AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES (A-22)

Report of Reference Committee A

Steve Y. Lee, MD, Chair

Your Reference Committee recommends the following consent calendar for acceptance:

RECOMMENDED FOR ADOPTION

1. Resolution 121 – Increase Funding, Research and Education for Post-Intensive Care Syndrome
2. Resolution 125 – Education, Forewarning and Disclosure regarding Consequences of Changing Medicare Plans

RECOMMENDED FOR ADOPTION AS AMENDED

3. Council on Medical Service Report 3 – Preventing Coverage Losses After the Public Health Emergency Ends
4. Council on Medical Service Report 4 – Parameters of Medicare Drug Price Negotiation
5. Resolution 101 – Fertility Preservation Benefits for Active-Duty Military Personnel
6. Resolution 109 – Piloting the Use of Financial Incentives to Reduce Unnecessary Emergency Room Visits
7. Resolution 116 – Reimbursement of School-Based Health Centers
8. Resolution 118 – Caps on Insulin Co-Payments for Patients with Insurance
9. Resolution 122 – Medicaid Expansion
10. Resolution 127 – Continuity of Care Upon Release from Correctional Systems

RECOMMENDED FOR ADOPTION IN LIEU OF

11. Resolution 108 – Payment for Regadenoson (Lexiscan)
12. Resolution 113 – Prevention of Hearing Loss-Associated-Cognitive-Impairment through Earlier Recognition and Remediation
    Resolution 114 – Oral Healthcare Is Healthcare
    Resolution 119 – Medicare Coverage of Dental, Vision, and Hearing Services
13. Resolution 120 – Expanding Coverage for and Access to Pulmonary Rehabilitation
14. Resolution 123 - Advocating for All Payer Coverage of Cosmetic Treatment for Survivors of Domestic Abuse and Intimate Partner Violence

RECOMMENDED FOR REFERRAL

15. Resolution 111 – Bundled Payments and Medically Necessary Care

RECOMMENDED FOR NOT ADOPTION

16. Resolution 103 – COBRA for College Students
17. Resolution 110 – Private Payor Payment Integrity

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

18. Resolution 117 – Expanding Medicaid Transportation to Include Healthy Grocery Destinations
19. Resolution 124 – To Require Insurance Companies Make the "Coverage Year" and the "Deductible Year" Simultaneous for Their Policies

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

The following resolutions were handled via the reaffirmation consent calendar:

- Resolution 102 – Bundling Physician Fees with Hospital Fees
- Resolution 104 – Consumer Operated and Oriented Plans (CO-OPs) as a Public Option for Health Care Financing
- Resolution 105 – Health Insurance that Fairly Compensates Physicians
- Resolution 106 – Hospice Recertification for Non-Cancer Diagnosis
- Resolution 107 – Medicaid Tax Benefits
- Resolution 112 – Support for Easy Enrollment Federal Legislation
- Resolution 115 – Support for Universal Internet Access
- Resolution 126 – Providing Recommended Vaccines Under Medicare Parts B And C
- Resolution 128 – Improving Access to Vaccinations for Patients

RECOMMENDED FOR ADOPTION

(1) RESOLUTION 121 – INCREASE FUNDING, RESEARCH AND EDUCATION FOR POST-INTENSIVE CARE SYNDROME

RECOMMENDATION:

Resolution 121 be <u>adopted</u>.

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

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

Your Reference Committee heard testimony in strong support of Resolution 121. Limited opposition wished to ensure that COVID research did not get narrowed to only focusing on PICS, which your Reference Committee did not feel that this resolution would do. Therefore, your Reference Committee recommends that Resolution 121 be adopted.

(2) RESOLUTION 125 – EDUCATION, FOREWARNING AND DISCLOSURE REGARDING CONSEQUENCES OF CHANGING MEDICARE PLANS

RECOMMENDATION:

Resolution 125 be <u>adopted</u>.

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

Our AMA will: (1) advocate for <u>provision of</u> transparent <u>print and audio/video</u> patient educational resources <u>to patients and families in multiple languages from health care systems and from Medicare - directly accessible - by consumers and families, explaining clearly the different benefits, as well as the varied, programmatic and other out-of-pocket costs for their medications under Medicare, Medicare Supplemental and Medicare Advantage plans</u> ~~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

<u>(2) advocate for printed and audio/video patient educational resources regarding personal costs, changes in benefits and provider panels that may be incurred when switching (voluntarily or otherwise) between Medicare, Medical Supplemental and Medicare Advantage or other plans, including additional information regarding federal and state</u>

health insurance assistance programs that patients and consumers could access directly; and

(~~2~~3) ~~support~~ advocate for increased funding for federal and state health insurance assistance programs and educate physicians, hospitals, and patients about the availability of and access to ~~these~~ such programs. (Modify Current HOD Policy)

Testimony was very supportive of Resolution 125. Several commenters emphasized that choosing and changing Medicare plans is complex and confusing for enrollees—and physicians—and that more transparency, education, and guidance is needed. Although testimony noted that new resources and educational materials will not guarantee greater understanding of Medicare and Medicare Advantage plans, several speakers also maintained that Resolution 125 makes important additions to Policy H-330.870. There was also a suggestion to refer the Resolution 125; however, there was insufficient support for referral. Therefore, your Reference Committee recommends that Resolution 125 be adopted.

RECOMMENDED FOR ADOPTION AS AMENDED

(3) COUNCIL ON MEDICAL SERVICE REPORT 3 – PREVENTING COVERAGE LOSSES AFTER THE PUBLIC HEALTH EMERGENCY ENDS

RECOMMENDATION A:

Recommendation 1 in Council on Medical Service Report 3 be <u>amended by addition</u> to read as follows:

1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. (New HOD Policy)
<u>g. Auto-transitions should preserve existing medical home and patient-physician relationships whenever possible.</u>
<u>h. Individuals auto-transitioned into a plan that does not include their physicians in-network should be able to receive transitional continuity of care from those physicians, consistent with Policy H-285.952.</u>

RECOMMENDATION B:

Council on Medical Service Report 3 be amended by addition of a new Recommendation to read as follows:

That our AMA reaffirm Policy H-285.952, which supports patients in an active course of treatment who switch to a new health plan having the opportunity to receive continued transitional care from their treating out-of-network physicians and hospitals. (Reaffirm HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Service Report 3 be adopted as amended and the remainder of the Report be filed.

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

1. That our American Medical Association (AMA) encourage states to facilitate transitions, including automatic transitions, from health insurance coverage for which an individual is no longer eligible to alternate health insurance coverage for which the individual is eligible, and that auto-transitions meet the following standards:
a. Individuals must provide consent to the applicable state and/or federal entities to share information with the entity authorized to make coverage determinations.
b. Individuals should only be auto-transitioned in health insurance coverage if they are eligible for coverage options that would be of no cost to them after the application of any subsidies.
c. Individuals should have the opportunity to opt out from health insurance coverage into which they are auto-transitioned.
d. Individuals should not be penalized if they are auto-transitioned into coverage for which they are not eligible.
e. Individuals eligible for zero-premium marketplace coverage should be randomly assigned among the zero-premium plans with the highest actuarial values.
f. There should be targeted outreach and streamlined enrollment mechanisms promoting health insurance enrollment, which could include raising awareness of the availability of premium tax credits and cost-sharing reductions, and special enrollment periods. (New HOD Policy)
2. That our AMA support coordination between state agencies overseeing Medicaid, Affordable Care Act marketplaces, and workforce agencies that will help facilitate health insurance coverage transitions and maximize coverage. (New HOD Policy)
3. That our AMA support federal and state monitoring of Medicaid retention and disenrollment, successful transitions to quality affordable coverage, and uninsured rates. (New HOD Policy)
4. That our AMA reaffirm Policy H-290.982, which calls for states to streamline Medicaid/Children's Health Insurance Program (CHIP) enrollment processes, use simplified enrollment forms, and undertake Medicaid/CHIP educational and outreach efforts. (Reaffirm HOD Policy)

5. That our AMA reaffirm Policy H-165.855, which calls for adoption of 12-month continuous eligibility across Medicaid, CHIP, and exchange plans to limit churn and assure continuity of care. (Reaffirm HOD Policy)
6. That our AMA reaffirm Policy H-165.823, which supports states and/or the federal government pursuing auto-enrollment in health insurance coverage that meets certain standards related to consent, cost, ability to opt out, and other guardrails. (Reaffirm HOD Policy)

Testimony was supportive of Council on Medical Service Report 3 and its approach to facilitating coverage as the COVID-19 public health emergency (PHE) unwinds. A member of the Council on Medical Service explained that the Council had initiated this report so that the AMA has policy to help ensure that, once the PHE expires and state eligibility redeterminations begin, individuals who remain eligible for Medicaid retain their coverage and those no longer eligible successfully transition to other affordable coverage for which they are eligible. A member of the Council on Legislation noted the potential for significant coverage losses in the post-PHE period while testifying in support of the report's recommendations.

An amendment to Recommendation 1 was proffered to make sure that the patient-physician relationship is not disrupted when enrollees are auto-transitioned into new coverage, and to ensure that individuals auto-transitioned into plans that do not include their physicians in network receive continuity of care from those physicians, consistent with Policy H-285.952. The authors of the amendment also requested reaffirmation of Policy H-285.952. Having heard testimony that supported these changes, your Reference Committee recommends that the recommendations in Council on Medical Service Report 3 be adopted as amended.

(4) COUNCIL ON MEDICAL SERVICE REPORT 4 – PARAMETERS OF MEDICARE DRUG PRICE NEGOTIATION

RECOMMENDATION A:

Recommendation 2 in Council on Medical Service Report 4 be amended by addition and deletion to read as follows:

~~2. That our AMA reaffirm Policy H-110.980, which outlines principles to guide AMA support for arbitration as well as the use of international drug price averages/indices in determining domestic drug prices. (Reaffirm HOD Policy)~~

2. That our AMA amend Policy H-110.980[2] by addition and deletion to read as follows:

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

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

a~~b~~. Any international drug price index or average should not be used to determine or set a drug's price, or determine whether a drug's price is excessive, in isolation;

b~~c~~. The use of any international drug price index or average should preserve patient access to necessary medications;

c~~d~~. The use of any international drug price index or average should limit burdens on physician practices; and

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

RECOMMENDATION B:

Recommendation 4 in Council on Medical Service Report 4 be amended by addition to read as follows:

4. That our AMA encourage the development of voluntary models under the auspices of the CMS Innovation Center (CMMI) to test the impact of offering Medicare beneficiaries additional enhanced alternative

health plan choices that offer lower, consistent, and predictable out-of-pocket costs for select prescription drugs. (New HOD Policy)

RECOMMENDATION C:

Recommendations in Council on Medical Service Report 4 be adopted as amended and the remainder of the report be filed.

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

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

Testimony on Council on Medical Service Report 4 was mixed, supporting amendment or referral. Amendments were proffered to the recommendations of the report to 1) support price negotiation for Medicare Part D drugs using a volume-weighted average percentage of the prices paid in comparable industrialized nations; 2) develop a proposal with interested physician organizations and submit it to the Centers for Medicare and Medicaid Services (CMS) that allows Medicare to negotiate drug prices for Medicare Part B physician-administered drugs based on the volume-weighted net average drug price in comparable industrialized nations; 3) reaffirm Policy H-110.987 that supports legislation that limits Medicare annual drug price increases to the rate of inflation; and 4) stipulate that the models encouraged in the fourth recommendation of the report should be voluntary in nature. Testimony in support of the amendments indicated that they were necessary so that our AMA could more actively “be at the table” as relevant legislation or regulations were put forward. Overall, testimony in support of the amendments stressed that current AMA policy guiding the use of international drug price averages/indices in Medicare drug price negotiation was too restrictive.

While there was substantial support for the amendments proffered, speakers raised concerns that amending Policy H-110.980 as proposed would have unintended

consequences. The chair of the Council on Medical Service underscored that existing Policy H-110.980 as currently worded provides the AMA with a solid foundation upon which to assess legislative and regulatory proposals that attempt to use international drug price averages to determine domestic drug prices. In the end, the chair shared that the Council believes that arbitration would serve as a more sustainable and effective lever in Medicare drug price negotiation, versus the use of an international price index.

The chair of the Council on Medical Service also stressed that our AMA already has policy addressing the value-based pricing of prescription drugs. Changing Policy H-110.980 to explicitly support the use of international price indices to determine domestic drug prices, in the end, amounts to importing the value assessments of other countries into our pricing system, thereby undermining existing AMA policy on the value-based pricing of drugs.

The chair of the Council on Medical Service and other speakers noted that that openly supporting an international price index to price domestic prescription drugs would invite more gaming into our pharmaceutical marketplace, not less. Testimony implicated that utilizing an international price index in Medicare drug price negotiation may incentivize pharmaceutical manufacturers to increase drug prices and delay new product introductions globally to impact the U.S. market. The chair of the Council also stated that evidence is lacking as to whether the savings achieved by any international price index would be sustainable, which is why our AMA has been multifaceted and diverse in its approach to lowering prescription drug costs. Medicare prescription drug price negotiation is only a piece of the larger drug pricing puzzle, which requires interventions to improve transparency and competition in the pharmaceutical marketplace; strengthen regulation of PBMs; limit drug price increases in Medicare to the rate of inflation; and ensure benefit design improves patient medication adherence.

The chair of the Council on Medical Services indicated during testimony that striking subpart 2a from Policy H-110.980 may serve as an acceptable compromise for how AMA policy can best move forward. It is the understanding of your Reference Committee that the sponsor of the amendments also agreed to this compromise. Your Reference Committee agrees with the compromise reached, and stresses that the remaining safeguards in AMA Policy H-110.980 will be absolutely critical as our AMA reviews relevant legislation and regulations on drug pricing in the coming months. Therefore, your Reference Committee recommends that the recommendations of Council on Medical Service Report 4 be adopted as amended, and the remainder of the report filed.

(5) RESOLUTION 101 – FERTILITY PRESERVATION BENEFITS FOR ACTIVE-DUTY MILITARY PERSONNEL

RECOMMENDATION A:

The second Resolve of Resolution 101 be <u>amended by addition and deletion</u> to read as follows:

RESOLVED, That our AMA work with interested organizations to encourage TRICARE to cover gamete preservation ~~prior to deployment~~ for active-duty military personnel <u>and activated reservist military personnel.</u> (Directive to Take Action)~~; and be it further~~

RECOMMENDATION B:

The third Resolve of Resolution 101 be <u>deleted</u>.

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

RECOMMENDATION C:

Resolution 101 be <u>adopted as amended</u>.

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

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

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

Testimony was supportive of the intent of Resolution 101. The potential cost of covering fertility preservation services for military personnel was raised, as was the potential benefit to service member morale, retention, and well-being. While speakers acknowledged existing AMA policy on coverage of and payment for fertility preservation and gamete preservation services by all payers, a preponderance of the testimony—from active-duty military members and others—supported Resolution 101 and the need for new policy specific to coverage of these services under TRICARE. Testimony further supported a proffered amendment to include “activated reservist military personnel” and delete “prior to deployment” in the second Resolve clause.

A member of the Council on Medical Service testified that the report requested in the third Resolve clause is not needed because the Council presented a report in 2016 on infertility

benefits provided through the Department of Defense (DOD), which administers TRICARE. No testimony was offered in support of the third Resolve clause, and your Reference Committee recommends that it be deleted and that Resolution 101 be adopted as amended.

(6) RESOLUTION 109 – PILOTING THE USE OF FINANCIAL INCENTIVES TO REDUCE UNNECESSARY EMERGENCY ROOM VISITS

RECOMMENDATION A:

Resolution 109 be amended by addition to read as follows:

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

RECOMMENDATION B:

Resolution 109 be adopted as amended with a change in title.

RECOMMENDATION C:

The title of Resolution 109 be changed to:

STUDY OF INCENTIVES TO ENCOURAGE EFFICIENT USE OF EMERGENCY DEPARTMENTS

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

Testimony was supportive of Resolution 109 and the need for additional study of incentives designed to encourage Medicaid enrollees to choose alternate sites of care instead of emergency departments. Although the need for another report on financial incentives was questioned, a preponderance of the testimony maintained that additional study specific to Medicaid and emergency department use was needed. An amendment was proffered to add “for physical and mental health conditions” to Resolution 109. Additional testimony questioned use of the term “unnecessary” in the title and also highlighted a range of reasons, beyond financial incentives, that people utilize emergency departments, including some patients not having access to primary care. Therefore, your Reference Committee recommends that Resolution 109 be adopted as amended with a change in title.

(7) RESOLUTION 116 – REIMBURSEMENT OF SCHOOL-BASED HEALTH CENTERS

RECOMMENDATION A:

Resolution 116 be amended by addition and deletion to read as follows:

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

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

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of physician-led school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

2. Our AMA recognizes that school-based health centers increase access to care in ~~underserved~~ disproportionately affected child and adolescent populations.

3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend ~~Medicaid reimbursement~~ insurance payments to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 116 be adopted as amended.

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

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

1. Our AMA supports ~~the concept of adequately equipped and staffed~~ the implementation, maintenance, and equitable expansion of school-based or school-linked health centers (SBHCs) for the comprehensive management of conditions of childhood and adolescence.

2. Our AMA recognizes that school-based health centers increase access to care in underserved child and adolescent populations.

3. Our AMA supports identifying school-based health centers in claims data from Medicaid and other payers for research and quality improvement purposes.

4. Our AMA supports efforts to extend Medicaid reimbursement to school-based health centers at the state and federal level, including, but not limited to the recognition of school-based health centers as a provider under Medicaid. (Modify Current HOD Policy)

Testimony was supportive of Resolution 116 and highlighted a variety of benefits of school-based health centers. It was noted in testimony that the Centers for Medicare & Medicaid Services will be issuing guidance on school-based health centers later this year. An amendment was offered to clarify that school-based health centers should be physician-led. Another speaker suggested using the term "disproportionately affected" in place of "underserved" in the second clause. Testimony also requested that efforts to expand payment from private insurers, in addition to Medicaid, be supported. Your Reference Committee recommends incorporation of these three amendments. Your Reference Committee does not believe that a fourth proffered amendment, to include colleges and trade schools within the scope of Policy H-60.921, is needed since that policy does not specify that it applies only to kindergarten through twelfth grades. Your Reference Committee recommends that Resolution 116 be adopted as amended.

(8) RESOLUTION 118 – CAPS ON INSULIN CO-PAYMENTS FOR PATIENTS WITH INSURANCE

RECOMMENDATION A:

Resolution 118 be amended by addition and deletion to read as follows:

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

Insulin Affordability H-110.984
Our AMA will: (1) encourage the Federal Trade Commission (FTC) and the Department of Justice to ~~monitor~~ investigate 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.; and (3) support state and national efforts to limit the ~~copayments~~ ultimate expenses incurred by insured patients ~~pay per month~~ for prescribed insulin. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 118 be adopted as amended.

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

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~~.~~; and (3) support state and national efforts to limit the copayments insured patients pay per month for prescribed insulin. (Modify Current HOD Policy)

There was highly supportive testimony on the intent of Resolution 118. Testimony stressed the impacts that high insulin cost-sharing has on medication adherence and health outcomes. An amendment was proffered to change “monitor” to “investigate” in Policy H-110.984, because the root cause of high insulin pricing reaches beyond the level at which co-pays are set by health plans. Other speakers noted that co-pay limits should be applied to other prescription drugs with high cost-sharing requirements that impede medication adherence. However, your Reference Committee notes that as Resolution 118 asks to amend AMA policy specific to insulin affordability, suggestions to broaden Resolution 118 to include more drugs are outside the scope of the resolution.

Other speakers supported reaffirming AMA policy in lieu of Resolution 118. A member of the Council on Medical Service noted that the Council presented a report in 2018 that addressed the issue of insulin affordability. In addition, in 2016, the Council presented a report that established policy supporting value-based pricing for pharmaceuticals. Further, existing policy already encourages payers to determine patient cost-sharing based on the clinical value of a health care service or treatment. The policy stipulates that consideration should be given to further tailoring cost-sharing requirements to patient income and other factors known to impact compliance. Other policy states that cost-sharing requirements for prescription drugs should be based on considerations such as the unit cost of medication, availability of therapeutic alternatives, medical condition being treated, personal income, and other factors known to affect patient compliance. Finally, policy advocates for economic assistance, including coupons and other discounts for patients, whether they are enrolled in government health insurance programs, enrolled in commercial insurance plans, or are uninsured.

While relevant existing policy is strong, your Reference Committee believes that our AMA needs to establish new policy that addresses the ultimate expenses incurred by insured patients for prescribed insulin. Your Reference Committee believes that AMA policy needs to address all of the underlying factors contributing to high insulin out-of-pocket requirements – based on the actions of pharmaceutical companies, pharmacy benefit managers and health plans. Without a more holistic look at this issue, simply limiting out-of-pocket expenses for insulin could cause higher health insurance premiums. As such, your Reference Committee is recommending an amendment to Resolution 118, and believes the resolution should be adopted as amended.

(9) RESOLUTION 122 – MEDICAID EXPANSION

RECOMMENDATION A:

Second Resolve of Resolution 122 be amended by addition and deletion to read as follows:

RESOLVED, That our AMA ~~produce informational brochures and other communications that can be distributed by~~ work with interested state medical associations and national medical specialty societies to provide AMA resources on Medicaid expansion and covering the uninsured to health care professionals to inform the public of the importance of expanded health insurance coverage to all. (Directive to Take Action)

RECOMMENDATION B:

Resolution 122 be adopted as amended with a change in title.

RECOMMENDATION C:

The title of Resolution 122 be changed to:

PROVIDING EDUCATIONAL RESOURCES ON MEDICAID EXPANSION

RESOLVED, That our American Medical Association continue to advocate strongly for expansion of the Medicaid program to all states and reaffirm existing policies D-290.979, H 290.965 and H-165.823 (Directive to Take Action); and be it further

RESOLVED, That our AMA produce informational brochures and other communications that can be distributed by health care professionals to inform the public of the importance of expanded health insurance coverage to all. (Directive to Take Action)

Testimony was supportive of Resolution 122, with several speakers highlighting the benefits to patients of Medicaid expansion. A member of the Council on Medical Service pointed to resources that the AMA has already developed on the benefits of Medicaid expansion and the AMA's plan to cover the uninsured, adding that these resources are available on the AMA website. An amendment to the first Resolve clause aimed to clarify that Medicaid payment rates should be increased to at least Medicare rates. However, a majority of the testimony opposed linking support for Medicaid expansion with increased payment rates. Your Reference Committee notes that existing AMA policy maintains that Medicaid should pay physicians a minimum of 100 percent of Medicare rates (Policy H-385.921 and H-290.976).

Because the AMA has already developed resources that can be shared with physicians and the public, your Reference Committee recommends amending the second Resolve clause to direct the AMA to work with interested organizations to make those resources

available. Your Reference Committee recommends that Resolution 122 be adopted as amended with a change in title that better reflects the resolution's intent.

(10) RESOLUTION 127 – CONTINUITY OF CARE UPON RELEASE FROM CORRECTIONAL SYSTEMS

RECOMMENDATION A:

Resolution 127 be <u>amended by addition and deletion to read as follows</u>:

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

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; and (c) the provision of longitudinal care from state supported social workers, to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people ~~to support their employment, education, housing, healthcare, and safety.~~; and (d) collaboration with community-based organizations and integrated models of care that support formerly incarcerated people with regard to their health care, safety, and social determinant of health needs, including employment, education, and housing.

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. (Modify Current HOD Policy)

RECOMMENDATION B:

Resolution 127 be adopted as amended.

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

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; and (c) the provision of longitudinal care from state supported social workers to perform foundational check-ins that not only assess mental health but also develop lifestyle plans with newly released people to support their employment, education, housing, healthcare, and safety.
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. (Modify Current HOD Policy)

Testimony was very supportive of Resolution 127 and the importance of providing continuity of care to people released from incarceration. Alternate language was offered to broaden the resolution's scope to support care beyond that offered by state-supported social workers, since these social workers may not be available in every state. Your Reference Committee believes the intent of the alternate language differs from the original Resolution 127 and recommends that Policy H-430.986[10] be amended to incorporate both the original and alternate language. Therefore, your Reference Committee recommends that Resolution 127 be adopted as amended.

RECOMMENDED FOR ADOPTION IN LIEU OF

(11) RESOLUTION 108 – PAYMENT FOR REGADENOSON (LEXISCAN)

RECOMMENDATION:

Alternate Resolution 108 be adopted <u>in lieu of Resolution 108</u>.

PAYMENT FOR PHYSICIAN-PURCHASED MEDICATIONS AND DIAGNOSTIC IMAGING AGENTS

RESOLVED, That our AMA advocate that health plan payments for drugs fully cover the physician's acquisition, inventory and carrying cost and that payments for drug administration and related services are adequate to ensure continued patient access to needed services and treatments. (New HOD Policy)

RESOLVED, That our American Medical Association petition the Centers for Medicare and Medicaid Services to investigate the disparity between the cost of medical agents and the reimbursement by insurance companies and develop a solution so physicians are not financially harmed when providing medical agents. (Directive to Take Action) (Modify Current HOD Policy)

Your Reference Committee heard mixed testimony on Resolution 108 with inclination of support given two separate amendments that were offered. A member of the Council on Medical Service proffered alternate Resolved wording to ensure the new policy is applicable to all scenarios raised in the resolution. This amendment was supported by other delegates; therefore, your Reference Committee is offering this alternate resolution language in lieu of original Resolution 108. Additionally, there was supportive testimony on the proffered title amendment to broaden the intent of the resolution beyond the sole pharmacologic agent “Regadenoson (Lexiscan)”. Therefore, your Reference Committee recommends adoption of Alternate Resolution 108 in lieu of Resolution 108.

(12) RESOLUTION 113 – PREVENTION OF HEARING LOSS-ASSOCIATED-COGNITIVE-IMPAIRMENT THROUGH EARLIER RECOGNITION AND REMEDIATION
RESOLUTION 114 – ORAL HEALTHCARE IS HEALTHCARE
RESOLUTION 119 – MEDICARE COVERAGE OF DENTAL, VISION, AND HEARING SERVICES

RECOMMENDATION:

Alternate Resolution 113 be adopted <u>in lieu of Resolutions 113, 114 and 119</u>.

INCREASING PATIENT ACCESS TO HEARING, DENTAL AND VISION SERVICES

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to encourage and promote research into hearing loss as a contributor to cognitive impairment, and to increase patient access to hearing loss identification and remediation services. (New HOD Policy); and be it further

RESOLVED, That our AMA work with interested national medical specialty societies and state medical associations to encourage and promote research into vision and dental health and to increase patient access to vision and dental services. (New HOD Policy); and be it further

RESOLVED, That our AMA study the impacts of covering vision, hearing, and dental benefits under the Medicare program. (Directive to Take Action)

RESOLUTION 113

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

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

RESOLVED, That our AMA advocate for increased hearing screening, and expanding all avenues for third party coverage for effective hearing loss remediation beginning in mid-life or whenever detected, especially when such loss is shown conclusively to contribute

significantly to the development of, or to magnify the functional deficits of cognitive impairment, and/or to limit the capacity of individuals for independent living. (Directive to Take Action)

RESOLUTION 114

RESOLVED, That our American Medical Association reaffirm that dental and oral health are integral components of basic health care and maintenance regardless of age (Reaffirm HOD Policy); and be it further

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

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

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

RESOLUTION 119

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

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

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

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, aural rehabilitative services, and hearing aids 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. (Modify Current HOD Policy)

Testimony on Resolution 113, Resolution 114 and Resolution 119 was mixed, each with calls for referral. Despite the mixed testimony, your Reference Committee heard numerous speakers in support of what each resolution is aiming to achieve – ultimately ensuring that our patients have access to and coverage of needed hearing, dental and vision services.

However, commenters noted that some of the asks of the resolutions did not align with USPSTF recommendations. Speakers noted that the USPSTF has concluded that there is insufficient evidence to recommend for or against screening for hearing loss in adults 50 years and over. Likewise, another commenter noted that the USPSTF concluded that the current evidence is insufficient to assess the balance of benefits and harms of screening for impaired visual acuity in older adults. As a result, there were calls for our AMA to support research into vision and dental health, as well as hearing loss as a contributor to cognitive impairment.

Testimony stressed that the expansion of health insurance coverage, and potentially Medicare benefits, of hearing, dental and vision services needs to be considered not only from the patient perspective but within the context of a Medicare payment infrastructure that is unsustainable for physician practices. In response to concerns raised regarding how coverage of these services in Medicare was going to be paid for, an amendment was proffered to ensure that our AMA supports new Medicare funding that is independent of the physician fee schedule to pay for the coverage of these services. However, your Reference Committee notes that expanding hearing, dental and vision coverage will still require “pay-fors” in the current congressional environment, pitting this against other AMA priorities that need funding. Also, other programs and issues of priority to our AMA could still be targets to achieve the necessary cost savings to pay for this dramatic expansion of Medicare coverage. In addition, there are other complicating factors in covering these services under Medicare, including the FDA’s recent ruling enabling hearing aids for mild to moderate hearing loss to be made available over the counter. The FDA’s action complicates the coverage issue since OTC items generally aren’t covered by insurance.

A member of Council on Medical Service offered alternate language to address the intent of Resolutions 113, 114 and 119, which your Reference Committee is proposing as part of Alternate Resolution 113. Your Reference Committee also recognizes that recent debates in Congress about expanding Medicare benefits have garnered substantial attention, underscoring the need for our AMA to study the impacts of covering vision, hearing, and dental benefits under the Medicare program. Accordingly, your Reference Committee recommends that Alternate Resolution 113 be adopted in lieu of Resolutions 113, 114 and 119.

(13) RESOLUTION 120 – EXPANDING COVERAGE FOR AND ACCESS TO PULMONARY REHABILITATION

RECOMMENDATION:

Alternate Resolution 120 be adopted <u>in lieu of Resolution 120</u>.

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations to support improved availability of pulmonary rehabilitation services, such as through better insurance coverage, for patients with chronic lung disease or chronic shortness of breath. (New HOD Policy)

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

Your Reference Committee heard supportive testimony on Resolution 120. A majority of testimony supported expanding access to pulmonary rehabilitation and noted the increased need for this service because of COVID-19. One commenter cautioned against adopting policy that advocates for new benefit mandates while another suggested changing the resolution's scope to support access to pulmonary rehabilitation for symptomatic patients with moderate to severe respiratory impairment. However, testimony favored using the terms "chronic lung disease or chronic shortness of breath" instead of moderate to severe respiratory impairment. A member of the Council on Medical Service offered alternate language that is consistent with AMA policy on benefit mandates while addressing the resolution's intent. Because testimony supported this alternate language, your Reference Committee recommends that Alternate Resolution 120 be adopted.

(14) RESOLUTION 123 – ADVOCATING FOR ALL PAYER COVERAGE OF COSMETIC TREATMENT FOR SURVIVORS OF DOMESTIC ABUSE AND INTIMATE PARTNER VIOLENCE

RECOMMENDATION:

Alternate Resolution 123 be adopted <u>in lieu of Resolution 123</u>.

ADVOCATING FOR ALL-PAYER COVERAGE OF RECONSTRUCTIVE TREATMENT FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE

RESOLVED, That our American Medical Association work with interested national medical specialty societies and state medical associations, payers, and other relevant stakeholders to encourage insurance coverage of and payment for reconstructive services for the treatment of physical injury sustained from intimate partner violence. (New HOD Policy)

RESOLVED, That our American Medical Association urge all payers to consider aesthetic treatments for physical lesions sustained from injuries of domestic and intimate partner violence as restorative treatments (Directive to Take Action); and be it further

RESOLVED, That our AMA work with relevant stakeholders such as medical specialty societies, third party payers, the Centers for Medicare and Medicaid Service, and other national stakeholders as deemed appropriate to require third party payers to include reimbursement for necessary aesthetic service for the treatment of physical injury sustained along with medically necessary restorative care for victims of domestic abuse. (Directive to Take Action)

Your Reference Committee heard mixed testimony on Resolution 123. Amendments and alternate Resolve clauses were proffered, including alternate language and a change in title submitted by the resolution's author. A member of the Council on Medical Service testified in support of the resolution's intent but suggested alternate language that would be more consistent with AMA policy on benefit mandates. Testimony generally supported deletion of references to aesthetic services with the focus instead on payment for reconstructive services for the treatment of physical injuries sustained from intimate partner violence. Your Reference Committee recommends adoption of Alternate Resolution 123 in lieu of Resolution 123.

RECOMMENDED FOR REFERRAL

(15) RESOLUTION 111 – BUNDLED PAYMENTS AND MEDICALLY NECESSARY CARE

RECOMMENDATION:

Resolution 111 be <u>referred</u>.

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

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

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

Your Reference Committee heard mixed testimony on the Resolution 111, with calls for referral. A member of the Council on Medical Service welcomed referral of the resolution and suggested that further study is needed on Medicaid episodes of care. Your Reference Committee believes that such a comprehensive study will be helpful in guiding future AMA policy development pertaining to payment reform. Accordingly, your Reference Committee recommends that Resolution 111 be referred.

RECOMMENDED FOR NOT ADOPTION

(16) RESOLUTION 103 – COBRA FOR COLLEGE STUDENTS

RECOMMENDATION:

Resolution 103 <u>not be adopted</u>.

RESOLVED, That our American Medical Association call for legislation similar to COBRA to allow college students to continue their healthcare coverage, at their own expense, for up to 18 months after graduation or other termination of enrollment. (Directive to Take Action)

Testimony on Resolution 103 was mixed. Testimony, including from a member of the Council on Medical Service, noted that graduating college students already have access to four avenues for accessing health insurance coverage: 1) they can stay on their parents' health plan up to age 26; 2) they can qualify for premium tax credits to purchase coverage on ACA marketplaces (made even more affordable under the American Rescue Plan); 3) they can secure coverage through new employment; or 4) they can qualify for Medicaid based on their income and state of residence. In addition, the member of the Council on Medical Service underscored that numerous AMA policies already address health insurance coverage of young adults, including graduating college students. Another noted that the continuous-coverage rationale for COBRA was obviated due to the aforementioned ACA mechanisms. Testimony in support of Resolution 103 indicated that the existing avenues for coverage available to graduating college students are difficult to navigate and insufficient in some circumstances.

With the existing coverage options available to graduating college students, your Reference Committee believes that requiring continuous coverage for plans offered to college students would require a tremendous legislative lift without offering substantial benefits to the affected population. Significantly, modeling continuous student coverage after COBRA would mean that graduating college students may face higher premiums for the same coverage, as they would be responsible for the full cost. In addition, your Reference Committee notes that requiring continuing coverage for graduating colleges students would have unintended consequences. First, not all health plans targeting college students are considered "student health plans" under current law, including short-term plans that do not have to be ACA-compliant. Also, if universities choose to self-insure their student health plans, these plans are not required to come into compliance with the ACA and therefore would not be subject to HHS regulation. Finally, even for some universities that have ACA-compliant health plans, there is not guaranteed coverage of contraceptives due to existing exemptions available. As such, your Reference Committee recommends that Resolution 103 not be adopted.

(17) RESOLUTION 110 – PRIVATE PAYOR PAYMENT INTEGRITY

RECOMMENDATION:

Resolution 110 <u>not be adopted</u>.

RESOLVED, That our American Medical Association advocate for private insurers to require, at a minimum, to pay for diagnosis and treatment options that are covered by government payers such as Medicare (Directive to Take Action); and be it further

RESOLVED, That our AMA seek to ensure by legislative or regulatory means that private insurers shall not be allowed to deny payment for treatment options as “experimental and/or investigational” when they are covered under the government plans; such coverage shall extend to managed Medicaid, Workers' Compensation plans, and auto liability insurance companies. (Directive to Take Action)

Your Reference Committee heard testimony that was mixed, but generally opposed to Resolution 110. A member of the Council on Medical Service noted that Medicare coverage determinations should not be the default for what private health plans should cover. In addition, the member of the Council added that existing AMA policy states that benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options. This testimony, and others, highlighted the complex issues of private and government payor coverage. Accordingly, your Reference Committee recommends that Resolution 110 not be adopted.

RECOMMENDED FOR REAFFIRMATION IN LIEU OF

(18) RESOLUTION 117 – EXPANDING MEDICAID TRANSPORTATION TO INCLUDE HEALTHY GROCERY DESTINATIONS

RECOMMENDATION:

Policies H-165.822 and H-150.925 be reaffirmed in lieu of Resolution 117.

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

Testimony on Resolution 117 was mixed. Alternate Resolved wording was introduced by the sponsor of Resolution 117 for our AMA to advocate for CMS and other relevant agencies to develop, test, and implement innovative models to address food insecurity, such as food delivery and transportation to locations such as supermarkets, food banks, pantries, and local farmer's markets for healthy food options. Another alternate Resolved wording option was offered for the AMA to advocate for the creation and support of programs that provide patients eligible for Medicaid transportation to supermarkets, food banks and pantries, and local farmers' markets.

Testimony raised concerns regarding the cost of covering non-medical transportation under Medicaid, and the difficulties associated with implementing the asks of Resolution 117. A speaker noted that there are certain opportunities for states to cover certain non-clinical services under the Medicaid benefit package. States may use the 1915(i) state plan option to cover case management services (such as providing assistance signing up for other social services), the 1915(c) waiver authority to cover home and community based services, and the 1115 demonstration waiver authority to make other changes to Medicaid that would otherwise not be permitted. Your Reference Committee notes that the avenues through which social determinants of health such as transportation and access to food and food security can be addressed in the Medicaid program was recently studied by the Council on Medical Service in 2020.

The resulting policy, Policy H-165.822, supports continued efforts by public and private health plans to address social determinants of health – including access to food and food security – in health insurance benefit designs. In addition, the policy encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. Accordingly, a member of the Council on Medical Service recommended that this policy be reaffirmed in lieu of Resolution 117. Your References Committee notes that Policy H-150.925 also addresses challenges accessing healthy foods. Your Reference

Committee recommends that Policies H-165.822 and H-150.925 be reaffirmed in lieu of Resolution 117.

Health Plan Initiatives Addressing Social Determinants of Health H-165.822
Our AMA:
1. recognizing that social determinants of health encompass more than health care, encourages new and continued partnerships among all levels of government, the private sector, philanthropic organizations, and community- and faith-based organizations to address non-medical, yet critical health needs and the underlying social determinants of health;
2. supports continued efforts by public and private health plans to address social determinants of health in health insurance benefit designs;
3. encourages public and private health plans to examine implicit bias and the role of racism and social determinants of health, including through such mechanisms as professional development and other training;
4. supports mechanisms, including the establishment of incentives, to improve the acquisition of data related to social determinants of health, while minimizing burdens on patients and physicians;
5. supports research to determine how best to integrate and finance non-medical services as part of health insurance benefit design, and the impact of covering non-medical benefits on health care and societal costs; and
6. encourages coverage pilots to test the impacts of addressing certain non-medical, yet critical health needs, for which sufficient data and evidence are not available, on health outcomes and health care costs. (CMS Rep. 7, I-20; Reaffirmed: CMS Rep. 5, I-21)

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)

(19) RESOLUTION 124 – TO REQUIRE INSURANCE COMPANIES MAKE THE “COVERAGE YEAR” AND THE “DEDUCTIBLE YEAR” SIMULTANEOUS FOR THEIR POLICIES

RECOMMENDATION:

Policy H-180.955 be reaffirmed in lieu of Resolution 124.

RESOLVED, That our American Medical Association advocate and support legislation to require all commercial insurance carriers to align their policies such that a policy holder’s “deductible year” and “coverage year” be the same time period for all policies. (Directive to Take Action)

There was limited testimony on Resolution 124. A member of the Council on Medical Service testified that existing policy more effectively addresses the underlying issues raised in the resolution. Policy H-180.955 supports legislation, regulation or other appropriate relief to require insurers to prorate annual deductibles to the date of contract enrollment. As such, your Reference Committee recommends that existing policy be reaffirmed in lieu of Resolution 124.

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

Mister Speaker, this concludes the report of Reference Committee A. I would like to thank Robert C. Gibbs, MD, Jay A. Gregory, MD, Tra'Chella Johnson Foy, MD, Joyce C. Lee, Sarah M. Marsicek, MD, Scott H. Pasichow, MD, and all those who testified before the Committee. I would also like to thank AMA staff: Courtney Perlino, MPP, Jane Ascroft, MPA, and Katie Palmer, MPH.

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