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REPORT 3 OF THE COUNCIL ON MEDICAL SERVICE (A-22)
Preventing Coverage Losses After the Public Health Emergency Ends
(Reference Committee A)

EXECUTIVE SUMMARY

During the COVID-19 public health emergency (PHE), states have been required to provide continuous coverage to Medicaid/Children's Health Insurance Program (CHIP) enrollees as a condition for receiving a temporary increase in federal matching funds. Partially as a result, Medicaid/CHIP enrollment has increased by more than 14 million individuals, or 20 percent. Once the PHE ends, states must begin redetermining eligibility for all Medicaid/CHIP enrollees, a massive undertaking that will be operationally challenging for states and may put some Medicaid/CHIP enrollees at risk of losing coverage and becoming uninsured. Because the mass redeterminations will significantly impact people of color, who make up more than half of Medicaid enrollees, it will be critical for policymakers to address health equity implications of the unwinding and how to prevent exacerbation of existing health care inequities. The Council on Medical Service initiated this report to develop American Medical Association (AMA) policy that will help ensure that, as the PHE unwinds, individuals who remain eligible for Medicaid/CHIP retain their coverage and those no longer eligible successfully transition to alternate coverage for which they are eligible, such as subsidized coverage through the Affordable Care Act (ACA) marketplace or employer-sponsored insurance.

At the time this report was written, the PHE remained in effect and states were at various stages of planning for the unwinding. The Council recognizes that the potential for coverage losses and the ability to transition individuals disenrolled from Medicaid/CHIP to other coverage will be highly dependent on how each state performs during the post-PHE period. This report describes the following strategies that are key to state efforts to prevent coverage losses:

- Streamlining enrollment/redetermination/renewal process;
- Investing in outreach and enrollment assistance;
- Adopting continuous eligibility;
- Encouraging auto-enrollment;
- Facilitating coverage transitions, including automatic transitions, to alternate coverage; and
- Monitoring and oversight.

Consistent with these strategies, the Council recommends new AMA policy encouraging states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate coverage for which the individual is eligible, and that auto-transitions meet certain standards. Additionally, the Council recommends supporting coordination between state agencies overseeing Medicaid, ACA marketplaces, and workforce agencies that will help facilitate coverage transitions, and monitoring certain enrollment indicators as the PHE unwinds. Finally, the Council recommends reaffirmation of AMA policies calling for streamlined Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982); adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans (Policy H-165.855); and auto-enrollment in health insurance coverage (Policy H-165.823).

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 3-A-22

Subject: Preventing Coverage Losses After the Public Health Emergency Ends

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

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

15

16 BACKGROUND

17

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

25

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

34

35 At the time this report was written, the PHE had been extended through mid-July 2022. Although it
36 is impossible to know exactly what will happen to Medicaid enrollment after the PHE expires, the
37 number of people covered by Medicaid could decrease substantially. Prior to the pandemic, it was
38 not uncommon for people to lose Medicaid coverage for procedural reasons (e.g., because they did

1 not respond to requests for information needed by the Medicaid agency to complete eligibility
 2 renewals or because they missed a paperwork submission deadline).² According to *Kaiser Health*
 3 *News*, Colorado officials anticipate that, of the 500,000 people whose eligibility will need to be
 4 reviewed post-PHE, 40 percent may lose Medicaid due to income while 30 percent will be at risk
 5 of losing coverage because of outstanding requests for information.³

6
 7 Workforce challenges across many state Medicaid agencies, and fiscal pressures that may drive
 8 some states to complete their redeterminations in an abbreviated timeframe, add to concerns that,
 9 post-PHE, Medicaid/CHIP coverage and continuity of care could be disrupted for potentially
 10 millions of Americans. Urban Institute has projected that Medicaid enrollment could decline by 13
 11 to 16 million people, depending on the PHE's end date.⁴ Additionally, a report from the
 12 Georgetown University Health Policy Institute estimated that more than 6 million of the 39.6
 13 million children enrolled in Medicaid/CHIP could lose coverage.⁵ Urban Institute projects that one-
 14 third of adults losing Medicaid coverage post-PHE could be eligible for premium tax credits for
 15 marketplace plans (the American Rescue Plan Act's [ARPA's] enhanced tax credits and
 16 elimination of the "subsidy cliff" are currently scheduled to expire after 2022), and an additional 65
 17 percent could have an offer of employer-sponsored coverage in their family. Additionally, Urban
 18 Institute estimates that more than half (57 percent) of children losing Medicaid coverage could
 19 qualify for CHIP coverage, while an additional 9 percent would be eligible for subsidized
 20 marketplace coverage.⁶ According to these estimates, most people leaving Medicaid should be
 21 eligible for alternate coverage through the marketplace, CHIP, or an employer-sponsored plan.
 22 However, without proper notice and assistance, not all will enroll in alternate coverage.

23
 24 Throughout the pandemic, the Centers for Medicare & Medicaid Services (CMS) has provided
 25 periodic guidance to states to support their planning for the eventual end of the PHE in a manner
 26 that mitigates coverage disruptions and bolsters consumer protections. CMS guidance⁷ includes the
 27 following directives:

- 28
- 29 • States must initiate all Medicaid/CHIP renewals and outstanding eligibility and enrollment
- 30 actions within 12 months after the month in which the PHE ends and will have two
- 31 additional months (14 months total) to complete all actions.
- 32 • States can begin their unwinding periods up to two months prior to the end of the month in
- 33 which the PHE ends but cannot terminate enrollees' Medicaid/CHIP coverage before the
- 34 first day of the month following the end of the PHE. States that begin disenrolling before
- 35 then can no longer claim the temporary Federal Medical Assistance Percentages (FMAP)
- 36 increase.
- 37 • States must develop an "unwinding operational plan" and determine how they will
- 38 prioritize and carry out their eligibility redeterminations.
- 39 • States should initiate no more than 1/9 of their total Medicaid/CHIP renewals in a given
- 40 month during the unwinding period.
- 41 • States are required to take steps to transition enrollees who are determined ineligible for
- 42 Medicaid to other insurance affordability programs, such as through ACA marketplaces.
- 43 As such, states must promptly assess an individual's potential eligibility for marketplace
- 44 coverage and transfer that individual's electronic account to the marketplace.
- 45 • To minimize coverage disruptions among Medicaid enrollees who became eligible for, but
- 46 did not enroll in, Medicare coverage during the PHE, states are encouraged to reach out
- 47 and encourage these people to enroll in Medicare.⁸
- 48

49 Policy changes relevant to the end of the PHE were also included in the US House of
 50 Representatives-passed Build Back Better Act, although the Senate had not acted by the time this
 51 report was written and it is unclear whether any of the House-passed provisions will be considered

1 in a separate bill. In addition to closing the Medicaid coverage gap—by allowing people with
 2 incomes below 138 percent of the federal poverty level to obtain zero-premium marketplace
 3 coverage through 2025—the House-passed provisions would extend premium tax credit generosity,
 4 cost-sharing assistance and elimination of the subsidy cliff provided under ARPA to the end of
 5 2025 and require 12 months of continuous eligibility for children under Medicaid/CHIP.

6
 7 HEALTH EQUITY CONCERNS

8
 9 Before the pandemic, available state Medicaid data showed that more than 60 percent of enrollees
 10 identified as Black, Latino/a, or other individuals of color, with studies finding that children of
 11 color experienced coverage disruptions at higher rates⁹ and enrollees of color experienced poorer
 12 outcomes and more barriers to care than whites.¹⁰ It will be critical for state and federal
 13 policymakers to address the health equity implications of the PHE unwinding and how to prevent
 14 exacerbation of existing health care inequities.

15
 16 As noted in [Council on Medical Service Report 5-Nov-20, Medicaid Reform](#), the pandemic
 17 disproportionately impacted Black, Latino/a and Native American communities and highlighted
 18 longstanding health inequities that disproportionately affect minoritized communities. Social
 19 drivers including racism contribute to higher rates of chronic diseases, lower access to health care,
 20 and lack of or inadequate health insurance, which help propel disparate health outcomes. Black and
 21 Latino/a people also experienced the pandemic’s economic impacts that contributed to higher
 22 unemployment and housing instability, especially among groups that struggle against economic
 23 marginalization.¹¹ Frequent changes in employment may put people at risk of losing Medicaid
 24 coverage as the PHE unwinds because income volatility can lead to procedural hurdles and
 25 multiple requests for income verification and notices from the state Medicaid agency. People who
 26 experience housing instability may also be at risk of being disenrolled by Medicaid if the state is
 27 not able to reach them because of outdated contact information.¹² Importantly, disenrollment may
 28 also have a particularly damaging impact on people with disabilities, for whom Medicaid can at
 29 times be the difference between living independently and in a facility.

30
 31 STRATEGIES FOR PREVENTING COVERAGE LOSSES AFTER THE PHE ENDS

32
 33 Because Medicaid is a joint federal-state program, eligibility and enrollment rules, and the
 34 processes for implementing these rules, can vary significantly by state. Accordingly, the potential
 35 for coverage losses and the ability to transition those disenrolled from Medicaid to other affordable
 36 coverage will be highly dependent on how each state performs during the post-PHE period. The
 37 following strategies may help ensure that, after the PHE ends, people still eligible for
 38 Medicaid/CHIP are appropriately retained while those found ineligible are seamlessly transitioned
 39 to subsidized ACA marketplace plans or other affordable coverage for which they are eligible.

40
 41 *Streamline Enrollment/Redetermination/Renewal Processes*

42
 43 Since Medicaid enrollees can lose coverage because they did not receive a renewal form or return
 44 information on time, it is important that states improve redetermination processes by maximizing
 45 the use of automatic renewals based on available data sources such as Internal Revenue Service and
 46 quarterly wage data, unemployment claims, or information from the Supplemental Nutrition
 47 Assistance Program or Temporary Assistance for Needy Families (TANF). The use of data sources
 48 to verify continued eligibility is known as *ex parte* renewal and it minimizes churn because it
 49 reduces administrative errors and does not require action by the enrollee. Medicaid rules generally
 50 require states to attempt to confirm eligibility *ex parte* before sending out renewal documents and
 51 requiring enrollees to respond.¹³ However, if an *ex parte* renewal cannot be completed, state

1 Medicaid agencies must contact enrollees directly to request information needed to verify
2 eligibility. Completing renewals by traditional means (e.g., forms transmitted through the mail) can
3 be problematic when enrollees are not aware of the steps they need to take to retain coverage or if
4 they have moved or have outdated contact information on file with the state.

5
6 Notably, state implementation of Medicaid rules intended to streamline renewal processes vary
7 significantly across states, as does the percentage of completed *ex parte* renewals, with some states
8 completing under a quarter of renewals *ex parte* and others renewing 75-90 percent using existing
9 data sources.¹⁴ While states will always have enrollees with complex situations or who otherwise
10 must be renewed using traditional formats—either online, in-person or by phone—states should be
11 encouraged to streamline renewals and improve *ex parte* renewal rates.

12 13 *Invest in Outreach and Enrollment Assistance*

14
15 Effective communications between states and Medicaid/CHIP enrollees, physicians and other
16 providers, health plans, and community organizations will be important to ensuring that everyone is
17 aware of and engaged in state preparations for the mass eligibility redeterminations. CMS has
18 encouraged states to conduct outreach to remind enrollees to update contact information on file
19 with the state Medicaid agency.¹⁵ Without such information, enrollees who have moved during the
20 pandemic may not receive renewal notices and could be disenrolled from Medicaid while still
21 actually eligible. States that effectively communicate with Medicaid enrollees may prevent
22 coverage losses by making people aware of upcoming redeterminations and actions they must take
23 to retain coverage.

24
25 It will also be important for states to target specific outreach to people with disabilities or limited
26 English proficiency and enrollees experiencing homelessness. Many states have planned outreach
27 campaigns to encourage people to make sure their contact information in the state health care
28 database is accurate and up to date. CMS has encouraged states to partner with health plans to
29 update contact information and communicate with Medicaid enrollees, using multiple modalities—
30 mail, email, and text—to reach people. Equally as important, states will need to communicate with
31 enrollees no longer deemed eligible for Medicaid that they may be eligible for no- or low-cost
32 marketplace plans and inform them how to enroll. Navigators embedded across community-based
33 organizations and health plans may be utilized to help conduct outreach and empower people to
34 enroll in marketplace plans.

35 36 *Adopt Continuous Eligibility*

37
38 Continuous eligibility policies, which allow enrollees in Medicaid, CHIP and marketplace plans to
39 maintain coverage for 12 months, have long been supported by the AMA as a strategy to reduce
40 churn that occurs when people lose coverage and then re-enroll within a short period of time.
41 Churn-induced coverage disruptions are most pronounced in Medicaid, both because income
42 fluctuations are common and because Medicaid enrollees can lose coverage for procedural
43 reasons.¹⁶

44
45 Once the PHE and FFCRA continuous enrollment requirements expire, continuous eligibility will
46 remain an option for states through Section 1115 waivers. While more states may be looking into
47 this option, at the time this report was written only New York and Montana had continuous
48 eligibility policies in place for adult enrollees. States have had the option to adopt continuous
49 eligibility for children with Medicaid and CHIP coverage since 1997 and many—but not all—
50 states have done so. At the time this report was written, 27 states had implemented continuous
51 eligibility for children enrolled in CHIP while 25 states had it for children enrolled in Medicaid.¹⁷

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

10
 11 *Encourage Auto-Enrollment*

12
 13 Auto-enrollment in marketplace coverage, Medicaid/CHIP, and employer-sponsored coverage was
 14 addressed by the Council in [Council on Medical Service Report 1-Nov-20](#) as a means of expanding
 15 coverage. Maryland’s Easy Enrollment Health Insurance Program is an auto-enrollment initiative
 16 that facilitates health coverage through tax filing by allowing filers to share insurance status and
 17 income on tax forms and authorize the state to determine whether they are eligible for Medicaid or
 18 subsidized marketplace plans.¹⁹ During the first year of implementation in 2020, over 60,000
 19 Marylanders shared their information via Easy Enrollment. Most were found eligible for Medicaid
 20 or marketplace coverage and over 4,000 people were auto-enrolled in coverage.²⁰ Other states
 21 considering similar “easy enrollment” programs include Colorado and New Jersey.²¹

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

30
 31 *Facilitate Coverage Transitions, Including Automatic Transitions*

32
 33 As states undertake redeterminations of all Medicaid and CHIP enrollees once the PHE expires,
 34 many people disenrolled because their incomes have risen will be eligible for subsidized coverage
 35 through state or federally facilitated marketplaces or through a Basic Health Program (BHP) in
 36 states that operate a BHP (Minnesota and New York). However, in most states transitioning people
 37 to marketplace coverage from Medicaid is not automatic and may be difficult for people to
 38 navigate. Additionally, some people disenrolled from Medicaid may not know that they are eligible
 39 for subsidized marketplace coverage or may think the plans are unaffordable.²⁴ Although ARPA
 40 increased subsidies for all those eligible, including newly eligible over 400 percent of the federal
 41 poverty level, these provisions will expire at the end of 2022 unless Congress extends them. If the
 42 ARPA subsidies expire, people enrolled in subsidized marketplace plans this year may be at risk of
 43 coverage lapses next year once eligibility and premiums are reset for their marketplace plans.

44
 45 Before the ACA, Massachusetts implemented its own subsidized health insurance exchange
 46 (Commonwealth Care) along with a policy that automatically switched premium lapsed into a free
 47 plan, if one was available, rather than disenrolling them. Researchers found that this policy
 48 prevented coverage losses among 14 percent of enrollees eligible for zero premium plans and that
 49 those retained were younger, healthier, and less costly to insure.²⁵ Another Massachusetts policy
 50 temporarily associated with its pre-ACA exchange auto-enrolled people who were found eligible

1 for Commonwealth Care—through either an application for the exchange or a Medicaid
 2 redetermination—but who did not actively choose a plan. This policy, which applied only to people
 3 with incomes below 100 percent of the federal poverty level, was found to significantly increase
 4 enrollment.²⁶

5
 6 Some state Medicaid agencies already partner with their state’s marketplace to identify strategies
 7 for improving transitions from Medicaid to marketplace coverage and identifying barriers to
 8 seamless transitions. Information technology (IT) challenges can present barriers to smooth
 9 coverage transitions, especially in states that have not updated and/or integrated their IT systems so
 10 they are able to share eligibility information between Medicaid/CHIP and the marketplace.²⁷ Those
 11 states that already have integrated IT systems in place may have an easier time auto-transitioning
 12 people from Medicaid to the marketplace, or from marketplace plans to Medicaid. However, at the
 13 time this report was written, most states had not integrated their Medicaid and marketplace
 14 eligibility systems, which could make it more difficult to switch people from one source of
 15 coverage to another. The degree to which state Medicaid and marketplace agencies work together
 16 matters greatly but varies across states and may be more challenging in states that do not run their
 17 own marketplaces.

18
 19 *Provide Monitoring and Oversight*

20
 21 It will be critical that states monitor the effectiveness of their policies and plans as the PHE
 22 unwinds so they become aware of concerning indicators signaling a need for the state to intervene
 23 or change course. In particular, states should monitor Medicaid/CHIP enrollment and disenrollment
 24 data and whether individuals are being disenrolled appropriately due to income or because of
 25 procedural or paperwork issues. States experiencing unusually high levels of churn may need to
 26 take steps to ensure that enrollees still eligible for Medicaid/CHIP are being appropriately retained.
 27 Similarly, increases in the numbers of newly uninsured individuals should suggest to states that
 28 new policy or action may be needed to address avoidable churn and/or whether new procedures are
 29 needed to facilitate transitions between coverage programs. CMS has indicated that the agency will
 30 monitor a state’s progress in completing its redeterminations and that states will need to submit
 31 baseline and then monthly data during the unwinding period.²⁸ At a minimum, states should be
 32 encouraged to track and make available key enrollment data to ensure appropriate monitoring and
 33 oversight of Medicaid/CHIP retention and disenrollment, successful transitions to new coverage,
 34 and numbers and rates of uninsured.

35
 36 **EXAMPLES OF STATE PLANS FOR THE UNWINDING OF THE PHE**

37
 38 At the time this report was written, the PHE remained in effect and states were in various stages of
 39 planning for the unwinding. In a January 2022 survey conducted by the Kaiser Family Foundation
 40 and Georgetown University Center for Children and Families, 27 states indicated that they had
 41 developed plans for resuming redeterminations once the continuous coverage requirement is
 42 lifted.²⁹ This survey also found that 39 states intend to take up to a full year to process
 43 redeterminations (9 states plan to do so more quickly); 46 states are planning to update enrollee
 44 mailing addresses before the PHE expires; and 30 states are taking steps to increase agency staffing
 45 in order to process the renewals. Among states that were able to project anticipated disenrollments
 46 as the PHE unwinds, estimates varied widely across states and ranged from 8 percent to 30 percent
 47 of total enrollees potentially losing Medicaid coverage.³⁰

48
 49 Washington State plans to use most of the time allotted by CMS after the PHE ends to complete its
 50 redeterminations. The State of Washington Health Care Authority has been keeping up with
 51 renewals throughout the PHE (without disenrolling anyone) and, once it expires, will attempt to

1 auto-renew enrollees using the state’s Healthplanfinder system.³¹ Because Healthplanfinder is an
 2 integrated system, it can help facilitate transitions of enrollees who are no longer Medicaid-eligible
 3 to marketplace plans for which they are eligible. Additionally, the State of Washington has over
 4 900 navigators located at clinics and community support organizations around the state and over
 5 1600 state-certified brokers available to help people stay covered.³²

6
 7 By the fall of 2021, California’s Department of Health Care Services was already preparing for
 8 redeterminations of nine to ten million Medi-Cal recipients by, among other strategies, working
 9 with health navigators, advocates, managed care plans and community-based organizations to
 10 communicate the need for enrollees to update their contact information.³³ Under state legislation
 11 (S.B. 260) passed in 2019, the state’s health insurance exchange—Covered California—is required
 12 to automatically enroll individuals no longer eligible for Medicaid (Medi-Cal) into the lowest cost
 13 silver plan before they are terminated.³⁴ As the PHE unwinds, California’s Healthcare Eligibility,
 14 Enrollment, and Retention System (CalHEERS)—an integrated system supporting eligibility,
 15 enrollment, and retention for Covered California, Medi-Cal, and Healthy Families—will be used to
 16 auto-transition individuals no longer eligible for Medi-Cal into subsidized Covered California
 17 plans.³⁵

18
 19 In Ohio, the state legislature included language in its biennial budget bill that set parameters around
 20 the state’s post-COVID Medicaid redeterminations. As passed by the General Assembly, H.B. 110
 21 requires the Ohio Department of Medicaid to conduct eligibility redeterminations of all Ohio
 22 Medicaid recipients within 90 days after the PHE expires. The legislation further requires
 23 expedited eligibility reviews of enrollees identified as likely ineligible for Medicaid within 90 days
 24 and—to the extent permitted under federal law—disenroll those people who are no longer
 25 eligible.³⁶ Multiple media outlets have reported that \$35 million was appropriated by the state to
 26 contract with an outside vendor (Boston-based Public Consulting Group) to automate its eligibility
 27 redeterminations in exchange for a share of the savings.^{37,38}

28
 29 **RELEVANT AMA POLICY**

30
 31 The AMA’s long-standing goals to cover the uninsured and improve health insurance affordability
 32 are reflected in a plethora of AMA policies and the AMA proposal for reform. Among the most
 33 relevant policies are those that support the adoption of 12-month continuous eligibility across
 34 Medicaid, CHIP, and exchange plans to limit patient churn and promote the continuity and
 35 coordination of patient care (Policies H-165.832 and H-165.855). AMA policy also supports
 36 investments in outreach and enrollment assistance activities (Policies H-290.976, H-290.971,
 37 H-290.982 and D-290.982). Policy H-290.982 calls for states to streamline enrollment in
 38 Medicaid/CHIP by, for example, developing shorter applications, coordinating Medicaid and
 39 TANF application processes, and placing eligibility workers where potential enrollees work, go to
 40 school, and receive medical care, and urges CMS to ensure that outreach efforts are culturally
 41 sensitive. This policy also urges states to undertake, and state medical associations to take part in,
 42 educational and outreach activities aimed at Medicaid and CHIP-eligible children. The role of
 43 community health workers is addressed under Policy H-440.828, while Policy H-373.994
 44 delineates guidelines for patient navigator programs.

45
 46 Policy D-290.979 directs the AMA to work with state and specialty medical societies to advocate
 47 at the state level in support of Medicaid expansion. Policy D-290.974 supports the extension of
 48 Medicaid and CHIP coverage to at least 12 months after the end of pregnancy. Policy H-290.958
 49 supports increases in states’ FMAP or other funding during significant economic downturns to
 50 allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.

1 Medicaid and incarcerated individuals addressed by Policy H-430.986. Policy H-290.961 opposes
2 work requirements as a criterion for Medicaid eligibility.

3
4 Policy H-165.839 advocates that health insurance exchanges address patient churning between
5 health plans by developing systems that allow for real-time patient eligibility information. Policy
6 H-165.823 supports states and/or the federal government pursuing auto-enrollment in health
7 insurance coverage that meets certain standards related to cost of coverage, individual consent,
8 opportunity to opt out after being auto-enrolled, and targeted outreach and streamlined enrollment.
9 Under this policy, individuals should only be auto-enrolled in health insurance coverage if they are
10 eligible for coverage options that would be of no cost to them after the application of any subsidies.
11 Candidates for auto-enrollment would therefore include individuals eligible for Medicaid/CHIP or
12 zero-premium marketplace coverage. Individuals eligible for zero-premium marketplace coverage
13 would be randomly assigned among the zero-premium plans with the highest actuarial values.
14 Policy H-165.823 also outlines standards that any public option to expand health insurance
15 coverage, as well any approach to cover individuals in the coverage gap, must meet. Principles for
16 the establishment and operation of state Basic Health Programs are outlined in Policy H-165.832.

17
18 Under Policy H-165.824, the AMA supports adequate funding for and expansion of outreach
19 efforts to increase public awareness of advance premium tax credits and encourages state
20 innovation, including considering state-level individual mandates, auto-enrollment and/or
21 reinsurance, to maximize the number of individuals covered and stabilize health insurance
22 premiums without undercutting any existing patient protections. Policy H-165.824 further supports:
23 (a) eliminating the subsidy “cliff”, thereby expanding eligibility for premium tax credits beyond
24 400 percent of the federal poverty level; (b) increasing the generosity of premium tax credits;
25 (c) expanding eligibility for cost-sharing reductions; and (d) increasing the size of cost-sharing
26 reductions.

27
28 Policy H-165.822 (1) encourages new and continued partnerships to address non-medical, yet
29 critical health needs and the underlying social determinants of health; (2) supports continued efforts
30 by public and private health plans to address social determinants of health in health insurance
31 benefit designs; and (3) encourages public and private health plans to examine implicit bias and the
32 role of racism and social determinants of health. Policy H-180.944 states that “health equity,”
33 defined as optimal health for all, is a goal toward which our AMA will work by advocating for
34 health care access, research and data collection; promoting equity in care; increasing health
35 workforce diversity; influencing determinants of health; and voicing and modeling commitment to
36 health equity.

37 38 DISCUSSION

39
40 Medicaid is the largest health insurance program in the US; the leading payer of medical costs
41 associated with births, mental health services and long-term care; and an indispensable safety net
42 for people exposed to poverty. Throughout the PHE, Medicaid and CHIP have provided health
43 coverage and care to more than 80 million people, including individuals affected by COVID-19
44 and those who experienced pandemic-related job losses. Because of the Medicaid continuous
45 enrollment requirement and enhanced FMAP provided under the FFCRA, states have largely
46 maintained Medicaid/CHIP coverage stability and prevented increases in uninsured rates that
47 would otherwise be expected during a once-in-a-lifetime PHE. The loss of enhanced federal
48 matching funds once the PHE expires will compound the many pressures already facing states and
49 their Medicaid agencies, including budgetary concerns, the duration of time that has passed since
50 the state has had contact with many enrollees, and an ongoing shortage of human services workers
51 trained to complete eligibility redeterminations.

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

16
 17 The [appended policy crosswalk](#) outlines the strategies described in this report along with AMA
 18 policy that supports adoption of these strategies. As noted, it is anticipated that most people who
 19 lose Medicaid/CHIP coverage as the PHE unwinds will qualify for subsidized coverage through the
 20 marketplace or for employer-sponsored insurance. Although the ACA expanded the availability of
 21 coverage options, transitioning between Medicaid, marketplace and employer-sponsored coverage
 22 remains challenging to navigate. Accordingly, the Council recommends encouraging states to
 23 facilitate coverage transitions, including automatic transitions, to alternate coverage for which
 24 individuals are eligible. If adopted, this new policy would support more seamless coverage
 25 transitions among individuals found ineligible for Medicaid/CHIP into other affordable plans.
 26 Notably, the recommended policy would also support other coverage transitions, such as: newly
 27 unemployed individuals transitioning into Medicaid or marketplace coverage; young adults aging
 28 out of CHIP or family coverage securing other affordable coverage for which they may be eligible;
 29 and individuals whose marketplace coverage has lapsed because of premium increases moving into
 30 a more affordable marketplace plan or Medicaid, if they are eligible. In all circumstances, the
 31 Council emphasizes that individuals should be transitioned into the best affordable plans for which
 32 they are eligible.

33
 34 The Council understands that states vary in terms of their ability to facilitate transitions from one
 35 source of coverage to another, and that few states are currently prepared to auto-transition people
 36 from Medicaid to marketplace coverage. However, we hope that states continue to pursue more
 37 seamless coverage transitions in the future. To that end, the Council believes that coordination
 38 among state agencies overseeing Medicaid, marketplace plans, and workforce/unemployment
 39 offices is integral to helping individuals maintain continuity of care across coverage programs.
 40 Accordingly, the Council recommends supporting coordination among state Medicaid, marketplace
 41 and workforce agencies that will help facilitate health coverage transitions. The Council also
 42 believes strongly that monitoring and oversight will be critical to preventing unnecessary coverage
 43 losses and recommends supporting federal and state monitoring of Medicaid retention and
 44 disenrollment, successful transitions to quality affordable coverage, and uninsured rates.

45
 46 Finally, the Council recommends reaffirmation of AMA policies calling for streamlined
 47 Medicaid/CHIP enrollment processes and outreach activities (Policy H-290.982) and adoption of
 48 12-month continuous eligibility across Medicaid, CHIP, and exchange plans (Policy H-165.855) to
 49 minimize churn and ensure that states are appropriately retaining Medicaid/CHIP enrollees. The

1 Council also recommends reaffirming AMA policy that encourages states to pursue auto-
2 enrollment in health insurance coverage (Policy H-165.823) as a means of expanding coverage.

3
4 RECOMMENDATIONS

5
6 The Council on Medical Service recommends that the following be adopted and the remainder of
7 the report be filed:

- 8
9 1. That our American Medical Association (AMA) encourage states to facilitate transitions,
10 including automatic transitions, from health insurance coverage for which an individual is no
11 longer eligible to alternate health insurance coverage for which the individual is eligible, and
12 that auto-transitions meet the following standards:
13 a. Individuals must provide consent to the applicable state and/or federal entities to share
14 information with the entity authorized to make coverage determinations.
15 b. Individuals should only be auto-transitioned in health insurance coverage if they are
16 eligible for coverage options that would be of no cost to them after the application of any
17 subsidies.
18 c. Individuals should have the opportunity to opt out from health insurance coverage into
19 which they are auto-transitioned.
20 d. Individuals should not be penalized if they are auto-transitioned into coverage for which
21 they are not eligible.
22 e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned
23 among the zero-premium plans with the highest actuarial values.
24 f. There should be targeted outreach and streamlined enrollment mechanisms promoting
25 health insurance enrollment, which could include raising awareness of the availability of
26 premium tax credits and cost-sharing reductions, and special enrollment periods. (New
27 HOD Policy)
28
29 2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable
30 Care Act marketplaces, and workforce agencies that will help facilitate health insurance
31 coverage transitions and maximize coverage. (New HOD Policy)
32
33 3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment,
34 successful transitions to quality affordable coverage, and uninsured rates. (New HOD Policy)
35
36 4. That our AMA reaffirm Policy H-290.982, which calls for states to streamline
37 Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified
38 enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts. (Reaffirm
39 HOD Policy)
40
41 5. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous
42 eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of
43 care. (Reaffirm HOD Policy)
44
45 6. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government
46 pursuing auto-enrollment in health insurance coverage that meets certain standards related to
47 consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Fiscal Note: Less than \$500.

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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)

REPORT 4 OF THE COUNCIL ON MEDICAL SERVICE (A-22)
Parameters of Medicare Drug Price Negotiation
(Alternate Resolution 113-N-21)
(Reference Committee A)

EXECUTIVE SUMMARY

At the November 2021 Special Meeting, the House of Delegates referred the second resolve of Alternate Resolution 113, 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, 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;

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 advocate on the issue of prescription drug pricing more actively and strongly. The AMA has been “at the table,” advocating AMA policy on drug pricing with Congress via meetings with legislators and their staff as well as 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.

The AMA’s advocacy priorities have been to preserve patient access to necessary medications, and limit burdens on and protect physician practices. While recent legislative and regulatory proposals incorporating international drug price averages and/or indices in Medicare drug pricing have not met these and other important thresholds outlined in Policy H-110.980, the Council believes that is not a reason to change AMA policy. AMA policy needs to be able to proactively respond to the more likely path forward on this issue—through regulation, targeting Medicare Part B drug payment—and needs to be consistent across not only all of Medicare, but across all health plans. The Council does, however, see promise in testing 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.

REPORT OF THE COUNCIL ON MEDICAL SERVICE

CMS Report 4-A-22

Subject: Parameters of Medicare Drug Price Negotiation
(Alternate Resolution 113-N-21)

Presented by: Asa C. Lockhart, MD, MBA, Chair

Referred to: Reference Committee A

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

11
12 In addition, the amendment proposed to amend Policy H-110.980[2(a)] by addition and deletion to
13 read as follows:

14
15 2. Our AMA will advocate that any use of international price indices and averages in
16 determining the price of and payment for drugs should abide by the following principles:

17
18 ~~a. Any international drug price index or average should exclude countries that have single-~~
19 ~~payer health systems and use price controls;~~

20
21 a. Any international drug price index used to determine Medicare Part D drug prices should be
22 based on a reasonable percentage of the drug's volume weighted net average price in at least
23 six large western industrialized nations;

24
25 This report provides background on the impacts of high and escalating prescription drug prices and
26 costs; outlines proposals to leverage an international price index in Medicare Parts B and D;
27 summarizes significant AMA policy and advocacy on prescription drug pricing; and presents
28 policy recommendations.

29
30 BACKGROUND

31
32 The Council understands that the intent of the amendments proposed to Policy H-110.980 was to
33 take significant and concrete action to lower Medicare Parts D and B drug prices and associated
34 patient cost-sharing. Some recent legislative proposals that incorporate international price indices
35 and averages in Medicare drug price negotiation, addressed by Policy H-110.980, would not only
36 extend negotiated prices to Medicare and Medicare Advantage, but also to private health insurance
37 unless the insurer opts out. The Council agrees wholeheartedly that unsustainably high and

1 escalating prescription drug prices and costs constitute a consistent and paramount concern for
2 patients and their physicians, employers, states, and the federal government, underpinning the
3 introduction of legislation, or promulgation of regulations, on both the federal and state levels.

4
5 Spending on retail prescription drugs totaled \$348.4 billion in 2020, accounting for eight percent of
6 total health spending.¹ Other estimates suggest that spending on prescription drugs as a percent of
7 total health spending is greater when other factors, including the non-retail drug markets and gross
8 profits of other stakeholders involved in drug distribution, payment, and reimbursement are
9 included. Significantly, spending on specialty drugs now constitutes more than one-half of drug
10 spending (53 percent).² The most recent National Health Expenditure data showed that retail
11 prescription drug spending was estimated to have increased by three percent in 2020. Drivers
12 behind the lower rate of growth in prescription drug spending include a slower overall utilization of
13 prescription drugs and a higher use of coupons, which resulted in a reduction in out-of-pocket
14 expenditures.³

15
16 Approximately 6.3 billion prescriptions were dispensed in the United States (US) in 2020, 90
17 percent of which were dispensed as generics.⁴ The retail price differentials between specialty,
18 brand-name and generic drugs are noteworthy. Examining the retail prices of drugs widely used by
19 older Americans in 2020—most of whom are Medicare beneficiaries who would be impacted by
20 the proposed, referred amendments to Policy H-110.980—the average annual retail price of therapy
21 with specialty drugs was \$84,442, dropping to \$6,604 for brand-name drugs, both dwarfing the
22 annual price of therapy for generics.⁵

23
24 In Medicare, patients face different cost-sharing for prescription drugs, depending on whether the
25 drugs are covered under Medicare Part B or D. In general, Medicare Part B covers prescription
26 drugs that typically are not self-administered; Part B drugs can be provided in a physician's office
27 as part of their service. In addition, Part B covers limited outpatient prescription drugs, including
28 certain oral cancer drugs. Most other retail prescription drugs for medically accepted indications
29 that are not covered by other parts of Medicare fall under Medicare Part D. Within Medicare Part
30 D, the typical formulary design consists of five tiers: preferred generics, generics, preferred brands,
31 non-preferred drugs, and specialty drugs. Within these tiers, among all stand-alone Medicare Part
32 D prescription drug plans, median standard cost sharing in 2022 is \$0 for preferred generics, \$5 for
33 generics, \$42 for preferred brands, 40 percent coinsurance for non-preferred drugs, and 25 percent
34 coinsurance for specialty drugs.⁶ For prescription drugs covered under Medicare Part B, for
35 traditional Medicare beneficiaries without a supplemental plan, cost-sharing for covered Part B
36 drugs equates to 20 percent of the Medicare-approved amount after paying any applicable Part B
37 deductible, with no out-of-pocket limit.⁷

38
39 Overall, in the Medicare program, between 2007 and 2019, Part D program spending grew by an
40 average annual rate of 5.5 percent and amounted to \$88.4 billion in 2019. Premiums paid by Part D
41 enrollees for basic benefits (not including low-income subsidy enrollees) amounted to \$13.9 billion
42 in 2019, a decrease of 2.1 percent from 2018, before which premiums paid by enrollees had been
43 growing by an average of 12 percent per year.⁸ Under Medicare Part B, total drug spending
44 amounted to \$37 billion in 2019, with the top 50 drugs ranked by total spending accounting for 80
45 percent of total Medicare Part B drug spending.⁹

46
47 Relevant to legislative proposals that extend drug prices achieved by Medicare drug price
48 negotiation to private health insurance, employer-sponsored health plans as well as health plans
49 sold in the individual market have also had to absorb the higher costs of prescription drugs. Higher
50 costs of prescription drugs often translate to higher premiums, higher prescription drug cost-
51 sharing, and additional prescription drug tiers to accommodate the higher costs of specialty and

1 certain generic drugs. In 2021, 88 percent of employees were enrolled in plans with three, four or
2 more cost-sharing tiers for prescription drugs.¹⁰

3
4 Overall, patient out-of-pocket costs for retail prescription drugs reached \$61 billion in 2020, with
5 non-retail out-of-pocket costs amounting to \$16 billion. Across Medicare, Medicaid and
6 commercial health plans, eight percent of patients pay more than \$500 per year out-of-pocket for
7 prescriptions. Medicare beneficiaries have a notably higher incidence rate of high out-of-pocket
8 expenses for prescription drugs, with 17 percent paying more than \$500 out-of-pocket.¹¹

9
10 The higher costs of prescription drugs impact patient health outcomes and physician practices.
11 Ultimately, prescription drug costs can impact the ability of physicians to place their patients on the
12 best treatment regimen, due to the regimen being unaffordable for the patient, or being subject to
13 coverage limitations and restrictions, as well as utilization management requirements, by the
14 patient's health plan. In the worst-case scenario, patients entirely forgo necessary treatments
15 involving drugs and biologics due to their high cost.

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

24
25 Notably, out-of-pocket costs for prescription drugs are linked to the rate at which patients newly
26 prescribed a drug either do not pick up their prescription or switch to another product. Many health
27 plans have a formulary design with fixed copays for brand drugs of less than \$30 for preferred
28 products, with a rate of abandonment of 12 percent or less. For non-preferred brand drugs with a
29 copay of \$75, the rate of abandonment is 26 percent or higher. Fifty-six percent of prescriptions
30 with a final cost of over \$500 are not picked up by patients.¹³

31 32 LEVERAGING AN INTERNATIONAL PRICE INDEX IN MEDICARE PARTS B AND D

33
34 Proposals previously put forward by the Trump Administration and members of Congress
35 attempted to lower US drug costs by tying them to international prices, and/or would have used an
36 average of international prices, or an international reference price, to help define whether a price of
37 a drug is excessive. While significant legislation addressing drug pricing has passed in the House
38 of Representatives, negotiations have stalled following House passage. The Biden Administration
39 has also stated that it will not implement a model utilizing an international price index in Medicare
40 Part B without further rulemaking.

41 42 *Current Status of Prescription Drug Price Negotiation in Medicare Parts D and B*

43
44 The “noninterference clause” in the Medicare Modernization Act of 2003 (MMA) states that the
45 Secretary of Health and Human Services (HHS) “may not interfere with the negotiations between
46 drug manufacturers and pharmacies and [prescription drug plan] PDP sponsors, and may not
47 require a particular formulary or institute a price structure for the reimbursement of covered part D
48 drugs.” Instead, participating Part D plans compete with each other based on plan premiums, cost-
49 sharing and other features, which provides an incentive to contain prescription drug spending. To
50 contain spending, Part D plans not only establish formularies, implement utilization management
51 measures, and encourage beneficiaries to use generic and less-expensive brand-name drugs, but are

1 required under the MMA to provide plan enrollees access to negotiated drug prices. Similar to how
2 drug prices are determined in other commercial plans available in the employer, individual and
3 small-group markets, these prices are achieved through direct negotiation with pharmaceutical
4 companies to obtain rebates and other discounts, and with pharmacies to establish pharmacy
5 reimbursement amounts.

6
7 In efforts to lower drug prices and patient out-of-pocket costs in Medicare Part D, multiple bills
8 have been introduced in Congress to enable and/or require the Secretary of HHS to negotiate
9 covered Part D drug prices on behalf of Medicare beneficiaries. However, historically, the
10 Congressional Budget Office (CBO), as well as Centers for Medicare & Medicaid Services (CMS)
11 actuaries, have estimated that providing the Secretary of HHS broad negotiating authority by itself
12 would not have any effect on negotiations taking place between Part D plans and drug
13 manufacturers or the prices that are ultimately paid by Part D.^{14,15}

14
15 In fact, CBO has previously acknowledged that, in order for the Secretary to have the ability to
16 obtain significant discounts in negotiations with drug manufacturers, the Secretary would also need
17 the “authority to establish a formulary, set prices administratively, or take other regulatory actions
18 against firms failing to offer price reductions. In the absence of such authority, the Secretary’s
19 ability to issue credible threats or take other actions in an effort to obtain significant discounts
20 would be limited.”¹⁶ CMS actuaries have concurred, stating “the inability to drive market share via
21 the establishment of a formulary or development of a preferred tier significantly undermines the
22 effectiveness of this negotiation. Manufacturers would have little to gain by offering rebates that
23 are not linked to a preferred position of their products, and we assume that they will be unwilling to
24 do so.”¹⁷

25
26 The Council underscores that recent legislative and regulatory proposals that aimed to incorporate
27 international drug price indices or averages in Medicare have targeted Part B in addition to Part D;
28 therefore, it is imperative to understand how prices of Part B drugs are determined as well. Under
29 current law, the Secretary of HHS also does not negotiate prices of and payment for Part B drugs.
30 Instead, Medicare reimburses physicians and hospitals for the cost of Part B drugs at a rate tied to
31 the average sales price (ASP) for all purchasers—including those that receive large discounts for
32 prompt payment and high-volume purchases—plus a percentage of the ASP. Accordingly, any
33 proposal to change how Part B drugs are priced—including the incorporation of international drug
34 price indices and/or averages—also could significantly change how and the level at which
35 physicians are paid for Part B drugs.

36 37 *Recent Significant Legislative Developments*

38
39 Legislation preceding Build Back Better, H.R. 3, the Elijah E. Cummings Lower Drug Costs Now
40 Act, which passed the House of Representatives during the 116th Congress, would have opened the
41 door to the Secretary of HHS to negotiate the prices of certain drugs. Title I of H.R. 3 would
42 require the Secretary of HHS to directly negotiate with manufacturers to establish a maximum fair
43 price for drugs selected for negotiation, which would be applied to Medicare, with flexibility for
44 Medicare Advantage and Medicare Part D plans to use additional tools to negotiate even lower
45 prices. Under H.R. 3, the Secretary of HHS would be required to negotiate maximum prices for:
46 (1) insulin products; (2) with respect to 2023, at least 25 single-source, brand-name drugs that do
47 not have generic competition and that are among either the 125 drugs that account for the greatest
48 national spending or the 125 drugs that account for the greatest spending under the Medicare
49 prescription drug benefit and Medicare Advantage (MA); (3) beginning in 2024, at least 50 such
50 single-source, brand-name drugs; and (4) newly approved single-source, brand-name drugs with
51 wholesale acquisition costs equal to or greater than the median household income. The negotiated

1 prices would be offered under Medicare and Medicare Advantage, as well as under private health
2 insurance unless the insurer opts out. An “average international market price” would be established
3 to serve as an upper limit for the price reached in any negotiation, if practicable for the drug at
4 hand, defined as no more than 120 percent of the drug’s volume-weighted net average price in six
5 countries—Australia, Canada, France, Germany, Japan and the United Kingdom.¹⁸

6
7 Showing the impact of negotiating leverage, the December 10, 2019 CBO cost estimate “Budgetary
8 Effects of H.R. 3, the Elijah E. Cummings Lower Drug Costs Now Act” stated that Title I of the
9 legislation would reduce federal direct spending for Medicare by \$448 billion over the 2020-2029
10 period.¹⁹ In its October 11, 2019 estimate, CBO estimated that the largest savings would be the
11 result of lower prices for existing drugs that are sold internationally, which would be impacted by
12 the application of the “average international market price” outlined in the bill.²⁰ CBO also
13 estimated that due to the collective provisions of H.R. 3, approximately eight fewer drugs would be
14 introduced to the US market over the 2020-2029 period, with approximately 30 fewer drugs
15 introduced to the US market over the following decade.²¹ There would be a reduction of drugs
16 introduced in the US market due to the enactment of H.R. 3 “because the potential global revenues
17 for a new drug over its lifetime would decline as a result of enactment, and in some cases the
18 prospect of lower revenues would make investments in research and development less attractive to
19 pharmaceutical companies....The effects would be larger in the 2030s because of the considerable
20 time needed to develop new drugs and because of the larger effects that would occur when more
21 phases of development are affected.”²² In addition, CBO estimated that “[t]he introduction of new
22 drugs would tend to be delayed in the six reference countries: Australia, Canada, France, Germany,
23 Japan, and the United Kingdom. Prices of new drugs in those countries would rise somewhat.”²³

24
25 While H.R. 3 was reintroduced in this Congress, the latest congressional action on drug pricing was
26 a part of H.R. 5376, the Build Back Better Act, which passed the House of Representatives in
27 November 2021. If enacted into law, the House-passed version of Build Back Better would allow
28 the Secretary of HHS to negotiate the prices of a small number of high-cost drugs covered under
29 Medicare Part D (starting in 2025) and Part B (starting in 2027). The negotiation process would
30 apply to no more than 10 single-source brand-name drugs or biologics that lack generic or
31 biosimilar competitors in 2025, ramping up to no more than 20 in 2028 and later years. The drugs
32 selected for negotiation would be required to be among the 50 drugs with the highest total
33 Medicare Part D spending and the 50 drugs with the highest total Medicare Part B spending. All
34 insulin products would also be subject to negotiation.²⁴

35
36 Certain drugs would be exempt from negotiation, including those that are less than nine years (for
37 small-molecule drugs) or 13 years (for biological products) from their U.S. Food and Drug
38 Administration (FDA)-approval or licensure date. “Small biotech drugs” would also be exempt
39 from negotiation until 2028; these drugs are defined as those which account for 1 percent or less of
40 Part D or Part B spending and account for 80 percent or more of spending under each part on that
41 manufacturer’s drugs. In addition, the legislation exempts from negotiation drugs with Medicare
42 spending of less than \$200 million in 2021 (increased by the Consumer Price Index for All Urban
43 Consumers (CPI-U) for subsequent years) and drugs with an orphan designation as their only FDA-
44 approved indication.²⁵

45
46 Due to lack of congressional support for incorporating international price indices/averages into the
47 Medicare drug price negotiation process for drugs covered under Medicare Parts D and B, the
48 Build Back Better Act as passed by the House of Representatives instead establishes an upper limit
49 for the negotiated price (the “maximum fair price”) equal to a percentage of the non-federal
50 average manufacturer price (AMP)—the average price wholesalers pay manufacturers for drugs
51 distributed to non-federal purchasers. The “maximum fair price” is defined as 75 percent of the

1 non-federal AMP for small-molecule drugs more than 9 years but less than 12 years beyond
2 approval; 65 percent for drugs between 12 and 16 years beyond approval or licensure; and 40
3 percent for drugs more than 16 years beyond approval or licensure. The payment for Part B drugs
4 selected for negotiation would be based on the maximum fair price, versus ASP under current
5 law.²⁶ The Council underscores that at the time this report was written, there remains insufficient
6 support in the House of Representatives and Senate to incorporate international price
7 indices/averages into the Medicare drug price negotiation process for drugs covered under
8 Medicare Parts D and B.

9
10 The significant differences between the drug negotiation provisions of the Build Back Better Act
11 and H.R. 3 cause more limited cost savings and impacts on drug development under the Build Back
12 Better Act. CBO estimated \$78.8 billion in Medicare savings in the 2022-2031 period from the
13 drug negotiation provisions in the Build Back Better Act. In addition, CBO estimated that one
14 fewer drug would come to the US market over the 2022-2031 period, four fewer over the
15 subsequent decade, and approximately five fewer the decade after that.²⁷

16 17 *Recent Regulatory Activity*

18
19 The regulatory process is a pathway that cannot be ignored in its potential to change the way and
20 level at which drugs are paid for under Medicare Part B through the incorporation of international
21 drug price indices or averages. Notably, the AMA has been active in its advocacy efforts in
22 response to regulatory proposals to date. In October of 2018, the Trump Administration released an
23 Advance Notice of Proposed Rulemaking (ANPRM) entitled “International Pricing Index Model
24 for Part B Drugs.” The ANPRM did not represent a formal proposal, but rather outlined the
25 Administration’s thinking at the time, and sought stakeholder input on a variety of topics and
26 questions related to this new drug pricing model prior to entering formal rulemaking. The ANPRM
27 outlined a new payment model for physician-administered drugs paid under Medicare Part B that
28 would transition Medicare payment rates for certain Part B drugs to lower rates that are tied to
29 international reference prices—referred to as the “international pricing index”—except where the
30 ASP is lower. The international reference price would partly be based on an average of prices paid
31 by other countries. To accomplish this, the proposal would create a mandatory demonstration
32 through the Centers for Medicare & Medicaid Innovation (CMMI), which would apply to certain
33 randomly selected geographic areas, representing approximately 50 percent of Medicare Part B
34 drug spending. Initially, the program would apply only to sole-source drug products and some
35 biologics for which there is robust international pricing data available.

36
37 In geographic areas included in the demonstration, CMS would contract with private-sector
38 vendors that would negotiate for, purchase, and supply providers with drug products that are
39 included in the demonstration. CMS would directly reimburse the vendor for the included drugs,
40 starting with an amount that is more heavily weighted toward the ASP instead of the international
41 pricing index, and transitioning toward a target price that is heavily based on the international
42 pricing index. Providers would select vendors from which to receive included drugs, but would not
43 be responsible for buying from and billing Medicare for the drug product. Instead, providers would
44 continue to be entitled to bill a drug administration fee, and would also be entitled to receive a drug
45 add-on fee. While the ANPRM was somewhat short on detail on exactly how this add-on fee would
46 be calculated, it appears the add-on fee would be a flat fee that is based on six percent of the
47 historical average sales price for the drug in question.²⁸

48
49 In September 2020, an executive order, “Lowering Drug Prices by Putting America First,” was
50 issued, and called for testing of payment models to apply international price benchmarking to Part
51 B and Part D prescription drugs and biological products. For Part B, the executive order instructed

1 the Secretary of HHS to implement rulemaking to test a payment model under which “Medicare
2 would pay, for certain high-cost prescription drugs and biological products covered by Medicare
3 Part B, no more than the most-favored-nation price.” The executive order defined the “most-
4 favored-nation price” as “the lowest price, after adjusting for volume and differences in national
5 gross domestic product, for a pharmaceutical product that the drug manufacturer sells in a member
6 country of the Organisation for Economic Co-operation and Development (OECD) that has a
7 comparable per-capita gross domestic product.” For Part D, the executive order instructed the
8 Secretary of HHS to develop and implement rulemaking to test a payment model for high-cost Part
9 D drugs, limiting payment to these drugs to the most-favored-nation price, to the extent feasible.²⁹

10
11 In November of 2020, the Trump Administration issued an interim final rule entitled “Most
12 Favored Nation (MFN) Model” to establish a model through CMMI that would phase in changing
13 Medicare’s payment for approximately 50 Part B drugs that make up a high percentage of Part B
14 spending from paying solely based on manufacturers’ ASP to the lowest adjusted international
15 price for the drug, defined as the lowest gross domestic product (GDP)-adjusted price paid by an
16 OECD member country with a GDP per capita (based on purchasing power parity) that is at least
17 60 percent of the US GDP per capita. Addressing physician payment, the add-on payment based on
18 six percent of ASP for the individual drug would be replaced with a flat payment per dose that
19 would be uniform for all included drugs in the MFN Model. As the model was scheduled to
20 become effective January 1, 2021, on December 28, 2020, the US District Court for the Northern
21 District of California issued a nationwide preliminary injunction in *Biotechnology Innovation*
22 *Organization v. Azar*, which preliminarily enjoined HHS from implementing the Most Favored
23 Nation Rule. Given this preliminary injunction, the MFN Model was not implemented on January
24 1, 2021. The interim final rule was formally rescinded in December 2021 and will not be
25 implemented without further rulemaking.³⁰

26 27 RELEVANT AMA POLICY

28
29 AMA policy on prescription drug pricing is diverse, multifaceted, and allows the AMA to advocate
30 on a breadth of issues to tackle high and escalating drug pricing, not limited to Medicare drug price
31 negotiation or opening the door for the use of international drug price indices and averages in
32 Medicare Parts D and B. This strong foundation of AMA policy addressing prescription drug
33 pricing, coverage and payment has allowed the AMA to actively engage on legislative and
34 regulatory proposals on drug pricing on both the federal and state levels.

35
36 Significantly, Policy H-110.987 supports legislation that limits Medicare annual drug price
37 increases to the rate of inflation—a significant provision that has been included in recent legislation
38 addressing prescription drug prices. The policy also supports legislation to shorten the exclusivity
39 period for FDA pharmaceutical products where manufacturers engage in anti-competitive
40 behaviors or unwarranted price escalations, as well as for biologics. The policy also supports drug
41 price transparency legislation that requires pharmaceutical manufacturers to provide public notice
42 before increasing the price of any drug (generic, brand, or specialty) by 10 percent or more each
43 year or per course of treatment and provide justification for the price increase; legislation that
44 authorizes the Attorney General and/or the Federal Trade Commission to take legal action to
45 address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for
46 patients; and the expedited review of generic drug applications and prioritizing review of such
47 applications when there is a drug shortage, no available comparable generic drug, or a price
48 increase of 10 percent or more each year or per course of treatment. In addition, it advocates for
49 policies that prohibit price gouging on prescription medications when there are no justifiable
50 factors or data to support the price increase. Finally, it states that our AMA will continue to
51 monitor and support an appropriate balance between incentives based on appropriate safeguards for

1 innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as
 2 part of the patent system.

3
 4 Policy H-110.980[3] supports the use of contingent exclusivity periods for pharmaceuticals, which
 5 would tie the length of the exclusivity period of the drug product to its cost-effectiveness at its list
 6 price at the time of market introduction. Policy D-100.983 outlines standards for the importation of
 7 prescription drug products. Policy H-110.986 supports value-based pricing programs, initiatives
 8 and mechanisms for pharmaceuticals that are guided by the following principles: (a) value-based
 9 prices of pharmaceuticals should be determined by objective, independent entities; (b) value-based
 10 prices of pharmaceuticals should be evidence-based and be the result of valid and reliable inputs
 11 and data that incorporate rigorous scientific methods, including clinical trials, clinical data
 12 registries, comparative effectiveness research, and robust outcome measures that capture short- and
 13 long-term clinical outcomes; (c) processes to determine value-based prices of pharmaceuticals must
 14 be transparent, easily accessible to physicians and patients, and provide practicing physicians and
 15 researchers a central and significant role; (d) processes to determine value-based prices of
 16 pharmaceuticals should limit administrative burdens on physicians and patients; (e) processes to
 17 determine value-based prices of pharmaceuticals should incorporate affordability criteria to help
 18 assure patient affordability as well as limit system-wide budgetary impact; and (f) value-based
 19 pricing of pharmaceuticals should allow for patient variation and physician discretion.

20
 21 Policy H-110.986 also supports the inclusion of the cost of alternatives and cost-effectiveness
 22 analysis in comparative effectiveness research. Finally, it supports direct purchasing of
 23 pharmaceuticals used to treat or cure diseases that pose unique public health threats, including
 24 Hepatitis C, in which lower drug prices are assured in exchange for a guaranteed market size.

25
 26 Numerous policies aim to improve generic drug pricing and access. Policy H-110.988 states that
 27 our AMA will work collaboratively with relevant federal and state agencies, policymakers and key
 28 stakeholders (e.g., the FDA, the U.S. Federal Trade Commission (FTC), and the Generic
 29 Pharmaceutical Association) to identify and promote adoption of policies to address the already
 30 high and escalating costs of generic prescription drugs. The policy also states that our AMA will
 31 work with interested parties to support legislation to ensure fair and appropriate pricing of generic
 32 medications and educate Congress about the adverse impact of generic prescription drug price
 33 increases on the health of our patients. In addition, the policy encourages the development of
 34 methods that increase choice and competition in the development and pricing of generic
 35 prescription drugs; and supports measures that increase price transparency for generic prescription
 36 drugs. Policy H-100.950 states that our AMA will advocate with interested parties for legislative or
 37 regulatory measures that require prescription drug manufacturers to seek FDA and FTC approval
 38 before establishing a restricted distribution system; will support requiring pharmaceutical
 39 companies to allow for reasonable access to and purchase of appropriate quantities of approved
 40 out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence
 41 assays; and will advocate with interested parties for legislative or regulatory measures that expedite
 42 the FDA approval process for generic drugs, including but not limited to application review
 43 deadlines and generic priority review voucher programs. Policy H-110.989 supports: (1) the FTC in
 44 its efforts to stop “pay for delay” arrangements by pharmaceutical companies; and (2) federal
 45 legislation that makes tactics delaying conversion of medications to generic status, also known as
 46 “pay for delay,” illegal in the United States.

47
 48 AMA policy also addresses other primary stakeholders in the prescription drug pricing arena,
 49 including pharmacy benefit managers (PBMs). Policy D-110.987 supports the active regulation of
 50 PBMs under state departments of insurance; supports requiring the application of manufacturer
 51 rebates and pharmacy price concessions, including direct and indirect remuneration (DIR) fees, to

1 drug prices at the point-of-sale; encourages increased transparency in how DIR fees are determined
2 and calculated; and supports efforts to ensure that PBMs are subject to state and federal laws that
3 prevent discrimination against patients, including those related to discriminatory benefit design and
4 mental health and substance use disorder parity. In addition, the policy outlines provisions to be
5 disclosed as part of improved transparency of PBM operations.
6

7 Addressing the impact of prescription cost-sharing requirements on rates of prescription
8 abandonment by patients, Policy H-125.979 contains significant AMA policy provisions promoting
9 improved prescription drug formulary transparency, which address mid-year formulary changes,
10 utilization management requirements and access to accurate, real-time formulary data at the point
11 of prescribing. Policy D-155.994 advocates for third-party payers and purchasers to make cost data
12 available to physicians in a useable form at the point of service and decision-making, including the
13 cost of each alternate intervention, and the insurance coverage and cost-sharing requirements of the
14 respective patient. Policy H-120.919 supports efforts to publish a Real-Time Prescription Benefit
15 (RTPB) standard that meets the needs of physicians, utilizing any electronic health record, and
16 prescribing on behalf of all patients.
17

18 AMA policy also recognizes that benefit design can be leveraged to ensure improved prescription
19 drug cost-sharing affordability to promote improved patient adherence to prescribed medication
20 regimens. Policy H-155.960 encourages third-party payers to use targeted benefit design, whereby
21 patient cost-sharing requirements are determined based on the clinical value of a health care service
22 or treatment. The policy stipulates that consideration should be given to further tailoring cost-
23 sharing requirements to patient income and other factors known to impact compliance. Similarly,
24 Policy H-110.990 states that cost-sharing requirements for prescription drugs should be based on
25 considerations such as the unit cost of medication, availability of therapeutic alternatives, medical
26 condition being treated, personal income, and other factors known to affect patient compliance.
27

28 Shifting to policies directly applicable to the referrals responded to by this report, Policy
29 D-330.954 states that: (1) our American Medical Association (AMA) will support federal
30 legislation which gives the Secretary of the Department of Health and Human Services the
31 authority to negotiate contracts with manufacturers of covered Part D drugs; (2) our AMA will
32 work toward eliminating Medicare prohibition on drug price negotiation; and (3) our AMA will
33 prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate
34 pharmaceutical pricing for all applicable medications covered by CMS.
35

36 Council on Medical Service Report 4-I-19 established a set of safeguards in AMA policy, now
37 Policy H-110.980[2], pertaining to the use of international price indices and averages in
38 determining the price of and payment for drugs. The following principles established in the policy
39 are applicable to the pricing of prescription drugs under any health plan or proposal, and are not
40 solely relevant to drugs covered under Medicare Part D, or even Medicare more broadly:
41

- 42 a. Any international drug price index or average should exclude countries that have single-
43 payer health systems and use price controls;
- 44 b. Any international drug price index or average should not be used to determine or set a
45 drug's price, or determine whether a drug's price is excessive, in isolation;
- 46 c. The use of any international drug price index or average should preserve patient access to
47 necessary medications;
- 48 d. The use of any international drug price index or average should limit burdens on physician
49 practices; and
- 50 e. Any data used to determine an international price index or average to guide prescription
51 drug pricing should be updated regularly.

1 Significantly, Policy H-110.980[1] advocates standards guiding the use of arbitration in
2 determining the price of prescription drugs to lower the cost of prescription drugs without stifling
3 innovation:

- 4
- 5 a. The arbitration process should be overseen by objective, independent entities;
- 6 b. The objective, independent entity overseeing arbitration should have the authority to select
7 neutral arbitrators or an arbitration panel;
- 8 c. All conflicts of interest of arbitrators must be disclosed and safeguards developed to
9 minimize actual and potential conflicts of interest to ensure that they do not undermine the
10 integrity and legitimacy of the arbitration process;
- 11 d. The arbitration process should be informed by comparative effectiveness research and cost-
12 effectiveness analysis addressing the drug in question;
- 13 e. The arbitration process should include the submission of a value-based price for the drug in
14 question to inform the arbitrator's decision;
- 15 f. The arbitrator should be required to choose either the bid of the pharmaceutical
16 manufacturer or the bid of the payer;
- 17 g. The arbitration process should be used for pharmaceuticals that have insufficient
18 competition; have high list prices; or have experienced unjustifiable price increases;
- 19 h. The arbitration process should include a mechanism for either party to appeal the
20 arbitrator's decision; and
- 21 i. The arbitration process should include a mechanism to revisit the arbitrator's decision due
22 to new evidence or data.
- 23

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

- 31
- 32 • it must be genuinely voluntary and not penalize practices that choose not to participate;
- 33 • it should provide supplemental payments to reimburse for costs associated with special
34 handling and storage for Part B drugs;
- 35 • it must not reduce reimbursement for services related to provision/administration of Part B
36 drugs, and reimbursement should be indexed to an appropriate health care inflation rate;
- 37 • it should permit flexibility such as allowing for variation in orders that may occur on the
38 day of treatment, and allow for the use of (CAP)-acquired drugs at multiple office
39 locations;
- 40 • it should allow practices to choose from multiple vendors to ensure competition, and
41 should also ensure that vendors meet appropriate safety and quality standards;
- 42 • it should include robust and comprehensive patient protections which include preventing
43 delays in treatment, helping patients find assistance or alternative payment arrangements if
44 they cannot meet the cost-sharing responsibility, and vendors should bear the risk of non-
45 payment of patient copayments in a way that does not penalize the physician;
- 46 • it should not allow vendors to restrict patient access using utilization management policies
47 such as step therapy; and
- 48 • it should not force disruption of current systems which have evolved to ensure patient
49 access to necessary medications.

1 AMA ADVOCACY ON PRESCRIPTION DRUG PRICING

2
3 The Council understands that the introduction of original Resolution 113-N-21, as well as
4 amendments made during consideration of Alternate Resolution 113-N-21, stemmed from strong
5 support in the House of Delegates for the AMA to more actively and strongly advocate on the issue
6 of prescription drug pricing. The AMA has been “at the table,” advocating for the enactment of
7 AMA policy pertaining to drug pricing with Congress via meetings with legislators and their staff
8 as well as through letters and other communications. The AMA also has engaged the
9 Administration through comment letters in response to regulatory activity as well as direct
10 interactions and meetings. Finally, the AMA and members of the Federation have similarly
11 advocated at the state level.

12
13 Showing the diversity and comprehensiveness of AMA policy and advocacy on drug pricing, the
14 Council is providing a summary below to the House of Delegates of recent significant comments,
15 letters and testimony addressing the introduction of and discussions surrounding prescription drug
16 pricing legislation, and the promulgation of regulations addressing drug pricing.

- 17
18 • In March 2022, the AMA submitted a comment [letter](#) in response to the proposed rule
19 outlining Medicare Advantage and prescription drug benefit policies for contract year
20 2023, in which the AMA supported the proposal to require the application of all pharmacy
21 price concessions, including DIR fees, to drug prices in Medicare Part D at the point-of-
22 sale.
- 23 • In August 2021, the AMA submitted a [letter](#) to congressional leadership to provide our
24 perspective on health care issues related to the budget reconciliation proposal (Build Back
25 Better). The letter supported efforts to eliminate prohibitions on the negotiation of
26 prescription drug prices within the Medicare program and outlined AMA policy
27 addressing the parameters of Medicare drug price negotiation, including the use of
28 international drug price averages/indices, arbitration and value-based drug pricing. The
29 letter also supported efforts to increase transparency in all aspects of the drug pricing
30 process, as well as measures to address increases in prescription drug prices that exceed
31 the rate of inflation. In addition, the letter outlined AMA policy on and support for efforts
32 to cap patient out-of-pocket prescription drug expenses; pay-for-delay agreements
33 between brand and generic drug manufacturers; and limit the use of drug utilization
34 management tools by payers.
- 35 • In December 2020, the AMA submitted a comment [letter](#) in response to the MFN Model
36 interim final rule, outlining significant concerns regarding the MFN Model and its impact
37 on patient access to essential treatments, as well as the model’s financial impact on
38 physician practices.
- 39 • In March 2020, the AMA submitted a comment [letter](#) in response to the Importation of
40 Prescription Drugs proposed rule.
- 41 • In February 2020, the AMA submitted a comment [letter](#) in response to released draft
42 guidance regarding the importation of certain FDA-approved human prescription drug and
43 biological products.
- 44 • In May of 2019, the AMA [testified](#) as part of the hearing before the U.S. House of
45 Representatives Committee on Energy and Commerce Subcommittee on Health titled,
46 “Lowering Prescription Drug Prices: Deconstructing the Drug Supply Chain,” submitting
47 [answers](#) to follow-up questions after the hearing in August.
- 48 • In April 2019, the AMA submitted a comment [letter](#) in response to the proposed rule,
49 “Removal of Safe Harbor Protections for Rebates Involving Prescription Pharmaceuticals
50 and Creation of a New Safe Harbor Protection for Certain Point-Of-Sale Reductions in

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

45
 46 DISCUSSION

47
 48 Since 2004, AMA Policy D-330.954 has supported giving the Secretary of HHS the authority to
 49 negotiate contracts with manufacturers of covered Part D drugs, and in 2017, formally prioritized
 50 AMA’s support for the CMS to negotiate pharmaceutical pricing for all applicable medications
 51 covered by CMS. As previously referenced in the report, the CBO and CMS actuaries have

1 estimated that providing the Secretary of HHS broad negotiating authority by itself would not have
2 any effect on negotiations taking place between Part D plans and drug manufacturers or the prices
3 that are ultimately paid by Part D. In order for the Secretary to have the ability to obtain significant
4 discounts in negotiations with drug manufacturers, CBO stated that the Secretary would also need
5 the “authority to establish a formulary, set prices administratively, or take other regulatory actions
6 against firms failing to offer price reductions.”
7

8 Addressing the need for administrative leverage in Medicare drug price negotiations, the Council
9 recognizes that incorporating international drug price indices and averages has become a popular
10 proposal to significantly lower drug prices through said negotiations. However, the Council notes
11 that recent legislative and regulatory proposals have not stopped at incorporating international
12 prescription drug prices in Part D—they have extended to Medicare Part B, as well as to private
13 health plans, unless they opt out. In fact, the proposal closest to being implemented in this arena
14 has been via regulation, and solely addressing payment for prescription drugs in Medicare Part B.
15 Therefore, AMA policy addressing the use of international drug price indices and averages in
16 determining domestic drug prices needs to be consistent across not only all of Medicare, but across
17 all health plans.
18

19 Recent legislative and regulatory proposals have not met the criteria established in Policy
20 H-110.980, which guides AMA support for the use of international drug price averages/indices in
21 determining domestic drug prices. Ultimately, the priority for the AMA in its advocacy efforts has
22 been to preserve patient access to necessary medications, and limit burdens on and protect
23 physician practices. While recent legislative and regulatory proposals have not met these and other
24 important thresholds outlined in the policy, the Council believes that is not a reason to change
25 AMA policy. In addition, the Council stresses that on the legislative front, at the time this report
26 was written, there remains insufficient support in the House of Representatives and Senate to
27 incorporate international price indices/averages into the Medicare drug price negotiation process
28 for drugs covered under Medicare Parts D and B. Therefore, AMA policy moving forward needs to
29 be able to respond to the more likely path to incorporate international drug price averages and/or
30 indices in Medicare drug pricing—through regulation, targeting Medicare Part B drug payment.
31

32 The amendments proposed to Policy H-110.980 would have significant, negative, unintended
33 consequences for the pricing of and payment for drugs under Medicare Part B, impacting patient
34 access and physician practices. It also could set a dangerous precedent guiding the future payment
35 of physician services. The Council instead firmly supports using arbitration as a lever in
36 prescription drug price negotiations, including in Medicare, instead of a price ceiling based on
37 international prices that does not meet existing policy principles. As such, the Council recommends
38 the reaffirmation of Policy H-110.980. The Council also recommends the reaffirmation of Policy
39 H-110.983, which advocates standards that any revised Medicare Part B Competitive Acquisition
40 Program must meet, as a vendor program has often been proposed along with a model or new
41 program to incorporate international drug price averages or indices in Medicare Part B.
42

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

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

9
10 RECOMMENDATIONS

11
12 The Council on Medical Service recommends that the following be adopted in lieu of the second
13 resolve of Alternate Resolution 113-N-21, as well as the referred amendment proffered during
14 consideration of Alternate Resolution 113-N-21, and that the remainder of the report be filed.

- 15
16 1. That our American Medical Association (AMA) reaffirm Policy D-330.954, which states that
17 our AMA will support federal legislation which gives the Secretary of the Department of
18 Health and Human Services the authority to negotiate contracts with manufacturers of covered
19 Part D drugs; work toward eliminating Medicare prohibition on drug price negotiation; and
20 prioritize its support for the Centers for Medicare & Medicaid Services (CMS) to negotiate
21 pharmaceutical pricing for all applicable medications covered by CMS. (Reaffirm HOD
22 Policy)
23
24 2. That our AMA reaffirm Policy H-110.980, which outlines principles to guide AMA support for
25 arbitration as well as the use of international drug price averages/indices in determining
26 domestic drug prices. (Reaffirm HOD Policy)
27
28 3. That our AMA reaffirm Policy H-110.983, which advocates standards that any revised
29 Medicare Part B Competitive Acquisition Program must meet. (Reaffirm HOD Policy)
30
31 4. That our AMA encourage the development of models under the auspices of the CMS
32 Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional
33 enhanced alternative health plan choices that offer lower, consistent, and predictable out-of-
34 pocket costs for select prescription drugs. (New HOD Policy)

Fiscal note: Less than \$500

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 101
(A-22)

Introduced by: Young Physicians Section

Subject: Fertility Preservation Benefits for Active-Duty Military Personnel

Referred to: Reference Committee A

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

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

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

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

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

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

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

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

1 Whereas, Fertility preservation for medical indications (such as prior to cancer treatment, organ
2 transplants, or treatment for rheumatologic diseases) are covered under the VA but not covered
3 by the DOD; and
4

5 Whereas, AMA Policy H-185.990 "Infertility and Fertility Preservation Coverage," states that:
6 "Our AMA supports payment for fertility preservation therapy services by all payers when
7 iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as
8 determined by a licensed physician, and will lobby for appropriate federal legislation requiring
9 payment for fertility preservation therapy services by all payers when iatrogenic infertility may be
10 caused directly or indirectly by necessary medical treatments as determined by a licensed
11 physician;"⁷ and
12

13 Whereas, AMA Policy H-185.922 "Right for Gamete Preservation Therapies" states that:
14 "Our AMA supports insurance coverage for gamete preservation in any individual for whom a
15 medical diagnosis or treatment modality is expected to result in the loss of fertility;"⁸ therefore
16 be it
17

18 RESOLVED, That our American Medical Association work with interested organizations to
19 encourage TRICARE to cover fertility preservation procedures (cryopreservation of sperm,
20 oocytes, or embryos) for medical indications, for active-duty military personnel and other
21 individuals covered by TRICARE (Directive to Take Action); and be it further
22

23 RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover
24 gamete preservation prior to deployment for active-duty military personnel (Directive to Take
25 Action); and be it further
26

27 RESOLVED, That our AMA report back on this issue at the 2023 Annual Meeting of the AMA
28 House of Delegates. (Directive to Take Action)

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

Received: 03/17/22

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

RELEVANT AMA POLICY

Infertility and Fertility Preservation Insurance Coverage H-185.990

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

payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

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

Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967

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

Citation: Res. 512, A-19

Right for Gamete Preservation Therapies H-185.922

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

Citation: Res. 005, A-19

Right for Gamete Preservation Therapies H-65.956

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

2. Our AMA supports the right of transgender or non-binary individuals to seek gamete preservation therapies.

Citation: Res. 005, A-19

Infertility Benefits for Veterans H-510.984

1. Our AMA supports lifting the congressional ban on the Department of Veterans Affairs (VA) from covering in vitro fertilization (IVF) costs for veterans who have become infertile due to service-related injuries.

2. Our AMA encourages interested stakeholders to collaborate in lifting the congressional ban on the VA from covering IVF costs for veterans who have become infertile due to service-related injuries.

3. Our AMA encourages the Department of Defense (DOD) to offer service members fertility counseling and information on relevant health care benefits provided through TRICARE and the VA at pre-deployment and during the medical discharge process.

4. Our AMA supports efforts by the DOD and VA to offer service members comprehensive health care services to preserve their ability to conceive a child and provide treatment within the standard of care to address infertility due to service-related injuries.

5. Our AMA supports additional research to better understand whether higher rates of infertility in servicewomen may be linked to military service, and which approaches might reduce the burden of infertility among service women.

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

Veterans Administration Health System H-510.991

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

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

Health Care for Veterans and Their Families D-510.994

Our AMA will: (1) work with all appropriate medical societies, the AMA National Advisory Council on Violence and Abuse, and government entities to assist with the implementation of all recommendations put forth by the President's Commission on Care for America's Wounded

Warriors; and (2) advocate for improved access to medical care in the civilian sector for returning military personnel when their needs are not being met by resources locally available through the Department of Defense or the Veterans Administration.

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

Health Care Policy for Veterans H-510.990

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

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

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

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

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

Access to Health Care for Veterans H-510.985

Our American Medical Association: (1) will continue to advocate for improvements to legislation regarding veterans' health care to ensure timely access to primary and specialty health care within close proximity to a veteran's residence within the Veterans Administration health care system; (2) will monitor implementation of and support necessary changes to the Veterans Choice Program's "Choice Card" to ensure timely access to primary and specialty health care within close proximity to a veteran's residence outside of the Veterans Administration health care system; (3) will call for a study of the Veterans Administration health care system by appropriate entities to address access to care issues experienced by veterans; (4) will advocate that the Veterans Administration health care system pay private physicians a minimum of 100 percent of Medicare rates for visits and approved procedures to ensure adequate access to care and choice of physician; (5) will advocate that the Veterans Administration health care system hire additional primary and specialty physicians, both full and part-time, as needed to provide care to veterans; and (6) will support, encourage and assist in any way possible all organizations, including but not limited to, the Veterans Administration, the Department of

Justice, the Office of the Inspector General and The Joint Commission, to ensure comprehensive delivery of health care to our nation's veterans.

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

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 102
(A-22)

Introduced by: New York

Subject: Bundling Physician Fees with Hospital Fees

Referred to: Reference Committee A

- 1 Whereas, There is some thought about bundling the fees of physicians with those of the hospital
2 in which the services are provided; and
3
4 Whereas, Such “bundled” payments will go to the hospital which will then control the
5 payments; and
6
7 Whereas, Such a policy will likely make it not only harder for the physician to get paid, but also
8 much more dependent on the hospitals; and
9
10 Whereas, Hospitals would similarly never agree to bundled payments that went directly to
11 physicians; therefore be it
12
13 RESOLVED, That our American Medical Association oppose bundling of physician payments
14 with hospital payments, unless the physician has agreed to such an arrangement in advance.
15 (New HOD Policy)

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

Received: 03/22/22

RELEVANT AMA POLICY

Health Care Reform Physician Payment Models D-385.963

1. Our AMA will: (a) work with the Centers for Medicare and Medicaid Services and other payers to participate in discussions and identify viable options for bundled payment plans, gain-sharing plans, accountable care organizations, and any other evolving health care delivery programs; (b) develop guidelines for health care delivery payment systems that protect the patient-physician relationship; (c) make available to members access to legal, financial, and ethical information, tools and other resources to enable physicians to play a meaningful role in the governance and clinical decision-making of evolving health care delivery systems; and (d) work with Congress and the appropriate governmental agencies to change existing laws and regulations (eg, antitrust and anti-kickback) to facilitate the participation of physicians in new delivery models via a range of affiliations with other physicians and health care providers (not limited to employment) without penalty or hardship to those physicians.
2. Our AMA will: (a) work with third party payers to assure that payment of physicians/healthcare systems includes enough money to assure that patients and their families have access to the care coordination support that they need to assure optimal outcomes; and (b) will work with federal authorities to assure that funding is available to allow the CMMI grant-funded projects that have proven successful in meeting the Triple Aim to continue to provide the information we need to guide decisions that third party payers make in their funding of care coordination services.
3. Our AMA advises physicians to make informed decisions before starting, joining, or affiliating with an ACO. Our AMA will provide information to members regarding AMA vetted legal and financial advisors and will seek discount fees for such services.
4. Our AMA will develop a toolkit that provides physicians best practices for starting and operating an

ACO, such as governance structures, organizational relationships, and quality reporting and payment distribution mechanisms. The toolkit will include legal governance models and financial business models to assist physicians in making decisions about potential physician-hospital alignment strategies. The toolkit will also include model contract language for indemnifying physicians from legal and financial liabilities.

5. Our AMA will continue to work with the Federation to identify, publicize and promote physician-led payment and delivery reform programs that can serve as models for others working to improve patient care and lower costs.

6. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives.

7. Our AMA will work with states to: (a) ensure that current state medical liability reform laws apply to ACOs and physicians participating in ACOs; and (b) address any new liability exposure for physicians participating in ACOs or other delivery reform models.

8. Our AMA recommends that state and local medical societies encourage the new Accountable Care Organizations (ACOs) to work with the state health officer and local health officials as they develop the electronic medical records and medical data reporting systems to assure that data needed by Public Health to protect the community against disease are available.

9. Our AMA recommends that ACO leadership, in concert with the state and local directors of public health, work to assure that health risk reduction remains a primary goal of both clinical practice and the efforts of public health.

10. Our AMA encourages state and local medical societies to invite ACO and health department leadership to report annually on the population health status improvement, community health problems, recent successes and continuing problems relating to health risk reduction, and measures of health care quality in the state.

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 103
(A-22)

Introduced by: New York

Subject: COBRA for College Students

Referred to: Reference Committee A

- 1 Whereas, The Consolidated Omnibus Budget Reconciliation Act (COBRA) is a health insurance
2 program that allows an eligible employee and his or her dependents the continued benefits of
3 health insurance coverage in the case that an employee loses his or her job or experiences a
4 reduction of work hours; and
5
6 Whereas, COBRA allows former employees to obtain continued health insurance coverage at
7 group rates that otherwise might be terminated and which are typically less expensive than
8 those associated with individual health insurance plans; and
9
10 Whereas, Such COBRA coverage reduces the disruption, financial and otherwise, that could
11 occur when a person's employment is terminated; and
12
13 Whereas, College students enjoy similar group rate discounts with student health
14 insurance; and
15
16 Whereas, These students, upon graduation or other termination of an enrollment, potentially
17 face similar disruption in their healthcare coverage; therefore be it
18
19 RESOLVED, That our American Medical Association call for legislation similar to COBRA to
20 allow college students to continue their healthcare coverage, at their own expense, for up to
21 18 months after graduation or other termination of enrollment. (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 104
(A-22)

Introduced by: New York

Subject: Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing

Referred to: Reference Committee A

- 1 Whereas, Consumer Operated and Oriented Plans (CO-OPs) were enacted as a part of the
2 Affordable Care Act (ACA) to improve competition in the health care marketplace; and
3
4 Whereas, CO-OPs may improve the cooperation of patients, physicians, and other providers to
5 improve health outcomes while controlling costs; and
6
7 Whereas, CO-OPs were anticipated to have at least a 33% failure rate but have exceeded that
8 rate substantially; and
9
10 Whereas, CO-OP failures have been due in large part to a combination of premiums that were
11 too low, benefits that were too generous, enrollees who were sicker than anticipated,
12 competition from bigger carriers with larger reserves, changing regulations for risk corridor
13 payments, and restrictions on enrollments from large group markets; and
14
15 Whereas, Four of the original 23 CO-OPs have continued to operate despite these
16 challenges; and
17
18 Whereas, The remaining CO-OPs have had some success in reducing the cost of premiums,
19 but have limited market share and restrictions on enrollment; and
20
21 Whereas, Changing regulations or legislation to allow CO-OPs to more effectively compete in
22 the larger health insurance marketplace, further improve governance, further improve
23 operations, and stabilize the regulatory environment in which they operate may allow CO-OPs
24 to enhance competition in the broader health insurance market; therefore be it
25
26 RESOLVED, That our American Medical Association study options to improve the performance
27 of Consumer Operated and Oriented Plans (CO-OPs) as a potential public option to improve
28 competition in the health insurance marketplace and to improve the value of health care to
29 patients (Directive to Take Action); and be it further
30
31 RESOLVED, That our AMA work with the National Alliance of State Health Co-Ops to request
32 that Congress and the US Department of Health and Human Services reestablish funding for
33 new health insurance co-operatives. (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 105
(A-22)

Introduced by: New York

Subject: Health Insurance that Fairly Compensates Physicians

Referred to: Reference Committee A

- 1 Whereas, There are increasing numbers of health insurance plans that do not adequately
2 compensate physicians for their services, including Medicaid, Medicare and many private
3 insurance plans; and
4
5 Whereas, Adequate insurance compensation is necessary for the continued independent
6 practice of medicine; and
7
8 Whereas, Hospitals and other groups providing medical goods and services would never accept
9 insurances that do not adequately compensate their services and products; therefore be it
10
11 RESOLVED. That our American Medical Association advocate for insurance plans to
12 adequately compensate physicians so that they are able to remain in practice independent of
13 hospital employment. (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 106
(A-22)

Introduced by: New York

Subject: Hospice Recertification for Non-Cancer Diagnosis

Referred to: Reference Committee A

1 Whereas, The number of Americans ages 65 and older is projected to more than double from 46
2 million today to over 98 million by 2060; and
3
4 Whereas, The rate of dementia and failure to thrive at the end of life for older Americans is
5 increasing because of these demographic shifts; and
6
7 Whereas, The ability to predict the end of life is an art as opposed to a science; and
8
9 Whereas, These patients will need hospice care; therefore be it
10
11 RESOLVED, That our American Medical Association request that the Centers for Medicare &
12 Medicaid Services allow automatic reinstatement for hospice if a patient survives for more than
13 6 months with a non-cancer diagnosis and that prognosis remains terminal. (Directive to Take
14 Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 107
(A-22)

Introduced by: New York
Subject: Medicaid Tax Benefits
Referred to: Reference Committee A

1 Whereas, There are many patients with Medicaid or no health insurance that physicians care for
2 routinely for little or no payment; and
3
4 Whereas, It may be politically complicated to rectify this fact directly with improved payments to
5 physicians; and
6
7 Whereas, One way to offset the problem would be to use tax deduction techniques; and
8
9 Whereas, The AMA currently has contrary policy, H-180.965, "Income Tax Credits or
10 Deductions as Compensation for Treating Medically Uninsured or Underinsured," that opposes
11 providing tax deductions or credits for the provision of care to the medically uninsured and
12 underinsured; therefore be it
13
14 RESOLVED, That our American Medical Association advocate for legislation that would allow
15 physicians who take care of Medicaid or uninsured patients to receive some financial benefit
16 through a tax deduction such as (a) a reduced rate of overall taxation or (b) the ability to use
17 the unpaid charges for such patients as a tax deduction. (Directive to Take Action)

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

Received: 03/22/22

RELEVANT AMA POLICY

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

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

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

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 108
(A-22)

Introduced by: New York

Subject: Payment for Regadenoson (Lexiscan)

Referred to: Reference Committee A

- 1 Whereas, During exercise stress testing in cardiology, many patients are unable to walk on the
2 treadmill due to arthritis of knees and hips, PVD or deconditioning; and
3
4 Whereas, For such patients, a pharmacologic stress test is used to evaluate presence of
5 coronary artery disease using Regadenoson (Lexiscan) which is adenosine related
6 compound; and
7
8 Whereas, Cost of this agent from the supplier is around \$248.00 for a single dose; and
9
10 Whereas, No insurance company including Centers for Medicare and Medicaid Services pays
11 the complete amount of \$248.00; and
12
13 Whereas, Some HMOs like Fidelis and WellCare pay as little as \$135.00, thus expecting the
14 stress test lab to absorb the loss of \$110.00 each time such patient is tested; and
15
16 Whereas, This practice of underpaying by HMOs and insurance companies discourages stress
17 test labs to use Regadenoson for these patients due to significant financial loss; and
18
19 Whereas, The costs of other medical agents, such as vaccines and chemotherapy, are also not
20 adequately reimbursed; therefore be it
21
22 RESOLVED, That our American Medical Association petition the Centers for Medicare and
23 Medicaid Services to investigate the disparity between the cost of medical agents and the
24 reimbursement by insurance companies and develop a solution so physicians are not financially
25 harmed when providing medical agents. (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 109
(A-22)

Introduced by: New York

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

Referred to: Reference Committee A

- 1 Whereas, According to the AMA Council on Medical Service (CMS), employers and insurance
2 companies are increasingly implementing programs (i.e., Financial Incentive Programs or FIPs)
3 that offer patients financial incentives when they use shopping tools to compare prices on health
4 care items and services and choose lower-cost options; and
5
- 6 Whereas, According to the CMS, empowering patients to pursue health care can minimize
7 financial burden and reduce societal health care costs; and
8
- 9 Whereas, According to the CMS, while considering these potential benefits of FIPs, it is critical
10 to ensure that patients are empowered to make fully informed decisions about their health care,
11 that they are never coerced into accepting lower-cost care if it could jeopardize their health, and
12 that programs that influence patient decision-making should be transparent about quality and
13 cost; and
14
- 15 Whereas, Multiple studies have shown that, on average, Medicaid recipients use emergency
16 rooms (ERs) more often than those with private insurance for non-urgent conditions; and
17
- 18 Whereas, Some states have implicated a copay system in an attempt to deter the overutilization
19 of ERs, but there is concern that such costs have been shown to cause people, especially those
20 within low-income and vulnerable populations, to forgo necessary care; and
21
- 22 Whereas, One multistate study found that charging higher copayments did not reduce ER use
23 by Medicaid recipients and reasons postulated for this finding include that copays are hard to
24 enforce, since ERs are legally obligated to examine anyone who walks through the doors,
25 whether or not they can pay; and
26
- 27 Whereas, One concept that has been implemented in a few states provides Medicaid recipients
28 with a prepaid card to cover a certain number of copays for ER visits and that any unutilized
29 amount on that copay card could be converted to a financial reward at the end of the year; and
30
- 31 Whereas, Some states have set up a 24-hour hotline staffed by nurses who can advise people
32 about whether they are having a true medical emergency; and
33
- 34 Whereas, There is also a compelling need to be very cautious regarding the creation of
35 disincentives for patients who are in need of care; therefore be it

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

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

Received: 03/22/22

RELEVANT AMA POLICY

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

1. Our AMA supports the following continuity of care principles for any financial incentive program (FIP):
 - a. Collaborate with the physician community in the development and implementation of patient incentives.
 - b. Collaborate with the physician community to identify high-value referral options based on both quality and cost of care.
 - c. Provide treating physicians with access to patients' FIP benefits information in real-time during patient consultations, allowing patients and physicians to work together to select appropriate referral options.
 - d. Inform referring and/or primary care physicians when their patients have selected an FIP service prior to the provision of that service.
 - e. Provide referring and/or primary care physicians with the full record of the service encounter.
 - f. Never interfere with a patient-physician relationship (eg, by proactively suggesting health care items or services that may or may not become part of a future care plan).
 - g. Inform patients that only treating physicians can determine whether a lower-cost care option is medically appropriate in their case and encourage patients to consult with their physicians prior to making changes to established care plans.
2. Our AMA supports the following quality and cost principles for any FIP:
 - a. Remind patients that they can receive care from the physician or facility of their choice consistent with their health plan benefits.
 - b. Provide publicly available information regarding the metrics used to identify, and quality scores associated with, lower and higher-cost health care items, services, physicians and facilities.
 - c. Provide patients and physicians with the quality scores associated with both lower and higher-cost physicians and facilities, as well as information regarding the methods used to determine quality scores. Differences in cost due to specialty or sub-specialty focus should be explicitly stated and clearly explained if data is made public.
 - d. Respond within a reasonable timeframe to inquiries of whether the physician is among the preferred lower-cost physicians; the physician's quality scores and those of lower-cost physicians; and directions for how to appeal exclusion from lists of preferred lower-cost physicians.
 - e. Provide a process through which patients and physicians can report unsatisfactory care experiences when referred to lower-cost physicians or facilities. The reporting process should be easily accessible by patients and physicians participating in the program.
 - f. Provide meaningful transparency of prices and vendors.
 - g. Inform patients of the health plan cost-sharing and any financial incentives associated with receiving care from FIP-preferred, other in-network, and out-of-network physicians and facilities.
 - h. Inform patients that pursuing lower-cost and/or incentivized care, including FIP incentives, may require them to undertake some burden, such as traveling to a lower-cost site of service or complying with a more complex dosing regimen for lower-cost prescription drugs.
 - i. Methods of cost attribution to a physician or facility must be transparent, and the assumptions underlying cost attributions must be publicly available if cost is a factor used to stratify physicians or facilities.
3. Our AMA supports requiring health insurers to indemnify patients for any additional medical expenses resulting from needed services following inadequate FIP-recommended services.
4. Our AMA opposes FIPs that effectively limit patient choice by making alternatives other than the FIP-preferred choice so expensive, onerous and inconvenient that patients effectively must choose the FIP choice.
5. Our AMA encourages state medical associations and national medical specialty societies to apply these principles in seeking opportunities to collaborate in the design and implementation of FIPs, with the goal of empowering physicians and patients to make high-value referral choices.
6. Our AMA encourages objective studies of the impact of FIPs that include data collection on dimensions such as:
 - a. Patient outcomes/the quality of care provided with shopped services;

- b. Patient utilization of shopped services;
 - c. Patient satisfaction with care for shopped services;
 - d. Patient choice of health care provider;
 - e. Impact on physician administrative burden; and
 - f. Overall/systemic impact on health care costs and care fragmentation.
- Citation: CMS Rep. 2, I-19

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

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

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

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

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

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

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

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

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

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

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

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

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

(13) supports increasing public and private investments in home and community-based care, such as adult day care, assisted living facilities, congregate living facilities, social health maintenance organizations, and respite care;

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

- (15) supports buy-ins for home and community-based care for persons with incomes and assets above Medicaid eligibility limits; and providing grants to states to develop new long-term care infrastructures and to encourage expansion of long-term care financing to middle-income families who need assistance;
 - (16) supports efforts to assess the needs of individuals with intellectual disabilities and, as appropriate, shift them from institutional care in the direction of community living;
 - (17) supports case management and disease management approaches to the coordination of care, in the managed care and the fee-for-service environments;
 - (18) urges CMS to require states to use its simplified four-page combination Medicaid / Children's Health Insurance Program (CHIP) application form for enrollment in these programs, unless states can indicate they have a comparable or simpler form; and
 - (19) urges CMS to ensure that Medicaid and CHIP outreach efforts are appropriately sensitive to cultural and language diversities in state or localities with large uninsured ethnic populations.
- Citation: BOT Rep. 31, I-97; Reaffirmed by CMS Rep. 2, A-98; Reaffirmation A-99 and Reaffirmed: Res. 104, A-99; Appended: CMS Rep 2, A-99; Reaffirmation A-00; Appended: CMS Rep. 6, A-01; Reaffirmation A-02; Modified: CMS Rep. 8, A-03; Reaffirmed: CMS Rep. 1, A-05; Reaffirmation A-05; Reaffirmation A-07; Modified: CMS Rep. 8, A-08; Reaffirmation A-11; Modified: CMS Rep. 3, I-11; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 3, I-21

Affordable Care Act Medicaid Expansion H-290.965

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
 2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
 3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
 4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
 5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
 6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
 7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
 8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
 9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
 10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
 11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
 12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
 13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
- Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 110
(A-22)

Introduced by: New York

Subject: Private Payor Payment Integrity

Referred to: Reference Committee A

- 1 Whereas, Private for-profit medical insurers often use self-developed payment guidelines to
2 their financial advantage in reducing or denying payment for necessary medical care; and
3
4 Whereas, For-profit private insurers have an unresolvable conflict of interest in denying payment
5 for diagnostic and treatment options approved by the FDA and adopted by CMS, Workers'
6 Compensation, auto liability insurance and other private payers and are considered medically
7 necessary by the patient and treating physician; therefore be it
8
9 RESOLVED, That our American Medical Association advocate for private insurers to require, at
10 a minimum, to pay for diagnosis and treatment options that are covered by government payers
11 such as Medicare (Directive to Take Action); and be it further
12
13 RESOLVED, That our AMA seek to ensure by legislative or regulatory means that private
14 insurers shall not be allowed to deny payment for treatment options as "experimental and/or
15 investigational" when they are covered under the government plans; such coverage shall extend
16 to managed Medicaid, Workers' Compensation plans, and auto liability insurance companies.
17 (Directive to Take Action)

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

Received: 03/22/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 111
(A-22)

Introduced by: American Academy of Physical Medicine and Rehabilitation
Ohio

Subject: Bundled Payments and Medically Necessary Care

Referred to: Reference Committee A

1 Whereas, Medicare operates bundled payment models that include several diagnoses, including
2 total knee replacement, total hip replacement, myocardial infarction, and others, where model
3 participants are responsible for managing the costs of all of the medical care furnished during
4 triggering admissions or procedures and for 90 days after discharge or 90 days after completion
5 of the procedure, with some exclusions; and
6

7 Whereas, State Medicaid programs are starting similar programs called Episodes of Care; and
8

9 Whereas, Even unrelated events (like cataract surgery or fractured hip from a fall) that occur
10 within 90 days after the initial hospital stay must be covered by the Medicare bundled payment;
11 and
12

13 Whereas, Some unrelated events can be very costly and cause significant spending beyond the
14 limits of the bundle which cannot be controlled by the initial physician; and
15

16 Whereas, One possible incentive for the physicians who are caring for the patient is to decrease
17 costs by decreasing access to services that the patient receives, regardless of the medical
18 needs of the patient, because the cost saved is returned to the physician/participant as a
19 financial bonus/payment; and
20

21 Whereas, Every patient is an individual with different responses to treatment and different
22 comorbidities; and
23

24 Whereas, Some patients need further therapy in an inpatient rehabilitation facility or skilled
25 nursing facility but are not offered those options due to cost containment; and
26

27 Whereas, In the absence of longitudinal care options such as care delivered in an inpatient
28 rehabilitation facility or skilled nursing facility, an overall increase in care per episode might
29 occur in some subpopulations with complications and comorbid conditions; therefore be it
30

31 RESOLVED, That our American Medical Association advocate that coverage rules for Medicaid
32 "Episodes of Care" be carefully reviewed to ensure that they do not incentivize limiting medically
33 necessary services for patients to allow better reimbursement for recipients of the bundled
34 payment (Directive to Take Action); and be it further
35

36 RESOLVED, That our AMA study the issue of "Bundled Payments and Medically Necessary
37 Care" with a report back to the AMA House of Delegates to explore the unintended long-term
38 consequences on health care expenditures, physician reimbursement, and patient outcomes
39 (Directive to Take Action); and be it further

- 1 RESOLVED, That our AMA advocate that functional improvement be a key target outcome for
- 2 bundled payments. (Directive to Take Action)

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

Received: 03/31/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 112
(A-22)

Introduced by: Maryland

Subject: Support for Easy Enrollment Federal Legislation

Referred to: Reference Committee A

1 Whereas, In 2019, the Maryland General Assembly passed legislation to establish the Maryland
2 Easy Enrollment Health Insurance Program with strong support from MedChi, The Maryland State
3 Medical Society; and
4

5 Whereas, The easy enrollment legislation established a statewide mechanism for uninsured
6 people filing Maryland income tax returns to begin the process of enrolling into health coverage
7 by consenting, on their tax return, to have relevant information shared with the health insurance
8 exchange serving state residents; and
9

10 Whereas, A federalized version of the Maryland legislation, entitled the Easy Enrollment in
11 Health Care Act, has been introduced by Senator Chris Van Hollen (D-Maryland) and
12 Congressman Ami Bera, MD (D-California); and
13

14 Whereas, The Easy Enrollment in Health Care Act is supported by the American Academy of
15 Pediatrics, the American Heart Association, and many other stakeholders in health care; and
16

17 Whereas, The legislation will “establish a program which allows any taxpayer who is not
18 covered under minimum essential coverage at the time their return of tax for the taxable year is
19 filed, as well as any other household member who is not covered under such coverage, to, in
20 conjunction with the filing of their return of tax for any taxable year which begins after December
21 31, 2022, elect to—
22

23 (1) have a determination made as to whether the household member who is not
24 covered under such coverage is eligible for an insurance affordability program; and (2)
25 have such household member enrolled into minimum essential coverage;” and
26

27 Whereas, The legislation establishes appropriate limitations, including a prohibition on the
28 collection of information relating to citizenship, immigration status, and health status of any
29 household member; and
30

31 Whereas, The legislation will establish a process for the easy enrollment information to be
32 immediately transferred to relevant health insurance exchange and insurance affordability
33 programs “in order to increase the potential for immediate determinations of eligibility for and
34 enrollment in insurance affordability programs and minimum essential coverage;” and
35

36 Whereas, The legislation aligns with our AMA’s mission to strive for the betterment of public
37 health; therefore be it

- 1 RESOLVED, That our American Medical Association advocate for the federal legislation known
- 2 as the Easy Enrollment in Health Care Act to allow Americans to receive health care information
- 3 and enroll in healthcare coverage through their federal tax returns. (Directive to Take Action)

References:

<https://www.vanhollen.senate.gov/imo/media/doc/Easy%20Enrollment%20in%20Health%20Care%20Act%20Final%20Bill%20Text.pdf>

<https://www.vanhollen.senate.gov/news/press-releases/van-hollen-bera-introduce-new-bicameral-bill-to-make-it-easier-for-americans-to-sign-up-for-health-care-close-massive-enrollment-gap>

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

Received: 04/05/22

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 113
(A-22)

Introduced by: Senior Physicians Section

Subject: Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation

Referred to: Reference Committee A

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

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

11 Whereas, Our AMA has prior policy supporting insurance coverage for hearing remediation⁹
12 as well as for dementia treatment;¹⁰ and
13

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

19 Whereas, The landmark Lancet Commission on Dementia Prevention, Intervention and Care of
20 2017, amplified by the 2020 follow-up report¹³⁻¹⁵ concluded that age-related hearing loss (ARHL)
21 may account for nine percent of all cases of dementia, making this the single largest potentially
22 modifiable risk factor for that condition, beginning in mid-life; and
23

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

28 Whereas, Based on prior and pilot studies,³⁰⁻³¹ the causative link between hearing impairment in
29 middle age and later life to cognitive impairment is likely to be confirmed by ongoing ACHIEVE³²
30 and other clinical trials now in progress; and
31

32 Whereas, The return on investment for hearing remediation, especially but not exclusively in
33 mid-life, will be substantial and time-sensitive because it may ameliorate (by delay in onset or
34 even prevention of cognitive decline) far more costly care for those with cognitive decline (direct
35 and indirect costs). Delaying the onset of Alzheimer’s Disease by even one year has significant
36 fiscal benefits. A 2014 study estimated a one-year delay in the onset of Alzheimer’s disease
37 would save the US \$113 Billion by 2030.³³⁻⁴⁰ This underscores the urgency of current action to
38 reduce subsequent dementia related healthcare costs (perhaps especially, to Medicare) while
39 simultaneously improving the quality of life of affected individuals; and

1 Whereas, A generally held calculation for the yearly cost of caring for those with dementia
2 exceeds \$307 billion as of 2010, and is expected to rise to \$624 billion in 2030 and \$1.5 trillion
3 by 2050. The current yearly market cost of hearing aids in the US is estimated at \$9 billion. This
4 suggests that, with a 9% increase in risk of development of cognitive loss later in life due to
5 unaddressed hearing loss,^{13,15} remediating even this single important element linked to cognitive
6 decline would be cost-effective immediately, and will be increasingly so in the future;^{39,40} and
7

8 Whereas, The issue of hearing impairment is also a matter of health and social equity, with
9 serious immediate and long-term consequences resulting from neglect of remediation.
10 Unaddressed hearing loss reduces earnings potential and increases disability during gainful
11 years, even before factoring in the likelihood of developing cognitive loss later. Sadly, the cost of
12 hearing amplification and other forms of remediation is significant enough (even with over-the-
13 counter products, which while possibly helpful do not come with professional guidance) to deter
14 purchase and implementation by an indigent population;⁴⁶ and
15

16 Whereas, It is indisputable that promotion of any possibly effective means of delay, prevention,
17 as well as timely treatment of cognitive impairment and dementia is highly desirable for public
18 health, for humane as well as financial reasons; and
19

20 Whereas, Congress has shown interest in expanding coverage for hearing remediation in the
21 most recent bill, HR 1118, 'Medicare Hearing Act of 2021,' filed in the current Congressional
22 Session, affording a strategic opportunity for our AMA to more effectively advocate now for
23 expanding coverage to include coverage of preventive strategies in middle age, by promoting
24 this as a way to mitigate future Medicare costs;⁴¹⁻⁴³ and
25

26 Whereas, Some developed countries such as Brazil have launched national efforts to bring
27 hearing remediation to the masses⁴⁵ as a means of reducing later cognitive decline, suggesting
28 that early remediating of hearing is felt by other nations to be a cost-effective pursuit; and
29

30 Whereas, The issues involved in analyzing all factors impeding adequate distribution of hearing
31 remediation are complex, and require physicians to be current, informed, and involved in the
32 discussion with patients;^{44,47-48} and
33

34 Whereas, A number of groups have a stake in promoting hearing remediation, including
35 professional and citizen and Federal Agencies, such as the Agency for Health Research and
36 Quality and the National Institute on Deafness and Other Communication Disorders (NIDCD);
37 therefore be it
38

39 RESOLVED, That our American Medical Association promote awareness of hearing impairment
40 as a potential contributor to the development of cognitive impairment in later life, to physicians
41 as well as to the public (Directive to Take Action); and be it further
42

43 RESOLVED, That our AMA promote, and encourage other stakeholders, including public,
44 private, and professional organizations and relevant governmental agencies, to promote the
45 conduct and acceleration of research into specific patterns and degrees of hearing loss to
46 determine those most linked to cognitive impairment and amenable to correction (Directive to
47 Take Action); and be it further
48

49 RESOLVED, That our AMA advocate for increased hearing screening, and expanding all
50 avenues for third party coverage for effective hearing loss remediation beginning in mid-life or
51 whenever detected, especially when such loss is shown conclusively to contribute significantly
52 to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit
53 the capacity of individuals for independent living. (Directive to Take Action)

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

Received: 04/07/22

REFERENCES

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 114
(A-22)

Introduced by: Senior Physicians Section
Subject: Oral Healthcare IS Healthcare
Referred to: Reference Committee A

1 Whereas, Nationwide, around 50% of Americans 65 and older lack any source of dental
2 insurance, and since its inception in 1965, Medicare has only covered dental care under
3 narrowly prescribed circumstances;¹ and
4
5 Whereas, Nearly half of Americans 65 and over didn't visit a dentist in the last year, citing
6 expense, (and 12% have not received dental care in five or more years). Nearly one in five have
7 lost all their natural teeth (even higher in black and non-Hispanic populations);² and
8
9 Whereas, Unaddressed tooth and gum disease dramatically increases the risks of
10 cardiovascular events such as heart attacks and stroke, and such events are leading causes of
11 death and disability in Medicare recipients, and there is a correlation between poor oral health
12 and chronic diseases more common in the elderly, such as diabetes and Alzheimer's, as well as
13 head and neck cancers;³ and
14
15 Whereas, Prevention and treatment of dental diseases is effective in reducing many of these
16 adverse health consequences;⁴ and
17
18 Whereas, Dental issues are a major source of pain, interfering directly with nutrition and
19 hydration, and painful dental infections are a common cause of emergency department visits,
20 some life threatening, requiring hospitalization and major expense; and
21
22 Whereas, In a 2019 AARP poll, 84 percent of Americans supported adding dental, vision and
23 hearing coverage to Medicare, even if their costs would increase;⁵ and
24
25 Whereas, In all populations, including seniors, dental issues are a major source of both
26 economic as well as healthcare disparity;⁶ and
27
28 Whereas, Expanded use of medication for Opioid Use Disorder has seen increasing prescription
29 of Suboxone in buccal or sublingual form, which delivery method has been shown to
30 dramatically increase the incidence of severe dental disease, including even loss of all teeth;⁷⁻⁹
31 and
32
33 Whereas, Congress is poised to consider Medicare expansion under various current and
34 pending proposals; therefore be it
35
36 RESOLVED, That our American Medical Association reaffirm that dental and oral health are
37 integral components of basic health care and maintenance regardless of age (Reaffirm HOD
38 Policy); and be it further

1 RESOLVED, That our AMA, through the Center for Health Equity, highlight the substantial
2 contribution of dental and oral healthcare disparities to health inequity as well as to social and
3 economic disparities (Directive to Take Action); and be it further
4

5 RESOLVED, That our AMA support ongoing research, legislative actions and administrative
6 efforts to promote access to and adequate coverage by public and private payers for
7 preventative and therapeutic dental services as integral parts of overall health maintenance to
8 all populations (New HOD Policy); and be it further
9

10 RESOLVED, That our AMA work with other organizations to explore avenues to promote efforts
11 to expand Medicare benefits to include preventative and therapeutic dental services, without
12 additional decreases in Medicare Part B Reimbursements. (Directive to Take Action)

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

Received: 04/07/22

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RELEVANT AMA POLICY

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

Citation: CMS Rep. 03, A-19;

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.

Citation: Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 115
(A-22)

Introduced by: Illinois
Subject: Support for Universal Internet Access
Referred to: Reference Committee A

1 I. Issues of internet access as a human right

2
3 Whereas, The United Nations has declared internet access as a human right¹; and

4
5 Whereas, The 2019 Broadband Deployment Report found that 21.3 million Americans lack
6 home internet access²; and

7
8 Whereas, Home internet access varies by socioeconomic status, with only 64.3% of households
9 that make less than \$25,000 of annual income having access to internet as opposed to 93.5%
10 of households with over \$50,000 of annual income^{3,4}; and

11
12 Whereas, One in three families who earn less than \$50,000 annually do not have high-speed
13 home internet⁵; and

14
15 II. Broadband as a social determinant of health

16
17 Whereas, The United States Congress defines broadband as a service that enables users to
18 originate and receive high-quality voice, data, graphics, and video telecommunications⁶; and

19
20 Whereas, The 2020 FCC Broadband Deployment Report set the minimum service that qualifies
21 as broadband at 25mbps upstream and 3mpbs downstream^{7,8}; and

22
23 Whereas, Despite the FCC's Congressional mandate to "holistically evaluate progress in the
24 deployment" of broadband, the FCC has declined to adopt benchmarks on affordability, data
25 allowances, or latency for either fixed or mobile broadband services, because "[w]hile factors
26 such as data allowances or pricing may affect consumers' use of [broadband] or influence
27 decisions concerning the purchase of these services in the first instance, such considerations
28 do not affect the underlying determination of whether [broadband] has been deployed and made
29 available to customers in a given area."⁷; and

30
31 Whereas, Healthy People 2020 has identified internet access as a social determinant of health⁹;
32 and

33
34 Whereas, Internet access is critical for receiving telehealth services, accessing childhood
35 education, and applying for job opportunities, all of which contribute to health¹⁰⁻¹³; and

36
37 Whereas, During the current pandemic, telehealth and virtual education have become
38 necessary to promote health and well-being¹⁴; and

1 Whereas, A majority of government applications for programs and benefits which affect health
2 are available mostly or sometimes only online, especially during the COVID pandemic^{12,13,15,16};
3 and
4

5 Whereas, Our AMA has committed itself to health equity and improving social determinants of
6 health, stating in H-65.960 that “optimizing the social determinants of health is an ethical
7 obligation of a civil society”; and
8

9 III. Broadband use in healthcare delivery

10 Whereas, The COVID pandemic has increased reliance on telehealth and has furthered the
11 divide between patients with and without internet access¹⁷; and
12
13

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

22 Whereas, A study commissioned by the US Chamber of Commerce found broadband has
23 helped to further broaden the scope of healthcare and has led to dramatic cost savings by
24 facilitating the fast and reliable transmission of critical health information, multimedia medical
25 applications, and lifesaving services to many parts of the country¹⁹; and
26

27 Whereas, Telemedicine has been demonstrated to allow for increased access to care, higher
28 show rates, shorter wait times, increased clinical efficiency, and higher convenience – all
29 affecting quality of patient care^{20,21}; and
30

31 Whereas, Telemedicine has been demonstrated to reduce patient and healthcare worker
32 exposure to COVID-19 among other diseases, reduce use of Personal Protective Equipment
33 (PPE), and reduce use of hospital beds and other limited resources^{14,20}; and
34

35 IV. Broadband use in education

36
37 Whereas, The COVID-19 pandemic caused a near-total shutdown of the U.S. school system,
38 forcing more than 55 million students to transition to home-based remote learning⁵; and
39

40 Whereas, One in five households with school-age children (ages 6-18), including 1.6 million
41 immigrant families, do not have personal broadband internet access at home during the COVID-
42 19 pandemic^{20,22}; and
43

44 Whereas, There are 4.6 million households with school aged children that access internet at
45 home solely through cell phones, and 1.5 million households with school aged children who
46 have no internet access of any kind at all, including cell phones²²; and
47

48 Whereas, One in three Black, Latino, and American Indian/Alaska Native families do not have
49 home internet access sufficient to support online learning during the COVID-19 pandemic²³; and

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

2
3 Whereas, The United States internet usage has increased 34% between January 2020 and
4 April 2020 during the COVID-19 pandemic²⁴; and

5
6 Whereas, The FCC Lifeline program provides a choice between either discounted mobile
7 internet access or discounted broadband access for qualifying low-income recipients²⁵; and

8
9 Whereas, The FCC recognizes there is insufficient evidence to conclude that fixed and mobile
10 broadband services are full substitutes in all cases⁷; and

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

14
15 Whereas, The FCC Lifeline program is a discount program and not a free/fully subsidized
16 program for which there is a significant backlog in applications and delay in application
17 approvals, as well as a lack of an automatic application or automatic appeal process²⁵; and

18
19 Whereas, During the COVID pandemic, after Lifeline expanded its capabilities, the program still
20 only allows 1 stream of 25mbps per household, limiting access for households with more than
21 one person working/attending school from home²⁸; and

22
23 Whereas, In the 2020 legislative session as of October 2020, 43 states have considered
24 legislation on broadband access²⁹; and

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

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

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

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

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

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

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

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

Received: 04/07/22

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RELEVANT AMA POLICY

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

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

Citation: Res. 208, I-18; Reaffirmed: CMS Rep. 7, A-21

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

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

Citation: Res. 021, A-19

Racial and Ethnic Disparities in Health Care H-350.974

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

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

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

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

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

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

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

and (c) supports research to identify the most effective strategies for educating physicians on how to eliminate disparities in health outcomes in all at-risk populations.

Citation: CLRPD Rep. 3, I-98; Appended and Reaffirmed: CSA Rep. 1, I-02; Reaffirmed: BOT Rep. 4, A-03; Reaffirmed in lieu of Res. 106, A-12; Appended: Res. 952, I-17; Reaffirmed: CMS Rep. 10, A-19; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

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

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

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

National Health Information Technology D-478.995

1. Our AMA will closely coordinate with the newly formed Office of the National Health Information Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health information technology infrastructure, while minimizing the financial burden to the physician and maintaining the art of medicine without compromising patient care.
 2. Our AMA: (A) advocates for standardization of key elements of electronic health record (EHR) and computerized physician order entry (CPOE) user interface design during the ongoing development of this technology; (B) advocates that medical facilities and health systems work toward standardized login procedures and parameters to reduce user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE user interface design specifically concerning key design principles and features that can improve the quality, safety, and efficiency of health care; and (D) advocates for continued research on EHR, CPOE and clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of these systems.
 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on patient safety and on the productivity and financial solvency of hospitals and physicians' practices; and (B) develop, with physician input, minimum standards to be applied to outcome-based initiatives measured during this rapid implementation phase of EMRs.
 4. Our AMA will (A) seek legislation or regulation to require all EHR vendors to utilize standard and interoperable software technology components to enable cost efficient use of electronic health records across all health care delivery systems including institutional and community based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to achieve interconnectivity and interoperability of electronic health records systems with independent physician practices to enable the efficient and cost effective use and sharing of electronic health records across all settings of care delivery.
 5. Our AMA will seek to incorporate incremental steps to achieve electronic health record (EHR) data portability as part of the Office of the National Coordinator for Health Information Technology's (ONC) certification process.
 6. Our AMA will collaborate with EHR vendors and other stakeholders to enhance transparency and establish processes to achieve data portability.
 7. Our AMA will directly engage the EHR vendor community to promote improvements in EHR usability.
 8. Our AMA will advocate for appropriate, effective, and less burdensome documentation requirements in the use of electronic health records.
 9. Our AMA will urge EHR vendors to adopt social determinants of health templates, created with input from our AMA, medical specialty societies, and other stakeholders with expertise in social determinants of health metrics and development, without adding further cost or documentation burden for physicians.
- Citation: Res. 730, I-04; Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed: BOT Rep. 24, A-13; Reaffirmed in lieu of Res. 724, A-13; Appended: Res. 720, A-13; Appended: Sub. Res. 721, A-13; Reaffirmed: CMS Rep. 4, I-13; Reaffirmation I-13; Appended: BOT Rep. 18, A-14; Appended: BOT Rep. 20, A-14; Reaffirmation A-14; Reaffirmed: BOT Rep. 17, A-15; Reaffirmed in lieu of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07, I-16; Reaffirmed: BOT Rep. 05, I-16; Appended: Res. 227, A-17; Reaffirmed in lieu of: Res. 243, A-17; Modified: BOT Rep. 39, A-18; Reaffirmed: BOT Rep. 45, A-18; Reaffirmed: BOT Rep. 19, A-18; Reaffirmation: A-19; Reaffirmed: CMS Rep. 3, I-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 116
(A-22)

Introduced by: Medical Student Section

Subject: Reimbursement of School-Based Health Centers

Referred to: Reference Committee A

1 Whereas, School Based Health Centers (SBHCs) are facilities located within the kindergarten
2 through twelfth grade school setting that provide an array of high-quality health care services to
3 students^{1,2}; and
4

5 Whereas, SBHCs were first established in the 1960's by the American Academy of Pediatrics to
6 increase access to primary health care and preventative health services, especially for the most
7 vulnerable underserved population of children³; and
8

9 Whereas, Services available are driven by community need, ranging from primary medical care
10 to dental, vision, and behavioral health services, alongside wraparound programming such as
11 substance abuse counseling and social case management, and about 40% of SBHCs employ
12 physicians^{1,2,4}; and
13

14 Whereas, The benefits of routine preventive care are well-established and are incredibly
15 important for children from infancy to adolescence, providing 1) prevention of serious medical
16 illnesses through vaccination and screening, 2) tracking growth and development, 3) raising
17 medical-related concerns, and 4) creating a strong patient-centered medical home⁵; and
18

19 Whereas, The SBHC model provides students with increased access to health care resources
20 and improved long- and short-term health care outcomes, including decreased emergency
21 department visits and hospital utilizations^{3,6,7}; and
22

23 Whereas, SBHCs act as a "safety net health care delivery model" for uninsured, underinsured
24 children or those who lack accessible healthcare⁸; and
25

26 Whereas, SBHCs can receive both grant funding by private organizations and the government,
27 and reimbursement for services rendered by a third-payer payer, most commonly Medicaid and
28 the Children's Health Insurance Program (CHIP); through private organizations⁹ or through
29 direct funding programs established by federal, state and local governments¹⁰; and
30

31 Whereas, The federally qualified health center (FQHC) program funds community health
32 centers that serve medically underserved populations, such as SBHCs, by providing cash
33 grants, drug discounts, legal protections, medical staff and, most uniquely, per-visit
34 reimbursement by Medicaid¹¹; and
35

36 Whereas, Funding SBHCs has been shown to be cost-effective by increasing access to
37 preventive care and reducing utilization of expensive acute care services, leading to a net
38 savings for Medicaid of \$30 to \$969 per visit¹²; and

1 Whereas, School-based health centers have grown substantially over the past two decades,
2 primarily due to an increase in federally qualified health center (FQHC) sponsorship, with 2,584
3 SBHCs in the United States in 2017, more than double in number present in 1998, and since
4 2008, SBHC growth in urban areas has been greatly outpaced by growth in rural and suburban
5 settings¹³; and

6
7 Whereas, The majority of students without access to SBHCs attend schools in low-income
8 communities eligible for Title I funding, and while increased FQHC sponsorship has greatly
9 contributed to recent growth, 80% of FQHCs are not currently partnered with SBHCs⁴; and

10
11 Whereas, Many SBHCs rely on public funding,⁹ although in 2014 only 89% of SBHCs billed
12 Medicaid and 71% billed CHIP in 2014⁴; and

13
14 Whereas, Not all services rendered can be reimbursed under Medicaid at SBHCs, since among
15 many requirements: 1) the child must be Medicaid-eligible, 2) the service must be among those
16 covered by Medicaid and 3) the service must be provided by a Medicaid-participating provider -
17 further, until 2014, reimbursement was not allowed for services given without charge to the
18 beneficiary, except under rare exceptions^{4,14,15}; and

19
20 Whereas, Apart from seven state Medicaid agencies, SBHCs are not considered a provider
21 type¹⁶ making the reimbursement of services more difficult for SBHCs;

22
23 Whereas, The lack of differentiation on claims data means that Medicaid is unable to identify
24 what services were rendered by an SBHC versus a different type of provider, making it difficult
25 to track and attribute improvements in quality of care or outcomes to SBHCs, making it difficult
26 for SBHCs to meet quality standards expected by the state¹⁶; and

27
28 Whereas, Multiple states have recently enacted policies that have facilitated or increased
29 Medicaid reimbursement to SBHCs, with seven states (Delaware, Illinois, Louisiana, Maine,
30 New Mexico, North Carolina, and West Virginia) naming SBHCs as a provider under Medicaid,
31 four states (Louisiana, Maryland, Michigan, and New Mexico) mandating Medicaid
32 reimbursement through a managed care organization, and eight states (Connecticut, Delaware,
33 Illinois, Louisiana, Maine, Maryland, North Carolina, and West Virginia) waiving prior
34 authorization¹⁶; and

35
36 Whereas, The AMA supports the study of SBHCs and recommends SBHC standards (H-
37 60.991), supports adequately resourced SBHCs for healthcare delivery to children and
38 adolescents (H-60.921), and supports physician service reimbursement and reimbursement for
39 physician practices (H-240.966; H-385.990; H-385.942; 385.952); therefore be it

1 RESOLVED, That our American Medical Association amend Policy H-60.921, "School-Based
2 and School-Linked Health Centers," by addition and deletion to read as follows:
3

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

- 5 **1. Our AMA supports the concept of adequately equipped and staffed the**
6 **implementation, maintenance, and equitable expansion of school-based or school-**
7 **linked health centers (SBHCs) for the comprehensive management of conditions of**
8 **childhood and adolescence.**
9 **2. Our AMA recognizes that school-based health centers increase access to care in**
10 **underserved child and adolescent populations.**
11 **3. Our AMA supports identifying school-based health centers in claims data from**
12 **Medicaid and other payers for research and quality improvement purposes.**
13 **4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health**
14 **centers at the state and federal level, including, but not limited to the recognition of**
15 **school-based health centers as a provider under Medicaid. (Modify Current HOD**
16 **Policy)**

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

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

(1) The AMA supports further objective research into the potential benefits and problems associated with school-based health services by credible organizations in the public and private sectors. (2) Where school-based services exist, the AMA recommends that they meet the following minimum standards: (a) Health services in schools must be supervised by a physician, preferably one who is experienced in the care of children and adolescents. Additionally, a

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

CSA Rep. D, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: Res. 412, A-05; Reaffirmed in lieu of Res. 908, I-12

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

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

CSAPH Rep. 1, A-15

Reimbursement to Physicians and Hospitals for Government Mandated Services H-240.966

(1) It is the policy of the AMA that government mandated services imposed on physicians and hospitals that are peripheral to the direct medical care of patients be recognized as additional practice cost expense.

(2) Our AMA will accelerate its plans to develop quantitative information on the actual costs of regulations.

(3) Our AMA strongly urges Congress that the RBRVS and DRG formulas take into account these additional expenses incurred by physicians and hospitals when complying with governmentally mandated regulations and ensure that reimbursement increases are adequate to cover the costs of providing these services.

(4) Our AMA will advocate to the CMS and Congress that an equitable adjustment to the Medicare physician fee schedule (or another appropriate mechanism deemed appropriate by CMS or Congress) be developed to provide fair compensation to offset the additional professional and practice expenses required to comply with the Emergency Medical Treatment and Labor Act.

Sub Res. 810, I-92; Appended by CMS 10, A-98; Reaffirmation: I-98; Reaffirmation: A-02; Reaffirmation: I-07; Reaffirmed in lieu of Res. 126, A-09; Reaffirmed: CMS Rep. 01, A-19

Payment for Physicians' Services H-385.990

Our AMA:

- (1) Recognizes the validity of a pluralistic approach to third party reimbursement methodology and recognizes that indemnity reimbursement, as a schedule of benefits, as well as "usual and customary or reasonable" (UCR), have positive aspects which merit further study.
- (2) Reaffirms its support for: (a) freedom for physicians to choose the method of payment for their services and to establish fair and equitable fees; (b) freedom of patients to select their course of care; and (c) neutral public policy and fair market competition among alternative health care delivery and financing systems.
- (3) Reaffirms its policy encouraging physicians to volunteer fee information to patients and to discuss fees in advance of services, where feasible.
- (4) Urges physicians to continue and to expand the practice of accepting third party reimbursement as payment in full in cases of financial hardship, and to voluntarily communicate to their patients through appropriate means their willingness to consider such arrangements in cases of financial need or other circumstances.

CMS Rep. B, I-83; Reaffirmed: BOT Rep. TT, I-92; Reaffirmed: CMS Rep. E, A-93; Reaffirmed: CLRPD Rep. 1, I-93; Reaffirmed: Sub. Res. 137, A-94; Reaffirmed: CMS Rep. 5, A-04; Reaffirmed: BOT Rep. 10, I-05; Reaffirmed in lieu of Res. 127, A-10; Reaffirmed: CMS Rep. 01, A-20

CMS Use of Regulatory Authority to Implement Reimbursement Policy H-385.942

The AMA urge (1) CMS in the strongest terms possible to solicit the participation and counsel of relevant professional societies before implementing reimbursement policies that will affect the practice of medicine; (2) CMS to make every effort to determine the clinical consequences of such reimbursement policy changes before the revised policies are put in place; and (3) CMS in the strongest terms possible not to misapply either quality measurement data or clinical practice guidelines developed in good faith by the professional medical community as either standards or the basis for changes in reimbursement policies.

Res. 124, A-98; Modified and Reaffirmed: CMS Rep. 4, A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmed: Res. 105, A-18

Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services H-385.952

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.

Res. 118, I-95; Reaffirmation: A-00; Reaffirmation: A-02; Reaffirmation: A-06; Reaffirmation: A-09; Reaffirmed: CMS Rep. 01, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 117
(A-22)

Introduced by: Medical Student Section

Subject: Expanding Medicaid Transportation to Include Healthy Grocery
Destinations

Referred to: Reference Committee A

- 1 Whereas, Food insecurity is defined as the disruption of food intake or eating patterns due to
2 lack of money and other resources¹⁻⁵; and
3
- 4 Whereas, Food insecurity increases the risk of developing chronic diseases such as obesity,
5 type II diabetes, and cardiovascular disease¹⁻⁷; and
6
- 7 Whereas, Health care expenditures from 2011-2013 of food-insecure individuals were \$1,863
8 higher per person compared to food-secure individuals, resulting in \$77.5 billion of additional
9 health care spending⁸; and
10
- 11 Whereas, Medicaid eligibility is correlated with food insecurity and lack of access to grocery
12 stores⁹; and
13
- 14 Whereas, In 2015, 12.7% of the United States census tracts were categorized as low income
15 and were concurrently categorized as areas with limited access to a food store (supermarket,
16 grocery store)¹⁰; and
17
- 18 Whereas, In 2015, 18.2 million housing units were estimated to be in low-income census tracts
19 where at least 100 households without a vehicle lived more than half a mile from the nearest
20 supermarket or large grocery store, or where at least a third of the tract was more than 20 miles
21 from the nearest store¹⁰; and
22
- 23 Whereas, Over 9.5 million parents, 15.6 million nonparents, and 25.8 million children were
24 eligible for Supplemental Nutrition Assistance Program (SNAP) and Medicaid benefits in 2015¹¹;
25 and
26
- 27 Whereas, Individuals of lower socioeconomic status report inadequate geographical location of
28 food stores as a major barrier to proper nutrition, including inadequate transportation¹²⁻¹⁵; and
29
- 30 Whereas, Lack of access to supermarkets, as compared to relatively ready access to
31 convenience stores, can limit the availability of healthy foods, resulting in poorer health
32 outcomes, such as obesity or diabetes¹⁶⁻²⁰; and
33
- 34 Whereas, There is extensive research to support that initiatives improving food access in low
35 income populations results in improved health outcomes²¹⁻²³; and

1 Whereas, Non-emergency medical transportation services (NEMT) covered by State Medicaid
2 includes transportation for prescriptions and medical supplies but not grocery stores, farmers
3 markets, food banks or pantries^{24,25}; and
4

5 Whereas, In the past 2 decades, various pilot programs in areas such as Los Angeles,
6 California, north Nampa, Idaho and Flint, Michigan were initiated to provide transportation to
7 and from specific grocery stores for residents in food deserts^{23,26-29}; and
8

9 Whereas, A 10-week pilot program in Michigan's Upper Peninsula to improve food access,
10 involving a local farmer's market and 32 patients with at least one chronic disease, motivation to
11 begin a healthy lifestyle, and demonstrated difficulty in accessing fruits and vegetables, resulted
12 in an increase of 1.2 cups of fruits and vegetables consumed per day and a significant increase
13 in reported quality of life²²; and
14

15 Whereas, Participants in an East Texas transportation voucher program that included grocery
16 store access reported improved health and well-being, and were more likely to be aware of and
17 utilize SNAP benefits³⁰; and
18

19 Whereas, Pilot test healthy food access programs found that when barriers such as cost and
20 access were removed, individuals from lower SES communities increased their purchase and
21 consumption of fruits and vegetables^{31,32}; and
22

23 Whereas, One study found that after a full-service supermarket was opened in a low-SES
24 neighborhood, the rate of increase of diagnosed high cholesterol and arthritis incidence was
25 reduced³³; and
26

27 Whereas, Many pilot programs, such as LyftUp Grocery Access Program, run for a limited
28 period of time, with ambiguity of future continuity, therefore offering only temporary aid^{34,35}; and
29

30 Whereas, Medicaid has offered NEMT services since 1966 under the Code of Federal
31 Regulations and authorized under the Social Security Act, providing 104 million healthcare-
32 related trips at no cost to eligible individuals in 2013^{24,36}; and
33

34 Whereas, NEMT costs Medicaid less than one percent of its total expenditures annually^{37,38};
35 and
36

37 Whereas, Current AMA policy (D-150.978) encourages the "development of a healthier food
38 system through tax incentive programs, community-level initiatives and federal legislation"; and
39

40 Whereas, Current AMA policy (H-130.954) only encourages the "development of non-
41 emergency patient transportation systems... [for the accessibility] of health care", there is no
42 policy that addresses the lack of transportation support to and from healthy grocery
43 destinations; therefore be it
44

45 RESOLVED, That our American Medical Association: (1) support the implementation and
46 expansion of transportation services for accessing healthy grocery options; and (2) advocate for
47 inclusion of supermarkets, food banks and pantries, and local farmers markets as destinations
48 offered by Medicaid transportation at the federal level; and (3) support efforts to extend
49 Medicaid reimbursement to non-emergent medical transportation for healthy grocery
50 destinations. (Directive to Take Action)

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

Non-Emergency Patient Transportation Systems H-130.954

The AMA: (1) supports the education of physicians and the public about the costs associated with inappropriate use of emergency patient transportation systems; and (2) encourages the development of non-emergency patient transportation systems that are affordable to the patient, thereby ensuring cost effective and accessible health care for all patients.

Res 812, I-93; Reaffirmed: CMS Rep 10, A-03; Reaffirmed in lieu of Res 101, A-12; Modified: CMS Rep 02, I-18

Food Environments and Challenges Accessing Healthy Food H-150.925

Our AMA (1) encourages the U.S. Department of Agriculture and appropriate stakeholders to study the national prevalence, impact, and solutions to challenges accessing healthy affordable food, including, but not limited to, food environments like food mirages, food swamps, and food deserts; (2) recognizes that food access inequalities are a major contributor to health inequities, disproportionately affecting marginalized communities and people of color; and (3) supports policy promoting community-based initiatives that empower resident businesses, create economic opportunities, and support sustainable local food supply chains to increase access to affordable healthy food.

Res 921, I-18; Modified: Res. 417, A-21

Improvements to Supplemental Nutrition Programs H-150.937

1. Our AMA supports: (a) improvements to the Supplemental Nutrition Assistance Program (SNAP) and Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) that are designed to promote adequate nutrient intake and reduce food insecurity and obesity; (b) efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations by encouraging the expansion, through increased funds and increased enrollment, of existing programs that seek to improve nutrition and reduce obesity, such as the Farmer's Market Nutrition Program as a part of the Women, Infants, and Children program; and (c) the novel application of the Farmer's Market Nutrition Program to existing programs such as the Supplemental Nutrition Assistance Program (SNAP), and apply program models that incentivize the consumption of naturally nutrition-dense foods in wider food distribution venues than solely farmer's markets as part of the Women, Infants, and Children program.

2. Our AMA will request that the federal government support SNAP initiatives to (a) incentivize healthful foods and disincentivize or eliminate unhealthful foods and (b) harmonize SNAP food offerings with those of WIC.

3. Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.

Res 414, A-10; Reaffirmed A-12; Reaffirmation A-13; Appended: CSAPH Rep 1, I-13; Reaffirmation A-14; Reaffirmation I-14; Reaffirmation A-15; Appended: Res 407, A-17; Appended: Res 233, A-18

Sustainable Food D-150.978

Our AMA: (1) supports practices and policies in medical schools, hospitals, and other health care facilities that support and model a healthy and ecologically sustainable food system, which provides food and beverages of naturally high nutritional quality; (2) encourages the development of a healthier food system through tax incentive programs, community-level initiatives and federal legislation; and (3) will consider working with other health care and public health organizations to educate the health care community and the public about the importance of healthy and ecologically sustainable food systems.

CSAPH Rep. 8, A-09; Reaffirmed in lieu of Res. 411, A-11; Reaffirmation: A-12; Reaffirmed in lieu of Res. 205, A-12; Modified: Res. 204, A-13; Reaffirmation: A-15

Medicare's Ambulance Service Regulations H-240.978

1. Our AMA supports changes in Medicare regulations governing ambulance service coverage guidelines that would expand the term "appropriate facility" to allow full payment for transport to the most appropriate facility based on the patient's needs and the determination made by physician medical direction; and expand the list of eligible transport locations from the current three sites of care (nearest hospital, critical access hospital, or skilled nursing facility) based upon the onsite evaluation and physician medical direction.

2. Our AMA will work with the Centers for Medicare & Medicaid Services (CMS) to pay emergency medical services providers for the evaluation and transport of patients to the most appropriate site of care not limited to the current CMS defined transport locations.

Res 37, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CMS Rep 3, A-08; Modified: Res 124, A-17

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 118
(A-22)

Introduced by: Medical Student Section, Endocrine Society

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

Referred to: Reference Committee A

1 Whereas, Diabetes affects approximately 9.4% of the U.S. population and is the seventh
2 leading cause of death nationally^{1,2}; and
3
4 Whereas, Direct medical costs for diagnosed diabetes were estimated at \$327.2 billion in 2017,
5 with nearly \$102 billion lost due to lower productivity resulting from diabetes³; and
6
7 Whereas, The annual average medical cost per person with diabetes is \$13,240 with
8 approximately 44% of expenditures stemming from prescription medications, including insulin⁴;
9 and
10
11 Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13
12 cents per unit to 25 cents per unit, translating to a daily cost increase from \$7.80 to \$15 for a
13 patient with Type 1 diabetes using an average amount of insulin (60 units per day)⁵; and
14
15 Whereas, One in four patients reported cost-related insulin underuse, including taking smaller
16 doses and skipping doses, which was independent of the patient's prescription drug coverage
17 plan⁶; and
18
19 Whereas, Patients who report cost-related underuse were more likely to have poor glycemic
20 control, which is associated with an increased risk for complications such as hypertension,
21 chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart
22 disease, depression, and cancer^{6,7}; and
23
24 Whereas, Seven states have approved legislation on insulin copayment caps since April 2020,
25 instituting a \$35-\$100 maximum copayment for a 30-day insulin supply⁸; and
26
27 Whereas, The Centers for Medicare & Medicaid Services (CMS) plans to limit insulin
28 prescription costs through Medicaid Part D for the 2021 plan year to a maximum \$35 copay for
29 a 30-day supply, and estimate annual out-of-pocket savings per patient to be reduced by 66%⁹;
30 and
31
32 Whereas, Individual and family savings resulting from caps on insulin copayments have the
33 potential to alleviate financial burden¹⁰; and
34
35 Whereas, The AMA has policy consistent with the principle of increasing access to prescription
36 medications including insulin for patients¹¹⁻¹⁶; and

1 Whereas, Some private insurance programs have shown the capability to offer a capped
 2 copayment on insulin for their customers, without any increased cost to their insurance premium
 3 or plan¹⁷; therefore be it
 4

5 RESOLVED, That our American Medical Association amend Policy H-110.984, "Insulin
 6 Affordability," by addition to read as follows:
 7

8 Insulin Affordability H-110.984

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

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

Date Received: 04/08/22

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RELEVANT AMA POLICY

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

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

Insulin Affordability H-110.984

Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to monitor insulin pricing and market competition and take enforcement actions as appropriate; and (2) support initiatives, including those by national medical specialty societies, that provide physician education regarding the cost-effectiveness of insulin therapies.
CMS Rep. 07, A-18

Pharmaceutical Costs H-110.987

1. Our AMA encourages Federal Trade Commission (FTC) actions to limit anticompetitive behavior by pharmaceutical companies attempting to reduce competition from generic

manufacturers through manipulation of patent protections and abuse of regulatory exclusivity incentives.

2. Our AMA encourages Congress, the FTC and the Department of Health and Human Services to monitor and evaluate the utilization and impact of controlled distribution channels for prescription pharmaceuticals on patient access and market competition.

3. Our AMA will monitor the impact of mergers and acquisitions in the pharmaceutical industry.

4. Our AMA will continue to monitor and support an appropriate balance between incentives based on appropriate safeguards for innovation on the one hand and efforts to reduce regulatory and statutory barriers to competition as part of the patent system.

5. Our AMA encourages prescription drug price and cost transparency among pharmaceutical companies, pharmacy benefit managers and health insurance companies.

6. Our AMA supports legislation to require generic drug manufacturers to pay an additional rebate to state Medicaid programs if the price of a generic drug rises faster than inflation.

7. Our AMA supports legislation to shorten the exclusivity period for biologics.

8. Our AMA will convene a task force of appropriate AMA Councils, state medical societies and national medical specialty societies to develop principles to guide advocacy and grassroots efforts aimed at addressing pharmaceutical costs and improving patient access and adherence to medically necessary prescription drug regimens.

9. Our AMA will generate an advocacy campaign to engage physicians and patients in local and national advocacy initiatives that bring attention to the rising price of prescription drugs and help to put forward solutions to make prescription drugs more affordable for all patients.

10. Our AMA supports: (a) drug price transparency legislation that requires pharmaceutical manufacturers to provide public notice before increasing the price of any drug (generic, brand, or specialty) by 10% or more each year or per course of treatment and provide justification for the price increase; (b) legislation that authorizes the Attorney General and/or the Federal Trade Commission to take legal action to address price gouging by pharmaceutical manufacturers and increase access to affordable drugs for patients; and (c) the expedited review of generic drug applications and prioritizing review of such applications when there is a drug shortage, no available comparable generic drug, or a price increase of 10% or more each year or per course of treatment.

11. Our AMA advocates for policies that prohibit price gouging on prescription medications when there are no justifiable factors or data to support the price increase.

12. Our AMA will provide assistance upon request to state medical associations in support of state legislative and regulatory efforts addressing drug price and cost transparency.

13. Our AMA supports legislation to shorten the exclusivity period for FDA pharmaceutical products where manufacturers engage in anti-competitive behaviors or unwarranted price escalations.

14. Our AMA supports legislation that limits Medicare annual drug price increases to the rate of inflation.

Citation: CMS Rep. 2, I-15; Reaffirmed in lieu of: Res. 817, I-16; Appended: Res. 201, A-17; Reaffirmed in lieu of: Res. 207, A-17; Modified: Speakers Rep. 01, A-17; Appended: Alt. Res. 806, I-17; Reaffirmed: BOT Rep. 14, A-18; Appended: CMS Rep. 07, A-18; Appended: BOT Rep. 14, A-19; Reaffirmed: Res. 105, A-19; Appended: Res. 113, I-21

Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988

1. Our American Medical Association will work collaboratively with relevant federal and state agencies, policymakers and key stakeholders (e.g., the U.S. Food and Drug Administration, the U.S. Federal Trade Commission, and the Generic Pharmaceutical Association) to identify and promote adoption of policies to address the already high and escalating costs of generic prescription drugs.

2. Our AMA will advocate with interested parties to support legislation to ensure fair and appropriate pricing of generic medications, and educate Congress about the adverse impact of generic prescription drug price increases on the health of our patients.
3. Our AMA encourages the development of methods that increase choice and competition in the development and pricing of generic prescription drugs.
4. Our AMA supports measures that increase price transparency for generic prescription drugs. Sub. Res. 106, A-15; Reaffirmed: CMS 2, I-15; Reaffirmed in lieu of: Res. 2017, A-17; Reaffirmed: BOT Rep. 14, A-18

Cost of Prescription Drugs H-110.997

Our AMA:

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

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

Reducing Prescription Drug Prices D-110.993

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

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

Prescription Drug Prices and Medicare D-330.954

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

Citation: Res. 211, A-04; Reaffirmation I-04; Reaffirmed in lieu of Res. 201, I-11; Appended: Res. 206, I-14; Reaffirmed: CMS Rep. 2, I-15; Appended: Res. 203, A-17; Reaffirmed: CMS Rep. 4, I-19; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 113, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 119
(A-22)

Introduced by: Medical Student Section

Subject: Medicare Coverage of Dental, Vision, and Hearing Services

Referred to: Reference Committee A

1 Whereas, The Social Security Act expressly prohibits coverage for most dental services,
2 specifically “services in connection with the care, treatment, filling, removal, or replacement of
3 teeth or structures directly supporting teeth,” by Original Medicare for its beneficiaries¹; and
4

5 Whereas, Though Medicare covers “medically necessary” dental care, the Centers for Medicare
6 & Medicaid Services presently interprets this to cover a very limited scope of services and
7 coverage determinations are often inconsistent--for example, Medicare Part A will cover an oral
8 examination as part of a comprehensive workup in preparation for a kidney transplant, but not
9 for transplantation of non-kidney organs^{2,3}; and
10

11 Whereas, Almost 24 million Medicare beneficiaries have no dental coverage, comprising nearly
12 half of Medicare beneficiaries⁴; and
13

14 Whereas, In 2021, 16.6 million Medicare Advantage enrollees have some dental benefits
15 through their plans, but 78% of those with coverage are enrolled in plans with annual dollar
16 limits on dental coverage (average annual limit of \$1,300), 10% are required to pay an
17 additional premium for dental coverage, and plans with coverage for extensive dental services
18 often necessitate significant coinsurance cost-sharing (most common cost-sharing of 50%)⁴;
19 and
20

21 Whereas, Lack of dental coverage and dental underinsurance leads to Medicare beneficiaries
22 forgoing recommended care, with 47% of those enrolled in Medicare not visiting the dentist in
23 2018⁴; and
24

25 Whereas, Racial inequities are perpetuated in access to dental services, with Black and
26 Hispanic Medicare enrollees most likely to have not seen a dentist in the past year (68% and
27 61%, respectively)⁴; and
28

29 Whereas, Only 7.27% of Medigap (Medicare Supplement) plans offer additional benefits such
30 as dental, hearing, and vision coverage⁵; and
31

32 Whereas, A 2016 analysis of over 1,200 older adult respondents in the Health and Retirement
33 Study found that only 68% used dental services, and two-thirds of those who wanted to use
34 dental services but did not do so reported cost as a reason they did not receive dental care⁶;
35 and
36

37 Whereas, The 2016 analysis of the Health and Retirement Study found that 42% of those using
38 dental services received a filling, bonding, or inlay; 34% received a crown, implant, or prosthetic;
39 26% received a gum treatment, tooth extraction, or surgery; and 10% received dentures⁶; and

1 Whereas, Poor dental health has myriad negative repercussions for patients' health, including
2 nutritional deficiencies secondary to tooth loss, exacerbation of diabetes and cardiovascular
3 disease by untreated caries and periodontal disease, infections, and delayed diagnoses
4 resulting in preventable complications and adverse outcomes, including for cancer^{7,8}; and
5

6 Whereas, Original Medicare does not cover routine eye examinations or refractions for
7 eyeglasses or contact lenses, nor does it cover eyeglasses or contact lenses themselves other
8 than eyeglasses following cataract surgery^{2,9}; and
9

10 Whereas, Untreated vision loss is correlated with increased risk of falls, depression, cognitive
11 impairment, hospitalization, and mobility limitations among older adults¹⁰; and
12

13 Whereas, Thirty-nine percent of Medicare beneficiaries reported having trouble seeing even
14 with their glasses, and low-income beneficiaries were most likely to have vision trouble¹⁰; and
15

16 Whereas, Among Medicare beneficiaries, forty-three percent who have difficulty seeing have not
17 had an eye exam within the last year¹¹; and
18

19 Whereas, Only thirty-seven percent of Medicare beneficiaries over the age of 65 had an eye
20 exam at least once every 15 months in one recent study¹²; and
21

22 Whereas, Medicare beneficiaries with supplemental vision plans spent an average of \$415 for
23 vision care, while those with Medicare Advantage spent an average of \$331, with 61% and 65%
24 of spending being comprised of out-of-pocket costs to the patient, indicating that even those
25 who have some vision care have significant out-of-pocket expenses for vision care¹⁰; and
26

27 Whereas, Medicare beneficiaries hospitalized for common illnesses were shown to have longer
28 mean lengths of stay, higher readmission rates, and higher costs both during hospitalization and
29 ninety days post-discharge if they had partial or severe vision loss compared to matched
30 hospitalized Medicare beneficiaries with no vision loss, resulting in an estimated \$500 million in
31 excess healthcare costs annually¹³; and
32

33 Whereas, Among Medicare beneficiaries, low vision is associated with an increased risk of hip
34 fractures, depression, anxiety, and dementia, and more prevalent among Black and Hispanic
35 patients¹⁴; and
36

37 Whereas, Medicare beneficiaries with vision impairment reported lower well-being, which was
38 found to be mediated by limitations on mobility and household activities/ instrumental activities
39 of daily living relative to Medicare patients without visual impairment¹⁵; and
40

41 Whereas, A 2018 study published in *JAMA Ophthalmology* found that Hispanic and Black
42 Medicare beneficiaries were significantly less likely to report using low-vision devices than white
43 patients, but there were no similar disparities for low-vision rehabilitation (which is covered by
44 Medicare), leading the study authors to conclude that "policy makers could consider expanding
45 Medicare coverage to include low-vision devices in an effort to address significant disparities in
46 the use of this evidence-based intervention"¹⁶; and
47

48 Whereas, Among adults over the age of 65, the prevalence of falls in the past year for patients
49 with vision impairment was over double that for patients without vision impairment (27.6%
50 versus 13.2%), and the prevalence of activity restriction due to fear of falling was much higher in
51 patients with vision impairment as well (50.8% versus 33.9% for patients without vision
52 impairment)¹⁷; and

1 Whereas, A 2017 *JAMA Ophthalmology* study indicated that visual impairment was associated
2 with a 1.9- to 2.8-fold increase in cognitive dysfunction or dementia among adults 60 years and
3 older¹⁸; and
4

5 Whereas, A study of over 22,000 nationwide respondents to the Medicare Current Beneficiary
6 Study found that beneficiaries with vision impairment were significantly more likely to be
7 hospitalized over a three-year period¹⁹; and
8

9 Whereas, Nearly 25% of people aged 65-74 and 50% persons of people over 75 suffer from
10 disabling hearing loss, which is associated with decreased quality of life, increased risk of
11 cognitive decline and hospitalization, and higher healthcare costs by thousands of dollars,
12 outweighing the relative cost of providing hearing services²⁰⁻²⁴; and
13

14 Whereas, Fewer than 30% of those aged 70 and older who could benefit from hearing aids have
15 ever used them, with many reporting cost as prohibitive, with an average cost of \$2,500 for a
16 pair of digital hearing aids and some ranging up to \$6,000²⁵⁻²⁶; and
17

18 Whereas, Original Medicare does not cover hearing exams, hearing aids, or aural rehabilitative
19 services, while Medicare Advantage charges additional premiums for hearing coverage, with
20 out-of-pocket costs and annual limits varying significantly across Advantage plans²⁷⁻²⁸; and
21

22 Whereas, The *Lancet* Commission has recognized hearing impairment as one of the most
23 important modifiable risk factors for dementia, and observed that “hearing aid use was the
24 largest factor protecting from decline” and “the long follow-up times in these prospective studies
25 suggest hearing aid use is protective, rather than the possibility that those developing dementia
26 are less likely to use hearing aids”²⁹; and
27

28 Whereas, Medicare beneficiaries with functional hearing difficulty (which reflects perceived
29 hearing under daily circumstances and takes the use of hearing aids into account for patients
30 that have them) experience more unmet healthcare needs, such that study investigators
31 concluded that “rethinking service delivery models to provide better access to hearing care
32 could lead to increased hearing aid use and improved interactions between providers and
33 patients with hearing loss”³⁰; and
34

35 Whereas, AMA Policy H-185.929, “Hearing Aid Coverage,” supports Medicare covering hearing
36 tests, but does not indicate support for hearing aids or aural rehabilitative services (which
37 includes fittings and adjustments); and
38

39 Whereas, Numerous recent proposals from the legislative and executive branches have
40 proposed the creation of new dental benefits for preventive and restorative services and
41 additional vision and hearing benefits for routine exams and aids under Medicare Part B,
42 including President Biden’s 2022 budget request, legislation (H.R. 3) passed by the House of
43 Representatives in 2019, and most recently, the Senate Democrats’ budget resolution^{5,31,32};
44 therefore be it
45

46 RESOLVED, That our American Medical Association support Medicare coverage of preventive
47 dental care, including dental cleanings and x-rays, and restorative services, including fillings,
48 extractions, and dentures (New HOD Policy); and be it further
49

50 RESOLVED, That our AMA support Medicare coverage of routine eye examinations and visual
51 aids, including eyeglasses and contact lenses (New HOD Policy); and be it further

1 RESOLVED, That our American Medical Association amend Policy H-185.929, "Hearing Aid
2 Coverage," by addition to read as follows:

3
4 **Hearing Aid Coverage H-185.929**

5 1. Our AMA supports public and private health insurance coverage that provides all
6 hearing-impaired infants and children access to appropriate physician-led teams
7 and hearing services and devices, including digital hearing aids.

8 2. Our AMA supports hearing aid coverage for children that, at minimum,
9 recognizes the need for replacement of hearing aids due to maturation, change in
10 hearing ability and normal wear and tear.

11 3. Our AMA encourages private health plans to offer optional riders that allow their
12 members to add hearing benefits to existing policies to offset the costs of hearing
13 aid purchases, hearing-related exams and related services.

14 4. Our AMA supports coverage of hearing tests administered by a physician or
15 physician-led team, aural rehabilitative services, and hearing aids as part of
16 Medicare's Benefit.

17 5. Our AMA supports policies that increase access to hearing aids and other
18 technologies and services that alleviate hearing loss and its consequences for the
19 elderly.

20 6. Our AMA encourages increased transparency and access for hearing aid
21 technologies through itemization of audiologic service costs for hearing aids.

22 7. Our AMA supports the availability of over-the-counter hearing aids for the
23 treatment of mild-to-moderate hearing loss. (Modify Current HOD Policy)

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

Received: 04/08/22

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RELEVANT AMA POLICY

Eye Exams for the Elderly H-25.990

Our AMA (1) encourages the development of programs and/or outreach efforts to support periodic eye examinations for elderly patients; and (2) encourages physicians to work with their state medical associations and appropriate specialty societies to create statutes that uphold the interests of patients and communities and that safeguard physicians from liability when reporting in good faith the results of vision screenings.

Res. 813, I-05; Reaffirmed: CSAPH Rep. 1, A-15

Hearing Aid Coverage H-185.929

1. Our AMA supports public and private health insurance coverage that provides all hearing-impaired infants and children access to appropriate physician-led teams and hearing services and devices, including digital hearing aids.

2. Our AMA supports hearing aid coverage for children that, at minimum, recognizes the need for replacement of hearing aids due to maturation, change in hearing ability and normal wear and tear.

3. Our AMA encourages private health plans to offer optional riders that allow their members to add hearing benefits to existing policies to offset the costs of hearing aid purchases, hearing-related exams and related services.

4. Our AMA supports coverage of hearing tests administered by a physician or physician-led team as part of Medicare's Benefit.

5. Our AMA supports policies that increase access to hearing aids and other technologies and services that alleviate hearing loss and its consequences for the elderly.

6. Our AMA encourages increased transparency and access for hearing aid technologies through itemization of audiologic service costs for hearing aids.

7. Our AMA supports the availability of over-the-counter hearing aids for the treatment of mild-to-moderate hearing loss.

CMS Rep. 6, I-15; Appended: Res. 124, A-19

Medicare Coverage for Dental Services H-330.872

Our AMA supports: (1) continued opportunities to work with the American Dental Association and other interested national organizations to improve access to dental care for Medicare beneficiaries; and (2) initiatives to expand health services research on the effectiveness of expanded dental coverage in improving health and preventing disease in the Medicare population, the optimal dental benefit plan designs to cost-effectively improve health and prevent disease in the Medicare population, and the impact of expanded dental coverage on health care costs and utilization.

CMS Rep. 03, A-19

Importance of Oral Health in Patient Care D-160.925

Our AMA: (1) recognizes the importance of (a) managing oral health and (b) access to dental care as a part of optimal patient care; and (2) will explore opportunities for collaboration with the American Dental Association on a comprehensive strategy for improving oral health care and education for clinicians.

Res. 911, I-16; Reaffirmed: CMS Rep. 03, A-19

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 120
(A-22)

Introduced by: American Thoracic Society

Subject: Expanding Coverage for and Access to Pulmonary Rehabilitation

Referred to: Reference Committee A

1 Whereas, Pulmonary Rehabilitation is defined as: “a comprehensive intervention based on a
2 thorough patient assessment followed by patient-tailored therapies that include, but are not
3 limited to, exercise training, education, and behavior change, designed to improve the physical
4 and psychological condition of people with chronic respiratory disease and to promote the long-
5 term adherence to health-enhancing behaviors (1);” and
6

7 Whereas, Pulmonary Rehabilitation has been shown to have numerous benefits for patients
8 with chronic respiratory disease, including measurable physiologic benefits, reduction in
9 symptoms of shortness of breath, psychosocial benefits, and economic benefits (2); and
10

11 Whereas, Pulmonary Rehabilitation has been shown to be effective for numerous conditions,
12 including COPD and sequelae of acute COVID-19 infection (3,4); and
13

14 Whereas, Pulmonary Rehabilitation is a cost-effective intervention with benefits to the health
15 care system in addition to individual patients (5); and
16

17 Whereas, While many physicians prescribe pulmonary rehabilitation programs for their patients
18 with a wide variety of respiratory diseases and symptoms, patients often struggle to obtain
19 insurance coverage for these services; and
20

21 Whereas, Improved insurance coverage of Pulmonary Rehabilitation programs would lead to
22 proliferation of such programs, which is difficult for many patients to find; therefore be it
23

24 RESOLVED, That our American Medical Association advocate for insurance coverage for and
25 access to pulmonary rehabilitation for any patient with chronic lung disease or chronic shortness
26 of breath. (Directive to Take Action)

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

Received: 04/08/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 121
(A-22)

Introduced by: Society of Critical Care Medicine

Subject: Increase Funding, Research and Education for Post-Intensive Care Syndrome

Referred to: Reference Committee A

- 1 Whereas, AMA Policy D-460.965, “Call for Increased Funding, Research and Education for Post
2 Viral Syndromes,” asks for coding and funding for the post-acute sequelae of COVID-19; and
3
4 Whereas, The COVID-19 pandemic has substantially increased the number of patients requiring
5 critical care; and
6
7 Whereas, After critical illness, new or worsening impairments in physical, cognitive, and/or
8 mental health function are common among patients who survive, independent of virally driven
9 mechanisms; and
10
11 Whereas, There is attention and heightened interest by both the public and medical
12 communities to understand post-COVID effects, with new terminologies being used such as
13 “long-COVID,” “long-haul COVID” and “Chronic COVID” which includes patients with COVID
14 discharged from the ICU; and
15
16 Whereas, Post-intensive care syndrome (PICS) is a defined term which the critical care
17 community is using in research, diagnosis and treatment and thus already captures an
18 important population of post-COVID patients making it topical to more formally define via ICD-10
19 codes and work efforts; and
20
21 Whereas, One-quarter to one-half or more of critical illness survivors will suffer from some
22 component of PICS, including muscle weakness, poor mobility, poor concentration, poor
23 memory, fatigue, anxiety, and depressed mood, which are typically corroborated by examination
24 and formal testing; and
25
26 Whereas, Although recovery is possible, many of the signs and symptoms of PICS last for
27 months to years, increasing health care utilization, particularly within the first 90 days of
28 discharge (1); and
29
30 Whereas, Only with specific ICD-10 codes can primary care physicians and health systems be
31 adequately recognized through risk adjustment for taking care of this population with increased
32 needs; and
33
34 Whereas, Current relevant ICD-10 codes are limited to G72.81, Critical illness myopathy, and
35 F43.1, Post-traumatic stress disorder, which do not encompass the breadth or specificity of
36 symptoms experienced by patients with PICS; therefore be it

1 RESOLVED, That our American Medical Association support the development of an ICD-10
2 code or family of codes to recognize Post-Intensive Care Syndrome (PICS) (New HOD Policy);
3 and be it further

4
5 RESOLVED, That our AMA advocate for legislation to provide funding for research and
6 treatment of PICS, including for those cases related to COVID-19. (Directive to Take Action)

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

Received: 04/08/22

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AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 122
(A-22)

Introduced by: Michigan
Subject: Medicaid Expansion
Referred to: Reference Committee A

1 Whereas, The Affordable Care Act, which beneficially expanded health insurance coverage in
2 the United States, allowed states to determine if they wished to enact Medicaid Expansion; and
3
4 Whereas, Lack of insurance coverage has devastating effects on the health of all persons,
5 affecting them, their families, and society in general; and
6
7 Whereas, Medicaid expansion in the states in which it has been enacted has been
8 demonstrated to have beneficial effects on the health status of enrollees and to save money;
9 therefore be it
10
11 RESOLVED, That our American Medical Association continue to advocate strongly for
12 expansion of the Medicaid program to all states and reaffirm existing policies D-290.979,
13 H-290.965 and H-165.823 (Directive to Take Action); and be it further
14
15 RESOLVED, That our AMA produce informational brochures and other communications that
16 can be distributed by health care professionals to inform the public of the importance of
17 expanded health insurance coverage to all. (Directive to Take Action)

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

Received: 04/08/22

RELEVANT AMA POLICY

Medicaid Expansion D-290.979

Our AMA, at the invitation of state medical societies, will work with state and specialty medical societies in advocating at the state level to expand Medicaid eligibility to 133% (138% FPL including the income disregard) of the Federal Poverty Level as authorized by the ACA and will advocate for an increase in Medicaid payments to physicians and improvements and innovations in Medicaid that will reduce administrative burdens and deliver healthcare services more effectively, even as coverage is expanded.

Citation: Res. 809, I-12; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, A-21; Reaffirmed: CMS Rep. 9, A-21; Reaffirmed: CMS Rep. 3, I-21; Reaffirmed: Joint CMS/CSAPH Rep. 1, I-21

Affordable Care Act Medicaid Expansion H-290.965

1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.

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

Citation: CMS Rep. 02, A-16; Reaffirmation: A-17; Reaffirmed in lieu of: Res. 807, I-18; Reaffirmed: CMS Rep. 02, A-19; Reaffirmed: CMS Rep. 5, I-20; Reaffirmed: CMS Rep. 3, I-21

Options to Maximize Coverage under the AMA Proposal for Reform H-165.823

1. Our AMA will advocate that any public option to expand health insurance coverage must meet the following standards:
 - a. The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.
 - b. Eligibility for premium tax credit and cost-sharing assistance to purchase the public option is restricted to individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.
 - c. Physician payments under the public option are established through meaningful negotiations and contracts. Physician payments under the public option must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.
 - d. Physicians have the freedom to choose whether to participate in the public option. Public option proposals should not require provider participation and/or tie physician participation in Medicare, Medicaid and/or any commercial product to participation in the public option.
 - e. The public option is financially self-sustaining and has uniform solvency requirements.
 - f. The public option does not receive advantageous government subsidies in comparison to those provided to other health plans.
 - g. The public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid – having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits – at no or nominal cost.

2. Our AMA supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets the following standards:
- a. Individuals must provide consent to the applicable state and/or federal entities to share their health insurance status and tax data with the entity with the authority to make coverage determinations.
 - b. 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/Children's Health Insurance Program (CHIP) or zero-premium marketplace coverage.
 - c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-enrolled.
 - d. Individuals should not be penalized if they are auto-enrolled into coverage for which they are not eligible or remain uninsured despite believing they were enrolled in health insurance coverage via auto-enrollment.
 - e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
 - f. Health plans should be incentivized to offer pre-deductible coverage including physician services in their bronze and silver plans, to maximize the value of zero-premium plans to plan enrollees.
 - g. Individuals enrolled in a zero-premium bronze plan who are eligible for cost-sharing reductions should be notified of the cost-sharing advantages of enrolling in silver plans.
 - h. 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 establishing a special enrollment period.
3. Our AMA: (a) will advocate that any federal approach to cover uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid--having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credit eligibility--make health insurance coverage available to uninsured individuals who fall into the coverage gap at no or nominal cost, with significant cost-sharing protections; (b) will advocate that any federal approach to cover uninsured individuals who fall into the coverage gap provide states that have already implemented Medicaid expansions with additional incentives to maintain their expansions; (c) supports extending eligibility to purchase Affordable Care Act (ACA) marketplace coverage to undocumented immigrants and Deferred Action for Childhood Arrivals (DACA) recipients, with the guarantee that health plans and ACA marketplaces will not collect and/or report data regarding enrollee immigration status; and (d) recognizes the potential for state and local initiatives to provide coverage to immigrants without regard to immigration status.

Citation: CMS Rep. 1, I-20; Appended: CMS Rep. 3, I-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 123
(A-22)

Introduced by: Illinois

Subject: Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence

Referred to: Reference Committee A

- 1 Whereas, The CDC reports that 1 in 4 women and 1 in 10 men 18 years of age or older
2 experience intimate partner violence (IPV)^{1,2}; and
3
4 Whereas, Domestic violence accounts for over 20% of all violent victimizations³; and
5
6 Whereas, Nearly half of all domestic and IPV cases result in injury, the most common of which
7 are physical burns and cuts³; and
8
9 Whereas, International organizations have reported a significant increase in reports of IPV since
10 the onset of the COVID-19 pandemic⁴⁻⁷; and
11
12 Whereas, Acquired facial trauma is associated with a higher likelihood of negative social and
13 functional outcomes including lower self-esteem and higher rates of depression, post-traumatic
14 stress disorder, anxiety disorders, alcohol use disorder, and unemployment^{8,9}; and
15
16 Whereas, Women were more likely to use self-pay to cover IPV-related medical care than to
17 use private insurance prior to the implementation of the Affordable Care Act¹¹; and
18
19 Whereas, Private insurer claims data have shown a rise in the use of private health insurance to
20 cover IPV-related emergency department visits¹¹; and
21
22 Whereas, Many private insurers do not cover medical expenses for cosmetic treatments to
23 injuries that are not considered to provide a gain in functional outcomes; and
24
25 Whereas, Cosmetic procedures may reduce the incidence of re-lived experiences of
26 psychological trauma by eliminating physical reminders of the acquired disfigurement; therefore
27 be it
28
29 RESOLVED, That our American Medical Association urge all payers to consider aesthetic
30 treatments for physical lesions sustained from injuries of domestic and intimate partner violence
31 as restorative treatments (Directive to Take Action); and be it further
32
33 RESOLVED, That our AMA work with relevant stakeholders such as medical specialty societies,
34 third party payers, the Centers for Medicare and Medicaid Service, and other national
35 stakeholders as deemed appropriate to require third party payers to include reimbursement for
36 necessary aesthetic service for the treatment of physical injury sustained along with medically
37 necessary restorative care for victims of domestic abuse. (Directive to Take Action)

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

Received: 05/02/22

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RELEVANT AMA POLICY

Definitions of "Cosmetic" and "Reconstructive" Surgery H-475.992

(1) Our AMA supports the following definitions of "cosmetic" and "reconstructive" surgery: Cosmetic surgery is performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem. Reconstructive surgery is performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. It is generally performed to improve function, but may also be done to approximate a normal appearance. (2) Our AMA encourages third party payers to use these definitions in determining services eligible for coverage under the plans they offer or administer. Citation: (CMS Rep. F, A-89; Reaffirmed: Sunset Report, A-00; Reaffirmed, A-03; Reaffirmed: CMS Rep. 4, A-13)

Insurance Discrimination Against Victims of Domestic Violence H-185.976

Our AMA: (1) opposes the denial of insurance coverage to victims of domestic violence and abuse and seeks federal legislation to prohibit such discrimination; and (2) advocates for equitable coverage and appropriate reimbursement for all health care, including mental health care, related to family and intimate partner violence.

Citation: Res. 814, I-94; Appended: Res. 419, I-00; Reaffirmation A-09; Reaffirmed: CMS Rep. 01, A-19;

Family and Intimate Partner Violence H-515.965

(1) Our AMA believes that all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors. Physicians have a major role in lessening the prevalence, scope and severity of child maltreatment, intimate partner violence, and elder abuse, all of which fall under the rubric of family violence. To support physicians in practice, our AMA will continue to campaign against

family violence and remains open to working with all interested parties to address violence in US society.

(2) Our AMA believes that all physicians should be trained in issues of family and intimate partner violence through undergraduate and graduate medical education as well as continuing professional development. The AMA, working with state, county and specialty medical societies as well as academic medical centers and other appropriate groups such as the Association of American Medical Colleges, should develop and disseminate model curricula on violence for incorporation into undergraduate and graduate medical education, and all parties should work for the rapid distribution and adoption of such curricula. These curricula should include coverage of the diagnosis, treatment, and reporting of child maltreatment, intimate partner violence, and elder abuse and provide training on interviewing techniques, risk assessment, safety planning, and procedures for linking with resources to assist survivors. Our AMA supports the inclusion of questions on family violence issues on licensure and certification tests.

(3) The prevalence of family violence is sufficiently high and its ongoing character is such that physicians, particularly physicians providing primary care, will encounter survivors on a regular basis. Persons in clinical settings are more likely to have experienced intimate partner and family violence than non-clinical populations. Thus, to improve clinical services as well as the public health, our AMA encourages physicians to: (a) Routinely inquire about the family violence histories of their patients as this knowledge is essential for effective diagnosis and care; (b) Upon identifying patients currently experiencing abuse or threats from intimates, assess and discuss safety issues with the patient before he or she leaves the office, working with the patient to develop a safety or exit plan for use in an emergency situation and making appropriate referrals to address intervention and safety needs as a matter of course; (c) After diagnosing a violence-related problem, refer patients to appropriate medical or health care professionals and/or community-based trauma-specific resources as soon as possible; (d) Have written lists of resources available for survivors of violence, providing information on such matters as emergency shelter, medical assistance, mental health services, protective services and legal aid; (e) Screen patients for psychiatric sequelae of violence and make appropriate referrals for these conditions upon identifying a history of family or other interpersonal violence; (f) Become aware of local resources and referral sources that have expertise in dealing with trauma from IPV; (g) Be alert to men presenting with injuries suffered as a result of intimate violence because these men may require intervention as either survivors or abusers themselves; (h) Give due validation to the experience of IPV and of observed symptomatology as possible sequelae; (i) Record a patient's IPV history, observed traumata potentially linked to IPV, and referrals made; (j) Become involved in appropriate local programs designed to prevent violence and its effects at the community level.

(4) Within the larger community, our AMA:

(a) Urges hospitals, community mental health agencies, and other helping professions to develop appropriate interventions for all survivors of intimate violence. Such interventions might include individual and group counseling efforts, support groups, and shelters.

(b) Believes it is critically important that programs be available for survivors and perpetrators of intimate violence.

(c) Believes that state and county medical societies should convene or join state and local health departments, criminal justice and social service agencies, and local school boards to collaborate in the development and support of violence control and prevention activities.

(5) With respect to issues of reporting, our AMA strongly supports mandatory reporting of suspected or actual child maltreatment and urges state societies to support legislation mandating physician reporting of elderly abuse in states where such legislation does not currently exist. At the same time, our AMA oppose the adoption of mandatory reporting laws for physicians treating competent, non-elderly adult survivors of intimate partner violence if the required reports identify survivors. Such laws violate basic tenets of medical ethics. If and where mandatory reporting statutes dealing with competent adults are adopted, the AMA believes the

laws must incorporate provisions that: (a) do not require the inclusion of survivors' identities; (b) allow competent adult survivors to opt out of the reporting system if identifiers are required; (c) provide that reports be made to public health agencies for surveillance purposes only; (d) contain a sunset mechanism; and (e) evaluate the efficacy of those laws. State societies are encouraged to ensure that all mandatory reporting laws contain adequate protections for the reporting physician and to educate physicians on the particulars of the laws in their states. (6) Substance abuse and family violence are clearly connected. For this reason, our AMA believes that:

(a) Given the association between alcohol and family violence, physicians should be alert for the presence of one behavior given a diagnosis of the other. Thus, a physician with patients with alcohol problems should screen for family violence, while physicians with patients presenting with problems of physical or sexual abuse should screen for alcohol use.

(b) Physicians should avoid the assumption that if they treat the problem of alcohol or substance use and abuse they also will be treating and possibly preventing family violence.

(c) Physicians should be alert to the association, especially among female patients, between current alcohol or drug problems and a history of physical, emotional, or sexual abuse. The association is strong enough to warrant complete screening for past or present physical, emotional, or sexual abuse among patients who present with alcohol or drug problems.

(d) Physicians should be informed about the possible pharmacological link between amphetamine use and human violent behavior. The suggestive evidence about barbiturates and amphetamines and violence should be followed up with more research on the possible causal connection between these drugs and violent behavior.

(e) The notion that alcohol and controlled drugs cause violent behavior is pervasive among physicians and other health care providers. Training programs for physicians should be developed that are based on empirical data and sound theoretical formulations about the relationships among alcohol, drug use, and violence.

Citation: CSA Rep. 7, I-00; Reaffirmed: CSAPH Rep. 2, I-09; Modified: CSAPH Rep. 01, A-19;

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 124
(A-22)

Introduced by: Illinois

Subject: To Require Insurance Companies Make the “Coverage Year” and the
“Deductible Year” Simultaneous for Their Policies

Referred to: Reference Committee A

- 1 Whereas, Health care insurance is expensive, and consumers pay high deductibles for their
2 medical care; and
3
4 Whereas, When a consumer pays his/her deductible, he/she expects the deductible to cover the
5 remainder of the coverage year; and
6
7 Whereas, Many health insurance companies count the “coverage year” from the date the policy
8 becomes effective and the “deductible year” from January 1 of each year; and
9
10 Whereas, A consumer whose policy begins mid-calendar year, and who pays the full deductible
11 for care before January 1 when the new “deductible year” begins, is not receiving a full year of
12 benefit for the full deductible he/she paid; and
13
14 Whereas, Insurance companies have sophisticated computer systems to track the “deductible
15 year” and the “coverage year” for each consumer; therefore be it
16
17 RESOLVED, That our American Medical Association advocate and support legislation to require
18 all commercial insurance carriers to align their policies such that a policy holder’s “deductible
19 year” and “coverage year” be the same time period for all policies. (Directive to Take Action)

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

Received: 05/02/22

RELEVANT AMA POLICY

Deductibles Should Be Prorated to Make Them Equitable for Enrollees H-180.955

Our AMA seeks legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment.

Citation: Res. 235, A-01; Reaffirmed: CMS Rep. 7, A-11; Reaffirmed: BOT Rep. 7, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 125
(A-22)

Introduced by: Senior Physicians Section

Subject: Education, Forewarning and Disclosure regarding Consequences of Changing Medicare Plans

Referred to: Reference Committee A

- 1 Whereas, 1 in 4 senior physicians with regular Medicare insurance already have a Medicare
2 Supplement Insurance or "Medigap," policy¹; and
3
4 Whereas, Some Seniors who enroll in Medicare Advantage plans are not able to use Medigap
5 insurance for their cost sharing and therefore stop paying their Medigap premiums; and
6
7 Whereas, If seniors decide to disenroll from Medicare Advantage and return to regular
8 Medicare, they may: (1) have difficulty getting a Medigap plan and may have to provide medical
9 information to qualify to purchase it; (2) may not be able to get the same Medigap plan they had
10 before; and/or (3) need to pay a higher premium for their new Medigap policy; and
11
12 Whereas, Most seniors with Medicare have an overwhelming number of plans from which to
13 choose from when turning 65 years of age: Medicare vs. Medicare Advantage, Medicare
14 supplemental policies, and Medicare Part D policies and without guidance to help them
15 understand the intricacies of transitioning from one plan to another, seniors can find themselves
16 with less robust coverage than they need; and
17
18 Whereas, It may not be widely appreciated that Medicare switching costs increase if you take
19 Medicare Advantage and then decide to go back to Medicare; and
20
21 Whereas, Under current programs being investigated by CMS' Center for Medicare and
22 Medicaid Innovation, beneficiaries may be funneled involuntarily into accountable care
23 organizations without warning or instructions on how they might opt out; therefore be it

1 RESOLVED, That our American Medical Association amend policy H-330.870, "Transparency
2 of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare
3 Advantage Plans," by addition and deletion to read as follows:
4

5 Our AMA will: (1) advocate for provision of transparent print and audio/video patient educational
6 resources to patients and families in multiple languages from health care systems and from
7 Medicare - directly accessible - by consumers and families, explaining clearly the different
8 benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications
9 under Medicare, Medicare Supplemental and Medicare Advantage plans on their personal costs
10 for their medications under Medicare and Medicare Advantage plans both printed and online
11 video which health care systems could provide to patients and which consumers could access
12 directly; and
13

14 (2) advocate for printed and audio/video patient educational resources regarding personal costs,
15 changes in benefits and provider panels that may be incurred when switching (voluntarily or
16 otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans,
17 including additional information regarding federal and state health insurance assistance
18 programs that patients and consumers could access directly; and
19

20 (23) support advocate for increased funding for federal and state health insurance assistance
21 programs and educate physicians, hospitals, and patients about the availability of and access to
22 these such programs. (Modify Current HOD Policy)

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

Received: 05/03/22

REFERENCE

(1) Boccuti, C., Jacobson, G., Orgera, K., & Neuman, T. (2018). Medigap enrollment and consumer protections vary across states. Kaiser Family Foundation.

RELEVANT AMA POLICY

Medicare Advantage Policies H-285.913

Our AMA will:

1. pursue legislation requiring that any Medicare Advantage policy sold to a Medicare patient must include a seven-day waiting period that allows for cancellation without penalty;
2. pursue legislation to require that Medicare Advantage policies carry a separate distinct page, which the patient must sign, including the statement, "THIS COVERAGE IS NOT TRADITIONAL MEDICARE. YOU HAVE CHOSEN TO CANCEL YOUR TRADITIONAL MEDICARE COVERAGE; NOT ALL PHYSICIANS, HOSPITALS AND LABORATORIES ACCEPT THIS NEW MEDICARE ADVANTAGE POLICY AND YOU MAY PERMANENTLY LOSE THE ABILITY TO PURCHASE MEDIGAP SECONDARY INSURANCE" (or equivalent statement) and specifying the time period before they can resume their traditional Medicare coverage; and
3. petition the Centers for Medicare and Medicaid Services to implement the patient's signature page in a Medicare Advantage policy.

Citation: Res. 907, I-07; Reaffirmation A-08; Reaffirmed: CMS Rep. 01, A-18; Reaffirmation: I-18

Deemed Participation and Misleading Marketing by Medicare Advantage Private Fee for Service Plans D-330.930

Our AMA will continue its efforts to educate physicians and the general public on the implications of participating in programs offered under Medicare Advantage and educate

physicians and the public about the lack of secondary coverage (Medigap policies) with Medicare Advantage plans and how this may affect enrollees.

Citation: BOT Action in response to referred for decision Res. 711, I-06; Reaffirmation A-08;
Modified: CMS Rep. 01, A-19

Legislation for Assuring Equitable Participation of Physicians in Medicare Advantage H-330.916

Our AMA seeks to have the CMS, while contracting with Medicare Advantage organizations for Medicare services, require the following guarantees to assure quality patient care to medical beneficiaries: (1) a Medicare Advantage patient shall have the right to see a duly licensed physician of the appropriate training and specialty; (2) if CMS decertifies a Medicare Advantage plan, enrollees in that plan who are undergoing a course of treatment by a physician at the time of such termination shall continue to receive care from their treating physician until an appropriate transfer is accomplished; and (3) any Medicare Advantage plan deselection of participating physicians may occur only after the physician has been given the opportunity to appeal the deselection decision to an Independent Review Body.

Citation: Res. 707, I-98; Reaffirmed: BOT Rep. 23, A-09; Modified: CMS Rep. 01, A-19

Transparency of Costs to Patients for Their Prescription Medications Under Medicare Part D and Medicare Advantage Plans H-330.870

Our AMA will: (1) advocate for transparent patient educational resources on their personal costs for their medications under Medicare and Medicare Advantage plans--both printed and online video--which health care systems could provide to patients and which consumers could access directly; and (2) support increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of these programs.

Citation: Res. 817, I-19

Medicare Advantage Opt Out Rules H-330.913

Our AMA: (1) opposes managed care "bait and switch" practices, whereby a plan entices patients to enroll by advertising large physician panels and/or generous patient benefits, then reduces physician reimbursement and/or patient benefits, so that physicians leave the plan, but patients who can't must choose new doctors; (2) supports current proposals to extend the 30 day waiting period that limits when Medicare recipients may opt out of managed care plans, if such proposals can be amended to create an exemption to protect patients whenever a plan alters benefits or whenever a patient's physician leaves the plan; and (3) supports changes in CMS regulations which would require Medicare Advantage plans to immediately notify patients, whenever such a plan alters benefits or whenever a patient's physician leaves the plan, and to give affected patients a reasonable opportunity to switch plans.

Citation: Res. 707, A-99; Reaffirmed: CMS Rep. 5, A-09; Modified: CMS Rep. 01, A-19

Support for Seamless Physician Continuity of Care H-390.836

Our AMA encourages physicians who encounter contractual difficulties with Medicare Advantage (MA) plans to contact their Centers for Medicare & Medicaid Services (CMS) Regional office.

Citation: BOT Action in response to referred for decision Res. 816, I-16

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 126
(A-22)

Introduced by: Idaho

Subject: Providing Recommended Vaccines Under Medicare Parts B And C

Referred to: Reference Committee A

- 1 Whereas, Many vaccines are recommended for routine use by the Advisory Committee for
2 Immunization Practices (ACIP) for Medicare-eligible beneficiaries; and
3
4 Whereas, Medicare patients usually have the opportunity to obtain recommended routine
5 vaccines at their usual source of care in the outpatient medical home; and
6
7 Whereas, The AMA believes that all public and private insurers should include immunizations
8 recommended by ACIP as a covered benefit and that patients should receive all immunizations
9 recommended by ACIP; and
10
11 Whereas, Under Section 2713 of the Patient Protection and Affordable Care Act, all private
12 health plans are required to cover, without cost sharing, ACIP recommended routine
13 immunizations; and
14
15 Whereas, Medicare currently does not cover some ACIP recommended routine vaccines under
16 parts B and C which results in the outpatient medical home being excluded from providing
17 recommended routine vaccines to Medicare beneficiaries; therefore be it
18
19 RESOLVED, That our American Medical Association support the expansion of coverage of all
20 Advisory Committee for Immunization Practices (ACIP) recommended immunizations for routine
21 use as a covered benefit by all public and private health plans (New HOD Policy); and be it
22 further
23
24 RESOLVED, That our AMA advocate to the Centers for Medicare and Medicaid Services
25 (CMS), and Congress if necessary, for expanded coverage of all ACIP recommended
26 immunizations for routine use to be a covered benefit without patient cost under Medicare parts
27 B and C for Medicare beneficiaries. (Directive to Take Action)

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

Received: 05/11/22

RELEVANT AMA POLICY

Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.
3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.
4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).
5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.
6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.
7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.
8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.
9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.
10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.

Citation: BOT Action in response to referred for decision Res. 524, A-06; Reaffirmation A-07; Appended: Res. 531, A-07; Reaffirmation A-09; Reaffirmed: Res. 501, A-09; Reaffirmation I-10; Reaffirmation A-11; Reaffirmed in lieu of Res. 422, A-11; BOT action in response to referred for decision Res. 422, A-11; Reaffirmation: I-12; Appended: Res. 227, I-12; Appended: Res. 824, I-14; Reaffirmed: Res. 411, A-17; Reaffirmed: CMS Rep. 3, I-20; Reaffirmed: Res. 228, A-21

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 127
(A-22)

Introduced by: Michigan

Subject: Continuity of Care Upon Release from Correctional Systems

Referred to: Reference Committee A

1 Whereas, The rate of recidivism, or the re-entry of formerly incarcerated people, is 70 percent in
2 the United States of America, and more than 50 percent of those incarcerated have been
3 incarcerated more than once; and
4

5 Whereas, Roughly 20-25 percent of those incarcerated have a severe mental illness with up to
6 90 percent reporting consistently poor mental health; and
7

8 Whereas, Mental health problems are by far the most significant cause of morbidity and the vast
9 majority of mental health conditions are not detected upon release; and
10

11 Whereas, The general American population has a substance use rate of approximately seven
12 percent, people who are incarcerated have a substance use rate of approximately 38 percent
13 and are found to relapse approximately 50 percent of the time post-release; and
14

15 Whereas, Incarcerated people with major psychiatric disorders are at an increased risk of
16 multiple incarcerations, and risk factors such as certain psychiatric disorders, substance use,
17 and lack of treatment adherence are risk factors for recidivism within the correctional system;
18 and
19

20 Whereas, For formerly incarcerated people, the mental and substance use services they receive
21 post-release are critical but inconsistent or inadequate; and
22

23 Whereas, Assertive and continuous post-release social work, consisting of frequent mental
24 health check-ins and referrals to addiction support groups significantly showed more post-
25 release connections to mental health services as well as a significant reduction in recidivism;
26 and
27

28 Whereas, Only 28 percent of county jails screen inmates for Medicaid eligibility after release,
29 and in the U.S., 16 states have no formal procedure to enroll people in Medicaid post-release,
30 which serves as a barrier to crucial health care services; and
31

32 Whereas, These barriers not only lead to worsened and more costly health outcomes, but it also
33 increases the rates of recidivism; and
34

35 Whereas, Recidivism rates have been shown to fall when newly released incarcerated people
36 have assistance in accessing medications, their medical records, and primary and specialty
37 care; and

1 Whereas, In a national study of 1,434 ex-prisoners, 31.7 percent had three or more emergency
2 department (ED) visits compared with only 6.5 percent of adults in the general population
3 having two or more ED visits; and
4

5 Whereas, Individuals with recent criminal justice involvement represent only 4.2 percent of the
6 population, but they make up 8.5 percent of all ED expenditures, which translates to an
7 additional \$5.2 billion in annual spending across the health care sector; and
8

9 Whereas, When inmates in Rhode Island received medications for opioid use disorder while
10 incarcerated, post-release emergency department visits were decreased, and similarly when
11 inmates leaving prisons in California received transitional care (including medication refills and
12 expedited primary care appointments), they had half as many annual emergency department
13 visits; and
14

15 Whereas, In Ohio the Medicaid Pre-Enrollment Reentry program resulted in 30 percent of newly
16 enrolled individuals participating in substance use treatment and 38 percent of individuals
17 reporting the cost relief by Medicaid reduced their odds of recidivism; and
18

19 Whereas, In 2020, Maryland's Returning Citizens HealthLink Program worked with 3,453
20 inmates and determined that 86.8 percent qualified for Medicaid; of those that qualified, 89
21 percent were enrolled prior to release; therefore be it
22

23 RESOLVED, That our AMA amend policy AMA policy H-430.986, "Health Care While
24 Incarcerated," by addition and deletion to read as follows:
25

- 26 1. Our AMA advocates for adequate payment to health care providers, including
27 primary care and mental health, and addiction treatment professionals, to encourage
28 improved access to comprehensive physical and behavioral health care services to
29 juveniles and adults throughout the incarceration process from intake to re-entry into
30 the community.
- 31 2. Our AMA advocates and requires a smooth transition including partnerships and
32 information sharing between correctional systems, community health systems and
33 state insurance programs to provide access to a continuum of health care services for
34 juveniles and adults in the correctional system.
- 35 3. Our AMA encourages state Medicaid agencies to accept and process Medicaid
36 applications from juveniles and adults who are incarcerated.
- 37 4. Our AMA encourages state Medicaid agencies to work with their local departments
38 of corrections, prisons, and jails to assist incarcerated juveniles and adults who may
39 not have been enrolled in Medicaid at the time of their incarceration to apply and
40 receive an eligibility determination for Medicaid.
- 41 5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility
42 of juveniles and adults upon intake into the criminal legal system and throughout the
43 incarceration process, and to reinstate coverage when the individual transitions back
44 into the community.
- 45 6. Our AMA advocates for Congress to repeal the "inmate exclusion" of the 1965
46 Social Security Act that bars the use of federal Medicaid matching funds from covering
47 healthcare services in jails and prisons.
- 48 7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services
49 (CMS) to revise the Medicare statute and rescind related regulations that prevent
50 payment for medical care furnished to a Medicare beneficiary who is incarcerated or in
51 custody at the time the services are delivered.

- 1 8. Our AMA advocates for necessary programs and staff training to address the
2 distinctive health care needs of women and adolescent females who are incarcerated,
3 including gynecological care and obstetrics care for individuals who are pregnant or
4 postpartum.
- 5 9. Our AMA will collaborate with state medical societies, relevant medical specialty
6 societies, and federal regulators to emphasize the importance of hygiene and health
7 literacy information sessions, as well as information sessions on the science of
8 addiction, evidence-based addiction treatment including medications, and related
9 stigma reduction, for both individuals who are incarcerated and staff in correctional
10 facilities.
- 11 10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon
12 release in order to accelerate access to comprehensive health care, including mental
13 health and substance use disorder services, and improve health outcomes among this
14 vulnerable patient population, as well as adequate funding; ~~and~~ (b) the collaboration of
15 correctional health workers and community health care providers for those
16 transitioning from a correctional institution to the community; and (c) the provision of
17 longitudinal care from state supported social workers to perform foundational check-ins
18 that not only assess mental health but also develop lifestyle plans with newly released
19 people to support their employment, education, housing, healthcare, and safety.
- 20 11. Our AMA advocates for the continuation of federal funding for health insurance
21 benefits, including Medicaid, Medicare, and the Children's Health Insurance Program,
22 for otherwise eligible individuals in pre-trial detention.
- 23 12. Our AMA advocates for the prohibition of the use of co-payments to access
24 healthcare services in correctional facilities. (Modify Current HOD Policy)

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

Received: 05/11/22

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RELEVANT AMA POLICY

Health Care While Incarcerated H-430.986

1. Our AMA advocates for adequate payment to health care providers, including primary care and mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to re-entry into the community.
2. Our AMA advocates and requires a smooth transition including partnerships and information sharing between correctional systems, community health systems and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system.
3. Our AMA encourages state Medicaid agencies to accept and process Medicaid applications from juveniles and adults who are incarcerated.
4. Our AMA encourages state Medicaid agencies to work with their local departments of corrections, prisons, and jails to assist incarcerated juveniles and adults who may not have been enrolled in Medicaid at the time of their incarceration to apply and receive an eligibility determination for Medicaid.
5. Our AMA advocates for states to suspend rather than terminate Medicaid eligibility of juveniles and adults upon intake into the criminal legal system and throughout the incarceration process, and to reinstate coverage when the individual transitions back into the community.
6. Our AMA advocates for Congress to repeal the “inmate exclusion” of the 1965 Social Security Act that bars the use of federal Medicaid matching funds from covering healthcare services in jails and prisons.
7. Our AMA advocates for Congress and the Centers for Medicare & Medicaid Services (CMS) to revise the Medicare statute and rescind related regulations that prevent payment for medical care furnished to a Medicare beneficiary who is incarcerated or in custody at the time the services are delivered.
8. Our AMA advocates for necessary programs and staff training to address the distinctive health care needs of women and adolescent females who are incarcerated, including gynecological care and obstetrics care for individuals who are pregnant or postpartum.
9. Our AMA will collaborate with state medical societies, relevant medical specialty societies, and federal regulators to emphasize the importance of hygiene and health literacy information sessions, as well as information sessions on the science of addiction, evidence-based addiction treatment including medications, and related stigma reduction, for both individuals who are incarcerated and staff in correctional facilities.
10. Our AMA supports: (a) linkage of those incarcerated to community clinics upon release in order to accelerate access to comprehensive health care, including mental health and substance use disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community health care providers for those transitioning from a correctional institution to the community.
11. Our AMA advocates for the continuation of federal funding for health insurance benefits, including Medicaid, Medicare, and the Children’s Health Insurance Program, for otherwise eligible individuals in pre-trial detention.
12. Our AMA advocates for the prohibition of the use of co-payments to access healthcare services in correctional facilities.

Citation: CMS Rep. 02, I-16; Appended: Res. 417, A-19; Appended: Res. 420, A-19; Modified: Res. 216, I-19; Modified: Res. 503, A-21; Reaffirmed: Res. 229, A-21