

AMERICAN MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution: 245  
(A-24)

Introduced by: Texas

Subject: Patient Access to Covered Benefits Ordered by Out-of-Network Physicians

Referred to: Reference Committee B

1 Whereas, rising health care costs, employer-directed benefit design, and network adequacy are  
2 issues that impact patients' ability to access care from their preferred physicians; and  
3

4 Whereas, the health care marketplace is increasingly hostile to solo, small, and independent  
5 practices through factors such as low payment rates that fail to keep up with inflation, increasing  
6 administrative burdens, the inability to find and retain staff, and exclusion from physician  
7 networks due to market consolidation and vertical integration; and  
8

9 Whereas, as a means to sustain their practices, a growing number of independent physicians  
10 are employing new direct-contracting care delivery and payment models to offer efficient,  
11 evidence-based, quality care without accepting insurance as payment; and  
12

13 Whereas, many health plans will not cover diagnostic studies, referrals, and/or prescription  
14 medications when ordered by out-of-network physicians although they are covered benefits  
15 delivered by physicians with long-standing patient relationships; and  
16

17 Whereas, noncoverage of valid orders for covered health plan benefits is another attempt by  
18 health plans to restrict access to covered benefits and leads to delays in care, increased costs  
19 to patients, and redundancy and inefficiency in the health care system; therefore be it  
20

21 RESOLVED, that our American Medical Association develop model legislation to protect  
22 patients managed by out-of-network physicians by prohibiting insurance plans from denying  
23 payment for covered services, based solely on the network participation of the ordering  
24 physician (Directive to Take Action); and be it further  
25

26 RESOLVED, that our AMA develop resources, toolkits, and education to support out-of-network  
27 care models. (Directive to Take Action)  
28

Fiscal Note: Resolve 1: Modest. Resolve 2: \$22,980 Develop a comprehensive portfolio of  
education, experts, and toolkits

Received: 5/10/2024

**REFERENCES**

1. Physicians Advocacy Institute. [Physician Employment Trends and Acquisitions of Medical Practices 2019-2023](#). Prepared by Avalere Health.
2. Cobra KL. Direct primary care may be the link to the 'fourth aim' of healthcare. Medical Economics. July 11, 2018. Accessed Jan. 12, 2021. [www.medicaleconomics.com/view/direct-primary-care-may-be-link-fourth-aim-healthcare](http://www.medicaleconomics.com/view/direct-primary-care-may-be-link-fourth-aim-healthcare).
3. Mechley AR. Direct primary care: a successful financial model for the clinical practice of lifestyle medicine. *AM J Lifestyle Med*, 2021 Sept-Oct 15(5):557-562. [www.ncbi.nlm.nih.gov/pmc/articles/PMC8504342/](http://www.ncbi.nlm.nih.gov/pmc/articles/PMC8504342/).
4. The Heritage Foundation Backgrounder No. 3635. Direct primary care: update and roadmap for patient centered reforms. June 28, 2021. [www.heritage.org/sites/default/files/2021-06/BG3635.pdf](http://www.heritage.org/sites/default/files/2021-06/BG3635.pdf).

5. State of Maine Department of Professional and Financial Regulation, Bureau of Insurance. Bulletin 434. Referrals by out-of-network direct primary care providers. June 7, 2019. [www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/434.pdf](http://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/434.pdf).
6. Dowd BE and Laugesen MJ. Fee-for-service is not the (main) problem. *Health Services Research*. 2020 Aug;55(4) 491-495. <https://pubmed.ncbi.nlm.nih.gov/32700387/>.

## RELEVANT AMA POLICY

### Direct Primary Care H-385.912

1. Our AMA supports: (a) inclusion of Direct Primary Care as a qualified medical expense by the Internal Revenue Service; and (b) efforts to ensure that patients in Direct Primary Care practices have access to specialty care, including efforts to oppose payer policies that prevent referrals to in-network specialists.

2. AMA policy is that the use of a health savings account (HSA) to access direct primary care providers and/or to receive care from a direct primary care medical home constitutes a bona fide medical expense, and that particular sections of the IRS code related to qualified medical expenses should be amended to recognize the use of HSA funds for direct primary care and direct primary care medical home models as a qualified medical expense.

3. Our AMA will seek federal legislation or regulation, as necessary, to amend appropriate sections of the IRS code to specify that direct primary care access or direct primary care medical homes are not health "plans" and that the use of HSA funds to pay for direct primary care provider services in such settings constitutes a qualified medical expense, enabling patients to use HSAs to help pay for Direct Primary Care and to enter DPC periodic-fee agreements without IRS interference or penalty. [Res. 103, A-16; Appended: Res. 246, A-18; Reaffirmation: A-18; Reaffirmation: I-18 Appended: Res. 102, A-19]

### Out-of-Network Care H-285.904

1. Our AMA adopts the following principles related to unanticipated out-of-network care:
  - A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
  - B. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
  - C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
  - D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
  - E. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
  - F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
  - G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
  - H. Independent Dispute Resolution (IDR) should be allowed in all circumstances as an option or alternative to come to payment resolution between insurers and physicians.
2. Our AMA will advocate for the principles delineated in Policy H-285.904 for all health plans, including ERISA plans.
3. Our AMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges. [Res. 108, A-17; Reaffirmation: A-18; Appended: Res. 104, A-18; Reaffirmed in lieu of: Res. 225, I-18; Reaffirmation: A-19; Reaffirmed: Res. 210, A-19; Appended: Res. 211, A-19; Reaffirmed: CMS Rep. 5, A-21; Modified: Res. 236, A-22; Reaffirmed: CMS Res., I-23; Reaffirmed: CMS Rep. 3, I-23]

**Out-of-Network Care D-285.962**

Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care. [Res. 108, A-17]

**Out-of-Network Restrictions of Physicians H-285.907**

Our American Medical Association opposes the denial of payment for a medically necessary prescription of a drug or service covered by the policy based solely on the network participation of the duly licensed physician ordering it. [Res. 126, A-15]

**Out-of-Network Coverage Denials for Physician Prescriptions and Ordered Services D-285.963**

Our American Medical Association will pursue regulation or legislation to prohibit any insurer from writing individual or group policies which deny or unreasonably delay coverage of medically necessary prescription drugs or services based on network distinctions of the licensed health care provider ordering the drug or service. [Res. 119, A-15]

**Physician Penalties for Out-of-Network Services H-180.952**

Our AMA vehemently opposes any penalties implemented by insurance companies against physicians when patients independently choose to obtain out-of-network services. [Res. 702, A-07; Reaffirmed: CMS Rep. 01, A-17]

**Subacute Care Standards for Physicians H-160.945**

AMA guidelines for physicians' responsibilities in subacute care include: (1) Physicians are responsible to their patients for delivery of care in all subacute care settings, 24 hours a day, 7 days a week. (2) Patients who might benefit from subacute care should be admitted to and discharged under the orders of the physician who is responsible for the continuous medical management needed to meet the patient's needs and safety and maintaining quality of care. (3) Physicians are responsible for coordinating care for their patients with other physicians including medical directors, primary care physicians, and appropriate specialists, to optimize the quality of care in subacute settings. (4) Physicians are responsible for supervision and coordination of the medical care for their patients and providing leadership for all other health care providers in subacute care. (5) Physicians should guide procedures for their patients performed within integrated practices and direct other health care providers, consistent with federal and state regulations. (6) Physicians are responsible for: (a) Fulfilling their roles and identifying the medical skills needed to deliver care in subacute facilities and for creating and developing continuing medical education to meet the special needs of patients in subacute care. (b) Identifying and appropriately utilizing subacute care facilities in their communities. (c) Oversight of physician credentialing in subacute settings (d) Promoting medical staff organization and by-laws that may be needed to support peer evaluations. (e) Planning care of their patients with acute and chronic conditions in subacute care, as well as pursuing efforts to restore and maintain functions for quality of life. (7) Subacute units and/or programs need physician medical directors to assure quality of medical care, provide peer group liaisons, and coordinate and supervise patients and families input and needs. (8) Physicians provide a plan of care for medically necessary visits after completing an initial assessment within 24 hours of admission that identifies the medical services expected during subacute care. (9) Attending physicians should: (a) make an on-site visit to review the interdisciplinary care plan within seventy two hours of admission. (b) Determine the number of medically necessary follow up visits; these may occur daily but never less often than weekly. (c) Document active involvement of physicians in interdisciplinary care and all major components of the patient care plan including completing a progress note for each patient visit. (10) Physicians should implement these guidelines through organized medical staff by-laws in subacute settings to assure quality patient care. [BOT Rep. 21, I-95; Reaffirmed: CMS Rep. 7, A-05; Reaffirmed: CMS Rep. 1, A-15]