also strongly supports Medicaid. (Examples include Policies H-290.986, D-290.979, D-290.985, and D-290.974). In addition, AMA policy emphasizes the importance of the SDOH and supports focus on the SDOH to improve overall health. (Key examples include Policies H-65.960, D-440.922, H-160.909, H-165.822, and D-440.916).

DISCUSSION

It is essential that the AMA continue to be welcomed into conversations on all sides of policy debates as a trusted, evidence-based advocate for patients and the physicians who care for them. Accordingly, the Council recommends a set of principles that do not prejudice any minimum wage policy proposal, but instead clearly articulate essential variables that any minimum wage policy proposal should explicitly evaluate to ensure that proposals will translate into benefit, and not unanticipated harm, to individuals and communities. Consistent with AMA advocacy efforts, while the AMA is not opposed to the concept of indexing minimum wage to inflation, it wants to ensure that any such proposal has been well-designed to avoid unintended consequences and ensure that the proposal, once implemented, does not result in decreased access to health.

First among the Council's recommended principles is a clear statement that poverty is detrimental to health. Next, the Council recognizes that the value of any set minimum wage will erode with the passage of time, but also recognizes that there are significant complexities and unintended consequences inherent in selecting an index for perpetual minimum wage adjustment. For this reason, the Council recommends a principle that broadly encourages federal, state, and/or local policies regarding minimum wage to include plans for adjusting the minimum wage level in the future and an explanation of how these adjustments can keep pace with inflation. In addition, the Council recommends building on Policies H-65.963 and H-65.960 to place those policies in the context of minimum wage debates. Accordingly, federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's: (1) commitment to speak against policies that create greater health inequities and be a voice for our most vulnerable populations who will suffer the most under such policies, and (2) principle that the highest attainable standard of health, in all its dimensions, is a basic human right and that optimizing the SDOH is an ethical obligation of a civil society.

The Council further appreciates that numerous variables impact the adequacy of a minimum wage for employees, as well as the potential burden on employers. Accordingly, the Council recommends that federal, state, and/or local policies regarding minimum wage should include an explanation of how variations in geographical cost of living have been considered. Similarly, federal, state, and/or local policies regarding minimum wage should include an estimate of the policy's impact on factors including: unemployment and/or reduction in hours; first-time job seekers; qualification for public assistance (e.g., food, housing, transportation, childcare, health care, etc.); working conditions; health equity, with specific focus on gender and minoritized and marginalized communities; income equity; local small business viability, including independent physician practices; and educational and/or training opportunities.

Finally, the Council emphasizes the importance of viewing income as among the many essential SDOH and the importance of coordinated public health systems to support advances in all SDOH. Accordingly, the Council recommends reaffirming Policy D-440.922, which supports programs and initiatives that strengthen public health systems to address health inequities and the SDOH and Policy H-165.822, which encourages coverage pilots to test

the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

RECOMMENDATIONS

The Council on Medical Service recommends that the following be adopted in lieu of Resolution 203-N-21 and that the remainder of the report be filed:

1. That our American Medical Association (AMA) affirm that poverty is detrimental to health.
2. That our AMA advocate for federal, state, and/or local policies regarding minimum wage that include plans for adjusting the minimum wage level in the future to keep pace with inflation.
3. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's commitment to speak against policies that create greater health inequities and be a voice for populations who will suffer the most under such policies, further widening the gaps that exist in health and wellness in our nation.
4. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should be consistent with the AMA's principle that the highest attainable standard of health, in all its dimensions, is a basic human right and that optimizing the social determinants of health is an ethical obligation of a civil society.
5. That our AMA affirm that federal, state, and/or local policies regarding minimum wage should include an explanation of how variations in geographical cost of living have been considered.
6. That our AMA reaffirm Policy D-440.922, which states that the AMA will enhance advocacy and support for programs and initiatives that strengthen public health systems to address health inequities and the social determinants of health.
7. That our AMA reaffirm Policy H-165.822, which encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs.

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